وزارة الصحة
Ministry of Health

Saudi Global Health Report:
SDGs & WHO 100 Core Indicators

Deputyship of Population Health
Global Health Affairs

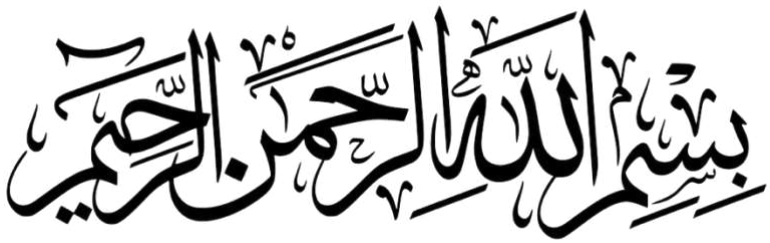
Version 1.0 (2025)

Ministry of Health (KSA), Deputyship of Population Health. Saudi Global Health Report: SDGs & WHO 100 Core Indicators. Riyadh: Ministry of Health; 2025.

Version 1.0 (2025):
Updated 30 August, 2025.

Contact:
Global Health Affairs, Deputyship of Population Health.
Email: GDGH@moh.gov.sa

Primary metadata source:
2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.


بسم الله الرحمن الرحيم

Foreword

The Kingdom of Saudi Arabia continues to advance a whole-of-government approach to population health, one that places evidence, equity, and accountability at the center of policy and planning. This Saudi Global Health Report consolidates priority indicators into a single, decision-ready reference that enables transparent benchmarking of Kingdom's scores against peer nations globally.

The report aligns with internationally recognized measurement standards, notably the WHO Global Reference List of 100 Core Health Indicators and health-related SDGs, which provide harmonized definitions and a concise set of indicators. Adherence to these standards strengthens comparability, reduces reporting burden, and focuses attention on measures most closely linked to population outcomes.

This publication also underscores our sustained investment in health information systems. By drawing on the World Health Statistics series and strengthening national data through the SCORE for Health Data package and data-quality toolkits, we aim to ensure that policy choices are anchored in timely, high-quality evidence.

I commend the teams across the MOH and our national partners for their leadership and collaboration. I call on all stakeholders, across health and non-health sectors alike, to use the insights herein to guide implementation, close information gaps, and sustain the gains we are making in the health and well-being of all who live in the Kingdom.

Dr. Abdullah Asiri
Deputy Minister for Population Health.
Deputyship of Population Health,
Ministry of Health

Preface

This report provides a unified, authoritative view of priority population-health indicators in the Kingdom of Saudi Arabia. It is designed for senior decision-makers who require concise signals and for technical teams who require consistent definitions and a coherent framework for measurement.

The report harmonizes indicator definitions, anchors them to international standards, and consolidates them into an accessible format for policy dialogue and performance oversight. Selection of indicators is referenced to the WHO Global Reference List of 100 Core Health Indicators and health-related SDGs, ensuring balance across health status, risk factors, service coverage, and health system capacity.

Chapters are organized by the four domains noted, followed by technical annexes containing indicator metadata (definitions, numerators/denominators, periodicity, and hyperlinked sources). This structure supports consistent application of measures across programs and facilitates alignment with international compilations such as World Health Statistics.

We extend our appreciation to colleagues across the MOH and the team at the Deputyship of Population Health, along with reviewers whose collaboration made this edition possible. This publication will be refreshed periodically to reflect methodological refinement and newly available data in line with international reporting standards.

Dr. Abdullah Alarifi
Project Lead,
Advisor to the Deputy Minister for Population Health,
Deputyship of Population Health,
Ministry of Health.

Contributors and Acknowledgements

This report was developed and reviewed by:

Contributors:

- Dr. Abdullah Alarifi
- Dr. Najim Alshahrani
- Dr. Sultan Alamri
- Ms. Wafa Alshammari
- Ms. Raniyah Alnahdi
- Dr. Nouf Alkalbi
- Dr. Shrouq Almalki
- Dr. Mohammed Qara
- Dr. Abdullah Alnizami
- Ms. Asma Alsarhani
- Dr. Ahmad Ganaini
- Dr. Zahir Alameen
- Mr. Sultan Alraqqas
- Ms. Ameerah Alhebshi

Reviewers:

- Mr. Abdulaziz Abdulbaqi
- Dr. Weam Banjar
- Dr. Arwa Alameen
- Ms. Nourah Aloraini
- Ms. Khoulod Alfaki
- Dr. Shaker Alomary
- Dr. Haleema Alserehi
- Dr. Saeed Alqahtani

Approved by:

- Dr. Abdullah Alarifi
- Dr. Abdullah Asiri

Acronyms and Abbreviations:

List of acronyms and abbreviation used as sources in this report:

- **GASTAT**: General Authority for Statistics
- **GOSI**: General Organization for Social Insurance
- **IARC**: International Agency for Research on Cancer
- **KSAWHS**: KSA World Health Survey
- **MOH**: Ministry of Health; indicates Statistical Yearbook 2023
- **UHC**: Universal Health Coverage; Indicates 2023 report
- **UNAIDS**: Joint United Nations Programme on HIV/AIDS
- **UN IGME**: United Nations Inter-agency Group for Child Mortality Estimation
- **UN NCD Portal**: United Nations Noncommunicable Diseases Data Portal
- **UN Stats**: United Nations Statistics Division
- **UNICEF**: United Nations Children's Fund
- **WHO eSPAR**: Electronic International Health Regulations States Parties Self-Assessment Annual Reporting Tool
- **WHO GLASS**: Global Antimicrobial Resistance and Use Surveillance System
- **WHO GHO**: Global Health Observatory
- **WHS**: World Health Statistics 2025

List of other acronyms and abbreviations within the report:

- **AIDS**: Acquired Immunodeficiency Syndrome
- **ART**: Antiretroviral Therapy
- **CD**: Communicable Disease
- **HIV**: Human Immunodeficiency Virus
- **NCD**: Non-communicable Disease
- **NTD**: Neglected Tropical Diseases
- **OECD**: Organisation for Economic Co-operation and Development
- **SHC**: Saudi Health Council
- **TB**: Tuberculosis
- **UHC**: Universal Health Coverage
- **UN**: United Nations
- **WB**: World Bank
- **WHA**: World Health Assembly
- **WHO**: World Health Organization

Executive Summary

The Saudi Global Health Report: SDGs & WHO 100 Core Indicators (Version 1.0, 2025) consolidates priority population-health indicators for the Kingdom of Saudi Arabia into a single, authoritative reference for leaders and technical teams. It standardizes indicator definitions and presentation, aligns measurement with internationally recognized frameworks, and enables transparent comparison between the Kingdom and global calculations. The report is designed as a decision-ready product: each indicator is presented with a concise specification, the most recent national value alongside a recent international value, clearly marked data sources and type of result, and an operational definition for consistent use across programs. This format supports rapid orientation for executives and researchers while preserving enough technical detail for analysts.

Purpose and scope

The report's primary purpose is to harmonize what we measure and how we measure it across the health system, ensuring that national tracking is consistent with global reports and vice versa. Indicator selection and structure follow the World Health Organization (WHO) Global Reference List of 100 Core Health Indicators (plus health-related SDGs), which provides a concise, standardized set spanning four domains—health status, risk factors, service coverage, and health system capacity. By anchoring to this reference set, the report reduces reporting burden, improves comparability, and keeps attention on measures most closely linked to population outcomes.

What does this report contain?

The content is organized by domains commonly used in WHO reporting and SDG monitoring, and it covers national and international values where available. Illustrative examples from this edition include: Health status: internationally recognized metrics such as maternal mortality ratio (SDG 3.1.1), with a clear definition, numerator/denominator, and notes on common data quality considerations; structured to mirror WHO metadata conventions. This layout is repeated for each section in their report.

Why international alignment matters?

Using internationally harmonized definitions reduces ambiguity and enables the Kingdom to interpret performance in a global context. This report deliberately presents national and international values side-by-side. Differences between them can occur because international repositories apply standardized methods to ensure cross-country comparability—using harmonized definitions and classifications, common population denominators, and transparent estimation and quality-control procedures—whereas national figures may reflect locally approved data-collection instruments, case definitions, reporting cycles, and processing rules. Such methodological and processing choices (e.g., adjustments, imputation, age-standardization, accounting frameworks, and timing of updates) can legitimately produce non-identical numbers even when both sources are of high quality. The report documents sources and methods so that users can interpret figures appropriately and choose the series that best fits the decision at hand.

Governance and continuity

The report reflects coordinated work across the MOH, and partner entities, and it is designed to be refreshed periodically as national and international data are updated. This ensures continued alignment with WHO's evolving statistical series and facilitates smooth integration of new methods and repositories as they are released.

Key Acheivements:

Drawing on WHO-aligned indicators across maternal and child health, communicable and noncommunicable diseases, injuries, immunization, and health systems performance, the Kingdom has posted substantial, measurable gains toward SDG 3. The review underpinning this report thematically groups indicators to clarify progress and highlight collective efforts and outcomes.

Maternal and child health.
Maternal mortality has continued to fall—down to 7.4 deaths per 100,000 live births in 2023, reflecting expanded UHC, stronger maternal-neonatal care, and evidence-based guidelines. Skilled birth attendance has reached 100% (2024), placing the Kingdom among global leaders, while under-five and neonatal mortality have declined to 6.2 per 1,000 live births (2023) and 3 per 1,000 live births (2023), respectively, supported by vaccination, pediatric care, and high-quality perinatal services.

Control of communicable diseases.
The country has achieved zero indigenous malaria cases in 2021, 2022, and 2023, following decades of vector control and rapid case management, with border controls sustaining gains. Tuberculosis incidence has fallen to 8.2 per 100,000 (2023), with 90% treatment success and a trajectory consistent with elimination targets. HIV control is among the strongest globally: Saudi Arabia is on track for the 95-95-95 targets, maintains very low incidence (<0.1 per 1,000 uninfcted population in 2024), and has ~93% treatment coverage among diagnosed individuals in 2024. Hepatitis B control is a standout: 0% prevalence among children under five by 2020 following universal vaccination. The Kingdom has also eliminated trachoma as a public-health problem (2022) and eliminated visceral leishmaniasis (by 2019); no human rabies has been reported since 2010.

Injury prevention.
Road safety reforms yielded a 54% decline in road traffic fatalities since 2016, reaching 12.13 per 100,000 in 2024 and surpassing the 2023 target. Immunization. Routine coverage is consistently high across key vaccines; DTP (97%), MCV (96%), and PCV (96%) in 2024, with additional targeted policies ensuring equitable access for high-risk groups.

Universal health coverage and financial protection.
The UHC service-coverage index rose from 65 (2000) to 74 (2021), driven by primary care strengthening, infrastructure expansion, and digital platforms; 100% of Saudis had coverage for basic healthcare expenses in 2024, with catastrophic health spending remaining low (1.31% in 2018).

Environmental health:
Mortality attributable to unsafe water, sanitation, and hygiene declined sharply from 11.54 per 100,000 (2016) to 1.9 (2019), reflecting successful policy and infrastructure investments.

Overall, Saudi Arabia's progress reflects sustained investment, governance reforms, prevention-first strategies, and high coverage of essential services—advancing SDG 3 while reinforcing the foundations of the health system documented throughout this report.

Source: Alarifi, A. M., Alshahrani, N. Z., Jokhdar, H., & Asiri, A. M. (2025). Advancing Health Through Sustainable Development Goals-Saudi Arabia's Mid-Journey Progress and Insights. Journal of epidemiology and global health, 15(1), 48. https://doi.org/10.1007/s44197-025-00385-y

List of Indicators

Part one:
Health status indicators

1 Life expectancy at birth

National Indicator Performance			
Recent international value		**Recent national value**	
76.4 years		**78.8 years**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	Vision 2030 Annual Report 2024	Registery

Key Indicator Specifications	
Abbreviated name	Life expectancy at birth
Indicator name	Life expectancy at birth
Definition	The average number of years that a newborn could expect to live if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory or geographical area
Numerator	(from life tables)
Denominator	(from life tables)
Unit	Years
Method of measurement	Life expectancy at birth is derived from life tables and is based on sex- and age-specific death rates. Life expectancy at birth values from the United Nations correspond to mid-year estimates, consistent with the corresponding United Nations fertility medium-variant quinquennial population projections.
Method of estimation	Final estimates of age-sex-specific mortality rates for years 1990-2019 were used to compute abridged life tables for 183 WHO Member States with population of 90,000 or greater in 2019. Life expectancies at birth are reported in World Health Statistics 2019 and full life tables are available in the WHO Global Health Observatory WHO applies standard methods to the analysis of Member State data to ensure comparability of estimates across countries. This will inevitably result in differences for some Member States with official estimates for quantities such as life expectancy, where a variety of different projection methods and other methods are used. These WHO estimates of mortality and life expectancies should not be regarded as the nationally endorsed statistics of Member States, which may have been derived using alternative methodologies and assumptions.
Measurement frequency	Annual if based on preferred data source; otherwise less frequent
KSA data source	Vision 2030. (2024). Annual Report 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.vision2030.gov.sa/media/r3ij40wu/en-annual-report-vision2030-2024.pdf
International data source	World Health Organization. (2025). Life expectancy at birth (years). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-(years)

2 Adolescent mortality rate

National Indicator Performance			
Recent international value		**Recent national value**	
Age 10-14: 71 deaths per 100,000 children aged 10 years **Age 15-19**: 414 deaths per 100,000 children aged 15 years **Age 10-19**: 484 deaths per 100,000 children aged 10 years		**Age 10-14**: 30 deaths per 100,000 children aged 10 years **Age 15-19**: 60 deaths per 100,000 children aged 15 years	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UN IGME	Estimated through the organization	UN IGME	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	Adolescent mortality rate
Indicator name	Adolescent mortality rate
Definition	Number of deaths among adolescents (10–19 years old) per 100,000 adolescent population.
Numerator	Number of deaths among adolescents aged 10–19.
Denominator	Number of adolescents aged 10–19.
Unit	Deaths per 100,000 adolescent population
Method of measurement	Civil or sample registration: mortality by age and sex are used to calculate age specific rates. Census: mortality by age and sex tabulated from questions on recent deaths that occurred in the household during a given period preceding the census (usually 12 months). Census or surveys: direct or indirect methods provide adult mortality rates based on information on survival of parents or siblings.
Method of estimation	Mortality rates by age and sex for WHO Member States are derived from life tables which draw on UN World Population Prospects 2015 revision, recent and unpublished analyses of all-cause and HIV mortality for countries with high HIV prevalence, vital registration data, and estimates of child mortality from UN Inter-agency Group for Child Mortality Estimation. Population numbers are taken from the United Nations' World Population Prospects 2015 revision. Predominant type of statistics: predicted.
Measurement frequency	Continuous data collection; dissemination every 3–5 years.
KSA data source	General Authority for Statistics. (2024). Estimated Saudi Age Specific Death Rate by gender and age group (5 years) 2011 - 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/en/statistics
International data source	United Nations Inter-agency Group for Child Mortality Estimation (2023). New York, United States. Retrieved [August 30, 2025], from https://childmortality.org/all-cause-mortality/data

3 **Adult mortality rate** (probability of dying between 15 and 60 years per 1,000 population)

National Indicator Performance			
Recent international value		**Recent national value**	
88 deaths per 1,000 population		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Adult mortality rate between 15 and 60 years of age.
Indicator name	Adult mortality rate (probability of dying between 15 and 60 years of age per 1,000 population)
Definition	Probability that a 15-year-old person will die before reaching his or her 60th birthday. The probability of dying between the ages of 15 and 60 years (per 1,000 population) per year among a hypothetical cohort of 100,000 people who would experience the age-specific mortality rate of the reporting year.
Unit	Deaths per 1,000 population
Numerator	Number of deaths between ages 15 years and 60 years in the synthetic life table population.
Denominator	Population alive at exact age 15 in the synthetic life table population.
Method of measurement	Civil or sample registration: Mortality by age and sex are used to calculate age-specific rates. Census: Mortality by age and sex is tabulated from questions on recent deaths that occurred in the household during a given period preceding the census (usually 12 months). Census or surveys: Direct or indirect methods provide adult mortality rates based on information on survival of parents or siblings.
Method of estimation	Empirical data from different sources are consolidated to obtain estimates of the level and trend of adult mortality by fitting a curve to the observed mortality points. However, to obtain the best possible estimates, judgement needs to be made on data quality and how representative it is of the population. Recent statistics based on data availability in most countries are point estimates at least 3–4 years old which need to be projected forward in order to obtain estimates of adult mortality for the current year. In case of inadequate sources of age-specific mortality rates, the latest life table analyses of the United Nations Population Division were used. Predominant type of statistics: predicted.
Measurement frequency	Annual if based on preferred data source; otherwise less frequent.
KSA data source	N/A
International data source	World Health Organization. (n.d.). Adult mortality rate (probability of dying between 15 and 60 years per 1,000 population). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adult-mortality-rate-(probability-of-dying-between-15-and-60-years-per-1000-population)

4 Under-five mortality rate [SDG 3.2.1]

National Indicator Performance			
Recent international value		**Recent national value**	
6.2 deaths per 1,000 live births		**11.79 deaths per 1,000 live births**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	MOH	Mortality registry

Key Indicator Specifications	
Abbreviated name	Under-five mortality rate [SDG 3.2.1]
Indicator name	Under-five mortality rate (probability of dying by age 5 per 1,000 live births).
Definition	The probability of a child born in a specific year or period who dies before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed per 1,000 live births. The under-five mortality rate as defined here is, strictly speaking, not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as a rate per 1,000 live births.
Unit	Deaths per 1,000 live births
Numerator	Number of deaths among children aged 0–4 years (0–59 months of age), broken down by age groups.
Denominator	Number of live births.
Method of measurement	The most frequently used methods using the above-mentioned data sources are as follows: Civil registration: Number of deaths at age 0 and population of the same age are used to calculate death rates which are then converted into age-specific probability of dying. Census and surveys: An indirect method is used based on questions to each woman of reproductive age as to how many children she has ever given birth to and how many are still alive. The Brass method and model life tables are then used to obtain an estimate of infant mortality. Surveys: A direct method is used based on birth history – a series of detailed questions on each child a woman has given birth to during her lifetime. To reduce sampling errors, the estimates are often presented as period rates for five years preceding the survey. A synthetic cohort method developed by the Demographic and Health Surveys (DHS) is used to compute period rates.
Method of estimation	The UN-IGME produces trends of under-five mortality with a standardized methodology by group of countries depending on the type and quality of source of data available. For countries with adequate trend of data from civil registration, the calculations of under-five and infant mortality rates are derived from a standard period abridged life table. For countries with survey data, under-five mortality rates are estimated using the Bayesian B-splines bias-adjusted model. See the UN-IGME link for details. These under-five mortality rates have been estimated by applying methods to the available data from all Member States in order to ensure comparability across countries and time; hence they are not necessarily the same as the official national data. Predominant type of statistics: adjusted and predicted
Measurement frequency	Annual if based on registration system; otherwise, less frequent (3–5 years based on surveys).
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

5 Infant mortality rate

National Indicator Performance			
Recent international value		**Recent national value**	
4.88 deaths per 1,000 live births		**4.88 deaths per 1,000 live births**	
Date	**Date**	**Date**	**Type of Result**
2023	2023	2023	Crude
Source	**Source**	**Source**	**Type of Source**
UNICEF	UNICEF	MOH	Mortality registry

Key Indicator Specifications	
Abbreviated name	Infant mortality rate
Indicator name	Infant mortality rate (probability of dying between birth and age of 1 year per 1,000 live births).
Definition	The probability that a child born in a specific year or period will die before reaching the age of 1 year, if subject to age-specific mortality rates of that period, expressed as a rate per 1,000 live births. The infant mortality rate is, strictly speaking, not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability.
Unit	Deaths per 1,000 live births
Numerator	Number of children who died before their first birthday (0–11 months of age).
Denominator	Number of live births.
Method of measurement	The most frequently used methods using the above-mentioned data sources are as follows: Civil registration: Number of deaths at age 0 and population for the same age are used to calculate the death rate which is then converted into the age-specific probability of dying. Census and surveys: An indirect method is used based on questions to each woman of reproductive age as to how many children she has ever given birth to and how many are still alive. The Brass method and model life tables are then used to obtain an estimate of infant mortality. Surveys: A direct method is used based on birth history – a series of detailed questions on each child a woman has given birth to during her lifetime. To reduce sampling errors, the estimates are often presented as period rates for five years preceding the survey. A synthetic cohort method developed by the DHS is used to compute period rates
Method of estimation	The Inter-agency Group for Child Mortality of Estimation (UN IGME) which includes representatives from UNICEF, WHO, the World Bank and the United Nations Population Division, produces trends of infant mortality rates with standardized methodology by group of countries depending on the type and quality of source of data available. For countries with adequate trend of data from civil registration, the calculations of under-five and infant mortality rates are derived from a standard period abridged life table. For countries with survey data, since infant mortality rates from birth histories of surveys are exposed to recall biases, infant mortality is derived from the projection of under-five mortality rates converted into infant mortality rates using the Bayesian B-splines bias-adjusted model. These infant mortality rates have been estimated by applying methods to all Member States to the available data from Member States, that aim to ensure comparability of across countries and time; hence they are not necessarily the same as the official national data. Predominant type of statistics: adjusted and predicted.
Measurement frequency	Annual if based on registration system; otherwise, less frequent (3–5 years based on surveys).
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	United Nations Children's Fund. (n.d.). Saudi Arabia country profile. Retrieved [August 30, 2025], from https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=SAU.CME_MRY0.&startPeriod=1970&endPeriod=2025&lastnobservations=1

