



The Sustainable Development Goals Report 2021

Extended Report

-Goal 3-



Ensure healthy lives and promote well-being for all at all ages

Note: The UN Statistics Division (UNSD) prepares the annual *The Sustainable Development Goals Report*, also known as the glossy report, based on storyline inputs submitted by UN international agencies in their capacity as mandated custodian agencies for the SDG indicators. However, due to space constraints, not all information received from custodian agencies is able to be included in the final glossy report. Therefore, in order to provide the general public with all information regarding the indicators, this 'Extended Report' has been prepared by UNSD. It includes all storyline contents for each indicator as provided by the custodian agencies and is unedited. For instances where the custodian agency has not submitted a storyline for an indicator, please see the custodian agency focal point information linked for further information.

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

Indicator 3.1.1: Maternal mortality ratio

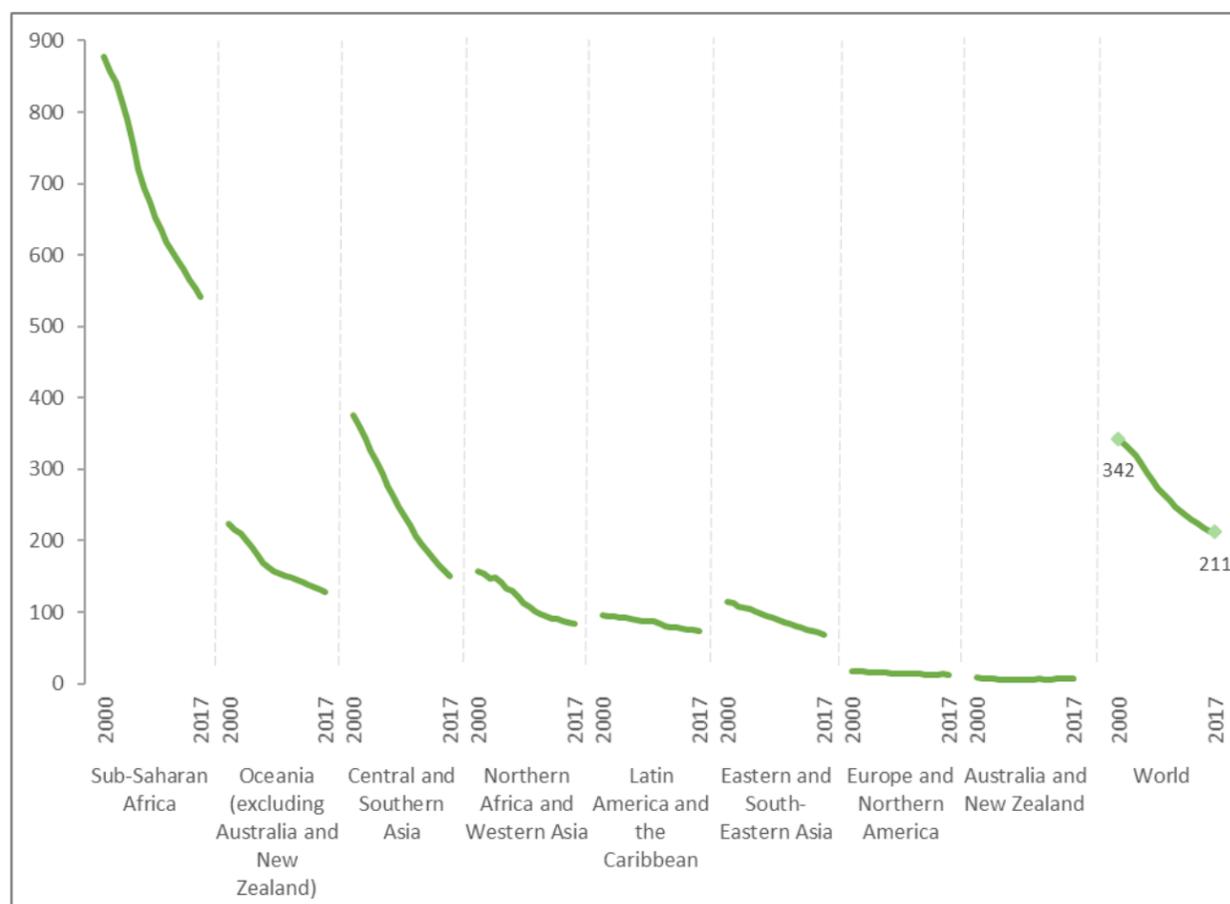
An unfinished agenda: Increased action is needed to ensure that improvements in maternal mortality are truly for all

Overall, globally, between 2000 and 2017 the maternal mortality ratio (MMR) fell by 38%, from 342 deaths to 211 deaths per 100 000 live births. This is encouraging progress. Nonetheless, the global average masks substantial inequalities: the lifetime risk of maternal death was estimated at 1 in 37 in sub-Saharan Africa compared with just 1 in 7800 in Australia and New Zealand.

Of concern, the 10 countries with the highest maternal mortality ratios in 2017 (South Sudan, Chad, Sierra Leone, Nigeria, Central African Republic, Somalia, Mauritania, Guinea-Bissau, Liberia, and Afghanistan) all have stagnant or slowing annual rates of reduction, and therefore remain at greatest risk. The impact of interruptions or loss of quality health services must be considered in crisis and other unstable settings.

Interruptions to maternity services are not limited to crisis settings, particularly during the ongoing COVID-19 pandemic. The current MMR estimates do not cover the period of the pandemic, but any impact will appear in future rounds. Reports of disruptions, including challenges travelling to attend antenatal, childbirth, or postpartum care, health personnel redeployments and shortages, and restrictions to birth companions are being reported in a wide range of settings across the world. Inequality in access to high-quality services may increase as COVID-19 vaccinations programmes progress at different speeds in different settings. For example, in South Africa, HIV-related indirect maternal deaths constitute 21% of all maternal deaths. Improved care and management of HIV disease in general, and during pregnancy, childbirth and postpartum care in particular, has been one of the success stories since the peak of the HIV epidemic in the mid-2000s. Of concern, high burden countries such as South Africa are reported to be experiencing disruption to antenatal HIV testing and ART initiation due to the COVID-19 pandemic, which appears to be increasing in severity in the region.

Maternal mortality ratio, 2000-2017 (maternal deaths per 100,000 live births)



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WHO

Indicator 3.1.2: Proportion of births attended by skilled health personnel

Despite continued progress towards ensuring that all births are attended by skilled health personnel, inequities in coverage remain and COVID-19 may threaten further advances

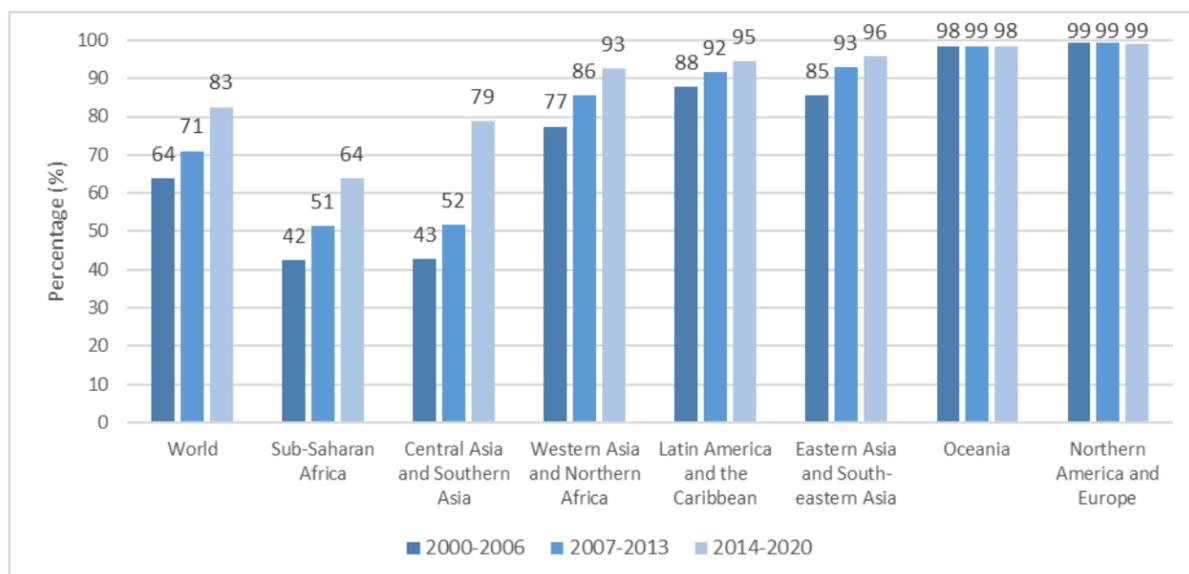
Having a skilled health personnel, including doctors, nurses and midwives, attending childbirth is paramount to the lives of women, newborns and their families. Skilled health personnel are competent to safely conduct normal childbirth, recognize and manage warning signs for complications, and refer those in need to emergency care, all of which is key to reducing maternal and newborn morbidity and mortality. Globally, an estimated 83 per cent of births were assisted by skilled health professionals for countries with data from 2014-2020, which is an increase of about 19 per cent compared to countries with data from 2000-2006.

Despite this progress, regional inequities remain, and the COVID-19 pandemic may threaten these advances. There is growing evidence^{1,2,3} that access to skilled and quality care during childbirth may be negatively impacted by country responses to the pandemic including lockdown measures, transportation disruptions, diversion of resources away from essential health services, and because of fears of infection. Future rounds of data collection may better reflect these indirect consequences of the COVID-19 pandemic.

Although more than four-fifths of live births were attended by skilled health personnel in recent years, inequities in coverage continue to exist around the world. While regions like Northern America and Europe, Oceania, Eastern and South-eastern Asia and Latin America and the Caribbean have achieved universal or nearly universal coverage, only 64 per cent of births in sub-Saharan Africa are attended by skilled health personnel. Projections estimate that sub-Saharan Africa will experience a 15 per cent increase in the number of annual births by 2030. If current coverage levels of skilled health personnel in sub-Saharan Africa stay the same, this projected increase in the number of births will translate into approximately 16 million births occurring without the attended of skilled health personnel in 2030. To avoid this outcome, countries in sub-Saharan Africa will need to substantially increase investments in maternal and newborn health services.

Despite these challenges, regions including sub-Saharan Africa and Central and Southern Asia have had the greatest progress in increasing coverage of births attended by skilled health personnel in the past two decades. Future data will show how these regional strides towards universal coverage are impacted by the COVID-19 pandemic.

Trends in proportion of births attended by skilled health personnel (%), SDG Regions and world, three periods: 2000-2006, 2007-2013, 2014-2020



Progress analysis: [See progress chart](#)

Additional resources, press releases, etc. with links:

- <https://data.unicef.org/topic/maternal-health/delivery-care/>
- <https://www.who.int/data/gho/data/themes/maternal-and-reproductive-health>

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¹ Fore, H. A wake-up call: COVID-19 and its impact on children's health and wellbeing. The Lancet Global Health 8, 7 (2020). [https://doi.org/10.1016/S2214-109X\(20\)30238-2](https://doi.org/10.1016/S2214-109X(20)30238-2)

² Kotlar, B. et al. The Impact of the COVID-19 Pandemic on Maternal and Perinatal Health: A Scoping Review. Reprod Health 18, 10 (2021). <https://doi.org/10.21203/rs.3.rs-96736/v1>

³ Roberton, T. et al. Early Estimates of the Indirect Effects of the COVID-19 Pandemic on Maternal and Child Mortality in Low-Income and Middle-Income Countries: A Modelling Study. The Lancet Global Health 8, 7 (2020). [https://doi.org/10.1016/s2214-109x\(20\)30229-1](https://doi.org/10.1016/s2214-109x(20)30229-1)

Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

Indicator 3.2.1: Under-5 mortality rate

Indicator 3.2.2: Neonatal mortality rate

Nearly 11 million under-5 deaths could be averted between now and 2030 if all countries reached the SDG under-5 mortality target

The world has made tremendous progress in reducing child mortality over the past two decades, and millions of children under age 5 are more likely to survive today than in 2000. The global under-5 mortality rate has fallen by 50 per cent from 76 deaths per 1,000 live births in 2000 to 38 deaths in 2019, and the global neonatal mortality rate fell by 42 per cent from 30 deaths per 1,000 live births in 2000 to 17 deaths in 2019. Still, the burden of child deaths remains immense—5.2 million children died before reaching age five in 2019 alone, with almost half of those deaths (2.4 million) occurring within the first 28 days of life.

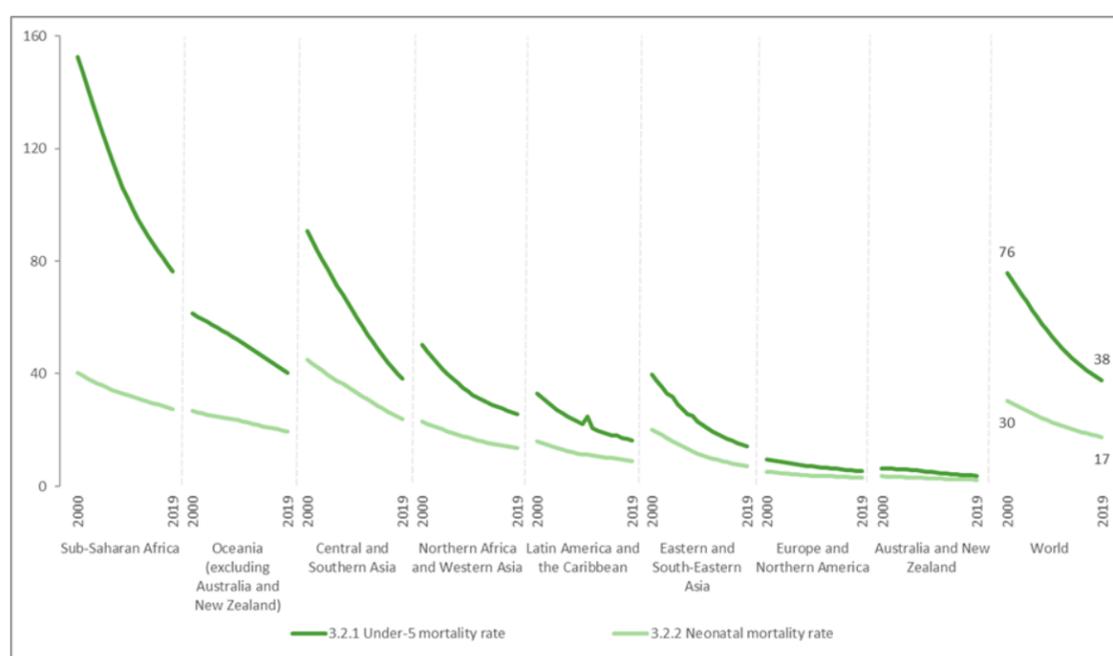
Whereas initial evidence suggests direct deaths of children from Covid-19 to be limited, indirect mortality impacts arising from significant disruptions to the continued provision of life saving interventions like antenatal care, childbirth delivery care, vaccination, and early childhood preventative and curative services could stagnate or even reverse the progress in child survival. Indeed, hindered delivery of vaccinations can put children at increased risk of contracting vaccine-preventable diseases, and following abrupt drops in household income, disruptions to the supply of affordable, nutritious foods, and interruptions to health, nutrition and social protection services, children are at increased risk of wasting, putting them at increased risk of death from infectious diseases. While it is not yet possible to know the total impact of Covid-19 pandemic on child survival, these Covid-related disruptions have the potential to substantially increase the under-5 deaths burden.

