

The Sustainable Development Goals Extended Report 2024

Inputs and information provided as of 30 April 2024

3 GOOD HEALTH AND WELL-BEING



Note: This unedited 'Extended Report' includes all indicator storyline contents as provided by the SDG indicator custodian agencies as of 30 April 2024. 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.

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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

A woman dies of preventable pregnancy-related causes every 2 minutes - every single one of these is a tragic loss of life

Between 2015 and 2020, the global maternal mortality ratio (MMR) almost stagnated, with only a marginally declined from 227 deaths per 100 000 live births in 2015 to 223 in 2020. The MMR of 223 in 2020 is over three times higher than the global target of 70 maternal deaths by 2030. Reaching this target requires an annual rate of reduction of 11 per cent between 2021 and 2030. Approximately 95% of all maternal deaths occurred in low and lower-middle-income countries in 2020, with sub-Saharan Africa accounting for 70% of these deaths. In 2020, the global lifetime risk of maternal mortality was estimated at one in 210; the lifetime risk of maternal death was one in 40 in sub-Saharan Africa compared to one in 16 000 in Australia and New Zealand. Humanitarian, conflict, and post-conflict settings hinder progress in reducing the burden of maternal mortality. In 2020, nine countries included in the Fragile States Index were in the category “very high alert” or “high alert” (from highest [most fragile] to lowest [least fragile]: Yemen, Somalia, South Sudan, the Syrian Arab Republic, the Democratic Republic of the Congo, the Central African Republic, Chad, Sudan and Afghanistan); these countries had MMRs ranging from 30 (the Syrian Arab Republic) to 1223 (South Sudan) in 2020. The average MMR for very high and high alert fragile states in 2020 was 551 per 100 000, over double the world average.

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Custodian agency(ies): WHO

Indicator 3.1.2 Proportion of births attended by skilled health personnel

Halfway to the SDG 2030 target, momentum is slowing in ensuring every woman receives competent, quality, and respectful childbirth care

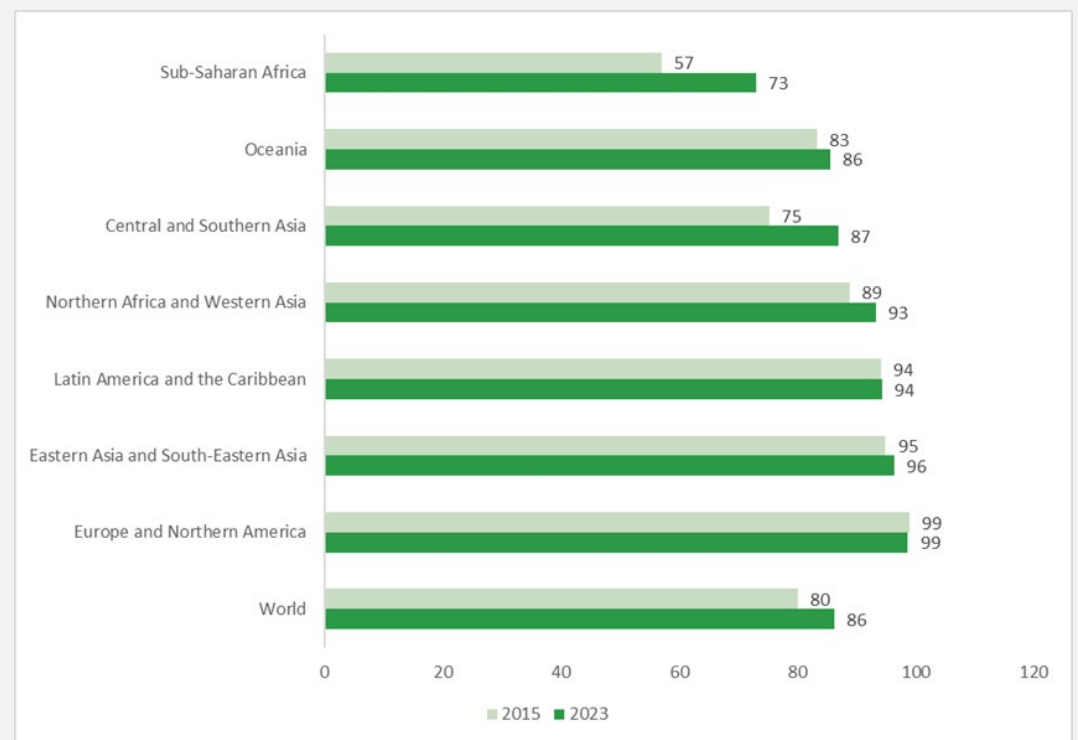
Skilled health personnel, including doctors, nurses, and midwives, are crucial to preventing maternal and newborn deaths. As we pass the midpoint of the 2030 Sustainable Development Goals timeline, the percentage of births attended by skilled professionals globally has increased from 79 per cent in 2015 to 86 per cent in 2023. However, 18 million births still occurred without skilled assistance in 2023. The slowdown in progress is also observed in maternal mortality and stillbirths, reflecting ongoing quality gaps despite higher coverage. Improved care quality could save up to 1 million newborns and 150,000 maternal lives annually. Delayed access to quality care contributes significantly to preventable deaths and stillbirths. Many health settings fail to meet WHO standards for quality maternal and newborn care, often due to a lack of person-centered care.

The Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM) are initiatives providing clear targets to improve the provision of quality and respectful assistance from skilled attendants during birth, with the goal of reaching 90 per cent globally by 2025. Only 73 per cent of births are attended by skilled personnel in sub-Saharan Africa the region with the lowest coverage, highlighting persistent inequities. In contrast, regions like Eastern Asia and South-Eastern Asia show impressive progress, with 96 per cent of births attended by skilled health personnel. Even within regions with high overall coverage, pockets of low access persist. There is a need for greater sub-national focus in planning, budgeting, and resource allocation for maternal and newborn health services to ensure timely and equitable access to quality care during birth.

Looking ahead, the escalating frequency of crises imperils maternal and newborn health progress by severely disrupting healthcare systems. Despite coverage of skilled health personnel demonstrating resilience compared to other health services, even minor disruptions can have fatal consequences. The most recent maternal mortality figures show that in 2020, approximately 287,000 women died during or following pregnancy and childbirth, while an estimated 2.3 million newborns died in 2021, with the majority of deaths occurring in low- and middle-income countries. Access to skilled health personnel during childbirth, who are prepared to manage potential complications and provide critical medical care, could prevent many of these deaths, underscoring the importance of maintaining and expanding such services even in the face of global crises.

Meeting global targets will require investment in healthcare infrastructure, quality improvement, training, and workforce development, particularly in underserved areas. Access to skilled health personnel during childbirth is crucial for improving health outcomes, advancing equity, strengthening health systems, and building resilience against future challenges. Significant progress has been made halfway to the 2030 SDG deadline, but much work remains to ensure safe, respectful childbirth for all women.

Percentage of birth attended by skilled health personnel, 2015 and 2023 (%)



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

Meeting SDG targets saves lives: More than 9 million lives of children under five could be saved between 2023 and 2030, if all countries reached the SDG under-5 mortality target

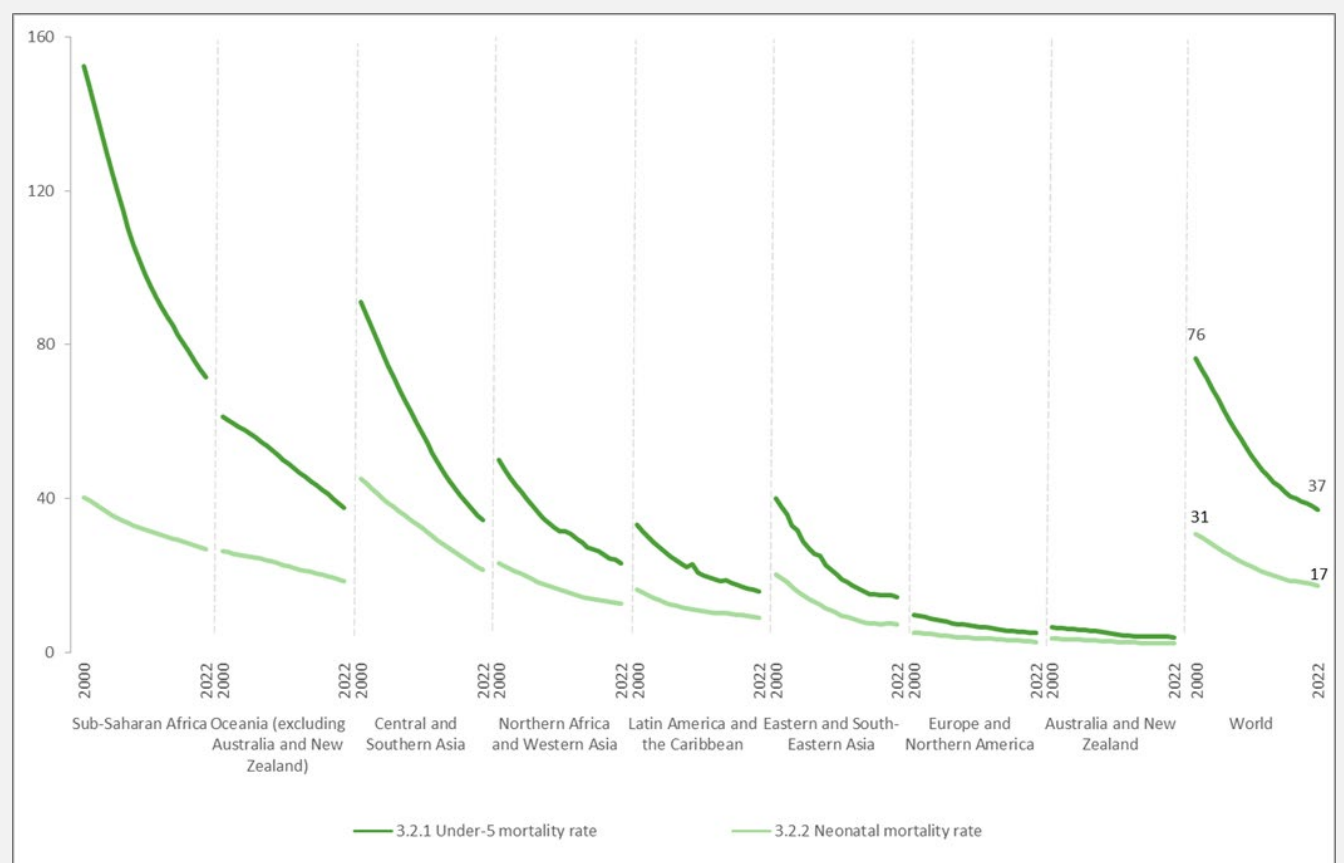
Global progress in reducing the risk of death to those under five years of age has led to fewer children dying before turning 5 than ever recorded, with 4.9 million under-five deaths in 2022 (2.3 million of which occurred in the neonatal period). The global under-5 mortality rate (U5MR) fell to 37 deaths per 1,000 live births in 2022, a 51 per cent reduction from the 2000 U5MR of 76 deaths and a 14 per cent reduction from the 2015 U5MR of 43 deaths. The global neonatal mortality rate (NMR) fell to 17 deaths per 1,000 live births in 2022, a 44 per cent reduction from the 2000 NMR of 31 deaths and a 12 per cent reduction from the 2015 NMR of 20 deaths. Moreover, progress in reducing under-five and neonatal mortality has slowed since 2015 (i.e., 2015–2022) compared to the period 2000–2015. Globally, the annual rate of reduction (ARR) in under-five mortality decreased from 3.8 per cent in 2000–2015 to 2.1 per cent in 2015–2022, while the trend in global neonatal mortality reduction followed a similar pattern, with the ARR decreasing from 3.0 per cent in 2000–2015 to 1.8 per cent in 2015–2022.

Despite that global progress and historic low in the number of global under-five deaths, children continue to face persistent regional disparities in their chances of survival. Children born in sub-Saharan Africa are subject to the highest regional risk of childhood death in the world, with a 2022 U5MR of 71 deaths per 1,000 live births, 18 times that of the lowest mortality region, Australia and New Zealand. Similarly, sub-Saharan Africa had the highest regional NMR in the world in 2022 at 27 deaths per 1,000 live births, 11 times the risk in the lowest neonatal mortality region, Australia and New Zealand.

