WORLD HEALTH STATISTICS

2021

MONITORING HEALTH FOR THE SDGs

SUSTAINABLE DEVELOPMENT GOALS

World Health Organization

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The World health statistics report is the World Health Organization's (WHO) annual compilation of the most recent available data on health and health-related indicators for its 194 Member States. The 2021 edition features the latest data for 50+ health-related indicators from the Sustainable Development Goals (SDG) and WHO Triple Billion targets. The 2021 report additionally focuses on the human toll and impact of the coronavirus disease 2019 (COVID-19) pandemic, highlighting the importance of tracking inequalities and the urgency to accelerate progress to get back on track and recover equitably with the support of robust data and health information systems.

World health statistics 2021: monitoring health for the SDGs, sustainable development goals

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FOREWORD

When the World Health Statistics was released last year, we were still in the early stages of the COVID-19 pandemic. Countries were responding rapidly under uncertain conditions, frontline health workers were making heroic efforts to contain the spread of the virus, and governments and partners were scrambling to assist those in need.

One year on, the world has made great strides. But the race against this coronavirus and its variants is still on, and there is still much work to be done. At the time of writing, more than 160 million confirmed COVID-19 cases and 3.3 million deaths had been reported to WHO. Yet these numbers are only a partial picture, as many countries have not been able to accurately measure and report on deaths that are either directly or indirectly attributable to COVID-19.

One of the greatest lessons from the pandemic is the importance of timely, reliable, actionable and disaggregated data. This requires strong country data and health information systems through collaboration between governments, ministries of health, national statistical offices, and registrar generals. It also requires engagement with the private sector, academia, nonprofit organizations, and the scientific community to ensure data is accessible as a public good

WHO's World Health Statistics report 2021 presents the latest data for more than 50 health-related indicators for the Sustainable Development Goals and WHO's "triple billion" targets.

It finds an overall increase in global life expectancy and healthy life expectancy at birth as a result of improvements in several communicable diseases, maternal, perinatal and nutritional conditions, noncommunicable diseases, injuries and their underlying determinants. Persisting inequalities also continue to impact population health in most, if not all, aspects. Despite the overall improvement in service coverage, between and within countries disadvantaged populations still have lower access to care and are at greater risk of facing catastrophic costs.

While premature deaths from noncommunicable diseases – the world's leading cause of death – continue to fall, progress has slowed in recent years and key risk factors including tobacco use and alcohol consumption, hypertension, obesity, and physical inactivity will require urgent and targeted intervention.

Deaths from communicable diseases have also declined but continue to claim millions of lives each year, particularly in lower-resource settings where many people cannot access quality health services. There has also been a steady decrease in mortality from suicide, homicide, unintentional poisoning and road traffic injuries, but many more of these deaths can still be prevented and men are at higher risk of dying from these causes than women.

To close these gaps and meet the global goals, we must continue to focus on the equitable distribution of services and access to quality, affordable healthcare and effective interventions in all countries and for all populations. We must also be on alert that COVID-19 has disrupted many essential services and that the distribution of health and care workers varies widely, with the lowest density of medical doctors, nurses and midwives in the areas where they are needed most. Out-of-pocket spending on healthcare is also on the rise, with the most vulnerable populations at greatest risk of being pushed into poverty, thus further widening inequalities.

Real-time, quality data to track population health is critical for every country to improve health outcomes and eliminate health inequalities. WHO is committed to work with countries and partners to strengthen health information systems and support data-driven policies and interventions. COVID-19 is not the first pandemic and likely will not be the last. In order to be better prepared we must have better data.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

ABBREVIATIONS AND ACRONYMS

AAR	After Action Review
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
ARR	annualized rate of reduction
ASR	age-standardized rate
BMI	body mass index
CDR	crude death rate
COPD	chronic obstructive pulmonary disease
COVID-19	coronavirus disease (2019)
CRD	chronic respiratory disease
CRVS	civil registration and vital statistics
CVD	cardiovascular disease
DALY	disability-adjusted life year
DBP	diastolic blood pressure
DHS	demographic and health survey
DTP3	diphtheria, tetanus and pertussis vaccine (third dose)
FCTC	Framework Convention on Tobacco Control
GHO	Global Health Observatory
GLASS	Global Antimicrobial Resistance and Use Surveillance System
GPMB	Global Preparedness Monitoring Board
GPW 13	Thirteenth General Programme of Work
HALE	healthy life expectancy
HCW	health and care workers
HEPI	Health Emergencies Protection Index
HIC	high-income country
HIV	human immunodeficiency virus
HWF	health workforce
IHR	International Health Regulations (2005)
IHR MEF	International Health Regulations Monitoring and Evaluation Framework
IPV	intimate partner violence
IQR	interquartile range
KAP	knowledge, attitudes and practices
LE	life expectancy
LIC	low-income country
LMIC	lower middle-income country
MICS	multiple indicator cluster survey
MMR	maternal mortality ratio

NCD	noncommunicable disease
NHWA	National Health Workforce Accounts
NTD	neglected tropical disease
ODA	official development assistance
$PM_{2.5}$	particulate matter 2.5 micrometres or less in diameter
RMNCH	reproductive, maternal, newborn and child health
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SBP	systolic blood pressure
SCI	service coverage index
SDG	Sustainable Development Goal
SimEx	Simulation Exercises
SPAR	State Party self-assessment and reporting tool
SPH	Strategic Partnership for Health Security and Emergency Preparedness
TB	tuberculosis
TFA	trans-fatty acid
UHC	universal health coverage
UHC SCI	universal health service coverage index
UN-DESA	United Nations Department of Economic and Social Affairs
UI	uncertainty interval
UMIC	upper middle-income country
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization
WHS+	World Health Survey Plus
YLD	years lived with disability

INTRODUCTION

The *World health statistics* report is the World Health Organization (WHO) annual compilation of the latest available data on health and health-related indicators for its 194 Member States. The report is produced by the WHO Division of Data, Analytics and Delivery for Impact, in collaboration with WHO technical departments and regional offices. The 2021 edition features the latest data for more than 50 health-related indicators from the Sustainable Development Goals (SDG) and the WHO Triple Billion targets. In the WHO Thirteenth General Programme of Work (GPW 13), all Member States are committed to deliver on the Triple Billion targets and to accelerate progress towards the 2030 Agenda for Sustainable Development as informed by national data and health information systems.

As the COVID-19 pandemic is unfolding and countries are responding, critical inequalities have surfaced, demanding global cooperation and concerted action to be better prepared to respond to this and other global health threats. With newly-confirmed COVID-19 cases at an all-time high globally, the scale of transmission elevates the risk of potentially more contagious, lethal and/or immune-evasive variants. The pandemic is entering a new phase characterized by a dramatic shift of its epicentre to the developing world, jeopardizing the world's collective goal to end it and risking further setbacks to the entire sustainable development agenda.

The commitment to "leave no one behind" is a cornerstone of the 2030 Agenda for Sustainable Development. But within and between countries, high and rising inequalities act as both visible and concealed impediments to progress in population health and human, social and economic development. Reducing inequality is a discrete SDG (SDG 10) and is vital to achieving all SDGs including ending poverty (SDG 1), ending hunger (SDG 2), ensuring healthy lives (SDG 3), ensuring inclusive and equitable quality education (SDG 4) and achieving gender equality (SDG 5).

Using both between country and within country inequality lenses, this report presents in Section 1 the latest available data on COVID-19: including cases, deaths, vaccination, disruptions to health services, impact on health workers, migrants and refugees and related data gaps. Section 2 summarizes the recent trends and levels in life expectancy, healthy life expectancy, and global and regional burden of disease and injuries. Section 3 addresses various behavioural, environmental and metabolic risk factors that comprise the underlying drivers of existing disease burden. Section 4 centres around universal health coverage (UHC), describing the trends in both service coverage and financial protection, with a closer look at different types of tracer interventions, including services for reproductive, maternal, newborn and child health (RMNCH), services for communicable diseases, health workforce (HWF) and health security. Section 5 concludes the report with a summary of recent progress towards and projections for achieving the Triple Billion targets and opportunities for accelerating progress towards the health-related SDGs by reducing health inequalities and strengthening data and health information systems.

KEY MESSAGES

COVID-19 poses major challenges to population health and well-being globally and thwarts the progress in meeting SDGs and the WHO Triple Billion targets.

Emerging only at the end of 2019, the COVID-19 pandemic has quickly become a global threat to population health, infecting over 153 million people, devastatingly costing more than 3.2 million lives by 1 May 2021 globally. COVID-19 has become a leading cause of death, caused a considerable number of additional deaths indirectly at global, regional and national levels and has inevitably shortened life expectancy in many countries, with still unknown long-term impact on morbidity. Preliminary WHO estimates suggest the total global excess deaths attributable to COVID-19, both directly and indirectly, amounts to at least 3 million in the year 2020. This is 1.2 million deaths more than the reported 1.8 million global COVID-19 deaths.

Acceleration of development, production and distribution of COVID-19 vaccines is underway in countries and through international cooperation including the COVAX initiative. However, fair and equitable access to the vaccines is far from being achieved, and the inequality across income groups is pronounced with only 1% of doses going to low Income countries as compared to the 19% administered in lower -middle-income countries, 33% in upper -middle-income countries and 47% in high-income countries as of 1 May 2021. Pre-pandemic inequalities have driven the unequal global distribution of vaccines and run the risk of perpetuating the pandemic, which in turn has amplified existing inequality and risks throwing the entire 2030 sustainable development agenda off-track. Achieving equal global vaccination is imperative, or the risk of a more virulent or transmissible variant remains high: no one is safe until everyone is safe.

Disruptions of essential health services due to COVID-19 have been widespread due to the shortage of medicines, staff, diagnostics and public transport services. The second WHO "pulse survey" of 135 countries and territories highlights persistent disruptions at a considerable scale over one year into the COVID-19 pandemic, with 90% of countries reporting one or more disruptions to essential health services. Improvements were seen within countries, however, with average reported disruptions in essential health services decreasing from about half in 2020 to just over one third in the first quarter of 2021. In response to service disruptions, the majority of countries are implementing mitigation strategies and approaches including community communications, triaging to identify priorities, recruitment of additional staff, and provision of home-based care.

COVID-19 is disproportionately impacting vulnerable populations, including the economically disadvantaged, older adults and those who live in congregate residential settings or with existing underlying health conditions. This draws further attention to persistent inequalities in both health outcomes and health determinants, including risk factors, social determinants and access to health services, within and across countries. The pandemic poses critical challenges to the health systems in low-resource settings and is jeopardizing the hard-won health and development gains towards achieving the WHO Triple Billion targets and UN Sustainable Development Goals (SDGs). However, the lack of disaggregated COVID-19 data and strong data infrastructure with good vital registration systems limits the development of more effective and better targeted policies and the allocation of resources that are data-driven for mitigating the pandemic situation and restoring progress towards the Triple Billion targets and SDGs.

Prior to the COVID-19 pandemic, improvements in health were made. However, the progress is inadequate for attaining the Triple Billion targets and health-related SDGs, calling for more effective disease and injury prevention and control programmes.

The global population continues to live longer and live more years in good health. Between 2000 and 2019, global life expectancy (LE) at birth increased from 66.8 years in 2000 to 73.3 years in 2019, and healthy life expectancy (HALE) increased from 58.3 years to 63.7 years. Sharing similar increasing trends but starting with different

baselines, LE and HALE among females were consistently higher than males. LE and HALE also rise with national income levels, however, the greatest improvements were observed in LICs, gaining over 11 years in LE and nearly 10 years in HALE in 2000 to 2019, predominantly reflecting the remarkable progress made in reducing mortality among children under 5 years of age. While both were rising, LE was improving moderately faster than HALE worldwide, leading to a slightly higher proportion of years lived with disability.

These patterns were driven by the rapid transitions and associated inequalities in the evolution of mortality and morbidity profiles since 2000. The dramatic decline in premature mortality due to communicable diseases, particularly in low-resource settings, has shifted the disease burden to noncommunicable diseases (NCD), increasing the global share of NCD deaths among all deaths from 60.8% in 2000 to 73.6% in 2019.

While NCDs accounted for up to over 85% of deaths in HICs – with heart disease, dementia and stroke being the leading causes – communicable diseases along with maternal, perinatal and nutritional conditions were still responsible for nearly half of all deaths in LICs with lower respiratory infections, diarrhoeal diseases, malaria, tuberculosis and HIV/AIDS remaining in the top 10 causes of death. LICs and lower middle-income countries (LMICs) bore the vast majority of the burden of communicable diseases, including that attributable to tuberculosis (TB), HIV, malaria, neglected tropical diseases (NTDs) and hepatitis B.

Despite the progress already made, the current pace of improvements is not rapid enough for many indicators to meet the SDG targets by 2030, including premature mortality from NCDs, the incidence of TB and malaria, and new HIV infections. These challenges underscore the need for strong disease and injury prevention and control programmes to adequately accelerate the current progress for meeting various national and international health targets.

> Indicators for health-related SDGs and the WHO Triple Billion targets have seen overall improvements, but progress is not fast enough and risks being set back by COVID-19. Further acceleration is needed for addressing risk factors, scaling up universal health coverage (UHC), and strengthening capacities to detect, assess, report on and respond to public health emergencies.

To prevent diseases and injuries and keep the population healthy in the first place, the WHO Triple Billion targets and SDGs both dedicate several indicators to addressing risk factors through the impact of multisectoral interventions. Progress in reducing exposure to risk factors is mixed and also manifests inequalities. While there has been a success in reducing tobacco use globally, the prevalence of adult obesity was on the rise with up to a quarter of the population in HICs being obese. The prevalence of hypertension also showed a mixed picture where the prevalence declined worldwide between 2000 and 2015, except for LICs where a slightly upward trend was seen. A notable decline for harmful use of alcohol was only seen recently after a plateau in 2010–2015. In addition, lower-resource countries continue to be exposed to ambient and household air pollution at higher rates than more developed countries. Children and women in low and lower-middle-income countries are also at higher risk of malnutrition , including stunting, wasting, and anaemia during pregnancy. Upper-middle income countries are more susceptible to overweight.

Many countries are already making progress towards UHC, although everywhere the COVID-19 pandemic impacted the ability of health systems to provide undisrupted health services. Improvements in coverage of essential health services have been recorded in all income groups and across different types of services, despite persistent inequalities. The UHC service coverage index (SCI) increased from a global average of 45 (of 100) in 2000 to 66 in 2017. The greatest progress has been in LICs, driven mainly by interventions for infectious diseases and, to a smaller extent, for reproductive, maternal, newborn, and child health (RMNCH) services. Globally and for many countries, however, the pace of progress has slowed since 2010, and the poorest countries and those affected by conflict generally lag furthest behind. Continued progress requires considerable strengthening of health systems, particularly in lower income settings. Unfortunately, the gains in service coverage have come at a major cost to individuals and their families. Overall, financial protection prior to COVID-19 has been deteriorating. The proportion of the population with out-of-pocket health spending exceeding 10% of their household budget rose from 9% to 13%, and those exceeding 25% rose from 1.7% to 2.9%, over the period 2000–2015. The impact of COVID-19 on the number of households spending a large share of their budgets on health care remains uncertain, as there is evidence of income shrinking, poverty increasing and households forgoing health care.

The pandemic also glaringly demonstrates the crucial role of health workers in public health capacity, exposing their inequitable availability, and unassured safety and well-being, adding new challenges to the already unevenly distributed workforce within and between countries.

In terms of global health security, trends in State Party self-assessment and reporting tool (SPAR) show stability and steady progress since 2018 in almost every core capacity except for a very small reduction observed in 2020, compared to 2019, in the capacities related to zoonotic events and human–animal health interface and chemical events. The COVID-19 experience shows the critical need for a coordinated multisectoral health emergency surge capacity and preparedness at all levels within countries. In addition, continuing efforts are needed to improve and maintain early warning systems to mitigate and manage public health risks within the national context and to consider worldwide pandemic context for national health emergency operational preparedness planning.