Even though under-5 and neonatal mortality declined in all regions, children continue to face extensive regional and economic disparities in their chances of survival. Sub-Saharan Africa remains the region with the highest under-5 mortality rate in the world at 76 deaths per 1,000 live births in 2019. That is equivalent to 1 in 13 children dying before reaching age 5, 20 times higher than the rate of 1 in 264 in the region of Australia and New Zealand and two decades behind the world average, which achieved a 1 in 13 rate by 1999.

By 2019, 122 countries had already met the SDG target on under-5 mortality, and 20 countries are expected to do so by 2030, if current trends continue. However, progress will need to accelerate in 53 countries, two-thirds of which are located sub-Saharan Africa, to meet the target by 2030. If these countries were to achieve the SDG under-5 mortality target, the number of under-5 deaths between 2020 and 2030 would be cut by nearly 11 million.

Even more countries are at risk of missing the neonatal SDG target—more than 60 countries will need to accelerate progress to meet that target by 2030. Most neonatal deaths take place in low- and lower-middle-income countries, where children’s lives are dependent on the continued and increased coverage of life saving interventions. If progress in reducing neonatal mortality is to continue during the Covid-19 crisis, it is critical to maintain essential care and services. Finally, in countries that have already met the SDG child survival targets, progress must be maintained and disparities in child survival should be reduced to save even more lives.

Under-5 and neonatal mortality rate by region, 2000-2019 (deaths per 1,000 live births)



Progress analysis: [See progress chart](#)

Additional resources, press releases, etc. with links:

- United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), ‘Levels & Trends in Child Mortality: Report 2020, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation’, United Nations Children’s Fund, New York, 2020; Link: <https://childmortality.org/wp-content/uploads/2020/09/UNICEF-2020-Child-Mortality-Report.pdf>; Website: <http://childmortality.org/>

Custodian agency(ies):

UNICEF

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

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

Inequalities slow efforts to achieve HIV global targets

Progress toward reducing new HIV infections remains far too slow despite significant progress in several high-burden countries. HIV incidence among adults (aged 15 to 49 years) declined by 24% since 2010, in large part because of the substantial 47% reduction achieved in sub-Saharan Africa. In contrast, this rate continued to rise in parts of Eastern Europe, Latin America and Northern Africa and Western Asia. Key populations continue to be left behind on nearly every continent. Barely any change has been registered in the global number of HIV infections among female sex workers, people who inject drugs and transgender women. HIV infections among gay men and other men who have sex with men increased by 25% between 2010 and 2019. In 2019, key populations and their sexual partners accounted for 62% of all new infections worldwide.

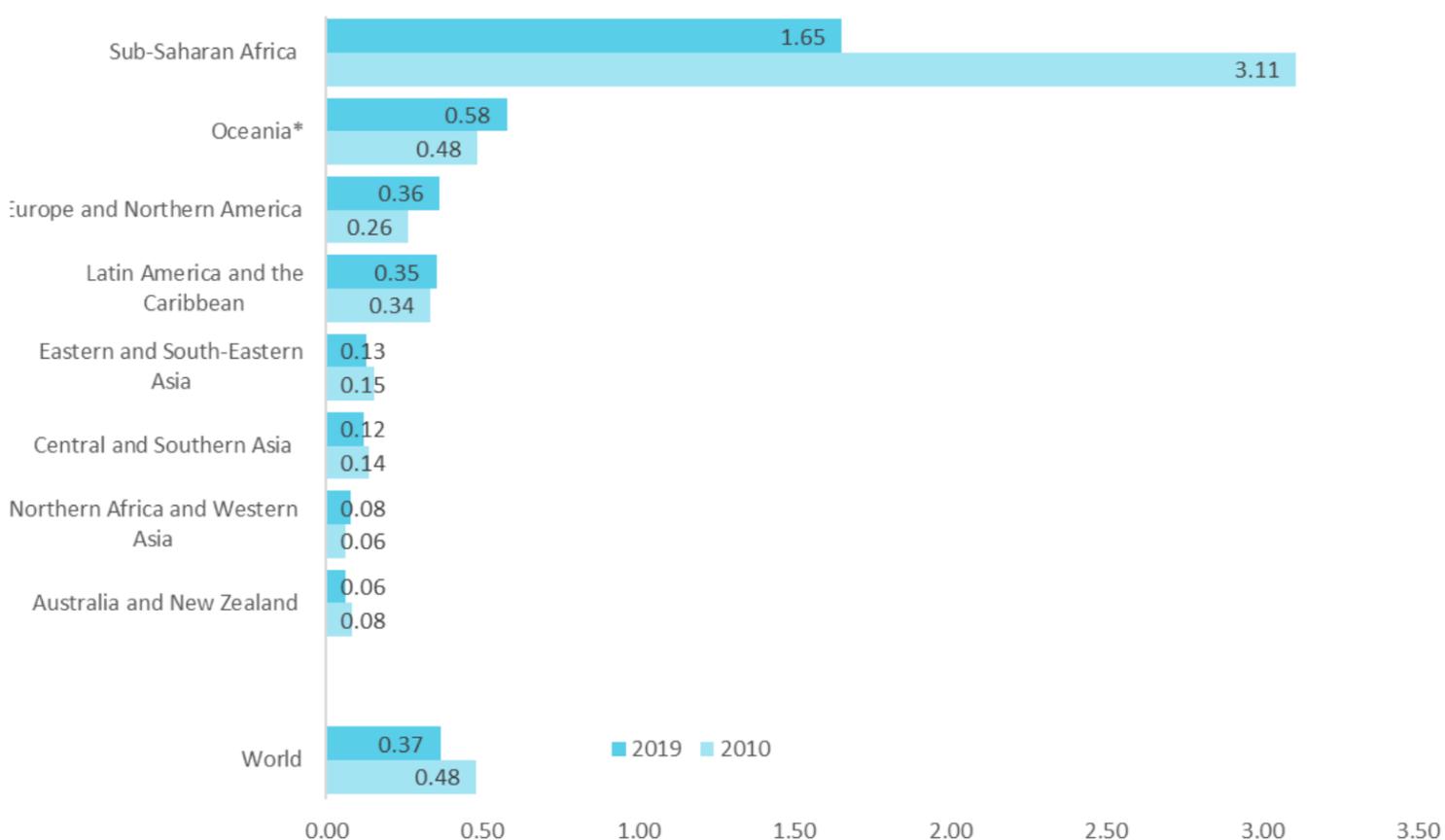
Gender inequality and gender-based violence leave adolescent girls and young women particularly vulnerable to HIV, especially in settings with high disease burden. In sub-Saharan Africa 24% of all new infections were among young women aged 15-24 years despite making up only 9% of the total population. Outside sub-Saharan Africa, in regions where HIV is concentrated among key populations that often have many more men than women, 48% of all new infections were among men aged 25-49 years despite making up 18% of the total population.

New HIV infections among children fell by more than half from 2010 to 2019, progress that in large part reflects the increased provision of antiretroviral therapy to pregnant women living with HIV. However, progress towards the elimination of HIV transmission from mother to child has largely stalled since 2016. In addition, treatment coverage among children living with HIV (53% in 2019) is at a level well below the coverage for adults (68%)—leaving 840,000 children without life-sustaining treatment.

Despite the lack of progress in HIV incidence there have been successes in the HIV response, notably due to treatment. The 690 000 AIDS-related deaths in 2019 was the lowest estimate since 1993 and reflects a 39% reduction since 2010. However, this success is uneven with data showing persistent inequalities. By the end of 2019, 13 countries had achieved 2020 targets for HIV testing and treatment, resulting in at least 73% of people living with HIV having viral load suppression while other countries still had very low and uneven access to treatment across populations.

The full impact of COVID-19 on new HIV infections is still unknown, with disruption in services potentially increasing new infections and social distancing potentially decreasing new infections. Programme data from 2020 show that there were considerable disruptions to HIV services including testing, initiation of treatment, voluntary medical male circumcision and pre-exposure prophylaxis. Over the course of the year many countries switched the provision of treatment to multi-month dispensing reducing the need for clinic visits by an estimated 28%. Community resilience and innovation learned over the course of the HIV epidemic, including rights-based approaches and community-led service delivery, have helped mitigate the impact of COVID-19.

HIV incidence rates, 2010 and 2019 (new cases per 1,000 uninfected adults aged 15 to 49 years)



* Excluding Australia and New Zealand

Progress analysis: [3.3.1 progress analysis.zip](#)

Additional resources, press releases, etc. with links:

- Global AIDS Report https://www.unaids.org/en/GR2020_documents_archive
- https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/july/20200706_global-aids-report
- www.aidsinfo.unaids.org

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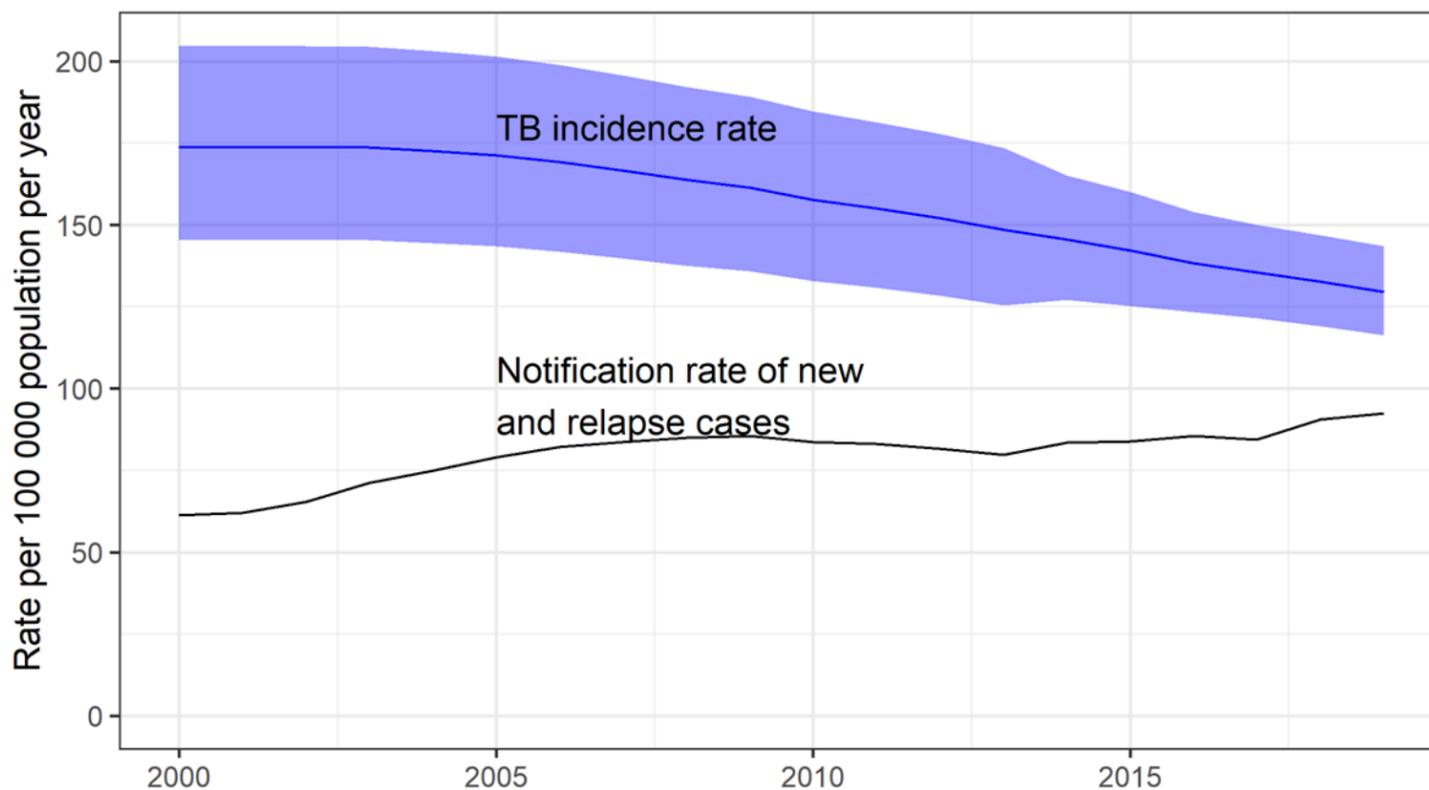
Custodian agency(ies):

UNAIDS

Indicator 3.3.2: Tuberculosis incidence per 100,000 population

Tuberculosis (TB) remains a leading cause of ill-health and death. In 2019, an estimated 10 million people fell ill with TB (56% were adult men, 32% adult women, 12% children, and 8.2% were people living with HIV) and it was the top killer from a single infectious agent. Although the burden is falling - globally, TB incidence declined from 174 new and relapse cases per 100 000 population in 2000 to 130 per 100 000 population in 2019 (a 25% decline in the 19-year period) and the TB mortality rate among HIV-negative people fell by 45% in the same period - large gaps in detection and treatment persist and the current pace of progress is not fast enough to meet the SDG target of ending the TB epidemic by 2030. Drug-resistant TB is a continuing threat: in 2019, there were 465 000 new cases with resistance to rifampicin, the most effective first-line drug, of which 78% had multidrug-resistant TB. The pandemic of COVID-19 threatens to reverse recent progress in reducing the global burden of TB disease.

Global trends in TB incidence rate (2000-2019)



Additional resources, press releases, etc. with links:

- Global TB Report 2020: http://www.who.int/tb/publications/global_report/en/

Custodian agency(ies):

WHO

Indicator 3.3.3: Malaria incidence per 1,000 population

Global malaria gains threatened by access gaps, COVID-19 and funding shortfalls

The 2020 edition of WHO's World malaria report highlights a period of unprecedented success in global malaria control. Beginning in the 1990s, the world laid the foundation for a renewed malaria response that contributed to 1.5 billion cases and 7.6 million deaths averted over the past two decades.

Many countries with a low burden of malaria have moved quickly towards the goal of elimination. Between 2000 and 2019, the number of countries with fewer than 100 indigenous malaria cases – a strong indicator that malaria elimination is within reach – increased from 6 to 27. Over this same period of time, 10 countries were certified malaria free by WHO.

However, in recent years, the global gains in combatting malaria have levelled off, and many countries with a high burden of the disease have been losing ground. In 2019, there were an estimated 229 million cases of malaria, an annual estimate that has remained virtually unchanged over the last 4 years. The disease claimed some 409 000 lives in 2019 compared to 411 000 the previous year.