As of 2022, 134 countries had already met the SDG target on under-five mortality, and seven countries are expected to do so by 2030, if current trends continue. However, progress will need to accelerate in 59 countries, nearly 75 per cent of which are located sub-Saharan Africa, to meet the target by 2030. Even more countries are at risk of missing the neonatal SDG target. While 126 countries have already met the target and another 10 are on pace to do so by 2030, 64 countries will need to increase the pace of mortality decline to meet the target on time.

If current trends continue, an estimated 35 million children under age 5 will die by 2030. But that dire scenario is not inevitable: if all countries met or exceeded the SDG target on under-five mortality, 9 million of those lives could be saved. Most under-five deaths take place in low- and lower-middle-income countries, where children's lives are dependent on the continued and increased coverage of life saving interventions. If progress in reducing under-five mortality is to continue, it is critical to maintain essential care and services.

Under-5 and neonatal mortality rate by region, 2000-2022 (deaths per 1,000 live births)



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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

HIV successes are saving millions of lives thanks to the leadership of communities and countries, but AIDS is not over!

Two decades ago, the global AIDS pandemic seemed unstoppable. More than 2.5 million people were acquiring HIV each year and AIDS was claiming two million lives annually. In 2022, 29.8 million of the 39 million [33.1 million–45.7 million] people living with HIV globally were receiving life-saving treatment. The estimated 1.3 million [1.0 million–1.7 million] new HIV infections in 2022 were over a third (38%) fewer than in 2010. Sub-Saharan Africa, the region with the highest HIV burden, has achieved a 55% reduction in annual new HIV infections since 2010. The steepest drops in numbers of new infections have been among children (aged 0–14 years) and young people (aged 15–24 years), who in recent years have been targeted with effective interventions.

Progress towards ending the AIDS pandemic has led to spillover effects, contributing to progress across multiple SDGs. The integration of HIV testing and treatment with maternal and childcare services has prevented over 3.4 million HIV infections in children since 2000. Thanks to the stronger integration of HIV and TB services, an estimated 6.4 million TB-related deaths have been averted among people living with HIV between 2010 and 2022.

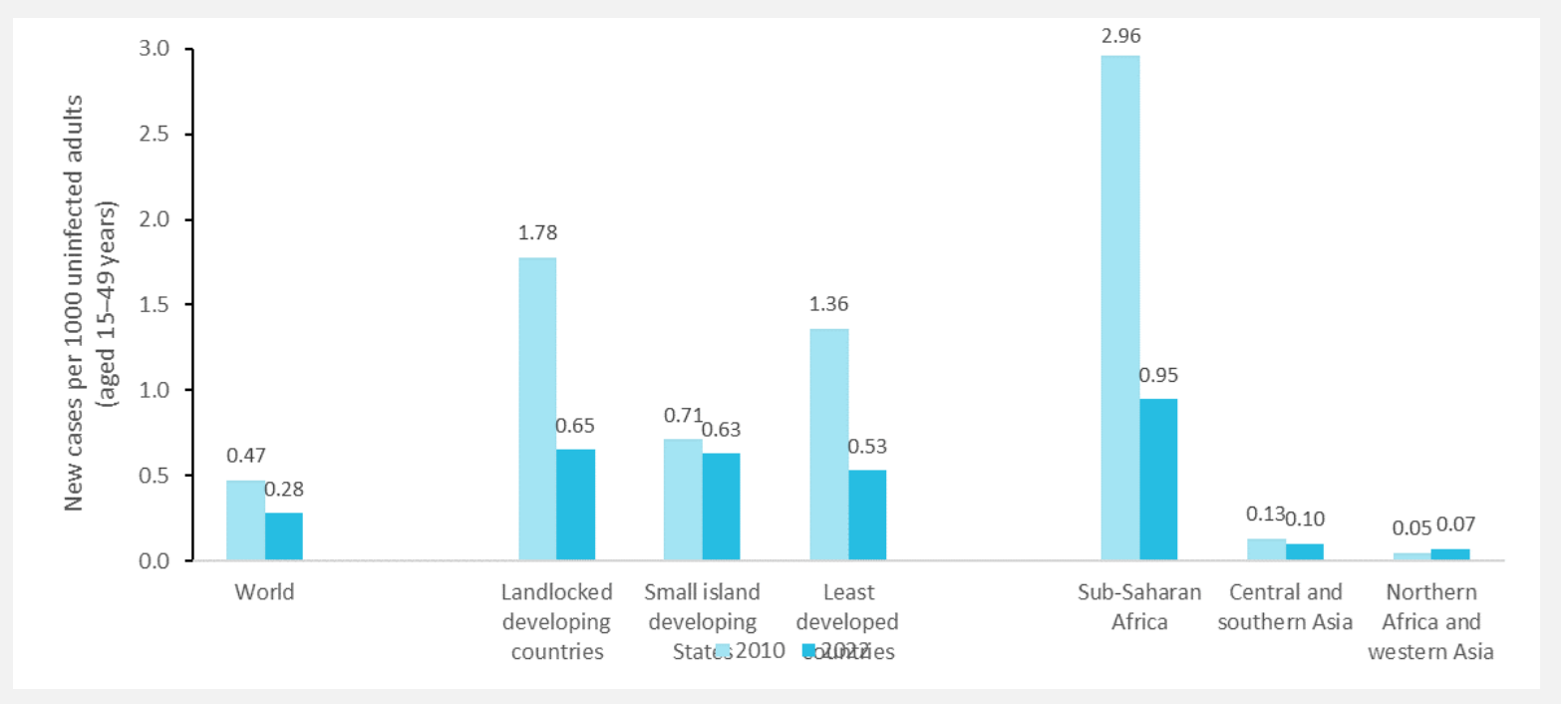
However, while increased access to HIV treatment has averted almost 20.8 million AIDS-related deaths in the past three decades, in a world marked by inequalities, not everyone is benefiting. Failure to protect people against HIV within key and other priority populations, including in humanitarian settings, will prolong the pandemic indefinitely, at huge cost to the affected communities and societies. In 2022, 43% of the 1.5 million [1.2 million–2.1 million] children living with HIV were not receiving treatment.

Every week, 4000 adolescent girls and young women acquired HIV; 3100 in sub-Saharan Africa where they still must contend with extraordinarily high risks of acquiring HIV infection. Beyond sub-Saharan Africa, reductions in new HIV infections have been modest. Almost a quarter of new HIV infections (24%) were in Asia in 2022, where numbers of new HIV infections are rising alarmingly in some countries. Steep increases in numbers of new HIV infections have continued in Western Asia and Northern Africa (75% increase). These trends are due primarily to a lack of prevention services for people from marginalized and key populations and to the barriers posed by punitive laws, violence and social stigma and discrimination. A backdrop to many of the remaining challenges is the widening funding gap for the global HIV response. A total of US\$ 20.8 billion was available for HIV programmes in low- and middle-income countries in 2022—2.6% less than in 2021 and well short of the US\$ 29.3 billion needed by 2025.

HIV responses succeed when they are: 1) anchored in the leadership of countries and communities; 2) follow the data and science; 3) protect human rights and tackle the inequalities holding back progress; 4) enable communities and civil society organizations in their vital role in the response; and, 5) ensure sufficient and sustainable funding. Progress on ending AIDS as a public health threat extends beyond health; it contributes to poverty reduction, building health security, empowering women, protecting LGBTQI+ rights.

The HIV response challenges discrimination through innovative partnerships, placing communities at the center and strengthening health systems globally. Overall, the HIV response has saved lives, strengthened health systems, stood for human rights; it has demonstrated the effect of our collective will, challenged intellectual property laws for health equity, and exemplified the spirit of the Agenda 2030.

HIV incidence rates among adults (aged 15–49 years), 2010 and 2022



Additional resources, press releases, etc. with links:

- [The path that ends AIDS: UNAIDS Global AIDS Update 2023 | UNAIDS](#)
- [Let Communities Lead — UNAIDS World AIDS Day report 2023 | UNAIDS](#)
- [AIDSinfo | UNAIDS](#)

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Custodian agency(ies): UNAIDS

Indicator 3.3.2 Tuberculosis incidence per 100,000 population

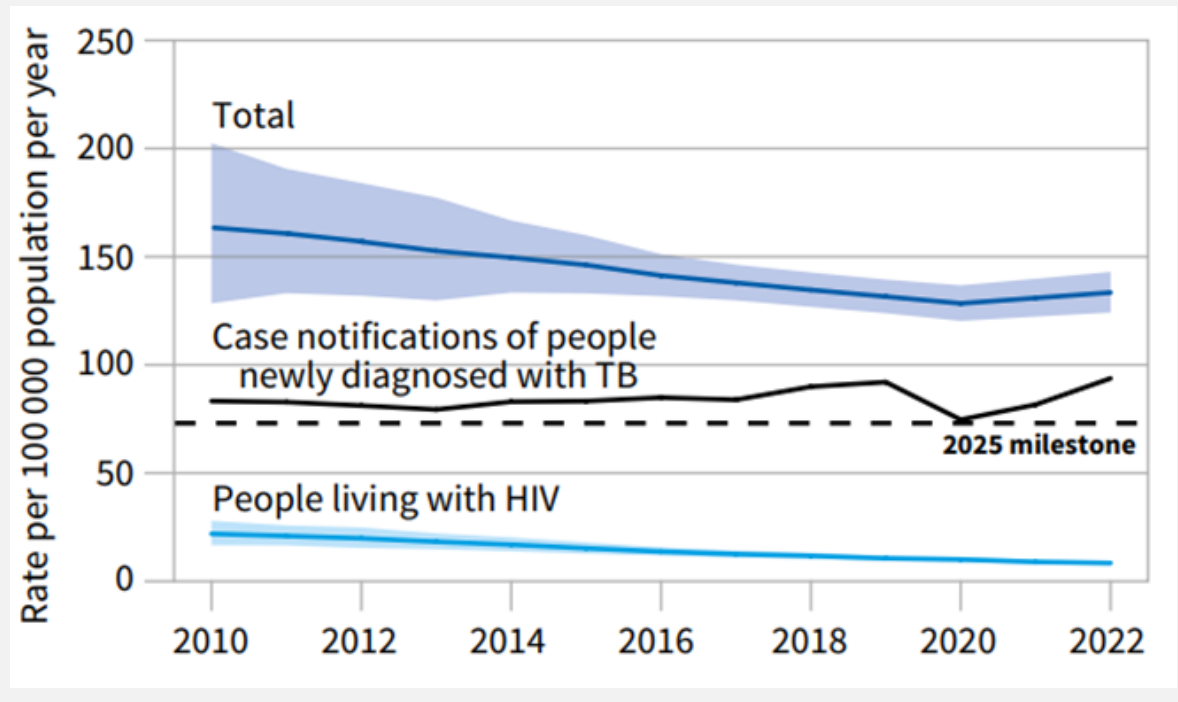
Major global recovery in the number of people diagnosed with TB but global targets to end TB epidemic are off-track

There was a major global recovery in the number of people diagnosed with TB and treated in 2022. This recovery has started to reverse or moderate the damaging impact of the pandemic on the number of people dying from, or falling ill with, TB. The reported global number of people newly diagnosed with TB was 7.5 million in 2022. This is the highest number since WHO began global TB monitoring in 1995, above the pre-COVID baseline (and previous historical peak) of 7.1 million in 2019, and up from 5.8 million in 2020 and 6.4 million in 2021. The number in 2022 probably includes a sizeable backlog of people who developed TB in previous years, but whose diagnosis and treatment was delayed by COVID-related disruptions that affected access to health services.

However, TB remained the world's second leading cause of death from a single infectious agent in 2022, after COVID-19. Globally in 2022, TB caused an estimated 1.30 million deaths (95% UI: 1.18–1.43 million). This was down from best estimates of 1.4 million in both 2020 and 2021 and almost back to the pre-pandemic level of 2019. The net reduction in the global number of deaths caused by TB from 2015 to 2022 was 19%, far from the WHO End TB Strategy milestone of a 75% reduction by 2025.

Worldwide, an estimated 10.6 million people (95% UI: 9.9–11.4 million) developed TB in 2022, up from best estimates of 10.3 million in 2021 and 10.0 million in 2020. The estimated TB incidence rate (new cases per 100 000 population per year) was 133 (95% UI: 124–143) in 2022. The net reduction from 2015 to 2022 was 8.7%, far from the WHO End TB Strategy milestone of a 50% reduction by 2025. A return to the pre-pandemic downward trend may occur in 2023 or 2024.