> The Triple Billion targets are critical for helping countries to accelerate the delivery of the SDGs, and require swift and enhanced political commitment and investment for achieving them by 2023. Inequalities continue to impede the achievement of optimal and equitable health gains. Strong health information systems with high-quality, timely and reliable disaggregated data are urgently needed to identify the health gaps and inequalities and to inform targeted, effective and cost-effective decision-making.

Before the COVID-19 pandemic, none of the Triple Billion targets was projected to be met; with UHC, Healthier Populations and Health Emergencies falling short of the one billion GPW 13 goals by 710, 100 and 80 million respectively. These projections have not taken the full impacts of COVID-19 into account, which is expected to further impede the attainment of many of the targets. COVID-19 has revealed that no country is prepared to deal with a pandemic of such magnitude, scale and impact. Getting back on track and accelerating progress towards meeting the Triple Billion targets requires multilateralism and equitable, rights-based and inclusive multisectoral responses to global health challenges.

A strong health information system is crucial for monitoring and accelerating progress towards the SDGs, GPW 13 Triple Billion targets, and national and subnational health priorities. It is critical that such a system can generate timely, reliable, disaggregated comparable and actionable data, to measure and track population health determinants and outcomes along with health inequality therein, and to ultimately drive strategic policy changes.

The WHO SCORE assessment showed that about 40% of the world's deaths remain unregistered, and 50% of countries have limited or less capacity for systematic monitoring health care quality, and only 59% of countries have good capacity to use data to drive policy and planning. The COVID-19 pandemic further highlighted the importance of closing existing data gaps with high-quality health data and strong health information systems for guiding all stages of policy to respond to daily needs for improving population health and unpredictable health emergencies.

Irrespective of the COVID-19 pandemic, existing inequalities, both within countries and between countries, impede appropriately targeted interventions and the accrual of equitable health gains. As evidenced throughout this report, populations in low-resource settings, those who are less educated, women, rural populations, racial and ethnic minorities, and migrants continue to have higher exposures to many health risks, lower access to health services and lower health literacy and consequently face poorer health outcomes.

Identifying health inequalities and their determinants is essential for achieving health equity and improving programme delivery. Knowing who is being left behind relies on equity-oriented national health information systems to produce and use inequality data for a fairer, healthier world. Yet, high-quality disaggregated data for monitoring health inequalities and for ensuring equitable health service access and uptake are lacking worldwide. In addition, even the available disaggregated data are often not made accessible to decision-makers as needed. Only 51% of 133 studied countries include data disaggregation in published national health statistical reports, ranging from 63% in HICs to only 46–50% for other income groups. Investment and political commitment are vital to enhancing country health information systems that generate disaggregated data by multiple inequality dimensions through various data sources including civil registration and vital statistics, population-based surveys, routine health facility data and administrative data.

1 THE IMPACT OF COVID-19 ON POPULATION HEALTH

Emerging only at the end of 2019 and declared by WHO as a global pandemic on 11 March 2020, the COVID-19 pandemic has wrought unprecedented devastation on global population health, infecting over 153 million people by 1 May 2021, and claiming more than 3.2 million lives globally. Available evidence indicates that COVID-19 has sharply shortened life expectancy (LE) in many countries to a degree that has not been seen in decades and is found to have long-term impact on morbidity among some individuals, exacerbating existing vulnerabilities linked to underlying inequity *(1–5)*. In addition to the direct epidemiological impact, the knock-on effects of the pandemic have resulted in disruptions to essential health services as observed through widespread shortages of medicines, staff, diagnostics and public transport services, as well as hesitancy to seek medical treatment due to fear of infection. The pandemic poses critical challenges to weak health systems in low-resource settings and the lack of timely, reliable and disaggregated COVID-19 data has challenged effective and better targeted policies and resource allocation. Furthermore, the pandemic also has remarkable social and economic impacts that are beyond the health sphere, including economic recession, unemployment, school closing and self-isolation, all of which have affected the health and well-being of the world population in important, indirect ways.

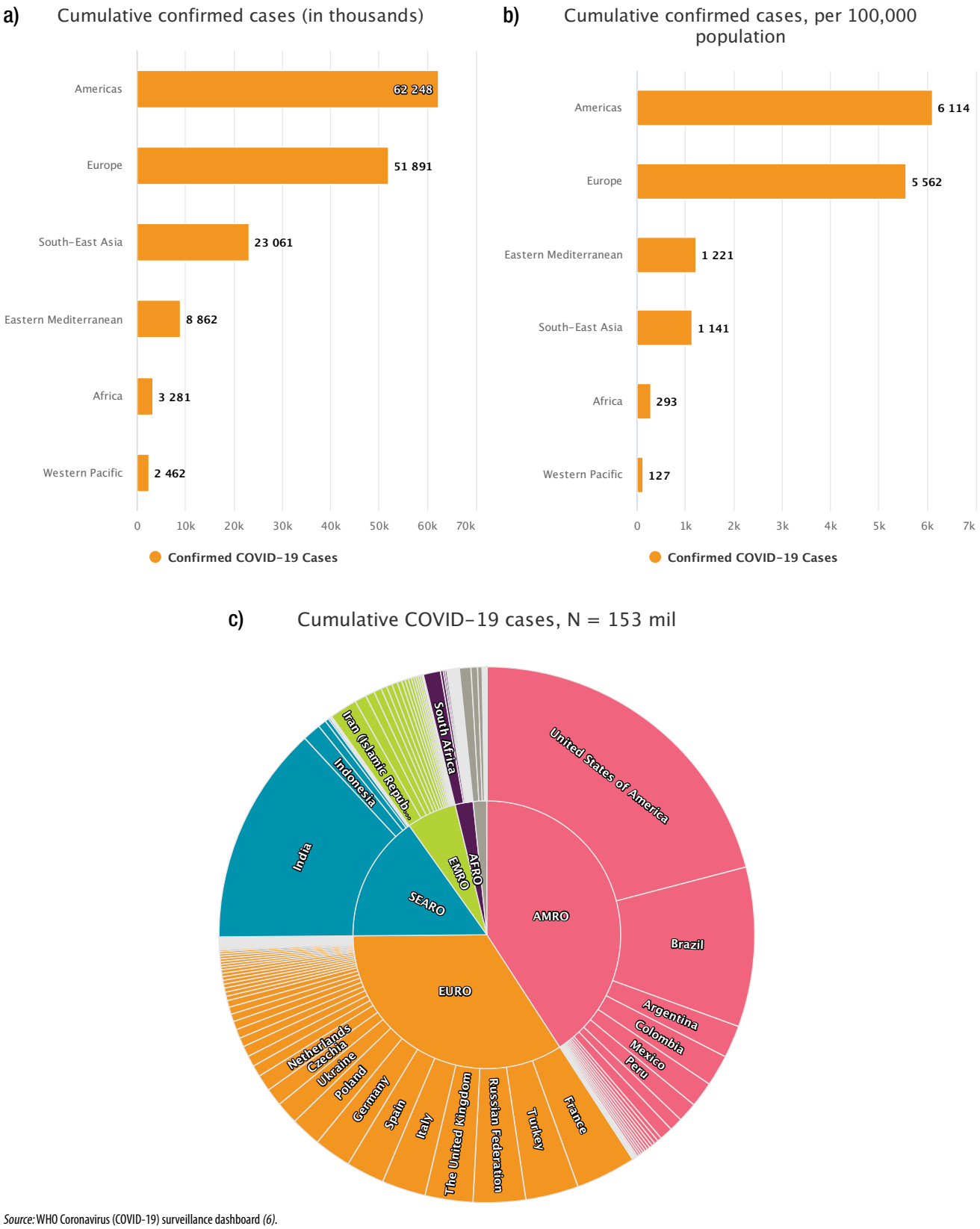
COVID-19 cases and deaths

As of 1 May 2021, more than 153 million confirmed COVID-19 cases and 3.2 million related deaths have been reported to WHO (Figs 1.1 and 1.2). The Region of the Americas and the European Region have been the most affected, together comprising over three quarters of cases reported globally, with respective case rates per 100 000 population of 5999 and 5455.

Of the 23.1 million cases reported in the South-East Asia Region to date, over 86% are attributed to India. Almost half (48%) of all reported COVID-19-associated deaths have occurred in the Region of the Americas, and one third (34%) in the European Region.

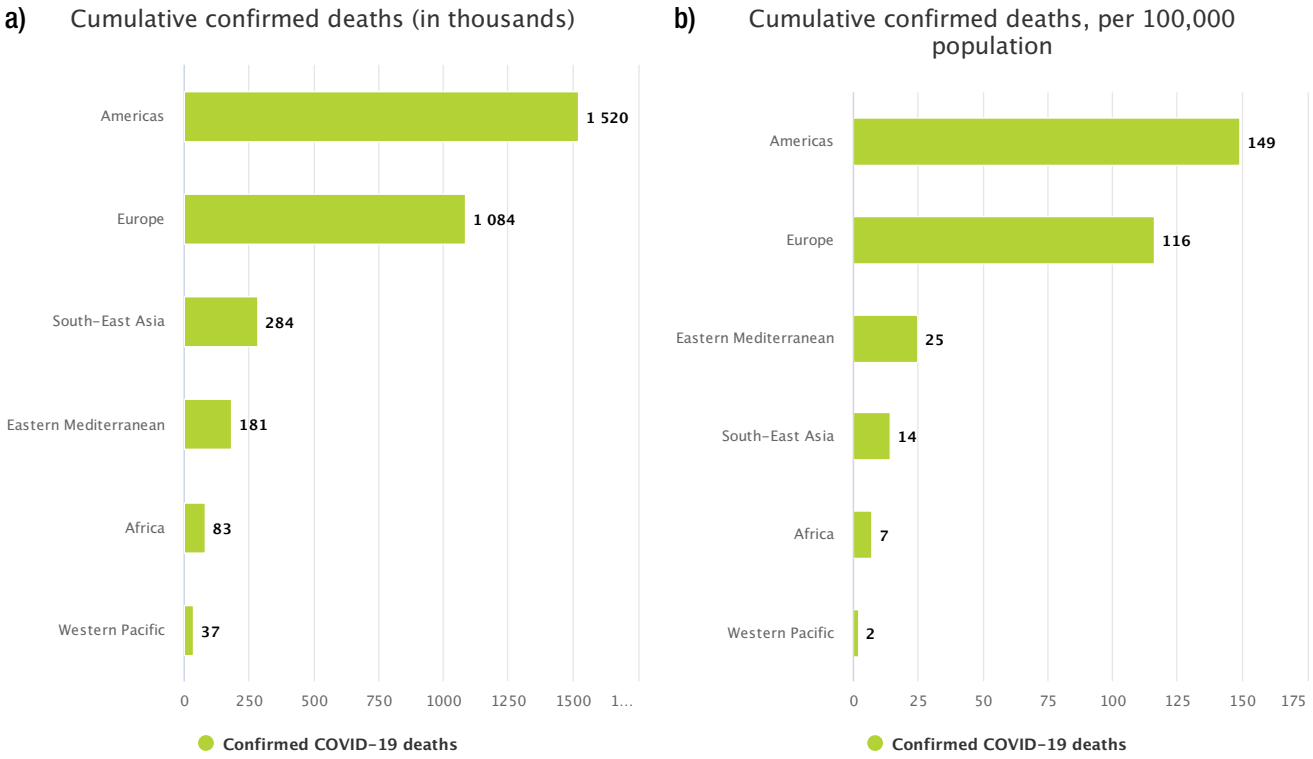
Despite the extensive spread of the virus, COVID-19 cases to date appear to be concentrated predominantly in high-income countries (HICs). As of 1 May 2021, the 20 most impacted HICs account for almost half (45%) of the world's COVID-19 cases, yet they represent only one eighth (12.4%) of the global population.

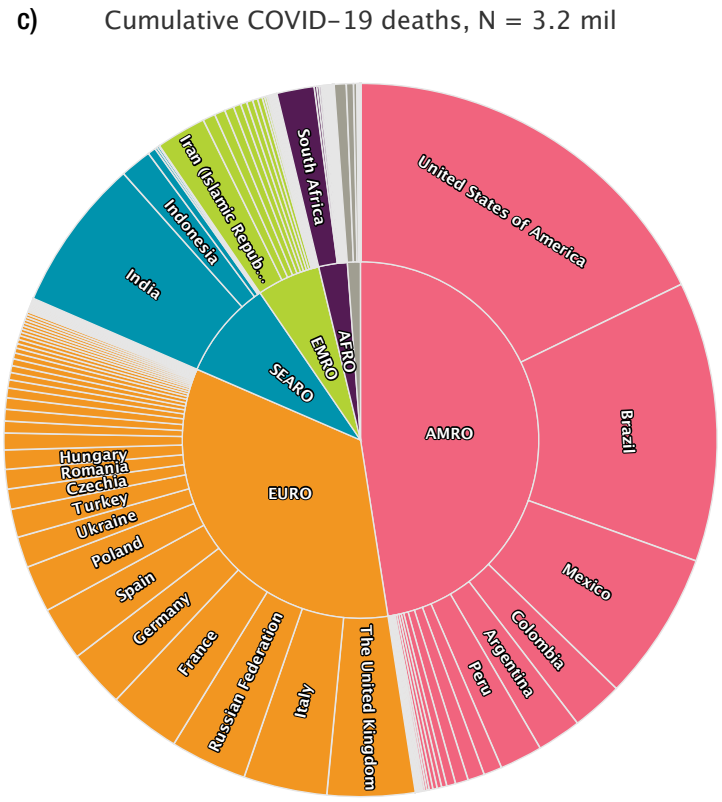
That said, a recent shift in distribution of cases and deaths from higher- to lower-resource settings is evident. For example, while HICs accounted for about 64% and 59% of the global monthly new cases and deaths, respectively, in January 2021, the shares dropped to 31% and 27%, respectively, in April 2021. This is in contrast to the rise of the share of global monthly new cases contributed by LMICs from 8% in January 2021 to 37% in April 2021, and the share for new deaths from 8% to 22% between January and April 2021.



Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.1. Cumulative confirmed COVID-19 cases as of 1 May 2021, by region: a) in thousands; b) per 100 000 population; and c) by location





Source: WHO Coronavirus (COVID-19) surveillance dashboard *(1)*.