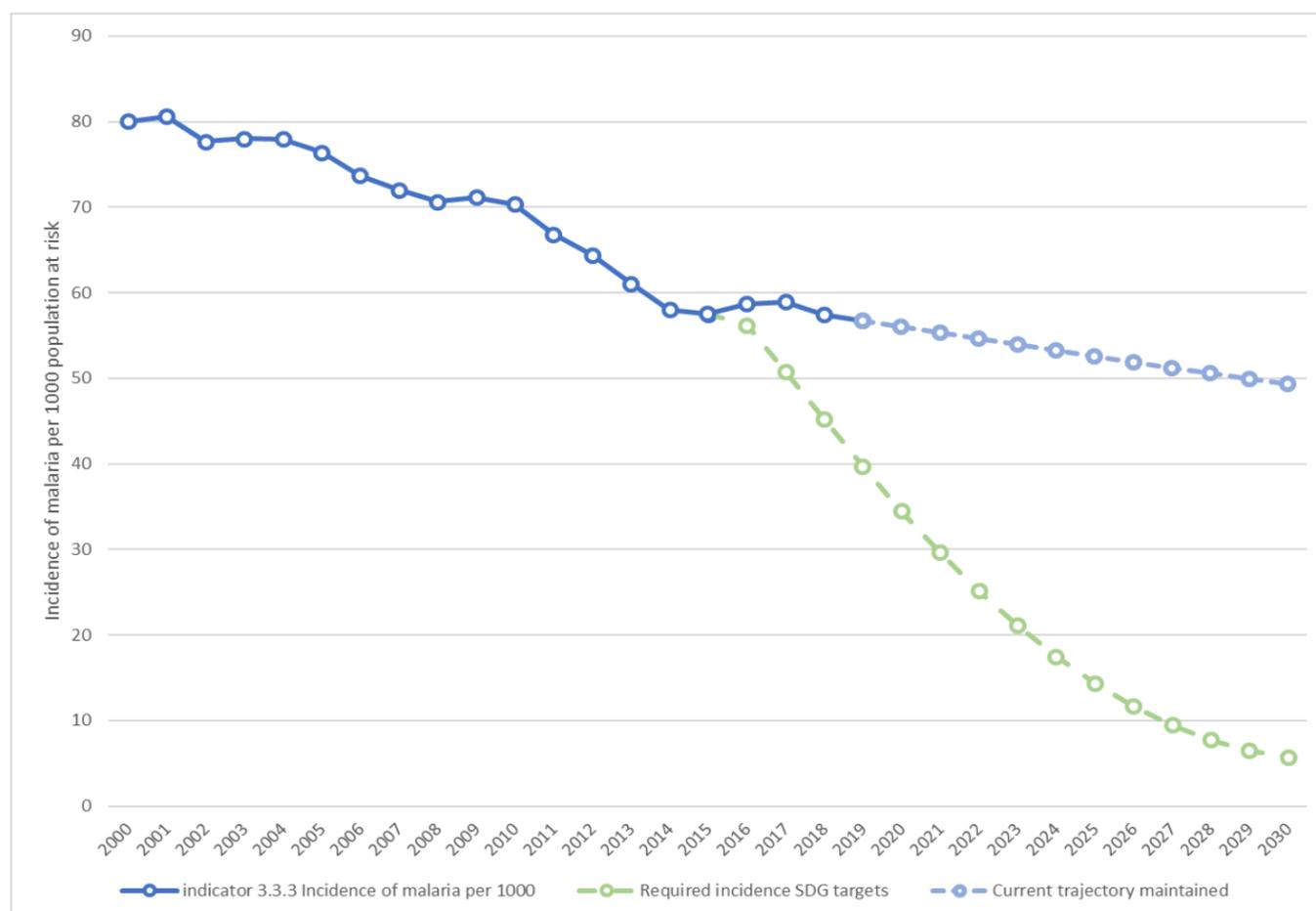
The WHO African Region continues to shoulder the heaviest burden of the disease. Globally in 2019, the region accounted for 94% of all malaria cases (215 million cases) and deaths (384 000 deaths). Approximately two-thirds of all malaria deaths in the region (265 000) were among children under the age of five.

Since 2017, WHO has warned that progress towards critical targets of its global malaria strategy was off track. Urgent and concerted action is needed to set the world back on a trajectory towards achieving both the WHO targets and the SDG target of ending malaria by 2030.

Insufficient funding – at both the international and domestic levels – poses a significant threat to future progress. In 2019, funding for malaria control and elimination totaled US\$ 3 billion, falling far short of the US\$ 5.6 billion target of the global strategy. Funding gaps have resulted in gaps in access to proven, WHO-recommended malaria control tools.

The COVID-19 pandemic has emerged as a serious additional challenge to malaria responses worldwide. In 2020, most malaria prevention campaigns were able to move forward without major delays. However, according to WHO projections, even moderate disruptions in access to antimalarial treatment could lead to a considerable loss of life. For example, a 10% disruption in access to effective treatment in sub-Saharan Africa could lead to 19 000 additional deaths in the region.

Comparison of global progress in malaria considering two scenarios: Current trajectory maintained and SDG targets achieved



Progress analysis: [See progress chart](#)

Additional resources, press releases, etc. with links:

- Global technical strategy for malaria 2016-2030: <https://www.who.int/publications/i/item/9789241564991>
- World malaria report 2020: <https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2020>

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Indicator 3.3.4: Hepatitis B incidence per 100,000 population

Prevalence of Hepatitis b surface antigen in children under 5 years of age

Worldwide the 2020 target of 1% seroprevalence in children under 5 years of age has been reached. However, the prevalence in some regions such as Sub-Saharan Africa and Oceania (excluding Australia and New Zealand) remain above the 2020 SDG target of 1%.

Most of the burden of disease from hepatitis B virus (HBV) infection comes from infections acquired before the age of 5 years. Therefore, prevention of HBV infection focuses on children under 5 years of age.

The use of hepatitis b vaccine in infants has considerably reduced the incidence of new chronic hepatitis b virus infections. Between the pre-vaccination era (that can vary from the 1980's to 2000 depending on the year of introduction) and 2020 the proportion of children under five years of age who became chronically infected fell from 4.7% to 0.9% in 2020.

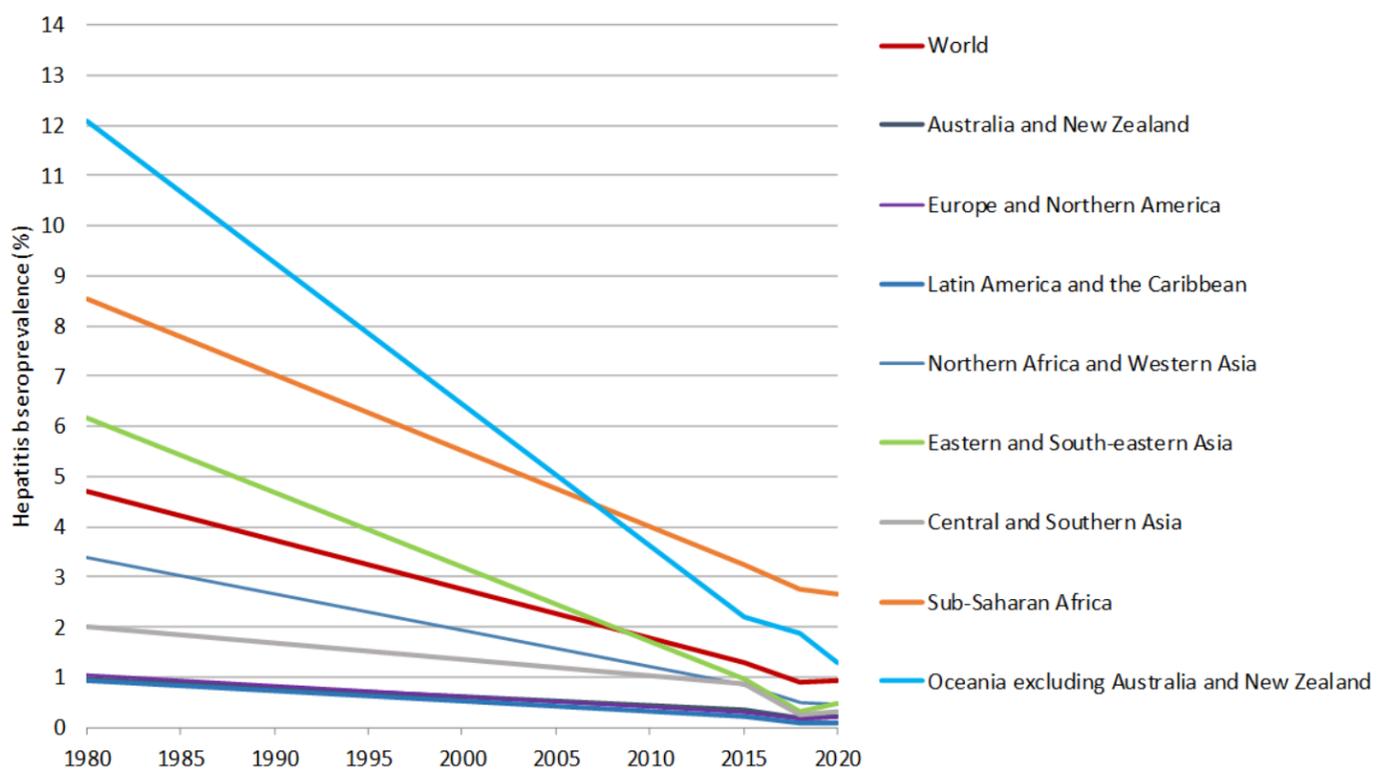
In May 2016, the World Health Assembly adopted the first "Global health sector strategy on viral hepatitis, 2016-2020". The strategy highlights the critical role of universal health coverage and sets targets that align with those of the Sustainable Development Goals.

The strategy has a vision to eliminate viral hepatitis as a public health problem. This is encapsulated in the global targets to reduce new viral hepatitis infections by 90% and reduce deaths due to viral hepatitis by 65% by 2030. Actions to be taken by countries and the WHO Secretariat to reach these targets are outlined in the strategy.

To support countries in achieving the global hepatitis elimination targets under the Sustainable Development Agenda 2030, WHO is working to:

- raise awareness, promote partnerships and mobilize resources;
- formulate evidence-based policy and data for action;
- increase health equities within the hepatitis response
- prevent transmission; and
- scale up screening, care and treatment services.

Hepatitis B surface prevalence in the under five years of age



Custodian agency(ies):

WHO

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

In 2019, 1.74 billion people were reported to require mass or individual treatment and care for neglected tropical diseases (NTDs), down from 2.19 billion in 2010, and about 12 million people fewer than reported in 2018. Most people require mass treatment for the diseases which are targeted with preventive chemotherapy: lymphatic filariasis, onchocerciasis, soil-transmitted helminthiases, schistosomiasis and trachoma. Progress in reducing the number of people requiring interventions has been driven largely by the fact that since 2010 at least one NTD has been eliminated in 42 countries, as acknowledged by WHO.

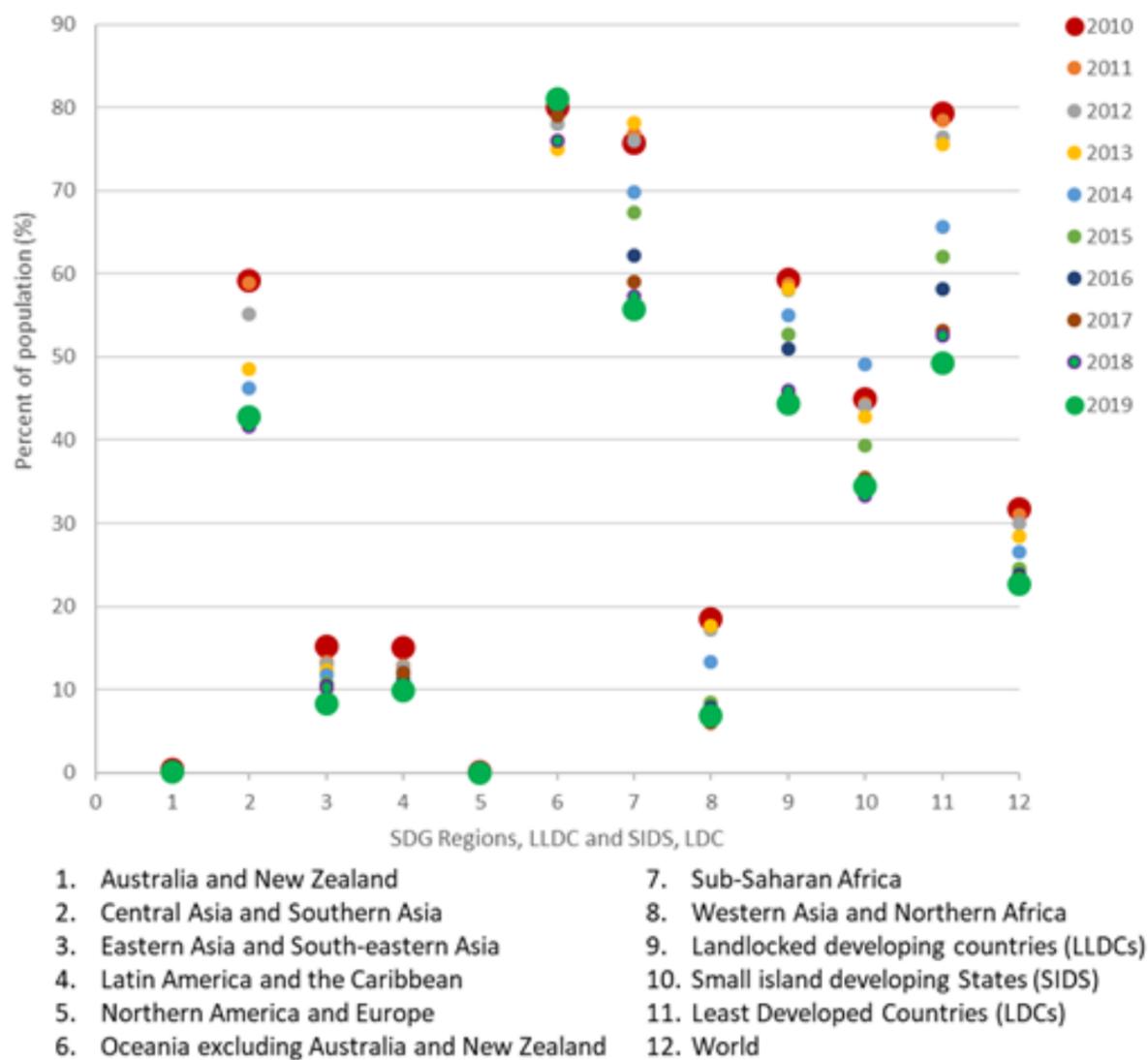
Dracunculiasis is on the verge of eradication, with 54 human cases reported in four countries in 2019; lymphatic filariasis and trachoma have been eliminated as a public health problem in 17 and 10 countries, respectively; onchocerciasis has been eliminated in four countries in the Region of the Americas; the annual number of cases of human African trypanosomiasis has fallen from more than 7000 in 2012 to 992 in 2019; and the number of new leprosy cases reported globally has continued to decline since 2010 at an average 1% per year after most endemic countries reached elimination as a public health problem.