Global trends in the case notification rate and the estimated incidence rate: overall in blue, and among people with HIV in light blue, 2010–2022



Additional resources, press releases, etc. with links:

- Global tuberculosis report 2023: <https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2023>

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

Custodian agency(ies): WHO

Indicator 3.3.3 Malaria incidence per 1,000 population

Known and emerging threats to the global response to malaria

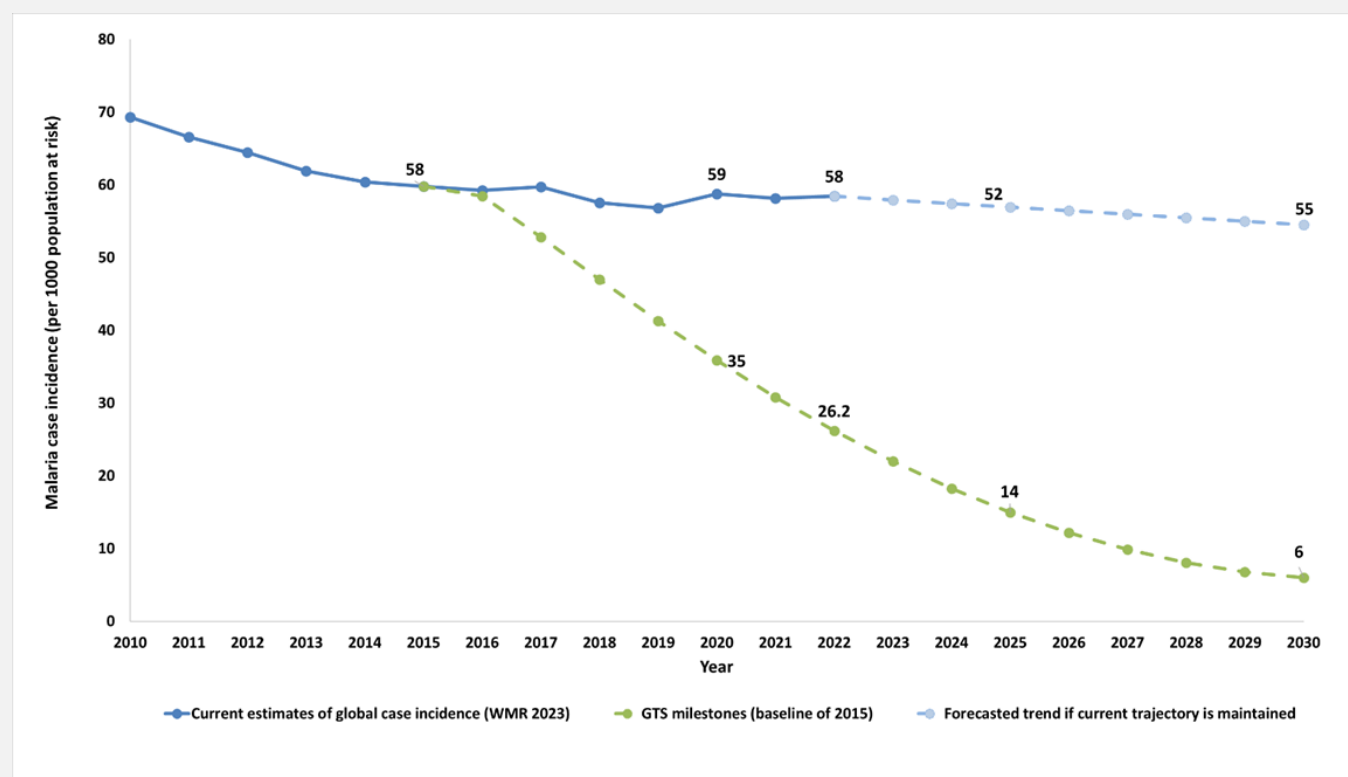
According to the latest World Malaria Report, there were an estimated 249 million malaria cases in 2022, exceeding the pre-pandemic level of 233 million. That same year, the disease claimed an estimated 608 000 lives, an increase of 32 000 compared to 2019.

Globally there were an additional five million malaria cases in 2022 compared to 2021, and five countries bore the brunt of these increases. Pakistan saw the largest increase, with about 2.6 million cases in 2022 compared to 500 000 in 2021. Significant increases were also observed in Ethiopia, Nigeria, Papua New Guinea and Uganda. Despite some progress in expanding access to WHO-recommended malaria interventions, too many people are still missing out on the services and quality care they need to prevent, detect and treat the disease.

Since 2015, for example, use of insecticide-treated nets (ITNs) among young children and pregnant women in sub-Saharan Africa has remained largely unchanged, at about 56%. An estimated 58% of pregnant women at risk of malaria in the region are still not benefiting from the recommended three or more doses of preventive malaria therapy. And about one third of children with a fever are not taken a health provider for care.

In addition to the disruptions caused by COVID-19, the global malaria response has faced a growing number of threats, such as drug and insecticide resistance, humanitarian crises, funding constraints, and delays in programme implementation, particularly in countries with a high burden of the disease. Together with the impacts of climate change, these challenges underscore the urgent need to adapt strategies and commit resources equal to the task of controlling and eliminating malaria

Comparison of global progress in malaria case incidence considering two scenarios: current trajectory maintained (blue) and if the Global Technical Strategy for malaria 2015-2023 targets are achieved (green)



Despite the challenges, there have been important achievements in the fight against malaria, such as the phased roll-out of the first WHO-recommended malaria vaccine, RTS,S/AS01, in three African countries, reducing early childhood deaths by 13%. In October 2023, WHO recommended a second safe and effective malaria vaccine, R21/Matrix-M. The availability of two malaria vaccines is expected to substantially increase supply and make broad-scale deployment across Africa possible.

Despite stalled progress in countries hardest hit by malaria, many countries with a low burden of the disease are moving steadily towards the goal of elimination. In 2022, for example, 25 countries reported fewer than 10 cases of malaria compared to 20 countries in 2015. Thirteen countries have been certified malaria-free by WHO since 2015.

To support countries in building more resilient malaria programmes, a substantial pivot in the fight against malaria is needed, with increased resourcing, strengthened political commitment, data-driven strategies and innovative tools. Innovation should focus on the development of more efficient, effective and affordable products.

The added threat of climate change calls for sustainable and resilient malaria responses that align with efforts to reduce the effects of climate change. Whole-of-society engagement is crucial to build integrated approaches.

Additional resources, press releases, etc. with links:

- World Malaria Report 2023: <https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2023#:~:text=Latest%20malaria%20report%20spotlights%20the,the%20malaria%2Dcarrying%20Anopheles%20mosquito.>
- Press release: <https://www.who.int/news/item/30-11-2023-who-s-annual-malaria-report-spotlights-the-growing-threat-of-climate-change>

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

Shrinking the number of people requiring interventions for neglected tropical diseases: a poverty-reduction strategy contributing to the well-being of entire communities

Neglected tropical diseases (NTDs) are a diverse group of conditions caused by parasites, bacteria, viruses, fungi and toxins. They typically affect poverty-stricken communities in least developed countries (LDCs), and are sometimes referred to as diseases of neglected populations.

Being affected by NTDs entails reduced educational outcomes for children and lower professional performance for adults, thus creating a vicious cycle of disease and poverty. Conversely, addressing the burden of NTDs breaks this cycle and can contribute to the health, social and economic well-being of entire communities.

In 2022, 1.619 billion people were reported to require mass or individual treatment and care for NTDs, down from 2.19 billion in 2010, and about 33.6 million people fewer than in 2021. The World Health Organization (WHO) estimates that between 2010 and 2022, the proportion of the population living in LDCs who require interventions against NTDs decreased from 79% to 45%: hundreds of millions of people were freed from the cycle of disease and poverty, although 501 million people living in LDCs still require interventions against NTDs every year.

The progress made 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 50 countries have eliminated at least one NTD.

However, this is not enough: the NTD road map 2021–2030 calls for a 90% reduction of the global population requiring NTD interventions between 2010 and 2030. As of 2022, the decline from 2010 has been 26.1%.

In recent years, progress towards reaching the 2030 target has been met by many challenges: a slow post-COVID-19 recovery of NTD programmes, an uncertain financial landscape, and the overarching threat of climate change, which is likely to have an impact on the distribution of many NTDs, especially those that are vector-borne.

A renewed effort is required to scale up coverage of NTD interventions especially in high-burden countries. More than 80% of people requiring interventions against NTDs (1.3 billion) live in 15 countries, eight of which are LDCs. WHO is facilitating these efforts by providing technical support and by strengthening the arsenal that programmes can deploy to defeat NTDs, including the development of innovative strategic approaches and tools such as medicines and diagnostics.

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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

[Custodian agency\(ies\):](#) WHO

Indicator 3.4.2 Suicide mortality rate

[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

About 1 in 11 people with drug use disorders receive treatment globally, with important differences across regions and sex

According to newly available estimates, only about 1 in 11 people with drug use disorders received drug-related treatment in 2022 globally. Drug-related treatment coverage at the global level has decreased from 11 to under 9 percent between 2015 and 2022. In a context where global crises, such as the COVID-19 pandemic, can impose important obstacles to the provision of health services to those in need, these estimates highlight the need for Member States to continue strengthening their capacities to provide such services and creating a legislative framework that ensures the availability of such treatment to all.

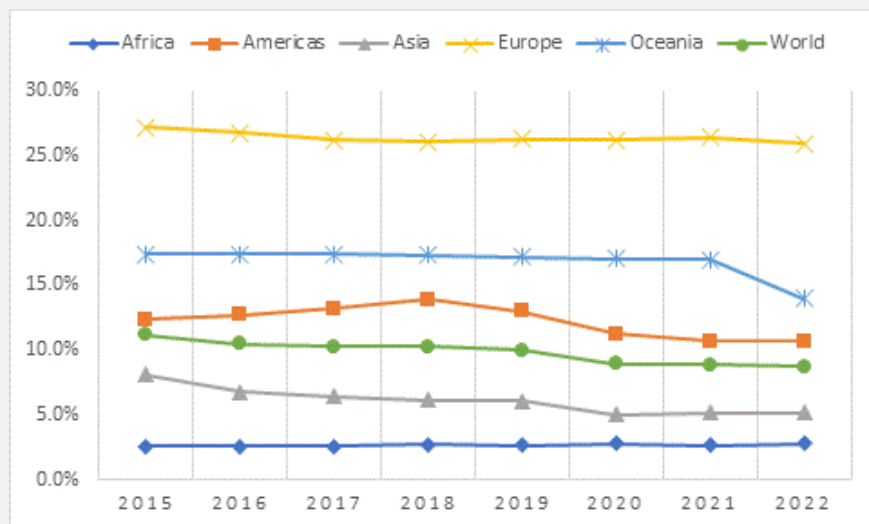
Certain regions show larger gaps than others in the provision of drug-related treatment. In Europe and Oceania drug-related treatment coverage reached about 26 and 14 percent respectively in 2022, with about 1 in 3 people with drug use disorders receiving treatment in sub-regions like Western and Southern Europe. On the other hand, regions like Africa and Asia show a drug-related treatment coverage of 2.8 and 5.1 percent respectively in 2022. The provision of drug-related treatment seems to have slowed down in the aftermath of COVID-19 globally and not recovered yet, especially in the Americas and Asia, where the proportions of people with drug use disorders receiving treatment during 2020-2022 are notably lower than those observed in 2015-2019.

Furthermore, drug-related treatment coverage is lower amongst women than it is amongst men in all five regions. About 1 in 18 women with drug use disorders received treatment globally in 2022, while the ratio was 1 in 7 for men. In regions like Africa and Asia, men in need of drug use treatment were over 5 times more likely to be treated than women, while in Europe men with drug use disorders were more than twice as likely as women to be treated. This underscores the need for Member States to put in place the necessary policies and infrastructure to make treatment equally available to everyone, regardless of their gender or sex, in all regions around the globe.

