Gates Foundation
GOALKEEPERS

2025 GOALKEEPERS REPORT

WE CAN'T STOP AT ALMOST

Goalkeepers is dedicated to accelerating progress toward the Sustainable Development Goals.

CONTENTS

KEY TAKEAWAYS

2025 is the first year of this century where child deaths will increase.

But we can stop this reversal before it becomes a trend, even in a time of tight budgets.

With proven solutions and next-generation innovations that do more with less, we can save millions of children's lives, protect the progress we've fought so hard for, and wipe out diseases that have plagued humanity for generations.

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By Bill Gates
Chair, Gates Foundation

A Generation of Progress, A Choice to Make

The death of a child is always a tragedy.

But there's something especially devastating about a child dying of a disease we know how to prevent.

For decades, the world made steady progress saving children's lives. But now, as challenges mount, that progress is reversing.

In 2024, 4.6 million children died before their fifth birthday. **In 2025, that number is projected to rise for the first time this century, by just over 200,000, to an estimated 4.8 million children.**

That means more than 5,000 classrooms of children, gone before they ever learn to write their name or tie their shoes.

It doesn't have to be like this.

The way I see it, there are two ways the next chapter can play out.

We could be the generation who had access to the most advanced science and innovation in human history—but couldn't get the funding together to ensure it saved lives.

Over the past several months, our foundation has worked with the Institute for Health Metrics and Evaluation (IHME) at the University of Washington to quantify the stakes.

What we found is sobering.

If funding for health decreases by 20 percent—the scale of cuts some major donor countries are currently considering—

12 MILLION MORE CHILDREN COULD DIE BY 2045.

If the cuts are steeper—30 percent—it's even worse:

16 MILLION MORE CHILDREN COULD DIE BY 2045.

If we take this path, we're the generation that *almost* ended preventable child deaths. *Almost* eradicated polio. *Almost* wiped malaria off the map. *Almost* made HIV history.

BUT WE CAN'T STOP AT *ALMOST.*

We know kids are dying. We know why. And we know how to stop it.

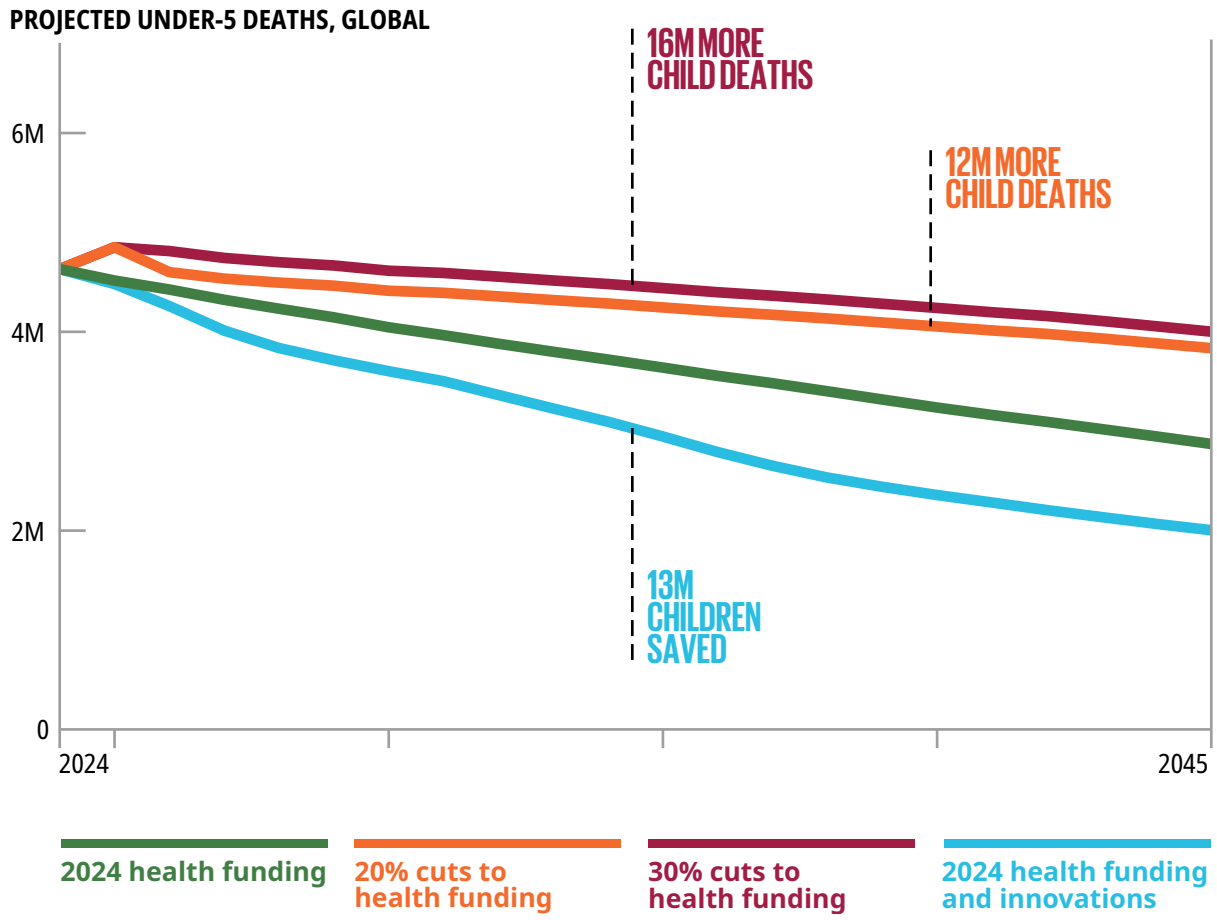
For the good of humanity,

WE NEED TO CHOOSE THE *OTHER* PATH:

one where we harness all we've learned and **make sure innovations reach the children who need them**—saving millions of young lives.

HUMANITY AT A CROSSROADS

Millions of Children's Lives at Stake



Health funding refers to development assistance for health (DAH)—aid from high-income countries and donors to improve health in low- and middle-income countries. The chart shows projected impacts of 20% and 30% reductions in DAH. See methodology for details.

I'll continue to advocate however and wherever I can for increased funding for the health of the world's children—and for efficiencies that improve our current system. But with millions of lives on the line, we have to do more with less, **now.**

That's not a new idea for health ministers around the world. They've long had to make limited budgets go further. But today, with so many countries spending more on debt than on health or education, every dollar has to work even harder.

Luckily, there are strategies and innovations that can help do exactly that.

This report is a roadmap to progress: where smart spending meets innovation at scale.

I wish we were in a position to do more with *more* because it's what the world's children deserve. But even in a time of tight budgets, we can make a big difference. Over the last 25 years, we've learned so much about how to save lives, even with scarce resources.

This isn't just about money. It's about priorities, commitment, and choices.

First, we'll need to **double down on the most effective interventions**: strong primary health systems and lifesaving vaccines.

Then, we need to **prioritize innovations that stretch each and every dollar**. I'm talking about solutions like vaccines that require fewer doses to give the same—or better—protection as old ones—or smart new uses of data that help ensure the most effective interventions against diseases like malaria are deployed in the exact places that need them the most.

Finally, we'll need to continue to **support the development of next-generation innovations** that are so effective, they could **end some of the deadliest threats to children for good**.

That won't just save children's lives. It will fundamentally change the world they inherit.

That may sound ambitious—and it is. But it's also within reach.

My hope is that by the end of this report, you won't just be optimistic we can get there—you'll be energized about making it happen.

I am.

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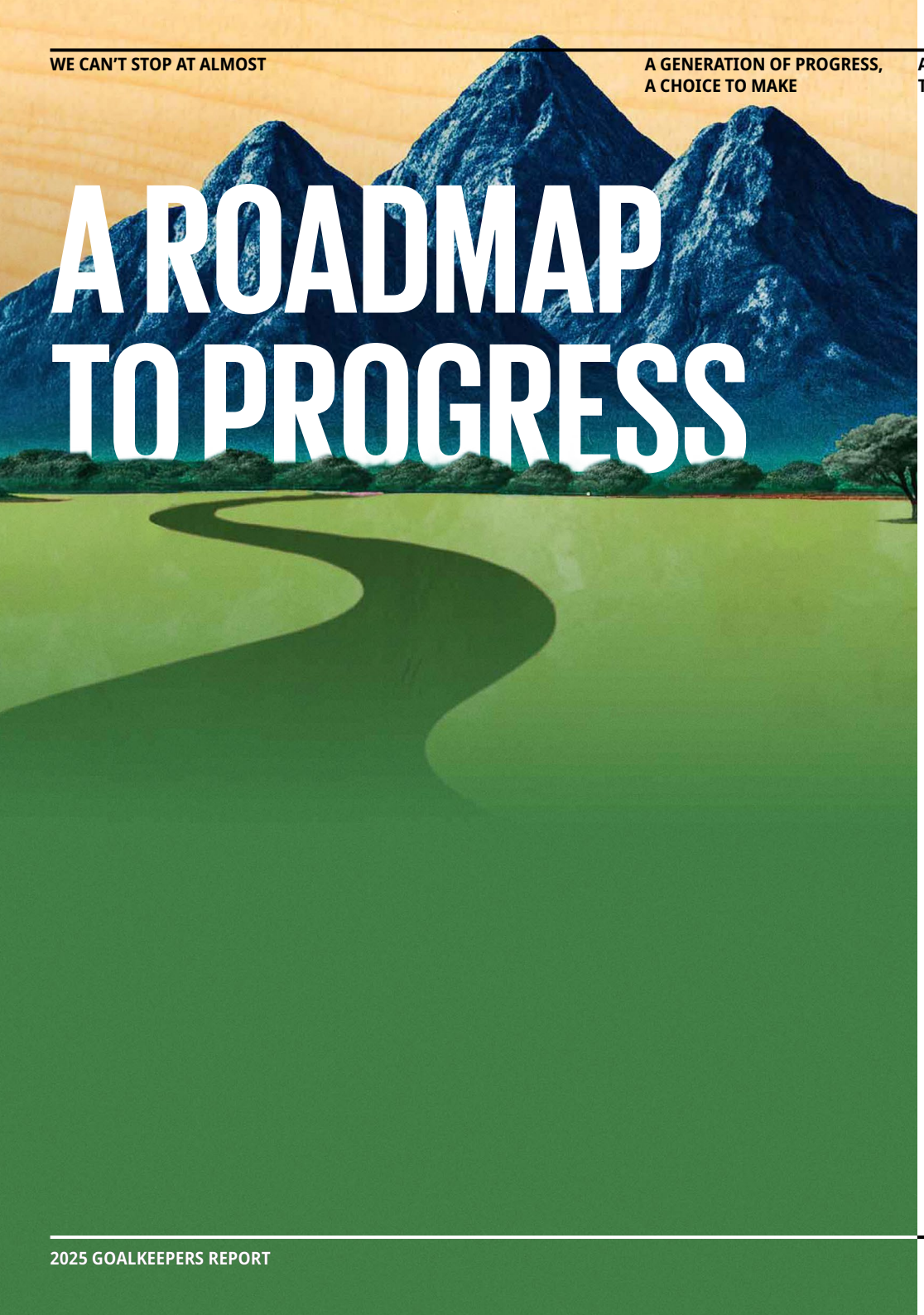

A ROADMAP TO PROGRESS

The smartest investment now is primary health care.

Primary health care is the quiet workhorse of every health system; the part that doesn't make headlines but **makes everything else possible**. It helps mothers deliver their babies safely. It catches pneumonia before it turns fatal. It vaccinates children before outbreaks happen. It spots new threats before they become full-blown emergencies.

And it's remarkably cost-effective. **For less than $100** per person per year, a robust primary health care system can prevent **up to 90 percent of child deaths**.

In short, investing in primary health care is our best bet at saving the most lives with limited resources.

On the pages that follow are some real examples:

In Nigeria, when faced with a tough budget deficit, Governor Muhammad Inuwa Yahaya of Gombe State didn't wait for perfection: he prioritized the basics.

Despite real setbacks, health workers like Josephine Barasa in Kenya haven't given up. They're doing everything they can, even with fewer resources and less support, to save lives every day.

Progress Through Partnership

By The Honorable Muhammad Inuwa Yahaya
Governor of Gombe State, Nigeria

Supplied by Governor's office

In 2019, when I became governor of Gombe State in Northern Nigeria, a historic budget deficit existed. We had broken systems, failing clinics, crumbling schools—and very little money to fix them. Our health system received only 3.5 percent of the state's total budget. Infrastructure was dilapidated, trained staff were few and often absent, and services were unaffordable for poor people. It would have been easy to wait to fix things and not spend money. But people weren't waiting, and so, neither could we.

Often, people think budget cuts save money. **But what really saves money—and lives—is spending with vision, discipline, and purpose.**

We made a choice to focus our resources and rebuild. We prioritized the basics: primary health, education, and trust. Today, Gombe has one renovated or newly built primary health center in every ward—114 in total—to deliver 24/7 services. More than 300,000 people are enrolled in our state's health insurance scheme. And we've constructed three general hospitals and rebuilt our specialist hospital. None of this was done with donor funding but with the budget we already had.

It wasn't easy. One of the hardest things I had to do was introduce biometric attendance for health workers. On paper, our facilities were staffed. But when I walked into clinics, I found nurses alone, treating twice the number of patients with half the team. We found 500 ghost workers. By addressing these issues—we saved ₦2.8 billion (US$ 1.8 million). And we reinvested all of it into training, hiring, and expanding care.

We're using that same lens now as health financing is changing to improve efficiency through technology—tracking not just attendance but service delivery too. **When you know where the gaps are, you know where to act.** And we improved coordination of external funding by appointing a special adviser who reports directly to me to ensure we're maximizing resources.

What I've learned is this: **You don't need perfect conditions to make progress. You need clarity, and the courage to stick to it.**

In Gombe, we didn't wait for perfection. We didn't wait to be rescued. But we didn't try to go it alone either. We started with what we had. We built what we needed. And then, we invited partners to walk with us—not because we had the loudest needs, but because we had a clear vision.

Leadership isn't about chasing recognition. It's about ensuring people no longer wake up fearing the same suffering they knew yesterday.

As a leader, you will face resistance and doubt. But if you stay grounded in your people—if you start with data, stay consistent, and lead with purpose—support will come. And change will follow.

We are not alone in this work. The path forward is one we walk together: communities, governments, and global partners, side by side. That's how real change is built, and how it lasts.

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I Still Show Up

By Josephine Barasa
Community Health Worker, Kenya

© Gates Foundation/Natalia Jidovanu, Kenya

They called me a "mother mentor."

That was my job title. I'm a health worker and a gender-based violence champion.

Women—girls, really—would come to me for help. Most had barely been allowed to be children before motherhood was thrust on them. Some of them had not chosen it. Many had experienced violence.

I know what it means to carry the weight of a wound you didn't ask for. As a young woman, I experienced violence, too. So, when I looked at these girls, I saw more than pain. I saw myself.

I walked with them through pregnancy and early motherhood. I was there through the fear, the confusion, the questions no one else would answer. And I taught them how to keep their babies healthy: when to vaccinate, what to eat, how to breastfeed, how to stay clean, when to visit the health clinic.

Then, one afternoon in January, everything stopped.

I received the email just after 2 p.m. It was brief.

"We are sorry. We no longer need your services."

I froze. And then I went silent. For four days, I didn't speak. I didn't leave my bed. I couldn't. For someone whose life had been built on being able to speak, to guide, to help, I felt that I had lost my voice.

Five days after the email, they brought me and my team in for a debrief. Talking together, all around the wreckage, I found the words slowly coming back. And I realized: **They could take away the money, but they couldn't take me away from my women.**

So, in February, I went back—unofficially, unpaid, and on my own. I still show up every day. I still screen women for gender-based violence. I still offer health education and basic care to their children. I still listen. **The support systems may have disappeared but the need has not. And neither have I.**

We've been trying to fill the gaps however we can. We've gone to churches, mosques, community centers, explaining what we're doing, asking for small donations, a place to meet, anything that can help us keep going, to keep caring for children, and to keep supporting their mothers. Sometimes we get a little support. Sometimes we're just told to come back later. But we keep trying.

The Kenyan government has stepped in where it can. The government has begun communicating more clearly and responding to some of the immediate gaps in maternal health services. It's a start.

And through it all, I still carry hope. I've seen what happens when a woman is supported—how she transforms not only her own life but also her child's, and her community's life, too. If we women don't do what we are supposed to do, our communities may never grow, may never change.

But I believe they can. I believe they will. **And every day that I show up, I'm choosing that future—for myself, for my children, and for the girls still learning how to become mothers.**

© Gates Foundation/Natalia Jidovanu, Kenya

Routine immunizations remain the best buy in global health.

Since 2000, the world has cut child deaths in half. The biggest reason? Vaccines, delivered to the children who need them most.

And every dollar spent on immunization gave countries a return of $54.

In a way, that actually undersells the impact per dollar. Because every health investment does more than saves lives—it transforms them. A healthy kid can go to school and learn. Healthy parents can work and provide for their families. And healthy societies are economically stronger and can invest more in their people.

For people in wealthy countries, it's hard to remember what life was like before vaccines were commonplace.

But Dr. Awa Marie Coll Seck, former two-time Minister of Health of Senegal, remembers.

She's talked about how in her culture, people once said that until a child reached the age of five and survived measles, you didn't truly "have" a child.

Senegal used to have hospital wards filled with children suffering from measles—many left with brain damage, and too many never went home.

But with support from Gavi, The Vaccine Alliance, Senegal strengthened their routine immunization system. As they reached more and more children with vaccines, cases plummeted—from a high of 24,000 in 2000 to just hundreds of cases in the past few years. Today, many of those once-crowded hospital wards have closed.

That progress is remarkable. But it's also fragile—because every time routine immunization slips, deadly diseases can return. And the cost of catching up is far higher than the cost of staying on track.

That's why reaching children today isn't just an investment in *their* futures—it's an investment in the future of entire nations.

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INNOVATIONS THAT STRETCH EVERY DOLLAR

To fight malaria, countries are targeting the most effective resources to the areas of highest need.

Today, in communities across sub-Saharan Africa every rainy season brings the same fear: the world's deadliest animal, the Anopheles mosquito, and the disease it carries, malaria.

It's so common that most people have been infected at some point in their lives, and so lethal that almost everyone has heard of someone who didn't survive malaria—a baby, a parent, a friend.

One big problem is that malaria doesn't behave the same way in every community across a country. A one-size-fits-all approach isn't the most effective strategy to save lives.

That's where subnational tailoring comes in. It's a process countries use to decide which malaria interventions to deploy, where, when, and at what intensity.

The upshot? Fewer campaigns to target malaria, only in the most important places.

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With the money saved by being more targeted about where to run these campaigns, countries can afford to layer on multiple interventions—giving children (and their families) even more protection.

By tailoring their response to make the biggest impact, **countries can maximize the number of lives saved per dollar**.

In Zambia, adding a digital smart map to guide spray teams to the highest-risk areas reduced the cost per case of malaria prevented by more than 20 percent.