6 Neonatal mortality rate [SDG 3.2.2]

National Indicator Performance			
Recent international value		**Recent national value**	
3 deaths per 1,000 live births		**5.2 deaths per 1,000 live births**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	MOH	Mortality registry

Key Indicator Specifications	
Abbreviated name	Neonatal mortality rate [SDG 3.2.2]
Indicator name	Neonatal mortality rate (per 1,000 live births).
Definition	Probability that a child born in a specific year or period will die in the first 28 days of life (0–27 days) if subject to age-specific mortality rates of that period, expressed per 1,000 live births. Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into early neonatal deaths, occurring during the first 7 days of life, and late neonatal deaths, occurring after the 7th day but before the 28th completed day of life.
Unit	Deaths per 1,000 live births
Numerator	Number of children who died during the first 28 days of life.
Denominator	Number of live births.
Method of measurement	Data from civil registration: The number of live births and the number of neonatal deaths are used to calculate age-specific rates. This system provides annual data. Data from household surveys: Calculations are based on full birth history, whereby women are asked for the date of birth of each of their children, whether each child is still alive and if not the age at death.
Method of estimation	To ensure consistency with mortality rates in children younger than 5 years (under-five mortality rate) produced by the UN-IGME and to account for variation in survey-to-survey measurement errors, country data points for the under-five and neonatal mortality rates were rescaled for all years to match the latest time series estimates of the under-five mortality rate produced by UN-IGME. This rescaling assumes that the proportionate measurement error in neonatal and under-five mortality rates is equal for each data point. The following multilevel statistical model was then applied to estimate neonatal mortality rates: log (neonatal mortality rate/1,000) = $\alpha 0 + \beta 1 * \log$(under-five mortality rate/1,000) + $\beta 2 * ([\log(\text{under-five mortality rate}/1{,}000)]\ 2\ )$ with random effects parameters or both level and trend regression parameters, and random effects parameters influenced by the country itself. For countries with high-quality civil registration data for neonatal deaths – defined as (i) 100% complete for adults and only civil registration data is used for child mortality, (ii) population greater than 800,000, (iii) and with at least three civil registration data points for the periods 1990–1994, 1995–1999, 2000–2004 and 2005 onwards – we used the same basic equation, but with random effects parameters for both level and trend regression parameters, and random effects parameters influenced by the country itself. Predominant type of statistics: adjusted and predicted. These neonatal rates are estimates, derived from the estimated UN-IGME neonatal rate infant population for World population prospects to calculate the live births; hence they are not necessarily the same as the official national statistics.
Measurement frequency	Annual if based on registration system; otherwise, less frequent (3–5 years based on surveys).
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

7 Stillbirth rate

National Indicator Performance			
Recent international value		**Recent national value**	
4.0 deaths per 1,000 births		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Stillbirth rate
Indicator name	Stillbirth rate
Definition	Number of stillbirths per 1,000 total births. Stillbirths can occur antepartum or intrapartum. In many cases, stillbirths reflect inadequacies in antenatal care coverage or intrapartum care. For purposes of international comparison, stillbirths are defined as third trimester fetal deaths (≥1,000 g or ≥28 weeks).
Unit	Deaths per 1,000 total births
Numerator	Number of fetuses and infants born per year with no sign of life and born after 28 weeks gestation, or weighing ≥1,000g
Denominator	Total births
Method of measurement	Data from civil registration: the number of stillbirths divided by the number of total births. Data from surveys: the number of pregnancy losses during or after the seventh month of pregnancy for the 5 years preceding the interview, divided by the sum of live births and late pregnancy losses in the same time period. Data from administrative reporting systems/registries: the number of stillbirths divided by the number of total births. Data from health facilities: the number of stillbirths divided by the number of total births documented in the facility.
Method of estimation	For data from countries with civil registration and good coverage, data meeting definition criteria of greater than or equal to 1,000g or 28 completed weeks gestation are taken directly from civil registration without adjustment. For other countries, stillbirth rates are estimated with a regression model.
Measurement frequency	Continuous data collection; dissemination every 3–5 years.
KSA data source	N/A
International data source	World Health Organization. (n.d.). Stillbirth rate (per 1,000 total births). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/stillbirth-rate-(per-1000-total-births)

8 Maternal mortality ratio [SDG 3.1.1]

National Indicator Performance			
Recent international value		**Recent national value**	
7.4 deaths per 100,000 live births		**15.9 deaths per 100,000 live births**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	MOH	Mortality registry

Key Indicator Specifications	
Abbreviated name	Maternal mortality ratio [SDG 3.1.1]
Indicator name	Maternal mortality ratio (per 100,000 live births)
Definition	The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period.
Unit	Maternal deaths per 100,000 live births
Numerator	Number of maternal deaths
Denominator	Number of live births.
Method of measurement	The maternal mortality ratio can be calculated by dividing recorded (or estimated) maternal deaths by total recorded (or estimated) live births in the same period and multiplying by 100,000. Measurement requires information on pregnancy status, timing of death (during pregnancy, childbirth, or within 42 days of termination of pregnancy), and cause of death. The maternal mortality ratio can be calculated from data collected through civil registration vital statistic (CVRS) systems, household surveys or other sources. There are often data quality problems, particularly related to the incompleteness and misclassification of maternal deaths. Therefore, data are often adjusted in order to take these data quality issues into account. Because maternal mortality is a relatively rare event, large sample sizes are needed if household surveys are used to identify recent maternal deaths in the household (e.g. last year). This may still result in estimates with large confidence intervals, limiting the usefulness for cross-country or over-time comparisons. To reduce sample size requirements, the sisterhood method used in the DHS and multiple indicator cluster surveys (MICS4 and MICS5) measures maternal mortality by asking respondents about the survival of sisters. It should be noted, regarding the sisterhood method results in pregnancy-related mortality, that regardless of the cause of death, all deaths occurring during pregnancy, birth or the six weeks following the termination of the pregnancy are included in the numerator of the maternal mortality ratio. Censuses have also included questions about maternal deaths with variable success. Reproductive Age Mortality Studies (RAMOS) is a special study that uses varied sources, depending on the context, to identify all deaths of women of reproductive age and ascertain which of these deaths are maternal or pregnancy-related.
Method of estimation	WHO, UNICEF, UNFPA, the United Nations Population Division and The World Bank Group have developed a method to adjust existing data in order to take into account these data quality issues and ensure the comparability of different data sources. This method involves assessment of data for completeness and, where necessary, adjustment for misclassification of deaths as well as development of estimates through statistical modelling for countries with no reliable national level data. Data on maternal mortality and other relevant variables are obtained through databases maintained by WHO, the United Nations Population Division, UNICEF, and The World Bank Group. Data available from countries varies in terms of source and methods. Given the variability of the sources of data, different methods are used for each data source in order to arrive at country estimates that are comparable and permit regional and global aggregation. Currently, only about one third of all countries/territories have good quality data available (CRVS type data), however, with the exception of very specialized studies such as confidential enquiries, most data points require some pre-analysis adjustment to account for misclassification. For about half of the countries included in the estimation process, country-reported estimates of maternal mortality are adjusted for the purposes of comparability of the methodologies. For the remainder of countries/territories those with no nationally representative eligible maternal mortality data – a statistical model is employed to predict maternal mortality levels. However, the calculated point estimates with this methodology might not represent the true levels of maternal mortality. It is advised to consider the estimates together with the reported uncertainty margins within which the true levels are more likely to lie. Predominant type of statistics: predicted.
Measurement frequency	Annual for civil registration; every 5 years or more for other sources
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (n.d.). Maternal mortality ratio (per 100,000 live births). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births)

9 Tuberculosis mortality rate (TB mortality rate)

National Indicator Performance			
Recent international value		**Recent national value**	
0.51 deaths per 100,000 population		**0.51 deaths per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Estimated through the organization	WHO Global Tuberculosis Report	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	TB mortality rate
Indicator name	Tuberculosis (TB) mortality rate (per 100,000 population)
Definition	Estimated number of deaths caused by TB in a given year, expressed as a rate per 100,000 population.
Unit	Deaths per 100,000 population
Numerator	Number of deaths due to TB (all forms) in a given year, excluding deaths in HIV-positive TB cases.
Denominator	Estimated population in the reporting year.
Method of measurement	Vital registration data based on ICD–10 are used where available (approximately 120 countries). ICD–10 codes used are A15–A19 and which are equivalent to codes 010–018, and 137 from ICD–9. For other countries, estimates of mortality are derived as the product of estimates of incidence and the case fatality rate.
Method of estimation	Estimates of TB mortality are generated through a consultative and analytical process led by WHO and are published annually. Uncertainty bounds are provided in addition to best estimates.
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22 TB profile

10 AIDS-related mortality rate

National Indicator Performance			
Recent international value		**Recent national value**	
<200 deaths		**<200 deaths**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UNAIDS	Estimated through the organization	UNAIDS	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	AIDS-related mortality rate
Indicator name	AIDS-related mortality rate (per 100,000 population).
Definition	Estimated number of adults and children who have died due to AIDS-related causes in a specific year, expressed as a rate per 100,000 population.
Unit	Total deaths or per 100,000 population
Numerator	Number of deaths due to AIDS x100,000
Denominator	Estimated population in the reporting year.
Method of measurement	Death registration data using ICD; verbal autopsy-based results are also used. The number of AIDS-related deaths can also be modelled using the Spectrum software.
Method of estimation	For countries with complete civil registration and households surveys with good coverage of verbal autopsy, estimates of AIDS-related mortality rates may be calculated directly. Adjustments are often still needed because of underreporting/misclassification of HIV/AIDS deaths. Modelling, using multiple inputs specific to the HIV epidemic context, is typically used to obtain an estimate of the AIDS-related mortality rate. UNAIDS supports most countries to produce estimates of the AIDS-related mortality rate annually using Spectrum.
Measurement frequency	To calculate mortality rates per 100,000, the total population is derived from the previous year's population estimates produced by the United Nations Population Division.
KSA data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia
International data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia

11 Malaria mortality rate

National Indicator Performance			
Recent international value		**Recent national value**	
0 deaths per 100,000 population		**0 deaths per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	WHO GHO	Estimated through the WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	Malaria mortality rate
Indicator name	Malaria mortality rate (per 100,000 population)
Definition	Number of adults and children who have died due to malaria in a specific year, expressed as a rate per 100,000 population.
Unit	Deaths per 100,000 population
Numerator	Number of deaths due to malaria.
Denominator	Population at risk x100,000
Method of measurement	Death registration data using ICD–10; verbal autopsy-based results are also used.
Method of estimation	Modelling, using multiple inputs, is often used to obtain a malaria mortality estimate. WHO compiles information supplied by ministries of health (i.e. the agencies responsible for malaria surveillance in endemic countries). The procedures for adjusting data to allow for international comparability are as follows: The number of malaria deaths is derived by one of two methods: 1. by multiplying the estimated number of *P. falciparum* malaria cases in a country by a fixed case-fatality rate. This method is used for all countries outside the WHO African Region and for countries in the African Region where estimates of case incidence are derived from routine reporting systems and where malaria accounts for less than 5% of all deaths in children under 5 years, as described in the Global Burden of Disease Incremental Revision for 2004. A case fatality rate of 0.45% is applied to the estimated number of *P. falciparum* cases for countries in the African Region and a case fatality rate of 0.3% for *P. falciparum* cases in other regions. (In situations where the fraction of all deaths due to malaria is small, the use of a case fatality rate in conjunction with estimates of case incidence is considered to provide a better guide to the levels of malaria mortality than attempts to estimate the fraction of deaths due to malaria.) 2. For countries in the African Region where malaria comprises 5% or more of all deaths in children under 5 years, the number of deaths is derived from an estimate of the number of people living at high, low or no risk of malaria. Malaria death rates for these populations are inferred from longitudinal studies of malaria deaths, as recorded in the published literature. The malaria death rate is expressed as the number of deaths due to malaria per 100,000 population per year with the population of a country derived from projections made by the United Nations Population Division. The adjustment procedures described above aim to take into account underreporting of cases if patients do not use public sector facilities or if there are gaps in public sector reporting systems. For countries that do not undertake laboratory confirmation of cases, the adjustments also aim to correct for over-diagnosis of malaria. Where data from surveillance systems are not available, or are considered to be of insufficient quality, incidence is derived from estimated levels of malaria risk and will chiefly be from sources other than locally-available estimates. Predominant type of statistics: predicted. Age standardization is done for comparability over time and between populations.
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Estimated malaria mortality rate (per 100,000 population). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-malaria-mortality-rate-per-100-000-population
International data source	World Health Organization. (n.d.). Estimated malaria mortality rate (per 100,000 population). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-malaria-mortality-rate-per-100-000-population

12 Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease [SDG 3.4.1]

National Indicator Performance			
Recent international value		**Recent national value**	
13.6%		**16%**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2022	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT Progress Towards SGDs Report	Estimated through the PHA

Key Indicator Specifications	
Abbreviated name	Premature noncommunicable disease (NCD) mortality [SDG 3.4.1]
Indicator name	Mortality between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases.
Definition	Probability of dying between the ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases, defined as the percent of 30-year-old-people who would die before their 70th birthday from cardiovascular disease, cancer, diabetes, or chronic respiratory disease, assuming that s/he would experience current mortality rates at every age and s/he would not die from any other cause of death (e.g., injuries or HIV/AIDS). This indicator is calculated using life table methods.
Unit	Percent (%)
Numerator	Number of deaths between ages 30 and 70 years from the four causes in a synthetic life-table population.
Denominator	Population at exact age 30 in the synthetic life-table population.
Method of measurement	Deaths from these four causes are based on the following ICD codes: 100–I99, COO–C97, E10–E14 and J30–J98.
Method of estimation	Modelling, using multiple inputs, is often used if no complete and accurate data are available.
Measurement frequency	Annual if civil registration data; otherwise every 3–5 years.
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

13 Mortality rate attributed to household and ambient air pollution [SDG 3.9.1]

National Indicator Performance			
Recent international value		**Recent national value**	
91 deaths per 100,000 population		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Mortality from household and ambient air pollution [SDG 3.9.1].
Indicator name	Mortality attributable to joint effects of household and ambient air pollution.
Definition	The mortality attributable to the joint effects of household and ambient air pollution can be expressed as number of deaths or death rates. Death rates are calculated by dividing the number of deaths by the total population (or indicated if a different population group is used, e.g. children under 5 years).
Unit	Deaths per 100,000 population
Numerator	Number of deaths.
Denominator	Population.
Method of measurement	
Method of estimation	Burden of disease (or in the present case attributable mortality) is calculated by first combining information on the increased (or relative) risk of a disease resulting from exposure, with information on how widespread the exposure is in the population (e.g. the annual mean concentration of particulate matter to which the population is exposed). This allows calculation of the population attributable fraction (PAF), which is the fraction of disease seen in a given population that can be attributed to the exposure (e.g. in this case the annual mean concentration of particulate matter). Applying this fraction to the total burden of disease (e.g. cardiopulmonary disease expressed as deaths or DALYs), gives the total number of deaths or DALYs that results from exposure to that particular risk factor (in the example given above, to ambient air pollution). To estimate the combined effects of risk factors, a joint population attributable fraction is calculated, as described in Ezzati et al (2003). Method of estimation of global and regional aggregates: for deaths, national figures are summed; for death rates, the country deaths are summed according to the region of interest and divided by the corresponding regional population.
Measurement frequency	
KSA data source	N/A
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

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

National Indicator Performance			
Recent international value		**Recent national value**	
1.92 deaths per 100,000 population		**<0.1 deaths per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	2016	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Mortality from unsafe water, unsafe sanitation and lack of hygiene [SDG 3.9.2].
Indicator name	Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe water, sanitation and hygiene for all (WASH) services).
Definition	Number of deaths from unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe WASH services) in a year, divided by the population, and multiplied by 100,000.
Unit	Deaths per 100,000 population
Numerator	Number of deaths from unsafe water, unsafe sanitation and lack of hygiene in a year x 100,000.
Denominator	Population.
Method of measurement	The included diseases are the WASH attributable fractions of diarrhoea (ICD–10 code A00, A01, A03, A04, A06–A09), intestinal nematode infections (ICD–10 code B76–B77, B79) and protein-energy malnutrition (ICD–10 code E40–E46).
Method of estimation	Burden of disease (or in the present case attributable mortality) is calculated by first combining information on the increased (or relative) risk of a disease resulting from exposure, with information on how widespread the exposure is in the population (in this case, the percentage of the population with exposure to unsafe water, sanitation and lack of hygiene). This allows calculation of the 'population attributable fraction' (PAF), which is the fraction of disease seen in a given population that can be attributed to the exposure, in this case lack of access to improved water, sanitation and hygiene. Applying this fraction to the total burden of disease (e.g. diarrhoeal diseases expressed as deaths or DALYs), gives the total number of deaths or DALYs that results from inadequate water, sanitation and hygiene. Method of estimation of global and regional aggregates: for deaths and DALYs, national figures are summed. For death and DALY rates, the country deaths, respectively DALYs, are summed according to the region of interest and divided by the corresponding regional population.
Measurement frequency	
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

15 Mortality rate attributed to unintentional poisoning [SDG 3.9.3]

National Indicator Performance			
Recent international value		**Recent national value**	
0.3 deaths per 100,000 population		**0.47 deaths per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2020	Estimate	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT Progress Towards SGDs Report	Registery

Key Indicator Specifications	
Abbreviated name	Mortality from unintentional poisoning [SDG 3.9.3]
Indicator name	Mortality rate attributed to unintentional poisoning (per 100,000 population)
Definition	Number of deaths from unintentional poisonings (per 100,000 population), for the year indicated.
Unit	Rate per 100,000 population
Numerator	Number of deaths from unintentional poisonings.
Denominator	Population
Method of measurement	Death registration data including cause of death, often with adjustments for underreporting.
Method of estimation	Modelling, using multiple inputs, is often used if no complete and accurate data are available.
Measurement frequency	Every 2–3 years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

16 Suicide mortality rate [SDG 3.4.2]

National Indicator Performance			
Recent international value		**Recent national value**	
0.9 deaths per 100,000 population		**2.29 deaths per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	GASTAT Progress Towards SGDs Report	Mortality registry

Key Indicator Specifications	
Abbreviated name	Suicide rate [SDG 3.4.2]
Indicator name	Suicide rate (per 100,000 population)
Definition	Suicide rate per 100,000 population in a specified period.
Unit	Deaths per 100,000 population
Numerator	Number of suicide deaths in year x 100,000.
Denominator	Population.
Method of measurement	Death registration data including cause of death, often with adjustments for underreporting.
Method of estimation	Modelling, using multiple inputs, is often used if no complete and accurate data are available.
Measurement frequency	Annual if civil registration data are available, otherwise every five years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	World Health Organization. (2025). Suicide rates. Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/themes/mental-health/suicide-rates

17 Death rate due to road traffic injuries [SDG 3.6.1]

National Indicator Performance			
Recent international value		**Recent national value**	
18.5 deaths per 100,000 population		**12.13 deaths per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	Health Sector Transformation Report 2024	Mortality registry

Key Indicator Specifications	
Abbreviated name	Death rate due to road traffic injuries [SDG 3.6.1]
Indicator name	Death rate due to road traffic injuries
Definition	Number of road traffic fatal injury deaths per 100,000 population.
Unit	Per 100,000 population
Numerator	Number of deaths due to road traffic crashes.
Denominator	Population
Method of measurement	Death registration data using ICD: I. ICD-10 4–character: V011–V019, V021–V029, V031–V039, V041–V049, V061–V069, V092, V093, V103–V109, V113–V119, V123–V129, V133–V139, V143–V149, V154–V159, V164–V169, V174–V179, V184–V189, V194–V199, V203–V209, V213–V219, V223–V229, V233 V239, V243–V249, V253–V259, V263–V269, V273–V279, V283–V289, V294–V299, V304–V309, V314–V319, V324–V329, V334–V339, V344–V349, V354–V359, V364–V369, V374–V379, V384–V389, V394–V399, V404–V409, V414–V419, V424–V429, V434–V439, V444 V449, V454–V459, V464–V469, V474–V479, V484–V489, V494–V499, V504–V509, V514–V519, V524–V529, V534–V539, V544–V549, V554–V559, V564–V569, V574–V579, V584–V589, V594–V599, V604–V609, V614–V619, V624–V629, V634–V639, V644–V649, V654 V659, V664–V669, V674–V679, V684–V689, V694–V699, V704–V709, V714–V719, V724–V729, V734–V739, V744–V749, V754–V759, V764–V769, V774–V779, V784–V789, V794–V799, V803–V805, V811, V821, V828, V829, V830–V833, V840–V843, V850–V853, V860–V863, V870–V879, V892, V893, V899, V99, Y850. II. ICD-10 3-character: V01–V04, V06, V09–V80, V87, V89, V99.
Method of estimation	Countries are classified into one of four following groups: 1. Countries with death registration data completeness of at least 80%. For this category we used one of the following data: death registration/ civil registration, projection of the most recent death registration, reported death or projected reported deaths. 2. Countries with other sources of information on cause of death. This group includes India, Iran, Thailand and Viet Nam. For these countries a regression method was used to project forward the most recent year for which an estimate of total road traffic deaths were available. 3. Countries with population less than 150,000 and did not have eligible death registration data. For these countries the death reported in the survey were used directly, without adjustment. 4. Countries without eligible death registration data. For these countries a negative binomial regression model was used. For more information about this process, see Global Status Report on Road Safety 2015.
Measurement frequency	Annual if civil registration data are available, otherwise every 2–3 years based on the data from Global Status Report on Road Safety.
KSA data source	Vision 2030. (2024). Health Sector Transformation Report 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.vision2030.gov.sa/media/h0yb5d03/health-sector-transformation-report-2024.pdf
International data source	United Nations Statistics Division. (n.d.). SDG global database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