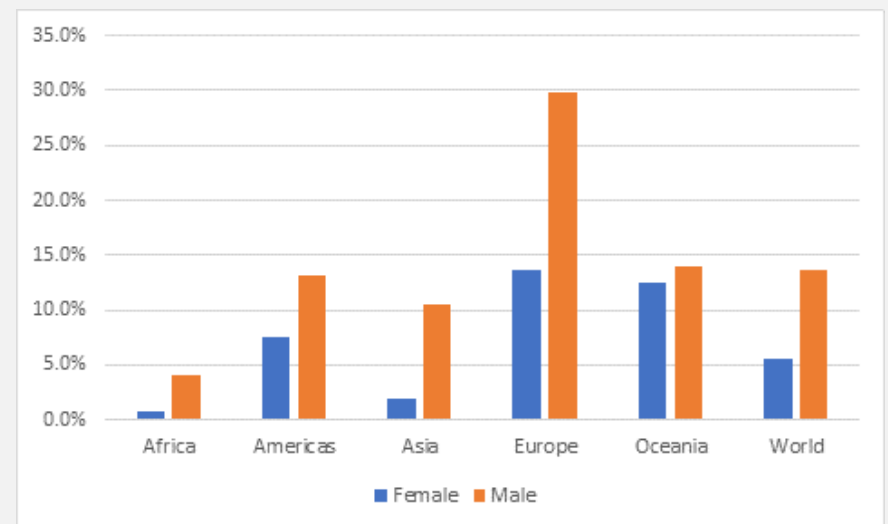
Available data on access to treatment for people with alcohol use disorders indicate even more appalling situation with treatment coverage ranging from extremely low (0.3%) to a maximum of 14% in countries that were able to report these data. Considering that about 283 million people (or 5% of adult population) live with alcohol use disorders, this represents a huge gap of hundreds million people not receiving treatment and care.

The capacity of national health systems to provide treatment for substance use disorders varies significantly between countries with differences ranging more than 20-fold from 1% to 80% as measured by the Service Capacity Index for Substance Use Disorders which is based on data collected from Member States on availability of health system elements important for treatment of these conditions.

Estimated proportion of people with drug use disorders that received treatment interventions, globally and by region, 2015-2022



Estimated proportion of people with drug use disorders that receive treatment, by region and sex, 2022



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

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

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

Over half of the member states experienced a decrease in road traffic fatalities since 2010

The estimated total number of road traffic deaths for the year 2021 is 1.2 million. Over half of the member states experienced a decrease in road traffic fatalities since 2010. Notably, ten countries successfully halved the number of road traffic deaths from 2010 to 2021 (during the first decade of the action on road safety), and 45 countries managed to reduce such fatalities by more than 30%. This indicates that endeavors to enhance road safety are yielding positive results, despite the substantial increase in motor traffic and population. On a global scale, there has only been a 5% reduction in road traffic deaths since 2010, emphasizing the need to intensify efforts to meet the Sustainable Development Goal (SDG) target 3.6.1.

Due to restrictions related to the COVID-19 pandemic in various countries, there has been a noteworthy decrease in the number of road traffic fatalities and rates, both globally and within the region, between 2010 and 2020. Specifically, there was an exceptional 11% reduction in fatalities and a 21% decrease in rates. Additionally, there was an 8% reduction observed between 2015 and 2020.

The Sub-Saharan Africa region continues to have the highest rate of road traffic deaths per 100,000 population, standing at 19.45, whereas both Australia and New Zealand, and Northern America and European regions boast the lowest rates, at 4.83 and 8.53 respectively. Notably, there has been a reduction in rates since 2010, with a 13% decrease in

Sub-Saharan Africa (from 22.25 to 19.45) and a significant 31% decrease in Australia and New Zealand (from 7.02 to 4.83).

The majority of road traffic deaths, a staggering 92%, are concentrated in upper-middle, lower-middle, and low-income countries combined. Specifically, 79% of road traffic deaths occur in lower-middle-income and upper-middle-income countries combined, with 44% and 35% respectively. Low-income countries account for 13%, while high-income countries make up the remaining 8%.

Between 2010 and 2021, there was a notable 15% reduction in road traffic deaths in upper-middle-income countries and an 11% reduction in high-income countries. However, an alarming increase in the number of road traffic deaths was observed in low-income countries, with a 21% rise, and a marginal 0.2% increase in lower-middle-income countries.

Despite these overall trends, vulnerable road users such as pedestrians, cyclists, and motorcyclists remain at a heightened risk, constituting more than 50% of all road traffic fatalities.

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

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

Since 2015, the proportion of women of reproductive age (15-49 years) having their need for family planning satisfied with modern methods has increased from 76.5 to 77.6 per cent in 2024 (Figure 1) – a net increase of 75 million users of modern methods globally. More than half of the global increase of users of modern contraception (56 per cent) has been in Central and Southern Asia, where the proportion of women of reproductive age (15-49 years) having their need for family planning satisfied with modern methods now exceeds 75 per cent. In contrast, there has been a decrease in the number of women using modern contraception in Europe and Northern America (-1 million) and Eastern and Southeastern Asia (-26 million) between 2015 and 2024, despite these regions continuing to have high proportions of women of reproductive age having their need for family planning satisfied with modern methods (81 per cent in Europe and Northern America and 87 per cent in Eastern and Southeastern Asia). This trend has been the result of decades of low fertility, which have led to smaller and smaller cohorts of women of reproductive age and therefore fewer users of modern contraceptive methods.

In sub-Saharan Africa, the use of modern methods of contraception among women of reproductive age who want to avoid pregnancy remains low (58 per cent in 2024). Yet, growth in the number of women using modern contraceptive methods has been rapid — from 49 million users in 2015 to 78 million users in 2024, which accounts for 28 per cent of the increase in modern contraceptive users worldwide in that period. The region continues to experience rapid population growth. By 2030, the population of women of reproductive age will increase by another 18 per cent. These demographic characteristics mean that in the coming decades global trends among women of reproductive age – including trends in the use of contraception – will be increasingly driven by the trends in sub-Saharan Africa, particularly as the rate of population aging accelerates in other regions where modern contraceptive use is much higher. As such, the future of global progress in the proportion of women of reproductive age having their need for family planning satisfied with modern methods will increasingly depend on the progress made in sub-Saharan Africa. Based on current projections, by 2030 sub-Saharan Africa will experience the largest increase in modern contraceptive users of any region – more than 4 million more women using modern contraception per year (Figure 2). The substantial expected growth in the number of users in the region will be a result of continuously growing cohorts of women of reproductive age due to high fertility rates as well as increases in the rate of contraceptive use. It is therefore critical that sufficient allocations and investments, including in infrastructure, commodities and human capital, are made in order to continue to keep pace with the growth of populations of women of reproductive age in order to live up to the commitments to 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.

Figure 1. Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods by SDG Region, 2015-2030

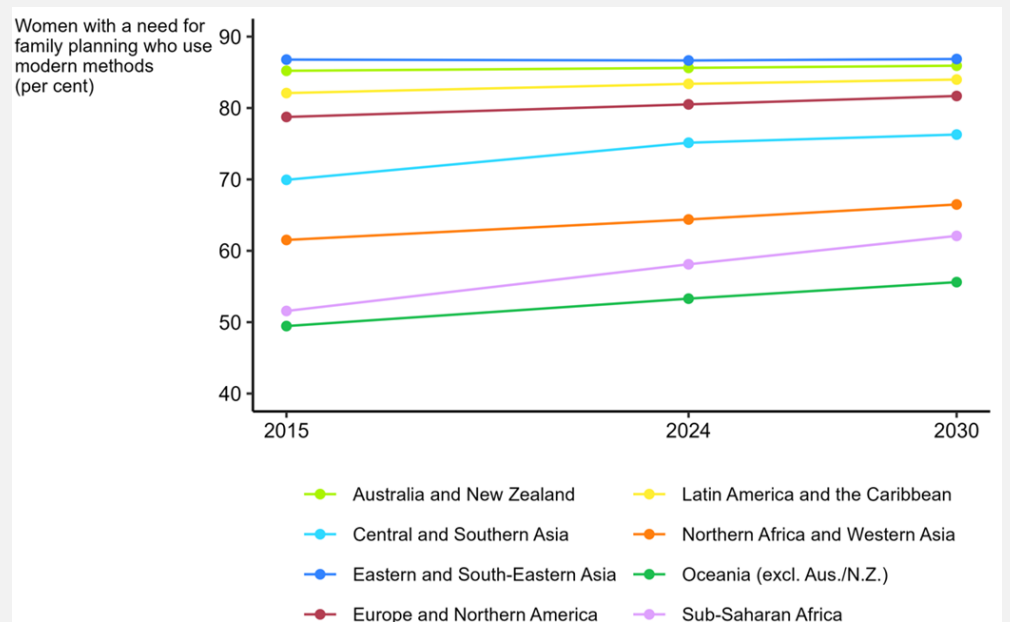
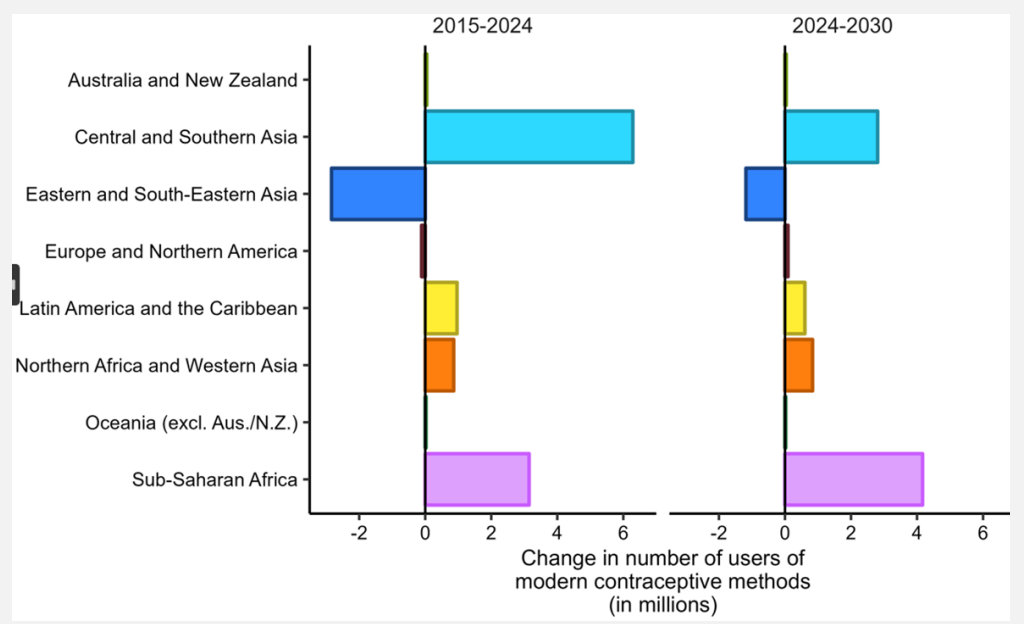


Figure 2. Average annual change in number of users of modern contraceptive methods by SDG region, 2015-2030



Additional resources, press releases, etc. with links:

- United Nations Department of Economic and Social Affairs, Population Division (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

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 Adolescent Birth Rates Decrease Significantly, Yet Uneven Progress Across 8 SDG Regions

In 2023, 13.1 million babies were born to adolescent mothers. Early pregnancy and motherhood present substantial adverse health, social, and economic consequences for both young mothers and their children. Furthermore, pregnancy complications and unsafe abortions are the leading causes of death among 15-19-year-old girls. Reducing adolescent pregnancies and birth rates continues to be a critical international priority, serving as a key indicator of the effectiveness of measures taken to prevent unintended pregnancies and ensure universal access to sexual and reproductive health-care services.

There has been progress in reducing adolescent birth rates (Figure 1). In 2023, the global adolescent birth rate for young women ages 15-19 was 41.3 births per 1,000 women in that age group, down from 47.2 in 2015 and 64.5 in 2000; a remarkable decline of one third since 2000. The global adolescent birth rate for girls aged 10-14 has also declined, from 3.3 births per 1,000 girls in that age group in 2000 to 1.8 births in 2015 and to 1.5 births in 2023; a total reduction of more than 50 percent over the past 20 years.