Fewer malaria cases mean more capacity to treat other diseases, too—because it's much easier to supply and staff a health center when it isn't completely swamped with malaria cases four months out of the year, every single year.

With vaccines that deliver the same protection in fewer doses, countries have more money to reinvest in health systems.

Pneumococcal conjugate vaccines (PCV) help protect children from pneumonia, the leading infectious killer of children under the age of 5.

In March of this year, the World Health Organization (WHO) updated its guidance on PCV. In countries with an established PCV program, they included a reduced dosing schedule. Instead of children having to get the traditional three doses (two initial doses plus a booster), they could get one primary PCV dose and one booster—and still have strong protection.

Dropping one shot may not seem like much. But it's game changing. Not only will it reduce costs and simplify logistics, but it also lessens the strain on health systems, all while keeping kids safe.

If eligible countries switch to two doses, it could save around $2 billion by 2050. With the money saved from the reduced dosing schedule, countries can reinvest in expanding vaccine coverage—or introduce vaccines to fight other diseases that disproportionately kill children.

The Power of Immunization

By Dr. Naveen Thacker, India
Consultant Pediatrician, Deep Children's Hospital, Gandhidham, Gujarat
Executive Director, International Pediatric Association

© Gates Foundation/Mansi Midha, India

Some breakthroughs take generations to leave their mark. Vaccines didn't. In my four decades as a pediatrician, I watched their impact unfold in real time, reshaping childhood within a single lifetime.

When I was growing up in Satna, India, it wasn't unusual to hear someone say, "We were seven, now we are five." Families had many children, not just by choice, but because it was quietly understood that not all of them would survive. Most people of my generation carry the same story: a sibling lost early to fever, pneumonia, or something unnamed that came suddenly and took them away.

Today, parents can choose to have one or two children because they trust they will live.

When I began my residency, the hospital ward was filled with children suffering from neonatal tetanus, diphtheria, pneumonia, and rotavirus. Later, I recall a time when I saw 55 cases of polio in a single month. I was considered an expert in meningitis simply because I had treated so many children who had it. The suffering I saw daily was profound. Many children did not survive, and those who did often had lifelong health challenges.

Today, those diseases have largely disappeared from my practice.

Why? **Because of vaccines.**

In India, the introduction of the pentavalent vaccine—which protects children against diphtheria, tetanus, pertussis (whooping cough), hepatitis B, and *Haemophilus influenzae* type b—and rotavirus vaccines helped cut deaths from pneumonia and diarrhea—once two of the biggest killers of children—by more than half. In 2024, 94 percent of eligible children received the pentavalent vaccine, one of the highest coverage rates in the region.

Mission Indradhanush, India's flagship immunization initiative launched in 2014, aims to ensure that every child under 2 and every pregnant woman is fully immunized against all vaccine-preventable diseases—with a focus on reaching low-coverage areas. The campaign has reached over 50 million children and 12 million pregnant women so far. It has helped close childhood immunization gaps by building on the lessons of polio eradication—microplanning, outreach, and community engagement. And now full immunization coverage in the world's largest country is well over 90 percent.

The Government of India's consistent investments in strengthening its supply chain and frontline healthcare workforce—while leveraging digital tools—have been critical to this success. Drawing on lessons from the COVID-19 vaccination effort, India digitized its national immunization system, recording over 79 million registered recipients and 292 million vaccine doses, making it one of the world's largest electronic immunization registries. The impacts are visible, not just in statistics but in the faces of the children who now thrive.

At a time when health budgets everywhere are under pressure, routine immunization stands out as one of the smartest investments we can make. Vaccines don't just save lives—they prevent outbreaks that strain hospitals, disrupt education, and pull resources from other priorities. Every dollar spent on immunization returns many more in averted treatment costs and preserved productivity. In other words, vaccines are not a cost center—they're a cost saver.

If we want to see more healthy children, affordability of vaccines is key. It's been a key driver in India's success and contributed to much of the progress we've seen in children's health around the world. India produces 60 percent of the world's vaccines, making immunization affordable and globally accessible, saving lives not only in India but also in Africa and Southeast Asia. Two major examples: the pneumococcal conjugate vaccine developed by the Serum Institute of India (SII) was introduced at just US$2 per dose; an India-developed rotavirus vaccine brought the price down to around US$1 per dose, enabling broad introduction across Africa and Asia.

When I started practicing medicine, I saw countless children fighting for a chance at life from diseases that today don't stand a chance against vaccines.

So much can change in one lifetime.

That's the power of immunization.

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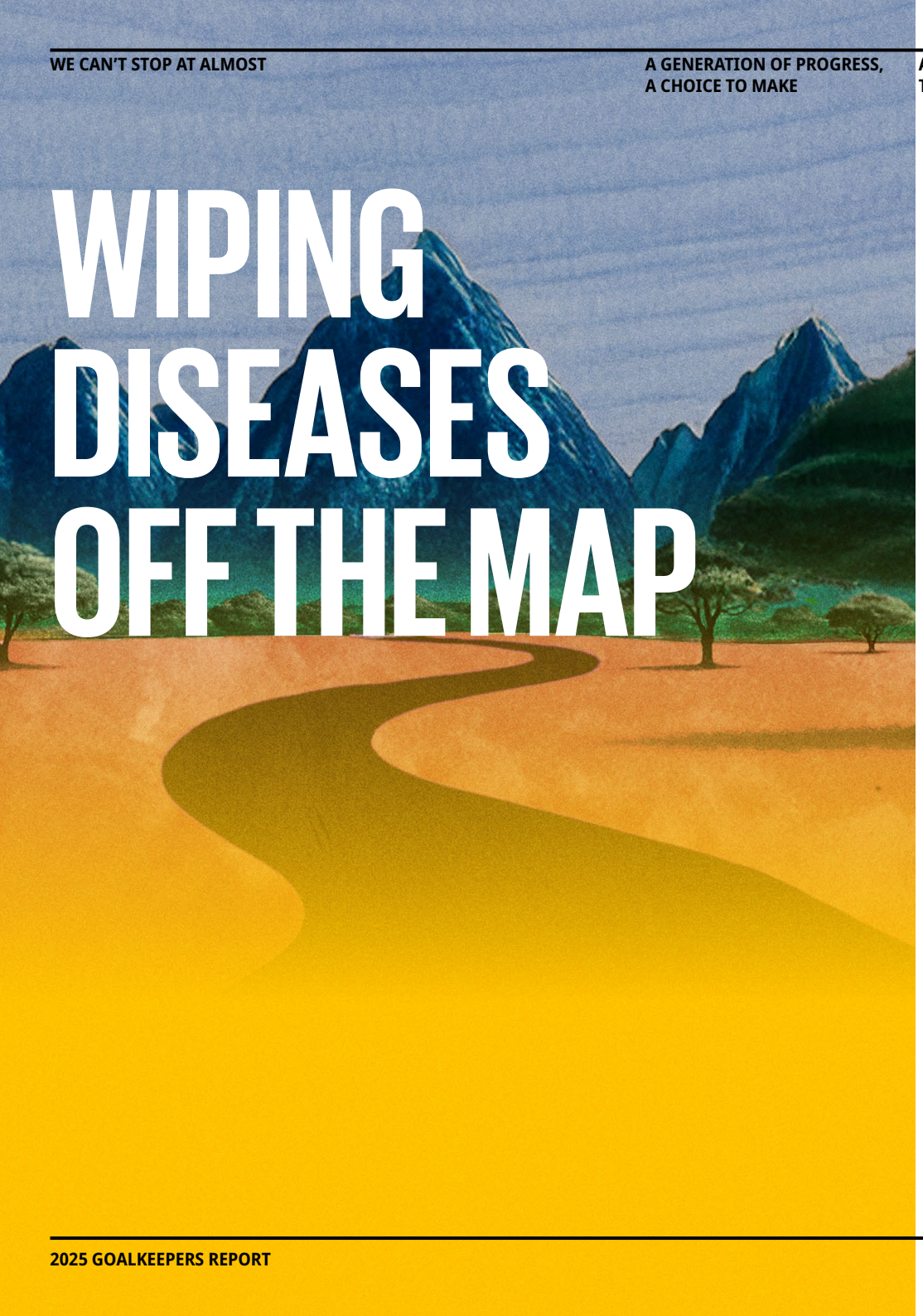

WIPING DISEASES OFF THE MAP

By the 2040s, new science could end malaria—eradicating a mosquito-borne illness that kills more than 400,000 children under the age of 5 every year.

A series of innovations are coming together, creating a triple-layered shield to keep malaria from killing:

Before the bite. Research into a new generation of vaccines has the potential to close critical gaps—protecting older children and those already exposed to the disease, especially in high-burden areas such as sub-Saharan Africa, where 94 percent of malaria cases occur.

During exposure. Approximately two decades ago, the widespread rollout of insecticide-treated bed nets in sub-Saharan Africa triggered the fastest drop in malaria deaths in history.

But as our defenses improved, mosquitoes have adapted.

In just 18 months, a single mosquito population can cycle through 20 generations, giving them plenty of chances to build resistance to the insecticide on those bed nets.

That's why scientists developed *dual*-insecticide bed nets, pairing two different insecticides to beat resistance. In early use across 17 countries in Africa, these bed nets have already helped prevent over 13 million cases.

Even though global funding cuts have slowed the rollout, the math is simple: **For a little over $1 per person, we can save tens of thousands of lives per year.**

But that's not all. A leading insect-repellent manufacturer has developed a small, poster-like spatial repellent—a square that sticks to the wall and keeps mosquitoes away around the clock. It looks like something you might see on a child's bedroom wall—perhaps next to a superhero poster. Only this poster *is* a superhero: It saves lives.

After infection. Treatment is becoming radically simpler. A single-dose cure will be able to clear certain types of malaria, replacing multi-day regimens with just one pill.

With these next-generation innovations, plus strong trust and partnership with local governments and experts, we can stop malaria from being common and expected, or even fatal.

And we're on our way to stop malaria from existing at all—within our lifetimes.

It's a bold idea, and African scientists are leading the way.

BY 2045,

5.7 MILLION

CHILDREN COULD BE SAVED

with next-generation malaria tools

A Future without Malaria

By Krystal Mwesiga Birungi, Uganda
Research and Outreach Associate, Target Malaria Uganda

© Gates Foundation/Zahara Abdul, Uganda

Some of my earliest memories are of my younger brother convulsing with fever while my mother tried desperately to cool his body. He had malaria. We knew treatment existed, but we could not afford it. All we could do was pray.

He didn't just suffer once—he suffered again and again. Watching him, I felt terror and helplessness. When I caught malaria myself, the pain was so unbearable that sometimes… I wished it would all just end. **That is the reality of malaria: You cannot avoid it when it strikes, and once it does, survival is never guaranteed.**

Back then, even mosquito nets were out of reach for my family. My mother once told me, "Nets are for rich people." She faced impossible choices: stay home to tend to a sick child and risk the family going hungry or go to work and risk losing her child. Many Ugandan parents still make those choices today.

Everything changed when the Global Fund to Fight AIDS, Tuberculosis and Malaria arrived in my country—I was 14 years old. Suddenly, mosquito nets and medicines were distributed free of charge. Community health workers could diagnose and treat malaria in our neighborhoods. For the first time, being poor didn't mean malaria was a death sentence. In countries where the Global Fund invests, like my own, malaria deaths have dropped by 29% in less than two decades. **Without these programs, malaria deaths would have doubled during that same time.**

Those interventions gave me a future—and a purpose. Today, I am an entomologist working with Target Malaria at the Uganda Virus Research Institute, developing new genetic technologies to reduce the number of mosquitoes that spread this disease. When I first learned about genetics as a teenager, I saw how powerful it could be. Many told me my dream to use genetics to combat malaria was impossible. My mother said otherwise. She was right.

Science has continued to advance since I was a child. Today, the world has more tools than ever to fight malaria. Newer, stronger bed nets, indoor spraying, medicines, and vaccines have saved millions of lives. But each faces limits. Mosquitoes develop resistance to insecticides. Parasites evolve resistance to drugs. Vaccines are lifesaving but not yet strong enough to stop transmission alone. And none are sufficient to stop malaria from existing. That is why we need new innovations that could break transmission altogether.

We are studying how gene drive technology—a tool that helps a specific genetic trait spread through a population much faster than normal—could help fight malaria. Only certain mosquito species carry and transmit the malaria parasite. African scientists, including at Target Malaria where I work, are exploring whether modifying the malaria-transmitting mosquitoes' genes could make them less able to reproduce or prevent them from passing the parasite to humans. Normally, such genetic changes are inherited only about half the time,

but with gene drive, the traits can be passed on to nearly all offspring—reducing or even eliminating malaria transmission in the local area.

Of course, research isn't just about science; it's about trust. So together with our partners, we are working hand-in-hand with communities—listening, explaining, and ensuring our work is shaped by them.

What drives me is simple: Children are still dying today from the disease that haunted my childhood. I survived because someone invested in me. Now it is my turn to make that possible for others.

A year ago, my son turned 5. For many parents, that milestone is about school readiness. For me, it was about survival. In Uganda, one in 25 children dies before their 5th birthday—most from malaria. When my son blew out his birthday cake candles, all I could think was: *He is alive. He made it.*

Every child deserves that chance. **Ending malaria is not only possible, it is urgent.** We African researchers know this—and we are leading the way. We have the innovations. We have the knowledge. And we are advancing our understanding of science to take us over the finish line.

© Gates Foundation/Zahara Abdul, Uganda

By the late 2040s, new innovations could virtually eliminate deaths from HIV/AIDS, once the world's deadliest pandemic.

Imagine it's the year 2044. A teenage girl in Botswana knows what HIV/AIDS is, but neither she, nor anyone her age, knows someone who has died from it.

When her grandparents were children, things were very different. No affordable or effective treatments for HIV/AIDS existed. A diagnosis was almost always a death sentence and onward transmission almost certain.

By the time her parents were young adults, HIV had become more manageable. Daily antiretroviral therapy, a daily combination of HIV medications (one pill a day), made it possible to live a long, healthy life with the disease. And PrEP (pre-exposure prophylaxis) pills helped prevent infection for people at risk. These tools had once been too expensive or hard to find, but thanks to efforts such as PEPFAR (the U.S. President's Emergency Plan for AIDS Relief) and the Global Fund, they became more widely available in low- and middle-income countries.

Still, it wasn't always easy to get these treatments. Clinics were often far away. Stigma kept people from seeking care. Some people, including children, couldn't avoid infection. Mothers passed the virus to their babies. And many of those babies didn't survive.

But that's a world our teenager can barely imagine. She opens her phone, taps her health app. It's a smart AI concierge that helps her navigate everything from mental health to contraception.

Today, it walks her through HIV prevention.

She learns about her risks, and a wide array of options for reliable, affordable, long-acting HIV prevention—a monthly pill, an annual injection, and even an effective vaccine.

She selects one.

Within hours, it's available.

It's a single shot—an injection called Lenacapavir. One dose a year. That's it.

That future may sound far away. It isn't.

Lenacapavir already exists—and when a generic is available in the next few years, it will be even more affordable. It's not one shot per year yet, although that may come by 2028. For now, it's two injections per year, which is still 363 fewer doses than the daily pill people rely on today, and even that pill is evolving: A monthly version of oral PrEP is now in late-stage trials.

In an era of scarce resources, this kind of innovation has never mattered more. Getting the twice-a-year version to just 4 percent of high-incidence areas could prevent up to 20 percent of new infections.

That's life-changing for everyone, but especially for children. **Fewer women infected means fewer babies born with the virus.**

New maternal vaccines that protect babies before they are even born are our chance to ensure that a baby's first few months aren't their last.

All these innovations will help save millions of children.

But there's one category of tragedy we still haven't solved. **Nearly half of all child deaths happen in the first month of life.**

Innovations like the pneumococcal vaccine (PCV) have helped turn the tide against bacterial pneumonia. But some viruses and bacteria strike so fast—within days or weeks of birth—that we can't immunize babies quickly enough.

BY 2045,

3.4 MILLION

CHILDREN COULD BE SAVED

by scaling new immunization products for RSV and pneumonia

Respiratory Syncytial Virus (RSV) is one of those threats. In high- and low-income countries alike, it's the leading cause of pneumonia in infants, and a major reason newborns land in the hospital struggling to breathe.

Not only that, babies who are hospitalized with RSV in the first 6 months of life are three times more likely to suffer from recurrent lower respiratory tract infections later in childhood.

Then there's Group B *streptococcus*, or GBS, a stealthier but equally deadly disease. Many pregnant women carry it without symptoms. But when it's passed to a newborn, it can lead to blood infections, brain damage, or death within hours of birth. And right now, there's no vaccine to prevent it.

In the late 2000s, scientists increased exploration of a different strategy: ***If we can't protect babies fast enough, what if we immunize their mothers instead?***

The idea is simple but powerful. When a pregnant woman is immunized, she passes antibodies to her baby through the placenta, providing protection before her baby is even born. It's like fitting a newborn with a suit of armor.

Maternal vaccines are already used to protect against tetanus and pertussis. But new vaccines for RSV and GBS could redefine what maternal immunization can do.

Safety comes first with all vaccines—and especially with vaccines for expectant mothers—which is why this approach has taken years of careful progress.

If you gave birth in the United States, United Kingdom, or Canada recently, you and your baby may have already benefitted from the RSV vaccine.

Mothers and babies *everywhere* deserve the best protection possible. Rollout of the RSV vaccine began in high-income countries two years ago. Now it will be available in Gavi-supported countries to protect babies in low-income countries where most of the deaths occur.

As for GBS, a vaccine is in development that could change the game. If successful, it would be the first ever vaccine to prevent GBS infections in newborns.

Delivery of these vaccines is being developed to specifically address the needs of low- and middle-income countries. Currently, the Gates Foundation is supporting the development of multidose vials—containers that hold enough vaccine for 2 to 20 people. These vials help cut costs and make distribution more efficient, especially in places where resources are scarce and demand is high.

These kinds of innovations have multiple benefits: saving lives, saving money, and freeing up resources for countries to spend on other critical priorities.

And for the babies whose lives are protected, they can change everything—not just in those first few precious months of life, but for everything that comes after.