NTDs are a diverse set of 20 diseases and disease groups with a singular commonality: their impact on impoverished communities

All SDG regions have made progress in reducing the proportion of their populations requiring treatment and care during 2010–2019. In 2019, some increase was reported in Oceania due the fact that the population requiring preventive interventions in Papua New Guinea (76% of the burden in the region) increased by 11% (0.7 million people) compared with the previous reporting year.

In 2019, 508 million people required treatment and care in the Least Developed Countries (LDCs) representing 49% of those countries’ populations, down from 79% in 2010. More than 1.2 billion people living outside the group of LDCs still required treatment and care for NTDs.

In January 2021, WHO launched the road map for NTDs 2021–2030⁴ which sets out global targets for 2030 and milestones to prevent, control, eliminate and eradicate a diverse set of 20 diseases and disease groups, as well as cross-cutting targets aligned with WHO’s Thirteenth General Programme of Work, 2019–2023 and the Sustainable Development Goals. One of the overarching global targets set for 2030 is a 90% reduction of people requiring interventions against NTDs.



Custodian agency(ies):

WHO

⁴ Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (<http://apps.who.int/iris/bitstream/handle/10665/338565/9789240010352-eng.pdf>, accessed 5 February 2021).

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

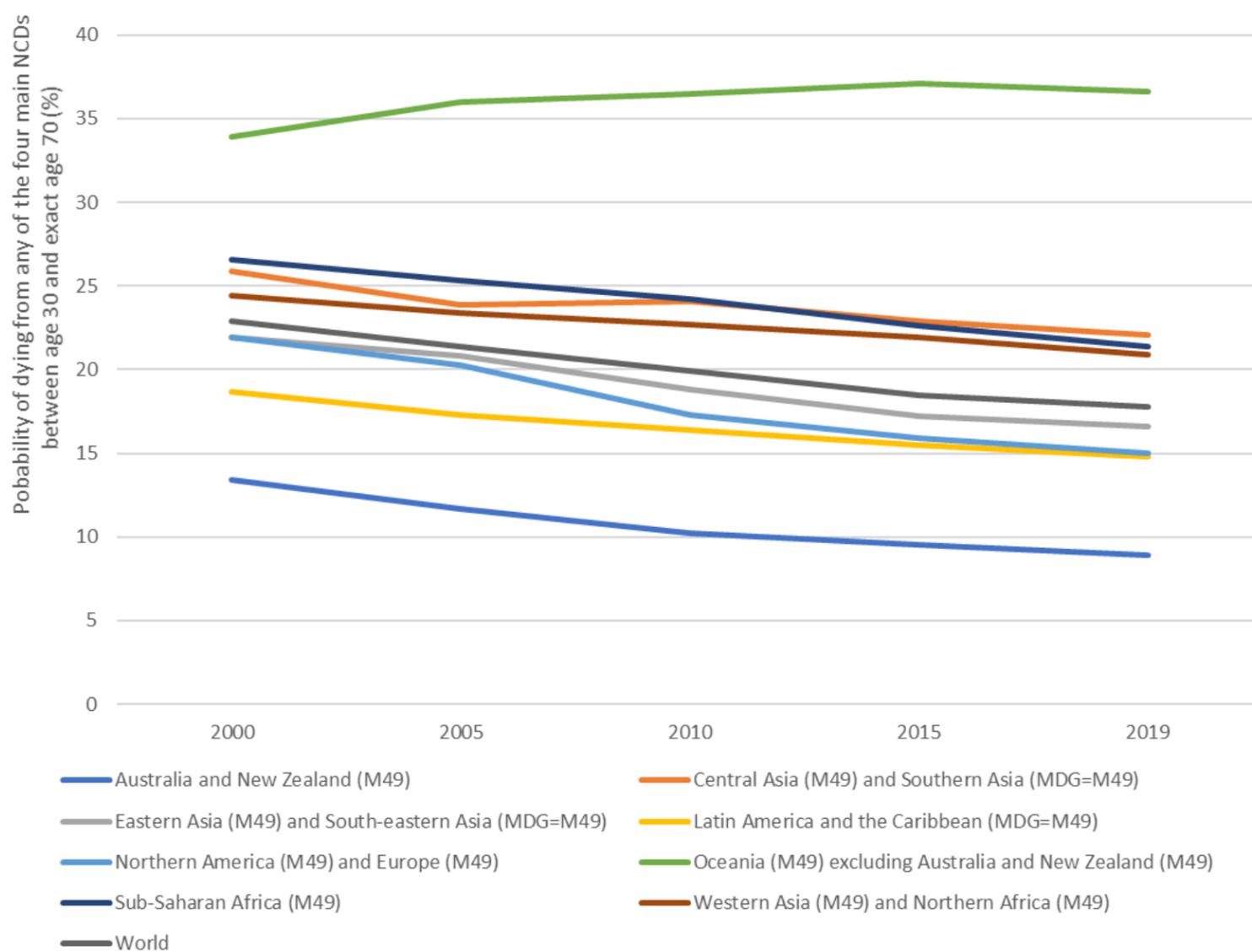
Indicator 3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
Most of the world is not on track to meet the SDG target on noncommunicable diseases

Globally, about three-quarters (74%) of all deaths in 2019 were caused by noncommunicable diseases (NCDs). The premature NCD mortality, measured by the unconditional probability of dying from any of the four main NCDs (cardiovascular disease, cancer, diabetes or chronic respiratory disease) between age 30 and exact age 70, has declined by 22.2% from 22.9% in 2000 to 17.8% in 2019. The rate of decline, however, was insufficient to meet SDG target 3.4.1 of a one-third reduction from 2015 values.

While the risk remains markedly higher for men globally (27.5% compared to 18.2% for women), some regions have seen the gender gap close considerably from 2000 to 2019. In Australia and New Zealand, Northern America and Europe and even Sub-Saharan Africa, where the gap has been historically small, the gender gap has closed by a third or more due to slightly greater reductions in premature NCD mortality among men. Whereas in Central Asia and Southern Asia as well as Western Asia and Northern Africa the gender gap has declined only slightly in the same period.

If the rates of decline in premature NCD mortality since 2000 could be sustained, only Northern America and Europe would be on track to reach the SDG 3.4.1 target. However, preventive, diagnostic and treatment services for NCDs have been disrupted since the COVID-19 pandemic began in early 2020, threatening progress made in the last two decades. At the same time, the COVID-19 pandemic underscores the need for further attention to NCD interventions, as people with underlying NCD conditions have higher risks of severe illness and death from COVID-19.

Probability of dying from any of the four main NCDs between age 30 and exact age 70 (%)



Additional resources, press releases, etc. with links:

- WHO Global Health Estimates 2019. Geneva: World Health Organization, 2020. <https://www.who.int/data/global-health-estimates>
- World Health Statistics 2021. Geneva: World Health Organization, 2021.

Custodian agency(ies):

WHO

Indicator 3.4.2: Suicide mortality rate

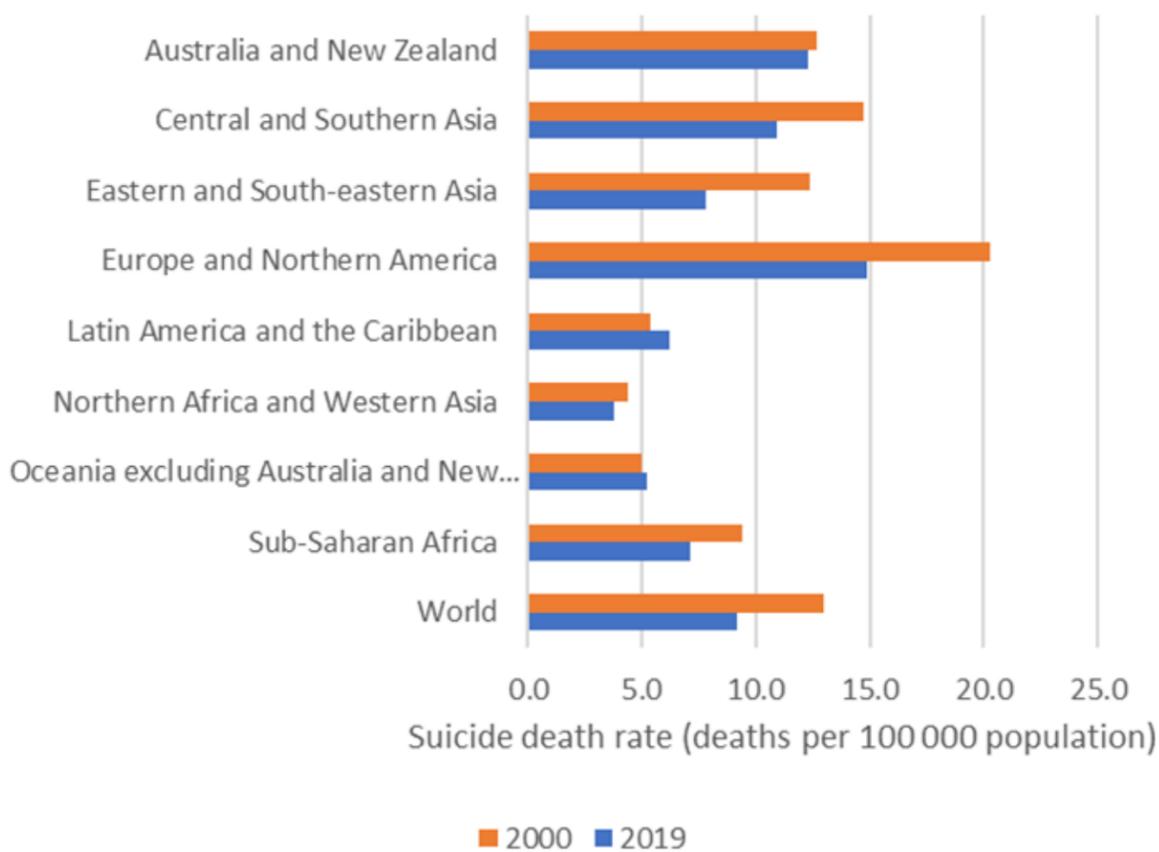
About 700 000 suicide deaths occurred in 2019 with death rate among men about double the rate among women. Men in Europe and Northern America had the highest rate of suicide deaths (23.6 deaths per 100 000 population), almost double the average rate among men globally (12.6 per 100 000 population). Among women, the rate was the highest in Central and Southern Asia (8.6 per 100 000 population).

Suicides occur throughout the lifespan, with the rate increasing as people get older. Globally, people aged 70 years or older had the highest suicide rate (24.0 per 100 000 population) across all age groups, however, suicide was the fourth leading cause of death among young people aged 15-29 years. It was the top cause of death among young people aged 15-29 years in Europe and Northern America in 2019, as well as among people aged 15-49 years in Australia and New Zealand.

Global suicide death rate declined by 29% from 13.0 deaths per 100 000 population in 2000 to 9.2 deaths per 100 000 population in 2019. Eastern and South-Eastern Asia saw the greatest reduction during the period (37%). While Europe and Northern America as a group also experienced a marked decline (27%), this grouping masks the stark difference in trends between the two regions: in Europe, suicide death rate declined by 40%, while in Northern America, the rate increased sharply by 41%. Latin America and the Caribbean also saw an increase of suicide death rate, by 15%.

There are concerns that suicides may be increasing during the COVID-19 pandemic. Based on the available data from the first months of the pandemic, there does not appear to be significant increases in high-income countries during this period. There are some suggestions that the picture may be different in low- and middle- income countries but it is not yet possible to be definitive about this due to the paucity of data from these countries. The relatively reassuring picture in high income countries should be interpreted with caution because the pandemic is still ongoing and suicide patterns may change over time. Many of the risk factors for suicide are being heightened by the pandemic, and some of these are yet to fully play out. People working in frontline services and for crisis lines report increased levels of distress. The economic consequences of the pandemic are of particular concern, and steps need to be taken to ensure appropriate safety nets are in place for people facing financial hardship because of the risk this poses for suicide.

Suicide death rate by region, 2000 and 2019



Additional resources, press releases, etc. with links:

- WHO Global Health Estimates 2019. Geneva: World Health Organization, 2020. <https://www.who.int/data/global-health-estimates>
- World Health Statistics 2021. Geneva: World Health Organization, 2021. <https://www.who.int/data/gho/publications/world-health-statistics>

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Custodian agency(ies):

WHO

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

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

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

WHO, UNODC

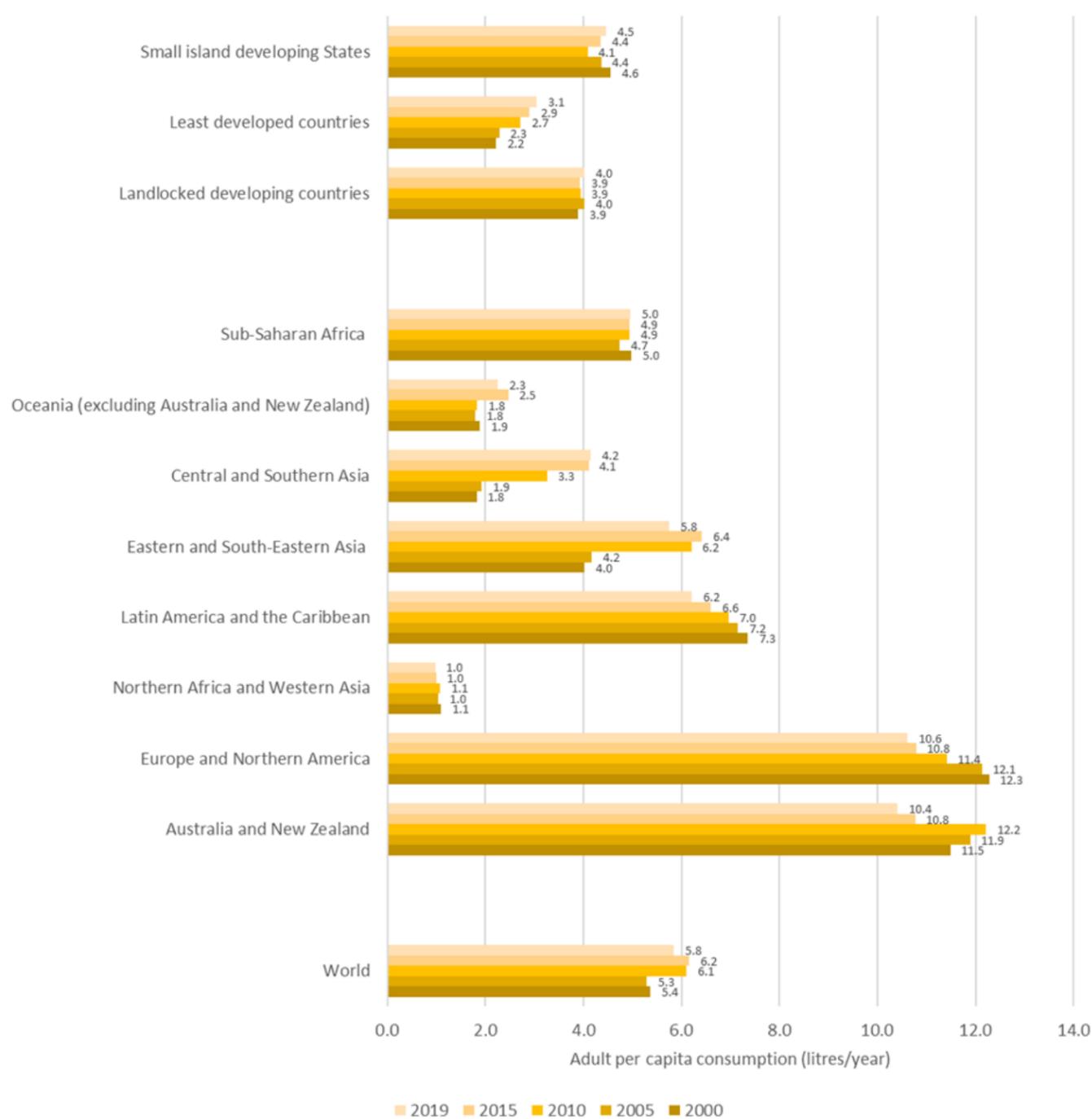
Indicator 3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
Harmful use of alcohol kills about 3 million people each year, most of them men

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

In 2019, alcohol consumption in the world, measured in litres of pure alcohol per person of 15 years of age or older, was 5.8 litres, which is a 5% relative decrease from 6.1 litres in 2010. Europe has the highest per capita consumption in the world (11.0 litres per capita in 2019), even though its per capita consumption has decreased by more than 10% since 2010. In all (SDG) regions, fewer women drink alcohol than men, and when they drink they drink less.