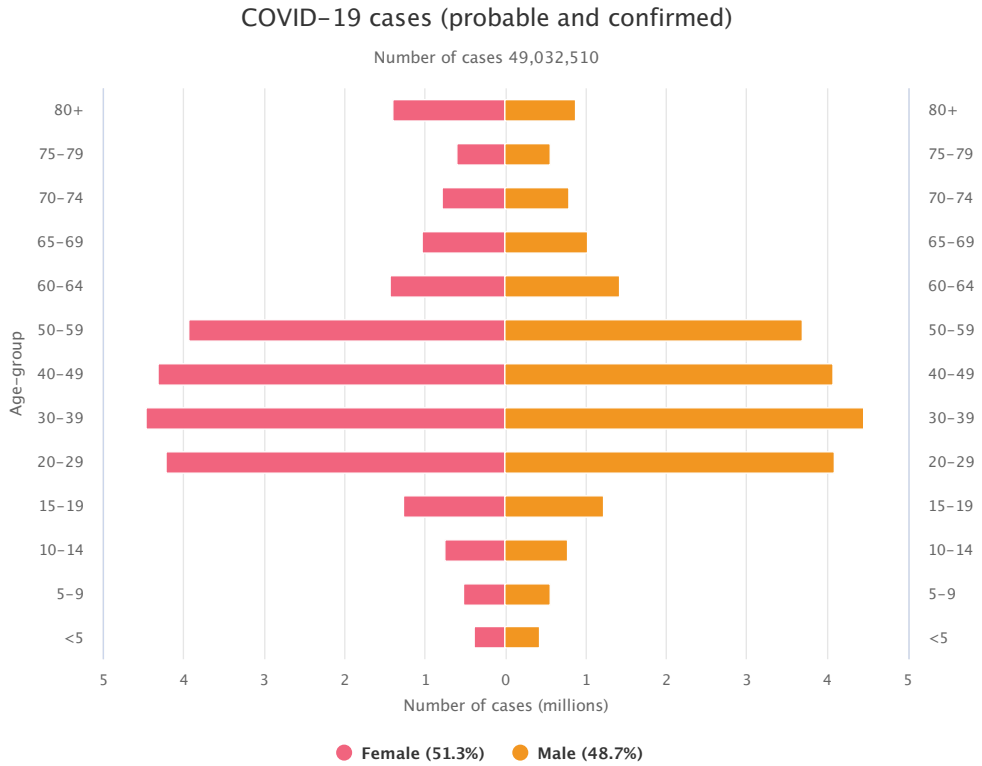
Fig. 1.2. Cumulative confirmed COVID-19 deaths as of 1 May 2021, by region: a) in thousands; b) per 100 000 population; and c) by location

Excess deaths

Excess mortality refers to the difference in the total number of deaths in a crisis-related period, compared to those expected under non-pandemic conditions. The excess mortality attributable to COVID-19 provides a more accurate picture of the full impact of the pandemic as it accounts for both the total COVID-19 deaths directly attributable to the disease as well as the indirect impacts of the pandemic and responses to it, such as travel restrictions. The excess includes the deaths due to COVID-19 that are correctly certified together with those that were not reported or incorrectly attributed to other causes, as well as the net effect of changes in other causes that are related to the pandemic and responses to it. The calculation of excess deaths requires the observed numbers of deaths for a specified time and place to be compared to those expected if the pandemic had not occurred. Available evidence from the countries with rapid mortality surveillance systems suggests that in many locations the reported number of COVID-19 deaths is a significant undercount of the full toll of the pandemic, and the estimated excess mortality can be many times higher *(7–9)*. However, it is also clear that responses to the pandemic in some locations have resulted in a number of deaths being averted.

Only a subset of countries has the mortality surveillance capacity to track this measure in real time. Responding to this critical data gap, WHO and the United Nations Department of Economic and Social Affairs (UN-DESA) has convened an expert group of epidemiologists, biostatisticians, demographers and officers from national statistical offices. The role of this technical advisory group (TAG) is to advise and assist WHO and Member States to obtain accurate estimates of numbers of deaths attributable to the pandemic for all locations of the world, including those without timely data *(10)*.

With the support of the TAG, preliminary assessments of excess mortality estimate 1.34–1.46 million excess deaths in the Region of the Americas during 2020, about 60% more than the reported 860 000 COVID-19 deaths. Likewise, 1.11–1.21 million excess deaths are estimated for the European Region, double the 590 000 reported COVID-19 deaths. There are significant data gaps in the African Region, the Eastern Mediterranean Region, the South-East Asia Region and the Western Pacific Region, for which just over 360 000 total COVID-19 deaths were reported for this period. Only 16 of the 106 Member States making up these regions have sufficient data from which to calculate the year 2020 excess mortality empirically. WHO is



Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.3. Total number of COVID-19 cases (probable and confirmed), by age and sex, January 2020 to April 2021

actively engaging with Member States to improve the quality of their available data and the TAG is currently exploring robust statistical frameworks to estimate excess mortality in the locations for which this is not currently feasible. A tentative extrapolation of the results from the Americas Region and the European Region assessments suggests that globally, over 3 million excess deaths attributable to the COVID-19 pandemic occurred in the year 2020. This is over 1.2 million deaths more than the reported 1.8 million COVID-19 deaths. However, further data collection and additional statistical modelling are needed to refine this estimate.

Age- and sex-related inequalities

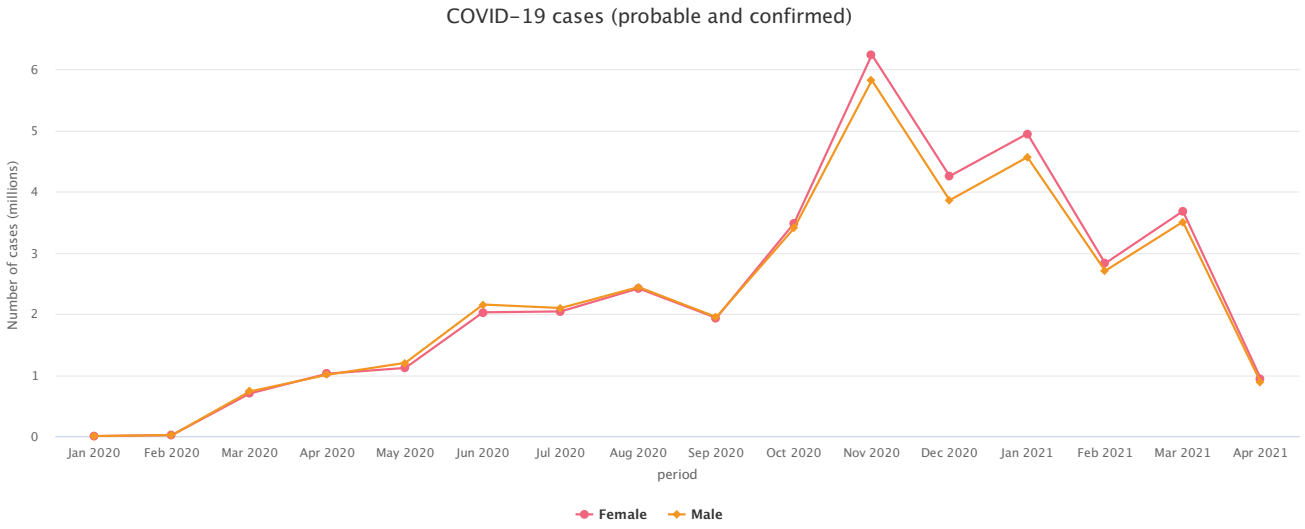
With the limited data available, the current analysis shows COVID-19 cases and deaths not only vary between countries, but also between population subgroups within countries, including between males and females and between different age groups.

Available global data show that the number of COVID-19 cases does not differ significantly between males and females (48.7% vs 51.3% of all reported cases), however the number of deaths is markedly higher among males than females (57.6% vs 42.4% of all deaths) (Fig. 1.3 to 1.6).

Among both males and females, the number of COVID-19 cases increases with age until age 30–39 years, then decreases until age 75–79 years, but is slightly elevated again for those aged 80 years or older. For both sexes, the highest numbers of COVID-19 cases are observed for ages 30–39 years, representing about 20% of all cases. About 60% of all cases occur among ages 20–60 years, for both males and females.

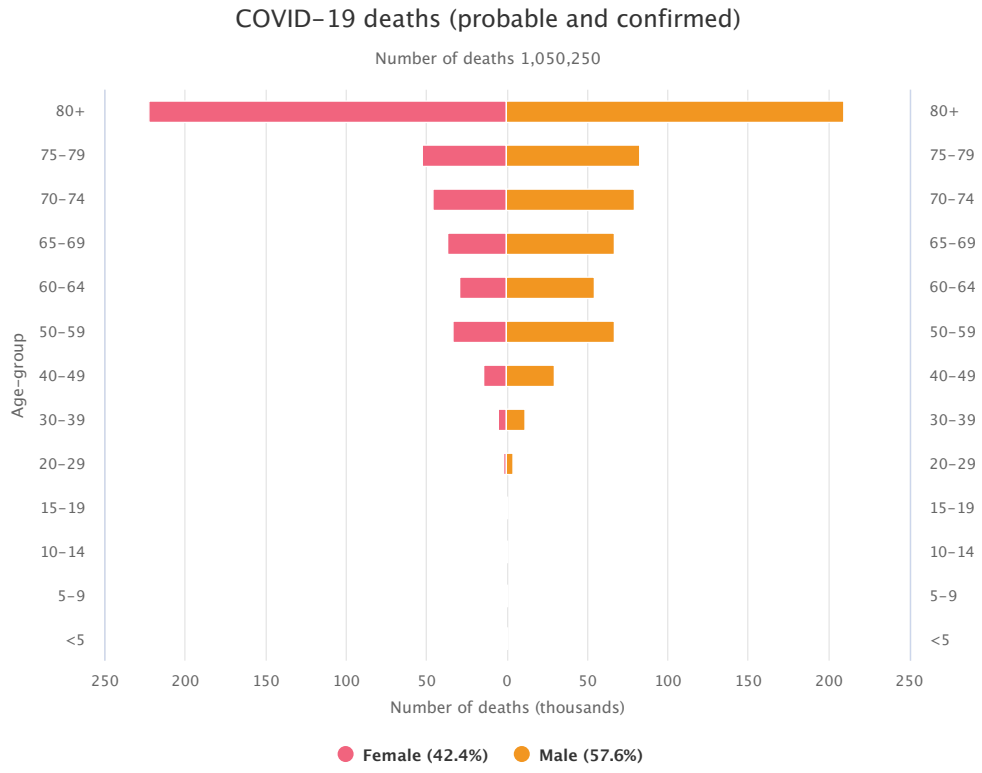
The number of COVID-19 deaths shows a very different pattern: overall, the number of COVID-19 deaths increases with age and is highest for those aged 80 years and older (representing one third of all deaths, among both males and females).

Available time trend data shows that, temporally, the number of cases was about the same between males and females (Fig. 1.4), while the number of deaths was continually higher among males than females (Figs 1.5 and 1.6).



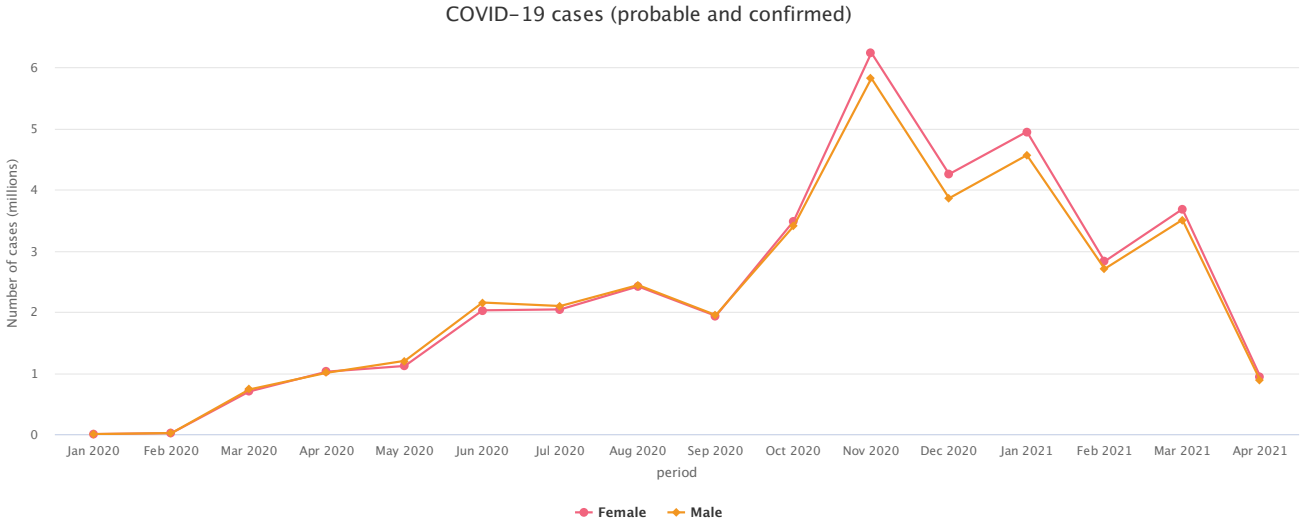
Note: The illustrated April cases are only up to 12 April and not the complete month.
Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.4. Change over time in number of COVID-19 cases (probable and confirmed), by sex, January 2020 to April 2021



Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.5. Total number of COVID-19 deaths (probable and confirmed), by age and sex, January 2020 to April 2021



Note: The illustrated April deaths are only up to 12 April and not the complete month.
Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.6. Change over time in number of COVID-19 deaths (probable and confirmed), by sex, January 2020 to April 2021

COVID-19 already a leading cause of death

To put deaths due to COVID-19 into perspective along with other leading causes of death, relative to causes described in the WHO Global Health Estimates 2019 *(11)*, the absolute number of reported deaths in 2020 would rank COVID-19 within the top 10 of causes of death globally, with only ischaemic heart disease, stroke, chronic obstructive pulmonary disease (COPD), lower respiratory infections and neonatal conditions ranked higher (Table 1.1) *(12)*.

Table 1.1. COVID-19 as a leading cause of death

Cause	2019	2020
Ischaemic heart disease	8 880 000	
Stroke	6 190 000	
COPD	3 220 000	
Lower respiratory infections	2 590 000	
Neonatal conditions	1 960 000	
COVID-19		**1 800 000**
Trachea, bronchus, lung cancers	1 760 000	
Alzheimer's disease and other dementias	1 590 000	
Diabetes mellitus	1 490 000	
Diarrhoeal diseases	1 450 000	

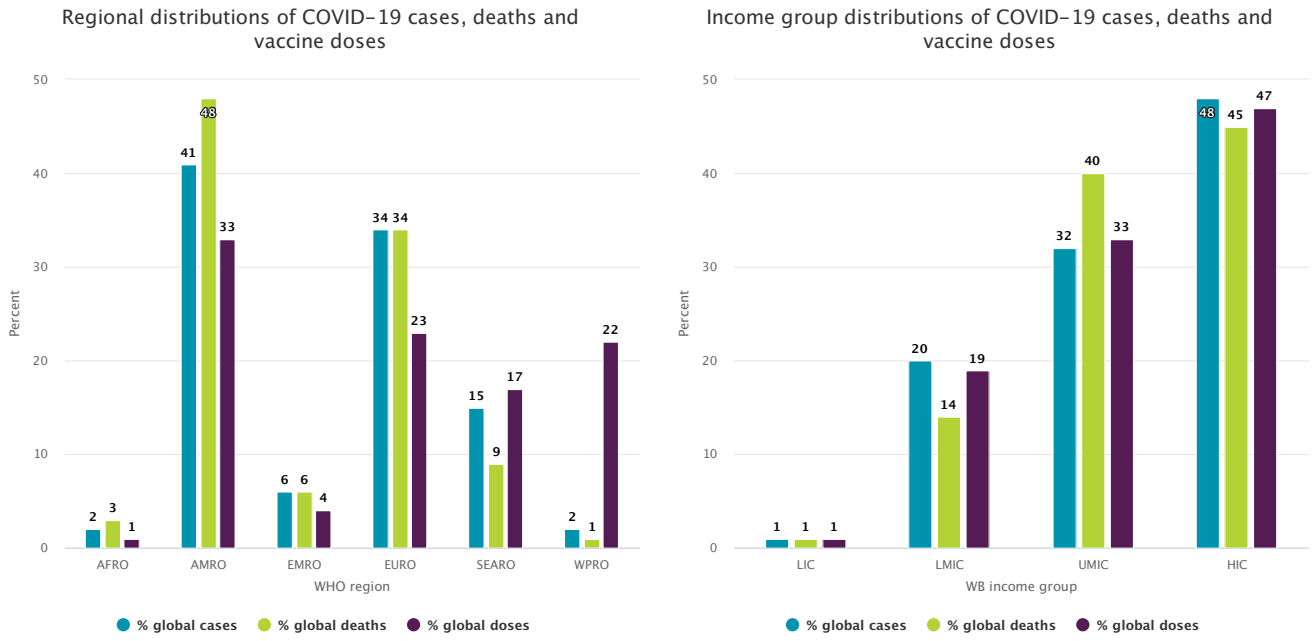
Note: Comparing total deaths estimated for leading causes in 2019 Global Health Estimates to the reported COVID-19 deaths for the year 2020. Comparing quantities from two different periods and so does not account for population growth or any epidemiological changes. However, gives an order of magnitude picture and expected relative ranking of causes for 2020 assuming mortality risks and levels for other causes have not changed significantly.