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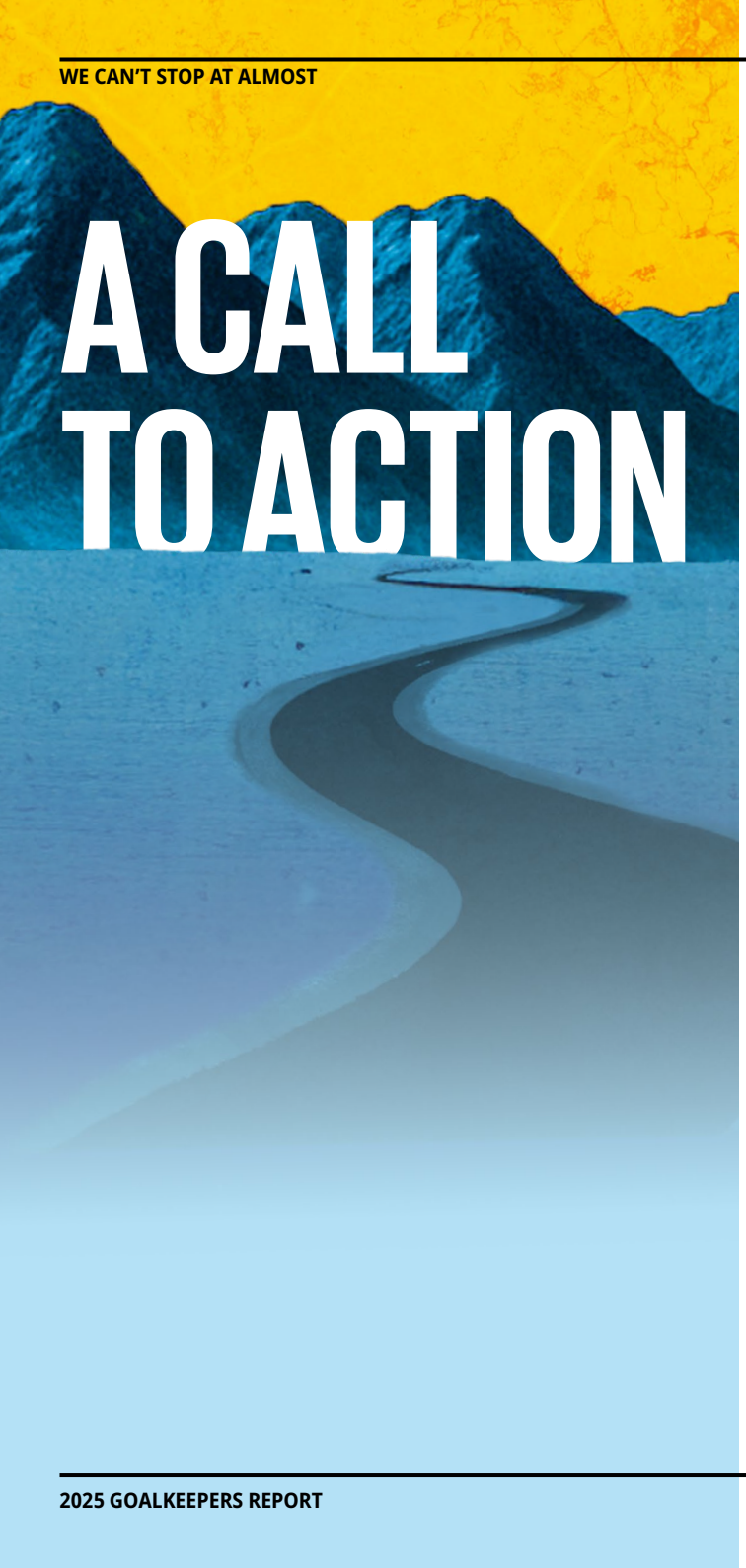


A CALL TO ACTION

I turned 70 this year, an age when many people retire. I'm not slowing down anytime soon because I know that over the next 20 years we can make an even bigger difference for the world's children.

We all have a role to play.

If you're a policymaker:

- Target health financing to best buys and fund proven successes like Gavi and the Global Fund.
- Protect and expand investment in primary health care and routine immunization.
- Support the development and uptake of health innovations to accelerate impact.

If you're an engaged citizen:

- Use your voice to remind leaders what we have in common: a belief that children should survive and thrive, no matter where they happened to be born.

The last generation proved that with innovation and commitment, we could save millions of children's lives.

We can do it again—this time faster, smarter, and more affordably.

Because parents deserve the chance to find out what their children will do when they grow up—not wonder if they'll grow up at all.

We can give them that chance.

If we do more with less now—and get back to a world where there's more resources to devote to children's health—then in 20 years, we'll be able to tell a different kind of story: The story of how we helped more kids survive childbirth, and childhood.

More first words, first steps, first days of school.

More candles on birthday cakes.

More lives that reach their full potential—not by luck but by design.

Because every life we protect is a future we create. And that's worth fighting for.

EXPLORE THE DATA

In 2015, 193 world leaders agreed to 17 ambitious Sustainable Development Goals (SDGs) to end poverty, fight inequality, and improve health by 2030. Goalkeepers works to accelerate progress toward these goals, focusing on Goals 1-6.

Each year, the Goalkeepers Report tracks 18 key indicators—from poverty to education—offering the latest estimates on where innovation and investment are driving progress, and where we're falling short. These data remind us that progress is possible but not inevitable.

With just five years left, the world is off track. And this year, reductions to health funding have put achieving the SDGs even further out of reach.

The 13 health indicators we track with our partner, the Institute for Health Metrics and Evaluation (IHME), incorporate the projected impact of potential health funding reductions, assuming a 20% reduction to Development Assistance for Health in 2026 compared to 2024 funding levels.

It's clear: Urgent action is needed to meet the SDG targets and create a more equitable, safer future for all by 2030.

Interact with the data

Visit our website to view an interactive version of these charts and access the raw data.

https://gates.ly/ExploretheData

Poverty

Stunting, Agriculture

Maternal Mortality, Under-5 Mortality, Neonatal Mortality, HIV, Tuberculosis, Malaria, Neglected Tropical Diseases, Family Planning, Universal Health Coverage, Smoking, Vaccines

Education

Gender Equality

Sanitation

Inclusive Financial Systems

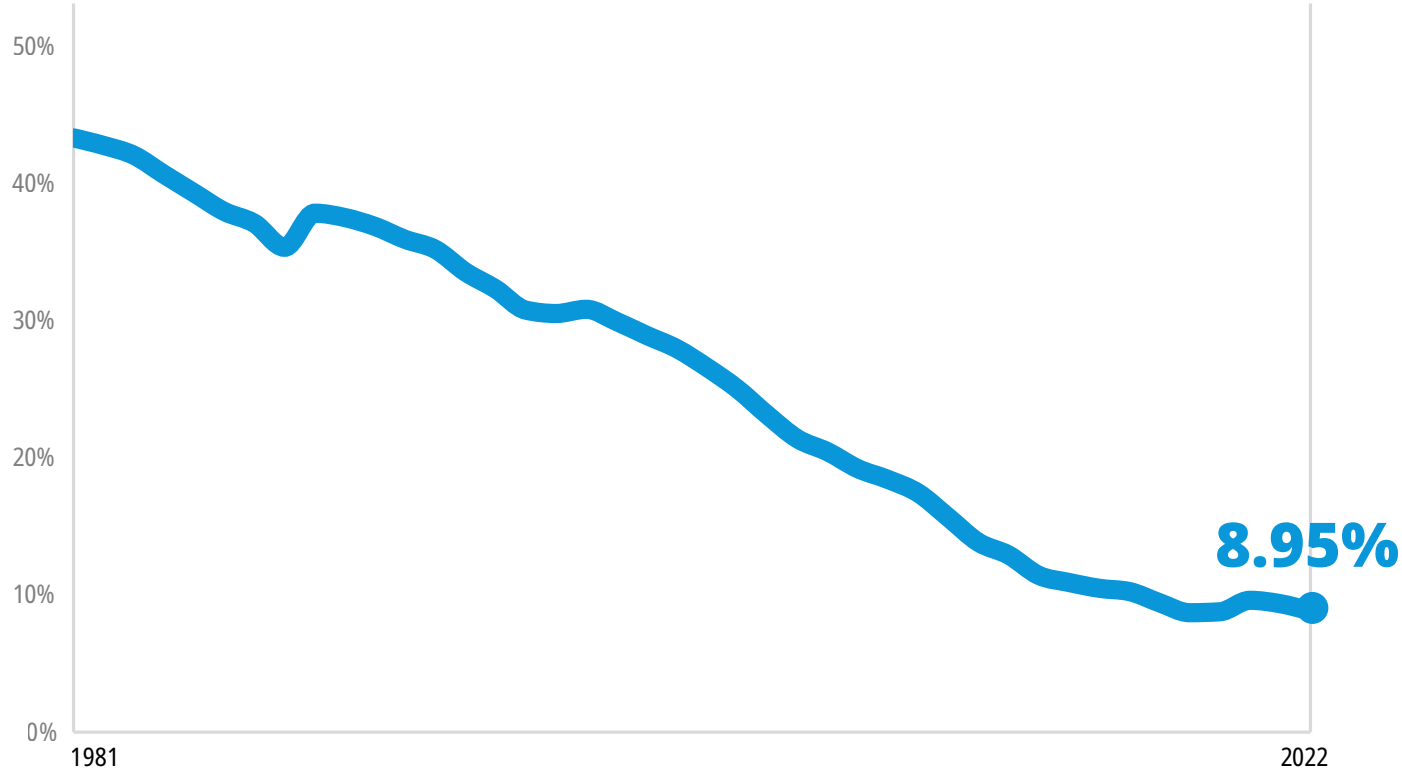
Poverty

SDG Target 1.1
Eradicate extreme poverty for all people everywhere.

Nine percent of the global population, or 712 million people, lived on less than the US$2.15 per day poverty line in 2022. At the current pace, nearly 7% of the world's population will remain in extreme poverty by 2030—that's 574 million people in extreme poverty.

(The new World Bank global poverty line will be used in the next edition of this report.)

Percentage of population below the international poverty line (US$2.15/day)



Legend

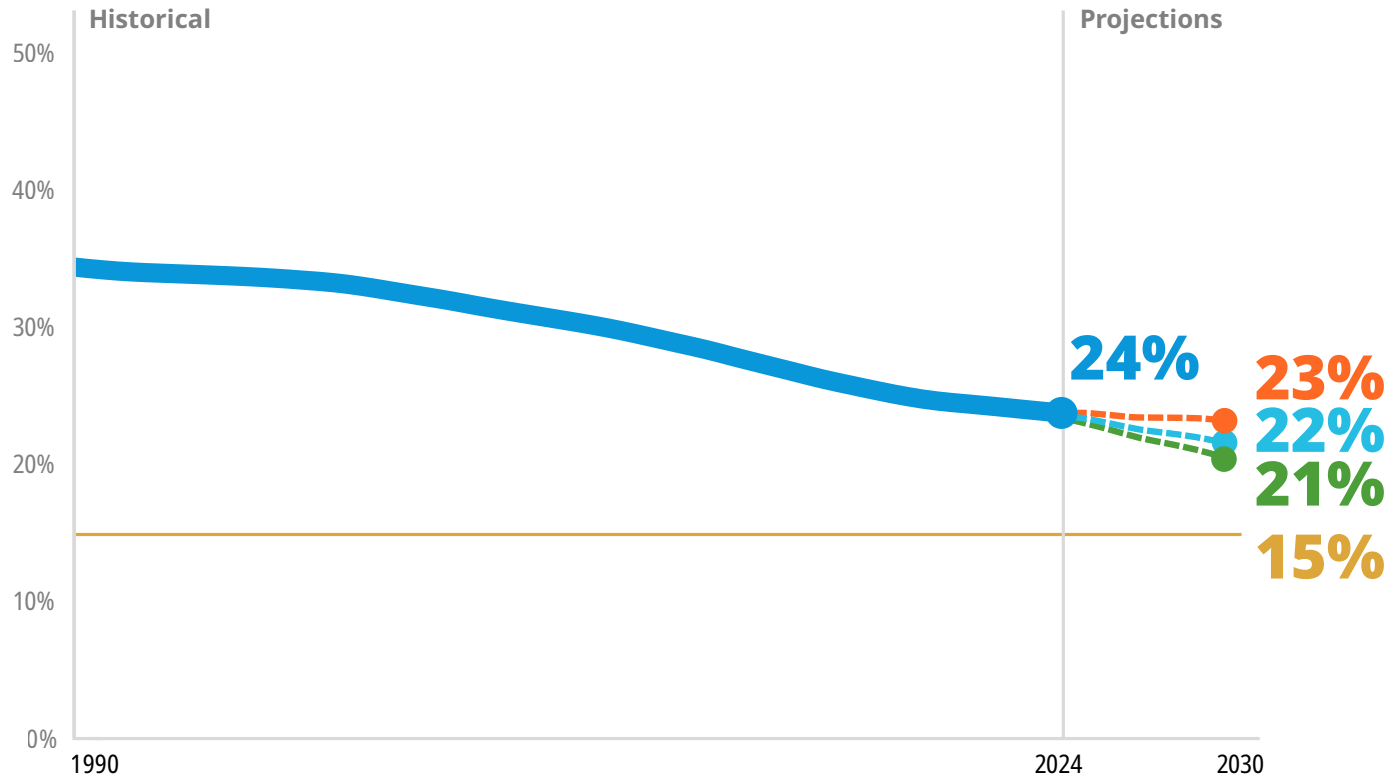
Historical average

Stunting

SDG Target 1.2
End all forms of malnutrition, including achieving, by 2025, the internationally agreed-upon targets on stunting and wasting in children under 5.

Stunting among children has stalled at 24% in 2024. The 2030 projection estimates that 22% of children under age 5 will be stunted—missing the 2030 stunting target of 15%.

Prevalence of stunting among children under age 5



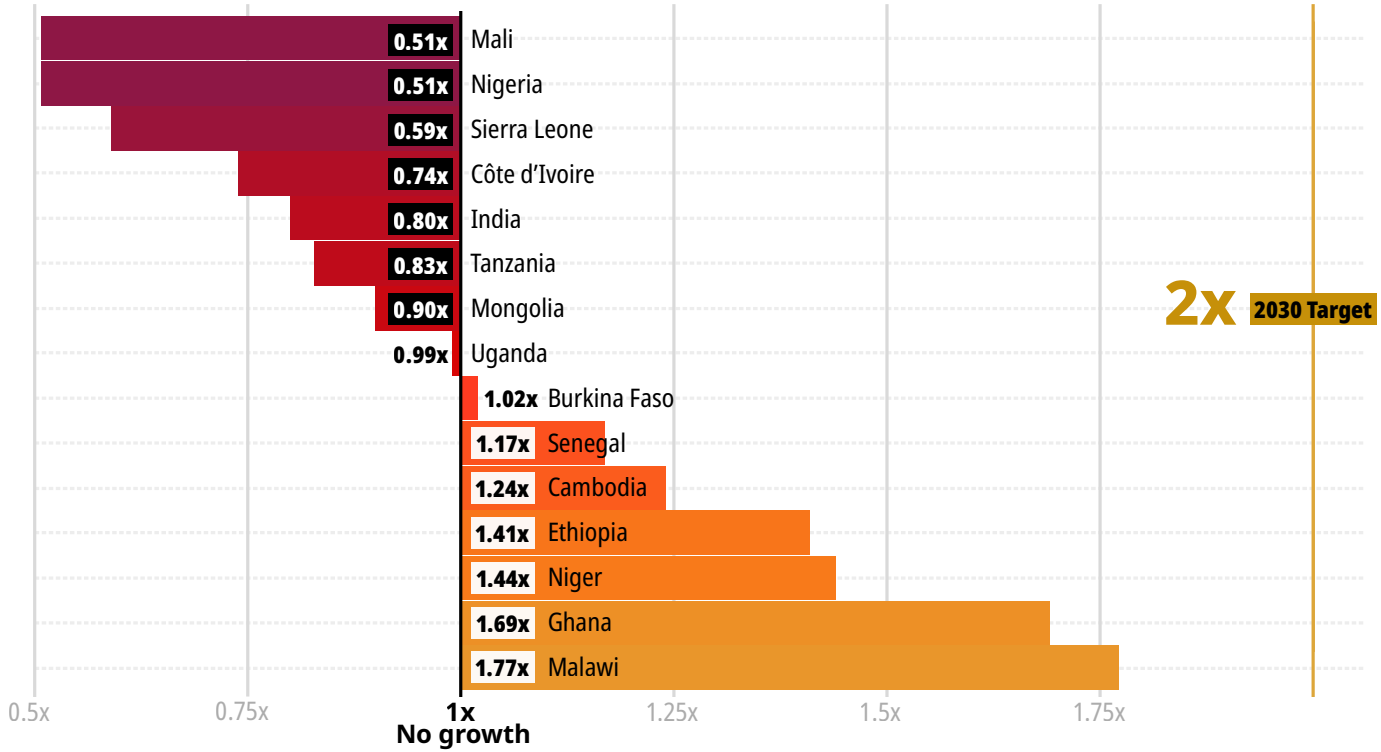
Agriculture

SDG Target 2.3
Double the agricultural productivity and incomes of smallholder food producers, in particular women, indigenous peoples, family farmers, pastoralists, and fishers.

Smallholder producers lag large-scale producers and face an income and productivity crisis. Innovations that allow small farmers to do more with their limited resources are needed in an environment where extreme weather events, conflict, and economic volatility pose serious challenges to their food security. Efforts are underway to bolster the scale up of agricultural statistics collection to continue learning more.

Note:
Country growth rates are not comparable since they are calculated over different year ranges. All date ranges can be found in data sources.

Rate of average annual income growth from agriculture for smallholder food producers



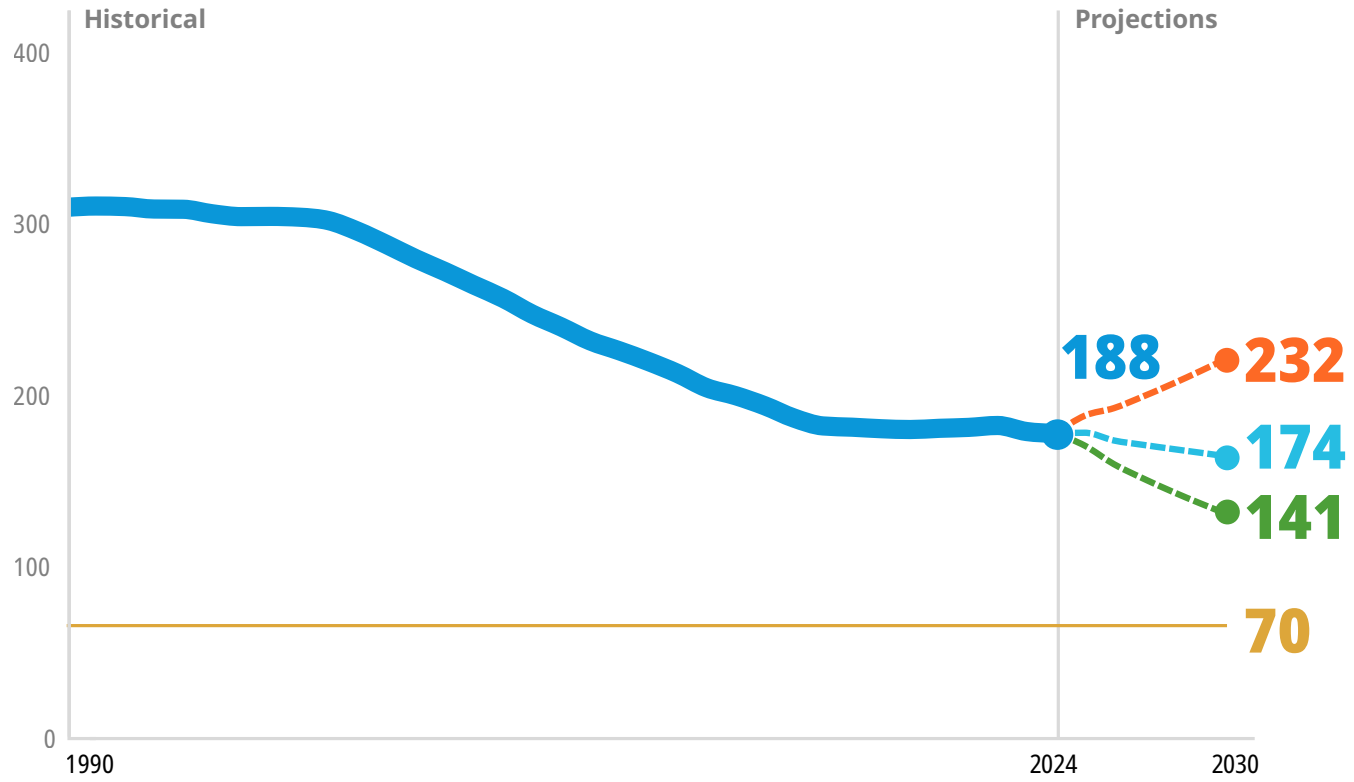
Maternal Mortality

3 GOOD HEALTH AND WELL-BEING

SDG Target 3.1
Reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

Progress on the global maternal mortality ratio has stalled since 2016. In 2024, the maternal mortality ratio was 188 per 100,000 live births. The 2030 projection estimates 174 maternal deaths per 100,000 live births. Achieving the target by 2030 will require an annual rate of reduction of 15%, a rate much faster than historical trends.