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

National Indicator Performance			
Recent international value		**Recent national value**	
Age 10-14: 0 per 1,000 women aged 10-14 **Age 15-19:** 8.28 per 1,000 women aged 15-19		**Age 15-19:** 7.4 per 1,000 women aged 15-19	
Date	**Type of Result**	**Date**	**Type of Result**
Age 10-14: 2005 Age 15-19: 2021	Estimate	2018	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Adolescent birth rate [SDG 3.7.2]
Indicator name	Adolescent birth rate (per 1,000 girls aged 10–14 years; aged 15–19 years).
Definition	Annual number of births to females aged 10–14 or 15–19 years per 1,000 females in the respective age group.
Unit	Annual number of births to females aged 10-14 or 15-19 years per 1,000 females in the respective age group.
Numerator	Number of live births to women aged 10–14 years or 15–19 years.
Denominator	Exposure to childbearing by women aged 10–14 years or 15–19 years.
Method of measurement	The adolescent birth rate is generally computed as a ratio. The numerator is the number of live births to women aged 15–19 years, and the denominator is an estimate of exposure to childbearing by women aged 15–19 years. The numerator and the denominator are calculated differently for civil registration and survey and census data. Civil registration: In the case of civil registration the numerator is the registered number of live births born to women aged 15–19 years during a given year, and the denominator is the estimated or enumerated population of women aged 15–19 years. Survey data: In the case of survey data, the adolescent birth rate is generally computed on the basis of retrospective birth histories. The numerator refers to births to women who were 15–19 years of age at the time of the birth during a reference period before the interview, and the denominator to person-years lived between the ages of 15 and 19 years by the interviewed women during the same reference period. Whenever possible, the reference period corresponds to the five years preceding the survey. The reported observation year corresponds to the middle of the reference period. For some surveys, no retrospective birth histories are available and the estimate is based on the date of last birth or the number of births in the 12 months preceding the survey. Census data: With census data, the adolescent birth rate is generally computed on the basis of the date of last birth or the number of births in the 12 months preceding the enumeration. The census provides both the numerator and the denominator for the rates. In some cases, the rates based on censuses are adjusted for under-registration based on indirect methods of estimation. For some countries with no other reliable data, the own-children method of indirect estimation provides estimates of the adolescent birth rate for a number of years before the census (see: http://mdgs.un.org/unsd/mdg/Metadata.aspx, accessed 20 July 2017). If numbers are available, adolescent fertility at ages under 15 years can also be computed. As measurement methods for 10–14 years are still under development, what is most frequently published is the birth rate for 15–19 years.
Method of estimation	World Fertility Data 2015 builds on the historical repository of demographic data and census and survey reports collected over the past 50 years by the Population Division and Statistics Division of the Department of Economic and Social Affairs (DESA) of the United Nations Secretariat. Data derived from censuses are generally reported by National Statistical Offices to the Statistics Division. Census data are also obtained from official census publications produced by National Statistical Offices. Estimates based on data compiled from civil registration systems are generally obtained from National Statistical Offices. Additional sources of data include the Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Surveys (MICS), the Reproductive Health Surveys (RHS), the Statistical office of the European Union (Eurostat), the Human Fertility Database (HFD) (www.humanfertility.org), the Human Fertility Collection (HFC) (www.fertilitydata.org), the Pan Arab Project for Child Development Surveys (PAPCHILD), the Pan-Arab Project for Family Health Survey (PAPFAM), national surveys, as well as fertility estimates produced by the Population Division of DESA. Estimate refers to the average of two five-year periods, 2010–2015 and 2015–2020.
Measurement frequency	Annual
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	World Health Organization. (2025). Adolescent birth rate (per 1000 women aged 15–19 years). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-(per-1000-women-aged-15-19-years)

19 Total fertility rate

National Indicator Performance			
Recent international value		**Recent national value**	
2.29 children per woman		**2.0 children per woman**	
Date	**Type of Result**	**Date**	**Type of Result**
2025	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	GASTAT	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	Total fertility rate
Indicator name	Total fertility rate
Definition	Mean number of children a woman would have by age 50 if she survived to age 50 and was subject, throughout her life, to the age-specific fertility rates observed in a given year. The total fertility is expressed as the number of children per woman. Total fertility is computed as the sum of age specific fertility rates divided by 1,000.
Unit	Children per woman
Numerator	
Denominator	
Method of measurement	Total fertility rate is directly calculated as the sum of age-specific fertility rates (usually referring to women aged 15–49 years), or five times the sum if data are given in five-year age groups. An age-specific or age-group-specific fertility rate is calculated as the ratio of annual births to women at a given age or age group to the population of women at the same age or age group, in the same year, for a given country, territory or geographical area. Population data from the United Nations correspond to mid-year estimated values, obtained by linear interpolation from the corresponding United Nations fertility medium-variant quinquennial population projections.
Method of estimation	Population data are taken from the most recent United Nations Population Division's World population prospects.
Measurement frequency	Annual if based on civil registration and vital statistics (CRVS); once every 3–5 years if based on surveys and census.
KSA data source	General Authority for Statistics. (2024). Population Estimates Statistics 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2067012/Population+Estimates+Statistics+2024+EN.pdf/9b71e303-5fd9-19cb-9913-850a9d521639?t=1738859947691
International data source	World Health Organization. (n.d.). Total fertility rate (live births per woman). Retrieved [August 30, 2025], from https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/MCA/total-fertility-rate-(live-births-per-woman)

20 New cases of vaccine-preventable diseases

National Indicator Performance			
Recent international value		**Recent national value**	
Measles: 1260 new cases **Congenital rubella syndrome**: 0 new cases **Mumps**: 265 new cases **Rubella**: 96 new cases **Diphtheria**: 10 new cases **Neonatal tetanus**: 4 new cases **Japanese encephalitis**: 0 new cases **Pertussis** 1090 new cases **Yellow fever**: 0 new cases **Poliomyelitis**: 0 new cases		**Measles**: 2254 new cases **Mumps**: 161 new cases **Rubella**: 182 new cases **Diphtheria**: 2 new cases **Neonatal tetanus**: 3 new cases **Yellow fever**: 0 new cases **Poliomyelitis**: 0 new cases	
Date	**Type of Result**	**Date**	**Type of Result**
All (except Poliomyelitis): 2024 Poliomyelitis: 2023	Crude	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Surveillance	MOH	Surveillance

Key Indicator Specifications	
Abbreviated name	New cases of vaccine-preventable diseases
Indicator name	New cases of vaccine-preventable diseases
Definition	Number of confirmed new cases of vaccine-preventable diseases that are included in the WHO recommended standards for surveillance of selected vaccine-preventable diseases, and vaccine-preventable diseases reported on the WHO-UNICEF reporting form in a specified time period.
Unit	New case
Numerator	Number of new cases
Denominator	
Method of measurement	Passive surveillance with regular reporting and quality control.
Method of estimation	Adjustments for underreporting may be needed. Currently only reported data without any adjustment are published.
Measurement frequency	Annually and monthly for measles and rubella
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (n.d.). Vaccine-preventable diseases. Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/gho-immunization-vaccine-preventable-communicable-diseases

21 HIV prevalence among adults aged 15-49 years (%)

National Indicator Performance			
Recent international value		**Recent national value**	
<0.1%		**<0.1%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UNAIDS	Estimated through the organization	UNAIDS	Estimated through UNAIDS in consultation with MOH

Key Indicator Specifications	
Abbreviated name	HIV prevalence rate
Indicator name	HIV prevalence (per 1,000 population)
Definition	The estimated number of adults aged 15-49 years with HIV infection, whether or not they have developed symptoms of AIDS, expressed as percent of total population in that age group.
Unit	Percentage (%)
Numerator	Total number of people aged 15-49 living with HIV.
Denominator	Total population
Method of measurement	Standardized tools and methods of estimation have been developed by UNAIDS and WHO in collaboration with the UNAIDS Reference Group on Estimation, Modelling and Projections. In countries with a generalized epidemic, national estimates of HIV prevalence are based on data generated by surveillance systems that focus on pregnant women who attend a selected number of sentinel antenatal clinics, and in an increasing number of countries on nationally representative serosurveys. In countries with a low level or concentrated epidemic national estimates of HIV prevalence are primarily based on surveillance data collected from populations at high risk (sex workers, men who have sex with men, injecting drug users) and estimates of the size of populations at high and low risk. These data are entered into the Estimation and Projection Package (EPP) software which fits a simple epidemiological model to the epidemic structure defined. EPP finds the best fitting curve that describes the evolution of adult HIV prevalence over time and calibrates that curve based on prevalence found in any national surveys or default values in case there is no national survey available. For countries with very little available prevalence data (less than three consistent surveillance sites) a point prevalence estimates and projection is made using spreadsheet models (the Workbook Method). The resulting point prevalence estimates for several years are entered into EPP to find the best fitting curve that describes the evolution of adult HIV prevalence over time.
Method of estimation	Modelling, using multiple inputs specific to the HIV epidemic context, is typically used to obtain an estimate of the HIV prevalence rate. UNAIDS and WHO support most countries to produce estimates of HIV prevalence annually using Spectrum.
Measurement frequency	Survey schedule; Spectrum model estimates updated every year.
KSA data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia
International data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia

22 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations [SDG 3.3.1]

National Indicator Performance			
Recent international value		**Recent national value**	
<0.1 case per 1,000 uninfected population		**0.04 case per 1,000 uninfected population**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UNAIDS	Estimated through the organization	MOH	Surveillance

Key Indicator Specifications	
Abbreviated name	HIV incidence rate [SDG 3.3.1]
Indicator name	HIV incidence (per 1,000 population)
Definition	Number of new HIV infections per 1,000 uninfected population. The incidence rate is the number of new cases per population at risk in a given time period.
Unit	New cases per 1,000 uninfected population.
Numerator	Number of new HIV infections.
Denominator	Uninfected population (which is the total population minus people living with HIV).
Method of measurement	Longitudinal data on uninfected individuals are the best source of data but are rarely available for large populations. Special diagnostic tests in population-based surveys or from health facilities can be used to obtain data on HIV incidence but results must be nationally representative and adjusted for performance of the diagnostic tests. Most countries will rely on modelled estimates using Spectrum, a UNAIDS-supported software tool. To calculate the uninfected population per 1,000, the estimate of the number of people living with HIV is subtracted from the previous year's population estimates produced by the United Nations Population Division.
Method of estimation	Modelling is often used to obtain an estimate of new infections.
Measurement frequency	Survey schedule; Spectrum model estimates updated every year
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/Ministry/Statistics/book/Pages/default.aspx
International data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia

23 Hepatitis B incidence per 100,000 population [SDG 3.3.4]

National Indicator Performance			
Recent international value		**Recent national value**	
0%		**0%**	
Date	**Type of Result**	**Date**	**Type of Result**
2020	Estimate	2020	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	WHO Data	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	Hepatitis B surface antigen prevalence
Indicator name	Prevalence of hepatitis B surface antigen
Other names	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years Hepatitis B surface antigen prevalence
Definition	Prevalence of hepatitis B surface antigen (HBsAg)-positive, adjusted for sampling design
Unit	Percentage (%)
Numerator	Number of survey participants with HBsAg positive test
Denominator	Number in survey with HBsAg result.
Method of measurement	The serosurvey sample should be drawn from the specific geographic region to be verified. For example, if the purpose is to estimate national childhood hepatitis B virus (HBV) transmission (including mother-to-child transmission) then the sampling should be geographically representative of the population. Convenience sampling is not appropriate. The sample size should be adequate to show with 95% confidence HBsAg prevalence of less than 1% with a precision of ± 0.5%. The target age is 5-years-old. Sampling 4–6 year olds may be appropriate. The serosurvey is cross sectional and therefore a point estimate time. The shorter time periods of data collection are therefore preferred. Data on HepB birth dose exposure and HepB3 completion should be drawn from official records. Where these are not available testing for HBsAb may be considered for the serosurvey. This is less preferable as it is more costly, but can also be done in addition. Specimen collection and transportation should be appropriate to minimize bias though specimen degradation in rural and remote areas. Where possible, it is advantageous to collect blood specimens for ELISA laboratory testing because the accuracy (sensitivity and specificity) is higher than for rapid tests. However, in some locations only rapid tests will be available hence test selection is resource dependent. This should be considered in designing overall study methodology. When an appropriate sampling strategy and size are used and quality testing assays and laboratory procedures are employed, the HBsAg prevalence in the serosurvey should be representative of the incidence of childhood HBV transmission in the specific geographic region (or country) in this age group.
Method of estimation	HBsAg is the most important input into estimation of Hepatitis B incidence which is defined as number of new hepatitis B infections per 100,000 population in a given year. Statistical modelling is used to make such estimates.
Measurement frequency	Intermittent, dependent on population seroprevalence and infant HBV vaccination coverage.
KSA data source	World Health Organization. (2024). Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years (%). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/62D8ABE/F513188
International data source	World Health Organization. (2024). Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years (%). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/62D8ABE/F513188

24 Congenital syphilis reported rate

National Indicator Performance			
Recent international value		**Recent national value**	
0 cases per 100,000 live births		**0 cases per 100,000 live births**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Crude	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Surveillance	WHO GHO	Surveillance in consultation with MOH

Key Indicator Specifications	
Abbreviated name	Congenital syphilis rate
Indicator name	Percentage of reported congenital syphilis cases (live births and stillbirths)
Definition	Congenital syphilis rate per 100,000 live births.
Unit	Cases per 100,000 live births
Numerator	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months x 100,000.
Denominator	Number of live births.
Method of measurement	It is collected through routine information systems. It is important to indicate in the comment section the case definition of congenital syphilis used in your country.
Method of estimation	
Measurement frequency	Recorded daily and reported quarterly to national or sub-national level; Also consolidated annually
KSA data source	World Health Organization. (n.d.). Congenital syphilis: number of reported cases. Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/congenital-syphilis-number-of-reported-cases
International data source	World Health Organization. (n.d.). Congenital syphilis: number of reported cases. Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/congenital-syphilis-number-of-reported-cases

25 TB incidence per 100,000 population [SDG 3.3.2]

National Indicator Performance			
Recent international value		**Recent national value**	
8.4 cases per 100,000 population		**Pulmonary TB:** 5.98 cases per 100,000 population **Extra-pulmonary TB:** 1.71 cases per 100,000 population **Both forms:** 7.66 cases per 100,000 population	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Surveillance	MOH	Surveillance

Key Indicator Specifications	
Abbreviated name	TB incidence rate [SDG 3.3.2]
Indicator name	TB incidence (per 100,000 population)
Definition	Estimated number of new and relapse TB cases (all forms of TB, including cases in people living with HIV) arising in a given year, expressed as a rate per 100,000 population.
Unit	Cases per 100,000 population
Numerator	Number of new and relapse TB cases arising in a specified time period, usually one year.
Denominator	Estimated population in a specified time period, usually one year.
Method of measurement	TB notification data from high-quality surveillance systems in which underreporting is negligible, in the context of strong health systems so that under or over-diagnosis is also negligible. For countries in which these criteria are not yet met, indirect estimates are based on either: a) notification data and estimates of levels of underreporting and under-diagnosis; or b) results from national TB prevalence surveys; or c) information from national vital registration systems.
Method of estimation	Estimates of TB incidence is produced through a consultative and analytical process led by WHO and are published annually. Estimates for each country are derived using one or more of the following approaches, depending on available data: 1. incidence = case notifications/estimated proportion of cases detected and officially reported; 2. incidence = prevalence/duration of disease; 3. incidence = deaths/proportion of incident cases that die; 4. results from a capture-recapture study. Uncertainty bounds are provided in addition to best estimates. Details are available in the online technical appendix to the WHO global tuberculosis report (http://www.who.int/tb/publications/global_report/en/, accessed 20 July 2017).
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (2024). Tuberculosis incidence (per 100,000 population). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/13B4226/C288D13

26 TB notification rate per 100,000 population (smear-positive cases)

National Indicator Performance			
Recent international value		**Recent national value**	
Crude: 2538 cases **Rate**: N/A		**Crude**: 2538 cases **Rate**: N/A	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Crude	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Surveillance	WHO Global Tuberculosis Report	Surveillance in consultation with MOH

Key Indicator Specifications	
Abbreviated name	TB notification rate
Indicator name	TB notification rate (per 100,000 population)
Definition	Number of new and relapse TB cases notified in a given year, per 100,000 population. The term "notification" means that TB is diagnosed in a patient and is reported within the national surveillance system, and then on to WHO.
Unit	Per 100,000 population
Numerator	Number of new and relapse cases of TB notified in a specified time period, usually one year.
Denominator	
Method of measurement	The number of notified cases is collected as part of routine national TB > Estimated population in a specified time period, usually one year. surveillance. Annual case notifications are reported by countries to WHO using a web-based data collection system. The TB case notifications reported by countries follow the WHO recommendations on case definitions and recording and reporting; they are internationally comparable and there is no need for any adjustment.
Method of estimation	
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22

27 Malaria incidence per 1,000 population [SDG 3.3.3]

National Indicator Performance			
Recent international value		**Recent national value**	
0 cases per 1,000 person		**0 cases per 1,000 person**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	MOH	Surveillance

Key Indicator Specifications	
Abbreviated name	Malaria incidence rate [SDG 3.3.3]
Indicator name	Malaria incidence rate (per 1,000 population)
Definition	Number of confirmed malaria cases per 1,000 persons per year.
Unit	Per 1,000 population
Numerator	Number of suspected malaria cases confirmed by either microscopy or rapid diagnostic test.
Denominator	Population at risk (number of people living in areas where malaria transmission occurs).
Method of measurement	Confirmed by microscopy or rapid diagnostics test. Microscopy: The number of cases confirmed by microscopy, including both inpatients and outpatients of all ages. Also includes cases detected by both active and passive case detection, but excludes cases detected in the community. Rapid diagnostic tests: The number of cases confirmed by rapid diagnostic tests, including both inpatients and outpatients of all ages. Also includes cases detected by both active and passive case detection, but excludes cases that are also confirmed by microscopy or that are detected and confirmed by community-based programmes.
Method of estimation	WHO compiles data on reported confirmed cases of malaria, submitted by the national malaria control programmes. The denominator is estimated, using risk mapping and population data.
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (2024). Malaria incidence (per 1000 population at risk). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/B868307/442CEA8

28 Cancer incidence, by type of cancer

National Indicator Performance			
Recent international value		**Recent national value**	
87.1 per 100,000 population		**87.1 per 100,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Age-standardized	2022	Age-standardized
Source	**Type of Source**	**Source**	**Type of Source**
IARC Global Cancer Observatory	Registry	WHO Global Cancer Observatory	Registry from SHC Cancer Registry

Key Indicator Specifications	
Abbreviated name	Cancer incidence, by type of cancer
Indicator name	Cancer incidence rate, by type of cancer (per 100,000 population)
Definition	Number of new cancers of a specific site/type occurring per 100,000 population.
Unit	Per 100,000 population
Numerator	Number of new cancer cases diagnosed in a specific year. This may include multiple primary cancers occurring in one patient. The primary site reported is the site of origin and not the metastatic site. In general, the incidence rate would not include recurrences.
Denominator	The at-risk population for the given category of cancer. The population used depends on the rate to be calculated. For cancer sites that occur only in one sex, the sex-specific population (e.g. females for cervical cancer) is used.
Method of measurement	Cancer registries.
Method of estimation	(Number of new cancer cases diagnosed in a specific year) / (at-risk population for that category) x 100,000. If cancer registries are incomplete, adjustments need to be made.
Measurement frequency	Annual
KSA data source	International Agency for Research on Cancer. (2022). Saudi Arabia fact sheet. Global Cancer Observatory. Retrieved [August 30, 2025], from https://gco.iarc.who.int/media/globocan/factsheets/populations/682-saudi-arabia-fact-sheet.pdf
International data source	International Agency for Research on Cancer. (2022). Saudi Arabia fact sheet. Global Cancer Observatory. Retrieved [August 30, 2025], from https://gco.iarc.who.int/media/globocan/factsheets/populations/682-saudi-arabia-fact-sheet.pdf

Part two:
Risk factors indicators

29 Exclusive breastfeeding rate 0–5 months of age

National Indicator Performance			
Recent international value		**Recent national value**	
31%		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
1996	Crude	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
World Bank	Survey	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Exclusive breastfeeding rate 0–5 months of age
Indicator name	Exclusive breastfeeding rate in infants 0–5 months of age
Definition	Percentage of infants 0–5 months of age (<6 months) who are fed exclusively with breast milk.
Unit	Percentage (%)
Numerator	Number of infants 0–5 months of age who are exclusively breastfed.
Denominator	Total number of infants 0–5 months of age surveyed
Method of measurement	Percentage of infants 0–5 months of age who received only breast milk on the previous day = (infants 0–5 months of age who received only breast milk during the previous day/infants 0–5 months of age) x 100. Current status data are used. Vitamins and minerals drop or medicines are not counted. DHS and MICS include questions on liquids and foods given the previous day to find out if the child is being exclusively breastfed
Method of estimation	WHO and UNICEF jointly collect data on infant and young child feeding, pooling information from national surveys. The WHO Programme of Nutrition, Physical Activity and Obesity, at the Regional Office for Europe compiles country information on exclusive breastfeeding independently. Note, many developed country data refer to exclusive breastfeeding at 6 months, which provides lower estimates than the standard measure of exclusive breastfeeding averaged over the first six months. The two sources have been combined to display all available data on exclusive breastfeeding. Predominant type of statistics: adjusted
Measurement frequency	Every 3–5 years
KSA data source	General Authority for Statistics. (2023). Women Health and Reproductive Care Statistics Publication 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435259/Women_Health_and_Reproductive_Care_Statistics_Publication_2023_EN.pdf
International data source	World Bank. (n.d.). Exclusive breastfeeding (% of children under 6 months) – Saudi Arabia. Retrieved [August 30, 2025], from https://data.worldbank.org/indicator/SH.STA.BFED.ZS?locations=SA