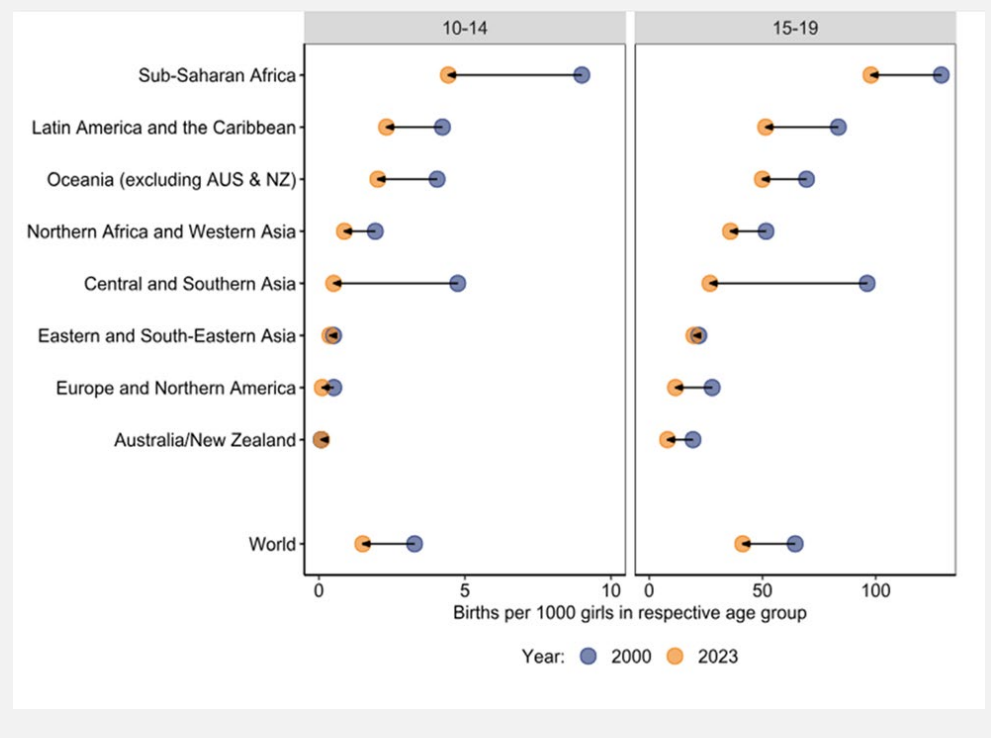
Significant progress has been achieved across the eight SDG regions from 2000 to 2023; however, this progress has been uneven among regions. The largest declines are reported for Central and South-Eastern Asia, from 96.2 births for 1,000 women aged 15-19 years in 2000 to 34.5 in 2015 and further to 26.8 in 2023 (a reduction of 72 per cent since 2000) and from 4.8 births per 1,000 girls aged 10-14 in 2000 to 0.7 in 2015 and 0.5 in 2023 (a reduction of 90 per cent).

In sub-Saharan Africa, adolescent birth rates have fallen recently; however, it still remains the highest among all regions, at 97.9 births per 1,000 young women aged 15 to 19 in 2023 and 4.4 births per 1,000 girls aged 10 to 14. Latin America and the Caribbean is the region with the second highest level of adolescent fertility, at 51.4 births per 1,000 women aged 15 to 19 and 2.3 births per 1,000 girls aged 10 to 14 (figure 1), followed by Oceania (excluding Australia and New Zealand) at 49.9 births per 1,000 girls aged 15 to 19 years and 2.0 births per 1,000 girls aged 10 to 14 years.

The development of global comparative estimates for levels and trends in early childbearing below age 19 represents a significant achievement. However, there are notable data gaps that needed to be addressed, including the evaluation of reporting completeness and the accuracy of reported maternal ages (United Nations, 2020). Despite overall declines, significant socio-economic, geographic, or other disparities in early childbearing may persist within countries. It is crucial to disaggregate data by relevant demographic characteristics to identify populations with the greatest needs.

These efforts must continue, with data not only illustrating broad demographic trends but also shining a light on those who are most vulnerable, marginalized, and in need. By asking the right questions, we can ensure no girl is left behind.

Adolescent birth rate (aged 10–14 years; 15–19 years) per 1,000 women in that age group, 2000 and 2023, SDG regions



Storyline authors(s)/contributor(s): Yumiko Kamiya and Karoline Schmid

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

Billions left behind on the path to universal health coverage (SDG target 3.8)

Achieving universal health coverage is a critical step in helping people escape and stay out of poverty, yet the latest data reveals that improvements to health services coverage (SDG 3.8.1) have stagnated since 2015, while financial hardship due to health out-of-pocket spending reached 2 billion people in 2019, including 1 billion facing catastrophic out-of-pocket health spending defined as exceeding 10% of a household budget (SDG indicator 3.8.2) and 344 million people going deeper into extreme poverty due to health costs.

There have been important gains in the global coverage of essential health services since 2000, notably due to substantial improvements in infectious disease services. Progress in services for noncommunicable diseases and maternal and child health, however, was minimal. Overall, country-level estimates of UHC SCI (SDG 3.8.1) have become more equal since 2000, as countries with the lower scores have made progress towards catching up to their peers with higher scores. However, there was an abrupt reversal in this trend after 2015 and within-country inequalities persist, with rural and poorer populations experiencing lower service coverage than national averages. The proportion of the population not covered by essential health services decreased by about 15% between 2000 and 2021, with minimal progress made after 2015. In 2021, about four and a half billion people were not covered by essential health services.

There hasn't been any significant progress in reducing financial hardship as measured by SDG 3.8.2 indicator defined as the proportion of the population spending more than 10% of their household budget on health out of pocket (OOP) which worsened since 2015 at 0.2 percentage points on average per year. It reached 13.5% in 2019 (about 1 billion people) from a baseline value of 12.6% in 2015 (about 940 million people). In addition, in 2019, 4.4% of the global population (about 344 million people) were pushed or further pushed into extreme poverty due to OOP payments for health. Out-of-pocket health payments can also cause individuals to forego essential care and force families to choose between paying for a visit to the doctor, buying food and water, or sending their children to school. Such trade-offs can spell the difference between the early treatment of a preventable disease and, at a later stage, suffering severe illness or even death. Addressing this problem requires progressive health financing policies that exempt those with limited ability to pay for health services. The combined macroeconomic, fiscal, and health impacts of the pandemic and emerging evidence on rising poverty point to a significant worsening of financial protection globally with higher rates of foregone care due to financial barriers, and more people incurring financial hardship due to relatively high and impoverishing OOP health payments. The economic outlook, including increasing debt burdens and slow reduction of inflation rates, will continue to pressure government and household budgets alike, indicating sustained worsening of financial protection in the medium-term without targeted policy action and without sufficient mobilization of public funding for health.

The global pattern of the recent stagnating progress in service coverage (SDG 3.8.1) while catastrophic health spending (SDG 3.8.2) increases continuously is consistent across almost all regions (Figure 1) and country income groups and most countries for which data are available on both UHC dimensions (95 out of 137) are off-track in either service coverage, financial protection, or both. Causes of this lack of progress vary by region and country and addressing them requires context-specific policies. But in general, significant advances towards UHC by 2030 require an acceleration in the expansion of all essential health services, especially those with minimal progress to date. Proactive policy efforts are needed to decrease financial hardship from OOP payments – specifically, public health funding needs to further increased and used more efficiently, coverage for medicines extended, and co-payments for the poor removed.

Progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2000–2019



Additional resources, press releases, etc. with links:

- Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2023. Licence: CC BY-NC-SA 3.0 IGO. <https://www.who.int/publications/i/item/9789240080379>
- Press release: [https://www.who.int/news/item/18-09-2023-billions-left-behind-on-the-path-to-universal-health-coverage#:~:text=The%20World%20Health%20Organization%20\(WHO,affordable%2C%20and%20accessible%20health%20care.](https://www.who.int/news/item/18-09-2023-billions-left-behind-on-the-path-to-universal-health-coverage#:~:text=The%20World%20Health%20Organization%20(WHO,affordable%2C%20and%20accessible%20health%20care.)
- Fact sheets: [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))
- Data: <https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major>

Storyline author(s)/contributor(s): WHO and World Bank

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

Low- and middle-income countries account for 93% of premature mortality caused by air pollution

Particulate air pollution, whether domestic or ambient, increases the risk of cardiovascular disease, respiratory disease and lung cancer. Estimates from 2019 show that it causes about 104 deaths per 100,000 people worldwide annually. Although this global mortality rate has shown a slight but steady decreasing trend since 2010, 93% of the attributable burden still falls on low- and middle-income countries (LMIC), mainly in Asia and Africa. Faced with this devastating impact on the poorest countries, and in times of the triple planetary crisis of climate change, biodiversity loss and pollution, as well as increasing inequality and unemployment, it is urgent to take action against air pollution through policies and programs focused on improving public health.

Non-communicable diseases such as ischemic heart disease (IHD, 41%), stroke (23%), chronic obstructive pulmonary disease (COPD, 16%) and lung cancer (5%) together account for 85% of the total burden of disease due to air pollution. The remaining 15% is due to acute lower respiratory tract infections (ALRI) in the general population, 31% of which occur in children under five years of age. Overall, of all NCD deaths worldwide, 77% occur in LMICs; confirming the urgent need to prioritize efforts in these countries.

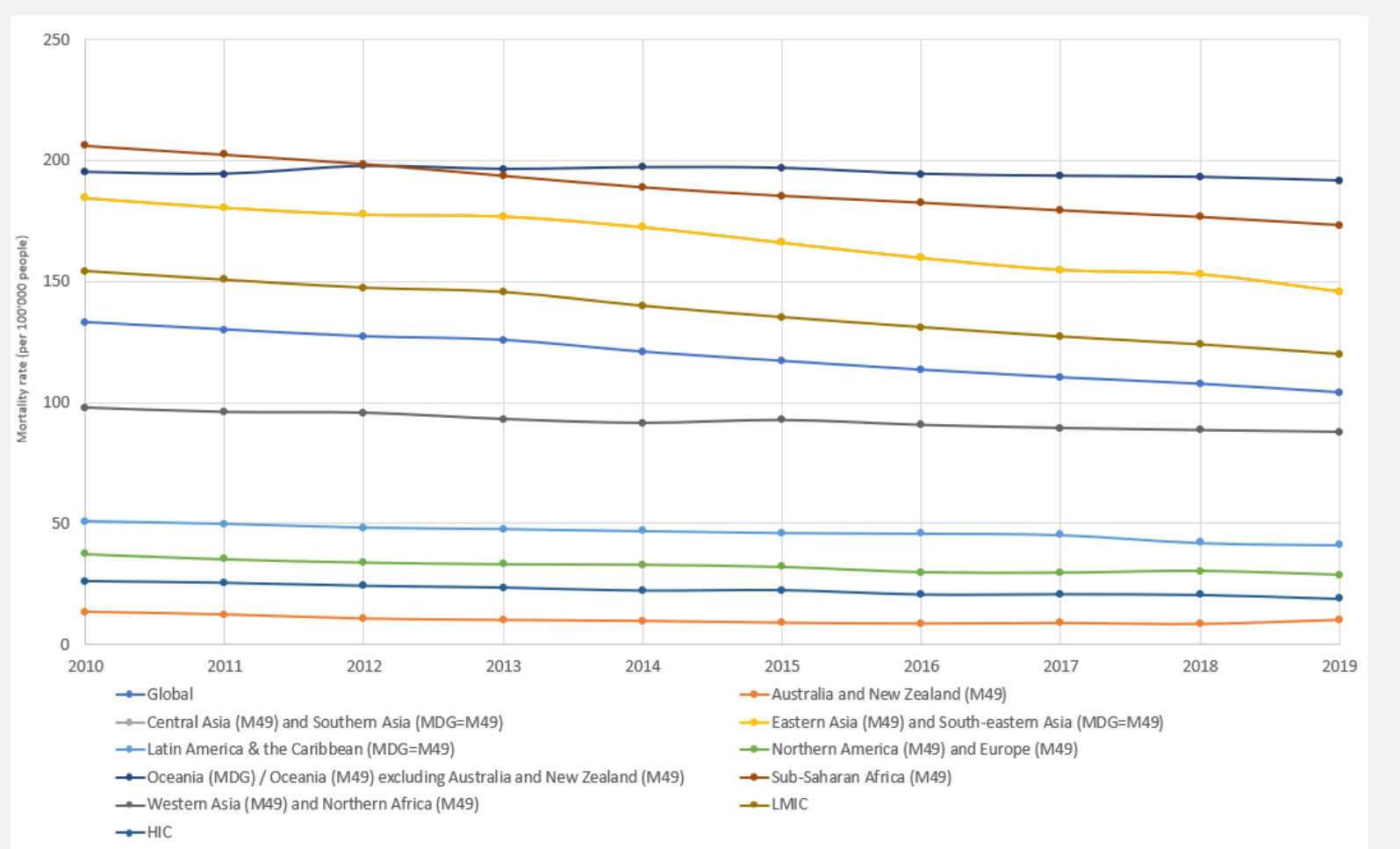
The causes of the observed differences in air pollution-attributable mortality rates between countries and regions are varied. First, they are due to the different (population-weighted) ambient and household PM2.5 concentrations, but also could be due to the different age distribution and underlying mortality prevalence and main causes of death.