Maternal deaths per 100,000 live births



Legend

2030 target | Historical average | Better | Reference | Worse

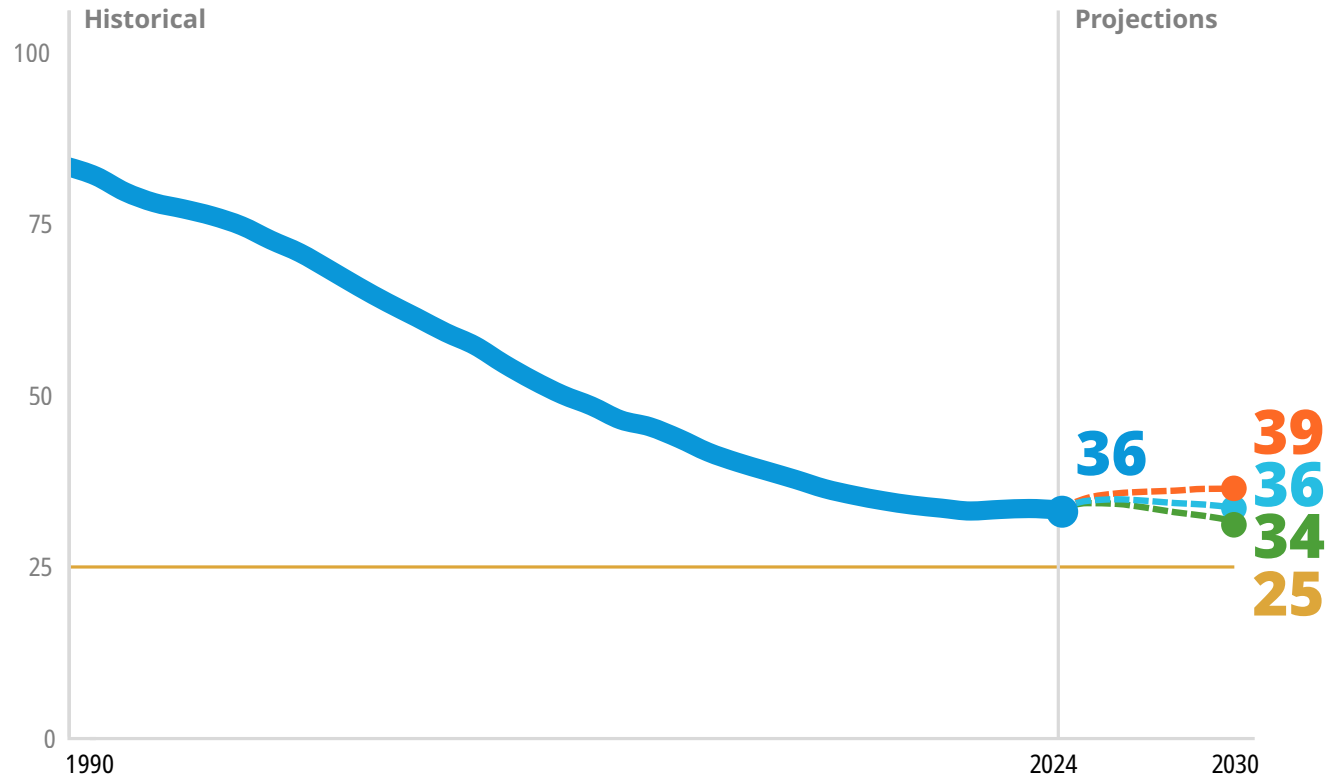
Under-5 Mortality

3 GOOD HEALTH AND WELL-BEING

SDG Target 3.2
End preventable deaths of children under 5 years of age, with all countries aiming to reduce under-5 mortality to at least as low as 25 per 1,000 live births.

Since 2021, the child mortality rate has stalled at 36 deaths per 1,000 live births. By 2030, the projected child mortality rate will remain at 36 per 1,000 live births—missing the target of 25 child deaths per 1,000 live births.

Under-5 deaths per 1,000 live births



Legend

2030 target | Historical average | Better | Reference | Worse

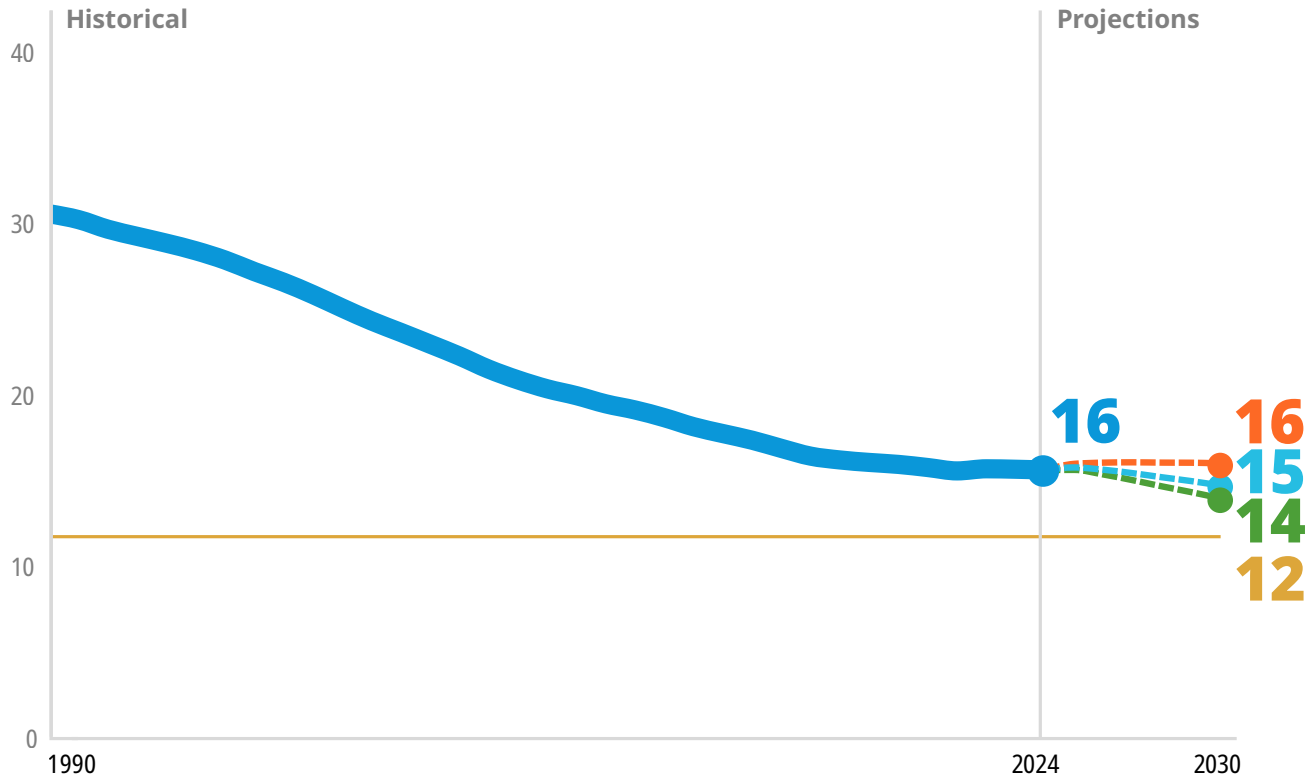
Neonatal Mortality

3 GOOD HEALTH AND WELL-BEING

SDG Target 3.2
End preventable deaths of newborns, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births.

Since 2018, the neonatal mortality rate has stalled globally at 16 neonatal deaths per 1,000 live births. By 2030, the projected rate will be 15 neonatal deaths per 1,000—missing the target of 12 neonatal deaths per 1,000 live births.

Neonatal deaths per 1,000 live births



Legend

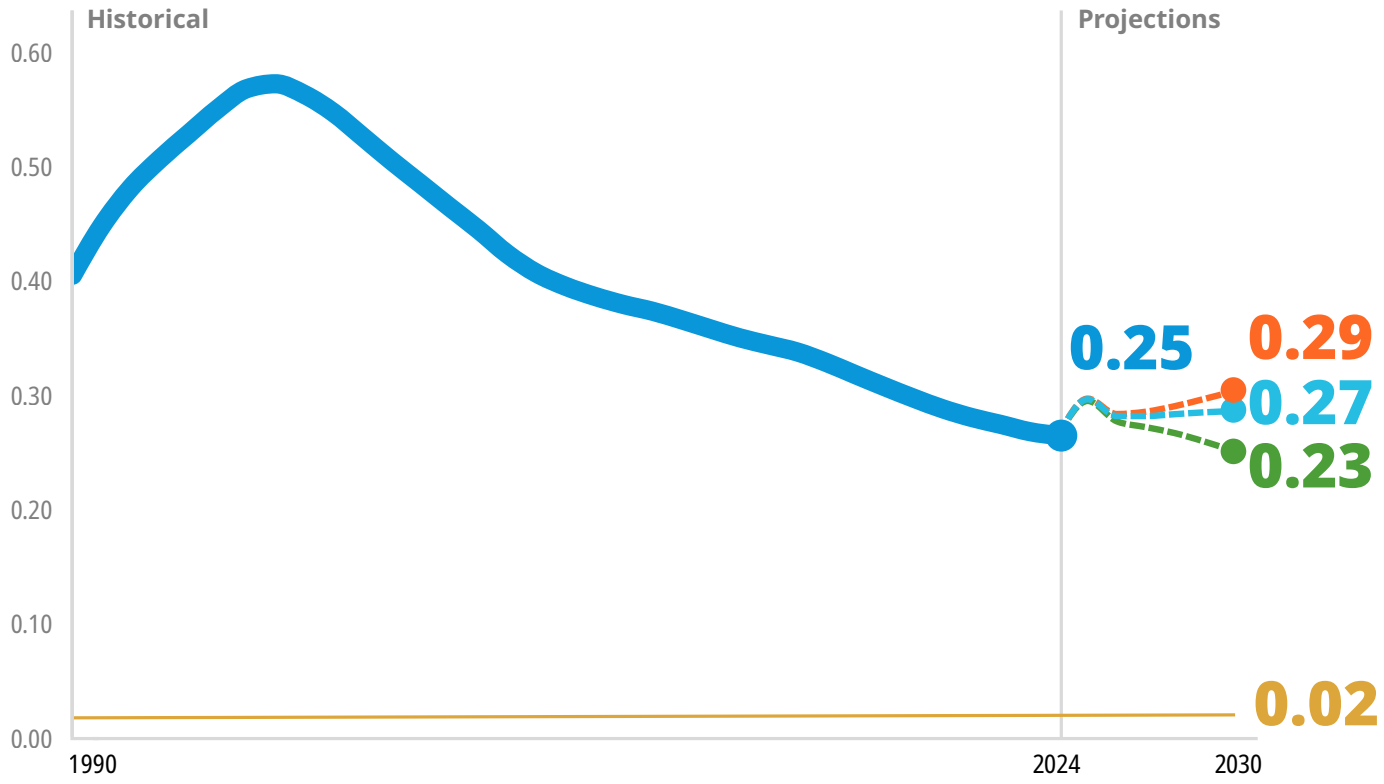
2030 target | Historical average | Better | Reference | Worse

HIV

SDG Target 3.3
End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.

Globally, HIV incidence has declined steadily since its peak, reaching a low of 0.25 in 2024. However, recent disruptions to HIV funding and programming have reversed that trend, with incidence now projected to rise to 0.27 per 1,000 people by 2030—more than 10 times the target of 0.02 per 1,000 people.

New cases of HIV per 1,000 people

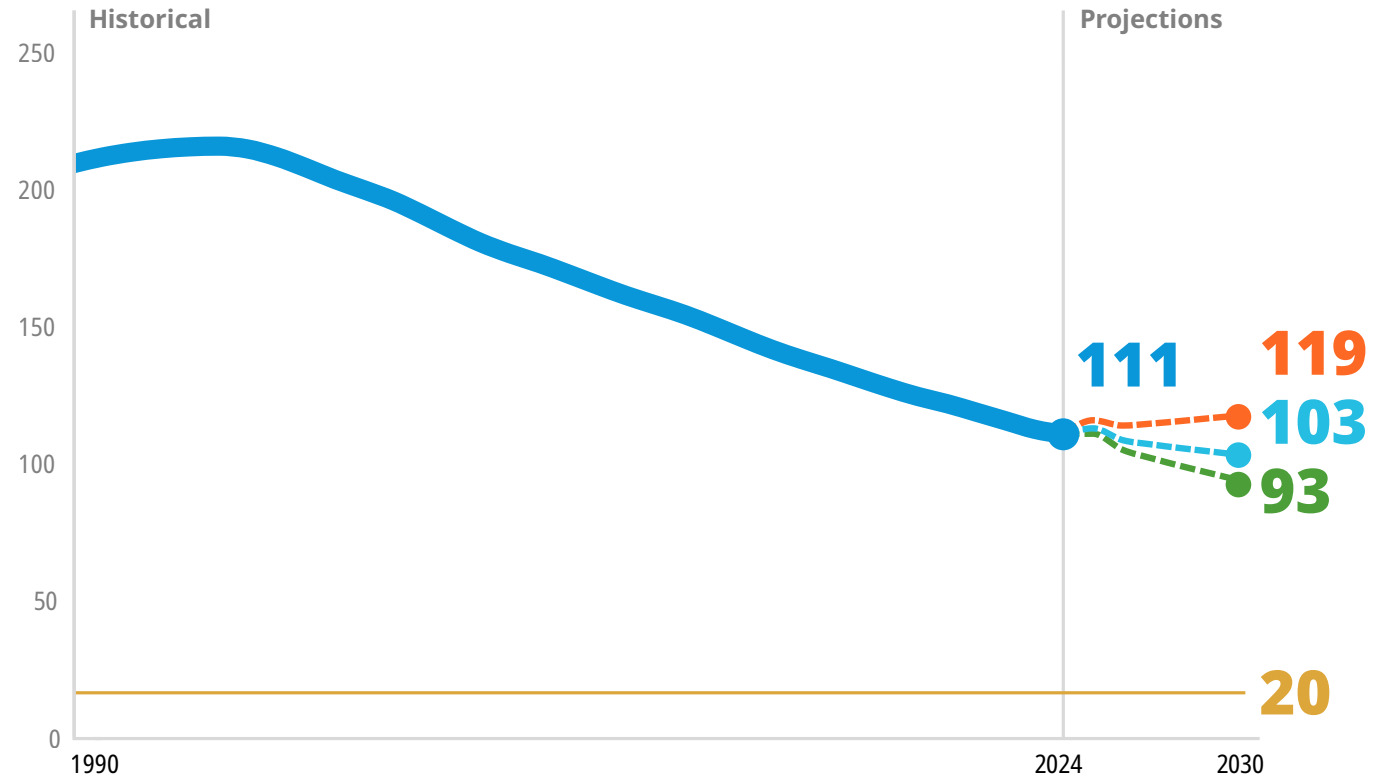


Tuberculosis

SDG Target 3.3
End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

Globally, there were 111 new cases of tuberculosis per 100,000 people in 2024. The estimate indicates that there could be static progress from 2025, with new cases of tuberculosis reaching 103 per 100,000 people in 2030—that's more than five times the target of 20 new cases per 100,000 people.

New cases of tuberculosis per 100,000 people



Legend

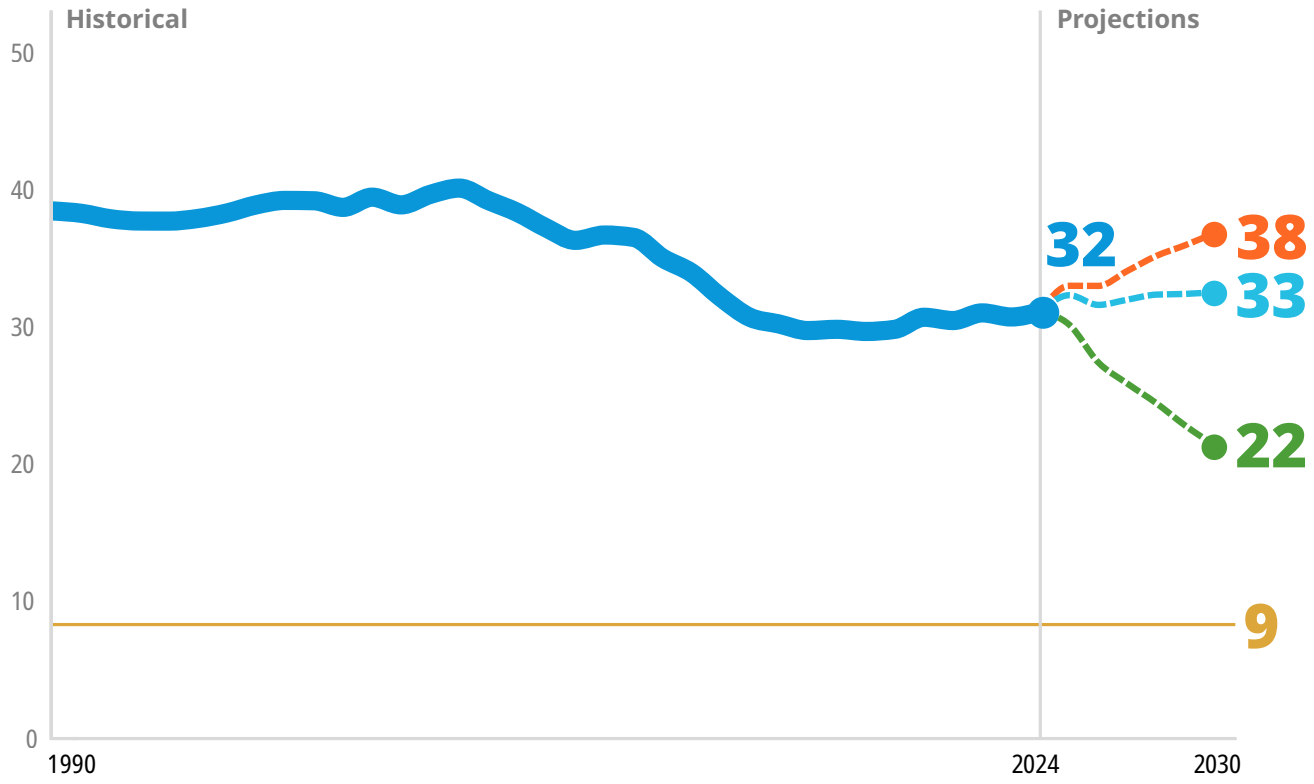
2030 target | Historical average | Better | Reference | Worse

Malaria

SDG Target 3.3
End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.