30 Early initiation of breastfeeding

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**65%**	
Date	**Type of Result**	**Date**	**Type of Result**
N/A	N/A	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
N/A	N/A	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Early initiation of breastfeeding
Indicator name	Early initiation of breastfeeding
Definition	Percentage of newborns breastfed within 1 hour of birth in a specified time period.
Unit	Percentage (%)
Numerator	Number of newborns breastfed within 1 hour of birth
Denominator	Number of live births in a specified time period
Method of measurement	Female survey respondents are asked about their youngest living child aged less than 24 months who is currently living with the respondent. The numerator and denominator include living and deceased children who were born within the past 24 months.
Method of estimation	Data compiled from household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).
Measurement frequency	Every 3–5 years
KSA data source	General Authority for Statistics. (2024). Women health and reproductive care statistics publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2067012/Women+Health+and+Reproductive+Care+Statistics+Publication+2024+EN+%281%29.pdf/33569118-478b-3be4-a6ef-d291a8399d11?t=1735117033009
International data source	N/A

31 Low birthweight prevalence (%)

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**Self-reported:** 15.5%	
Date	**Type of Result**	**Date**	**Type of Result**
2020	Estimates	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UNICEF	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Incidence of low birth weight among newborns
Indicator name	Incidence of low birth weight among newborns
Definition	Percentage of live births that weigh less than 2500g
Unit	Percentage (%)
Numerator	Number of live-born neonates with weight less than 2500 g at birth.
Denominator	Number of live births
Method of measurement	Delivery registers (hospital management and information systems – HMIS). This method provides data on the incidence of low birth weight among newborns delivered in health institutions. Household surveys which collect data on birth weight (recalled by mother) and relative size of the newborn at birth allow for an adjusted value even where many infants are not weighed at birth.
Method of estimation	The relative size at birth and recalled birth-weight data are used to estimate incidence. UNICEF maintains a global database in which adjustments are made using survey data (mainly DHS and MICS) and administrative estimates are used where the percentage of weighed newborns is high
Measurement frequency	Continuous
KSA data source	General Authority for Statistics. (n.d.). Statistical Publications and Reports. Retrieved [August 30, 2025], from https://www.stats.gov.sa/en/statistics-tabs?tab=436312&category=123902
International data source	World Health Organization. (n.d.). Low birthweight prevalence (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/low-birth-weight-prevalence-(-)

32 Prevalence of stunting (height for age <-2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age [SDG 2.2.1]

National Indicator Performance			
Recent international value		**Recent national value**	
12.4%		**10.3%**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	2020	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	GASTAT Progress Towards SGDs Report	Surveillance

Key Indicator Specifications	
Abbreviated name	Children under 5 years who are stunted [SDG 2.2.1]
Indicator name	Children under 5 years who are stunted (moderate and severe)
Definition	Percentage of stunted (moderate and severe) children aged 0–59 months (moderate = height-for-age below -2 standard deviations from the WHO Child Growth Standards median; severe = height-for-age below -3 standard deviations from the WHO Child Growth Standards median).
Unit	Percentage (%)
Numerator	Number of children aged 0–59 months who are stunted.
Denominator	Total number of children aged 0–59 months who were measured
Method of measurement	Percentage of children aged < 5 years stunted for age = (number of children aged 0–59 months whose z-score falls below -2 standard deviations from the median height-for-age of the WHO Child Growth Standards/total number of children aged 0–59 months who were measured) x 100. Children's weight and height are measured using standard equipment and methods (e.g. children younger than 24 months are measured lying down, while standing height is measured in children aged 24 months and older
Method of estimation	WHO maintains the Global Database on Child Growth and Malnutrition, which includes population-based surveys that fulfil a set of criteria. Data are checked for validity and consistency and raw data-sets are analysed according to a standard procedure to obtain comparable results. Prevalence below and above defined cut-off points for weight-for-age, height-for-age, weight-for-height and body mass index (BMI)-for-age in pre-school children are presented using z-scores based on the WHO Child Growth Standards. Predominant type of statistics: adjusted.
Measurement frequency	Every 3–5 years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	World Health Organization. (2024). Prevalence of stunting in children under 5 (%). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/A5A7413/5F8A486

33 Prevalence of malnutrition (weight for height >+2 or <-2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) [SDG 2.2.2]

A. Wasting

National Indicator Performance			
Recent international value		**Recent national value**	
3.9%		**5.5%**	
Date	**Type of Result**	**Date**	**Type of Result**
2020	Estimate	2020	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	GASTAT Progress Towards SGDs Report	Surveillance

Key Indicator Specifications	
Abbreviated name	Children under 5 years who are wasted [SDG 2.2.2]
Indicator name	Children under 5 years who are wasted (moderate and severe)
Definition	Percentage of wasted (moderate and severe) children aged 0–59 months (moderate = weight-for-height below -2 standard deviations of the WHO Child Growth Standards median; severe = weight-for-height below -3 standard deviations of the WHO Child Growth Standards median)
Unit	Percentage (%)
Numerator	Number of children aged 0–59 months who are wasted.
Denominator	Total number of children aged 0–59 months
Method of measurement	Percentage of children aged < 5 years wasted = (number of children aged 0–59 months whose z-score falls below -2 standard deviations from the median weight-for-height of the WHO Child Growth Standards/total number of children aged 0–59 months who were measured) x 100. Children's weight and height are measured using standard equipment and methods (e.g. children under 24 months are measured lying down, while standing height is measured in children aged 24 months and older.
Method of estimation	WHO maintains the Global Database on Child Growth and Malnutrition, which includes population-based surveys that fulfil a set of criteria. Data are checked for validity and consistency and raw data sets are analysed according to a standard procedure to obtain comparable results. Prevalence below and above defined cut-off points for weight-for-age, height-for-age, weight-for-height and BMI-for-age, in pre-school children are presented using z-scores based on the WHO Child Growth Standards. A detailed description of the methodology and procedures of the database – including data sources, criteria for inclusion, data quality control and database workflow – are described in a paper published in 2003 in the International Journal of Epidemiology (de Onis M, Blössner M)
Measurement frequency	Every 3–5 years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	World Health Organization. (2024). Prevalence of wasting in children under 5 (%). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/6461116/FC5231F

34 Prevalence of malnutrition (weight for height >+2 or <-2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) [SDG 2.2.2]

B.Overweight

National Indicator Performance			
Recent international value		**Recent national value**	
8.4%		**7.5%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2020	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHS 2025	[Type of source]	GASTAT Progress Towards SGDs Report	Surveillance

Key Indicator Specifications	
Abbreviated name	Children aged under 5 years who are overweight [SDG 2.2.2]
Indicator name	Children aged under 5 years who are overweight
Definition	Prevalence of weight-for-height in children aged 0–59 months defined as above +2 standard deviations of the WHO Child Growth Standards median
Unit	Percentage (%)
Numerator	Number of children aged 0–59 months who are overweight.
Denominator	Total number of children aged 0–59 months who were measured
Method of measurement	Percentage of children aged < 5 years who are overweight for age = (number of children aged 0–59 months whose z-score is over two standard deviations above the median weight-for-height of the WHO Child Growth Standards/total number of children aged 0–59 months who were measured) x 100. Children's weight and height are measured using standard technology (e.g. children under 24 months are measured lying down, while standing height is measured in children 24 months and older. The data sources include national nutrition surveys, any other nationally representative population-based surveys with nutrition modules, and national surveillance systems.
Method of estimation	WHO maintains the Global Database on Child Growth and Malnutrition, which includes population-based surveys that fulfil a set of criteria. Data are checked for validity and consistency and raw data-sets are analysed according to a standard procedure to obtain comparable results. Prevalence below and above defined cut-off points for weight-for-age, height-for-age, weight-for-height and BMI-for-age in pre-school children are presented using z-scores based on the WHO Child Growth Standards. A detailed description of the methodology and procedures of the database – including data sources, criteria for inclusion, data quality control and database workflow – are described in a paper published in 2003 in the International Journal of Epidemiology (de Onis M, Blössner M) Predominant type of statistics: adjusted.
Measurement frequency	Every 3–5 years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	World Health Organization. (2025). World Health Statistics 2025: Tables of Health Statistics by Country and Area, WHO Region and Globally. Geneva, Switzerland. Retrieved [August 30, 2025], from https://www.who.int/data/gho/whs-annex

35 Prevalence of anaemia in children aged 6–59 months (%)

National Indicator Performance			
Recent international value		**Recent national value**	
21.8%		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Anaemia prevalence in children
Indicator name	Prevalence of anaemia in children aged 6–59 months
Other names	Prevalence of anemia in children aged 6–59 months (%)
Definition	Percentage of children aged 6–59 months with a haemoglobin concentration of less than 110 g/L, adjusted for altitude.
Unit	Percentage (%)
Numerator	Number of children aged 6–59 months with a haemoglobin concentration of less than 110 g/L, adjusted for altitude.
Denominator	Total number of children aged 6–59 months who had haemoglobin concentration assessed during the survey.
Method of measurement	The anaemia status of children is assessed using blood haemoglobin concentration. In surveys, blood haemoglobin concentrations are typically measured using the direct cyanmethemoglobin method in a laboratory or with a portable, battery-operated, haemoglobin photometer in the field that uses the azide-methaemoglobin method. In the cyanmethemoglobin method, a fixed quantity of blood is diluted with a reagent and haemoglobin concentration is determined after a fixed time interval in an accurate, well calibrated photometer. The principle of this method is based on the conversion of hemoglobin to cyanmethemoglobin by the addition of potassium cyanide and ferricyanide whose absorbance is measured at 540 nm in a colorimeter or spectrophotometer against a standard solution. The cyanmethemoglobin measurement is the reference laboratory method for the quantitative determination of haemoglobin and is used for comparison and standardization of other methods. A portable photometer system may consist of disposable microcuvettes containing reagent in dry form and a single purpose designed photometer. The reaction in the microcuvette is a modified azide-methaemoglobinn reaction. Sodium deoxycholate haemolyses erythrocytes and haemoglobin is released. Sodium nitrite converts haemoglobin to methaemoglobin which, together with sodium azide, gives azidemethaemoglobin. The absorbance is measured at two wavelengths (570 nm and 880 nm). This methodology of haemoglobin determination has been shown to be stable and durable in field setting
Method of estimation	WHO estimates haemoglobin distributions by country and year using a Bayesian hierarchical mixture model. This model systematically addressed missing data, non-linear time trends, and representativeness of data sources. Full details on statistical methods may be found here: Global, regional, and national trends in haemoglobin concentration and prevalence of total and severe anaemia in children and pregnant and non-pregnant women for 1995–2011: a systematic analysis of population-representative data (Stevens et al, 2013).
Measurement frequency	Every 3–5 years
KSA data source	N/A
International data source	World Health Organization. (n.d.). Prevalence of anaemia in children aged 6–59 months (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-anaemia-in-children-under-5-years-(-)

36 Prevalence of anaemia in pregnant women (aged 15-49) [SDG 2.2.3] (%)

National Indicator Performance			
Recent international value		**Recent national value**	
20.8%		**9%**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2019	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	KSAWHS	Survey

Key Indicator Specifications	
Abbreviated name	Anaemia prevalence in women of reproductive age (Also: severe anaemia)
Indicator name	Prevalence of anaemia in women aged 15–49, by age and pregnancy status
Definition	Percentage of women aged 15–49 years with a haemoglobin concentration less than 120 g/L for non-pregnant women and lactating women, and less than 110 g/L for pregnant women, adjusted for altitude and smoking
Unit	Percentage (%)
Numerator	Number of women aged 15–49 years with haemoglobin concentration below the indicated cut-off, adjusted for altitude and smoking.
Denominator	Total number of women aged 15–49 years with haemoglobin concentration assessed during a specified period
Method of measurement	The anaemia status of women of reproductive age is assessed using blood haemoglobin concentration. In surveys, blood haemoglobin concentrations are typically measured using the direct cyanmethemoglobin method in a laboratory or with a portable, battery-operated, haemoglobin photometer in the field that uses the azide-methaemoglobin method. In the cyanmethemoglobin method, a fixed quantity of blood is diluted with a reagent and haemoglobin concentration is determined after a fixed time interval in an accurate, well calibrated photometer. The principle of this method is based on the conversion of hemoglobin to cyanmethemoglobin by the addition of potassium cyanide and ferricyanide whose absorbance is measured at 540 nm in a colorimeter or spectrophotometer against a standard solution. The cyanmethemoglobin measurement is the reference laboratory method for the quantitative determination of haemoglobin and is used for comparison and standardization of other methods. A portable photometer system may consist of disposable microcuvettes containing reagent in dry form and a single purpose designed photometer. The reaction in the microcuvette is a modified azide-methaemoglobinn reaction. Sodium deoxycholate haemolyses erythrocytes and haemoglobin is released. Sodium nitrite converts haemoglobin to methaemoglobin which, together with sodium azide, gives azidemethaemoglobin. The absorbance is measured at two wavelengths (570 nm and 880 nm). This methodology of haemoglobin determination has been shown to be stable and durable in field settings.
Method of estimation	WHO estimates haemoglobin distributions by country and year using a Bayesian hierarchical mixture model. This model systematically addressed missing data, non-linear time trends, and representativeness of data sources. Full details on statistical methods may be found here: Global, regional, and national trends in haemoglobin concentration and prevalence of total and severe anaemia in children and pregnant and non-pregnant women for 1995–2011: a systematic analysis of population-representative data (Stevens et al, 2013).
Measurement frequency	Every 3–5 years
KSA data source	Ministry of Health. (2021). Maternal Health & Child Immunization: World Health Survey Saudi Arabia (KSAWHS). Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/Indicator/Documents/Maternal-Health-Child-Immunization.pdf
International data source	World Health Organization. (n.d.). Prevalence of anaemia in pregnant women (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-anaemia-in-women-of-reproductive-age-(-)

37 Proportion of population using safely managed drinking water services [SDG 6.1.1]

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**99.91%**	
Date	**Type of Result**	**Date**	**Type of Result**
N/A	N/A	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
N/A	N/A	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Population using safely managed drinking-water services [SDG 6.1.1]
Indicator name	Proportion of population using safely managed drinking-water services
Definition	Population using an improved drinking water source (piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tube wells; protected dug wells; protected springs, rainwater, packaged or delivered water) which is located on premises, available when needed, and free of faecal and priority chemical contamination
Unit	Percentage (%)
Numerator	Population using safely managed drinking-water services
Denominator	Total population
Method of measurement	The indicator is computed as the ratio of the number of people who use a safely managed drinking-water service, urban and rural, expressed as a percentage. Data from household surveys or censuses provide information on the types of basic drinking-water sources listed above. Such data will be combined with water quality data from direct testing of water quality at the household level as well as data from administrative records or regulatory frameworks for various aspects of safe management. The percentage of the total population using a safely managed drinking-water service is the population-weighted average of the previous two numbers. Access to water and sanitation are considered core socioeconomic and health indicators and key determinants of, inter alia, child survival, maternal and children's health, family well-being and economic productivity. Additionally, the use of drinking-water sources and sanitation facilities is part of the wealth index used by household surveys to divide the population into wealth quintiles. As a result, most nationally representative household surveys include information about basic water and sanitation. The survey questions and response categories pertaining to access to basic drinking-water sources are fully harmonized between DHS and MICS and are adopted from the standard questionnaire promoted for inclusion in survey instruments by the WHO/UNICEF Joint Monitoring Programme on Water Supply and Sanitation. This can be accessed via http://www.wssinfo.org. Administrative data on faecal and chemical contamination, and regulation by appropriate authorities, will be collected by JMP through consultation with the government departments responsible for drinking-water supply and regulation.
Method of estimation	The JMP assembles, reviews and assesses data collected by national statistics offices and other relevant institutions including sectoral authorities. Linear regression is used to provide estimates of the population using improved drinking water supplies, as well as the proportion of improved supplies which are located on premises, available when needed, and free from contamination. Regression is restricted to the years 2000 to present. Since data on location, availability and quality are not generally available from the same datasets, the estimates resulting from independent regressions are combined. The indicator is calculated by taking the minimum of the three elements (location, availability, quality) and multiplying this by the estimate of the population using improved water supplies).
Measurement frequency	Biennial
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	

38 Proportion of population using (a) safely managed sanitation services and (b) a hand- washing facility with soap and water [SDG 6.2.1]

A. Safely managed sanitation services

National Indicator Performance			
Recent international value		**Recent national value**	
80%		**99.03%**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Population using safely managed sanitation services
Indicator name	Proportion of population using safely managed sanitation service
Definition	The proportion of the population using safely managed sanitation services is defined as the proportion of the population using an improved sanitation facility which is not shared with other households and where excreta are safely disposed of in situ or removed and treated off-site. 'Improved' sanitation facilities are those designed to hygienically separate human excreta from human contact. These include wet sanitation technologies such as flush and pour flush toilets connected to sewers, septic tanks or pit latrines, and dry sanitation technologies such as dry pit latrines with slabs, ventilated improved pit latrines and composting toilets.
Unit	Percentage (%)
Numerator	Population using safely managed sanitation services.
Denominator	Total population
Method of measurement	Data on improved sanitation facilities are routinely collected in household surveys and censuses. These data sources may also collect information on sharing of sanitation facilities are shared among two or more households, and on emptying of on-site sanitation facilities. Household-level responses, weighted by household size, are used to compute population coverage. Household surveys routinely collect information on the availability of handwashing facilities in the home. In most cases, the enumerator asks to see the place where members of the household most often wash their hands. The enumerator then observes if water and soap are available at that place. Household-level responses, weighted by household size, are used to compute population coverage.
Method of estimation	The JMP assembles, reviews and assesses national data collected by statistics offices and other relevant institutions including sectoral authorities. Linear regression is used to provide estimates of the population using improved sanitation facilities, as well as the proportion practising open defecation. Regressions are also made to estimate the population using improved sanitation facilities connected to sewers and septic tanks; these are constrained to not exceed the estimates for total improved facilities. The proportion of the population sharing sewered and non-sewered sanitation facilities is estimated by taking an average of all available data on sharing from household surveys and censuses. Basic sanitation services are calculated by multiplying the proportion of the population using improved sanitation facilities by the proportion of improved sanitation facilities which are not shared among two or more households. Separate estimates are made for urban and rural areas, and national estimates are generated as weighted averages of the two, using population data from the most recent report of the United Nations Population Division. The most recent household survey or census available for most countries was typically conducted two to six years ago. The JMP extrapolates regressions for two years beyond the last available data point. Beyond this point the estimates remain unchanged for up to four years unless coverage is below 0.5 percent or above 99.5 percent, in which case the line is extended indefinitely. . For more information see https://washdata.org/monitoring/methods/estimation-methods Predominant type of statistics: adjusted and predicted
Measurement frequency	Biennial
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://data.who.int/indicators/i/4CDFDDA/12EE54A?m49=682

39 Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water [SDG 6.2.1]:

B.Hand-washing facility with soap and water

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**98.39%**	
Date	**Type of Result**	**Date**	**Type of Result**
N/A	N/A	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
N/A	N/A	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Population using safely managed sanitation services [SDG 6.2.1a/6.2.1b]
Indicator name	Proportion of population using safely managed sanitation service
Definition	The proportion of the population with basic hygiene services is defined as the proportion of population with a handwashing facility with soap and water available at home. Handwashing facilities may be located within the dwelling, yard or plot. They may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.
Unit	Percentage (%)
Numerator	Handwashing facilities with soap and water
Denominator	Total population
Method of measurement	Currently, weighted averages of national estimates are used for the global estimates as this is a new indicator. Estimation methods will be refined following improved population coverage of this indicator
Method of estimation	Currently, weighted averages of national estimates are used for the global estimates as this is a new indicator. Estimation methods will be refined following improved population coverage of this indicator
Measurement frequency	Biennial
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	N/A

40 Proportion of population with primary reliance on clean fuels and technology [SDG 7.1.2]

National Indicator Performance			
Recent international value		**Recent national value**	
100%		**100%**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2022	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT Progress Towards SGDs Report	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	Population with primary reliance on clean fuels and technologies [SDG 7.1.2]
Indicator name	Percentage of the population with primary reliance on clean fuels and technologies at the household level (household air pollution)
Definition	Percentage of households/population with primary reliance on clean fuels and technologies for cooking/heating/lighting where clean is defined by the recommendations set forth in the WHO guidelines for indoor air quality: household fuel combustion.
Unit	Percentage (%)
Numerator	Number of households (population) with primary reliance on clean fuels and technologies for cooking/heating/lighting.
Denominator	Total number of households (population).
Method of measurement	The indicator is calculated as the number of people using modern fuels and technologies divided by the total population, expressed as a percentage. Data on the use of fuels and technologies for different end uses (e.g. cooking, heating, lighting) are routinely collected at national and subnational levels in most countries using censuses and surveys. Currently, modern fuels exclude solid fuels and kerosene. For the purpose of estimating the health impacts, it is recommended to monitor the use of kerosene also as a separate category.
Method of estimation	The indicator is modelled with household survey data compiled by WHO. The information on cooking fuel use and cooking practices from more than 700 nationally representative data sources, such as those listed above, is used in combination with the most recent survey data available on heating and lighting fuels and technologies. Unless stated otherwise, estimates for cooking using modern fuels and technologies for the total (urban and rural) population for a given year were obtained separately using a multilevel model. The model accounts only for regions, countries and time as a spline function, and estimates were restricted to values ranging from zero to one. All analyses were conducted using STATA software (version 12, StataCorp LP, College Station, TX, USA). Estimates for countries with no available surveys were obtained as follows: When no information on the fuels and technologies use in the home was available for the country, the regional population-weighted mean was used. Note that this approach was also applied to Equatorial Guinea instead of the one used for high-income countries (see below); Countries classified as high-income with a Gross National Income (GNI) of more than US$ 12 616 per capita (The World Bank, http://data.worldbank.org/about/country-classifications, accessed 20 July 2017) are assumed to have made a complete transition to using modern fuels and technologies as the primary source of domestic energy for cooking and heating, and solid fuel use is reported to be less than 5%.
Measurement frequency	Every 3–5 years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