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

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



Additional resources, press releases, etc. with links:

- Global Information System on Alcohol and Health (GISAH): <https://www.who.int/data/gho/data/themes/global-information-system-on-alcohol-and-health>
- World Health Statistics 2021: <https://www.who.int/data/gho/publications/world-health-statistics>

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

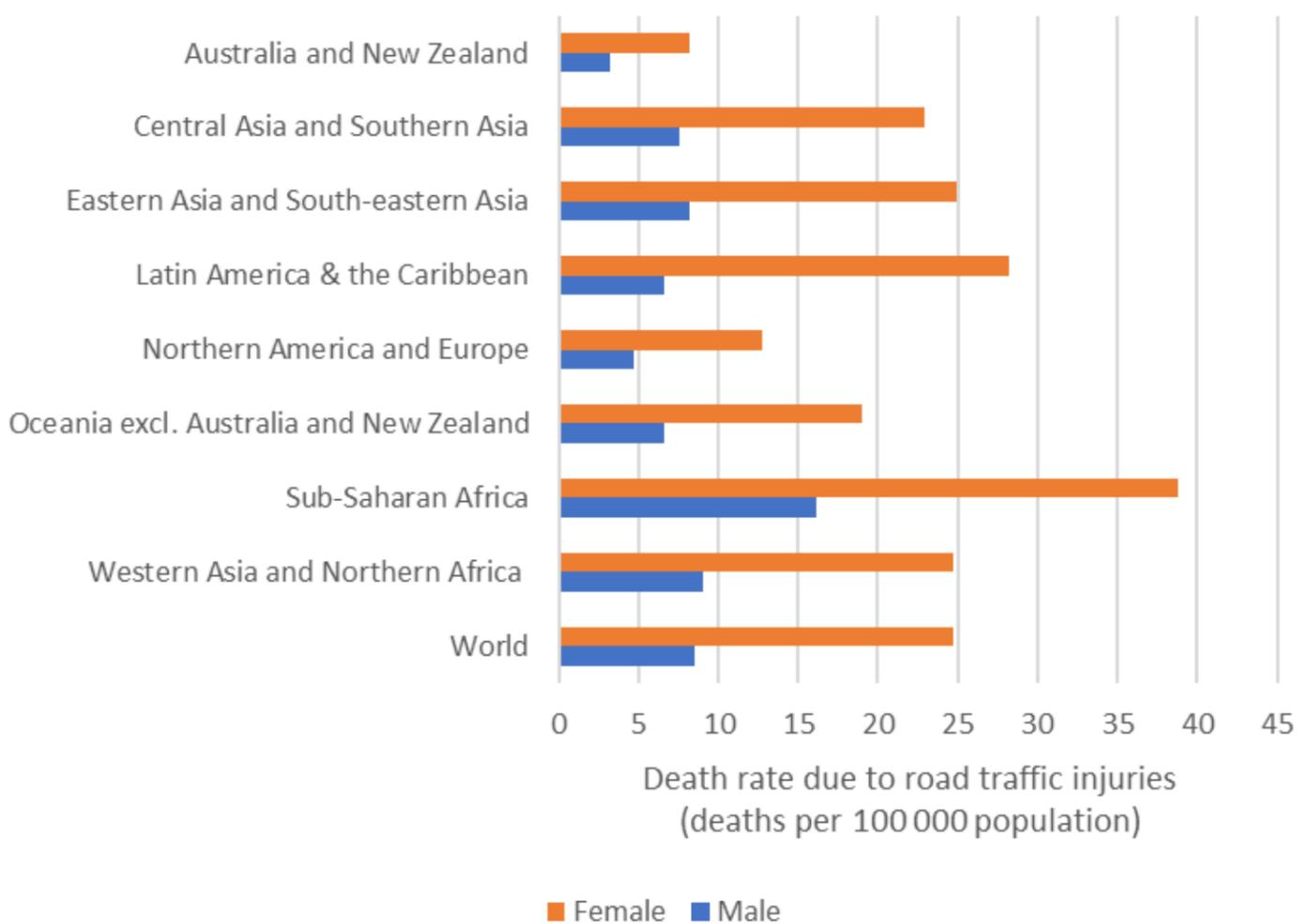
Indicator 3.6.1: Death rate due to road traffic injuries

Road traffic crashes killed about 1.3 million people worldwide in 2019. Latin America and the Caribbean had the largest gap in death rates between men and women (male death rate was four times female death rate), while Sub-Saharan Africa had the smallest gap (male death rate was 2.4 times female death rate). Both these regions had higher death rates due to road traffic injuries compared to the global average. The death rate was over 3.5 times higher in low-income countries than in high-income countries despite lower rates of vehicle ownership in low-income countries. The global mortality rate due to road traffic injuries declined by 8.3% from 18.1 deaths per 100 000 population in 2010 to 16.6 per 100 000 population in 2019. In addition to these deaths, road traffic crashes leave millions of people with non-fatal injuries every year. Road traffic injuries was the leading cause of death among young people aged 15-29 years worldwide, as well as among children aged 5-14 years in Latin America and the Caribbean, and among children and young people aged 5-29 years in Eastern Asia and South-eastern Asia, and Western Asia and Northern Africa

UN General Assembly resolution on road safety, 2020 (A/RES/74/299) proclaimed the period of 2021-2030 as the Second Decade of Action for Roads Safety and revised the target date of SDG target 3.6 from 2020 to 2030. The General Assembly called on Member States to continue working on the reduction in road traffic deaths and injuries to reach the target of halving road traffic deaths and injuries by 2030.

A comprehensive global assessment of the impact of COVID19 on road traffic injuries is currently lacking. However, there are preliminary regional and country studies. For example, an assessment conducted in the European Union shows that in April 2020, 910 people lost their lives in road collisions in the 25 countries of this region, compared to 1415 on average during 2010-2019, which shows that 505 (36%) deaths were prevented during COVID19.

Road traffic mortality by region, 2019



Additional resources, press releases, etc. with links:

- WHO Global Health Estimates 2019. Geneva: World Health Organization, 2020. <https://www.who.int/data/global-health-estimates>
- The impact of COVID-19 lockdowns on road deaths in April 2020: European Transport Safety Council, July 2020: <http://www.etsc.eu/pincovid19>

Custodian agency(ies):

WHO

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

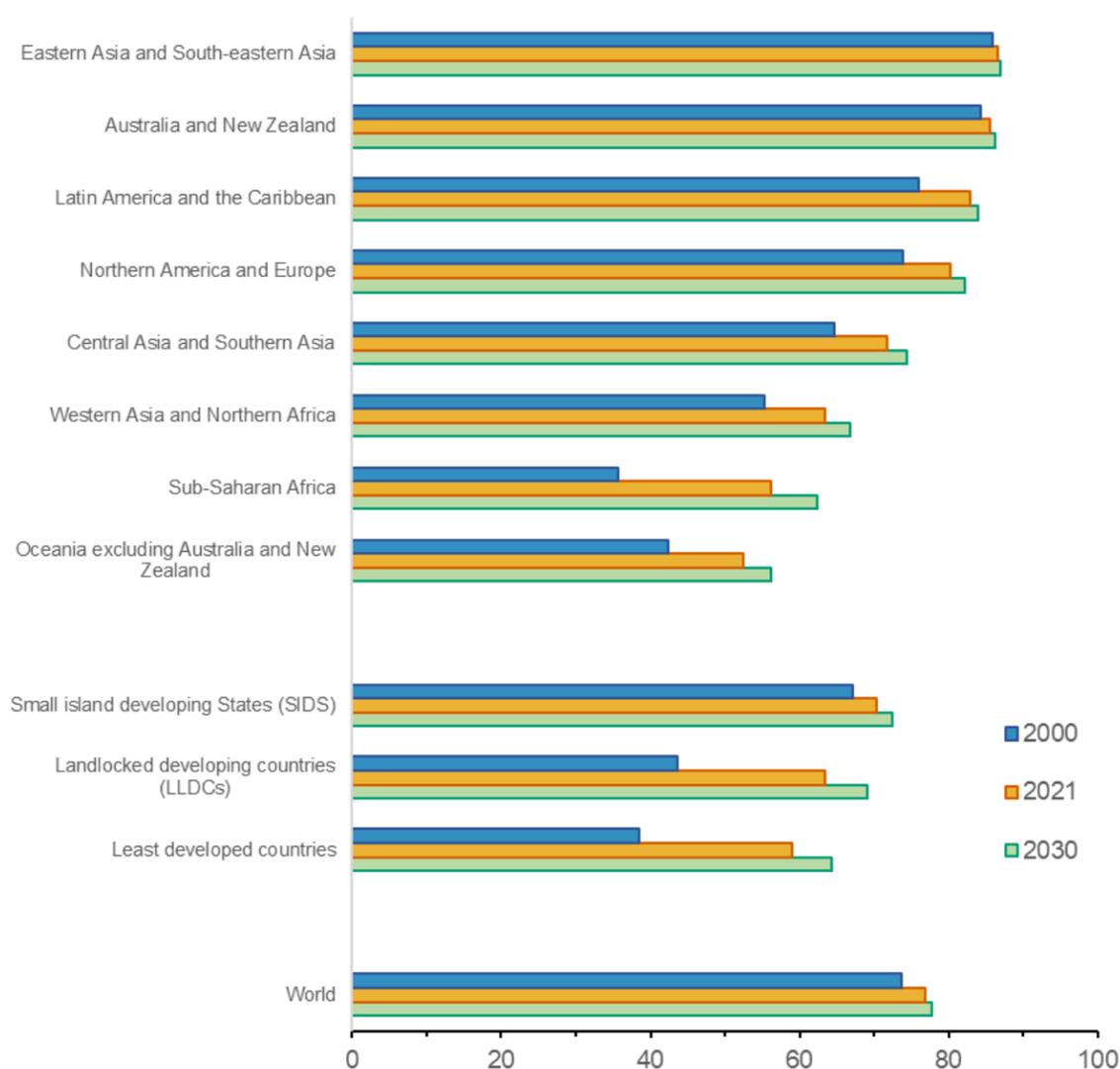
Indicator 3.7.1: Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods

In nearly all regions of the world, the proportion of women who have their need for family planning satisfied by modern methods has increased since 2000, but the COVID-19 pandemic adds to the uncertainty of achieving universal access to sexual and reproductive health-care services

The proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern contraceptive methods has increased worldwide from 74 per cent in 2000 to 77 per cent in 2021. The values for 2021 are projections based on past trends and do not account for the sudden disruptions caused by the COVID-19 pandemic in 2020 and 2021. In Eastern and South-eastern Asia and Australia and New Zealand, the proportion of women of reproductive age who have their need for family planning satisfied with modern methods has remained constant at a high level since 2000 (at 87 and 86 per cent in 2021, respectively). Other regions, however, have witnessed substantial growth in the proportion of need satisfied with modern methods over the same period. Central and Southern Asia, Latin America and the Caribbean, Northern America and Europe, Oceania (excluding Australia and New Zealand) and Western Asia and Northern Africa have increased the proportion of women using modern methods among those who have a need for family planning by 5 to 10 percentage points since 2000. Sub-Saharan Africa has experienced the greatest progress, where the proportion of need satisfied with modern methods increased from 36 per cent in 2000 to an estimated 56 per cent in 2021. That proportion is projected to reach 62 per cent by 2030 assuming a resumption of the previously projected trends, fully recovering from short-term COVID-19 disruptions. Despite the considerable progress made, in 2021 still more than a third of women in need of family planning are not using a modern method of contraception in Oceania (excluding Australia and New Zealand), sub-Saharan Africa, Western Asia and Northern Africa.

Globally, the number of women who want to avoid pregnancy but are not using any form of contraception has increased from 150 million in 2000 to 171 million in 2021 and is projected to remain roughly at that level until 2030. This is largely a result of growth in the number of women of reproductive age in need of family planning in sub-Saharan Africa, posing challenges to the expansion of reproductive health-care services to keep pace with these growing needs. In 2000, 19 per cent of the world’s women with an unmet need for family planning resided in sub-Saharan Africa; by 2021, this figure has increased to 26 per cent and is projected to reach 30 per cent in 2030. The ongoing COVID-19 pandemic may further increase the number of women with unmet need for family planning, as a result of supply-chain disruptions and decreased access to family planning services as well as changes in fertility intentions and family planning needs. These challenges underscore the need to build on the progress made over the past two decades and redouble efforts to make family planning accessible, available, and affordable for all.

Percentage of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern contraceptive methods in 2000, 2021 and projections for 2030



Source: United Nations, Department of Economic and Social Affairs, Population Division (2021). *Estimates and Projections of Family Planning Indicators 2021*. New York: United Nations.