Progress on decreasing the number of new cases of malaria have stalled, reaching 32 cases per 1,000 people in 2024. The 2030 projection estimates reversal of progress, with new cases increasing to 33 cases per 1,000 people by 2030.

New cases of malaria per 1,000 people



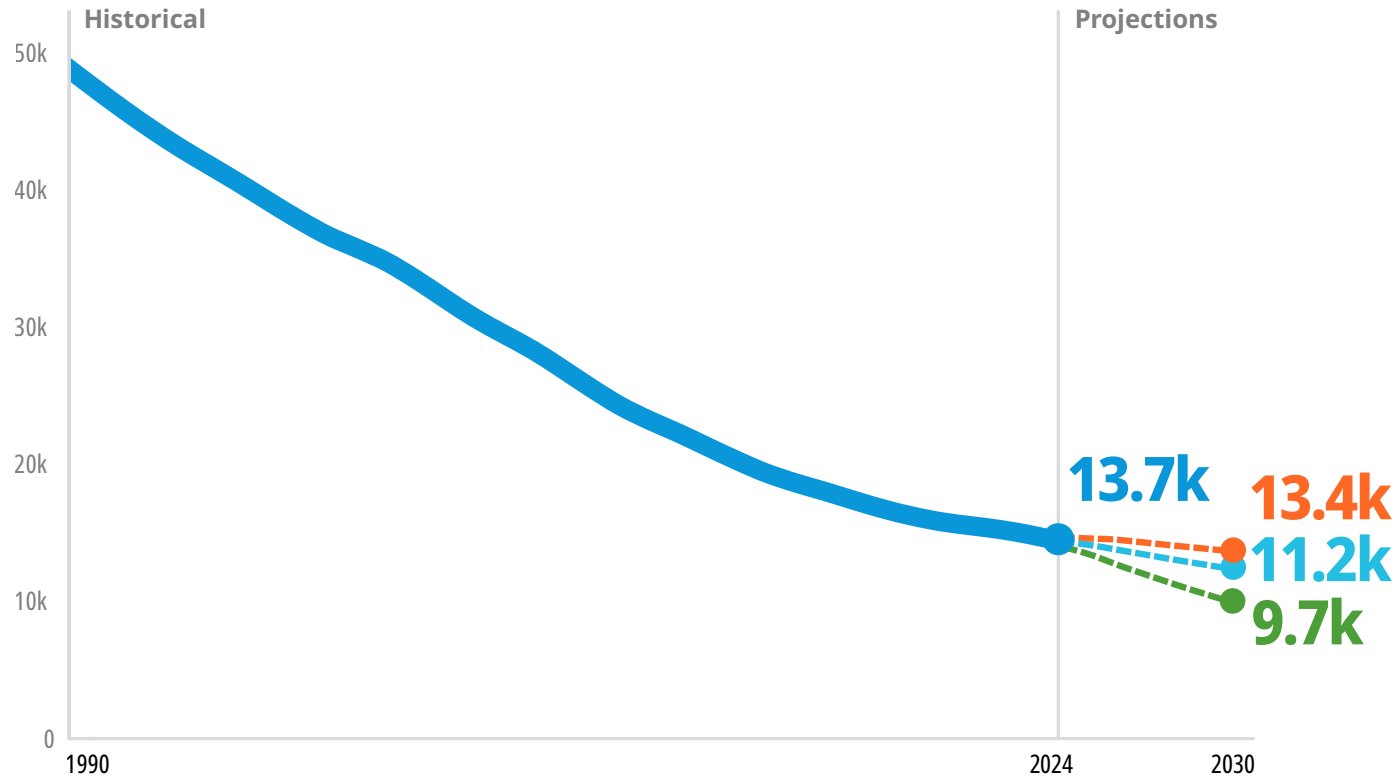
Neglected Tropical Diseases

3 GOOD HEALTH AND WELL-BEING

SDG Target 3.3
End the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases (NTDs) and combat hepatitis, water-borne diseases, and other communicable diseases.

For 15 NTDs, it is estimated that the total prevalence has declined globally in 2024 to 13,697 cases per 100,000 people from 14,171 per 100,000 people in 2023. The prevalence of these 15 NTDs is projected to continue to decline to 11,165 per 100,000 by 2030.

Prevalence of 15 NTDs per 100,000 people



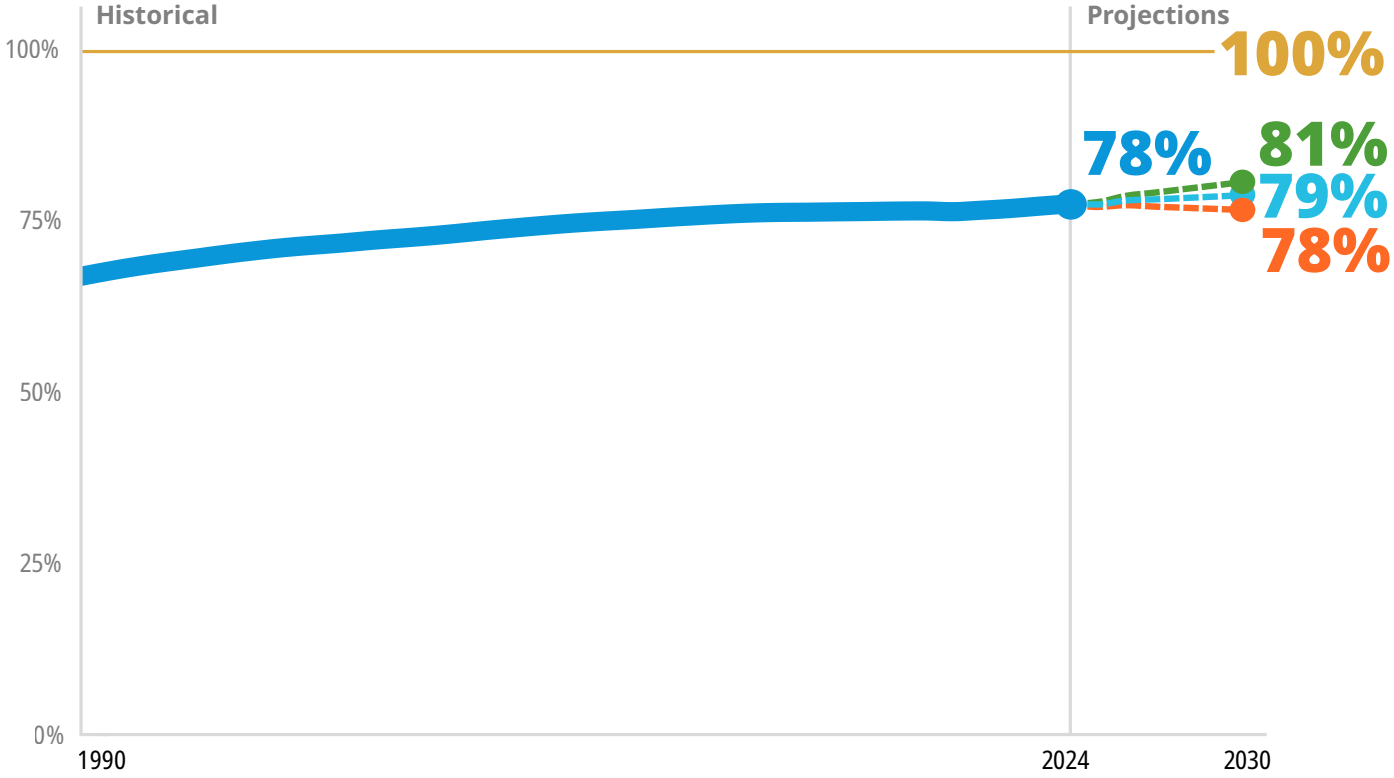
Family Planning

3 GOOD HEALTH AND WELL-BEING

SDG Target 3.7
Ensure universal access to sexual and reproductive health care services, including those for family planning.

Globally, it is estimated that almost 8 out of 10 women who identified as having a need for contraception are using a modern method to achieve their reproductive goals. Projections suggest progress to meet their need will stall through 2030—missing the universal access target of 100%.

Percentage of women of reproductive age (15–49) who have their need for family planning satisfied with modern methods

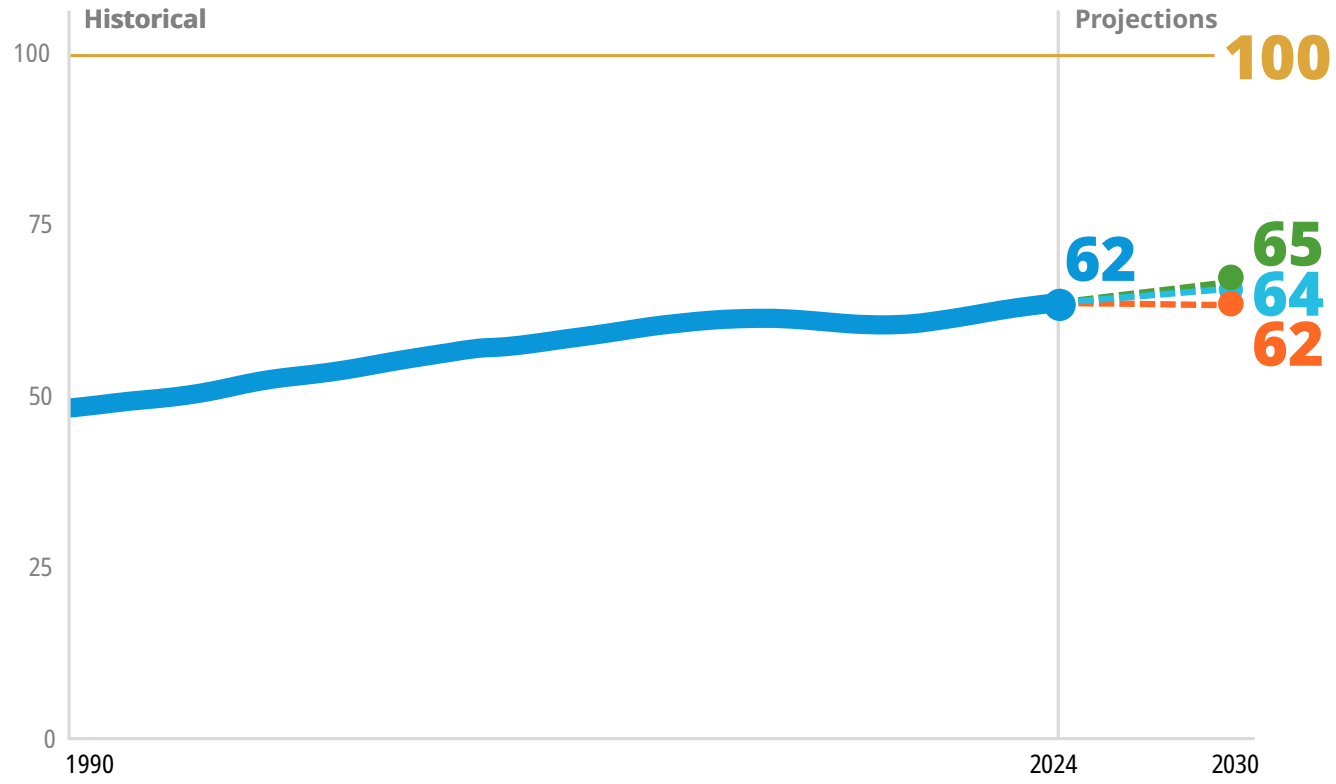


Universal Health Coverage

SDG Target 3.8
Achieve universal health coverage for all

Coverage of essential health services is still recovering following pandemic reversals, increasing from an index score of 60 in 2020 to 62 in 2024. The score is estimated to increase slightly to 64 by 2030, indicating that more work is needed to ensure universal health coverage for all.

Performance score of the UHC effective coverage index



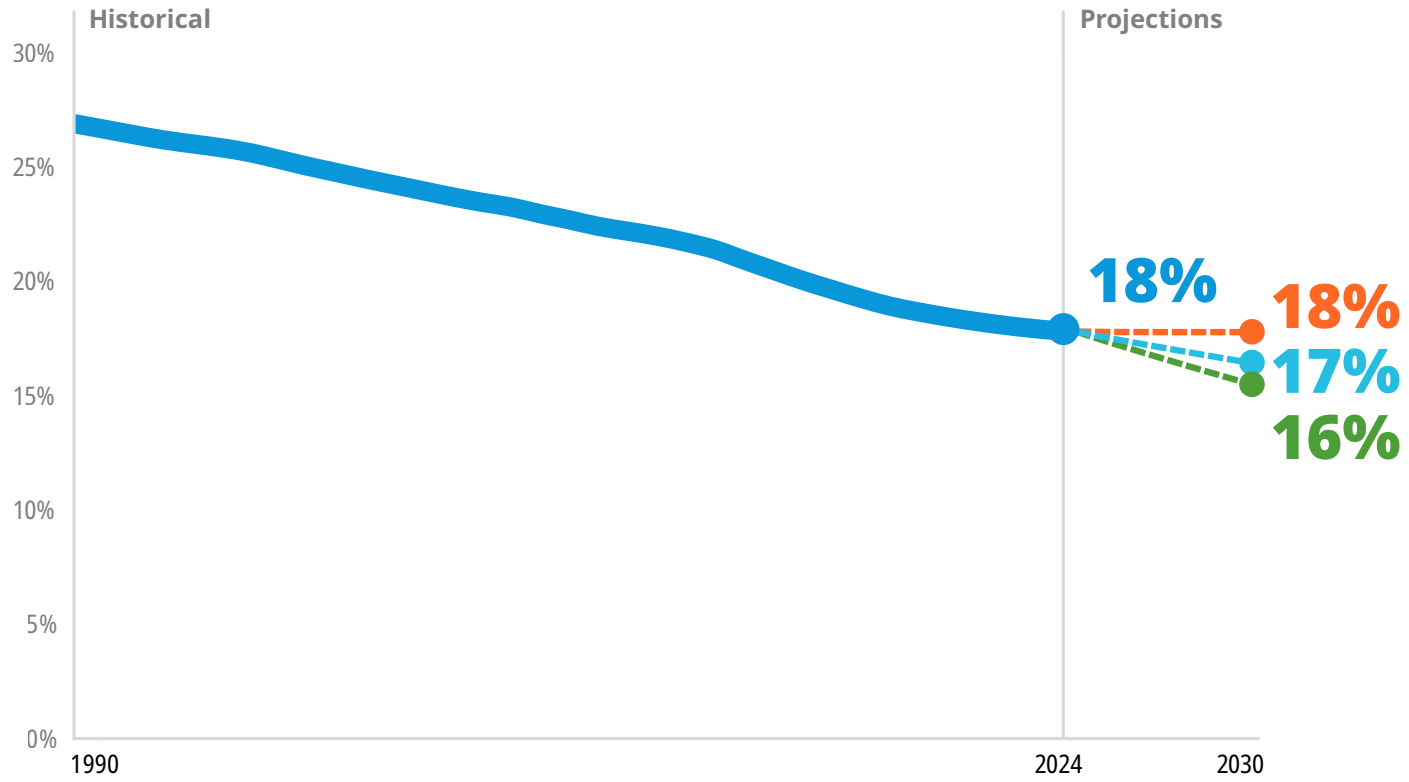
Smoking

SDG Target 3.A
Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control (FCTC) in all countries.

Globally, the percentage of people aged 15 and older who use any tobacco product has declined over the last decade, reaching 18% in 2024. Projections estimate further decline to 17% by 2030.

According to WHO's latest Global Tobacco Control Report, 6.1 billion people are now covered by at least one evidence-based policy from the FCTC.

Age-standardized smoking prevalence among people ages 15 and older



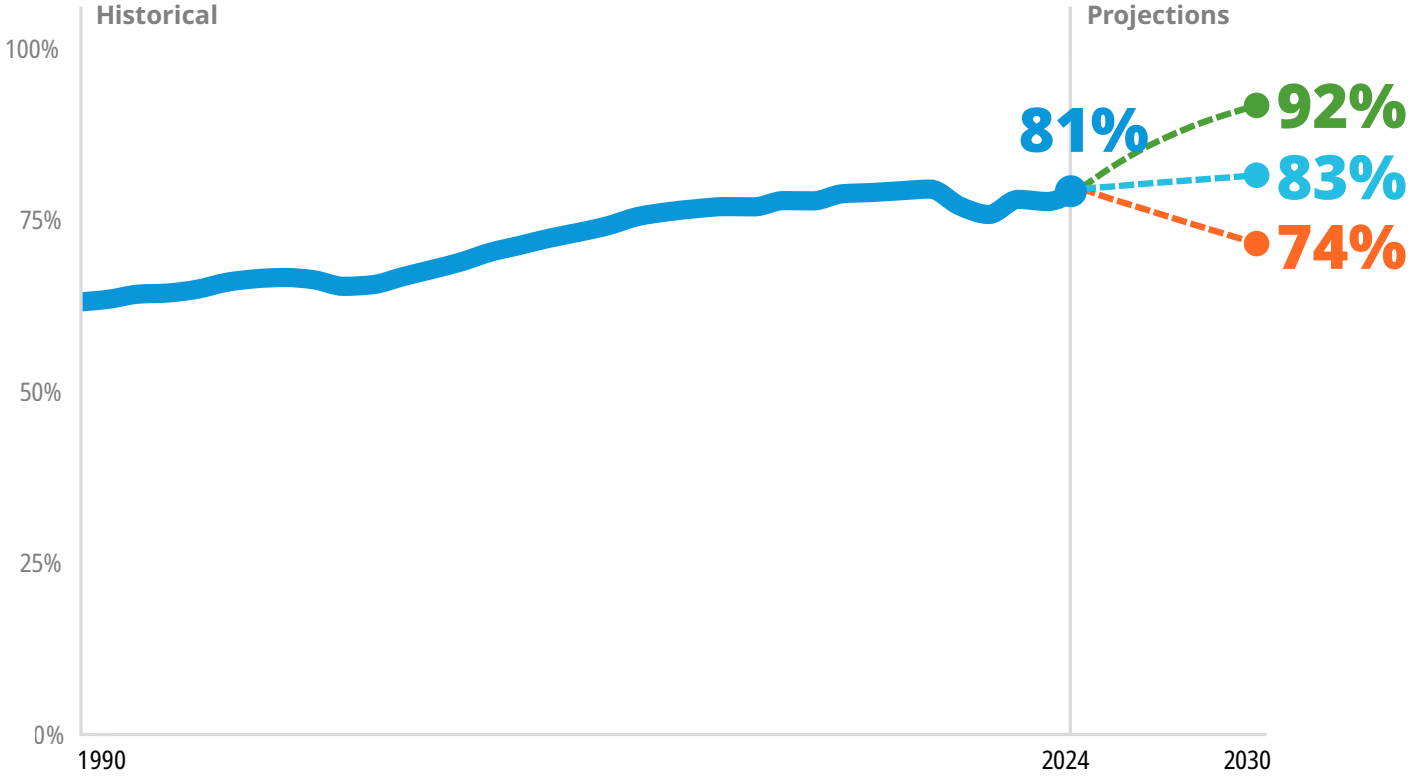
Vaccine

SDG Target 3.B
Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries and provide access to affordable essential medicines and vaccines.