41 Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted) [SDG 11.6.2]

National Indicator Performance			
Recent international value		**Recent national value**	
57.16 micrograms per cubic meter		**Numbers are reported for each region separately**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Air pollution level in cities [SDG 11.6.2]
Indicator name	Air pollution level in cities (particulate matter [PM2.5])
Definition	The annual mean concentration of fine suspended particles of less than 2.5 microns in diameters, population-weighted for urban population in a country, expressed in microgram per cubic meter [ug/m3].
Unit	Micrograms per cubic meter [µg/m3]
Numerator	
Denominator	
Method of measurement	The mean annual concentration of fine suspended particles of less than 10 or 2.5 microns in diameters is a common measure of air pollution. The mean city concentration is based on daily measurements, or data which could be aggregated into annual means.
Method of estimation	The annual urban mean concentration of PM2.5 is estimated with improved modelling using data integration from satellite remote sensing, population estimates, topography and ground measurements.
Measurement frequency	Every 2 years
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591 National Center for Environmental Compliance. Official website of the National Center for Environmental Compliance. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.ncec.gov.sa/ar/Pages/default.aspx
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

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

National Indicator Performance			
Recent international value		**Recent national value**	
0 liters of pure alcohol		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimated	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Total alcohol per capita (age 15+ years) consumption [SDG 3.5.2]
Indicator name	Total alcohol per capita (age 15+ years) consumption
Other names	Alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol [SDG 3.5.2].
Definition	Total alcohol per capita is the total amount (sum of recorded alcohol per capita three-year average and unrecorded alcohol per capita) of alcohol consumed per adult (15+ years) in a calendar year, in litres of pure alcohol. Recorded alcohol consumption refers to official statistics (production, import, export, and sales or taxation data), while unrecorded alcohol consumption refers to alcohol which is not taxed and is outside the usual system of government control. In circumstances in which the number of tourists per year is at least the number of inhabitants, tourist consumption is also taken into account and is deducted from a country's recorded alcohol per capita
Unit	Litres of pure alcohol
Numerator	Sum of recorded and unrecorded alcohol consumed in a population during a calendar year, in litres.
Denominator	Mid-year resident population aged 15+ for the same calendar year
Method of measurement	Recorded consumption: Recorded alcohol per capita (15+ years) consumption of pure alcohol is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits, other) from different sources. The first priority in the decision tree is given to government statistics, the second are country-specific alcohol industry statistics in the public domain (Canadian, IWSR-International Wine and Spirit Research, OIVInternational Organisation of Vine and Wine, Wine Institute, historically World Drink Trends), and third is the Food and Agriculture Organization of the United Nations' statistical database (FAOSTAT). For countries where the data source is FAOSTAT, unrecorded consumption may be included in the recorded consumption. Unrecorded consumption: The first priority in the decision tree is given to nationally representative empirical data, often from general population surveys in countries where alcohol is legal. The second priority are specific other empirical investigations, while the third is expert opinion
Method of estimation	Sum of recorded and unrecorded alcohol consumed in a population during a calendar year
Measurement frequency	Annual
KSA data source	N/A
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

43 Age-standardized prevalence of current tobacco use among persons aged 15 years and older [SDG 3.a.1]

National Indicator Performance			
Recent international value		**Recent national value**	
15%		**12.4%**	
Date	**Type of Result**	**Date**	**Type of Result**
2025	Age-standardized	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Tobacco use among persons aged 15+ years [SDG 3.a.1] (Also: adolescents)
Indicator name	Age-standardized prevalence of current tobacco use among persons aged 15+ years
Definition	Age-standardized prevalence of current tobacco use among persons aged 15+ years. "Smoked tobacco products" includes cigarettes, cigarillos, cigars, cheroots, bidis, pipes, shisha (water pipes), roll-your-own tobacco, kreket, and any other form of tobacco that is consumed by smoking. "Smokeless tobacco" includes moist snuff, plug, creamy snuff, dry snuff, plug, dissolvables, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas/naswar, shammah, betel quid, toombak, pan (betel quid), iq'mik, mishri, tapkeer, tombol and any other tobacco product that is consumed by sniffing, holding in the mouth, or chewing. "Current use" means use at the time of the survey, whether daily use or occasional use
Unit	Percentage (%)
Numerator	Number of current tobacco users aged 15+ years
Denominator	Total population aged 15+ years
Method of measurement	Number of respondents aged 15+ years currently using any tobacco product (smoked or smokeless) / (number of survey respondents aged 15+ years) x 100
Method of estimation	A statistical model based on a Bayesian negative binomial meta-regression is used to model prevalence of current tobacco smoking for each country, separately for men and women. A full description of the method is available as a peer-reviewed article in The Lancet, volume 385, No. 9972, p966–976 (2015). Once the age-and-sex-specific prevalence rates from national surveys are compiled into a dataset, the model is fitted to calculate trend estimates from the year 2000 to 2030. The model has two main components: (a) adjusting for missing indicators and age groups, and (b) generating an estimate of trends over time as well as the 95% credible interval around the estimate. Depending on the completeness of survey data from a particular country, the model at times makes use of data from other countries to fill information gaps. To fill data gaps, information is "borrowed" from countries in the same UN subregion. The resulting trend lines are used to derive estimates for single years, so that a number can be reported even if the country did not run a survey in that year. In order to make the results comparable between countries, the prevalence rates are age-standardized to the WHO Standard Population
Measurement frequency	At least every 5 years
KSA data source	General Authority for Statistics. (2024). Health Determinants Statistics Publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435259/Health+Determinants+Statistics+Publication+2024+EN.pdf/84a7831c-e181-a40b-555a-e04de9400f31?t=1734054219308
International data source	World Health Organization. (2024). Age-standardized prevalence of tobacco use among persons 15 years and older (%). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/847662C/75DDA77

44 Age-standardized prevalence of hypertension among adults aged 30-79 years (%)

National Indicator Performance			
Recent international value		**Recent national value**	
Adults aged 30-79 years: 34%		**Age-standardized**: Adults aged 18 and older: 24.5% **Crude**: Adults aged 18 and older 13%	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Age-standardized	2019	Age-standardized and crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO Data	Estimated through the organization	KSAWHS KSAWHS Report	Survey

Key Indicator Specifications	
Abbreviated name	Age-standardized prevalence of hypertension among adults aged 30-79 years (%)
Indicator name	Age-standardized prevalence of hypertension among adults aged 30 to 79 years (%)
Previous name	Raised blood pressure among adults 18+ years
Definition	The prevalence of hypertension (defined as having systolic blood pressure ≥140 mmHg, diastolic blood pressure ≥90 mmHg, or taking medication for hypertension) among adults aged 30 to 79.
Unit	Percentage (%)
Numerator	Number of respondents with systolic blood pressure ≥ 140mmHg or diastolic blood pressure ≥ 90mmHg.
Denominator	All survey respondents with a valid measurement
Method of measurement	Three blood pressure measurements should be taken and the average systolic and diastolic readings of the second and third measures should be used in this calculation.
Method of estimation	(Number of respondents aged 18+years with systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg)/(number of survey respondents aged 18+ years) x 100.
Measurement frequency	At least every 5 years
KSA data source	Ministry of Health (Saudi Arabia). (2019). World Health Survey Saudi Arabia 2019. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/Population-Health-Indicators/Documents/World-Health-Survey-Saudi-Arabia.pdf Ministry of Health (Saudi Arabia). (2023). Hypertension Treatment Coverage and Prevalence of Non-Raised Hypertension: Based on World Health Survey 2019 Data. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/MediaCenter/Publications/Pages/Hypertension-Treatment-Prevalence.pdf
International data source	World Health Organization. (2024). Age-standardized prevalence of hypertension among adults aged 30 to 79 years (%). Retrieved [August 30, 2025], from https://data.who.int/indicators/i/7DA4E68/608DE39

45 Prevalence of overweight among adults, BMI ≥25 (age-standardized estimate) (%)

National Indicator Performance			
Recent international value		**Recent national value**	
Adults aged 18 years and older with BMI ≥25: 73%		**Overweight, adults aged 18 years and older**: 38.2% **Obese, adults aged 18 years and older**: 20.2% **Total, adults aged 18 years and older**: 58.4%	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	2019	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	KSAWHS	Survey

Key Indicator Specifications	
Abbreviated name	Overweight and obesity in adults (Also: school-age children and adolescents)
Indicator name	Age-standardized prevalence of overweight and obesity in persons aged 18+ years
Definition	Percentage of adults (18+ years) who are overweight (defined as having a BMI ≥ 25 kg/m²) and obese (defined as having a BMI ≥ 30 kg/m²).
Unit	Percentage (%)
Numerator	Number of respondents aged 18+ years who are overweight. Number of respondents aged 18+ years who are obese.
Denominator	All survey respondents with valid height and weight measurements
Method of measurement	BMI is calculated by dividing weight in kilograms by height in meters squared. Overweight is defined as having a BMI ≥ 25 kg/m² and obesity is defined as having a BMI ≥ 30 kg/m²
Method of estimation	(Number of survey respondents aged 18+ years who are overweight)/(number of survey respondents aged 18+ years) x 100. (Number of survey respondents aged 18+ years who are obese)/(number of survey respondents aged 18+ years) x 100
Measurement frequency	At least every 5 years
KSA data source	Ministry of Health (Saudi Arabia). (2019). World Health Survey Saudi Arabia 2019. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/Population-Health-Indicators/Documents/World-Health-Survey-Saudi-Arabia.pdf
International data source	World Health Organization. (n.d.). Prevalence of overweight among adults, BMI ≥ 25 (age-standardized estimate) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-overweight-among-adults-bmi-=-25-(age-standardized-estimate)-(-)

46 Prevalence of diabetes

National Indicator Performance			
Recent international value		**Recent national value**	
Age-standardized: 20.8% **Estimated crude:** 15.5%		**Age-standardized:** 16.7%	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Age-standardized	2019	Age-standardized
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	KSAWHS	Survey

Key Indicator Specifications	
Abbreviated name	Raised blood glucose/diabetes among adults
Indicator name	Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years or on medication for raised blood glucose
Previous name	Raised blood glucose/diabetes among adults
Definition	Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years or on medication for raised blood glucose (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/dL) or on medication for raised blood glucose among adults aged 18+ years)
Unit	Percentage (%)
Numerator	Number of respondents aged 18+ years with fasting plasma glucose value ≥7.0 mmol/L (126 mg/dL) or on medication for raised blood glucose.
Denominator	All survey respondents with a valid fasting plasma glucose measurement
Method of measurement	Fasting blood glucose must be measured, not self-reported, and measurements must be taken after the person has fasted for at least eight hours
Method of estimation	(Number of respondents aged 18+ years with fasting plasma glucose value ≥ 7.0 mmol/L [126 mg/dL] or on medication for raised blood glucose)/ (number of survey respondents aged 18+ years) x 100
Measurement frequency	At least every 5 years
KSA data source	Ministry of Health (Saudi Arabia). (2019). World Health Survey Saudi Arabia 2019. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/Population-Health-Indicators/Documents/World-Health-Survey-Saudi-Arabia.pdf
International data source	World Health Organization. (n.d.). Mean fasting blood glucose (age-standardized estimate). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mean-fasting-blood-glucose-age-standardized-estimate

47 Mean population salt intake

National Indicator Performance			
Recent international value		**Recent national value**	
Adults aged 25+: 6.27g per day per person		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO NCD Portal	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Salt intake
Indicator name	Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years
Definition	Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.
Unit	Per day in grams for a person
Numerator	The sum of sodium excretion in urine samples from all respondents aged 18+ years.
Denominator	All respondents of the survey aged 18+ years.
Method of measurement	The gold standard for estimating salt intake is through 24-hour urine collection. However, other methods such as spot urine and food frequency surveys may be more feasible to administer at the population level.
Method of estimation	Sum of sodium excretion in urine samples from all respondents aged 18+ years/number of survey respondents aged 18+ years.
Measurement frequency	At least every 5 years
KSA data source	N/A
International data source	World Health Organization. (2019). Saudi Arabia: Noncommunicable Diseases (NCD) Country Profile. Retrieved [August 30, 2025], from https://ncdportal.org/CountryProfile/GHE110/SAU

48 Prevalence of insufficient physical activity among adults aged 18+ years (age-standardized estimate) (%)

National Indicator Performance			
Recent international value		**Recent national value**	
51.5%		**41.5%**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Age-standardized	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Insufficient physical activity in adults (Also: adolescents)
Indicator name	Age-standardized prevalence of insufficiently physically active persons aged 18+ years
Definition	Age-standardized prevalence of insufficiently physically active persons aged 18+ years (percentage of adults aged 18+ years not meeting any of the following criteria: 150 minutes of moderate-intensity physical activity per week; 75 minutes of vigorous-intensity physical activity per week; an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 metabolic equivalent minutes per week (minutes of physical activity can be accumulated over the course of a week but must be of a duration of at least 10 minutes). *Metabolic equivalent (MET) is the ratio of a person's working metabolic rate relative to the resting metabolic rate. One metabolic equivalent is defined as the energy cost of sitting quietly and is equivalent to a caloric consumption of 1 kcal/kg per hour. Physical activities are frequently classified by their intensity, using the metabolic equivalent as a reference
Unit	Percentage (%)
Numerator	Number of respondents where all three of the following criteria are true: weekly minutes* of vigorous activity < 75 minutes; weekly minutes* of moderate activity < 150 minutes; weekly metabolic equivalent minutes** < 600.
Denominator	All respondents of the survey aged 18+ years.
Method of measurement	* Weekly minutes are calculated by multiplying the number of days on which vigorous/moderate activity is done by the number of minutes of vigorous/moderate activity per day. ** Weekly metabolic equivalent minutes are calculated by multiplying the weekly minutes of vigorous activity by 8 and the number of weekly minutes of moderate activity by 4 and then adding these two results together
Method of estimation	(Number of respondents aged 18+ years not meeting the aforementioned criteria for physical activity)/(number of survey respondents aged 18+ years) x 100.
Measurement frequency	At least every 5 years
KSA data source	General Authority for Statistics. (2024). Physical Activity Statistics Publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435259/Physical+Activity+Statistics+Publication+2024+EN.pdf/65c87784-25c2-bddd-74f5-c1e6d8ed7d73?t=1734054719811
International data source	World Health Organization. (n.d.). Prevalence of insufficient physical activity among adults aged 18+ years (age-standardized estimate) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-insufficient-physical-activity-among-adults-aged-18-years-(age-standardized-estimate)-(-)

Part three:
Service coverage indicators

49 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months or lifetime, by form of violence and by age [SDG 5.2.1/5.2.2]

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**Husband physical violence (lifetime):** 2% **Husband emotional violence (lifetime):** 2% **In the previous 12 months:** N/A	
Date	**Type of Result**	**Date**	**Type of Result**
N/A	N/A	2019	Crude
Source	**Type of Source**	**Source**	**Type of Source**
N/A	N/A	KSAWHS	Survey

Key Indicator Specifications	
Abbreviated name	Intimate partner violence prevalence [SDG 5.2.1]
Indicator name	Intimate partner violence prevalence
Definition	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months. Note: Measurement and methodological efforts are underway to ensure that the more expansive definition of the SDG indicator above is reported on. Given the data available currently, estimates will focus on the following: "Proportion of women aged 15-49 subjected to physical and/or sexual violence by an intimate partner in the last 12 months".
Unit	Percent (%)
Numerator	Total number of ever-partnered women aged 15 years and older (or aged 15–49) who reported having experienced physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months
Denominator	Total number of ever-partnered women aged 15 years and older (or aged 15–49).
Method of measurement	Population-based surveys focused on violence against women or population-based surveys with special module on violence against women. There are a series of questions asked to women currently or previously in a partnership inquiring about experience of specific acts of physical and sexual violence and psychological abuse by their partner. These questions are ideally asked by specially trained interviewers in household surveys dedicated to measurement of violence against women.
Method of estimation	Lifetime and last 12 month rates of intimate partner violence are estimated by age group and region by pooling data from population-based studies in models that control for definition of physical or sexual violence, survey type, interviewer training, whether survey was on all women or only currently partnered women, whether study was national or subnational, and whether prevalence refers to lifetime exposure or past year only. Results weighted by population size and age distribution. Method of estimation of global and regional aggregates: results weighted by population size and age distribution. The combined 15–49 or 15–69 age group estimates for regional and global prevalence of intimate partner violence are based on a more complete dataset than the age-specific estimates. The combined 15–49 or 15–69 age group world estimate for WHO regions is based on the aggregated world estimate using weighting of GBD regions.
Measurement frequency	Every 5 years
KSA data source	Ministry of Health. (2021). Maternal Health & Child Immunization: World Health Survey Saudi Arabia (KSAWHS). Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/Indicator/Documents/Maternal-Health-Child-Immunization.pdf
International data source	N/A

50 Fatal and non-fatal occupational injuries per 100,000 workers, by sex and migrant status [SDG 8.8.1]

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**Crude injuries:** 27,133 **Occupational injuries per 100,000 workers:** N/A	
Date	**Type of Result**	**Date**	**Type of Result**
N/A	N/A	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
N/A	N/A	GOSI 2023 Report	Surveillance

Key Indicator Specifications	
Abbreviated name	Frequency rates of occupational injuries [SDG 8.8.1]
Indicator name	Frequency rates of fatal and non-fatal occupational injuries
Definition	Frequency rates of fatal and non-fatal occupational injuries provide information on the number of cases of fatal and non-fatal occupational injury per hours worked by the concerned population during the reference period. It is a measure of risk of having a fatal or non-fatal occupational injury based on the duration of exposure to adverse work-related factors. The rates for fatal and non-fatal occupational injury rates are calculated separately.
Unit	Cases per 100,000 workers
Numerator	Number of new cases of fatal injury during the reference year, and number of new cases of non-fatal injury during the reference year, respectively.
Denominator	Total number of hours worked by workers in the reference group during the reference year, multiplied by 1,000,000.
Method of measurement	The frequency rates of fatal and non-fatal occupational injuries will be calculated separately, since statistics on fatal injuries tend to come from a different source than those on non-fatal injuries, which would make their sum into total occupational accidents inaccurate. The fatal occupational injury frequency rate is calculated as the number of new cases of fatal injury during the reference year divided by the total number of hours worked by workers in the reference group during the reference year, multiplied by 1,000,000. Similarly, the non-fatal occupational injury frequency rate is calculated as the number of new cases of non-fatal injury during the reference year divided by the total number of hours worked by workers in the reference group during the reference year, multiplied by 1,000,000. Ideally, the denominator should be the number of hours actually worked by workers in the reference group. When this is not possible, the denominator can be calculated on the basis of normal hours of work taking into account entitlements to periods of paid absence from work, such as paid vacations, paid sick leave and public holidays. If the data needed to calculate frequency rates is not available, incidence rates may be calculated instead. The fatal occupational injury incidence rate is calculated as the number of new cases of fatal injury during the reference year divided by the average number of workers in the reference group during the reference year, multiplied by 100,000. Similarly, the non-fatal occupational injury incidence rate is calculated as the number of new cases of non-fatal injury during the reference year divided by the average number of workers in the reference group during the reference year, multiplied by 100 000. In calculating the average number of workers, the number of part-time workers should be converted to full-time equivalents. For the calculation of rates, the numerator and the denominator should have the same coverage. For example, if self-employed persons are not covered by the source of statistics on fatal occupational injuries, they should also be taken out of the denominator.
Method of estimation	(Number of new cases of fatal injury during the reference year) / (Total number of hours worked by workers in the reference group during the reference year) x 1,000,000, and; (Number of new cases of non-fatal injury during the reference year) / (Total number of hours worked by workers in the reference group during the reference year) x 1,000,000, respectively.
Measurement frequency	Annual
KSA data source	General Organization for Social Insurance. (2023). Annual Report 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://cdn.gosi.gov.sa/StatisticsAndData/files/Report-2023.pdf
International data source	N/A

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

National Indicator Performance			
Recent international value		**Recent national value**	
All women: 54.5%		**Married women:** 56%	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimated	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Family Planning	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Demand for family planning satisfied with modern methods [SDG 3.7.1]
Indicator name	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
Definition	The percentage of women of reproductive age (15–49 years) who desire either to have no (additional) children or to postpone the next child and who are currently using a modern contraceptive method.
Unit	Percentage (%)
Numerator	Number of women of reproductive age (15–49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method.
Denominator	Total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning
Method of measurement	The percentage of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods is also referred to as the proportion of demand satisfied by modern methods. The components of the indicator are contraceptive prevalence (any method and modern methods) and unmet need for family planning. Currently, the variant of this indicator that is measured is "Percentage of women of reproductive age (15–49 years) who are sexually active and who have their need for family planning satisfied with modern methods."
Method of estimation	A Bayesian hierarchical model is used to generate regional and global estimates and projections of the indicator. Aggregate estimates and projections are weighted averages of the model-based country estimates, using the number of married or in-union women aged 15–49 for the reference year in each country. Regional averages are provided only if data are available on contraceptive prevalence for at least 50 percent of the women of reproductive age who are married or in union in the region
Measurement frequency	Annual
KSA data source	General Authority for Statistics. (2024). Women Health and Reproductive Care Statistics Publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435273/Women+Health+and+Reproductive+Care+Statistics+Publication+2024+EN.pdf/33569118-478b-3be4-a6ef-d291a8399d11?t=1735117033009
International data source	United Nations, Department of Economic and Social Affairs, Population Division. (n.d.). Family Planning Indicators. Retrieved [April 23, 2025], from https://www.un.org/development/desa/pd/data/family-planning-indicators