Ambient and household pollution also contribute differently to the overall burden due to air pollution in different regions. Oceania (excluding Australia and New Zealand), sub-Saharan Africa and most of Asia have the highest air pollution attributable mortality rates. This is largely due to high levels of exposure to air pollution in households, where a large proportion of the population continues to rely on polluting fuels and technologies for cooking, lighting, and heating, resulting in around 3.2 million deaths worldwide. Health risks from household air pollution are particularly high among women and children, who tend to spend more time in and around the stove.

The COVID-19 pandemic has shown that people with pre-existing chronic diseases, such as cardiovascular diseases, respiratory diseases, cancer and diabetes, were heavily over-represented among COVID-19 patients. These at-risk groups have shown to be at higher risk of severe illness and death. As mentioned above, the same diseases are impacted by chronic exposure to air pollution. Moreover, current scientific evidence suggests that air pollution weakens the immune system against infectious diseases.

Since particulate matter induces inflammation in lung cells, the exposure to this air pollutant could increase the susceptibility and severity of the COVID-19 patient symptoms. Hence it is critical to pursue efforts to mitigate air pollution levels and reduce exposure for the most vulnerable individuals.

Trends of the age-standardized mortality rates (per 100,000 people) attributed to air pollution (household and ambient) by region.



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

Tobacco use declines despite tobacco industry efforts to block progress

Tobacco use is harmful not only to health but to equitable and sustainable societies and environments. t. 182 countries are now Parties to WHO Framework Convention on Tobacco Control (WHO FCTC), demonstrating strong political will to reduce the demand and reduce supply of tobacco products and the results are encouraging. In 2022, the global prevalence of current tobacco use among the population aged 15+ was estimated at 20.9%. This represents a notable decline since 2015 when it was 23.9%. 150 countries are currently registering decreases in prevalence, and only 6 countries are still seeing increases.

The Tenth session of the Conference of the Parties (COP10) to the WHO FCTC, in February 2024, took a number of important decisions. Among them there is a decision to protect the environment and the health of people from the ravages of tobacco. In this decision Parties are urged to take into account the environmental impacts from the cultivation, manufacture, consumption and waste disposal of tobacco products, and to strengthen national policies related to tobacco and protection of the environment.

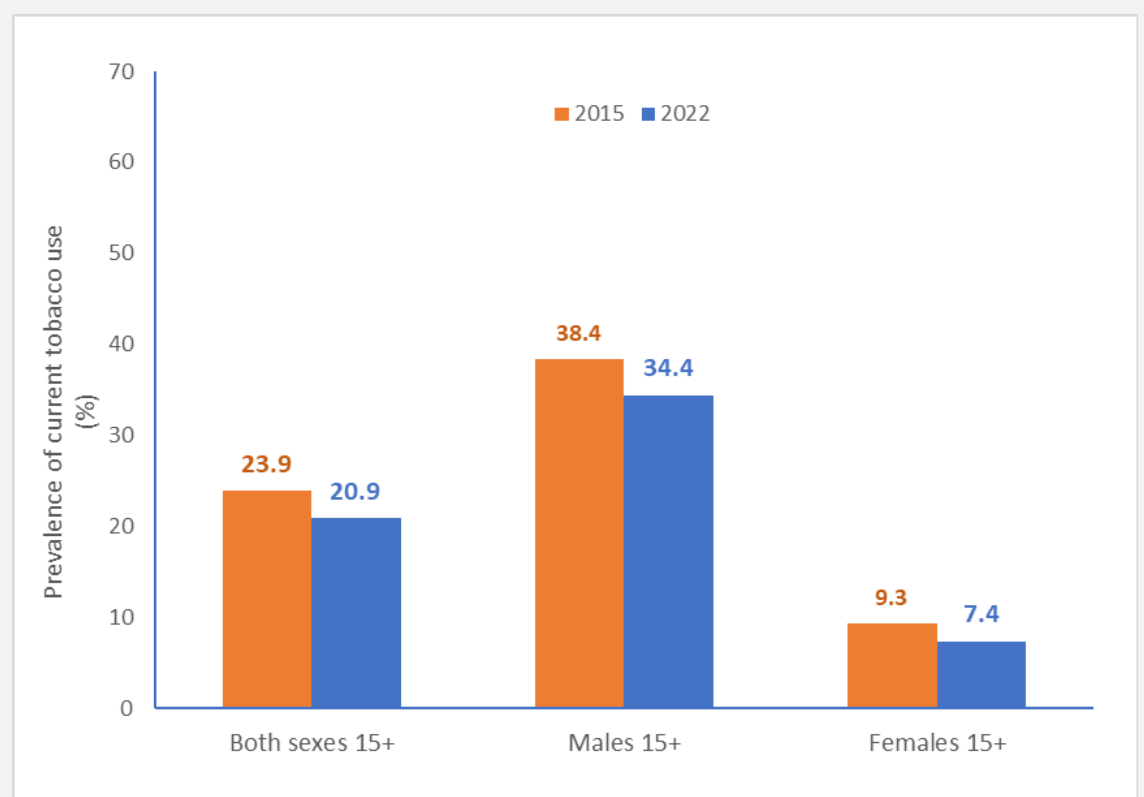
Additionally, Parties agreed to adopt new guidelines on cross-border tobacco advertising, promotion and sponsorship, and the depiction of tobacco in the entertainment media. This goes in line with the recognition that tobacco companies increasingly use digital communication platforms for tobacco advertising and interfering with implementation of tobacco control measures. Access to entertainment media is increasingly digital and crossing national borders, increasing adolescent and young people's exposure to tobacco marketing, which may encourage youth smoking uptake.

The COP10 also considered the work under Article 26 of the WHO FCTC, in which "the Parties recognize the important role that financial resources play in achieving the objective of this Convention". International resource mobilization is critical for the support to Parties on Global Strategy. An analysis of the funding gap between existing levels of funding for tobacco control versus those needed to achieve full implementation of the WHO FCTC found that the current amount of resources dedicated to tobacco control is around US\$ 1.2 billion, while the total amount of funding needed for full WHO FCTC implementation is US\$ 9.6 billion, meaning that only 12.5% of needed funding for tobacco control is currently available and allocated. This leaves an annual funding gap of US\$ 8.4 billion.

Another study estimated that tobacco use resulted in US\$ 1.7 trillion in social and economic losses in 2022, the equivalent of 1.7% of annual global gross domestic product (GDP). By investing in and enforcing nine proven tobacco control measures, over 15 years, global smoking prevalence could decline by over half, saving 42.8 million lives and generating US\$ 6.2 trillion in social and economic benefits, including US\$ 2.3 trillion in direct healthcare savings.

Tobacco control has demonstrated to be a good investment which can both save lives and benefit national and global economies, reducing the threats posed by the use of tobacco products.

Age-standardised tobacco use rates, global by age and sex, 2015 and 2022



Additional resources, press releases, etc. with links:

- [Tobacco use declines despite tobacco industry efforts to jeopardize progress \(who.int\)](#)

Storyline author(s)/contributor(s): WHO Tobacco Free Initiative; Secretariat to the Framework Convention on Tobacco Control

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

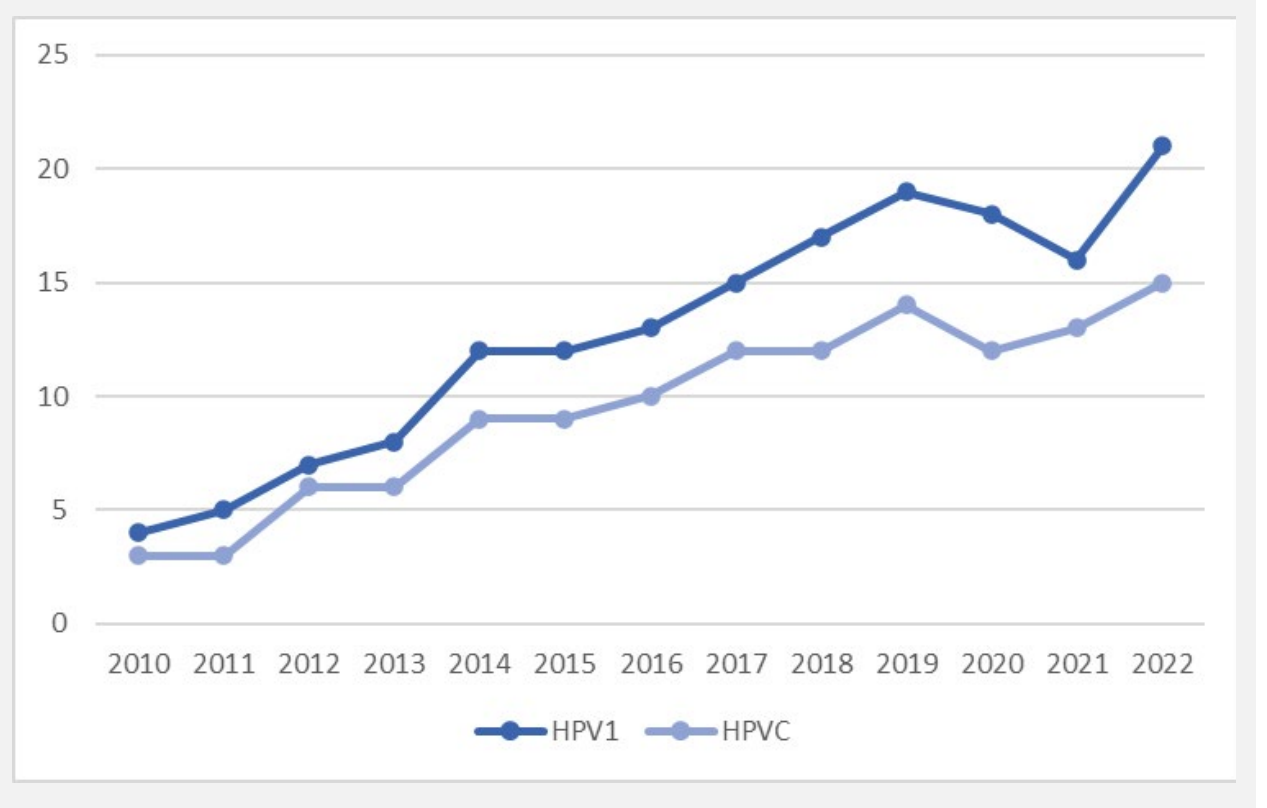
Indicator 3.b.1 Proportion of the target population covered by all vaccines included in their national programme

HPV vaccine coverage rebound to pre-COVID levels

In 2019 the global coverage with a complete schedule of HPV vaccines (HPVc) reached 14%. During the COVID-19 pandemic in 2020 and 2021 the levels dropped to 12%. This drop represents a relative reduction of more than 15% thereby exceeding that of any other vaccine in the national immunization schedule.

A main driver behind this large reduction was the closure of schools – the predominant site for HPV vaccination - for extended periods of time and decisions in some programmes to focus on maintaining coverage of vaccines against epidemic prone diseases and childhood vaccines including COVID vaccines. In a subset of countries it led to interruption of the HPV vaccine programme. Following a call to action by UN agencies WHO and UNICEF and GAVI, a renewed focus on HPV vaccination during 2022 has resulted in strongly improved coverage particularly in Low and Middle Income countries. Global HPV coverage for the first time surpassed the 2019 levels and reached 15% in 2022. In addition to improved performance in existing programmes, this coverage improvement was further supported by an strong increase in new introductions of the HPV vaccine. This trend towards accelerated introductions was reconfirmed in 2023 including in several countries with large populations and has the potential to further boost global coverage of HPV vaccination in years to come.

Global female HPV vaccination trend, 2010-2022 (percentage)



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

Custodian agency(ies): WHO, UNICEF

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

ODA to basic health more than doubled since 2015 driven by COVID-19 response

ODA for basic health from all donors increased by 4.4% in 2022 compared to 2021 and more than doubled in real terms since 2015, from USD 10.5 billion to USD 21.1 billion in 2022 (constant 2022 prices), driven by the response to the COVID-19 pandemic.

COVID-19 control (e.g. information, education and communication; testing; prevention; immunization, treatment and care) represented the largest share of ODA for basic health (42%), totaling USD 8.8 billion of which USD 1.6 billion were for vaccine donations. Over the period from 2020 to 2022, COVID-19 control amounted USD 22.5 billion (constant 2022 prices) in total.