In 2024, the global estimate for diphtheria, tetanus, and pertussis (DTP) third-dose vaccine coverage is 81%. By 2030, DTP third-dose vaccine coverage is estimated to be 83%.

These global estimates mask significant differences at the subnational level that need to be better understood to address inequities in vaccine coverage.

Coverage of DTP (third dose)



Legend

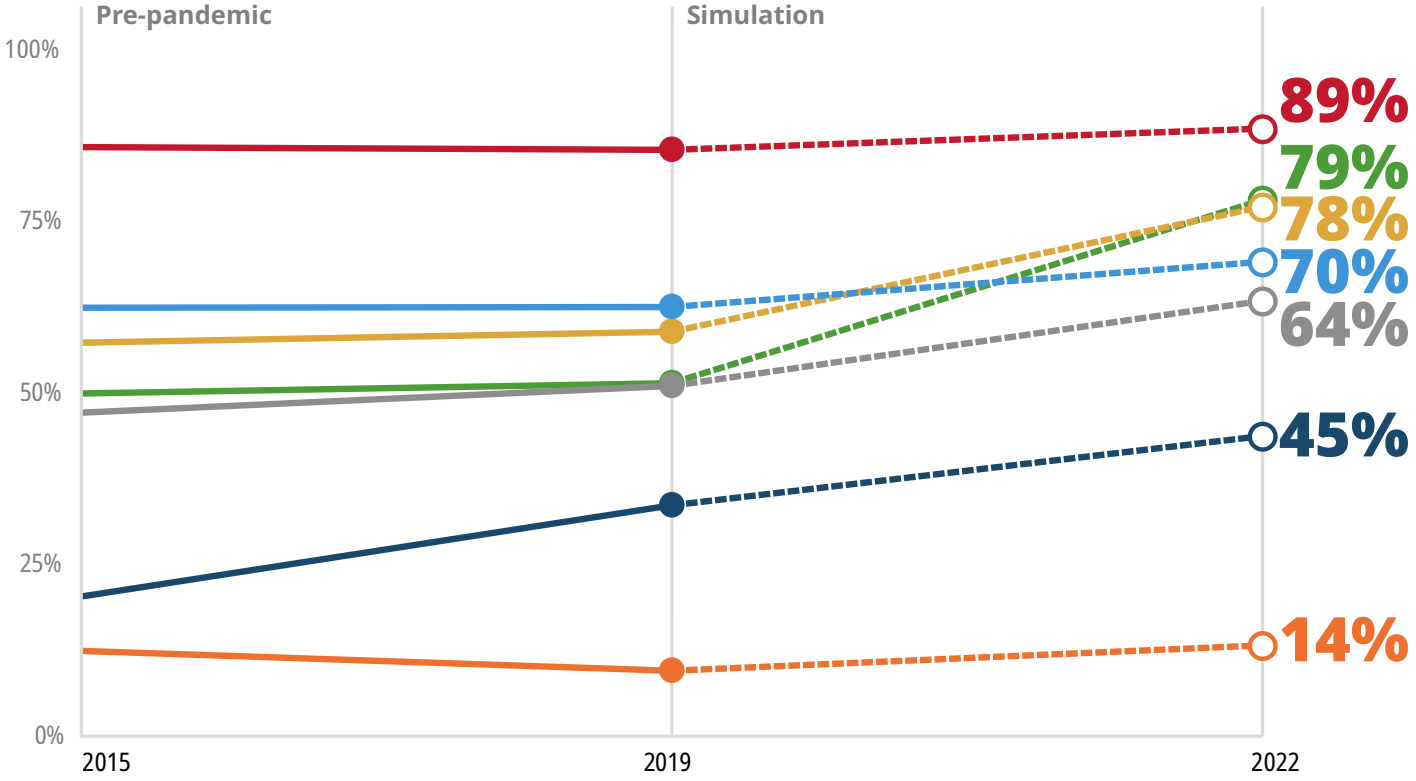
Historical average | Better | Reference | Worse

Education

SDG Target 4.1
Ensure that all girls and boys complete free, equitable, and quality primary and secondary education leading to relevant and effective learning outcomes.

The latest simulations suggest that 70% of children in low- and middle-income countries are not able to read and understand a text by age 10, even if they are in school.

Proportion of children who cannot read and understand a simple text by age 10

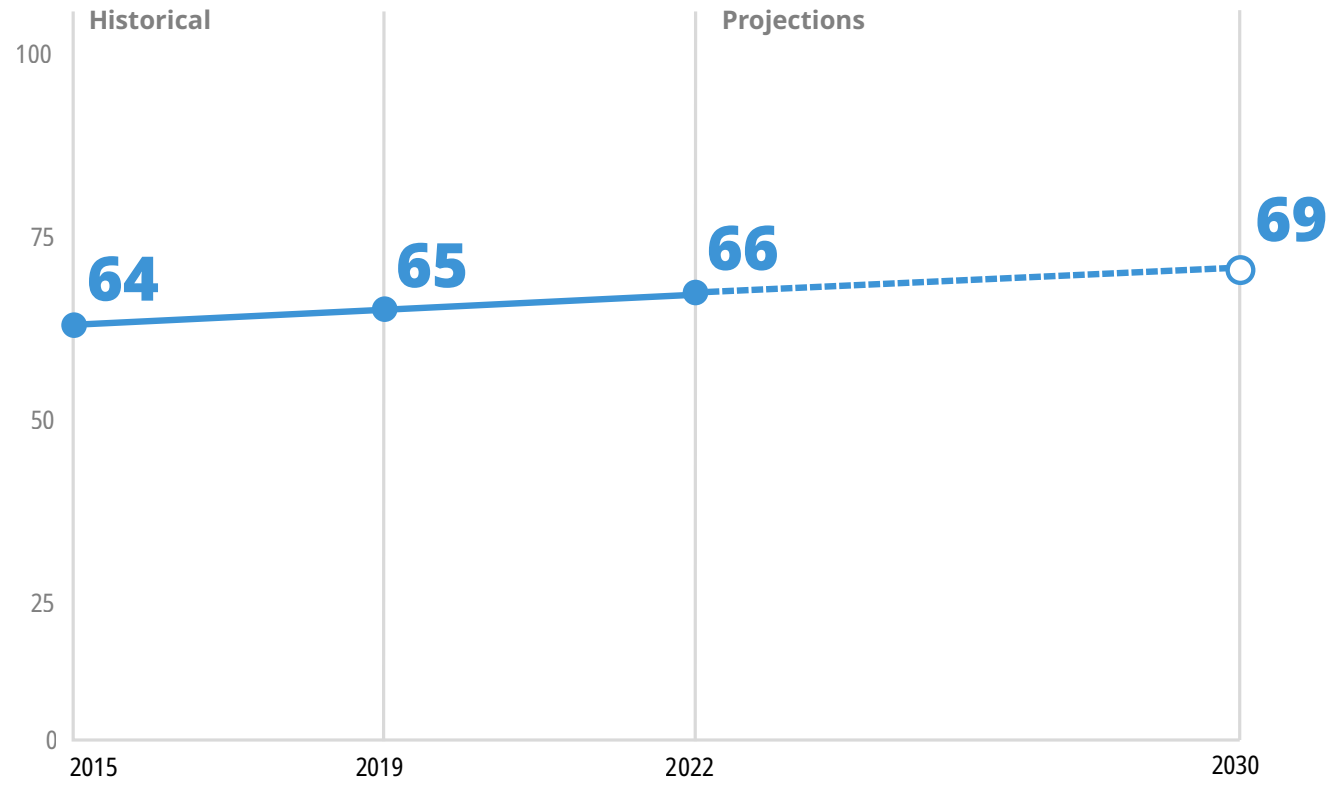


Gender Equality

SDG Target 5
Achieve gender equality and empower all women and girls.

Nearly three-quarters of the SDG targets—particularly those under SDG 1 (poverty), SDG 4 (education), SDG 5 (gender equality), and SDG 8 (decent work)—rely on gender equality. Yet no country is on track to achieve gender equality across the SDGs by 2030. If the current trends continue, global gender equality won't be achieved until the 22nd century.

SDG Gender Index score

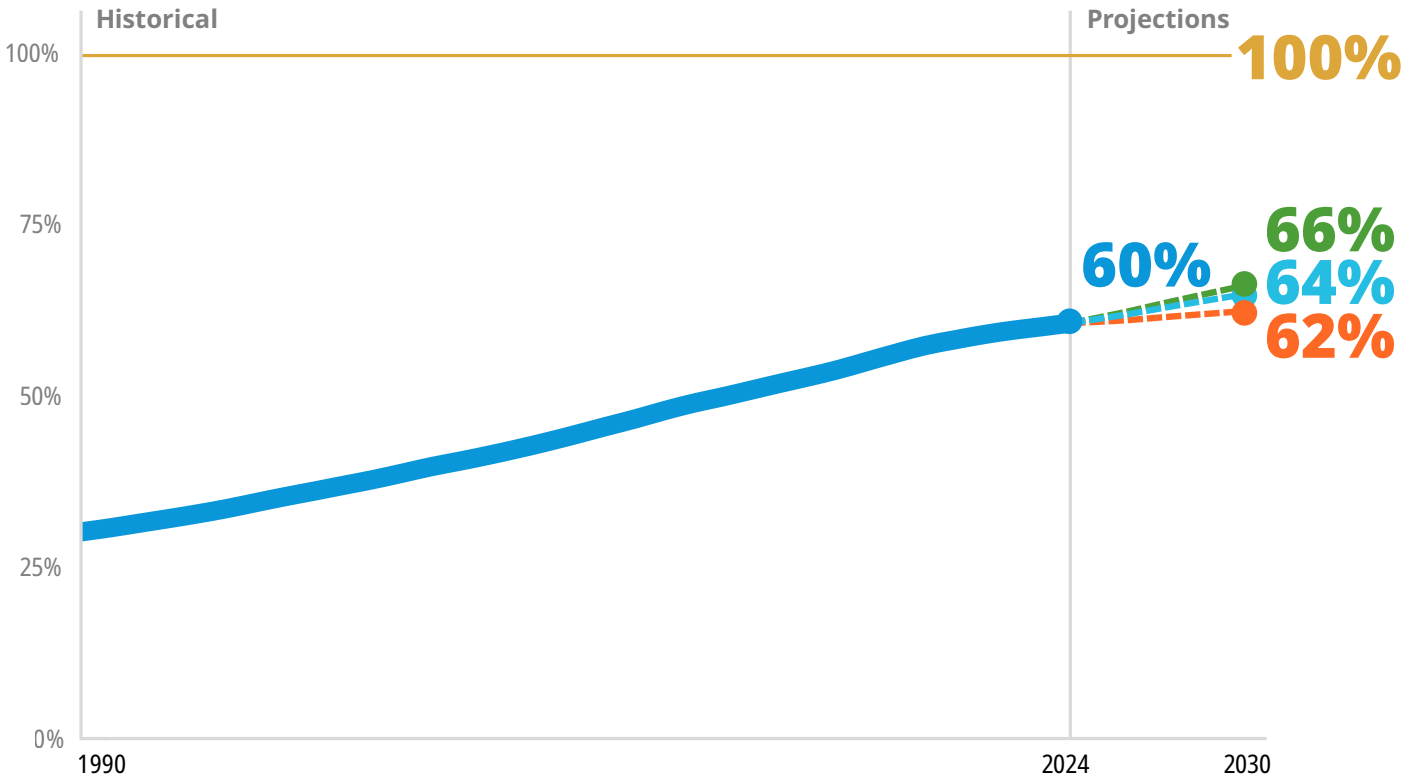


Sanitation

SDG Target 6.2
Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

The proportion of the population using safely managed sanitation has been rising. In 2024, 60% of the global population were using safely managed sanitation. By 2030, it is estimated that progress will slowly increase to 64% of the global population—missing the target to ensure safe sanitation for all.

Proportion of population using safely managed sanitation

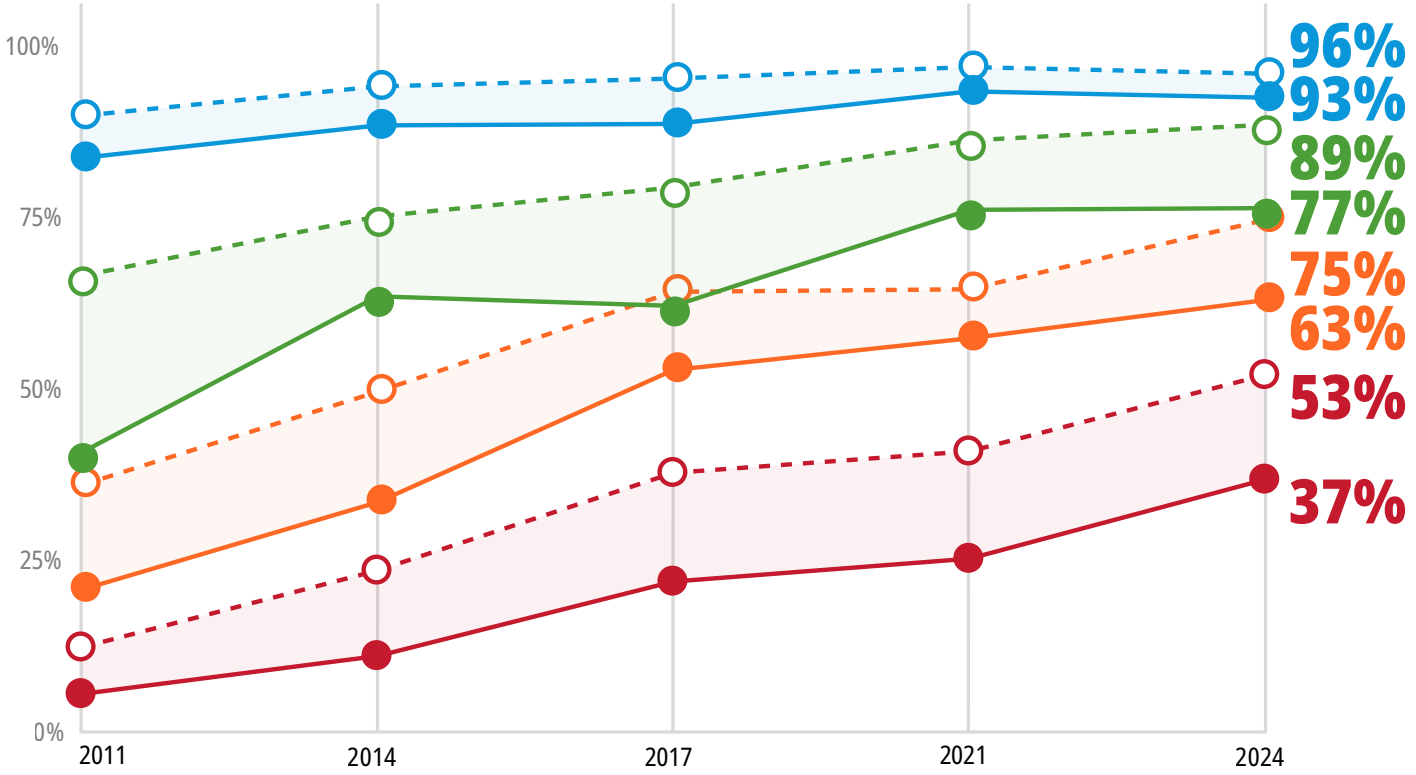


Inclusive Financial Systems

SDG Target 8.10
Strengthen the capacity of domestic financial institutions to encourage and expand access to banking, insurance, and financial services for all.

Over the past decade, the world has made rapid progress in expanding financial inclusion. Globally, 79% of adults now own a financial account, up from 51% in 2011.

Percentage of adults (ages 15 and older) with an account at a bank or other financial institution or with a mobile-money service provider, poorest and richest

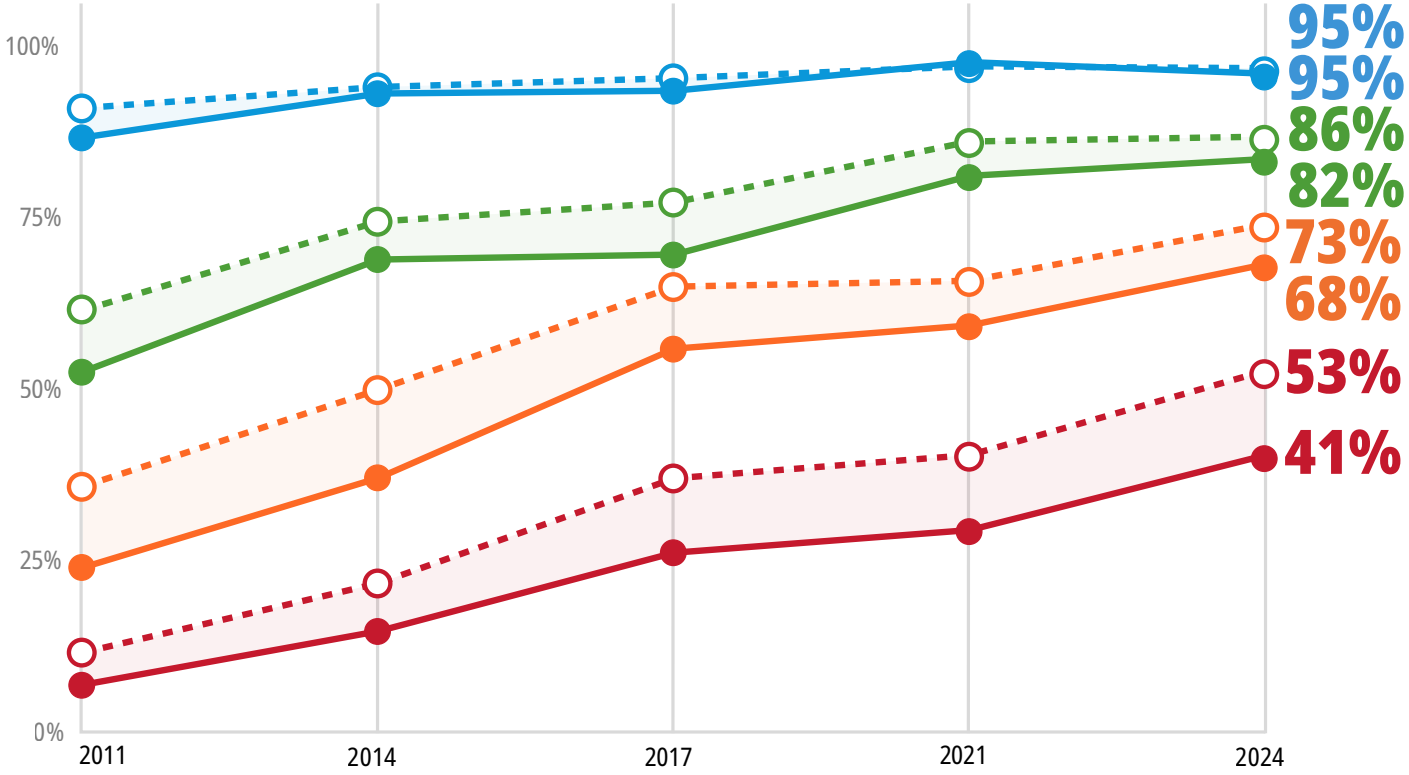


Inclusive Financial Systems

SDG Target 8.10
Strengthen the capacity of domestic financial institutions to encourage and expand access to banking, insurance, and financial services for all.