Progress analysis: [3.7.1 progress analysis.zip](#)

Additional resources, press releases, etc. with links:

- Resources available at the family planning theme webpage of the Population Division: <https://www.un.org/development/desa/pd/themes/family-planning>
- <https://www.un.org/development/desa/pd/content/making-family-planning-count>
- Resources available at SDG Indicator 3.7.1 theme webpage of the Population Division: <https://www.un.org/development/desa/pd/data/sdg-indicator-371-contraceptive-use>

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

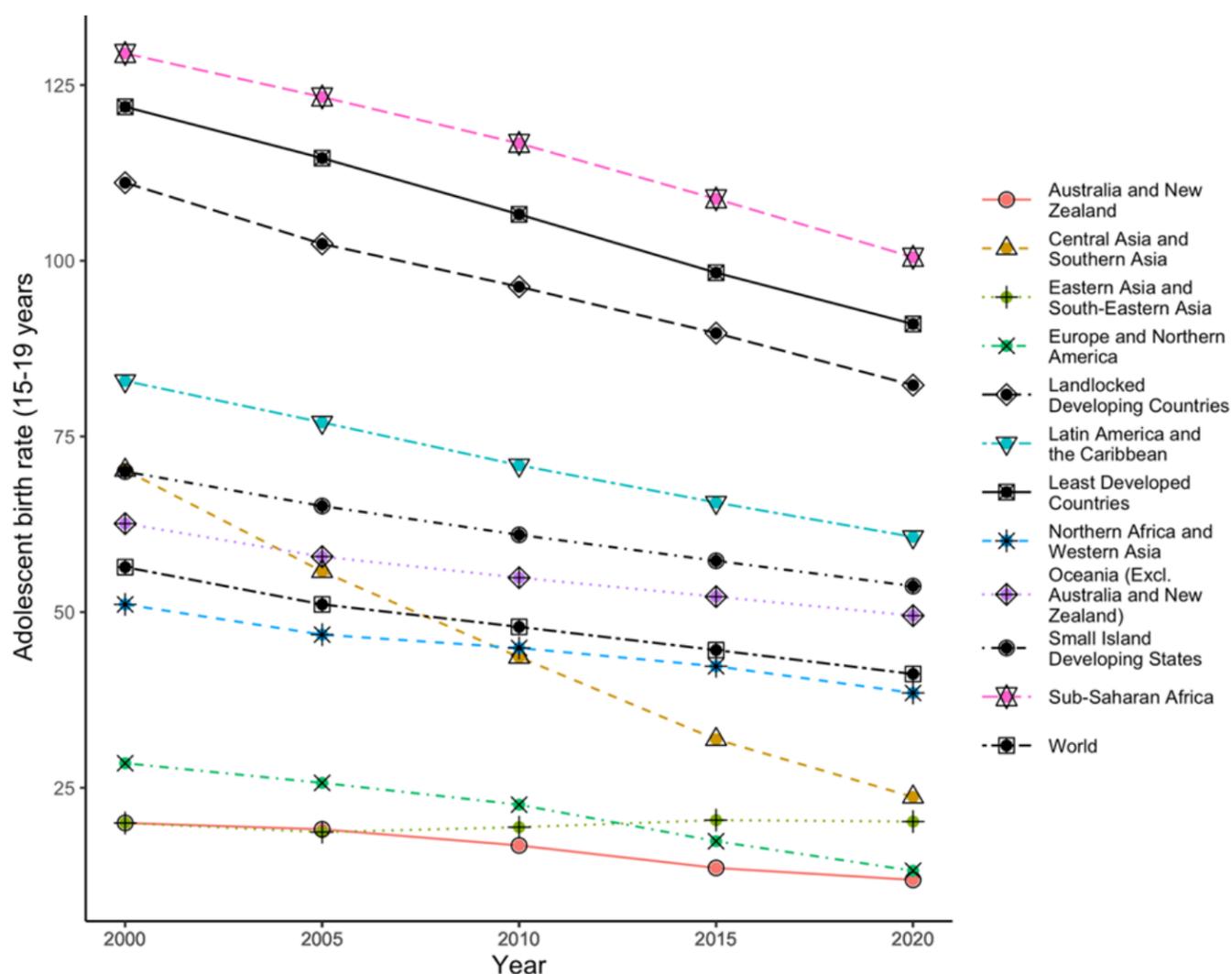
Reducing adolescent pregnancies and adolescent birth rates (the number of births per 1,000 women aged 15-19), is an important priority for the international community. The adolescent birth rate is an indicator of the effectiveness of measures taken to prevent unintended pregnancy and to ensure universal access to sexual and reproductive health-care services. Adolescent fertility is also linked to other Sustainable Development Goals—including ending poverty in all its forms, as poverty is associated to teenage marriages, pregnancies and births.

The decline in the adolescent birth rate has been almost universal since 2000 across major regions and countries. In 2020, the global adolescent birth rate was 41.2 births per 1,000 women aged 15-19 years, down from 47.9 in 2010 and 56.4 in 2000. A remarkable decline in the adolescent birth rate occurred in Central Asia and Southern Asia from 70.2 in 2000 to 23.7 in 2020. In regions that already had lower levels of the adolescent birth rate in 2000, the adolescent birth rate either stagnated (in Eastern Asia and South-eastern Asia), or declined more slowly (in Northern America and Europe, and Australia and New Zealand).

By 2020, the adolescent birth rate was below 50 per 1000 births in all regions except Sub-Saharan Africa and Latin America and the Caribbean. It remained high in landlocked developing countries, least developed countries and small island developing states, reflecting the association between adolescent birth rates and income levels and the challenges faced by these countries, many of which are located in Africa and in Latin America and the Caribbean.

In 2020, 71 per cent of adolescent women aged 15-19 lived in regions where the adolescent birth rate was below the global rate (41.2 per 1000 women). In two of these regions, Eastern Asia and South-Eastern Asia and Northern America and Europe, the number of adolescent women declined by 16 per cent between 2000 and 2020, and this resulted in reduced annual numbers of births. In Sub-Saharan Africa, despite a decline in the adolescent birth rate, the estimated annual number of births increased, from 4,510 in 2000 to 5,860 in 2020. This was due to an increase (of 67 per cent) in the population of adolescent women aged 15-19 years. The data on adolescent births for 2020 do not reflect the impact of COVID-19, which caused disruptions in all spheres of human activity, including data collection, public health, contraceptive supply chains and sheltering in place.

Adolescent birth rates, 2000 – 2020



Additional resources, press releases, etc. with links:

E-learning tool for Indicator 3.7.2:

- [E-Learning tool for SDG indicator 3.7.2 | Population Division \(un.org\)](#)
- [SDG indicator 3.7.1 E-Learning PowerPoint \(un.org\)](#)

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Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

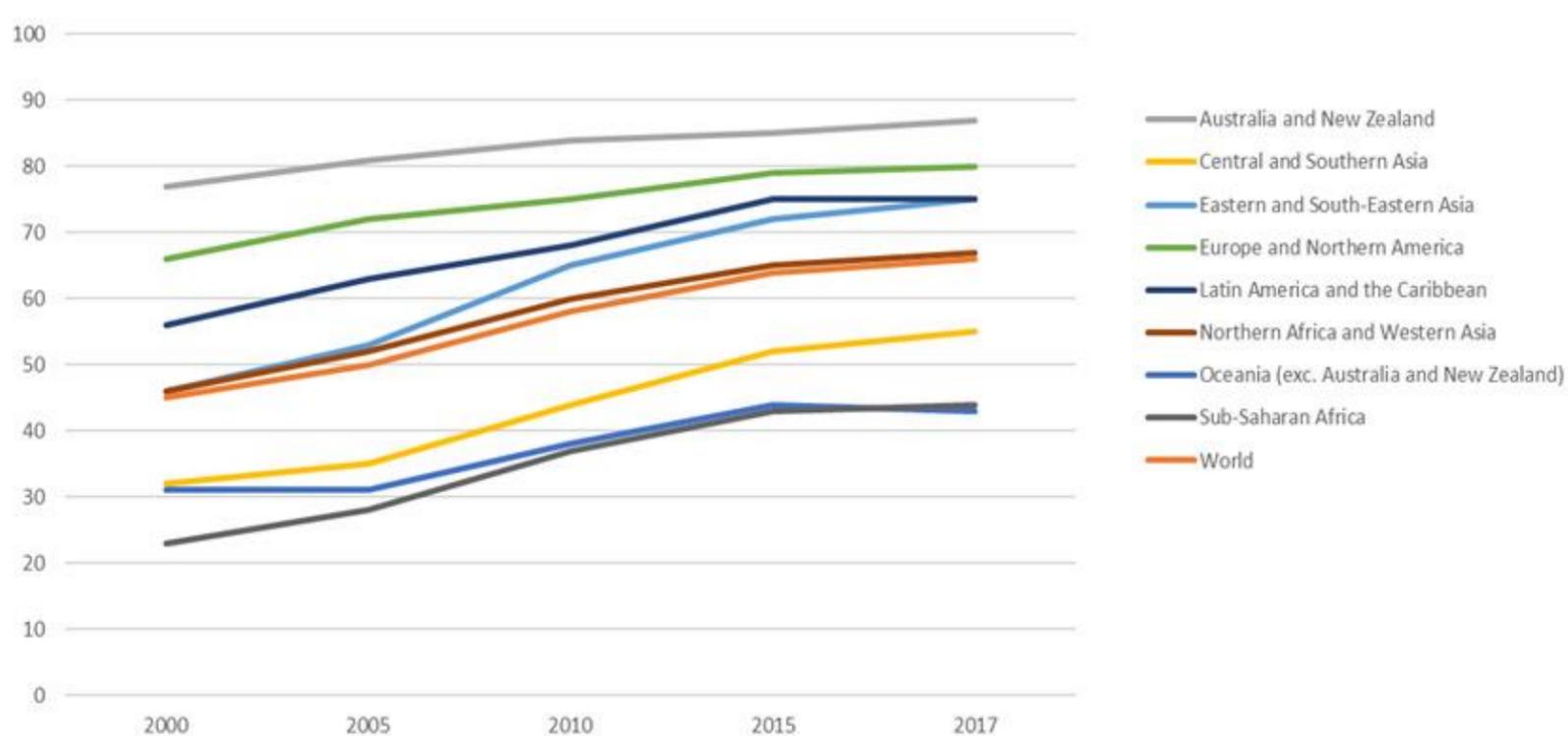
Indicator 3.8.1: Coverage of essential health services

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. Improvement in essential health services, measured by universal health coverage (UHC) service coverage index (SCI), increased from a global average of 45 (of 100) in 2000 to 66 in 2017. The fastest increases were seen in Sub-Saharan Africa and Central and Southern Asia, which started the millennium with some of the lowest values of SCI. Globally and for many countries, the pace of progress has slowed since 2010. The poorest countries and those affected by conflict generally lag furthest behind.

Supplementary analysis based on a complementary metric indicates that the number of people covered by essential health services in 2017 was between 2.5 to 3.7 billion, or around one third to half of the global population. If the trends observed between 2000 and 2017 continued, only 39% to 63% of the global population would be covered by essential health services by 2030.

The COVID-19 pandemic, however, is throwing progress even further off track. It has caused many deaths and suffering, overwhelmed health systems, and disrupted health services. Growth in the provision and use of essential health services must accelerate considerably if universal health coverage is to become a reality by 2030.

Universal Health Coverage (UHC) Service Coverage Index (SCI), by SDG region, 2000-2017



Additional resources, press releases, etc. with links:

- Primary health care on the road to universal health coverage: 2019 monitoring report. Executive summary. Geneva: World Health Organization, 2020.
- <https://www.who.int/publications/i/item/primary-health-care-on-the-road-to-universal-health-coverage-2019-monitoring-report>
- World Health Statistics 2021. Geneva: World Health Organization, 2021

Custodian agency(ies):

WHO

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

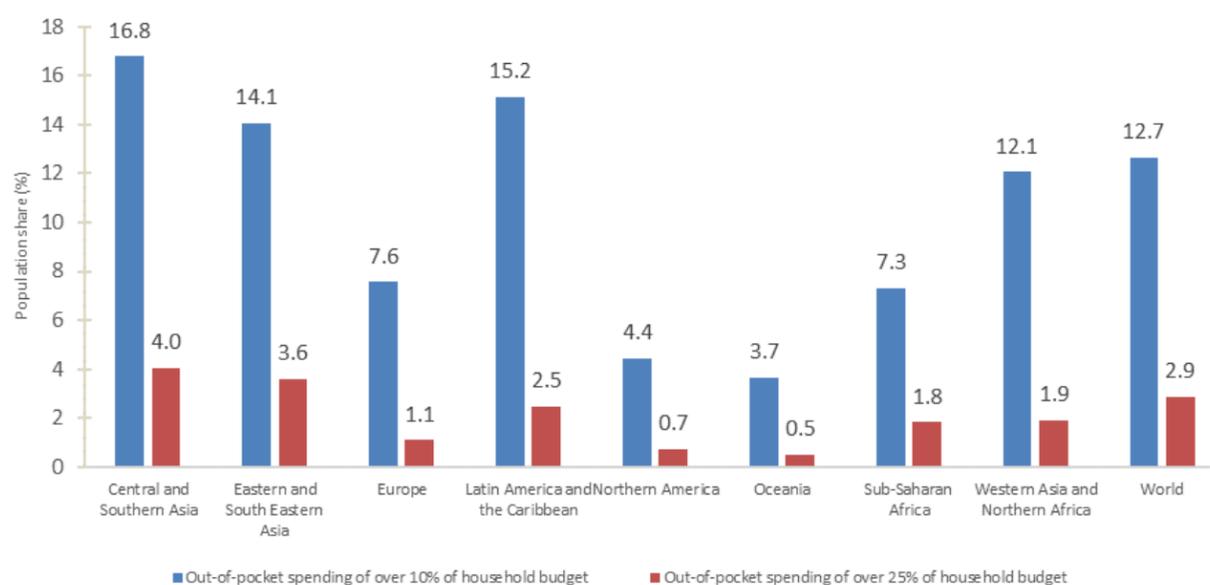
Out-of-pocket payments for health care absorbed more than 10% of the household's budget of 927 million people prior to the COVID-19 pandemic. With income shrinking, poverty levels increasing, out-of-pocket health spending will be an even greater threat to spending on other essential goods like food and education and source of barrier to access healthcare.

The impact of COVID-19 on the number of households spending a large share of their budgets on healthcare remains uncertain, as both household income and healthcare seeking are strongly affected. Prior to the pandemic, an estimated 927 million people, or 12.7% of the global population made out-of-pocket healthcare payments of more than 10% of their household budgets, and for 209 million, or 3%, the healthcare spending share exceeded 25%, posing an even greater threat to spending on other essential goods like food and education. The population shares affected by high out-of-pocket spending varied regionally, with particularly high rates in Asia and in Latin America and the Caribbean (Figure 1). Moreover, 87% of the people with medical spending of more than 10% of their household budget resided in middle-income countries as of 2015.

Globally, the share of the population with high medical spending has steadily risen since 2000, but whether this trend will continue, halt, or even be reversed by the pandemic remains uncertain as income shrinks in the current economic crisis and households increasingly forgo care due to diminished ability to pay or fear of contracting COVID-19 in healthcare settings. In the current context, it is even more important to analyse reductions in the proportion of people whose medical spending absorbs a large share of their household's budget along with changes in service coverage and access to services as people could be simply avoiding to seek needed care.