Other than COVID-19 control, USD 3.7 billion were spent on infectious disease control, in addition, USD 2.4 billion on malaria control and USD 2.2 billion on basic health care.

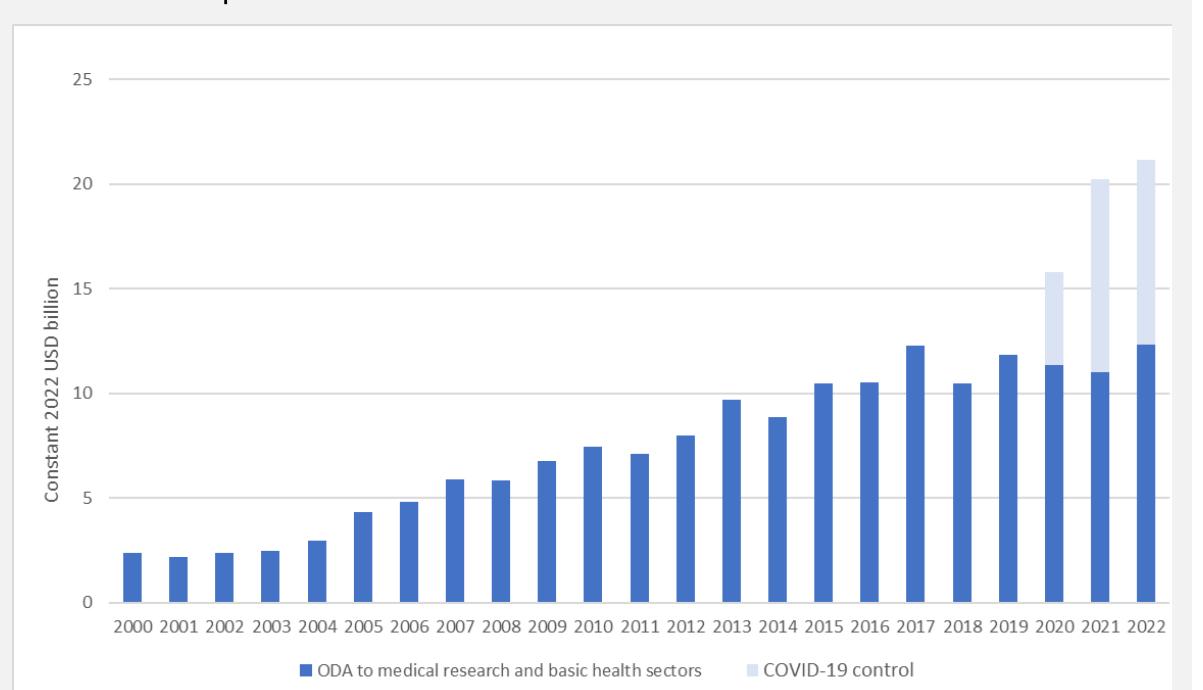
The increase in 2022 compared with 2021 was mainly due to increased support to Sub-Saharan Africa, which was the region that received the largest volume and share of aid for basic health (USD 6.6 billion or 33% of the total), and to global contributions to developing countries, which were not allocated by recipient country, and driven by an increase for COVID-19 and other diseases control (USD 8 billion or 41% of the total). Aid for basic health in Asia was USD 4.1 billion, a decrease of 20% from 2021 due to USD 1.4 billion less contributions to COVID-19 control.

Least Developed Countries received USD 6.6 billion representing an increase in volume of 9.4% and 31% of the total aid.

The largest recipients in 2022 were Nigeria (USD 827 million), Democratic Republic of the Congo (USD 762 million) and Bangladesh (USD 732 million).

The United States, Germany, the Global Fund and GAVI accounted for more than half of the 2022 total (54%), providing, USD 4.4 billion, USD 2.7 billion, USD 2.4 billion, and USD 1.8 billion respectively.

Total official development assistance to medical research and basic health sectors



Storyline authors(s)/contributor(s): 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

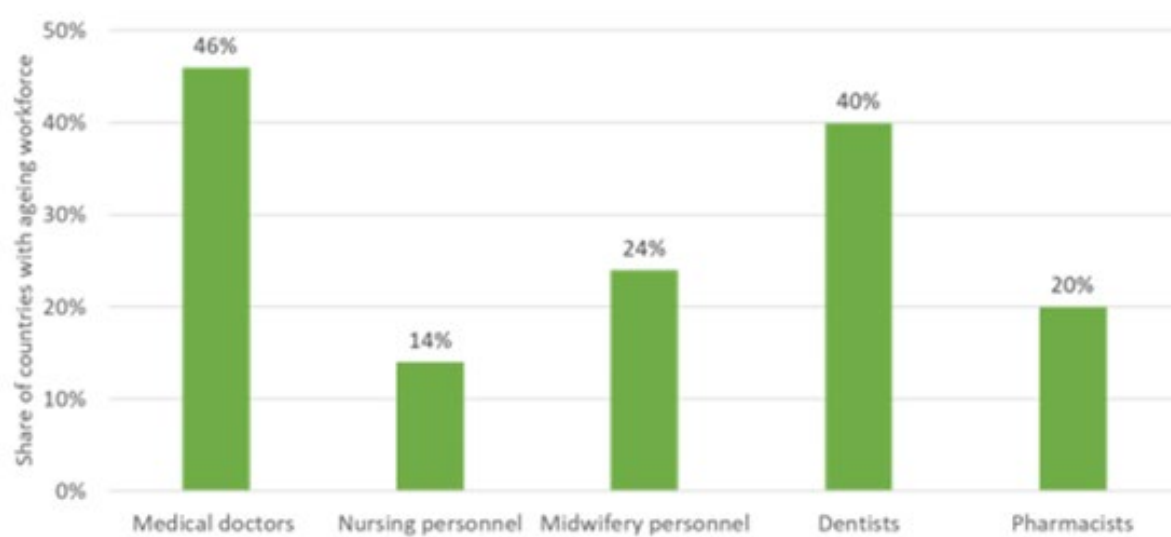
Indicator 3.c.1 Health worker density and distribution

Ageing population demands and ageing health workforce widens the health workforce shortage gap

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.

Share of countries with ageing workforce, by health occupation



Medical doctors, n=93; Nursing personnel, n=110; Midwifery personnel, n=67, Dentists, n=45; Pharmacists, n=46

Additional resources, press releases, etc. with links:

- National Health Workforce Accounts: levels and trends 2024. The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage?
- DOI: 10.1136/bmjgh-2022-009316

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

International Health Regulations (IHR) capacity and health emergency preparedness

The International Health Regulations (2005) (IHR 2005) represent a vital framework of international law binding on 196 States Parties, including all 194 WHO Member States. Under Article 54.1 of the Regulations, all parties are obligated to annually report on their progress in implementing the IHR. The e-SPAR platform (<https://extranet.who.int/e-spar/>), established in 2018 supports the online submission of the IHR State Parties Self-assessment Annual Report (SPAR) and is a repository of data submitted by States Parties since 2010.

Ninety-nine percent (194/196) of States Parties submitted the SPAR 2023 to WHO, marking a notable four-point increase from SPAR 2022 (95%) and representing the highest submission rate since 2010. Furthermore, multisectoral collaboration in the SPAR process witnessed a commendable six-point increase, rising from 70% to 76%.

SPAR capacities that registered high scores include Surveillance (SPAR2-C05) at 79%, Health Services Provision (SPAR2-C08) at 72%, and Laboratory (SPAR2-C04) and Health Emergency Management (SPAR2-C07), both at 70%. Policy, Legal, and Normative Instruments to Implement IHR (SPAR2-C01) and Chemical Events (SPAR2-C14) both scored 54%, along with Radiation Emergencies (SPAR2-C15) at 57%.

The SPAR tool has undergone revision in 2020. Since 2021, the SPAR tool second edition has been used by States Parties for reporting progress in IHR implementation to WHO. From 2021 to 2022, the global capacity score increased by two points and decreased by 66% (2022) to 64% (2023). Surveillance (SPAR2-C05) and Laboratory (SPAR2-C04) experienced a four-point decrease from 2022 to 2023. It is important to note that the increase in the number of States Parties reporting in 2023 compared to 2022 complicates the interpretation of these score changes.

According to SDG region classification, Northern America M49 (21) exhibited the highest score at 93%, followed by Australia and New Zealand M49 (53) and Eastern Asia M49 (30). Sub-Saharan Africa M49 (202) and Least Developed Countries (199) scored 49%.

The increased engagement of States Parties in fulfilling their IHR mandate, enhanced multisectoral involvement in the SPAR process and WHO's support across all organizational levels reflects a continued commitment to improving global health security. Strengthening capacities to manage existing health threats and anticipate and prepare for potential future pandemics is imperative. Sustained international collaboration and multisectoral engagement remain indispensable in advancing global health security and achieving the objectives outlined under SDG 3.d.1.

Figure 1: Average capacity scores by SPAR reporting cycle.

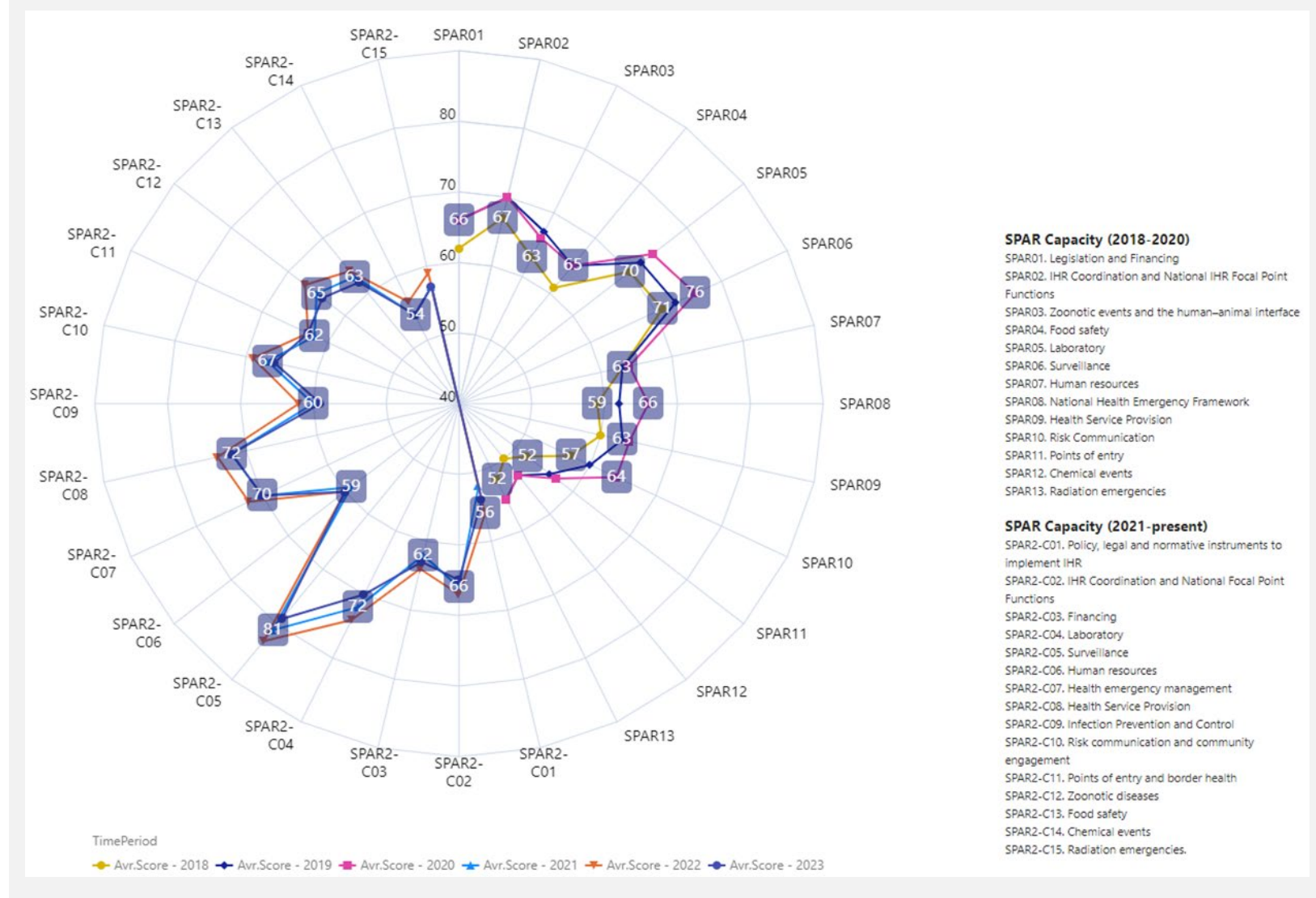


Figure 2:

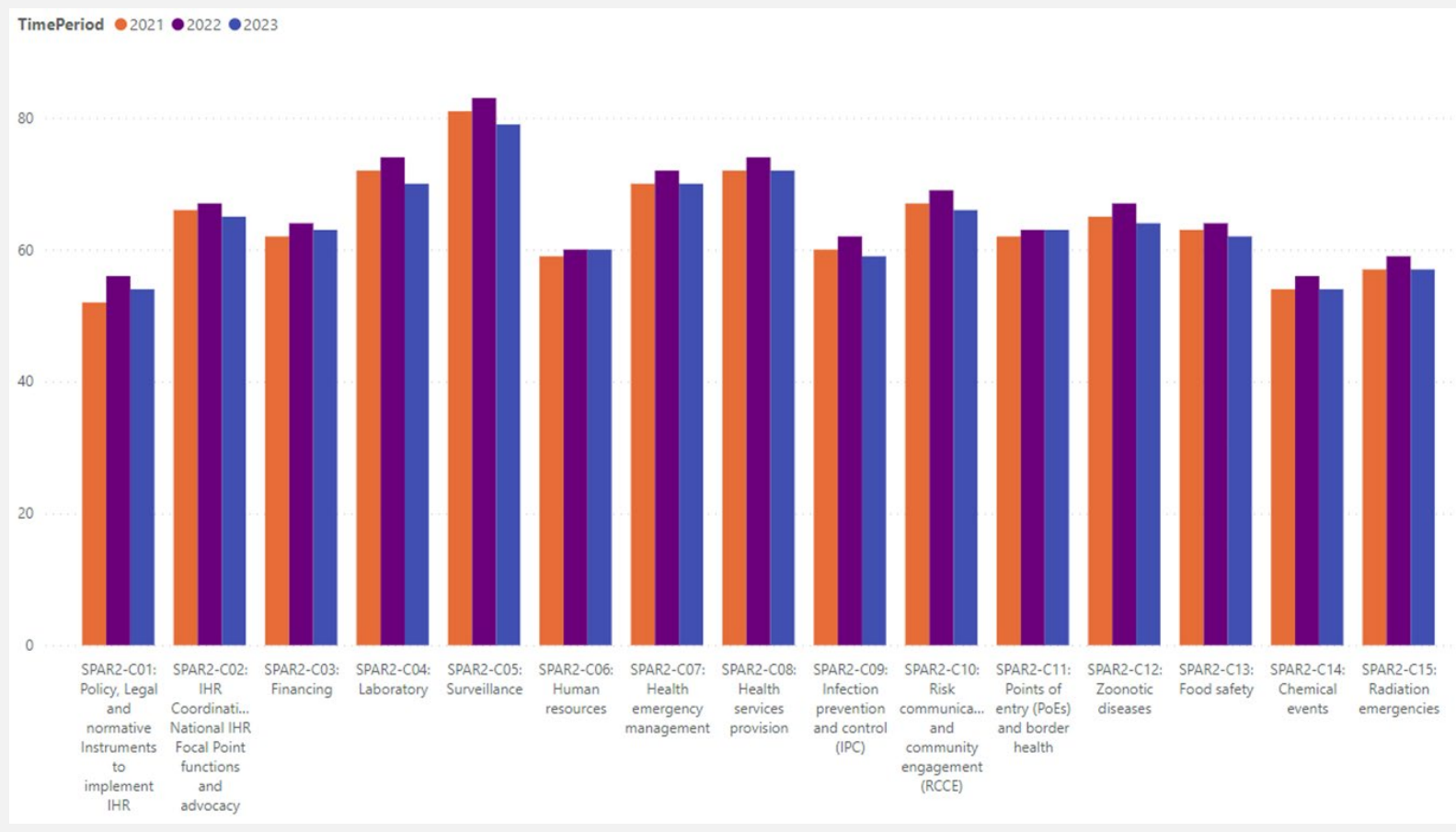


Figure 3: SDG M49 regions

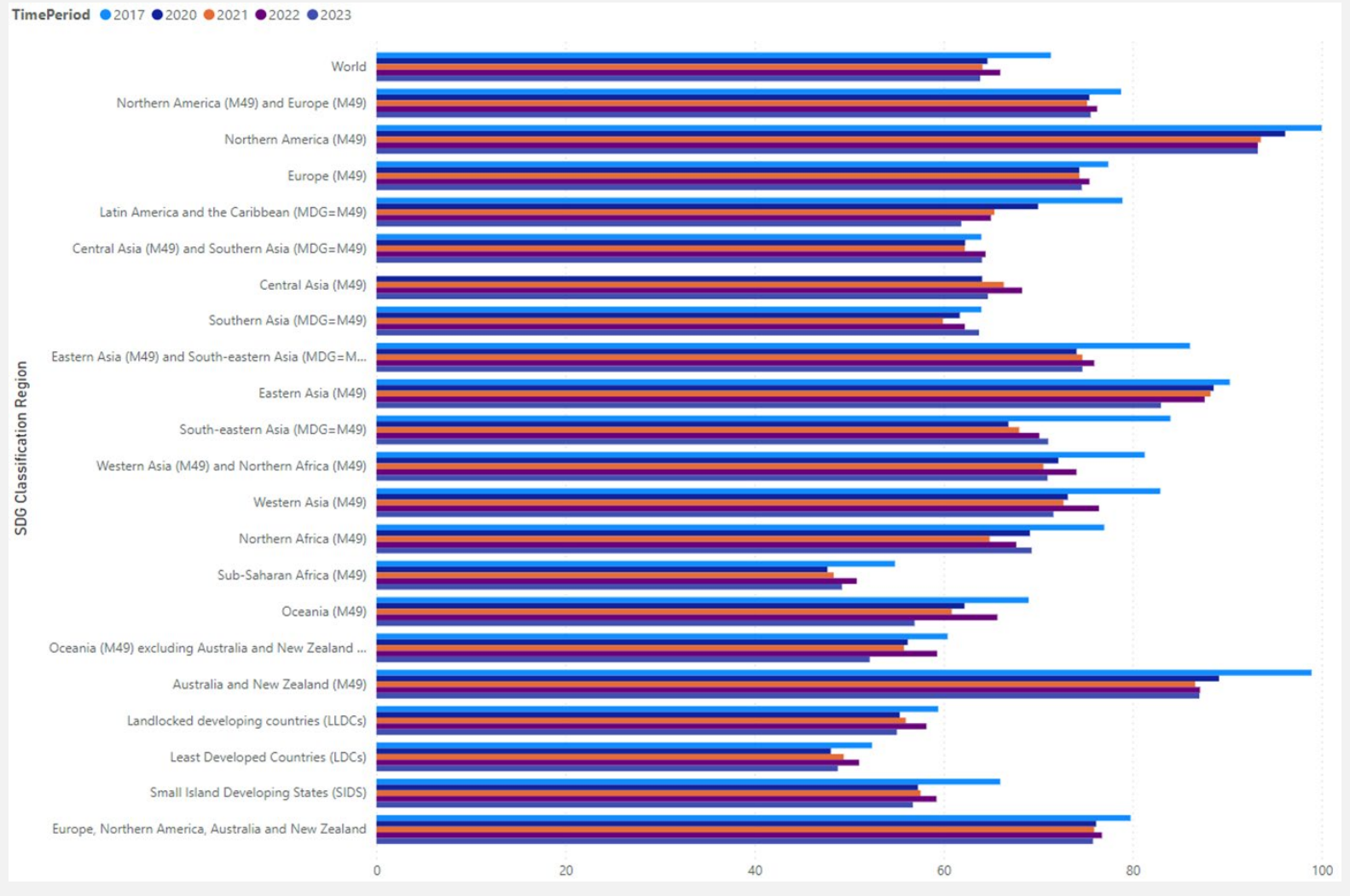
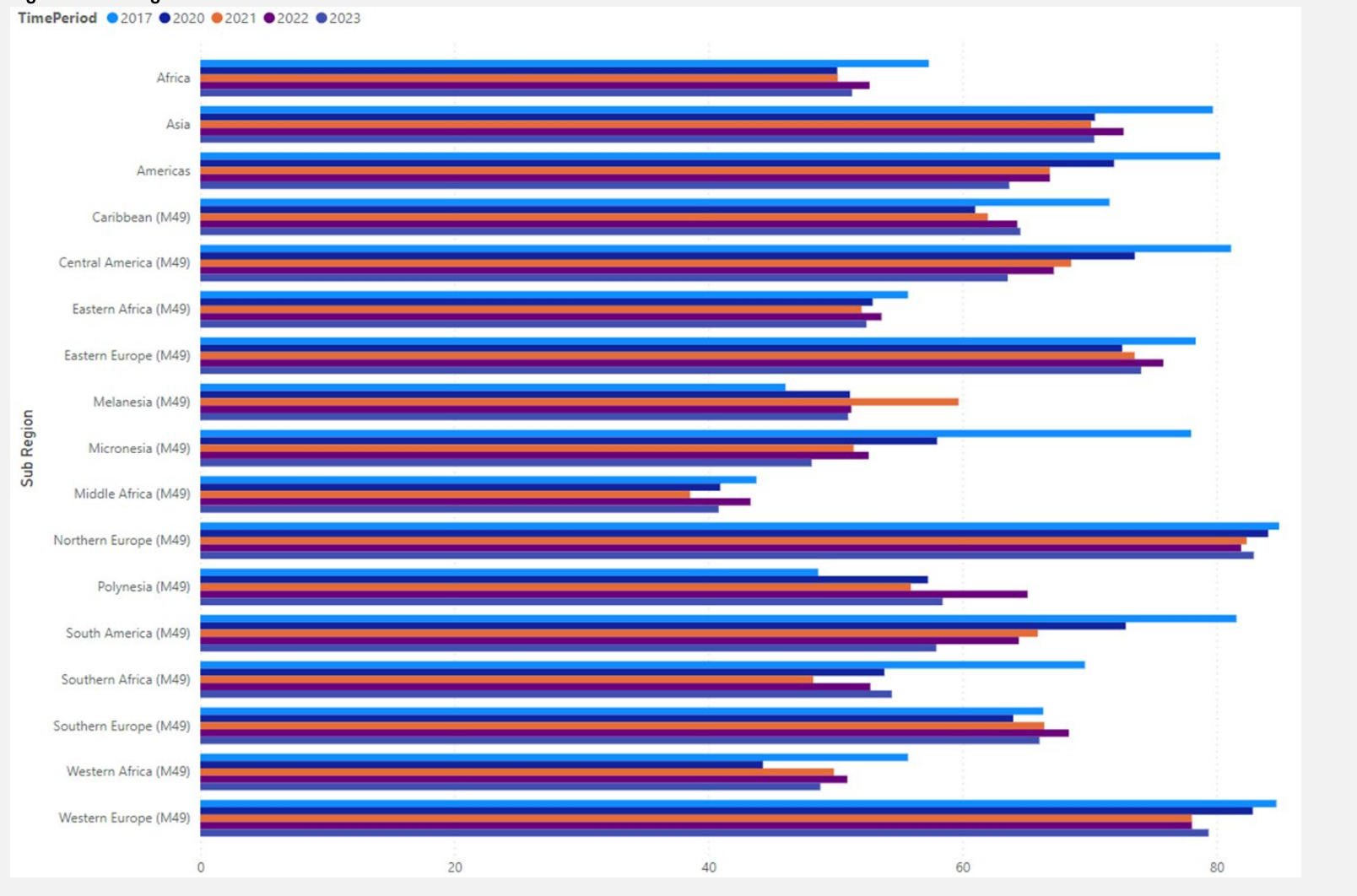


Figure 4: sub-regions



Additional resources, press releases, etc. with links:

- SPAR tool 1st edition was used from 2018 to 2020 reporting cycle. SPAR tool 2nd edition is used by States Parties since 2021. There is a difference between the two editions. See [9789240040120-eng-new.pdf \(who.int\)](#) for more information.

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

Custodian agency(ies): WHO

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

Custodian agency(ies): WHO