Importantly, the gender gap in account ownership is decreasing.

Percentage of adults (ages 15 and older) with an account at a bank or other financial institution or with a mobile-money service provider, women and men



2025 Data Sources

The data sources for facts and figures featured in the 2025 Goalkeepers Report are listed here by section. Brief methodological notes are included for unpublished analyses. Full citations, links to source materials, and additional references can be found on the Goalkeepers website at https://gates.ly/2025GKDataSources.

We Can't Stop at Almost

A Generation of Progress, A Choice to Make

References to reduction in global health funding used in this report refer to cuts to overseas development assistance (ODA) announced by donor governments in 2025 (Australia, Austria, Belgium, Canada, China, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Republic of Korea, Spain, Sweden, Switzerland, United Kingdom, United States). The Institute for Health Metrics and Evaluation (IHME) assumes that changes in ODA proportionally affect development assistance for health (DAH).

Institute for Health Metrics and Evaluation, (October 2025). [Bespoke modeling. Full methodology is detailed below].

Other estimates also show a reduction in under-five deaths every year from 2000 to 2024, including data published by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME).

This calculation, meant solely for illustrative purposes, assumes that a student population of 200,000 and an average classroom size of 40 students roughly equals 5,000 classrooms.

Humanity at a Crossroads: Millions of Children's Lives at Stake

Institute for Health Metrics and Evaluation, (October 2025). [Bespoke modeling. Full methodology is detailed below].

The chart shows the projected number of under-5 deaths from 2024 through 2045. The estimate for 2025 reflects the current best assumptions with the known and announced funding cuts as of October 17, 2025. Estimates for 2026 through 2045 show 20% and 30% reductions in global development assistance for health (DAH), relative to the 2024 levels.

12 million: An additional 12.5 million child deaths could occur by 2045 if DAH is reduced by 20% from 2024 levels. This assumes average government response to funding gaps.

16 million: An additional 16.3 million child deaths could occur by 2045 if DAH is reduced by 30% from 2024 levels. This assumes average government response to funding gaps.

13 million: Up to 13.2 million children's lives could be saved by 2045 if DAH is restored to 2024 funding levels and new innovations against malaria, lower respiratory illness, diarrheal diseases, and maternal and neonatal disorders are scaled up.

United Nations Development Programme, 2023, *A world of debt: A growing burden to global prosperity,* https://unctad.org/publication/world-debt-2023

A Roadmap to Progress

The smartest investment now is primary health care.

The Lancet Child Survival Series, (2003), www.iycn.org/resource/the-lancet-series-on-child-survival.

World Health Organization, *World Health Report 2008: Primary Health Care—Now More Than Ever*, Primary Health Care Performance Initiative, 2018, www.paho.org/sites/default/files/PHC_The_World_Health_Report-2008.pdf.

Routine immunizations remain the best buy in global health.

United Nations Inter-agency Group for Child Mortality Estimation, (2023), *Levels and Trends in Child Mortality*: Report 2023, https://data.unicef.org/resources/levels-and-trends-in-child-mortality-2023/.

World Health Organization, (2023), Immunization coverage fact sheet, www.who.int/data/gho/data/themes/topics/immunization-coverage.

Ozawa, S., Clark, S., Portnoy, A., Grewal, S., Brenzel, L., & Walker, D. G. (2016), "Return on investment from childhood immunization in low- and middle-income countries, 2011–20." *Health Affairs*, www.healthaffairs.org/doi/10.1377/hlthaff.2015.1086.

World Health Organization, (2023), Measles cases by country – Senegal, www.who.int/data/gho/data/indicators/indicator-details/GHO/measles---number-of-reported-cases.

Innovations that Stretch Every Dollar

To fight malaria, countries are targeting the most effective resources to the areas of highest need.

World Health Organization, (2018), *High burden to high impact: A targeted malaria response*, www.who.int/publications/i/item/WHO-CDS-GMP-2018.25.

Winters, A., et al, (2024), "Cost and cost effectiveness of geospatial planning and delivery tools added to standard health campaigns in Luapula Province, Zambia," *Oxford Open Digital Health*, www.academic.oup.com/oodh/article/2/Supplement_2/ii66/7911916.

World Health Organization, (2023), Pneumonia in children fact sheet, www.who.int/news-room/fact-sheets/detail/pneumonia.

With vaccines that deliver the same protection in fewer doses, countries have more money to reinvest in health systems.

Our World in Data, Causes of death in children under five, World (2021), www.ourworldindata.org/grapher/causes-of-death-in-children-under-5.

World Health Organization, (2025), *Pneumococcal conjugate vaccine reduced-dosing schedule: A systematic review and meta-analysis*, www.who.int/publications/m/item/report_who_sage_pcv_2025 who.int.

Gates Foundation, Integrated Portfolio Management, (2025), *Budgetary impact of WHO's SAGE recommendation on reduced (1+1) PCV dosing*, [Unpublished, internal document].

The Power of Immunization

Government of India Ministry of Health and Family Welfare Press Information Bureau. (2025). India's percentage of zero-dose children to the total population has declined from 0.11% in 2023 to 0.06% in 2024, positioning it as a global exemplar in child health, as acknowledged by the UN Inter-agency Group for Child Mortality Estimation in its 2024 report, www.pib.gov.in/PressReleasePage.aspx?PRID=2140343.

Wiping Diseases off the Map

By the 2040s, new science could end malaria—eradicating a mosquito-borne illness that kills more than 400,000 children under the age of 5 every year.

World Health Organization, (2023), *World malaria report 2023*, www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2023.

World Health Organization, (2021), *World malaria report 2021*, www.who.int/publications/i/item/9789240040496.

CDC, (2024), Life cycle of *Anopheles* mosquitoes, www.cdc.gov/mosquitoes/about/life-cycle-of-anopheles-mosquitoes.html.

The Global Fund, (2024, April 17), "New Nets Prevent 13 Million Malaria Cases in Sub-Saharan Africa," Geneva: The Global Fund, www.theglobalfund.org/en/news/2024/2024-04-17-new-nets-prevent-13-million-malaria-cases-sub-saharan-africa.

The Global Fund, (2023), "Accelerating the introduction of new nets through Global Fund grants," https://resources.theglobalfund.org/en/updates/2023-10-11-accelerating-the-introduction-of-new-nets-through-global-fund-grants/.

SC Johnson, (2023), "SC Johnson and partners pilot new spatial repellent to protect communities from mosquitoes in malaria-endemic regions," www.scjohnson.com/en/news-stories/press-releases/major-milestone-breakthrough-mosquito-repellent-tool.

GSK plc, (2024), "First single-dose medicine for P. vivax malaria prequalified by WHO and included in WHO Guidelines," www.gsk.com/en-gb/media/press-releases/first-single-dose-medicine-for-p-vivax-malaria-prequalified-by-who.

By 2045, 5.7 million children can be saved from next generation malaria tools

Institute for Health Metrics and Evaluation, (August 2025). [Bespoke modeling. Full methodology is detailed below].

New analyses (unpublished from the Gates Foundation) on a broad portfolio of new innovations against malaria show that if the tools are used effectively and deployed at scale, 5.7 million children's lives can be saved by 2045. The projection assumes an innovation trajectory approximating median level of impact. The tools included in the modeling are innovations in vector control (dual active ingredient insecticide nets, novel indoor residual spraying, attractive targeted sugar baits, gene drive); drugs (single-encounter radical cure, novel dual drug combination, long-acting injectable drug, monoclonal antibody, endectocide); vaccines (next-generation malaria vaccine); and diagnostics (novel rapid diagnostic test, non-invasive diagnostic tool).

By the late 2040s, new innovations could virtually eliminate deaths from HIV/AIDS, once the world's deadliest pandemic.

Gilead, (June 2024), "Gilead's Twice-Yearly Lenacapavir Demonstrated 100% Efficacy and Superiority to Daily Truvada® for HIV Prevention," www.gilead.com/news/news-details/2024/gileads-twice-yearly-lenacapavir-demonstrated-100-efficacy-and-superiority-to-daily-truvada-for-hiv-prevention.

Merck, (2025), "Merck to Initiate Phase 3 Trials for Investigational Once-Monthly HIV Prevention Pill," www.merck.com/news/merck-to-initiate-phase-3-trials-for-investigational-once-monthly-hiv-prevention-pill/.

Institute for Disease Modeling, (2025), *Geographic HIV risk-prioritization for delivery of long-acting PrEP*, [Unpublished internal document], Gates Foundation.

Wu, L., Kaftan, D., Wittenauer, R., Arrouzet, C., Patel, N., Saravis, A.L., Pfau, B., Mudimu, E., Bershteyn, A., and Sharma, M. (2024), "Health and budget impact, and price threshold for cost-effectiveness of lenacapavir for PrEP in Eastern and Southern Africa: a modeling analysis," *medRxiv*, https://www.medrxiv.org/content/10.1101/2024.08.20.24312137v1.

Lynch, S., Cohen, R.M., Kavanagh, M., Sharma, A., Raphael, Y., Pillay, Y., and Bekker, L. (2025), "Lessons for long-acting lenacapavir: catalysing equitable PrEP access in low-income and middle-income countries," *The Lancet HIV*, https://pubmed.ncbi.nlm.nih.gov/40659026/.

New maternal vaccines that protect babies before they are even born are our chance to ensure that a baby's first few months aren't their last.

UNICEF, (2025), Levels and trends in child mortality 2024, https://data.unicef.org/topic/child-survival/under-five-mortality/.

Gavi, (March 2025), "Gavi welcomes first-ever prequalification of a maternal RSV vaccine," www.gavi.org/news/media-room/gavi-welcomes-first-ever-prequalification-maternal-rsv-vaccine.

Madhi, S. A., Anderson, A. S., Absalon, J., Radley, D., et al. (2023), "Potential for maternally administered vaccine for infant group B streptococcus," *The New England Journal of Medicine*, www.nejm.org/doi/10.1056/NEJMoa2116045.

By 2045, 3.4 million children's lives could be saved by scaling new immunization products for RSV and pneumonia

Institute for Health Metrics and Evaluation, (August 2025), [Bespoke modeling. Full methodology is detailed below].

Methodology for 2025 Goalkeepers Bespoke Modeling

Measuring the impact of foreign aid cuts on child mortality

To estimate the impact of recent aid cuts, there are two primary areas of work that IHME undertook: (i) modeling and estimating the impact of funding cuts across all relevant sources on projections of development assistance for health (DAH) and total health spending; and (ii) estimating the associated impact that reductions in health spending will have on the Goalkeepers 2025 SDG indicators.

Measuring funding cuts to foreign aid and their impact on SDGs

To comprehensively measure foreign aid cuts made both domestically and internationally, IHME collected and standardized estimates of global health spending from diverse data sources, including commitments and disbursements from development project records, annual budgets, financial statements, and revenue reports. Estimates of DAH and total health expenditure (THE) were adjusted to account for donor announcements and budget cuts. Long-term projections through 2045 for DAH were generated using donor targets, historical trends, and GDP-based forecasting, while future THE was predicted through ensemble models assessing key indicators such as government expenditure and out-of-pocket costs. IHME's estimates and forecasts of foreign aid are based on publicly available data as of October 17, 2025. Detailed methodologies are available in the online Methods Annex of the *Financing Global Health* 2025 report: www.healthdata.org/research-analysis/library/financing-global-health-2025-cuts-aid-and-future-outlook.

The following funding scenarios were produced:

Scenario	Description
Pre-2025 funding	Ensemble model of past trends prior to 2025
20% reduction to DAH	Based on estimated funding cuts for the year 2025, and a 20% reduction in global DAH by recipient country, relative to 2024 levels, was applied to 2026 and onward.
30% reduction to DAH	Based on estimated funding cuts for the year 2025, and a 30% reduction in global DAH by recipient country, relative to 2024 levels, was applied to 2026 and onward.

To quantify the impact of reductions in development aid on the SDG indicators, IHME analyzed the relationship between each indicator and historical health spending, using a nonparametric stochastic frontier analysis approach where the "frontier" represents the best possible outcome (e.g., the lowest number of new tuberculosis cases) for a given level of health spending. The model assumes that this "efficiency" persists into the future to calculate the marginal cost of decreased health coverage, lives lost, or additional cases because of funding reductions. For each SDG indicator in this report, forecasts were produced based on the 20% reduction to DAH scenario, while both the 20% and 30% reduction to DAH scenario were produced for under-five child mortality.

Measuring the impact of new innovations on under-5 mortality

IHME also analyzed the lives saved should a suite of new innovations be effectively delivered through the future health scenarios framework. The innovations included a portfolio of products and effect sizes on cause-specific mortality using simulations from the Gates Foundation. IHME used these effect sizes to estimate both cause-specific and total under-5 lives saved through innovation activities.

Cause	Products
Malaria	• Vector control: dual active ingredient insecticide nets; novel indoor residual spraying; attractive targeted sugar baits; gene drive • Drugs: single-encounter radical cure; novel dual drug combination; long-acting injectable; monoclonal antibody; endectocide • Next-generation malaria vaccine • Diagnostics: novel rapid diagnostic test; non-invasive diagnostic tool
Neonatal disorders	• Group B streptococcus vaccine • Preterm prevention: Multiple Micronutrient Supplementation / Multiple Micronutrient Supplementation Plus (MMS/MMS); preeclampsia risk screening / prevention drug; preeclampsia diagnosis / treatment drug and respiratory distress syndrome (RDS)-specific prevention & treatment; AI ultrasound; antenatal corticosteroids (ACS); continuous positive airway pressure (CPAP); lung surfactant • Prevention: AI Intrapartum sensors to enable appropriate risk-targeting of caesarean section; Bifidobacterium longum subspecies infantis • Treatment: Amoxicillin / Gentamicin
Diarrhea	• Next-generation rotavirus vaccine • Shigella vaccine
Lower Respiratory Infection	• RSV monoclonal antibody; RSV maternal vaccine • 20-valent pneumococcal conjugate vaccine plus (PCV 20+)
Meningitis	• 20-valent pneumococcal conjugate vaccine plus (PCV 20+)

References:
GBD 2021 Forecasting Collaborators. (2024), "Burden of disease scenarios for 204 countries and territories, 2022–2050: A forecasting analysis for the Global Burden of Disease Study 2021," *The Lancet*, doi: 10.1016/S0140-6736(24)00685-8.

Explore the Data

IHME methodology

Our primary data partner, IHME, produced estimates and forecasts for 13 of the Sustainable Development Goal (SDG) indicators included in the 2025 Goalkeepers Report. IHME worked together with many partners and used novel methods to generate a set of contemporary estimates, some as part of the Global Burden of Disease project. The indicator estimates presented may differ from other sources, particularly at the subnational level, due to differences in statistical models, data inputs, and assumptions used between modeling groups. The section below provides detail on how each indicator is estimated.

Indicators estimated by IHME

IHME produced estimates and forecasts for 13 of the SDG indicators included in the Goalkeepers Report. The section below provides details on how each indicator is estimated.

Stunting
IHME measures stunting prevalence as height-for-age more than two standard deviations below the reference median on the height-age growth curve based on WHO 2006 growth standards for children 0–59 months. Estimates leveraged several methods and data processing improvements, including ensemble model predictions for severity-specific stunting prevalence and mean height-for-age z-scores (HAZ), further disaggregation of under-5 age groups, and a standardized age-sex splitting approach.

Forecasts of stunting prevalence were driven by climate scenarios of days above 30 degrees Celsius, consumption per capita, the socio-demographic index (SDI), and location random effects. The better and worse scenarios were produced by taking the 85th and 15th percentile rates of change observed across location-years in the past and applying those rates of change to all locations in the future.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased total health spending including development assistance from the World Food Programme—varying by country and year—would increase stunting and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

Maternal mortality ratio

The maternal mortality ratio (MMR) is defined as the number of maternal deaths among women ages 15–49 years during a given time period per 100,000 live births during the same time period. It depicts the risk of maternal death relative to the number of live births to approximate the risk of death in pregnancy. Projections to 2030 were modeled using an ensemble approach to forecast MMR, using SDI as a key driver.

Differences in MMR estimates from the 2024 Goalkeepers Report are primarily driven by changes in the all-cause mortality envelope and the inclusion of additional input data sources. Methodological improvements in estimation of all-cause mortality allowed for the addition of more granular age-specific sources of input data, which generally resulted in increased estimates of all-cause mortality among women of reproductive age. Increases in all-cause mortality are most notable in sub-Saharan Africa, resulting in higher estimates of MMR. Conversely, all-cause mortality estimates among women of reproductive age were notably lower in Afghanistan compared to previous reports, resulting in lower estimates of MMR.

Data added since the last report cover additional location-years of the pandemic. COVID-19 impacts on maternal mortality were seen in the data for many locations and reflected in resulting model estimates, including countries in the Caribbean and Latin America, southern Latin America, high-income North America, Central Asia, Central Europe, and Southeast Asia.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would increase MMR and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

Under-5 mortality rate

The under-5 mortality rate (U5MR) is the probability of death between birth and age 5. It is expressed as the number of deaths per 1,000 live births. Estimates used all available data from vital registration, sample registration, surveys, and censuses, which were modeled via a newly developed statistical model for age-specific mortality rates that incorporates both parametric and non-parametric methods. Age specific mortality rates for ages 0-6 days, 7-27 days, 1-5 months, 6-11 months, 1-2 years, and 2-4 years were jointly estimated in the model, then converted to U5MR. Projections were based on a combination of key drivers, including Global Burden of Disease (GBD) risk factors, selected interventions (e.g., vaccines), and SDI. Changes in U5MR estimates in this report came from new and additional input mortality data incorporated since the previous Goalkeepers report, as well as the new statistical model.