Source: WHO Global Health Estimates 2019 *(11)* and WHO Covid-19 surveillance dashboard *(6)*.

COVID-19 vaccines and vaccination

In light of the still unfolding pandemic, global equitable access to vaccines – with a focus on protecting priority populations including health care workers and those most at risk – is one of the most important measures to mitigate the tragic health and economic impacts and bring the pandemic under control. This is anticipated to prevent the loss of US$ 375 billion to the global economy every month. Multiple viable vaccines have been developed in record time, however the world continues to face challenges to rapidly ramp up vaccine production to respond to the overwhelming demand globally. To accelerate development, production and delivery – and guarantee fair and equitable access to COVID-19 vaccines – WHO, in collaboration with GAVI, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations, co-led the COVAX initiative. As of 1 May 2021, COVAX has shipped approximately 53 million doses to 121 participating countries *(13)*.

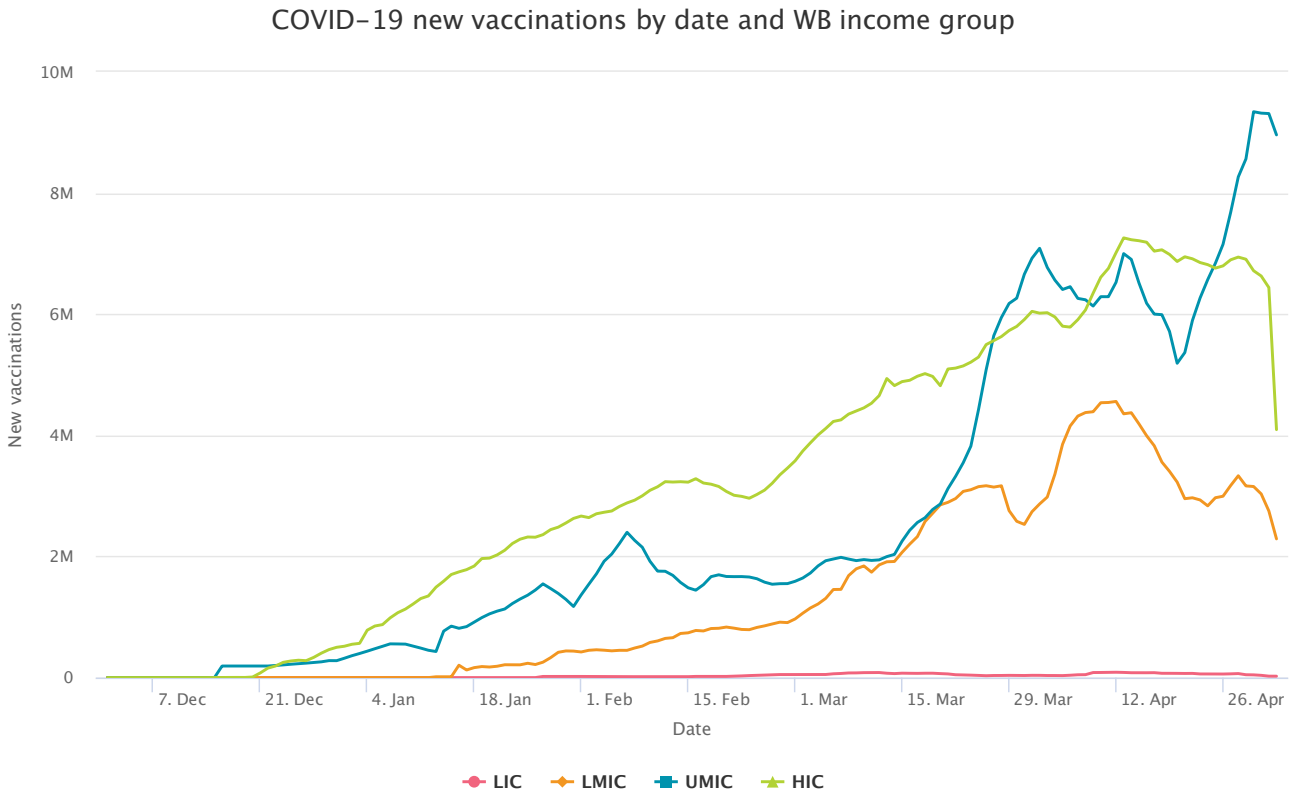
As of 1 May 2021, just over a billion COVID-19 vaccine doses had been administered globally (Fig. 1.7). The highest number of doses has been administered in the Region of the Americas (33%) followed by the European Region and Western Pacific Region (23% and 22%, respectively). The remaining 23% were administered to the South-East Asia Region, the Eastern Mediterranean Region and the African Region (accounting for 17%, 4% and 1%, respectively). The inequality across income groups is pronounced with only 1% of doses going to LICs as compared to the 19% administered in LMICs, 33% in upper middle-income countries (UMICs) and 47% in HICs (Fig. 1.8).



Note: WB = World Bank.

Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.7. Distribution of COVID-19 vaccine doses by WHO regions and World Bank income groups



Notes: Timeline shown is from December 2020 until April 2021. M = million; WB = World Bank.
Source: Our world in data *(14)*.

Fig. 1.8. Distribution of new COVID-19 vaccinations doses by World Bank income group and date

Unequal roll-out of vaccines amidst the spread of new variants puts lower-resourced settings at greater risk and partly explains the recent shift of mortality distribution from higher to lower-resource settings. Pre-pandemic inequalities have driven the unequal global distribution of vaccines and run the risk of perpetuating the pandemic, which in turn has amplified existing inequality and risks throwing the entire 2030 sustainable development agenda off-track. Global solidarity to boost the manufacturing of vaccines and to guarantee their equitable access is critical to prevent potentially more transmissible, lethal or immune-evasive variants from spreading and to eventually keep the global community safe from the virus.

However, vaccines alone will not be sufficient to end the pandemic. Sustained downturns in weekly cases and deaths at global level are still yet to be seen: we need to do everything possible – including social distancing, wearing masks and frequently cleaning hands – to stop the spread of the virus and prevent mutations that may compromise the efficacy of existing vaccines.

Disruption of essential health services

The second round of the WHO "pulse survey" of 135 countries and territories (April 2021) highlights persistent disruptions to health services at considerable scale over one year into the COVID-19 pandemic, with 90% of countries reporting one or more disruptions to essential health services. Improvements, however, were seen within countries, with average reported disruptions falling from about half of essential health services in 2020 to just over one third in the first quarter of 2021 *(15,16)*. Health workforce-related reasons, including reassignment within the health system, remain the most common causes of service disruption, affecting two thirds of the surveyed countries. Disrupted supply chains persist in nearly one third of surveyed countries, limiting the availability of essential medicines, diagnostics and the PPE required to safeguard health workers to effectively provide care. Other most frequently cited reasons for discontinuing or reducing services were cancellations of planned prevention and treatment services and a decrease in public transport services.

On the demand side, patients not seeking care due to community mistrust and fears of infections is reported in over half of surveyed countries. Financial challenges also exacerbate the situation, being the major reasons for disruptions in service utilization in 43% of the surveyed countries. Consequently, millions of people are still missing out on vital health care. Provision of day-to-day primary care for preventing and managing some of the most common health conditions is the most impacted, affecting nearly half of surveyed countries. Older and/or disabled people are severely affected due to the disruptions in long-term care for chronic conditions, rehabilitation and palliative end-of-life care.

The most extensively affected types of services are those for mental, neurological and substance use disorders; neglected tropical diseases; tuberculosis (TB); human immunodeficiency virus (HIV) and hepatitis B and C; cancer screening, and services for other noncommunicable diseases including hypertension and diabetes; family planning and contraception; urgent dental care; and malnutrition. Over 40% of the surveyed countries reported disruptions in these types of services.

Although significant progress was made in reducing disruptions to immunization services in health facilities and outreach immunization services by 20% and 30%, respectively, compared to 2020, more than one third of the surveyed countries still report disruptions in these services. Similarly, one or more malaria services were still disrupted in about 40% of surveyed countries, notwithstanding the improvements compared to 2020.

In response to the service disruptions, the majority of the countries surveyed are implementing mitigation strategies and approaches. The most common ones include use of community communications (66%), triaging to identify priorities (60%), recruitment of additional staff (56%), redirection of patients to alternate care sites, provision of home-based care (51%) and replacement of in-person consultations with telemedicine (48%).

Health workers are regularly reported among COVID-19 cases

Health and care workers (HCW) are at the forefront of any disease outbreak and their unwavering dedication has been critical to national and local responses to the COVID-19 pandemic *(17)*. A major proportion of their functions and roles is associated with the risk of exposure to hazards having serious potential impacts on their welfare and that of their families. Based on case reporting forms from surveillance data submitted to WHO by Member States, HCWs have been regularly reported as being among new cases of COVID-19 infection. Although these data are only a subset of all cases, they demonstrate that HCWs comprised more than 10% of all new COVID-19 cases in the first three months of the pandemic, declining to less than 5% by June 2020, and to approximately 2.5% by September 2020 *(18)*. These data illustrate the burden of COVID-19 among HCWs, particularly at the early stages of the pandemic, suggesting that increased adoption and use of protective measures decreased their risk.

In addition to this risk of COVID-19 exposure, the pandemic in 2020 was associated with further mental health challenges, burnout, adapting to reprogramming of health services, and deteriorating working conditions for HCWs, which all combined to lead to strikes as well as occupational stigma and discrimination. Together, these factors have further impacted the availability of HCWs and disrupted the already fragile health services in many countries.

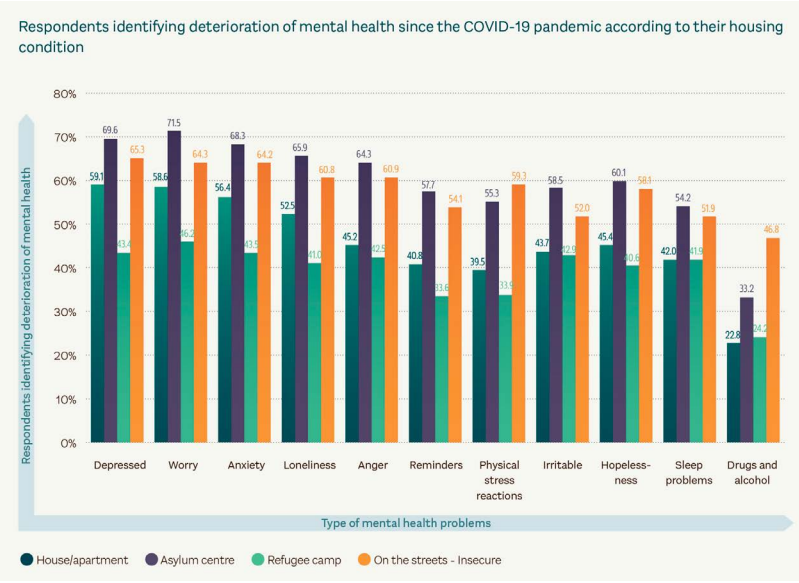
THE PANDEMIC ALSO IMPACTS REFUGEES AND MIGRANTS

Recent data also demonstrate that the COVID-19 pandemic has further worsened the already distressed living and health conditions of refugees and migrants. In 2020, the *ApartTogether* survey *(19)* captured self-reported data from 30 000 refugees and migrants in 170 countries, originating from 159 countries or territories. The participants indicated that since the start of the pandemic they were feeling significantly more depressed, worried, anxious, lonely, angry, stressed, irritated, hopeless, were having more sleep-related problems and used more drugs and alcohol (Fig. 1.9).

Using such administrative data, however, has limitations. Data quality is still a concern. In addition, DTP dropout rates only reflect one aspect of an immunization programme and do not include children who are unvaccinated. For effective equity monitoring, subnational dropout rates should therefore be combined with other indicators, such as the proportion of 'zero-dose' children. This underscores the need for continued strengthening of health information systems, so that sufficient data can be collected and used to monitor and inform equity-oriented immunization programmes.

Among the participants reporting worsening of their mental health status, refugees and migrants living in asylum centres or on the streets reported greater worsening than those in houses, apartments or even refugee camps. About 1200 respondents reported not seeking health care even when they showed COVID-19 symptoms. Lack of financial means, fear of deportation, lack of availability of health care or no entitlement were cited as reasons by almost two thirds (60%) of those not seeking health care (Fig. 1.10).

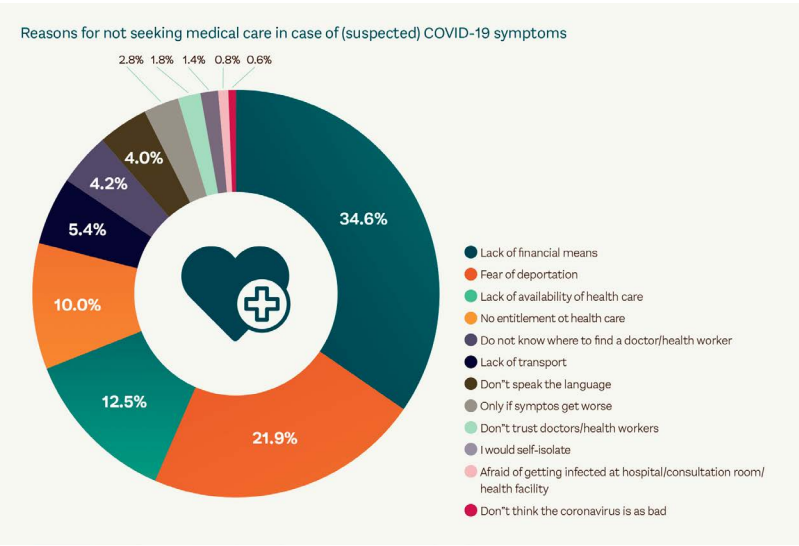
Despite a significant focus on ensuring the inclusion of refugees and migrants in the global response to COVID-19 and related recovery efforts, irregular migrants remain among the most excluded from access to health care. In most countries, they can only access health services if they are able to cover full related costs. Asylum seekers' access to national health insurance schemes is also impacted by the political and legal context in the host country. The *UN Framework for the immediate socioeconomic response to COVID-19* *(20)* highlights refugees and migrants as at-risk populations experiencing the highest degree of socioeconomic marginalization, requiring specific attention and disaggregated data collection.



Notes: Number of respondents for each issue: 15 278 depression, 15 483 worry, 15 291 anxiety, 14 730 loneliness, 13 340 anger, 13 454 reminders, 12 344 physical stress reactions, 13 343 irritability, 13 314 hopelessness, 13 232 sleep problems, 8915 drugs and alcohol (survey question used this term); number of participants differed by housing situation (e.g. for depression the numbers responding were 13 562 for house/apartment, 359 for asylum centre, 1190 for refugee camp, 167 for on the streets or in insecure accommodation).

Source: Apart Together survey *(19)*.

Fig. 1.9. Refugees and migrants identifying deterioration of mental health since the COVID-19 pandemic, by housing type



Note: Data from 1198 respondents.

Source: Apart Together survey *(19)*.