52 Contraceptive prevalence (%)

National Indicator Performance			
Recent international value		**Recent national value**	
39.9%		**29.9%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimated	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Family Planning	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Contraceptive prevalence rate
Indicator name	Contraceptive prevalence rate
Definition	Percentage of women aged 15–49 years, married or in union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used
Unit	Percentage (%)
Numerator	Number of women using or partner using a contraceptive method.
Denominator	Number of women married or in a union.
Method of measurement	Contraceptive prevalence = (women of reproductive age [15–49 years] who are married or in a union and who are currently using any method of contraception)/(total number of women of reproductive age [15–49 years] who are married or in a union) x 100. Household surveys that can generate this indicator include DHS, MICS, Fertility and Family Surveys (FFS), Reproductive Health Surveys (RHS) and other surveys based on similar methodologies
Method of estimation	The United Nations Population Division compiles data from nationally representative surveys, including the DHS, MICS, FFS, the CDC-assisted RHS and national family planning, or health, or household, or socioeconomic surveys. In general, all nationally representative surveys with comparable questions on current use of contraception are included. There is no attempt to provide estimates when country data are not available. The results are published regularly in the World Contraceptive Use report. Predominant type of statistics: adjusted
Measurement frequency	Biennial
KSA data source	General Authority for Statistics. (2024). Women Health and Reproductive Care Statistics Publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435273/Women+Health+and+Reproductive+Care+Statistics+Publication+2024+EN.pdf/33569118-478b-3be4-a6ef-d291a8399d11?t=1735117033009
International data source	United Nations, Department of Economic and Social Affairs, Population Division. (n.d.). Family Planning Indicators. Retrieved [August 30, 2025], from https://www.un.org/development/desa/pd/data/family-planning-indicators

53 Antenatal care coverage - at least four visits (%)

National Indicator Performance			
Recent international value		**Recent national value**	
88.8%		**88.8%**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Crude	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Survey	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Antenatal care coverage
Indicator name	Percentage of women aged 15–49 who received four or more antenatal care visits
Definition	Percentage of women aged 15–49 years with a live birth in a given time period who received antenatal care, four times or more times from any provider. Note: A new indicator is currently being developed in line with the new WHO guideline which recommends "ANC models with a minimum of eight contacts are recommended to reduce perinatal mortality and improve women's experience of care.
Unit	Percentage (%)
Numerator	Number of women aged 15–49 years with a live birth in a given time period who received antenatal care four or more times
Denominator	Total number of women aged 15–49 years with a live birth in the same period.
Method of measurement	The number of women aged 15-49 with a live birth in a given time period that received antenatal care four or more times during pregnancy is expressed as a percentage of women aged 15-49 with a live birth in the same period. (Number of women aged 15-49 attended at least four times during pregnancy by any provider for reasons related to the pregnancy/total number of women aged 15-49 with a live birth) x 100. The ANC4+ indicator is based on standard question that ask if and how many times the health of the woman was checked during pregnancy. Unlike antenatal care coverage (at least one visit), antenatal care coverage (at least four visit) includes care given by any provider, not just skilled health personnel. This is because the key national level household surveys do not collect information on type of provider for each visit. Household surveys that can generate this indicator includes Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Fertility and Family Surveys (FFS), Reproductive Health Surveys (RHS) and other surveys based on similar methodologies. Registry/facility reporting system can be used where the coverage is high, usually in industrialized countries
Method of estimation	WHO and UNICEF compile empirical data from household surveys. Before data are included into the global databases, UNICEF and WHO undertake a process of data verification that includes correspondence with field offices to clarify any questions regarding estimates. Regional and global aggregates are weighted averages of the country data, using the number of live births for the reference year in each country as the weight. No figures are reported if less than 50 percent of the live births in the region are covered
Measurement frequency	Annual from routine facility reports; every 3–5 years from survey
KSA data source	General Authority for Statistics. (2023). Women Health and Reproductive Care Statistics Publication 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435259/Women_Health_and_Reproductive_Care_Statistics_Publication_2023_EN.pdf/80acf6e8-affb-2273-e8da-f99c9ded57b4?t=1734054426346
International data source	World Health Organization. (n.d.). Antenatal care coverage—at least four visits (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/antenatal-care-coverage-at-least-four-visits

54 Proportion of births attended by skilled health personnel [SDG 3.1.2]

National Indicator Performance			
Recent international value		**Recent national value**	
100%		**99.6%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Births attended by skilled health personnel [SDG 3.1.2] (Also: Institutional Delivery – overall and in "baby-friendly" institutions)
Indicator name	Proportion of births attended by skilled health personnel (%)
Definition	Percentage of live births attended by skilled health personnel during a specified time period.
Unit	Percentage (%)
Numerator	Number of births attended by skilled health personnel (doctors, nurses or midwives) trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the postpartum period, to conduct deliveries on their own, and to care for newborns.
Denominator	The total number of live births in the same period.
Method of measurement	Definition of skilled birth attendant varies between countries. The percentage of births attended by skilled health personnel is calculated as the number of births attended by skilled health personnel (doctors, nurses or midwives) expressed as a percentage of the total number of live births in the same period. Births attended by skilled health personnel = (number of births attended by skilled health personnel) / (total number of live births) x 100. In household surveys, such as DHS, MICS and RHS, the respondent is asked about the most recent birth and who helped during delivery for a period up to five years before the interview. Service/facility records could be used where a high proportion of births occur in health facilities and are therefore recorded
Method of estimation	Data for global monitoring are reported by UNICEF and WHO. These agencies obtain the data – both survey and registry data – from national sources. Before data can be included in the global databases, UNICEF and WHO undertake a process of data verification that includes correspondence with field offices to clarify any questions. In terms of survey data, some survey reports may present a total percentage of live births attended by a type of provider that does not conform to the joint statement by WHO, ICM and FIGO (e.g. total includes providers who are not considered skilled, such as community health workers). In this case, the percentage delivered by a physician, nurse or midwife are totaled and entered into the global database as the SDG estimate. Predominant type of statistics: adjusted.
Measurement frequency	Annual
KSA data source	General Authority for Statistics. (2024). Women Health and Reproductive Care Statistics Publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435273/Women+Health+and+Reproductive+Care+Statistics+Publication+2024+EN+%281%29.pdf
International data source	World Health Organization. (n.d.). Births attended by skilled health personnel (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/births-attended-by-skilled-health-personnel-(-)

55 Postpartum care coverage for mothers (%)

National Indicator Performance			
Recent international value		**Recent national value**	
71.4%		**78.2%**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UNICEF	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Postpartum care coverage – women
Indicator name	Postpartum care coverage – women
Definition	Proportion of women who have postpartum contact with a health provider within 2 days of delivery.
Numerator	Number of women who received postpartum care within two days of childbirth.
Denominator	Total number of women aged 15–49 years with a live birth in the specified time period.
Unit	Percentage (%)
Method of measurement	Female survey respondents are asked about their most recent live birth, and when, if at all, their health was checked following delivery. This should include births at home and those in a health facility
Method of estimation	Data are taken from UNICEF database (see link below), which compiled data from household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). Method of estimation of global and regional aggregates: population weighed average
Measurement frequency	Annual from routine facility reports; every 3–5 years from survey
KSA data source	General Authority for Statistics. (2023). Women Health and Reproductive Care Statistics Publication 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435259/Women_Health_and_Reproductive_Care_Statistics_Publication_2023_EN.pdf
International data source	United Nations Children's Fund (UNICEF). (n.d.). Postnatal care for mothers: Saudi Arabia. Retrieved [August 30, 2025], from https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=SAU.MNCH_PNCMOM.&startPeriod=1970&endPeriod=2024

56 Postnatal care coverage for newborns (%)

National Indicator Performance			
Recent international value		**Recent national value**	
77.7%		**99.2%**	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UNICEF	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Postnatal care coverage – newborn
Indicator name	Percentage of newborns who have a postnatal contact with a health provider within 2 days of delivery
Definition	Proportion of newborns who have a postnatal contact with a health provider within 2 days of delivery
Unit	Percentage (%)
Numerator	Number of newborns who received postnatal care within two days of childbirth
Denominator	Total number of last live births in the specified time period
Method of measurement	Female survey respondents are asked about their most recent live birth, and when, if at all, their newborn's health was checked following delivery. This should include births at home and those in a health facility, but older surveys may only obtain this information for newborns born at home
Method of estimation	Data are taken from UNICEF database (see link below), which compiled data from household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). Method of estimation of global and regional aggregates: population weighted average.
Measurement frequency	Annual from routine facility reports; every 3–5 years from survey
KSA data source	General Authority for Statistics. (2023). Women Health and Reproductive Care Statistics Publication 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435259/Women_Health_and_Reproductive_Care_Statistics_Publication_2023_EN.pdf
International data source	United Nations Children's Fund (UNICEF). (n.d.). Postnatal care for newborns: Saudi Arabia. Retrieved [August 30, 2025], from https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=SAU.MNCH_PNCNB.&startPeriod=1970&endPeriod=2024

57 Care-seeking for children with symptoms of acute respiratory infection (%)

National Indicator Performance			
Recent international value		**Recent national value**	
>80%		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
UHC Report	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Care-seeking for symptoms of pneumonia
Indicator name	Percentage of children under 5 years of age with suspected pneumonia taken to an appropriate health facility or provider
Definition	Percentage of children under 5 years of age with suspected pneumonia (cough and difficult breathing NOT due to a problem from a blocked nose) in the two weeks preceding the survey taken to an appropriate health facility or provider.
Numerator	Number of children with suspected pneumonia in the two weeks preceding the survey taken to an appropriate health facility or provider
Denominator	Number of children with suspected pneumonia in the two weeks preceding the survey
Unit	Percentage (%)
Method of measurement	During the UNICEF/WHO Meeting on Child Survival Survey-based Indicators, held in New York, USA, on 17–18 June 2004, it was recommended that suspected Acute Respiratory Infection (ARI) be described as "presumed pneumonia" to better reflect the probable cause and the recommended interventions. The definition of ARI used in the DHS and MICS was chosen by the group and is based on the mother's perceptions of a child who has a cough, is breathing faster than usual with short, quick breaths or is having difficulty breathing, excluding children who had only a blocked nose.
Method of estimation	
Measurement frequency	Every 3–5 years
KSA data source	N/A
International data source	World Health Organization and International Bank for Reconstruction and Development / The World Bank. (2023). Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization. Retrieved [August 30, 2025], from https://iris.who.int/bitstream/handle/10665/374059/9789240080379-eng.pdf?sequence=1

58 Proportion of the target population covered by all vaccines included in their national programme [SDG 3.b.1]

National Indicator Performance			
Recent international value		**Recent national value**	
DTP3 coverage among 1 year olds: 97% **MCV2 coverage by the nationally recommended age:** 96% **PCV3 coverage among 1-year olds:** 96% **HPV vaccine full dose programme coverage:** 39%		**DTP3 coverage among 1 year olds:** 96.8% **MCV2 coverage by the nationally recommended age:** 96% **PCV3 coverage among 1-year olds:** 96%	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Immunization Data	Estimated through the organization	WHO Immunization Data	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	Immunization coverage rate by vaccine for each vaccine in the national schedule [SDG 3.b.1]
Indicator name	Immunization coverage rate by vaccine for each vaccine in the national schedule
Other name	Proportion of the target population covered by all vaccines included in their national program [SDG 3.b.1]
Definition	Percentage of the target population that has received the last recommended dose of the basic series for each vaccine recommended in the national schedule by vaccine. This should include all vaccines within a country's routine immunization schedule (e.g., Bacillus Calmette–Guérin (BCG); polio; pneumococcal conjugate vaccine (PCV); rotavirus; diphtheria, tetanus, pertussis (DTP) containing vaccines, Hepatitis B containing vaccines, Haemophilus influenzae type b containing vaccines; measles-containing vaccine (MCV); rubella containing vaccines; human papilloma virus (HPV); tetanus toxoid (TT); tetanus-diphtheria toxoids (Td); influenza; and others as determined by the national schedule).
Numerator	The number of individuals in the target group for each vaccine that has received the last recommended dose in the basic series. For vaccines in the infant immunization schedule, if coverage is measured by administrative system it would be the birth cohort for BCG and Hepatitis B birth dose and surviving infants for the other antigens, in countries where measles is administered at first year of life will be children 12–23 months old. In case of coverage measured by survey this would be the number of children aged 12–23 months in the sample who have received the specified vaccinations before their first birthday.
Denominator	The total number of individuals in the target group for each vaccine. For vaccines in the infant immunization schedule, this would be the total number of infants surviving to age one. In case coverage is measured m by survey it would be the total number of 12–23 months of infants in the sample.
Unit	Percentage (%)
Method of measurement	Administrative reports from countries where the number of individuals in the target group that has received each vaccine is the numerator and the target population is the denominator or household surveys. In addition, WHO and UNICEF annually produce National Estimates of National Immunization Coverage for most vaccines
Method of estimation	For survey data, the vaccination status of children aged 12–23 months is used for vaccines included in the infant immunization schedule, collected from child health cards or, if there is no card, from recall by the care-taker
Measurement frequency	In most countries annual tracking through facility information systems, supplemented by periodic estimation through household surveys
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (n.d.). Saudi Arabia: Immunization Dashboard. Retrieved [August 30, 2025], from https://immunizationdata.who.int/dashboard/regions/eastern-mediterranean-region/SAU

59 People living with HIV who know their status

National Indicator Performance			
Recent international value		**Recent national value**	
94%		**94%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UNAIDS	Estimated through the organization	UNAIDS	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	People living with HIV who know their status
Indicator name	People living with HIV who know their status
Definition	Percentage of people living with HIV who know their status
Unit	Percentage (%)
Numerator	Number of people living with HIV who know their status
Denominator	Estimated number of people living with HIV
Method of measurement	For countries with HIV case-based surveillance, the numerator can be calculated by taking the number of cumulative cases reported and subtracting deaths since the start of the epidemic. Household surveys with HIV testing and questions to assess whether respondents know their positive status can also be used. For the denominator, countries will typically rely on modelled estimates of people living with HIV produced using Spectrum, a UNAIDS-supported software tool
Method of estimation	For the numerator, if HIV case-based surveillance systems are not regularly updated with deaths or survey data directly asking respondents about their knowledge of status are not available, other proxy data such as the percentage of people living with HIV who know their HIV status (ever, and in the past 12 months) can be used to triangulate estimates. For the denominator, modelling, using multiple inputs specific to the HIV epidemic context, is typically used to obtain an estimate of the number of people living with HIV. UNAIDS supports most countries to produce estimates of the number of people living with HIV annually using Spectrum
Measurement frequency	Annual (unless survey-based)
KSA data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia
International data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia

60 Number of pregnant women living with HIV who received antiretrovirals (ARV) for preventing mother-to-child transmission

National Indicator Performance			
Recent international value		**Recent national value**	
98% (Number of pregnant women who received ARV: 29)		**98%** (Number of pregnant women who received ARV: 29)	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UNAIDS	Estimated through the organization	UNAIDS	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	Prevention of mother-to-child transmission
Indicator name	Prevention of mother-to-child transmission
Definition	Percentage of HIV-positive pregnant women provided with ART to reduce the risk of mother-to-child transmission during pregnancy
Unit	Percentage (%)
Numerator	Number of HIV-positive pregnant women who received ARV
Denominator	Estimated number of HIV-positive pregnant women
Method of measurement	The numerator can be calculated from national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms. The denominator of the estimated number of HIV-positive pregnant women is typically obtained using Spectrum, a UNAIDS-supported software tool.
Method of estimation	Modelling, using multiple inputs specific to the HIV epidemic context, is typically used to obtain an estimate of the number of HIV-positive pregnant women and national programme records are used to determine the number receiving ARV. UNAIDS supports most countries to produce estimates of the number of HIV-positive pregnant women annually using Spectrum.
Measurement frequency	Annual (unless survey-based)
Monitoring and evaluation framework	Outcome
KSA data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia
International data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia

61 Estimated antiretroviral therapy coverage among people living with HIV (%)

National Indicator Performance			
Recent international value		**Recent national value**	
93%		**94.3%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	WHO GHO	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	Antiretroviral therapy (ART) coverage
Indicator name	Antiretroviral therapy (ART) coverage
Definition	Percentage of people living with HIV currently receiving ART among the estimated number of adults and children living with HIV The percentage of adults and children with HIV infection currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocols (or WHO/UNAIDS standards) among the estimated number of adults and children with HIV infection
Unit	Percentage (%)
Numerator	Number of adults and children who are currently receiving ART at the end of the reporting period
Denominator	Estimated number of adults and children living with HIV
Method of measurement	Numerator: The numerator can be generated by counting the number of adults and children who received antiretroviral combination therapy at the end of the reporting period. Data can be collected from facility-based ART registers or drug supply management systems. These are then tallied and transferred to cross-sectional monthly or quarterly reports which can then be aggregated for national totals. Patients receiving ART in the private sector and public sector should be included in the numerator where data are available. Denominator: The denominator is generated by estimating the number of people with advanced HIV infection requiring (in need of/eligible for) ART. This estimation must take into consideration a variety of factors, including, but not limited to, the current number of people with HIV, the current number of patients on ART and the natural history of HIV from infection to enrolment on ART. A standard modelling HIV estimation method, such as in the Spectrum model, is recommended
Method of estimation	Modelling, using multiple inputs specific to the HIV epidemic context, is typically used to obtain an estimate of the number of people living with HIV and national programme records are used to determine the number receiving treatment. UNAIDS supports most countries to produce estimates of the number of people living with HIV annually using Spectrum
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (n.d.). Estimated antiretroviral therapy coverage among people living with HIV (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-antiretroviral-therapy-coverage-among-people-living-with-hiv-(-)

62 People living with HIV who have suppressed viral loads

National Indicator Performance			
Recent international value		**Recent national value**	
92%		**92%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Estimate	2024	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UNAIDS	Estimated through the organization	UNAIDS	Estimated through the organization

Key Indicator Specifications	
Abbreviated name	HIV viral load suppression
Indicator name	HIV viral load suppression
Definition	Percentage of people on ART who are virologically suppressed (VL level ≤ 1,000 copies/mL)
Unit	Percentage (%)
Numerator	Number of adults and children living with HIV and on ART who have a suppressed viral load (< 1,000 copies/mL)
Denominator	Estimated number of people living with HIV.
Method of measurement	Viral load data recorded in patient records and reported through facilities. If there are representative surveys collecting viral load data among people living with HIV and those on ART, the survey values can be used. Nationally representative surveys of acquired drug resistance also provide information on viral suppression.
Method of estimation	If a viral load measure is not available from a sufficiently representative sample of people living with HIV who are on ART, the level of viral load suppression among those on ART but without a viral load measurement in the past 12 months needs to be estimated. Estimates can be derived on the basis of characteristics among those without a viral load measure and their expected viral load suppression.
Measurement frequency	Annual
KSA data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia
International data source	Joint United Nations Programme on HIV/AIDS. (n.d.). Saudi Arabia. Retrieved [August 30, 2025], from https://www.unaids.org/en/regionscountries/countries/saudiarabia

63 Percentage of TB patients who had an HIV test result recorded in the TB register

National Indicator Performance			
Recent international value		**Recent national value**	
93%		**93%**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	**2023**	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Estimated through the organization	WHO Global Tuberculosis Report	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	HIV test results for TB patients
Indicator name	HIV test results for registered new and relapse TB patients
Definition	Number of new and relapse TB patients who had an HIV test result recorded in the TB register, expressed as a percentage of the number registered in a specified time period
Unit	Percentage (%)
Numerator	Number of new and relapse TB patients registered during a specified time period (usually one year) who had an HIV test result recorded in the TB register
Denominator	Total number of new and relapse TB patients registered in the TB register during the specified time period
Method of measurement	TB treatment cards and TB registers should document the HIV status of TB patients. The history of previous TB treatment should also be documented systematically to identify new and relapse TB patients. The status of all TB patients should be recorded in TB registers as soon as possible and preferably at the time of TB diagnosis, along with information on past history of TB treatment
Method of estimation	
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22

64 HIV-positive TB patients on ART (antiretroviral therapy) (%)

National Indicator Performance			
Recent international value		**Recent national value**	
100%		**100%**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	WHO GHO	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	HIV-positive new and relapse TB patients on ART during TB treatment
Indicator name	HIV-positive new and relapse TB patients on antiretroviral therapy (ART) during TB treatment
Definition	Number of HIV-positive new and relapse TB patients who received antiretroviral therapy (ART) during TB treatment, expressed as a percentage of those registered for TB treatment in a specified time period
Unit	Percentage (%)
Numerator	Total number of HIV-positive new and relapse TB patients started on TB treatment during a specified time period (usually one year) who are already on ART or started on ART during TB treatment
Denominator	Total number of HIV-positive new and relapse TB patients registered during the specified time period
Method of measurement	Not applicable
Method of estimation	Annual
Measurement frequency	Outcome
KSA data source	World Health Organization. (n.d.). HIV-positive TB patients on ART (antiretroviral therapy) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hiv-positive-tb-patients-on-art-(antiretroviral-therapy)-(-)
International data source	World Health Organization. (n.d.). HIV-positive TB patients on ART (antiretroviral therapy) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hiv-positive-tb-patients-on-art-(antiretroviral-therapy)-(-)