Before the pandemic, almost 90 million people, or 1.2% of the population worldwide, were pushed below the extreme poverty line of \$1.90 per person per day because of out-of-pocket medical payments. This statistic is not part of the SDG monitoring framework, but it is monitored by WHO and the World Bank to capture the impact of direct spending on health on poverty. Medical impoverishment was declining globally since 2000, as household incomes rose. The ongoing economic downturn threatens to reverse this progress, as with falling incomes those living with less than \$1.90 per person per day will be pushed further into poverty by out-of-pocket health payments and non-poor people will be more vulnerable to medical impoverishment, even if their healthcare spending diminishes in light of higher rates of forgone care.

Pre-pandemic population shares with large out-of-pocket health spending, 2015 estimates, by SDG region



Notes: household budgets are defined as household total consumption expenditures or income. Income is only used when there is no information on household consumption expenditures. Source: WHO & World Bank estimates based on [Global monitoring report on financial protection in health 2019](https://www.who.int/publications/m/item/global-monitoring-report-on-financial-protection-in-health-2019).

Additional resources, press releases, etc. with links:

- World Health Organization and World Bank, 2019. Global monitoring report on financial protection in health 2019
- World Health Organization, 2019. Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report.
- World Health Organization, 2020. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic.
- World Bank. 2020. Poverty and Shared Prosperity 2020: Reversals of Fortune. Washington, DC: World Bank.
- Links: https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/; <http://apps.who.int/gho/portal/uhc-financial-protection-v3.jsp>; <https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic>
- <https://openknowledge.worldbank.org/bitstream/handle/10986/34496/9781464816024.pdf>
- Website: https://www.who.int/health_financing/topics/financial-protection/en/; <http://datatopics.worldbank.org/universal-health-coverage/>

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WHO, World Bank

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

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

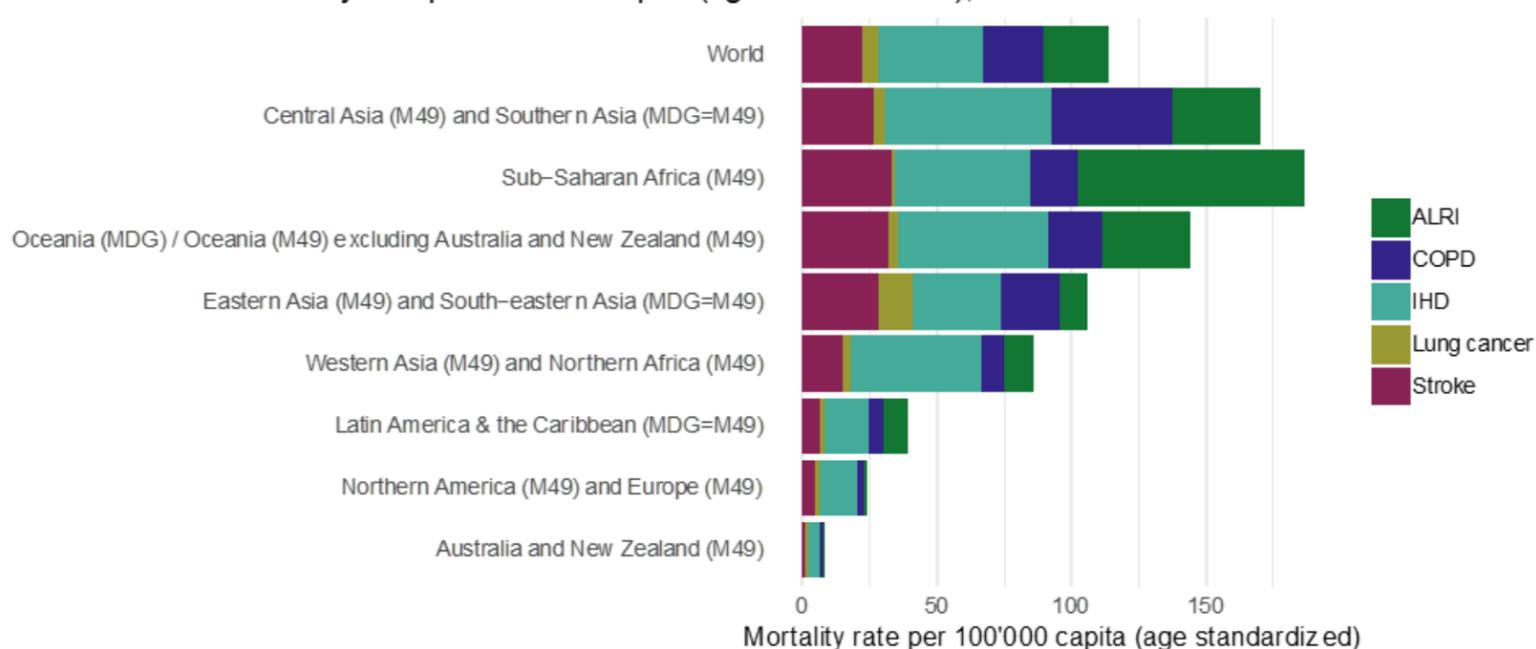
Air pollution may increase the number of people in the at-risk group for COVID-19

Air pollution from particulate matter, whether household or ambient increases the risk of cardiovascular disease, stroke, chronic obstructive pulmonary disease, lung cancer and acute lower respiratory infections, leading to some 7 million deaths worldwide. Non-communicable diseases such as chronic obstructive pulmonary disease (COPD, 18%), ischaemic heart disease (IHD, 34%), lung cancer (LC, 7%) and stroke (20%) account together for 79% of the total deaths due to air pollution, the remaining 21% are due to acute lower respiratory infection (ALRI).

The differences in the mortality rates attributable to air pollution, across the regions are not only due to different concentrations (population weighted) of ambient and household PM2.5 but also to the different age distribution and underlying disease prevalence. Furthermore, the relative contribution of the different diseases to the overall mortality due to air pollution related diseases varies by region, due to different population structure and main cause of deaths. Ambient and household have also different contributions to the overall burden due to air pollution, in the different regions. Sub-Saharan Africa, most of Asia and Oceania (excluding Australia/New Zealand), have the highest mortality rate from air pollution. This is largely due to the high levels of household air pollution exposure in these regions where a large proportion of the population still rely on polluting fuels and technologies for cooking, leading to around 4 million deaths worldwide. Health risks from household air pollution are particularly high among women and children, who tend to spend more time in and around the stove. In 2016, ambient air pollution from traffic, industry, power generation, waste burning and residential fuel combustion resulted in 4.2 million deaths.

The COVID-19 pandemic has shown that people with pre-existing chronic diseases, such as cardiovascular diseases, respiratory diseases, cancer and diabetes, were heavily over-represented among COVID-19 patients. These at risk groups have shown to be at higher risk of severe illness and death. As mentioned above, the same diseases are impacted by chronic exposure to air pollution. In addition, current scientific evidence suggests that air pollution weakens the immune system against infectious diseases. Hence it is critical to pursue efforts to mitigate air pollution levels and reduce exposure for the most vulnerable individuals.

Mortality rate per 100'000 capita (age standardized), in 2016



Custodian agency(ies):

WHO

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

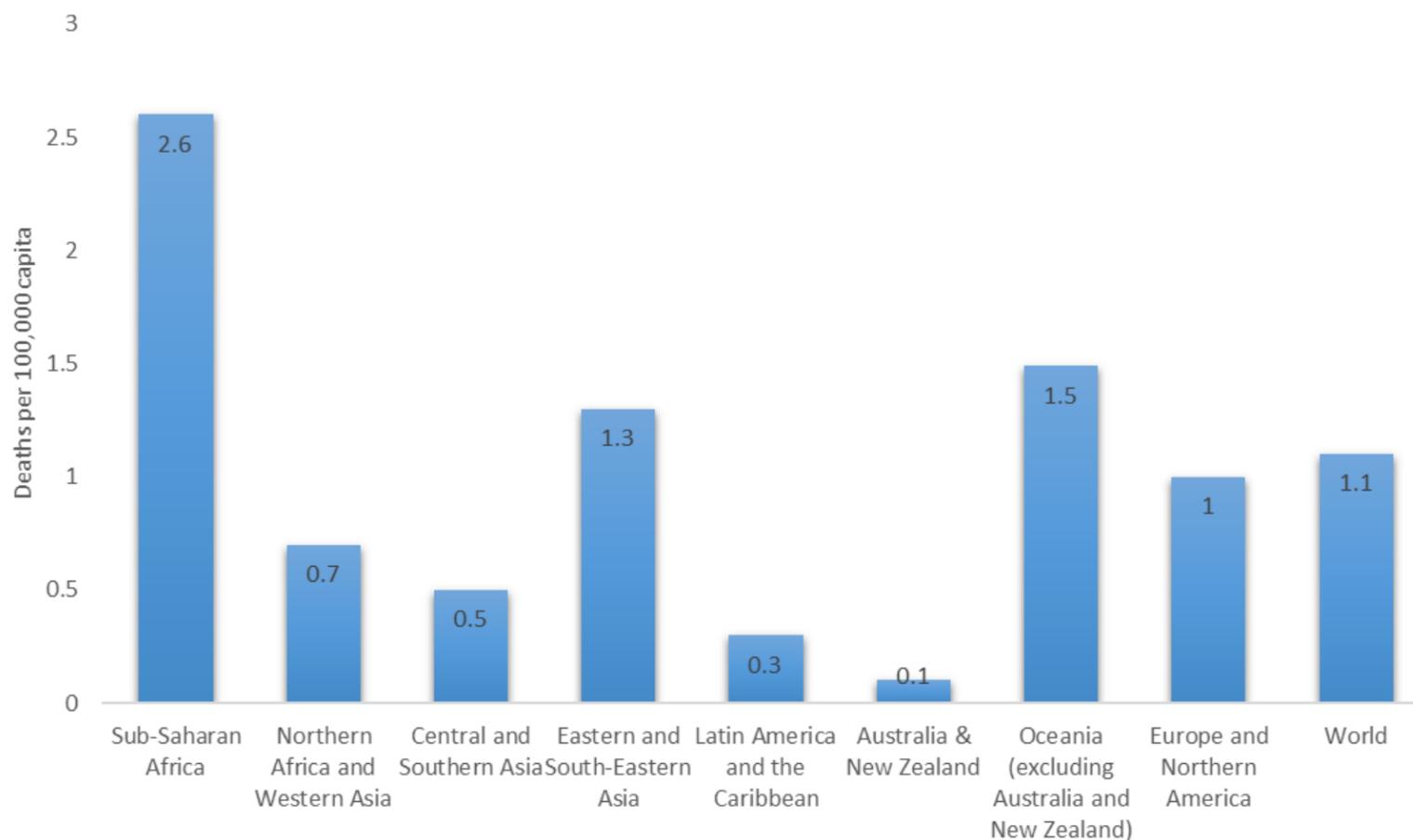
[Custodian agency\(ies\):](#)

WHO

Indicator 3.9.3: Mortality rate attributed to unintentional poisoning

Unintentional poisonings were responsible for more than 84 000 deaths in 2019. Although the number of deaths from unintentional poisonings has steadily declined since 2000, mortality rates continue to be relatively high in low-income countries (over two times the global average). A third of all deaths from unintentional poisonings occurred in Sub-Saharan Africa alone. Due to occupational exposures, deaths rates from unintentional poisonings are lower in females compared to males – more than 40% lower on a global basis. Unintentional poisoning can be caused by household chemicals, pesticides, kerosene, carbon monoxide and medicines or can be the result of environmental contamination or occupational chemical exposure.

Death rate from unintentional poisonings, 2019 (by SDG region)



Additional resources, press releases, etc. with links:

- Public health impact of chemicals: knowns and unknowns (will be updated in 2021) <https://www.who.int/publications/i/item/WHO-FWC-PHE-EPE-16.01-eng>

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WHO

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

Indicator 3.a.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older
[Custodian agency\(ies\):](#)

WHO, WHO-FCTC

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

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

Progress analysis: [See progress chart](#)

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

WHO, UNICEF

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

ODA for basic health from all donors has increased by 59% in real terms since 2010 and reached USD 11 billion in 2019. The Global Fund, GAVI and the United States accounted for more than half of this total, providing, USD 2.4 billion, USD 1.9 billion and USD 1.8 billion respectively. In 2019, about USD 3.4 billion were million was spent on basic health care, USD 2.2 billion on infectious disease control, excluding HIV/AIDS and USD 2.2 billion on malaria control.

Custodian agency(ies):

OECD

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

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

WHO

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

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

COVID-19 pandemic highlights the crucial role of health and care workers in health service delivery

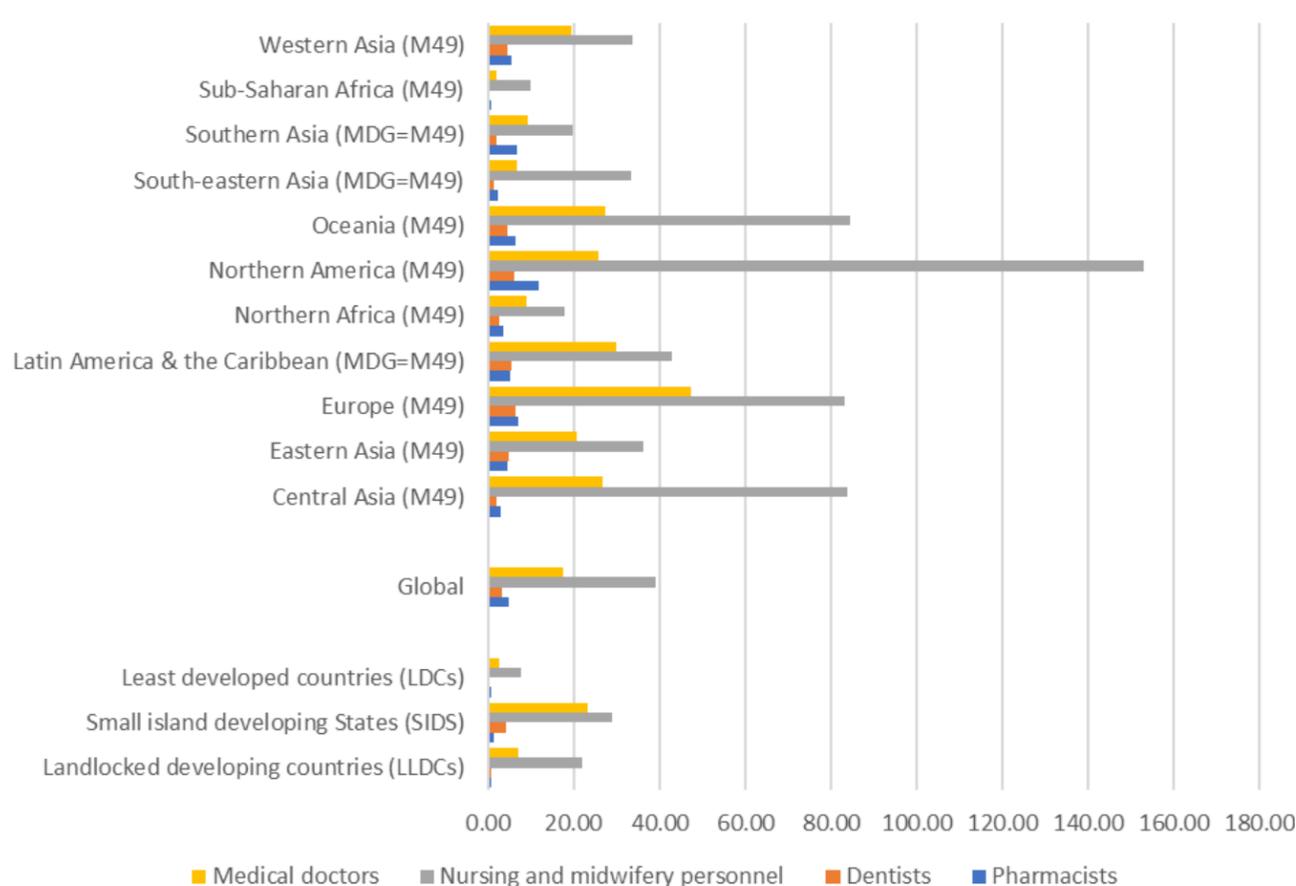
The COVID-19 pandemic has disrupted countries' economies and continues to test the resilience of national health systems. The global focus on the health workforce stands at peak levels. The global response to the pandemic demonstrates the crucial role health workers in each and every measure of public health capacity, exposing their inequitable availability, and unassured safety and wellbeing. Global solidarity actions and initiatives are urgently needed to protect and invest in a global health workforce that can deliver on equitable and quality-driven essential health services.