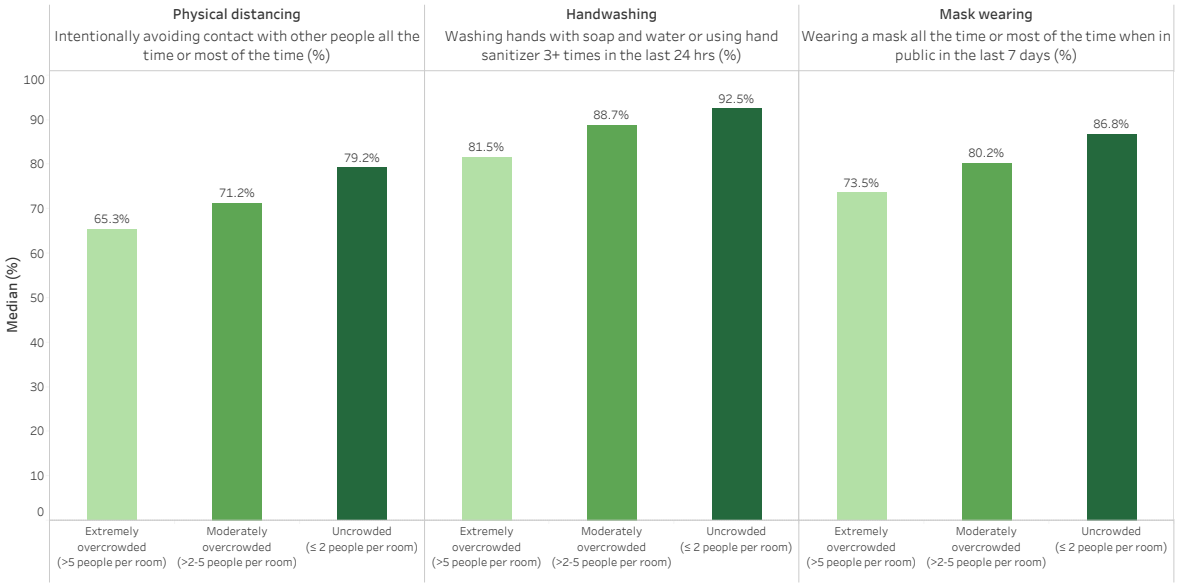
Fig. 1.10. Reasons for refugees and migrants not seeking medical care in case of (suspected) COVID-19 symptoms

SOCIOECONOMIC STATUS AFFECTS COVID-19 PREVENTION BEHAVIOURS

An ongoing survey conducted in a partnership between Facebook and the University of Maryland in 35 HICs shows that in the past 10 months (between May 2020 and February 2021), the more deprived people are, the less they apply protective behaviours against COVID-19. Household overcrowding is an indicator of socioeconomic status, with extremely overcrowded defined as more than five people per room used for sleeping, moderately overcrowded defined as more than two but less than or equal to five, and uncrowded defined as two or less. Survey respondents constituted between 1% and 21% of the adult population living in moderately overcrowded conditions, and 0.01% to 3.1% living in extremely overcrowded conditions across the 35 countries.

People living in overcrowded households are overall less likely to intentionally avoid contact with others, practice regular handwashing each day, and wear masks in public when compared to people living in uncrowded households. Preventive behaviours decrease as the amount of overcrowding increases (Fig. 1.11).

Overall, 79% of people living in uncrowded households[1] reported trying to physically distance themselves from others, compared to 71% in moderately overcrowded and 65% in extremely overcrowded households. Regular daily handwashing practices were also more common among people who lived in uncrowded households (93%) than in moderately overcrowded (89%) and extremely overcrowded households (82%). In terms of mask wearing in public, overall, 87% of people living in uncrowded households wore a mask all or most of the time when in public in the last seven days, compared to 80% of people living in moderately overcrowded conditions and 74% of people living in extremely overcrowded conditions.



Note: Overcrowding is measured by the number of persons per room used for sleeping. The number of people per room considers rooms used for sleeping. Physical distancing is defined as intentionally avoiding contact with other people all the time or most of the time. Handwashing is defined as washing hands with soap and water or using hand sanitizing three or more times in the last 24 hours. Mask-wearing refers to wearing a mask all the time or most of the time when in public in the last 7 days.

Source: WHO calculations using COVID-19 World Symptoms Survey data.

Fig. 1.11. Combined data for preventive indicators: physical distancing, handwashing and wearing masks, by 'household crowding' in 35 HICs

[1] Median value of 35 countries.

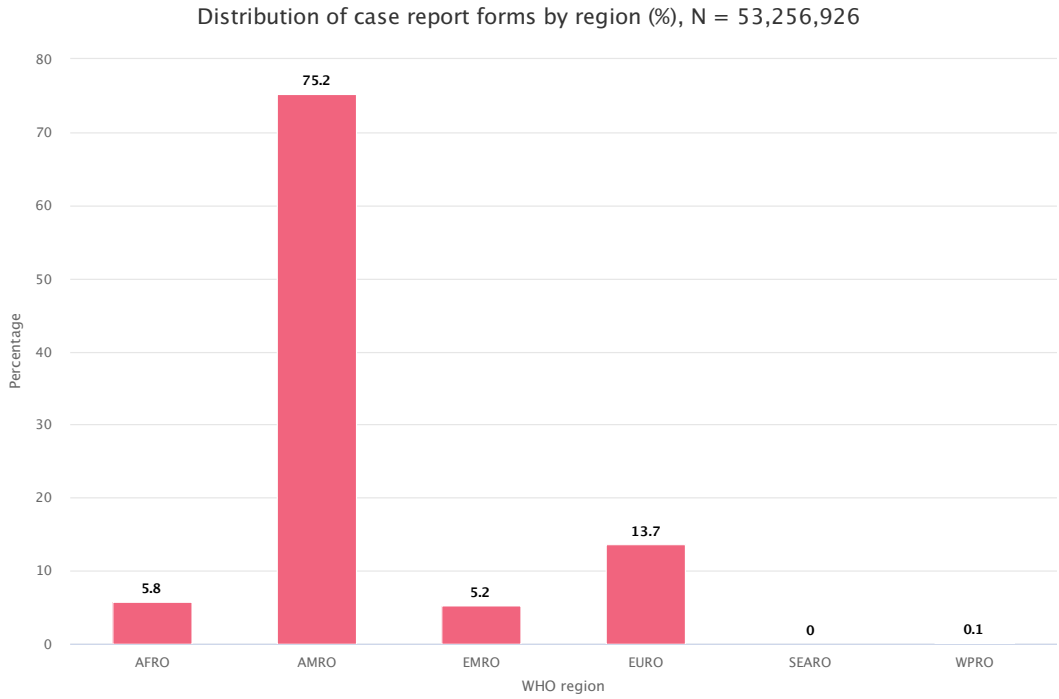
Data gaps

The main challenge to determining the factors that are primarily associated with elevated COVID-19 infection and related mortality risk is the paucity of available data, particularly the absence of identifiers such as sex and age in a significant proportion of the data that have been reported. Importantly, analysis of COVID-19 cases and deaths by sex and age relies on the availability of high-quality, timely and reliable disaggregated data. Active COVID-19 surveillance represents a substantial additional burden for public health surveillance systems, especially in low- and middle-income countries. Countries have prioritized reporting in different ways, and opportunities for sex and age disaggregation have been limited for some countries, and at different stages of the pandemic.

From the onset of the pandemic, completed WHO case report forms have provided an important source of information for real-time monitoring and tracking of the impact of the pandemic. These data are submitted to WHO by Member States in line with the Global surveillance system for COVID-19 set up in January 2020 under the framework of the *International Health Regulations (2005) (21)*. An interim case reporting form for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) confirmed and probable cases was posted on the WHO website and Member States were requested to submit completed forms within 48 hours of case identification. On 27 February 2020, a revised form was posted with the request to resubmit forms when patient outcomes were known or 30 days after the first submission. Countries were requested to submit case report forms as feasible and data submitted up to

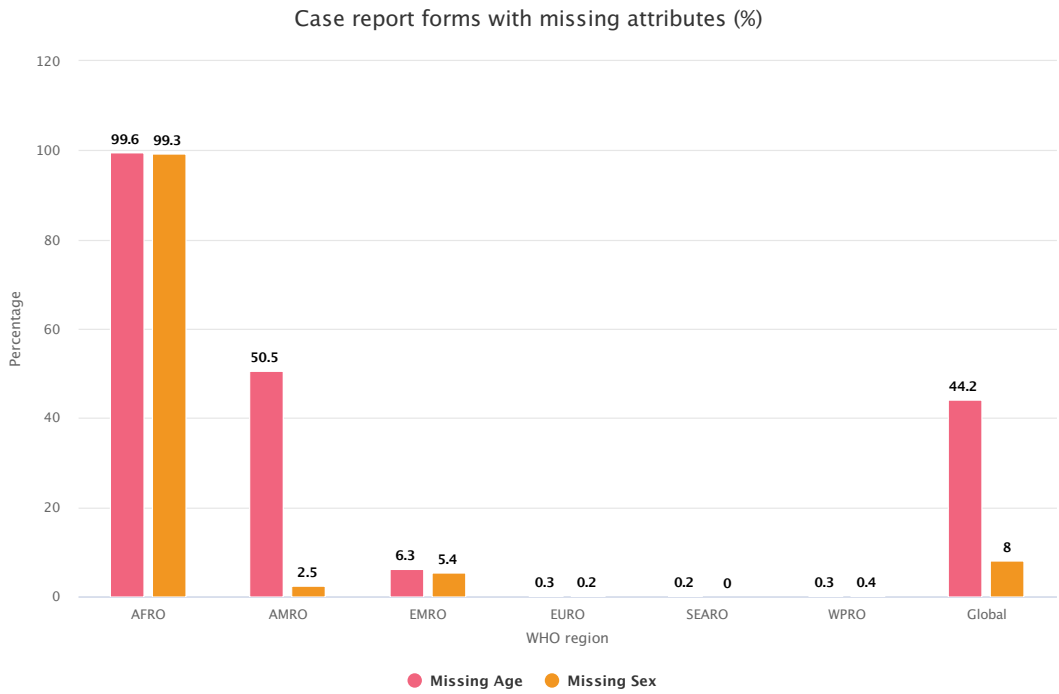
28 February 2021 have been assessed for quality and information gaps (Figs 1.12 and 1.13).

Overall, between January 2020 and April 2021, only 41 out of 236 countries, area or territories (17%) report sex-disaggregated data for at least 95% of cases, whereas 72 countries (30%) report sex-disaggregation for at least 70% of cases. Globally, sex was reported for just over half of all cases (51%). Compared to the year 2020, the percentage is higher for May and April of 2021, reflecting some improvement of surveillance and reporting.



Note: Data comprises 53 256 926 eligible case report forms.
Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.12. Distribution of SARS-CoV-2 case report forms, by region (%)



Note: Data comprises 53 256 926 eligible case report forms.
Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

Fig. 1.13. SARS-CoV-2 case report forms with missing attributes, by region (%)

In addition, data gaps were evident through assessment of the proportion of countries reporting COVID-19 cases among the health workforce (HWF) (Table 1.2). Inclusion of HCW identifiers averaged 81% globally and ranged from 50% in the South-East Asia Region to 98% in the African Region.

It is over one year since the first recognition of the COVID-19 pandemic, and many important lessons remain to be fully documented and harnessed. Looking ahead, numerous opportunities exist for improving routine COVID-19 monitoring systems, data collection and disaggregation. This includes alignment of COVID-19 surveillance with the continuous strengthening of health information systems and its integration with other existing routine surveillance, such as demographic and geographic monitoring systems. COVID-19 surveillance and monitoring must also be combined with (and de-segregated as needed from) tracking of SDG goals and targets, UHC and IHR-related national preparedness indicators, as well as broader examination of coverage by vaccines and water, sanitation and hygiene (WASH) services.

Investment of attention and resources must be ensured so that development of COVID-19 surveillance systems can occur at a pace and scale similar to COVID-related vaccine and clinical research, and with a similar intensity of innovation *(15,16)*.

Table 1.2. Health workforce data in SARS-CoV-2 case report forms, by region

WHO region	Number of countries reporting cases	Total cases reported	Number of countries reporting HWF data	Proportion of countries reporting HWF data	Number of HWF cases
AMR	40	56 189 932	30	75%	1 118 000
EUR	54	45 551 551	40	74%	692 408
AFR	47	3 089 961	46	98%	104 625
EMR	21	5 807 616	17	81%	39 327
WPR	10	1 842 207	9	90%	23 244
SEAR	10	15 330 286	5	50%	660
Total	**182**	**127 811 553**	**147**	**81%**	**1 978 264**

Note: HWF = health workforce; AMR = Region of the Americas; EUR = European Region; AFR = African Region; EMR = Eastern Mediterranean Region; WPR = Western Pacific Region; SEAR = South-East Asia Region.
Source: WHO Coronavirus (COVID-19) surveillance dashboard *(6)*.

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2 HEALTHY LIFE EXPECTANCY AND BURDEN OF DISEASE

Healthy life expectancy (HALE) is the overarching indicator for the WHO Triple Billion targets and is a critical measure to evaluate the progress towards SDG 3. The average life expectancy (LE) and HALE in 2019 have increased markedly since 2000. These trends indicate the progress being made against many diseases and injuries, both for the whole population and/or targeted groups. This section describes the latest trends in LE, HALE, and burden of disease for a list of communicable and noncommunicable diseases as well as injuries and related inequalities.

Global trends in life expectancy and healthy life expectancy

Prior to the COVID-19 pandemic, population health was improving globally, increasing the global average life expectancy at birth from 66.8 years in 2000 to 73.3 years in 2019, and healthy life expectancy at birth from 58.3 years in 2000 to 63.7 years in 2019 (1). In 2019, LE and HALE for males reached 70.9 years and 62.5 years, respectively. For females, the equivalent figures are 75.9 years and 64.9 years, respectively (Fig. 2.1).

The African Region still had the lowest LE and HALE among WHO regions in 2019, at only 64.5 and 56.0 years, respectively, despite experiencing the largest gains over the past two decades. The Region of the Americas had the highest LE (74.1 years) in 2000 but dropped to third place (77.2 years) in 2019 as the European Region and Western Pacific Region made accelerated gains, reaching 78.2 and 77.7 years, respectively. The latter two regions also had the highest HALE in 2019, at 68.3 and 68.6 years, respectively.

A metric to assess the health of older adults, LE at 60 years of age, has also improved globally from 18.8 in 2000 to 21.1 in 2019. However, HALE at 60 years has only risen from 14.1 to 15.8 in the same period.

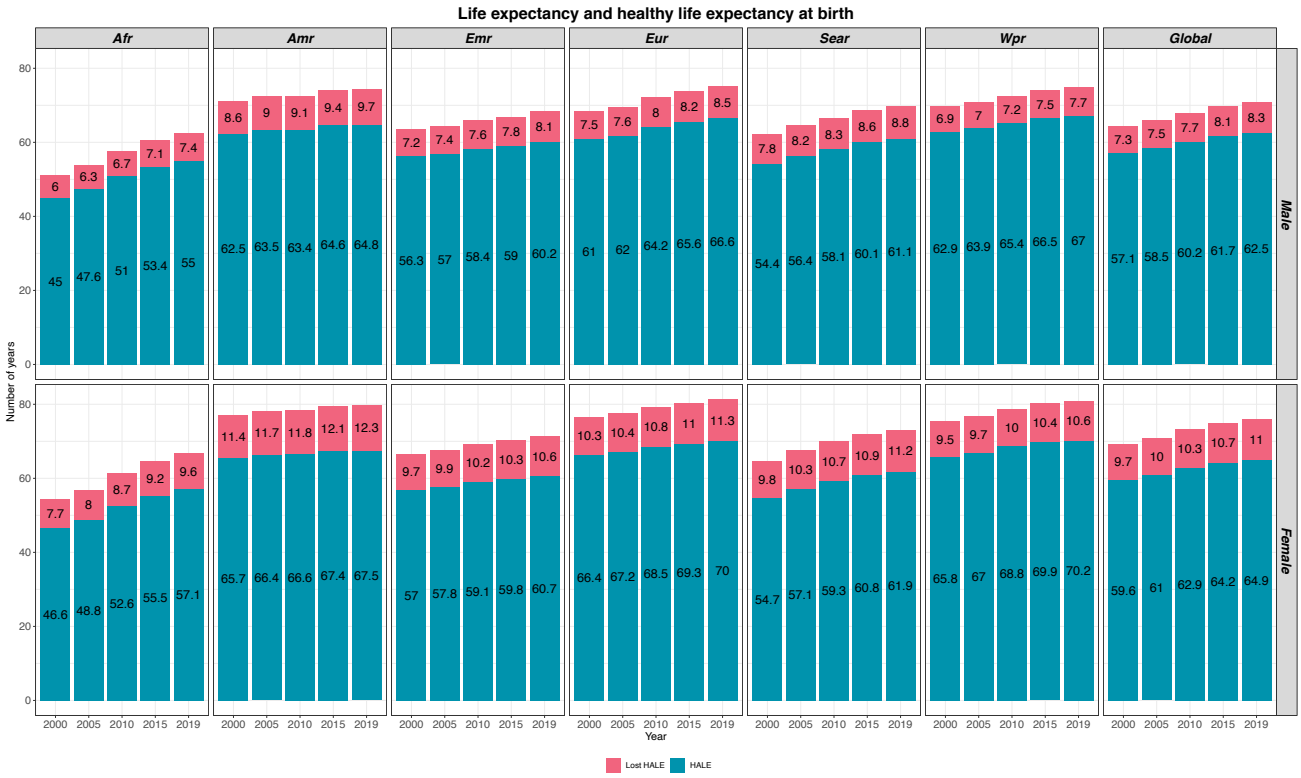


Fig. 2.1. Life expectancy and healthy life expectancy, by sex, global and WHO region, 2000–2019

Inequalities in healthy life expectancy and life expectancy

Globally, LE and HALE for males were consistently around 5 years and 2.4 years lower than females, and there has been very little change in the gaps between women and men in the past 20 years.