65 Tuberculosis patients with result for isoniazid and rifampicin drug susceptibility testing

National Indicator Performance			
Recent international value		**Recent national value**	
92%		**92%**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Estimated through the organization	WHO Global Tuberculosis Report	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	Drug susceptibility testing coverage for TB patients
Indicator name	Percentage of TB patients with test results for at least susceptibility to rifampicin
Previous names	Drug susceptibility testing coverage for TB patients
Definition	Percentage of TB cases with drug susceptibility test results for at least rifampicin, during a specified time period (usually one year)
Unit	Percentage (%)
Numerator	Number of notified TB cases with drug susceptibility testing results for at least rifampicin resistance during a specified time period, usually one year
Denominator	Number of TB cases notified during the specified time period (usually one year)
Method of measurement	DST results should be recorded in the TB facility register and treatment card. The number of notified cases is collected as part of routine national TB surveillance (see also method of measurement for the indicator "TB case notification rate")
Method of estimation	Not applicable.
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22

66 TB treatment coverage

National Indicator Performance			
Recent international value		**Recent national value**	
91%		**91%**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Estimated through the organization	WHO Global Tuberculosis Report	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	TB treatment coverage
Indicator name	TB treatment coverage for all forms of tuberculosis
Definition	Number of new and relapse cases that were notified and treated in a given year, divided by the estimated number of incident TB cases in the same year, expressed as a percentage.
Unit	Percentage (%)
Numerator	Number of new and relapse cases notified and treated in a given year.
Denominator	Number of estimated incident cases in the same year
Method of measurement	Notification data reported by national TB programmes or national surveillance systems (see also TB notification rate indicator). For methods used for TB incidence, see methods described for "TB incidence rate"
Method of estimation	For TB incidence, see methods described for the indicator "TB incidence rate".
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22

67 Treatment coverage for drug-resistant TB

National Indicator Performance			
Recent international value		**Recent national value**	
People started on treatment for TB that is resistant to rifampicin (MDR/RR-TB): 86% (Cohort)		**People started on treatment for TB that is resistant to rifampicin (MDR/RR-TB)**: 86% (Cohort)	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2021	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Estimated through the organization	WHO Global Tuberculosis Report	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	Treatment coverage for drug-resistant TB
Indicator name	Treatment coverage for TB cases with rifampicin-resistant or multidrug-resistant TB (MDR-TB/RR-TB)
Definition	Number of cases of MDR/RR-TB who were detected and enrolled on a second-line MDR-TB treatment regimen in a given year, divided by the estimated number of MDR/RR-TB cases among notified TB cases in the same year, expressed as a percentage
Unit	Percentage (%)
Numerator	Number of rifampicin-resistant cases (presumptive or confirmed) registered and started on a prescribed MDR-TB treatment regimen in a given year
Denominator	Estimated number of notified TB patients with MDR/RR-TB in the same year
Method of measurement	Number of cases started on treatment is counted from the second-line TB treatment register. Number of notified TB patients with RR/MDR-TB is estimated by combining the number of notifications with evidence about the proportion of cases that have MDR-TB from drug resistance surveys or continuous surveillance systems with high coverage of diagnostic testing for drug resistance.
Method of estimation	The estimated number of notified TB cases with RR/MDR-TB is based on results from drug resistance surveillance. See Global TB Report 2016
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22charts%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22

68 Number of people requiring interventions against neglected tropical diseases (NTD) [SDG 3.3.5]

National Indicator Performance			
Recent international value		**Recent national value**	
New cases requiring individual treatment: 15,056		**New cases requiring individual treatment**: 3,243	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Crude	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Surveillance	MOH	Surveillance

Key Indicator Specifications	
Abbreviated name	Number of people requiring interventions against neglected tropical diseases [SDG 3.3.5]
Indicator name	Number of people requiring interventions against neglected tropical diseases
Definition	Number of people requiring treatment and care for any one of the neglected tropical diseases (NTDs) targeted by the WHO NTD Roadmap and World Health Assembly resolutions and reported to WHO. Treatment and care is broadly defined to allow for preventive, curative, surgical or rehabilitative treatment and care. In particular, it includes both: • Average annual number of people requiring mass treatment known as preventive chemotherapy (PC) for at least one PC-NTD; and, • Number of new cases requiring individual treatment and care for other NTDs.
Unit	Number of people
Numerator	• Average annual number of people requiring preventive chemotherapy (PC) for at least one PC-NTD • Number of new cases requiring individual treatment and care for other NTDs.
Denominator	N/A
Method of measurement	
Method of estimation	Some estimation is required to aggregate data across interventions and diseases. There is an established methodology that has been tested and an agreed international standard. 1. Average annual number of people requiring PC for at least one PC-NTD: People may require PC for more than one PC-NTD. The number of people requiring PC is compared across the PC-NTDs, by age group and implementation unit (e.g. district). The largest number of people requiring PC is retained for each age group in each implementation unit. The total is considered to be a conservative estimate of the number of people requiring PC for at least one PC-NTD. Prevalence surveys (e.g. transmission assessment surveys) determine when an NTD has been eliminated or controlled and PC can be stopped or reduced in frequency, such that the average annual number of people requiring PC is reduced. 2. Number of new cases requiring individual treatment and care for other NTDs: The number of new cases is based on country reports, whenever available, of new and known cases of Buruli ulcer, Chagas disease, cysticercosis, dengue, guinea-worm disease, echinococcosis, human African trypanosomiasis (HAT), leprosy, the leishmaniases, rabies and yaws. Where the number of people requiring and requesting surgery for PCNTDs (e.g. trichiasis or hydrocele surgery) is reported, it can be added here. Similarly, new cases requiring and requesting rehabilitation (e.g. leprosy or lymphoedema) can be added whenever available. Case reports may not be comparable over time; some further estimation may be required to adjust for changes in case-finding and reporting. Populations referred to under 1) and 2) may overlap; the sum would overestimate the total number of people requiring treatment. The maximum of 1) or 2) is therefore retained at the lowest common implementation unit and summed to get conservative country, regional and global aggregates. By 2030, improved co-endemicity data and models will validate the trends obtained using this simplified approach.
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

69 Prevalence of cervical cancer screening among women aged 30-49 years (%)

National Indicator Performance			
Recent international value		**Recent national value**	
During the last year: 8% **During the last 3 years**: 9% **During the last 5 years**: 14% **In lifetime**: 19%		**In lifetime:** Women aged 30-39 years:14.0%. Women aged 40-49 years:12.6%. **During last 3 years:** Women aged 30-39 years: 10.4%. Women aged 40-49 years: 9.8%.	
Date	**Type of Result**	**Date**	**Type of Result**
2019	Estimate	2019	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	KSAWHS	Survey

Key Indicator Specifications	
Abbreviated name	Cervical cancer screening
Indicator name	Cervical cancer screening
Definition	Proportion of women aged 30–49 years who report they were screened for cervical cancer using any of the following methods: visual Inspection with acetic acid/vinegar (VIA), pap smear, human papilloma virus (HPV) test.
Unit	Percentage (%)
Numerator	Proportion of women aged 30–49 years who report they were screened for cervical cancer using any of the following methods: visual Inspection with acetic acid/vinegar (VIA), pap smear, human papilloma virus (HPV) test.
Denominator	All female respondents aged 30–49 years.
Method of measurement	
Method of estimation	Number of female respondents aged 30–49 years who report ever having had a screening test for cervical cancer) / (number of female respondents aged 30–49 years) x 100.
Measurement frequency	At least every 5 years
KSA data source	Ministry of Health (Saudi Arabia). (2019). World Health Survey Saudi Arabia 2019. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/Population-Health-Indicators/Documents/World-Health-Survey-Saudi-Arabia.pdf
International data source	World Health Organization. (n.d.). Prevalence of cervical cancer screening among women aged 30–49 years (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-cervical-cancer-screening-among-women-aged-30-49-years-(-)

70 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders [SDG 3.5.1]

National Indicator Performance			
Recent international value		**Recent national value**	
Alcohol coverage: 3.18% **Drugs coverage:** 19.8%		**Substance use disorder:** 100%	
Date	**Type of Result**	**Date**	**Type of Result**
Alcohol: 2016 Drugs: 2018	Estimate	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Treatment coverage for alcohol and drug dependence [SDG 3.5.1]
Indicator name	Treatment coverage for alcohol and drug dependence
Definition	Treatment coverage is defined as the proportion of people with alcohol or drug dependence (including those who are not seeking treatment) that are in contact with treatment services, i.e. currently receiving treatment or in remission or relapse, but still in contact with treatment services.
Unit	Percentage (%)
Numerator	Number of people with alcohol or drug dependence in contact with treatment services, i.e. currently receiving treatment or in remission or relapse, but still in contact with treatment services.
Denominator	Number of people with alcohol or drug dependence (including those who are not seeking treatment
Method of measurement	Estimation of treatment coverage in populations is based on the data from the global survey of key informants in national health authorities implemented by WHO periodically (WHO ATLAS survey on prevention and treatment resources for substance use disorders – ATLAS SU) and supported by available data on prevalence of substance use disorders and treatment coverage. Special efforts are undertaken by WHO to improve availability of data for treatment coverage estimation.
Method of estimation	
Measurement frequency	Every 3–5 years based on the WHO Global ATLAS-SU survey and Annual supportive data available from countries including routine health facility reports produced annually in some countries
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	World Health Organization. (n.d.). Contact coverage of treatment services for substance use disorders (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/contact-coverage-of-treatment-services-for-substance-use-disorders

71 Coverage of essential health services [SDG 3.8.1]

National Indicator Performance			
Recent international value		**Recent national value**	
74%		**74%**	
Date	**Type of Result**	**Date**	**Type of Result**
2021	Estimate	2021	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	MOH	Estimated through the organization in consultation with MOH

Key Indicator Specifications	
Abbreviated name	Coverage of essential health services [SDG 3.8.1]
Indicator name	Coverage of essential health services
Definition	Universal health coverage (UHC) includes both access to quality health services and medicines and financial risk protection. The definition in this section focuses on the coverage of essential health services. The indicator on financial risk protection. The coverage of essential health services, as defined by SDG indicator 3.8.1, is the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population. These tracer indicators are combined into a service coverage index, which provides a summary indicator of service coverage. Current tracer indicators are grouped into the four categories as follows: Reproductive, maternal, newborn and child health: Demand satisfied for family planning with modern methods; ANC4 coverage; three doses of DTP; care-seeking for children with symptoms of pneumonia. Infectious disease: TB case detection and treatment; ART coverage; ITN coverage; improved sanitation facilities. Non-communicable diseases: Non-raised blood pressure; fasting plasma glucose; not smoking tobacco; and cervical cancer screening. Service capacity and access: Hospital beds per capita; health workforce density (physicians, surgeons and psychiatrists per capita); access to essential medicines; health security. The aim of monitoring of UHC by countries is to ensure that progress towards UHC reflects the country's unique epidemiological and demographic profile, health system and level of economic development and the population's demands and expectations. While the country context determines the measures used, the domains to be monitored – coverage with good-quality essential services and with financial protection – are relevant to all countries, regardless of their level of income, their demographic profile or their health needs. Periodic global monitoring permits comparison of progress towards UHC, so that countries can learn from one another. Global monitoring is not, however, a substitute for country monitoring, and countries are encouraged to tailor their measures of UHC by drawing on this framework to best reflect their context. Furthermore, because of the dynamic nature and progressive realization of UHC, the priorities for monitoring will differ among countries.
Unit	The indicator is an index reported on a unitless scale of 0 to 100.
Numerator	
Denominator	
Method of measurement	Metadata for the specific indicators included in UHC service coverage index are included in the relevant indicator pages.
Method of estimation	Values for indicators used in the UHC service coverage index are taken from existing, publicly available data sources, such as UN interagency estimates or household survey data compiled by WHO. All indicators are structured so they occur on a scale of 0 to 100%, with 100% the target. For example, non-use of tobacco, rather than use of tobacco, is used, and hospital bed density and health professional density are rescaled onto a scale of 0 to 100%. The index is constructed from geometric means of component indicators, first within each of the four categories, and then across those category-specific means to obtain the final summary index.
Measurement frequency	Every 3–5 years
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

Part four:
Health systems indicators

72 TB treatment success rate

National Indicator Performance			
Recent international value		**Recent national value**	
90%		**90%**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	2022	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
WHO Global Tuberculosis Report	Estimated through the organization	WHO Global Tuberculosis Report	Estimated through WHO in consultation with MOH

Key Indicator Specifications	
Abbreviated name	TB treatment success rate
Indicator name	TB treatment success rate
Definition	Percentage of TB cases successfully treated (cured plus treatment completed) among TB cases notified to national health authorities during a specified period, usually one year.
Unit	Percentage (%)
Numerator	Number of TB cases registered in a specified time period that were successfully treated.
Denominator	Total number of TB cases registered in the same period.
Method of measurement	TB register and related quarterly reporting system, or electronic TB registers
Method of estimation	
Measurement frequency	Annual
KSA data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22tables%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22
International data source	World Health Organization. (n.d.). Tuberculosis country profile: Saudi Arabia. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/tb_profiles/?inputs&tab=%22tables%22&lan=%22EN%22&iso2=%22SA%22&entity_type=%22country%22

73 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms [SDG 3.d.2]

National Indicator Performance			
Recent international value		**Recent national value**	
MRSA: 52.04% **ESBL-E.Coli**: 52.83%		**MRSA**: 52.04% **ESBL-E.Coli**: 52.83%	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	2022	Estimate
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	WHO GLASS	Estimated through the organization in consultation with PHA

Key Indicator Specifications	
Abbreviated name	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms [SDG 3.d.2]
Indicator name	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms [SDG 3.d.2]
Definition	Percentage of bloodstream infection due to methicillin-resistant Staphylococcus aureus (MRSA) and Escherichia coli resistant to 3rd-generation cephalosporin (e.g., ESBL- E. coli) among patients seeking care and whose blood sample is taken and tested. • Presumptive methicillin-resistant S. aureus (MRSA) isolates as defined by oxacillin minimum inhibitory concentration (MIC) and cefoxitin disc diffusion tests according to current internationally recognized clinical breakpoints (e.g., EUCAST or CLSI) • E. coli resistant to third generation cephalosporins: E. coli isolates that are resistant as defined by current internationally recognized clinical breakpoints for third generation cephalosporins (e.g., EUCAST or CLSI), specifically ceftriaxone or cefotaxime or ceftazidime.
Unit	Percentage (%)
Numerator	Number of patients with growth of methicillin-resistant S. aureus or E. coli resistant to third generation cephalosporins in tested blood samples
Denominator	Total number of patients with growth of S. aureus or E. coli in tested blood samples
Method of measurement	The WHO Global AMR Surveillance System (GLASS) supports countries to implement an AMR standardized surveillance system. Cases of AMR infection are found among patients from whom routine clinical samples have been collected for blood culture at surveillance sites (health care facility) according to local clinical practices, and antimicrobial susceptibility tests (AST) are performed for the isolated blood pathogens as per international standards. The microbiological results (bacteria identification and AST) are de-duplicated and combined with the patient data and related to population data from the surveillance sites. GLASS does collect information on the origin of the infection, either community origin (less than 2 calendar days in hospital) or hospital origin (patients hospitalized for more than 2 calendar days). Data are collated and validated at national level and reported to GLASS where epidemiological statistics and metrics are generated. GLASS has published guidelines on the set up of national AMR surveillance systems and the GLASS methodology implementation manual is available to countries. Although national representativeness of generated AMR rates is not a strict requirement, GLASS encourages countries to derive representative national data.
Method of estimation	
Measurement frequency	Annual
KSA data source	World Health Organization. (2022). GLASS Data Visualization Dashboard. Retrieved [August 30, 2025], from https://worldhealthorg.shinyapps.io/glass-dashboard/_w_3ad1defc/#!/cta-profiles
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

74 Number of outpatient visits per person per year

National Indicator Performance			
Recent international value		**Recent national value**	
5.2 visits per person per year		**1.9 visits per person per year**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO IRIS	Assessment	MOH	Registry

Key Indicator Specifications	
Abbreviated name	Outpatient service utilization (Also: inpatient admissions and surgical volume)
Indicator name	Outpatient service utilization
Definition	Number of outpatient department visits per person per year.
Unit	Per person per year
Numerator	Number of outpatient department visits per person per year.
Denominator	Total population.
Method of measurement	
Method of estimation	Requires complete and reliable recording and reporting of the number of outpatient department visits by public and private facilities. Recall in population surveys can also be used.
Measurement frequency	
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (2024). Monitoring health and health system performance in the Eastern Mediterranean Region: Core indicators and indicators on the health-related Sustainable Development Goals 2023. Cairo: WHO Regional Office for the Eastern Mediterranean. Retrieved [August 30, 2025], from https://iris.who.int/handle/10665/377287

75 Density of hospitals (per 100,000 population)

National Indicator Performance			
Recent international value		**Recent national value**	
1.04 hospital per 100,000 population		**499 hospitals (1.41 hospital per 100,000 population)**	
Date	**Type of Result**	**Date**	**Type of Result**
2013	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	survey	MOH	Assessment

Key Indicator Specifications	
Abbreviated name	Health facility density and distribution (Also: access to emergency surgery)
Indicator name	Health facility density and distribution
Definition	Number of hospitals, including the following hospital categories: rural and district, provincial (second level referral), regional/specialized/teaching and research hospitals (tertiary care), from the public and private sectors, per 100,000 population.
Unit	Per 100,000 population
Numerator	Number of facilities in public and private sectors
Denominator	Total population.
Method of measurement	
Method of estimation	Information collected directly from country focal points from ministries of health through the baseline country survey on medical devices 2013 update, conducted by HQ/HIS/EMP/PAU. The population data was obtained from World Population Prospects 2012 Revision (2013 medium estimates). Predominant type of statistics: Unadjusted.
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (n.d.). Total density per 100,000 population: Hospitals. Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/total-density-per-100-000-population-hospitals

76 Hospital beds (per 10,000 population)

National Indicator Performance			
Recent international value		**Recent national value**	
24.5 beds per 10,000 population		**23.7 beds per 10,000 population**	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO IRIS	Assessment	MOH	Registery

Key Indicator Specifications	
Abbreviated name	Hospital bed density
Indicator name	Hospital bed density (per 10,000 population)
Definition	Total number of hospital beds per 10,000 population
Unit	Bed per 10,000 population
Numerator	Number of hospital beds (excluding labour and delivery beds).
Denominator	Total population
Method of measurement	A national database is usually maintained. Regular updates through surveys or facility censuses are needed
Method of estimation	
Measurement frequency	Annual or biannual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (2024). Monitoring health and health system performance in the Eastern Mediterranean Region: Core indicators and indicators on the health-related Sustainable Development Goals 2023. Cairo: WHO Regional Office for the Eastern Mediterranean. Retrieved [August 30, 2025], from https://iris.who.int/handle/10665/377287

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

National Indicator Performance			
Recent international value		**Recent national value**	
N/A		**98.4%**	
Date	**Type of Result**	**Date**	**Type of Result**
N/A	N/A	2020	Crude
Source	**Type of Source**	**Source**	**Type of Source**
N/A	N/A	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	Access to a core set of relevant essential medicines [SDG 3.b.3]
Indicator name	Access to a core set of relevant essential medicines (with 2 dimensions, availability and affordability)
Definition	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. Availability: will be calculated based on currently existing data on average proportion of medicines available in health facilities per country. Affordability: methodology is still under discussion. Data available on lowest price per drugs at facility level.
Unit	Percentage (%)
Numerator	Number of surveyed health facilities with the core set of relevant essential medicines available per country.
Denominator	Total number of surveyed facilities per country.
Method of measurement	Facility type, facility managing authority (public/private), specific type of medicine/commodity (e.g. priority medicines for women and children, vaccines, ART, family planning, essential NCD medicines) WHO-recommended essential core list of medicines: bronchodilator inhaler, steroid inhaler, glibenclamide, metformin, insulin, angiotensin-converting-enzyme (ACE) inhibitor, calcium channel blocker, statin, aspirin, thiazide diuretic, beta-blocker, omeprazole tablet, diazepam injection, fluoxetine tablet, haloperidol tablet, carbamazepine tablet, amoxicillin tablet/capsule, amoxicillin suspension, ampicillin injection, ceftriaxone injection, gentamicin injection, oral rehydration salts, zinc sulfate. Essential NCD medicines: at least aspirin, a statin, an ACE inhibitor, thiazide diuretic, a long-acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant. Priority medicines for women and children: amoxicillin tablet/capsule, amoxicillin suspension, ampicillin injection, ceftriaxone injection, gentamicin injection, oral rehydration salts, zinc sulphate, oxytocin injection, magnesium sulphate injection. Suggested core list of medicines for pricing/affordability surveys: Salbutamol inhaler 100 mcg per dose (200 doses); beclometasone inhaler 100 mcg/dose (200 doses); glibenclamide 5 mg tablet; metformin 500 mg tablet; insulin regular 100 IU/ml, 10 ml vial; enalapril 5 mg tablet; amlodipine 5 mg tablet; simvastatin 20 mg tablet; aspirin 100 mg tablet; hydrochlorothiazide 25 mg tablet; carvedilol 12.5 mg tablet; omeprazole 20 mg tablet; diazepam 10 mg/2 ml injection; fluoxetine 20 mg tablet; haloperidol 5 mg tablet; carbamazepine 200 mg tablet; amoxicillin 500 mg capsule/tablet; amoxicillin 250 mg/5 ml suspension; ampicillin 500 mg injection; ceftriaxone 1 G vial; gentamicin 80 mg/2 ml injection; oral rehydration salts (sachet for 1 litre); zinc sulfate 2 0mg tablet; oxytocin injection (5 or 10 iu); magnesium sulfate 50% injection 10 ml vial.
Method of estimation	Current proposed methodology used by EMP and under review for the SDG indicator: On the basis of 2 existing and well-established methodologies, the WHO Service Availability and Readiness Assessment (SARA) and the WHO/Health Action International (HAI) Survey (details on these 2 methodologies below in this table), WHO has developed a data collection application, the EMP Price and Availability Monitoring Mobile App, to be used at facility level to collect information on availability and price of the agreed core basket of medicines. The proposed core list is composed of essential medicines to be present at all time in primary health care facilities. The medicines in the list will be annually monitored and provide the basis for comparisons among countries. The countries will anyway have the possibility to add more modules to the data collection tool to cover medicines to be present at secondary/tertiary level facilities or special categories of medicines (i.e. cancer drugs, medicines for pain, controlled medicines, HIV/AIDS, antibiotics, etc.). The proposed methodology is similar to the WHO/HAI Methodology in which the following types of facilities are suggested for surveying in each country. Total Facilities Surveyed in Country: ~91 Each country will choose the facilities to survey using a randomized sampling from the national master facility list. The collected information refers to the availability of the product TODAY and to the price-to-patient for the CHEAPEST available product.
Measurement freq.	Annual or biannual
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
Int. data source	N/A