To estimate the impact of reduced DAH, IHME used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would increase under-five mortality and adjusted the forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

References:
Schumacher, A.E., et al. (2024), "Global age-sex-specific all-cause mortality and life expectancy estimates for 204 countries and territories and 660 subnational locations, 1950–2023: A demographic analysis for the Global Burden of Disease Study 2023," *The Lancet*. Unpublished manuscript.

Neonatal mortality rate

IHME defines the neonatal mortality rate as the probability of death in the first 28 completed days of life. It is expressed as the number of deaths per 1,000 live births. Estimates used all available data from vital registration, sample registration, surveys, and censuses, which were modeled via a newly developed statistical model for age-specific mortality rates that incorporates both parametric and non-parametric methods. Age specific mortality rates for ages 0-6 days and 7-27 days were jointly estimated in the model, then converted to neonatal mortality rate. Projections were based on a combination of key drivers, including GBD risk factors, selected interventions (e.g., vaccines), and SDI. Most of the changes in neonatal mortality estimates in this year's Goalkeepers report are the result of new data and the methodological changes discussed for the under-5 mortality rate estimates.

To estimate the impact of reduced development assistance for health, we used a nonparametric

stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would increase neonatal mortality and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

References:
Schumacher, A.E., et al. (2024), "Global age-sex-specific all-cause mortality and life expectancy estimates for 204 countries and territories and 660 subnational locations, 1950–2023: A demographic analysis for the Global Burden of Disease Study 2023," *The Lancet*, Unpublished manuscript.

HIV
IHME estimates the HIV rate as new HIV infections per 1,000 population. Changes in incidence in this year's report were due to updates made during GBD 2023 estimation, which reflect substantial data updates from the following sources. Population-based HIV Impact Assessment (PHIA): Five countries published their first ever reports for 2020-2023 and seven countries provided new microdata. Household Surveys: 13 countries provided new surveys. Case Reports: 54 countries were updated with recent years providing 546 additional country-years. UNAIDS: 145 countries provided refreshed time series in their Spectrum country files.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would result in decreased anti-retroviral therapy (ART) coverage. ART coverage modifies rates of mortality and incidence in our model, so both epidemiological metrics are affected by changes in ART. We took the estimated declines in ART coverage and simulated their impact in our forecasting framework.

Tuberculosis
IHME estimates new and relapse tuberculosis (TB) cases diagnosed within a given calendar year (incidence) using data from prevalence surveys, case notifications, remission estimates, excess mortality estimates, and cause-specific mortality estimates as inputs to a statistical model that enforces internal consistency among the estimates. At the global level, TB incidence estimates for this report show a slightly steeper downward trend than those from last year. This trend is influenced by the updated TB mortality time trend, which incorporates an updated mortality envelope for the GBD 2025 cycle, updated covariates informed by recent data, and newly available cause of death data.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would increase TB and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

Malaria
IHME estimates the malaria rate as the number of new cases per 1,000 population. Estimates of malaria include new data points since last year, including three new national surveys from Ghana, Liberia, and Mozambique. On top of routine data updates, for the first time in several years, updates were also made to the reporting completeness data. These improvements have impacted results across several countries including Côte d'Ivoire, Ghana, Liberia, Mozambique, Senegal, and Guyana. Large spikes in the estimates for Myanmar, Ethiopia, Pakistan, and Zimbabwe can be attributed to known outbreaks.

Projections to 2030 used the malaria forecasting models developed for climate scenario models. In brief, these models had five components, all fit at the second administrative level. Model 1: modeling *plasmodium falciparum prevalence* in 2-10 year olds (pfpr2-10). Model 2: modeling the all-age prevalence-case rate given pfpr2-10. Model 3: modeling the age- and sex-specific case rate given all-age case rate. Model 4: modeling the all-age prevalence-fatality rate given pfpr2-10. Model 5: modeling the age- and sex-specific fatality rate given the all-age fatality rate. Each model used Admin 2-level data from 2000 to 2022 on both the malaria outcomes but also the weighted fraction of the year where temperature is suitable for transmission (weighted by level of suitability), yearly flood days per capita, GDP per capita, and DAH spending on malaria.

Our reference forecast was based on forecasted estimates of each covariate (using RCP 4.5 for climate-

based covariates) and the reference estimates of DAH malaria spending.

References:
World Health Organization, (2022), T*hird round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic (November – December 2021)*, www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1.

Neglected tropical diseases
IHME measures the sum of the prevalence of 15 NTDs per 100,000 that are currently measured in the annual Global Burden of Disease Study: human African trypanosomiasis, Chagas disease, cystic echinococcosis, cysticercosis, dengue, food-borne trematodiases, Guinea worm, soil-transmitted helminths (STH, comprising hookworm, trichuriasis, and ascariasis), leishmaniasis, leprosy, lymphatic filariasis, onchocerciasis, rabies, schistosomiasis, and trachoma. Projections to 2030 used an ensemble model, driven both by trends in the past as well as projections of SDI.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would increase NTD prevalence and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

Family planning
IHME estimates the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern contraceptive methods. Modern contraceptive methods include the current use of male or female sterilization, male or female condoms, diaphragms, cervical caps, sponges, spermicidal agents, oral hormonal pills, patches, rings, implants, injections, intrauterine devices (IUDs), and emergency contraceptives. Need is defined as it is defined by the Demographic and Health Surveys. Projections to 2030 used an ensemble model, based both on past trends as well as using SDI as a key driver, which incorporates projections of income per capita and education and the effects of the COVID-19 pandemic.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would decrease met need for modern contraceptive prevalence and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

References:
Performance Monitoring for Action, (2020), Performance Monitoring for Action (PMA) Survey, www.pmadata.org/data.

Bradley, Sarah E.K., Trevor N. Croft, Joy D. Fishel, and Charles F. Westoff, (2012), *Revising Unmet Need for Family Planning, DHS Analytical Studies,* 25, ICF International, www.dhsprogram.com/pubs/pdf/AS25/AS25[12June2012].pdf.

Universal health coverage
The universal health coverage (UHC) effective coverage index is a metric composed of 23 effective coverage indicators that cover population-age groups across the entire life course (maternal and newborn age groups, children under age 5, youths ages 5–19 years, adults ages 20–64, and adults ages 65 years old or older). These indicators fall within several health service domains: promotion, prevention, and treatment.

Health system promotion indicators include met need for family planning with modern contraception.

Health system prevention indicators include the proportion of children receiving the third dose of the diphtheria-tetanus-pertussis vaccine and children receiving the first dose of measles-containing vaccine. Antenatal care for mothers and antenatal care for newborns are considered indicators of health system prevention and treatment of diseases affecting maternal and child health.

Indicators of treatment of communicable diseases are scaled mortality-to-incidence (MI) ratios for lower respiratory infections, diarrhea, and TB, as well as coverage of ART among those with HIV/AIDS. Indicators of treatment of non-communicable diseases include scaled MI ratios for acute lymphoid leukemia, appendicitis, paralytic ileus and intestinal obstruction, cervical cancer, breast cancer, uterine

cancer, and colorectal cancer. Indicators of treatment of non-communicable diseases also include scaled mortality-to-prevalence (MP) ratios for stroke, chronic kidney disease, epilepsy, asthma, chronic obstructive pulmonary disease, diabetes, and the risk-standardized death rate due to ischemic heart disease. The effective coverage indicators are weighted in the index according to the potential health gain that each country could achieve if it were to improve coverage of that indicator.

To produce forecasts of the UHC index from 2025 to 2030, a meta-stochastic frontier model for UHC was fit, using total health spending per capita projections as the independent variable. Country- and year-specific inefficiencies were then extracted from the model and forecasted to 2030 using a linear regression with exponential weights across time for each country level. These forecasted inefficiencies, along with forecasted total health spending per capita estimates, were substituted into the previously fit frontier to obtain forecasted UHC for all countries for 2025–2030.

To estimate the impact of reduced DAH, we used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would decrease universal health care coverage and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

Smoking

IHME measures the age-standardized prevalence of any current use of smoked tobacco among those aged 15 and older. IHME collates information from available representative surveys that include questions about self-reported current use of tobacco and information on the type of tobacco product smoked (including cigarettes, cigars, pipes, hookahs, as well as local products). IHME converts all data to its standard definition of any current smoking within the last 30 days so that meaningful comparisons can be made across locations and over time. Projections to 2030 used SDI as a key driver, which incorporates projections of income per capita, education, and the effect of the COVID-19 pandemic.

Vaccines

IHME's measurement of immunization coverage reports on the coverage of the following vaccines separately: three-dose diphtheria-tetanus-pertussis (DTP3), measles second dose (MCV2), and three-dose pneumococcal conjugate vaccine (PCV3).

IHME estimated the pandemic era (2020–2023) effects on vaccine coverage using trends in country-reported coverage. To do this, IHME extended the modelling framework used to capture other acute temporal disruptions (i.e., drops) in coverage due to stockouts or other similar events. In that framework, IHME first modelled the magnitude of disruptions for vaccine-country-years with reported stockout events reported via the 2025 Joint Reporting Form or other identified disruption events. To do this, IHME first estimated counterfactual country-reported coverage using models that excluded vaccine-country-years with identified disruptions, then compared these counterfactual estimates to the values reported by countries for those years. These disruption magnitudes were then included as a covariate in vaccine coverage modelling. To account for disruptions due to the COVID-19 pandemic, IHME considered all vaccine-country-years for 2020–2023 as candidates for disruptions. For vaccine-country-years in the pandemic period without available country-reported data, we imputed disruption magnitudes based on vaccine-year-specific distributions from locations with data.

These estimates also reflect new methods to better account for rapid scale-ups in coverage in MCV2 and PCV3 in years following country-specific introductions using hierarchical spline models. For each vaccine, the model first estimated global scale-up patterns, then used these global patterns as priors for country-specific scale-up models. This approach better captures country-specific scale-up where data were available and borrows strength from global scale-up patterns to inform estimates where data are missing.

To estimate the impact of reduced DAH, IHME used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased spending—varying by country and year—would decrease vaccine coverage and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

References:
World Health Organization, (July 2025), "Global childhood vaccination coverage holds steady, yet over 14 million infants remain unvaccinated," news release, www.who.int/news/item/15-07-2025-global-childhood-vaccination-coverage-holds-steady-yet-over-14-million-infants-remain-unvaccinated-who-unicef.

GBD 2023 Vaccine Coverage Collaborators, (2024), "Global, regional, and national trends in routine childhood vaccination coverage from 1980 to 2023 with forecasts to 2030: A systematic analysis for the Global Burden of Disease Study 2023," *The Lancet*, www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)01037-2/abstract.

Sanitation

IHME estimates the proportion of the population with access to safely managed sanitation. As defined by the Joint Monitoring Programme (JMP), safely managed facilities must meet three criteria: 1) not shared with multiple households, 2) an improved sanitation facility, and 3) wastewater is disposed of safely (World Health Organization 2021). Safe wastewater disposal can consist of being treated and disposed of in situ, stored temporarily and treated off-site, or transported through a sewer and treated (World Health Organization, 2021). Safely managed treated wastewater must have received at least secondary treatment (World Health Organization 2021). IHME measured households with piped sanitation (with a sewer connection or septic tank); households with improved sanitation but without a sewer connection (pit latrine, ventilated improved latrine, pit latrine with slab, composting toilet); households without improved sanitation (flush toilet that is not piped to sewer or septic tank, pit latrine without a slab or open pit, bucket, hanging toilet or hanging latrine, no facilities); and wastewater treatment type for sewer-connected households, as defined by the JMP for Water Supply and Sanitation.

For the 2025 Goalkeepers Report, IHME developed models to estimate three components of safely managed sanitation: 1) the proportion of treated wastewater that receives at least secondary treatment, 2) the proportion of sewer-connected facilities that are safely managed, and 3) the proportion of improved, non-sewer facilities that are safely managed.

Data for estimating the proportion of treated wastewater that receives at least secondary treatment were extracted from Eurostat, Aquastat, the Organisation for Economic Co-operation and Development (OECD), and national surveys. Data for estimating the proportion of sewer-connected facilities that are safely managed were extracted from Eurostat, Aquastat, Demographic and Health Surveys (DHS), UNICEF Multiple Indicator Cluster Surveys (MICS), OECD, and national surveys (Republic of Korea, Singapore, Andorra, Austria, and Ireland). Data for estimating the proportion of improved, non-sewer facilities that are safely managed were extracted from MICS, DHS, Eurostat, and national surveys (Canada, Norway, and the United States).

IHME estimated the proportion of the total population with safely managed sanitation as the sum of the proportion of the population with safely managed sewer-connected facilities and the proportion of the population with safely managed improved non-sewer facilities.

To estimate the impact of reduced DAH, IHME used a nonparametric stochastic frontier approach (as detailed in the "Measuring funding cuts to foreign aid and their impact on SDGs" section above) to model how decreased government and overseas development for water, sanitation and hygiene (WASH)—varying by country and year—would decrease the proportion of population with access to safely managed sanitation. and adjusted our forecasts per the 20% reduction to DAH scenario for each country through 2030 accordingly.

References:
World Health Organization & UNICEF Joint Monitoring Programme, (2021), *WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) | UN_Wate*r, www.washdata.org/sites/default/files/2022-01/jmp-2021-metadata-sdg-621a.pdf.

IHME indicator sources

Data source information for each indicator are below, a detailed reporting of data sourcing for GBD 2021 estimates can be found at https://ghdx.healthdata.org/gbd-2021/sources.

Indicator and Component	GBD 2023 Total Sources
Child mortality	24,025
Child stunting	1,748
Family planning (met need)	1,119
Malaria	13,099
Maternal mortality	8,107
Neonatal mortality	24,025
HIV	6,320
NTD chagas	1,199
NTD visceral leishmaniasis	5,815
NTD cutaneous and mucocutaneous leishmaniasis	1,503
NTD African trypanosomiasis	3,075
NTD schistosomiasis	3,855
NTD cysticercosis	3,901
NTD cystic echinococcosis	3,731
NTD lymphatic filariasis	496
NTD onchocerciasis	351
NTD trachoma	109
NTD dengue	3,950
NTD rabies	4,058
NTD ascariasis	4,599
NTD trichuriasis	868
NTD hookworm disease	873
NTD food-borne trematodiases	57
NTD leprosy	1,595
NTD guinea worm disease	458
Sanitation safely managed	1,243
Smoking prevalence	3,859
Tuberculosis	8,422
UHC maternal disorders	8,107
UHC met need	1,123
UHC live births	15,981
UHC neonatal mortality	24,025
UHC diphtheria	4,185
UHC pertussis	9,667
UHC tetanus	4,421
UHC DTP vaccination	9,005
UHC measles	11,333
UHC measles vaccination	8,893
UHC LRI	4,594
UHC diarrhea	6,087
UHC HIV treatment	6,320
UHC TB	4,578
UHC lymphoid leukemia	3,518
UHC asthma	3,106
UHC diabetes	4,368
UHC IHD treatment	4,348
UHC stroke	4,373
UHC chronic kidney disease	4,592
UHC chronic obstructive pulmonary disease	3,123
UHC cervical cancer	5,261

Indicator and Component	GBD 2023 Total Sources
UHC breast cancer	5,264
UHC uterine cancer	5,237
UHC colon and rectum cancer	5,327
UHC epilepsy	4,131
UHC appendicitis	4,213
UHC paralytic ileus and intestinal obstruction treatment	4,086
Vaccine coverage DTP3	9,005
Vaccine coverage MCV2	3,266
Vaccine coverage PCV3	1,897

Indicators estimated from other sources

Poverty
World Bank, (2025), Poverty headcount ratio at $2.15 a day (2017 PPP) (% of population), [Data set], https://data360.worldbank.org/en/indicator/WB_PIP_HEADCOUNT_IPL.

For methodology, see: World Bank, (2025), *Poverty and inequality platform methodology handbook*, https://datanalytics.worldbank.org/PIP-Methodology/.

This report uses the international poverty line and purchasing power parity (PPP) data that were in effect prior to the World Bank's June 2025 update. The new poverty line and PPPs will be incorporated in the next edition of this report to ensure consistency and comparability over time.

Agriculture
Food and Agriculture Organization of the United Nations, (2025), Average annual income from agriculture, [Data set], www.dataexplorer.fao.org

Small food producers' income growth for selected countries with at least two entries in the data set are included. For all countries without data for 2014 and 2019, the earliest and most recent years were used to calculate income growth. Small food producers' income growth is calculated per country using years listed below:

Location	Year Range
Burkina Faso	2014–2019
Cambodia	2009–2021
Côte d'Ivoire	2008–2019
Ethiopia	2014–2019
Ghana	2013–2017
India	2005–2012
Malawi	2011–2020
Mali	2014–2019
Mongolia	2014–2019
Niger	2011–2019
Nigeria	2013–2019
Senegal	2011–2022
Sierra Leone	2011–2018
Tanzania	2009–2021
Uganda	2010–2020

Education
World Bank, UNESCO Institute for Statistics, UNICEF, USAID, Bill & Melinda Gates Foundation, & Foreign, Commonwealth, and Development Office, (2022), *The State of Global Learning Poverty: 2022 Update* [Conference edition], www.unicef.org/media/122921/file/StateofLearningPoverty2022.pdf.

Source for Learning Poverty 2022 simulations: Azevedo, J. P., Demombynes, G., & Wong, Y. N. (2023), "Why has the pandemic not sparked more concern

for learning losses in Latin America? The perils of an invisible crisis," *Education for Global Development,* https://blogs.worldbank.org/en/education/why-hasnt-pandemic-sparked-more-concern-learning-losses-latin-america-perils-invisible.

Gender equality
The Equal Measures 2030 (EM2030) SDG Gender Index is the most comprehensive global tool to measure progress toward gender equality aligned to the Sustainable Development Goals (SDGs). The index tracks 56 key gender indicators that provide the "big picture" across and within 14 of the 17 SDGs.

It is the only index that adds a gender lens to each of the goals, including the many SDGs that lack such a lens in the official framework. Going beyond SDG 5 (the single goal dedicated to gender equality) is important in capturing the broader trends that influence progress on gender equality and highlighting how issues such as hunger, poverty, and climate change affect girls and women.

The 2024 index covers 139 countries, which represent 96 percent of the world's women and girls. The index tracks scores for three reference years: 2015, 2019, and 2022 and forecasts a scenario for 2030 based on current trends.

This is the third edition of the SDG Gender Index—it was previously released in 2019 and 2022. It is one of the few global gender indices to be formally audited by the Competence Centre on Composite Indicators and Scoreboards (JRC-COIN) at the European Union's Joint Research Centre.

The index was developed by a coalition of national, regional, and global leaders from feminist networks, civil society, and international development.

Resources:
To download 2024 index data and the latest index report and for more information about index methodology, see: www.equalmeasures2030.org/2024-sdg-gender-index

To access interactive index data visualizations, see: www.equalmeasures2030.org/2024-sdg-gender-index/explore-the-data/

To view the technical audit conducted by the COIN center of the EU's Joint Research Centre, see www.equalmeasures2030.org/2024-sdg-gender-index/about-the-index/

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Inclusive financial systems
The "income" comparison refers to what the World Bank calculates as account ownership of the richest 60 percent of households versus the poorest 40 percent of households.

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