Across country income groups, however, there are different patterns of sex-related inequality in HALE. HALE is lowest in LICs for both men and women and has been improving the fastest of all income groups. However, the situation has been improving slightly faster for women than men, and the gap in HALE has consequently widened. Conversely, in HICs the gap between women and men is narrowing, as HALE among men has improved at a faster pace.

When examined according to WHO regions, the European Region and Western Pacific Region observed the widest male–female gaps in LE and HALE in 2019, at 6.2 and 6.1 years for LE and 3.4 and 3.2 years for HALE, respectively. In contrast, the Eastern Mediterranean and South-East Asia regions had the narrowest gaps at 3.0 and 3.2 years for LE and 0.5 and 0.8 years for HALE, respectively. Compared to 2000, the gaps were widening in the African, South-East Asia and Western Pacific regions, but closing in the Americas, European and Eastern Mediterranean regions.

Despite the remarkable gains in LE and HALE in the past 20 years, LICs remain behind the global average with 65.1 and 56.7, respectively (Fig. 2.2). LICs have been improving the fastest, gaining over 11 years (21.0%) in LE and nearly 10 years (20.8%) in HALE since 2000. However, in the latest 2015–2019 period, the pace of change in LICs has slowed down.

In HICs, increases were only 3.2 (4.2%) years in LE and 2.1 years (3.1%) in HALE since 2000, reaching 80.9 and 69.8 years respectively in 2019.

The marked gains in LE and HALE at birth in LICs and LMICs, relative to UMICs and HICs, predominantly reflect the significant progress made in the past 20 years in reducing mortality among children under 5 years of age in these settings *(2)*. The reduction is up to 53% in LICs, down from 143.6 deaths per 1000 live births in 2000 to 67.6 in 2019 *(2)*.

Examining LE and HALE at age 60 years, the income gradient associated with improvements reversed, with UMICs and HICs gaining more years than LMICs and LICs between 2000 and 2019. For example, LE and HALE at 60 years in LICs increased by 2.2 years (from 15.2 to 17.4 years) and 1.6 years (from 11.4 to 13.0 years), respectively; whereas in UMICs the increase was 2.7 years (from 18.5 to 21.2 years) and 2.0 years (from 14.0 to 16.0 years), respectively. This is in line with

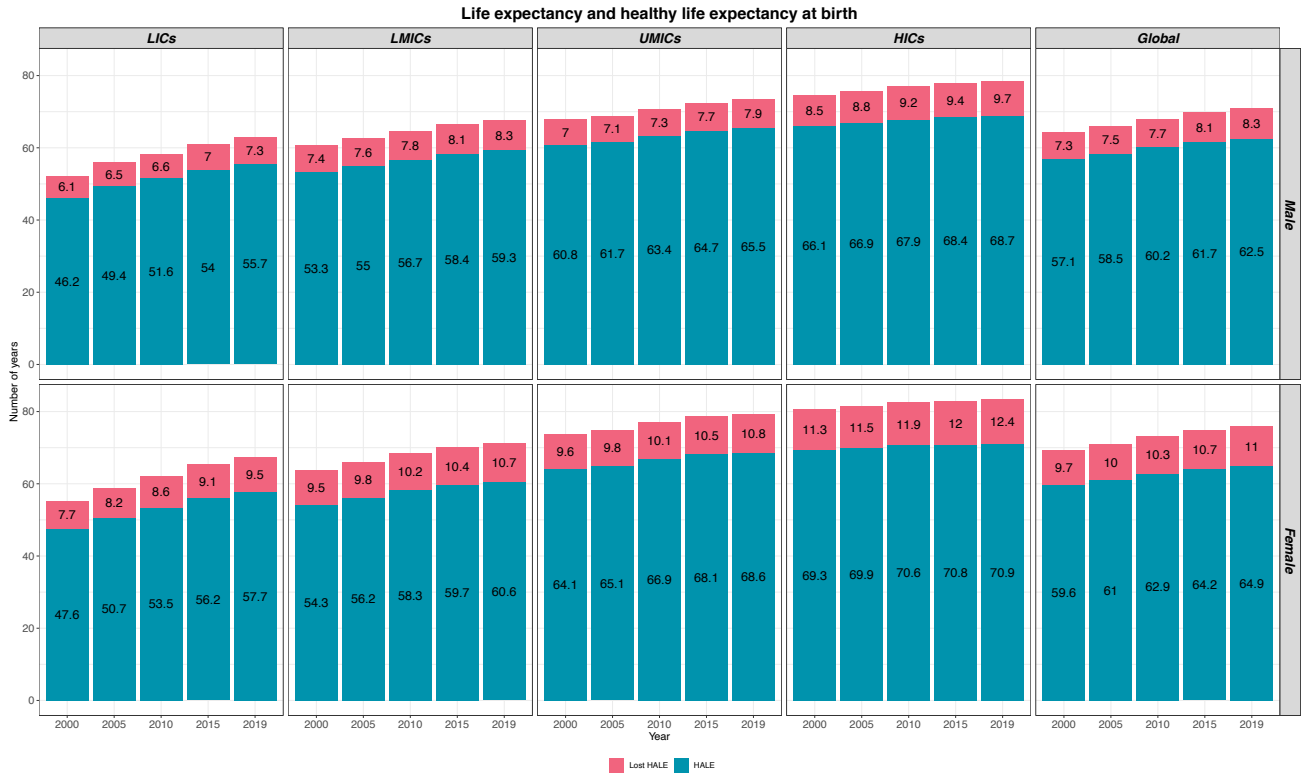


Fig. 2.2. Life expectancy and healthy life expectancy by sex, globally and by World Bank income group, 2000–2019

the greater mortality reduction at older ages in higher resource settings since the beginning of the century, mainly driven by a rapid decline in noncommunicable disease (NCD) mortality, partly because of the success in curbing cardiovascular diseases (CVDs) in many parts of the world.

Improvements in longevity, health and the changing disease burden

In relative terms, HALE as a proportion of overall LE at birth – at global, regional and income levels – remained largely constant with a slight downward trend at approximately 87–90% for men and 84–87% for women. The trends for the HALE/LE ratio at age 60 years are similar but with lower levels, at approximately 73–78% for men and 70–75% for women. The corresponding downward trends in UMICs and HICs were greater than other income groups, with up to a 1% decline between 2000 and 2019. Similarly, the Region of the Americas, the European Region and the Western Pacific Region also had a relatively higher rate of decline compared to other regions, signalling the rising levels of disability partly due to extended longevity in higher-resourced settings.

With improvements in longevity, the average number of years a male infant is expected to live in less than full health has risen by about one year since 2000, to 8.3 years in 2019 at the global level, and by 1.3 years for a female infant, reaching 11.0 years. From 2000 to 2019, the increases in the same figure at 60 years were 0.6 and 0.7 years, and reaching 4.7 and 6.0 years, respectively, for men and women. This shows that females, irrespective of age, on average live more years in disability and that the sex gap is widening as LE continues to grow overall.

These gains in LE and HALE reflect rapid transitions in the mortality and morbidity profiles in the past two decades. Globally, across WHO regions, age-standardized rates (ASR) of deaths and disability-adjusted life years (DALYs) dropped between 2000 and 2019 across all three broad categories of causes of death: communicable, maternal, perinatal and nutritional conditions (communicable diseases hereafter); noncommunicable diseases (NCDs); and injuries. This trend is underpinned by a dramatic decline in communicable diseases, most significantly in LICs and LMICs with reductions in ASRs of over 50%, at least doubling the decline seen in NCDs and injuries over the same period *(1)*.

The rapid decline in communicable diseases and attributable deaths – relative to NCDs and injuries – has led to overall population ageing as more individuals survive to older ages at which NCDs become the predominant health risks. Seven of the 10 leading causes of deaths in 2019 were NCDs. Globally, NCDs accounted for 60.8 % of all deaths in 2000, rising to 73.6% in 2019, with nearly all increase shifted from the percentage decline in communicable diseases, while

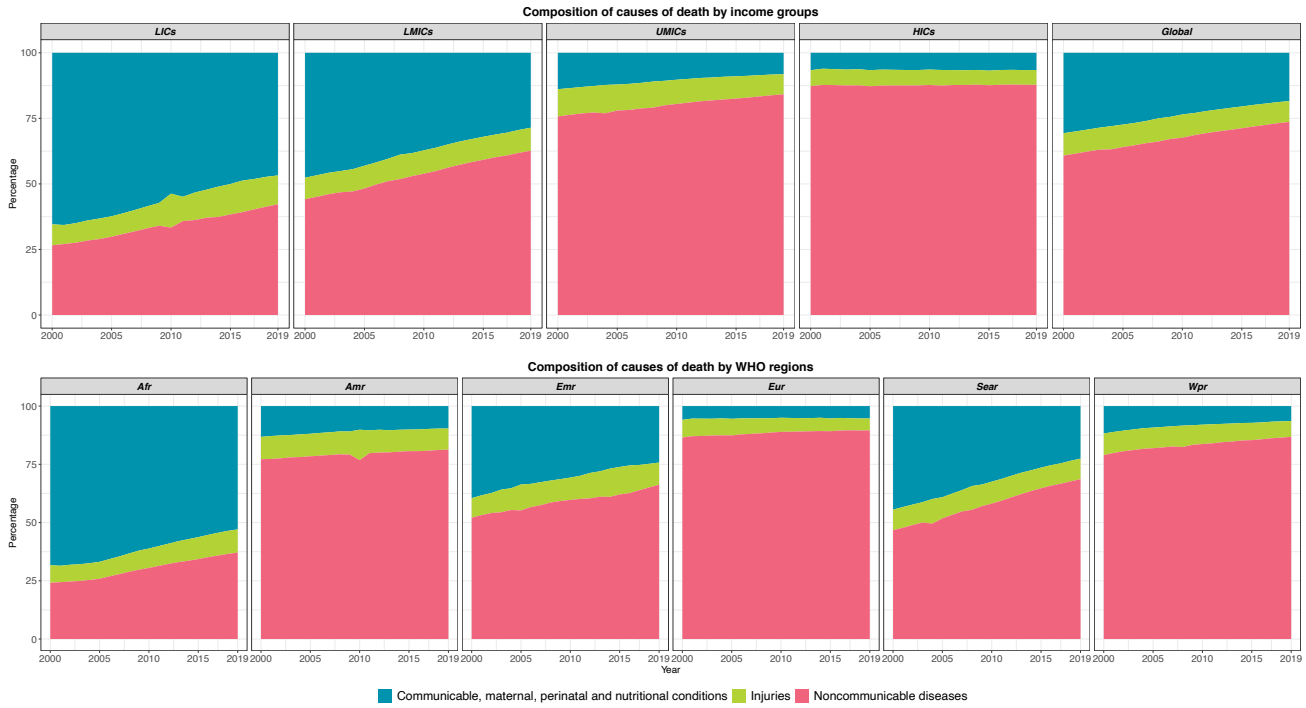


Fig. 2.3. Composition of causes of death, by World Bank income group and region, 2000–2019

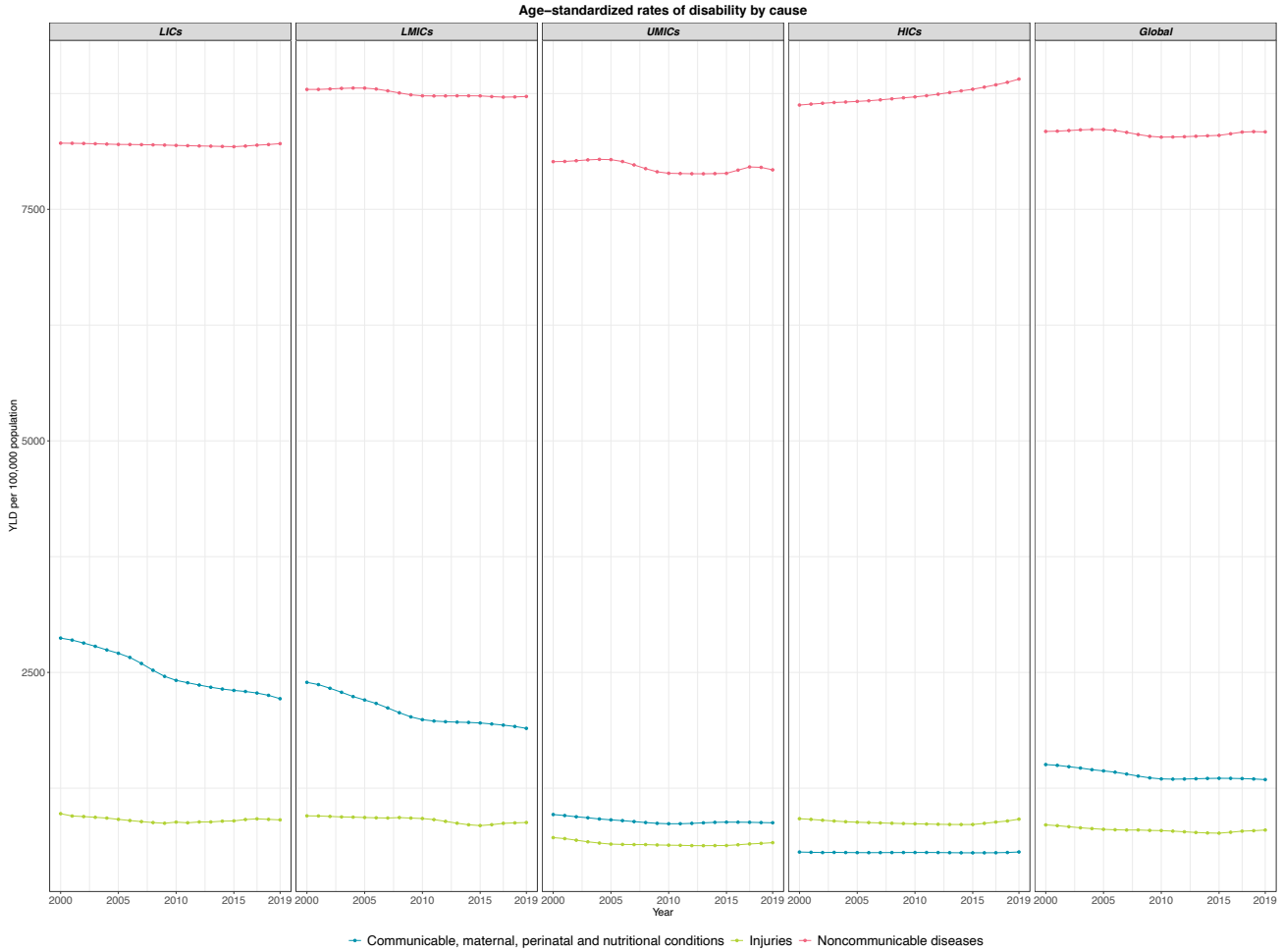


Fig. 2.4. Age-standardized rates of years lived with disability, by cause and World Bank income group, 2000–2019

the fraction for injuries remained relatively constant at about 10% (Fig. 2.3). NCDs accounted for a large proportion of deaths worldwide in 2019, as high as over 85% of mortality in HICs. Notwithstanding the rapid decline in ASR, communicable diseases were still responsible for nearly half (46.4%) of all deaths in LICs, and while the proportion of deaths from injuries has dropped in HICs, it has increased in LICs and LMICs.