78 Health worker density and distribution [SDG 3.c.1]

National Indicator Performance			
Recent international value		**Recent national value**	
Health worker density: 43.06 Medical doctors per 10,000 population 64.07 Nursing personnel per 10,000 population 1.50 Midwives per 10,000 population 7.81 Dentists per 10,000 population 11.07 Pharmacists per 10,000 population **Health worker distribution:** Percentage of male doctors: 63.8% Percentage of female doctors: 36.2% Percentage of male nursing personnel: 23.5% Percentage of female nursing personnel: 76.5%		**Health worker density:** 33.7 Physicians per 10,000 population 63.2 Nursing personnel per 10,000 population 1.50 Midwives per 10,000 population 7.7 Dentists per 10,000 population 10.9 Pharmacists per 10,000 population **Health worker distribution:** Percentage of male doctors: 63.7% Percentage of female doctors: 36.3% Percentage of male nursing personnel: 24.05% Percentage of female nursing personnel: 75.95%	
Date	**Type of Result**	**Date**	**Type of Result**
2023	Crude	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO NHWA Data Portal	Assessment	MOH	Registry

Key Indicator Specifications	
Abbreviated name	Health worker density and distribution [SDG 3.c.1]
Indicator name	Health worker density and distribution
Definition	**Health worker density:** Density of medical doctors: The density of medical doctors is defined as the number of medical doctors, including generalists and specialist medical practitioners per 10,000 population in the given national and/or subnational area. The International Standard Classification of Occupations (ISCO) unit group codes included in this category are 221, 2211 and 2212 of ISCO-08. Density of nursing and midwifery personnel: The density of nursing and midwifery personnel is defined as the number of nursing and midwifery personnel per 10,000 population in the given national and/or subnational area. The ISCO-08 codes included in this category are 2221, 2222, 3221 and 3222. Density of dentists: The density of dentists is defined as the number of dentists per 10,000 population in the given national and/or subnational area. The ISCO-08 codes included in this category are 2261. Density of pharmacists: The density of pharmacists is defined as the number of pharmacists per 10,000 population in the given national and/or subnational area. The ISCO-08 codes included in this category are 2262. **Health worker distribution by sex:** Percentage of male/female medical doctors: Male/female doctors as percentage of all medical doctors at national level. The ISCO-08 codes included in this category are 221, 2211 and 2212. Percentage of male/female nursing personnel: Male/female nursing personnel as percentage of all nursing personnel at national level. The ISCO-08 codes included in this category are 2221 and 3221.
Unit	Health worker densities by occupation: Per 10,000 population Health worker distribution by sex and type of occupation: Percentage (%)
Numerator	Number of health workers.
Denominator	Total population.
Method of measurement	**Health worker densities by occupation** The figures for number of medical doctors (including generalist and specialist medical practitioners) depending on the nature of the original data source may include practicing medical doctors only or all registered medical doctors. The figures for number of nursing and midwifery include nursing personnel and midwifery personnel, whenever available. In many countries, nurses trained with midwifery skills are counted and reported as nurses. This makes the distinction between nursing personnel and midwifery personnel difficult to draw. The figures for number of dentists include dentists in the given national and/or subnational area. Depending on the nature of the original data source may include practicing (active) only or all registered in the health occupation. The figures for number of pharmacists include in the given national and/or subnational area. Depending on the nature of the original data source may include practicing (active) only or all registered in the health occupation.. In general, the denominator data for workforce density (i.e. national population estimates) are obtained from the United Nations Population Division's World Population Prospects database. In cases where the official health workforce report provides density indicators instead of counts, estimates of the stock were then calculated using the latest population estimates from the United Nations Population Division's World population prospects database.
Method of estimation	If there is a national database or registry, there should be regular assessment of completeness using census data, professional association registers, facility censuses, etc.
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (n.d.). National Health Workforce Accounts (NHWA) Data Portal. Retrieved [August 30, 2025], from https://apps.who.int/nhwaportal/

79 Output training institutions

National Indicator Performance			
Recent international value		**Recent national value**	
Physicians: 11 per 100,000 population **Nursing and midwifery**: 11.9 per 100,000 population **Dentists**: 4.9 per 100,000 population **Pharmacists**: 6.8 per 100,000 population		**Physicians**: **3,519** (10.93 per 100,000 population) **Nursing and midwifery**: **2,301** (7.51 per 100,000 population **Dentists**: **1,151** (3.57 per 100,000 population) **Pharmacists**: **2,070** (6.43 per 100,000 population)	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	2022	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO IRIS	Assessment	MOH	Registry

Key Indicator Specifications	
Abbreviated name	Output training institutions
Indicator name	Density of graduates from health education and training programmes
Definition	Density of graduates from health education and training programmes during the last academic year per 10,000 population.
Unit	Per 100,000 population
Numerator	Density of graduates from health education and training programmes during the last academic year per 10,000 population.
Denominator	Total population.
Method of measurement	Databases on education and training statistics (with capacity data at institutional level); education and training institutions
Method of estimation	
Measurement frequency	Annual
KSA data source	Ministry of Health. (2024). Statistical yearbook 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.moh.gov.sa/en/Ministry/Statistics/book/Pages/default.aspx
International data source	World Health Organization. (2024). Monitoring health and health system performance in the Eastern Mediterranean Region: Core indicators and indicators on the health-related Sustainable Development Goals 2023. Cairo: WHO Regional Office for the Eastern Mediterranean. Retrieved [August 30, 2025], from https://iris.who.int/handle/10665/377287

80 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age [SDG 16.9.1]

National Indicator Performance			
Recent international value		**Recent national value**	
99.2%		**99.9%**	
Date	**Type of Result**	**Date**	**Type of Result**
2018	Estimate	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT	Registry

Key Indicator Specifications	
Abbreviated name	Birth registration [SDG 16.9.1]
Indicator name	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age
Definition	Proportion of children under 5 years of age whose births have been registered with a civil authority.
Unit	Percentage (%) of children under 5 years of age
Numerator	Number of children underage of five whose births are reported as being registered with the relevant national civil authorities.
Denominator	Total number of children under the age of five
Method of measurement	Birth registration: Questions are asked about registration status in household surveys. The numerator of this indicator includes children whose mother or care-taker says the birth has been registered (whether or not the birth certificate was seen by the interviewer). Civil registration: systems that are functioning effectively compile vital statistics that are used to compare teh estimated total number of births in a country with the absolute number of registered births during a given period.
Method of estimation	Number of children underage of five whose births are reported as being registered with the relevant national civil authorities divided by the total number of children under the age of five in the population x 100.
Measurement frequency	Annual (for civil registration); every 5 years for household surveys
KSA data source	General Authority for Statistics. (2024). Early Childhood Development and Child Well-Being Statistics Publication 2024. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435273/Early+Childhood+Development+and+Child+Well-Being+Statistics+Publication+2024+EN.pdf
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

81 Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 percent birth registration and 80 percent death registration [SDG 17.19.2]

A. Countries that have conducted at least one population and housing census in the last 10 years

National Indicator Performance			
Recent international value		**Recent national value**	
Yes		**Yes**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Not applicable	2022	Not applicable
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Assessment	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	
Indicator name	
Definition	The indicator tracks the proportion of countries that have conducted at least one population and housing census in the last 10 years. This also includes countries which compile their detailed population and housing statistics from population registers, administrative records, sample surveys or other sources or a combination of those sources.
Unit	Yes/No
Numerator	
Denominator	
Method of measurement	
Method of estimation	
Measurement frequency	In the past 10 years from measurement
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

82 Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 percent birth registration and 80 percent death registration [SDG 17.19.2]:

B. Countries that have achieved 100 percent birth registration and 80 percent death registration

National Indicator Performance			
Recent international value		**Recent national value**	
At least 90% birth complete: Yes **At least 80% death registration**: Yes		**Birth registration**: 99.2% **Death registration**: Yes	
Date	**Type of Result**	**Date**	**Type of Result**
90%: 2021 80%: 2023	Not applicable	Birth: 2022 Death: 2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats UN Stats	Assessment	GASTAT Progress Towards SGDs Report	Assessment

Key Indicator Specifications	
Abbreviated name	
Indicator name	
Definition	Proportion of countries that have achieved 100 percent birth registration and 80 percent death registration.
Unit	Percentage (%)
Numerator	Number of countries that have achieved 100 percent birth registration
Denominator	Total number of countries
Method of measurement	The two sub-indicators of the indicator 17.19.2b are expressed as proportions: at the global level, the proportion of countries that have achieved 100 percent birth registration is measured as the number of countries that have achieved 100 percent birth registration divided by the total number of countries. The computation is done in an analogous manner for the death registration part as well as for the regional measurements of both birth and death registration sub-indicators.
Method of estimation	
Measurement frequency	Annually
KSA data source	General Authority for Statistics. (2022). Progress Towards the Sustainable Development Goals 2022. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/documents/20117/2435263/Stats_SDG+2022_EN_0.pdf/b4d99c26-2c35-2d7e-4e48-239ea4b14b20?t=1734895978591
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database United Nations Statistics Division. (2023). Birth and Death Registration Completeness Dataset (April 2023). Retrieved [August 30, 2025], from https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://unstats.un.org/unsd/demographic-social/crvs/documents/2023-completeness.xlsx&ved=2ahUKEwir6LfqiP-MAxX6caQEHZsyMGMQFnoECBgQAQ&usg=AOvVaw0DKdVP078GA1rxeRQynKoI

83 Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%)

National Indicator Performance			
Recent international value		**Recent national value**	
4.62%		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Total current expenditure on health as % of gross domestic product
Indicator name	Total current expenditure on health as percentage of gross domestic product
Other names	Total capital expenditure on health as % of current + capital expenditure on health
Definition	Total current expenditure on health as a percentage of gross domestic product
Unit	Percentage (%)
Numerator	Sum of all current expenditure on health (12-month period)
Denominator	Gross domestic product.
Method of measurement	This includes all current expenditure, regardless of the source (domestic and donor funding)
Method of estimation	
Measurement frequency	Annual
KSA data source	Saudi Health Council. (2023). National Health Accounts 2022–2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://shc.gov.sa/Arabic/NewStrategyDepartment/NationalAccountsDocx/National%20Health%20Accounts-%202022-2023.pdf
International data source	World Health Organization. (n.d.). Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/current-health-expenditure-(che)-as-percentage-of-gross-domestic-product-(gdp)-(-)

84 Domestic general government health expenditure (GGHE-D) as percentage of current health expenditure (CHE) (%)

National Indicator Performance			
Recent international value		**Recent national value**	
78.24%		**N/A**	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Estimate	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Estimated through the organization	N/A	N/A

Key Indicator Specifications	
Abbreviated name	Public domestic sources of current spending on health as % of current health expenditure (Also: private)
Indicator name	Public domestic sources of current spending on health as % of current health expenditure
Previous name	Public domestic sources of current spending on health as % of current health expenditure (Also: private)
Definition	Current expenditure on health publically funded as a share of total current expenditure on health (expressed as a % of total current expenditure on health). This is the sum of current health outlays funded from domestic public funds such as taxes, social contributions, compulsory private insurance contributions or other government revenues.
Unit	Percentage (%)
Numerator	Sum of all public domestic sources of current spending on health (12-month period).
Denominator	Total current expenditure on health
Method of measurement	Excludes any donor funding passing through government and compulsory entities
Method of estimation	
Measurement frequency	Annual
KSA data source	Saudi Health Council. (2023). National Health Accounts 2022–2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://shc.gov.sa/Arabic/NewStrategyDepartment/NationalAccountsDocx/National%20Health%20Accounts-%202022-2023.pdf
International data source	World Health Organization. (n.d.). Domestic general government health expenditure (GGHE-D) as percentage of current health expenditure (CHE) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/domestic-general-government-health-expenditure-(gche-d)-as-percentage-of-current-health-expenditure

85 External health expenditure (EXT) as percentage of current health expenditure (CHE) (%)

National Indicator Performance			
Recent international value		**Recent national value**	
0%		N/A	
Date	**Type of Result**	**Date**	**Type of Result**
2022	Crude	N/A	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO GHO	Assessment	N/A	N/A

Key Indicator Specifications	
Abbreviated name	External source of current spending on health (% of current expenditure on health)
Indicator name	External sources of current spending on health as a percentage of current expenditure on health
Previous name	External source of current spending on health (% of current expenditure on health
Definition	Current expenditure on health funded by external sources of revenue, expressed as a percentage of total current expenditure on health.
Unit	Percentage (%)
Numerator	Total external (rest of the world) funding (12-month period).
Denominator	Total current expenditure on health.
Method of measurement	This indicator traces the financing flows from external sources that provide the funds to public and private financing schemes. It includes resources in cash and in kind provided as concessional loans and grants. Health accounts track records of transactions without double counting in order to reach a comprehensive coverage. Resources are accounted for in the same period as when they are used by financing schemes.
Method of estimation	
Measurement frequency	Annual
KSA data source	Saudi Health Council. (2023). National Health Accounts 2022–2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://shc.gov.sa/Arabic/NewStrategyDepartment/NationalAccountsDocx/National%20Health%20Accounts-%202022-2023.pdf
International data source	World Health Organization. (n.d.). External health expenditure (EXT) as percentage of current health expenditure (CHE) (%). Retrieved [August 30, 2025], from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/external-health-expenditure-(ext)-as-percentage-of-current-health-expenditure-(che)-(-)

86 Proportion of the population with large household expenditure on health as a share of total household consumption or income [SDG 3.8.2]

National Indicator Performance			
Recent international value		**Recent national value**	
Greater than 10%: 1.31% **Greater than 25%**: 0.58%		**Greater than 10%**: 1.97% **Greater than 25%**: 0.18%	
Date	**Type of Result**	**Date**	**Type of Result**
2018	Estimate	2023	Crude
Source	**Type of Source**	**Source**	**Type of Source**
UN Stats	Estimated through the organization	GASTAT	Survey

Key Indicator Specifications	
Abbreviated name	Proportion of the population with large household expenditure on health as a share of total household consumption or income [SDG 3.8.2]
Indicator name	Proportion of the population with large household expenditure on health as a share of total household consumption or income
Definition	The proportion of the population with household expenditure on health exceeding 25% of total household expenditure or income.
Unit	Percentage (%)
Numerator	Total number of people with large household expenditure on health as a share of total household expenditure or income (i.e. greater than 10% and 25%).
Denominator	Total number of people.
Method of measurement	
Method of estimation	Health expenditures are likely to expose households to financial hardship, in particular when they exceed a pre-defined threshold of a household's ability to pay. When this happens, they are characterized as being catastrophic. Within the SDG monitoring framework (SDG indicator 3.8.2), the proportion of the population facing catastrophic expenditures is measured as the population-weighted average of the number of households with "large household expenditures on health" as a share of total household expenditure or income (household's budget). Large is defined as health expenditures exceeding 10% or 25% of total household expenditure or income. The household's sample weight multiplied by the household size is used to obtain representative numbers per person. If the sample is self-weighting, then only the household size is used as the weight. Household expenditures on health are defined as formal and informal payments made at the time of getting any type of care (promotive, curative, rehabilitative, palliative or long-term care) provided by any type of provider. These payments include the part not covered by a third party such as the government, health insurance fund or private insurance but exclude insurance premiums as well as any reimbursement by a third party. They might be financed by income, including remittance, savings or borrowings. With this definition, health expenditures are labelled Out-Of-Pocket (OOP) payments in the classification of health care financing schemes (HF) of the International Classification for Health Accounts (ICHA). The population with household health expenditures greater than 25% of total household expenditure or income (SDG indicator 3.8.2) can be disaggregated at "rural" and "urban" levels if the survey has been designed to provide representative estimates and/or there were enough observations. Other types of disaggregation are possible, for example, by quintiles of the household welfare measures (total household consumption expenditure or income). To fully understand progress towards UHC within the SDG monitoring framework, SDG indicator 3.8.2 should be monitored jointly with SDG indicator 3.8.1 on coverage of essential health services. Other definitions than the one used for SDG 3.8.2 can be used to monitor catastrophic health spending, and they are also part of WHO regional monitoring frameworks. Other definitions than the one used for SDG 3.8.2 can be used to monitor catastrophic health spending, and they are also part of WHO regional monitoring frameworks.
Measurement frequency	Every 1–5 years depending on implementation of population-based household expenditure surveys led by national statistics offices
KSA data source	General Authority for Statistics. (2023). Household income and expenditure survey 2023. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.stats.gov.sa/en/statistics-tabs?tab=436312&category=127329
International data source	United Nations Statistics Division. (n.d.). SDG Global Database. Retrieved [August 30, 2025], from https://unstats.un.org/sdgs/dataportal/database

87 International Health Regulations (IHR) core capacity index [SDG 3.d.1]

National Indicator Performance			
Recent international value		**Recent national value**	
95%		**95%**	
Date	**Type of Result**	**Date**	**Type of Result**
2024	Crude	2024	Crude
Source	**Type of Source**	**Source**	**Type of Source**
WHO eSPAR	Assessment	WHO eSPAR	Assessment in consultation with MOH

Key Indicator Specifications	
Abbreviated name	International Health Regulations (IHR) core capacity index [SDG 3.d.1]
Indicator name	International Health Regulations (IHR) capacity and health emergency preparedness
Definition	Percentage of attributes of 13 core capacities that have been attained at a specific point in time. The 13 core capacities are: (1) National legislation, policy and financing; (2) Coordination and National Focal Point communications; (3) Surveillance; (4) Response; (5) Preparedness; (6) Risk communication; (7) Human resources; (8) Laboratory; (9) Points of entry; (10) Zoonotic events; (11) Food safety; (12) Chemical events; (13) Radionuclear emergencies.
Unit	Percentage (%)
Numerator	Number of attributes attained.
Denominator	Total number of attributes
Method of measurement	Based on a set of attributes of 13 core capacities from a standard WHO instrument
Method of estimation	
Measurement frequency	Biannual
KSA data source	World Health Organization. (n.d.). Electronic IHR States Parties Self-Assessment Annual Reporting Tool (e-SPAR). Retrieved [August 30, 2025], from https://extranet.who.int/e-spar/
International data source	World Health Organization. (n.d.). Electronic IHR States Parties Self-Assessment Annual Reporting Tool (e-SPAR). Retrieved [August 30, 2025], from https://extranet.who.int/e-spar/

88 Existence of a comprehensive national health sector policy/strategy/ plan with goals and targets updated within the last 5 years

National Indicator Performance			
Recent international value		**Recent national value**	
Yes		**Yes**	
Date	**Type of Result**	**Date**	**Type of Result**
2020	N/A	2021	N/A
Source	**Type of Source**	**Source**	**Type of Source**
WHO Country Planning Cycle Database	N/A	Health Sector Transformation Program	N/A

Key Indicator Specifications	
Abbreviated name	Existence of national health sector policy/strategy/plan
Indicator name	Existence of a comprehensive national health sector policy/ strategy/ plan with goals and targets updated within the last 5 years
Definition	Whether or not a country has a comprehensive national health sector policy/ strategy/ plan with goals and targets, updated within the last 5 years. The aggregated information is then used to measure indicator 4.1 of the WHO's Global Programme of Work 2014-2019, i.e. the number of countries having a comprehensive national health sector policy/ strategy/ plan with goals and targets updated within the last 5 years.
Unit	Yes/No
Numerator	
Denominator	
Method of measurement	
Method of estimation	WHO collects data through regular national and regional consultations and maintains the Global Database on National health sector policy/ strategy/ plans which includes a repository of the national sector policy strategy and plans. The indicator is verified through the regional office as part of WHO's General Programme of Work 2014-2019.
Measurement frequency	Annual
KSA data source	Vision 2030. (2021). Health Sector Transformation Program Delivery Plan 2021–2025. Riyadh, Saudi Arabia. Retrieved [August 30, 2025], from https://www.vision2030.gov.sa/media/u5xapka3/2021-2025-health-sector-transformation-program-delivery-plan-en.pdf
International data source	World Health Organization. (n.d.). Country Planning Cycle Database: Saudi Arabia. Retrieved [August 30, 2025], from https://extranet.who.int/countryplanningcycles/file-repository?iso3=SAU

[End]