Honouring the dedication and sacrifice of the health and care workers, be it in a prime or emergency setting, as that entailed by a global pandemic such as COVID-19, the 73rd World Health Assembly declared 2021 as the International Year of Health and Care Workers (YHCW).

In 2016, WHO Member States adopted the Global Strategy on HRH: Workforce 2030, and through it the implementation of the National Health Workforce Accounts (NHWA)⁵. This has paved the way to expand the scope and demand for health workforce data availability and quality. Today, the NHWA offers global, reliable and annually updated information on the demographics, distribution and mobility patterns of health workers to address national, regional and global level health workforce challenges. Countries progressive implementation of NHWA, with support from WHO at three-levels, is an evidence-based roadmap to strengthen their human resources for health information systems. Ultimately, every country attains increased capacities to plan, implement and monitor its health workforce policies to achieve UHC and the health and health-related SDGs.

In the past two decades, data collected on the health workforce unequivocally displayed that health workers are distributed unevenly within and between countries globally. Regions with the highest burden of disease have the lowest proportion of health workforce to deliver the health services. Even when national densities are sizeable, disparities in densities persist between rural, remote and hard to reach areas compared to capital cities and urban centers. Nurses constitute the single largest category of health workers in all regions, sometimes twice the number of medical doctors, in many countries and WHO regions. The density of nursing and midwifery personnel in North America is over 150 per 10,000 population, which is almost twice that in Oceania, Europe and Central Asia. The density of medical doctors in North America, Oceania, Europe and Central Asia remain around 25 per 10,000 population. Conversely, the Sub Saharan African region remains with the lowest density of medical doctors (2 per 10,000 population), and, nursing and midwifery personnel (less than 10 per 10,000 population).

Density of select health professionals per 10,000 population, 2013-2019 (latest available)



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WHO

⁵ National Health Workforce Accounts: <http://www.who.int/hrh/statistics/nhwa/en/>

WHO 2016 - Global strategy on human resources for health (GSHRH): http://who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf?ua=1

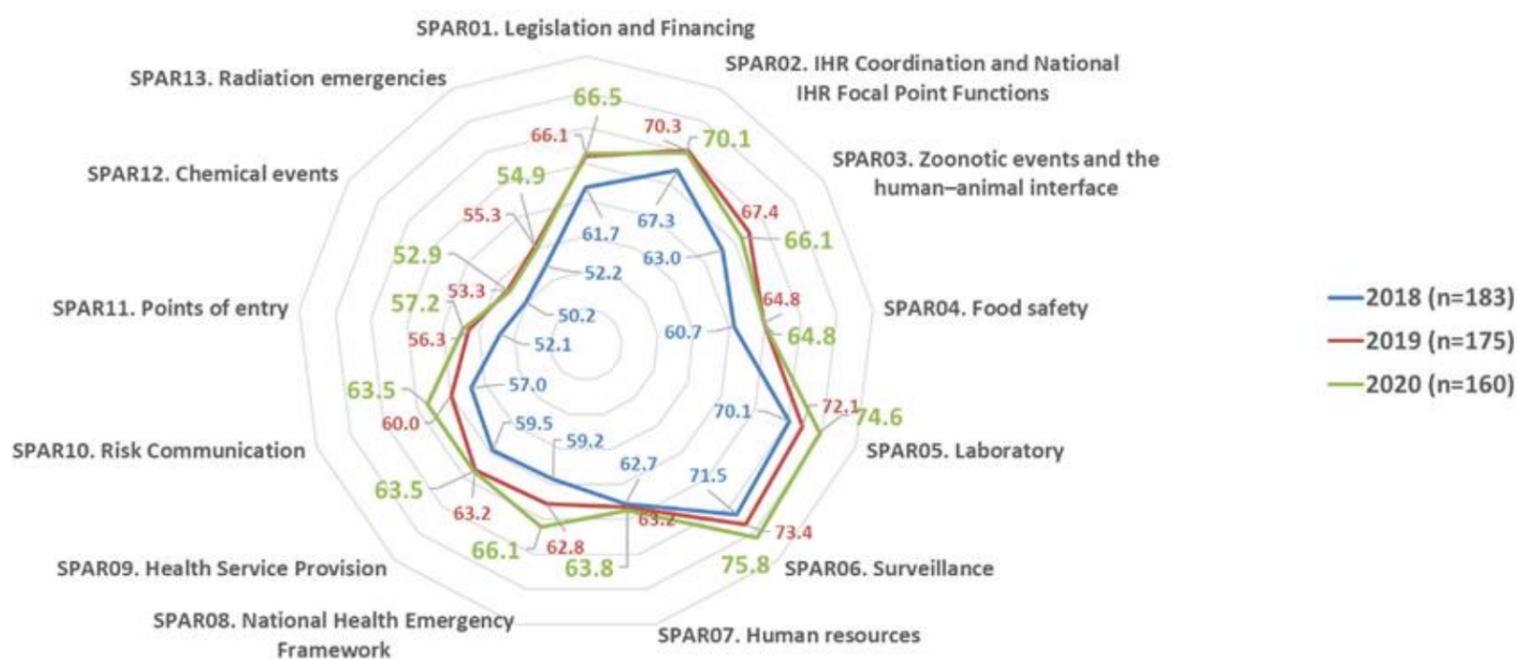
Target 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

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

Covid-19 experience shows clear need of a coordinated multi-sectoral health emergency surge capacity and preparedness at all levels of country

The current experience with the COVID-19 pandemic continues to show the challenges countries face scaling up existing capacities for public health emergency response at all levels and to maintain the multisectoral coordination and international collaboration. The COVID-19 has also impacted on the activity of national self-assessment and reporting of the status of implementation of the International Health Regulations (2005). As of 01.04.2021, 160 countries reported their data for 2020, against the 175 countries that reported by July 2019 and the 183 countries that reported in 2018, on their capacities required under the IHR (2005). The data analysis shows stability and steady progress since 2018 in almost every core capacity except for a small reduction observed in 2020 on the capacities related to zoonotic events and human-animal health interface and chemical events. Although more work remains to be done in most areas measured by the indicators, the 2020 reports provided clear evidence of the strong political commitment to fulfil obligations under the International Health Regulations. They also showed that continuing efforts are needed to improve and maintain early warning systems and to mitigate and manage public-health risks within the national context and to consider world-wide pandemic context for national health emergency operational preparedness planning. Lower scores were found in regard to capacities required at points of entry (ports, airports and ground crossings), chemical events and radiation emergencies, but these scores may also reflect to different need of these capacities, according to specific national contexts.

SDG Indicator 3.d.1 - IHR STATE PARTIES ANNUAL REPORTS
Score in percentage by capacities according to the International Health Regulations
SPAR2018 - SPAR2019 - SPAR2020 (as reported in 01.04.2021)



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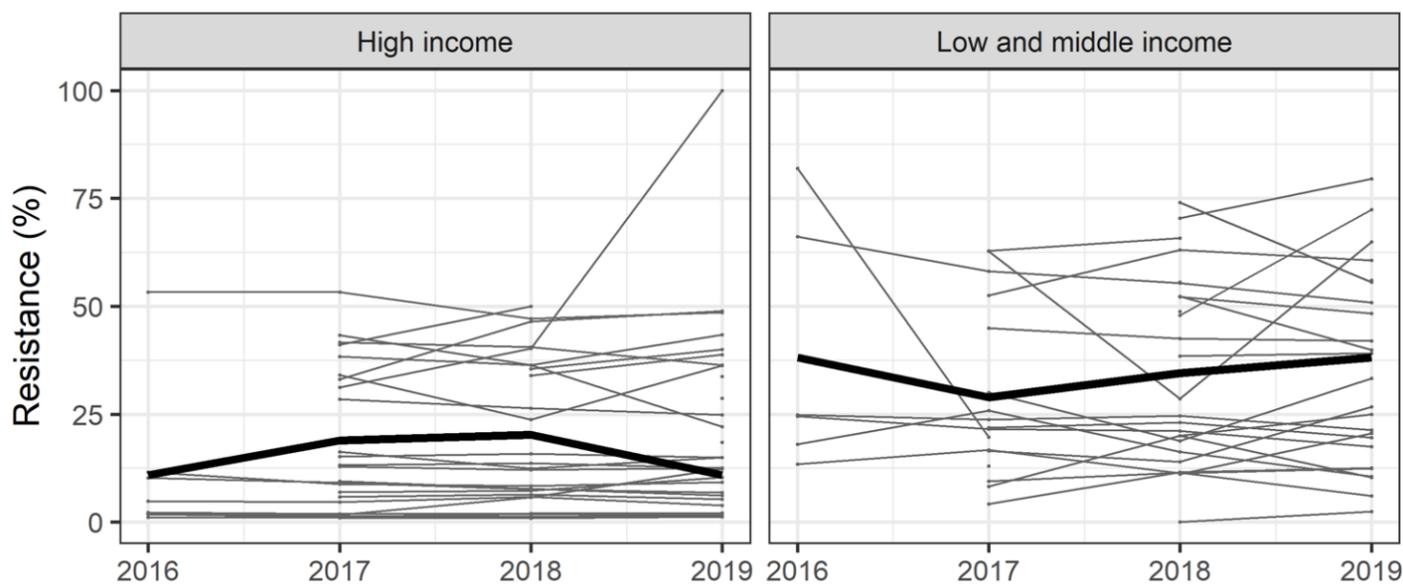
[Custodian agency\(ies\):](#)

WHO

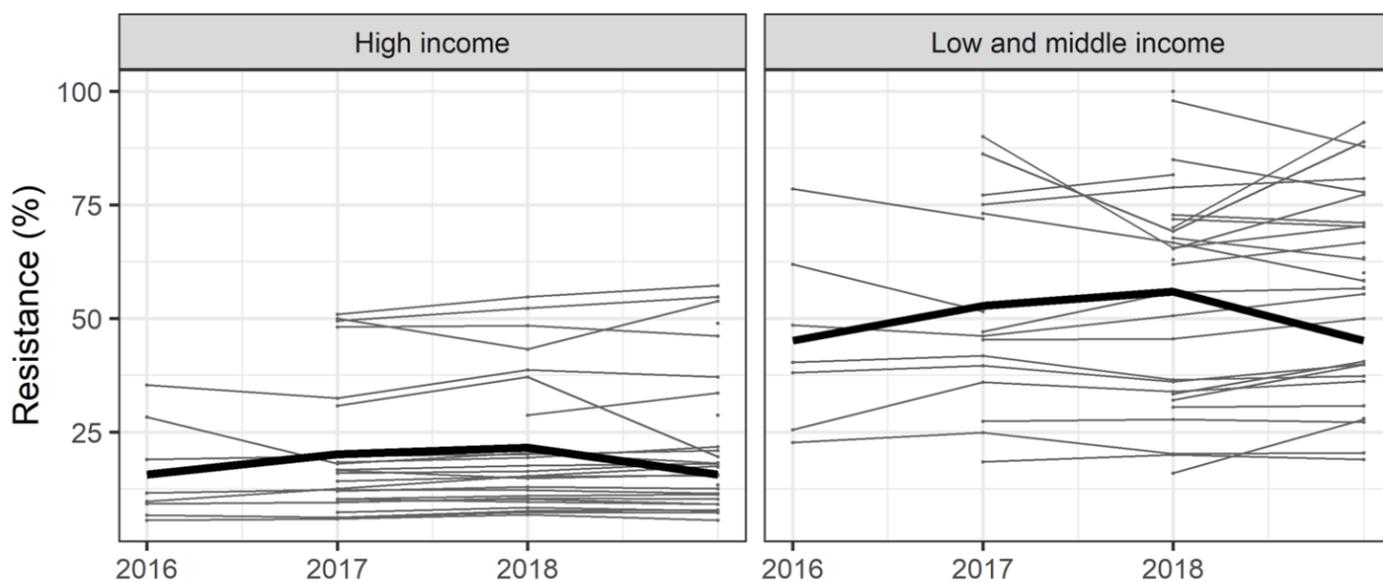
Indicator 3.d.2: Percentage of bloodstream infections due to selected antimicrobial-resistant organisms

A new SDG indicator of antimicrobial resistance in two pathogens responsible for bloodstream infections and linked to target 3.D “strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks” was added in 2020 to the list of SDG indicators (tier 2). The first measure included in the indicator is the proportion of bloodstream infections due to E. coli resistant to 3rd generation cephalosporins, reported by 60 countries for the year 2019 (global median, 37% with resistance, interquartile range (IQR) 17-58%). The second measure is the proportion of methicillin-resistant Staphylococcus aureus, reported by 54 countries for 2019 (global median 25% with resistance, IQR 11-40%). Resistance rates for the two pathogens do not show interpretable time trends over time but lower values are observed in the group of high-income countries (Figure). National representativeness of the reported data remains problematic particularly in low-resourced countries generally still at an early stage of antimicrobial resistance surveillance.

Proportion of patients with BSIs caused by E. coli resistant to 3rd generation cephalosporins by countries income level



Proportion of patients with BSIs caused by MRSA, by countries income level



Additional resources, press releases, etc. with links:

- GLASS web portal: <https://www.who.int/initiatives/glass>

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