In 2019, communicable diseases accounted for over half (52.9%) of all deaths in the African Region, 24.3% in the Eastern Mediterranean Region and 22.6% in the South-East Asia Region. In the European Region, the Western Pacific Region and the Region of the Americas, NCDs have the highest toll of deaths with 89.6%, 86.8% and 81.3%, respectively.

Despite the decline in mortality, a comparable improvement in morbidity was absent and in fact worsened to some extent because of decreased fatality of many health conditions. Globally, the ASR for years lived with disability (YLDs) per capita remained at approximately 0.15 years throughout 2000–2019, largely reflecting the stagnation of disability due to NCDs and injuries, although the ASR due to communicable diseases has declined by approximately 10.8% (Fig. 2.4). The trends by WHO regions and World Bank income groups are more diverse. LICs, LMICs and countries in the African Region have seen declining ASR for total YLDs, primarily driven by the reduction in YLD rates from communicable diseases. In contrast, HICs and countries in the Region of the Americas have seen small increases in ASR for total YLDs attributed to the upward trend for NCDs together with stagnation in injuries. Worldwide, the changes in ASR for YLDs in 2000–2019 are small and independent of cause of disability, the exception being communicable diseases for which considerable progress was seen in lower-resource settings.

Due to population growth and ageing, the total number of years the global population lived with disability (YLDs) was 825 million years in 2019, an increase of 214 million years since 2000. In parallel, the share of YLDs as part of the total DALYs increased by 10%. Among these, causes that constitute some of the largest number of deaths – including diabetes, COPD, stroke, road injuries, Alzheimer's disease, ischaemic heart disease, and cancers (e.g. lung, colorectal) – have all undergone a marked – up to twofold – increase in disability as measured by YLDs.

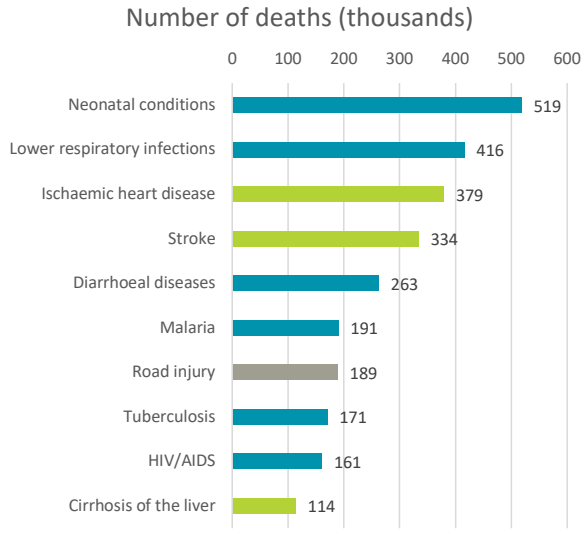
The world needs to remain alert to combat communicable diseases

2020 has shown the world how communicable diseases can expand in a matter of days from a small cluster to a health threat of international concern.

The global impact of communicable diseases[1] has been in steady decline since 2000 but they were still responsible for more than 10.2 million (95% uncertainty interval (UI)[2] 6.2 million to 16.7 million) deaths in 2019, representing 18% of all deaths *(1)*.

In the past 20 years, investments in diagnosis, treatment and control of child and maternal conditions as well as major communicable diseases – such as HIV/AIDS, malaria and TB – have had positive impacts and we have seen declines in their prevalence, incidence and mortality at the global level. However, these diseases persist in the top 10 causes of death in LICs in 2019 (Fig. 2.5).

Declining trends confirm the effectiveness of prevention programmes that exist in many countries to combat HIV/AIDS and the successful therapies that dramatically reduce viral load. They also confirm the effectiveness of early TB diagnosis, adequate treatment and focused efforts, including among vulnerable populations (e.g. people living with HIV). Through a combination of vector control, chemoprevention, diagnosis and treatment, 1.5 billion malaria cases and 7.6 million deaths are estimated to have been averted since 2000, despite slowing of progress since 2015. Progress is also anticipated with the pilot implementation of the first malaria vaccine in three countries of the African Region.



Source: WHO Global Health Estimates, 2019 *(1)*.

Fig. 2.5. Leading causes of death in LICs, 2019

[1] Communicable, maternal, perinatal and nutritional conditions.

[2] All uncertainty intervals are presented using 95% limits, unless otherwise stated.

Child mortality

Remarkable declines were seen for child mortality, yet disparities remain. In 2019, an estimated 5.2 million children (90% UI 5.0 to 5.6) died before reaching 5 years of age, with 2.4 million (90% UI 2.3 to 2.7) (47%) dying within the first 28 days of life (the neonatal period). Under-five and neonatal mortality rates have declined considerably over the past 30 years. In 2019, the under-five mortality rate was 37.7 per 1000 live births (90% UI 36.1 to 40.8), which is a 59% reduction from the 93 per 1000 live births (90% UI 91.7 to 94.5) seen in 1990. Neonatal deaths reached 17.5 per 1000 live births (90% UI 16.6 to 19) in 2019, which is a 52% reduction from 36.6 in 1990 (90% UI 35.6 to 37.8). Most of the under-five deaths were concentrated in two SDG regions: sub-Saharan Africa and Central and Southern Asia, which together accounted for more than 80% of deaths in 2019 yet only 52% of the under-five population.

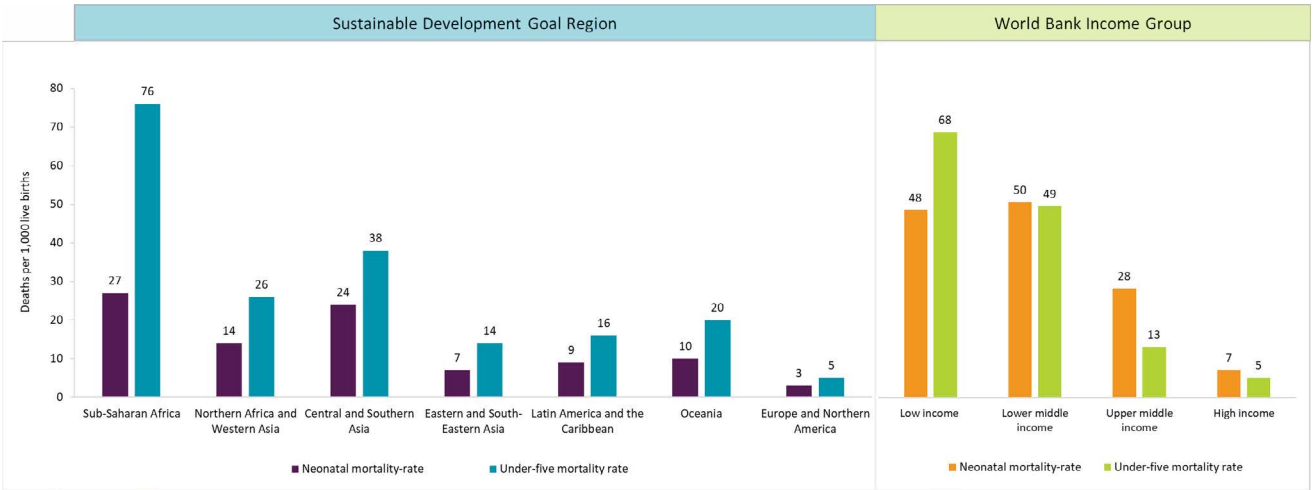
With the general declines in under-five mortality rates across all SDG regions and income groups, the lowest levels of child mortality have been achieved in UMICs and HICs (Fig. 2.6) with under-five mortality rates at 13.4 (90% UI 12.7 to 14.3) and 5.0 (90% UI 4.9 to 5.3), respectively. 122 countries and territories have already met the SDG target for under-five mortality and 20 countries are expected to do so by 2030. Intensified efforts are needed in 53 countries, three quarters of which are in sub-Saharan Africa.

The COVID-19 pandemic risks reversing the remarkable improvements seen over the past two decades in child and adolescent survival *(2)*. There is evidence that children and adolescents experience milder symptoms with SARS-CoV-2, the virus that causes COVID-19 disease, compared to adults. Nonetheless, they have been severely affected by disruptions in essential health, education and other services and by increasing poverty and inequality *(3,4)*.

Maternal mortality

Maternal mortality has shown uneven burden and progress. In 2017, an estimated 295 000 women (80% UI 279 000 to 340 000) died globally from causes related to or aggravated by pregnancy and childbirth, with a maternal mortality ratio (MMR) of 211 maternal deaths per 100 000 live births (80% UI 199 to 243). This represents a 35% reduction from the 451 000 (80% UI 431 000 to 485 000) maternal deaths, and a 38% reduction from the MMR of 342 (80% UI 327 to 368), estimated in 2000. LICs and LMICs accounted for 94% of the global maternal deaths in 2017 with an MMR of 462 (80% UI 437 to 540) and 254 (80% UI 226 to 307), respectively. Examining SDG regions, the burden was highest in sub-Saharan Africa with 196 000 (80% UI 180 000 to 235 000) maternal deaths and an MMR of 542 (80% UI 498 to 649) followed by Central and Southern Asia with 58 000 (80% UI 50 000 to 69 000) maternal deaths and an MMR of 151 (80% UI 131 to 181) (Fig. 2.7).

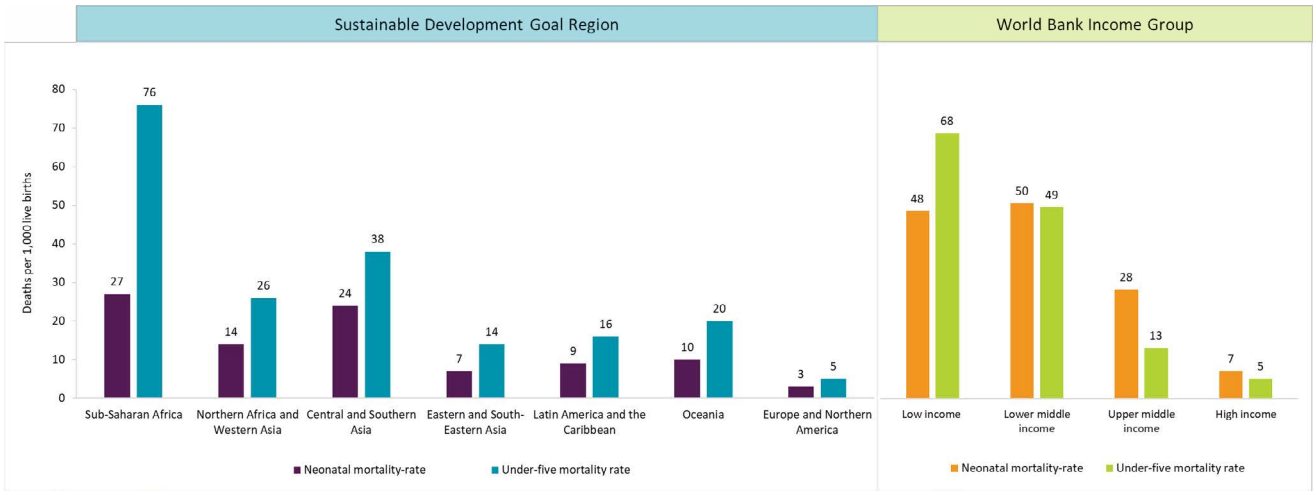
Intensified global efforts are needed to accelerate progress and achieve the global maternal mortality SDG target of less than 70 maternal deaths per 100 000 live births by 2030. The current projection is that achieving this global goal will require countries to reduce their MMR by an average annualized rate of reduction (ARR) of 6.1% per year between 2016 and 2030; currently only 16 countries have demonstrated reductions at this rate or higher. The average ARR for the global MMR during



Source: Levels and trends in child mortality: Report 2020. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation *(2)*.

Fig. 2.6. Estimates of under-five and neonatal mortality rate (deaths per 1000 live births) by Sustainable Development Goal regions and World Bank income groups, 2019

the 2000–2017 period was 2.9%. For the countries with the highest MMRs, substantially higher annual rates of reduction will be required to attain levels below 140 maternal deaths per 100 000 live births by 2030, which is the supplementary national target *(7)*. Between 2000 and 2017, Southern Asia achieved the greatest overall percentage reduction in MMR: 59% (from 384 to 157), which equates to an average ARR of 5.3%. Sub-Saharan Africa – where the overall burden is greatest – achieved an overall percentage reduction in the MMR of 38% between 2000–2017, equating to an average ARR of 2.8%.



Sources: Maternal mortality: Levels and trends 2000 to 2017 *(5)*; WHO Global Health Observatory *(6)*.

Fig. 2.7. Estimates of maternal mortality ratio by Sustainable Development Goal regions and World Bank income group, 2000 and 2017

Global efforts and strategies to eradicate/eliminate major communicable diseases by 2030

WHO and the international community have jointly developed global strategies towards achieving the global health-related targets embodied within the SDGs and the WHO Triple Billion targets. Several of these strategies focus on ending certain communicable diseases by 2030 such as TB, HIV, malaria, neglected tropical diseases (NTDs) and polio, with a focus on sustained investments in countries (Table 2.1).

Table 2.1. Summary of selected global strategies on communicable diseases

	Milestones	2030 Goal	2030 SDG target
End TB strategy *(8)*			
TB deaths	2020: ↓ 35%* 2025: ↓ 75%	↓ 95%	"End the epidemic of TB across all countries"
TB incidence rate	2020: ↓ 20% 2025: ↓ 50%	↓ 80%	
TB-affected families facing catastrophic costs due to TB (%)	2020: 0% 2025: 0%	0%	
Global health sector strategy on HIV 2016–2021 *(9)*			
New HIV infections	2020: < 500 000/year	↓ 90%	"End the epidemic of HIV across all countries"
AIDS-related deaths	2020: < 500 000/year	↓ 90%	
Global AIDS strategy 2021–2026 *(10)*			
New HIV infections	2025: < 370 000/year	↓ 90%	"End the epidemic of HIV across all countries"
AIDS-related deaths	2025: < 250 000/year	↓ 90%	
Global technical strategy for malaria 2016–2030 *(11)*			
Malaria incidence	2020: ↓ 40% (at least) 2025: ↓ 75% (at least)	↓ 90% (at least)	"End the malaria epidemic across all countries"
Malaria deaths	2020: ↓ 40% (at least) 2025: ↓ 75% (at least)	↓ 90% (at least)	
Countries eliminating malaria	2020: 10 countries 2025: 20 countries	35 countries	
Road map for neglected tropical diseases (NTDs) 2021–2030 *(12)*			
People requiring interventions against NTDs	Disease-specific targets set for each NTD include 2023 and 2025 milestones	↓ 90%	"End the NTDs epidemics across all countries"
Disability-adjusted life years related to NTDs		↓ 75%	
Countries eliminating at least one neglected tropical disease		100	
NTDs eradicated		2	
Polio endgame strategy 2019–2023 *(13)*			
Wild poliovirus transmission	2030: Eradication of polio		

Note: * % declines are relative to 2015 baselines.

Tuberculosis

Two thirds of the global tuberculosis burden are concentrated in eight countries

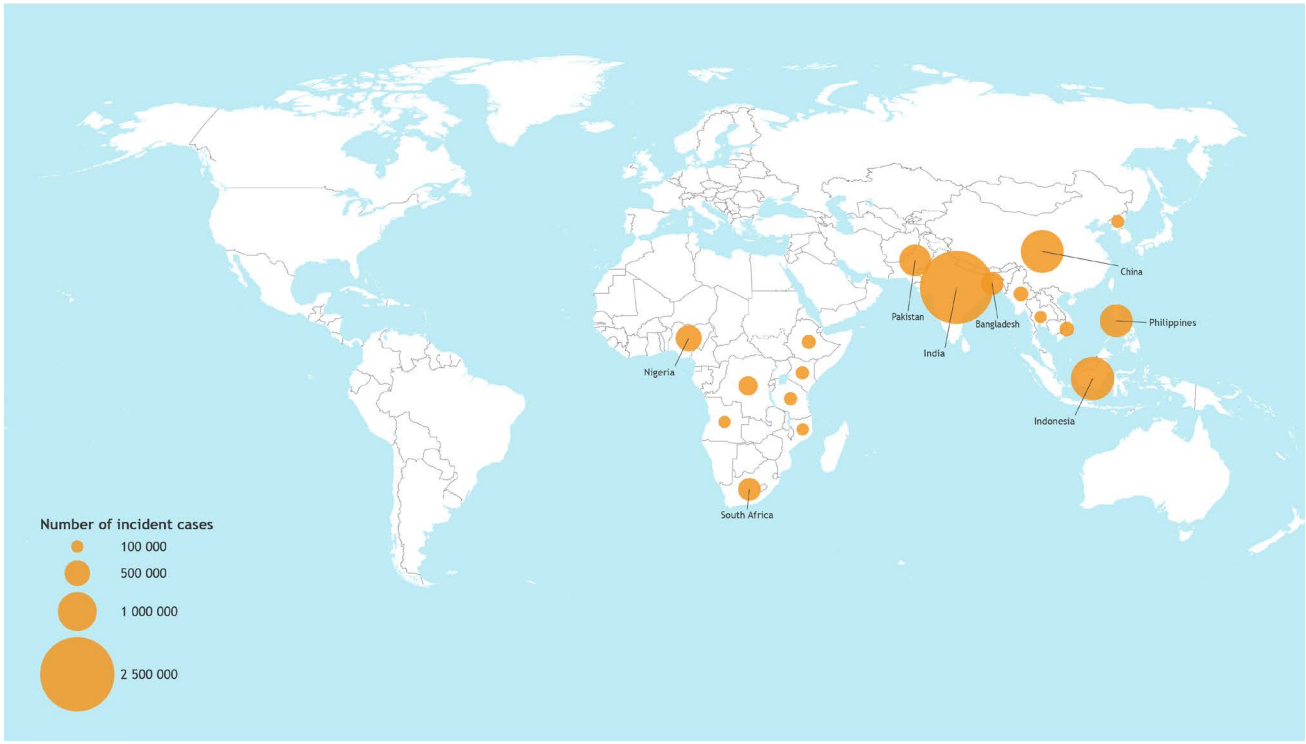
There were an estimated 10 million (UI 8.9 to 11.0) new (incident) TB cases worldwide in 2019, of which 56% occurred among men (aged 15+ years), 32% in women and 12% in children (aged 0–14 years). People living with HIV accounted for 8.2% of the global TB burden. Regions most heavily affected by TB in 2019 were the South-East Asia Region (44%), the African Region (25%) and the Western Pacific Region (18%), with smaller proportions in the Eastern Mediterranean Region (8.2%), the Region of the Americas (2.9%) and the European Region (2.5%). Two thirds of all TB globally was attributed to just eight countries with the highest burdens: India, Indonesia, China, the Philippines, Pakistan, Nigeria, Bangladesh and South Africa (Fig 2.8).

Although global TB incidence declined by 25% from 174 (UI 145 to 205) new and relapsed cases per 100 000 population in 2000 to 130 (UI 116 to 143) per 100 000 population in 2019, large gaps in detection and treatment persist in some countries. Current progress is insufficient to meet the SDG target of ending the TB epidemic by 2030. The European Region has made progress towards the 2020 milestone of a 20% reduction (from 2015) reporting a 19% decrease in the TB incidence rate in 2019. The African Region has also made good progress, with a reduction of 16%.

Tuberculosis remains the world's leading cause of death from a single infectious agent, the leading killer of people with HIV and a major cause of deaths related to antimicrobial resistance. Although preventable and curable, in 2019 approximately 1.2 (UI 1.1 to 1.3) million HIV-negative people died from TB, with an additional 208 000 (UI 177 000 to 242 000) deaths among people living with HIV. The highest reported TB mortality occurs in the African Region and South-East Asian Region.

Nevertheless, the annual number of TB deaths globally has fallen by 45% between 2000 and 2019, but not sufficiently fast to reach the 2030 SDG target of a 90% reduction of the 2015 mortality baseline. Only the European Region is on track to reach the 2020 milestone of a 35% decline, with a 31% reduction in TB deaths from 2015 to 2019.

Drug resistant TB continues to be a public health threat. In 2019, 465 000 (UI 400 000 to 535 000) new cases of TB had resistance to rifampicin, the most potent first-line anti-TB drug, of which over three quarters were also resistant to isoniazid (multidrug-resistant TB). Few new drugs are in the development pipeline to address resistance.



Source: Global tuberculosis report 2020 *(14)*.

Fig. 2.8. Countries with the highest TB burden (at least 100 000 incident cases), 2019

HIV/AIDS

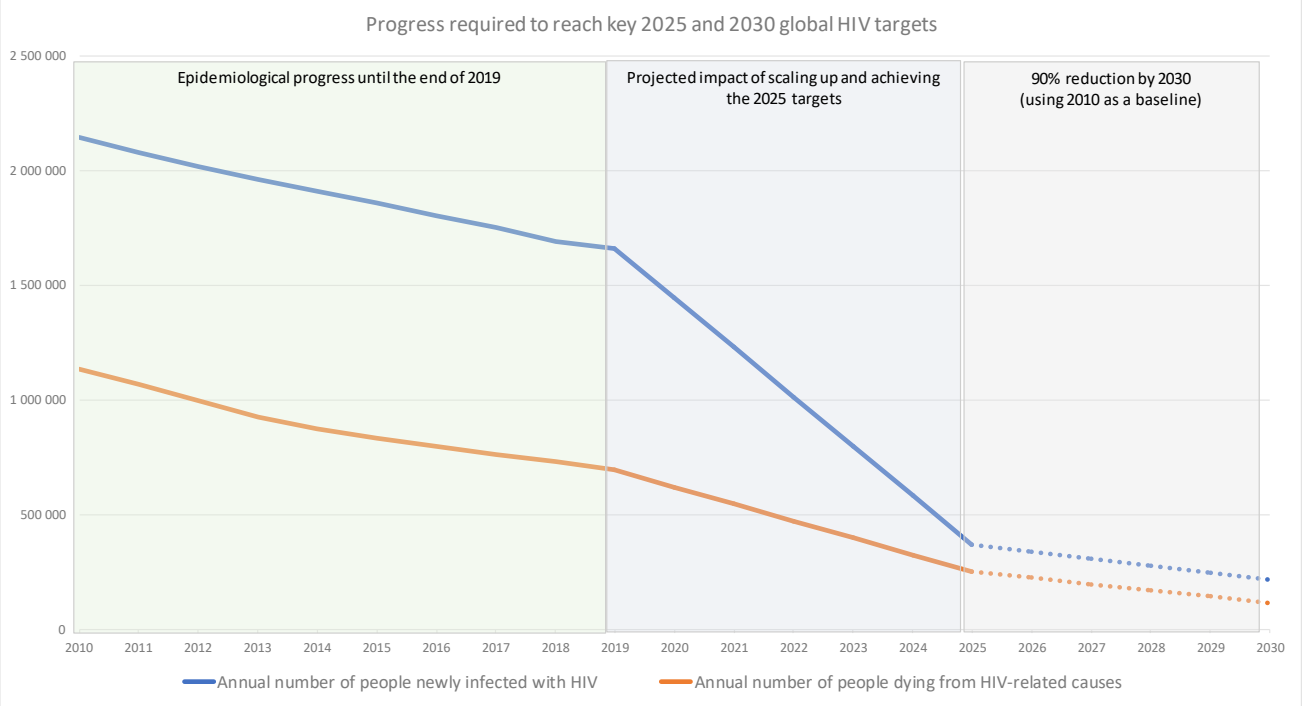
Far from the 2020 milestone of <500 000 annual HIV infections

Although HIV/AIDS is no longer necessarily a life-threatening condition, and people living with HIV can increasingly regard it as a chronic disease, there is still no cure or preventive vaccine.

In 2019, an estimated 38.0 million (UI 31.6 to 44.5 million) people were living with HIV worldwide. An estimated 36.2 million (UI 30.2 to 42.4 million) were adults (aged 15+ years) and 1.8 million (UI 1.3 to 2.2 million) were children (0–14 years). New annual HIV infections have been reduced by 40% since the peak at 2.8 million (UI 2.0 to 3.7 million) infections in 1998. In 2019, around 1.7 million (UI 1.2 to 2.2 million) people were newly infected with HIV. Nevertheless, this is far from the 2020 global milestone of <500 000 new infections annually.

Globally, women and girls accounted for about half (48%) of all new HIV infections in 2019. In sub-Saharan Africa, 59% of all new HIV infections were among women and girls. In some regions, women who have experienced physical or sexual intimate partner violence (IPV) are 1.5 times more likely to acquire HIV than women who have not experienced such violence.

HIV-related deaths have been reduced by 60% since the peak at 1.7 million (UI 1.2 to 2.4 million) deaths globally in 2004 (Fig. 2.9). In 2019, around 690 000 (UI 500 000 to 970 000) people died from HIV-related illnesses worldwide. This brings the world close to reaching the 2020 milestone of <500 000 deaths annually, although that target is also likely to be missed, given current trends. Coinfection with TB remains the leading cause of death among people living with HIV, accounting for around one in three HIV-related deaths *(15)*.



Sources: AIDSinfo. Joint United Nations Programme on HIV/AIDS (UNAIDS) *(16)*; and WHO Global Health Observatory (GHO) data *(17)*.

Fig. 2.9. Global trends in HIV incidence and mortality, and progress required to reach key 2025 and 2030 global targets, 2010–2030

Malaria

Malaria case incidence and mortality declining in all WHO regions

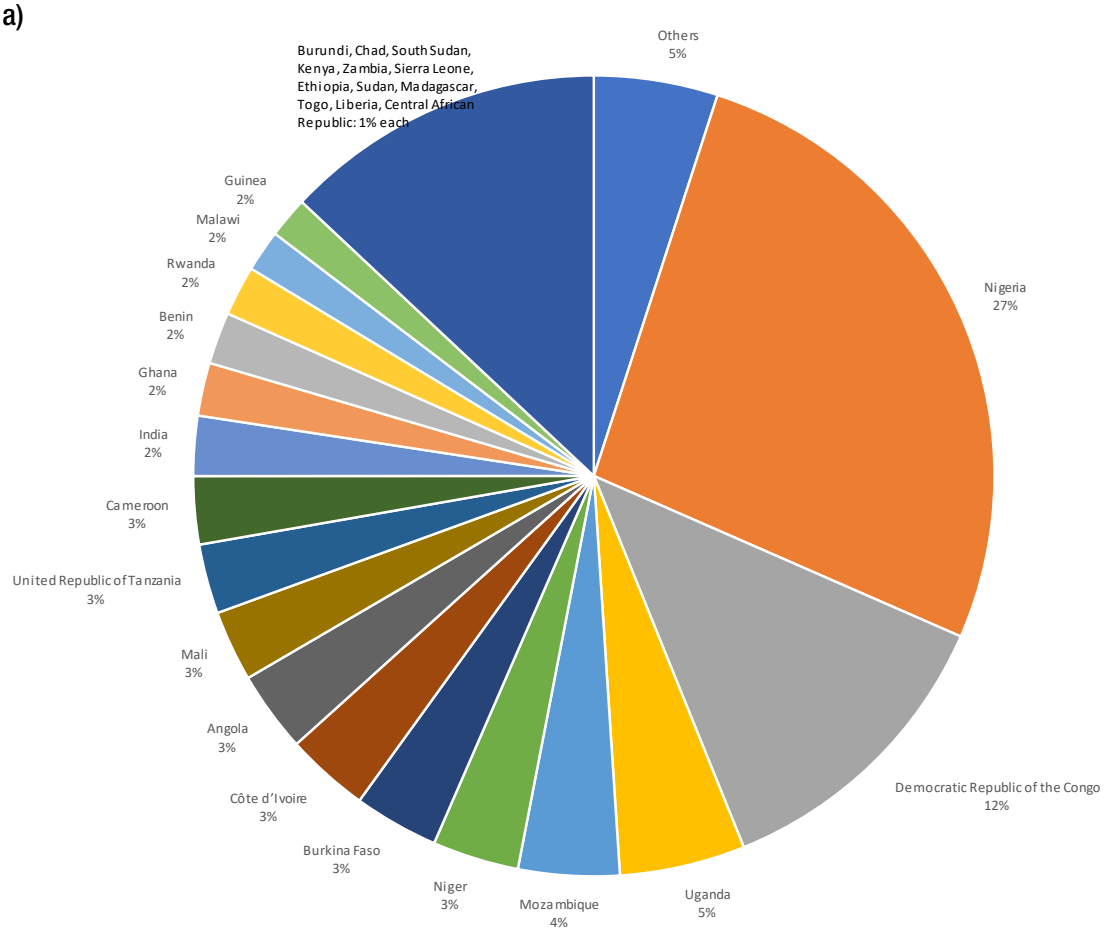
Malaria case incidence fell from 80 (UI 75 to 87) per 1000 population at risk in 2000 to 57 (UI 52 to 62) per 1000 in 2019. Although this led to a total estimated decline in malaria cases – from 238 million (UI 222 to 259 million) in 2000 to 229 million (UI 211 to 252 million) in 2019 – progress has stalled over the past 4 years, and only a 3% reduction in incidence was achieved in 2019 compared to the 2015 baseline. This is far from the milestone of a 40% reduction by 2020 and much too slow to meet the SDG target of at least 90% reduction by 2030.

However, the malaria mortality rate (deaths per 100 000 population at risk) was reduced from 25 deaths per 100 000 population at risk in 2000 to 10 per 100 000 in 2019. The total number of deaths worldwide fell from 736 000 (UI 697 000 to 782 000) in 2000 to 409 000 (UI 387 000 to 460 000) in 2019. Despite this remarkable progress, only an 18% reduction in malaria mortality rate was achieved in 2019 compared to 2015, far from the milestone of a 40% reduction by 2020, and off-track to meet the SDG target of at least 90% reduction by 2030.

All WHO regions have shown reductions in malaria case incidence and mortality since 2000, and the entire European Region has been free of malaria since 2015. The African Region continues to shoulder the heaviest burden of the disease. Globally in 2019, the region accounted for 94% (215 million cases, UI 187 million to 237 million) of all malaria cases and 94% (386 000 deaths, UI 365 000 to 433 000) of all malaria deaths, with Nigeria and Democratic Republic of the Congo accounting for the heaviest share in both cases and deaths (Fig 2.10). Malaria is the fourth leading cause of DALYs lost in the region in 2019, accounting for 6% of all DALYs *(1)*. Malaria continues to take a heavy toll on pregnant women and children, particularly in the African Region. In 2019, an estimated 11.6 million pregnant women living in 33 African countries with moderate to high transmission were infected with malaria (35% of all pregnancies). As a result, an estimated 822 000 children in these 33 countries were born with a low birth weight *(18)*.

Nonetheless, 21 countries reported at least three consecutive years of zero indigenous malaria cases, and 10 of these countries were certified malaria-free by WHO between 2000 and 2019. Malaria was prevented from re-establishment in all malaria-free countries.

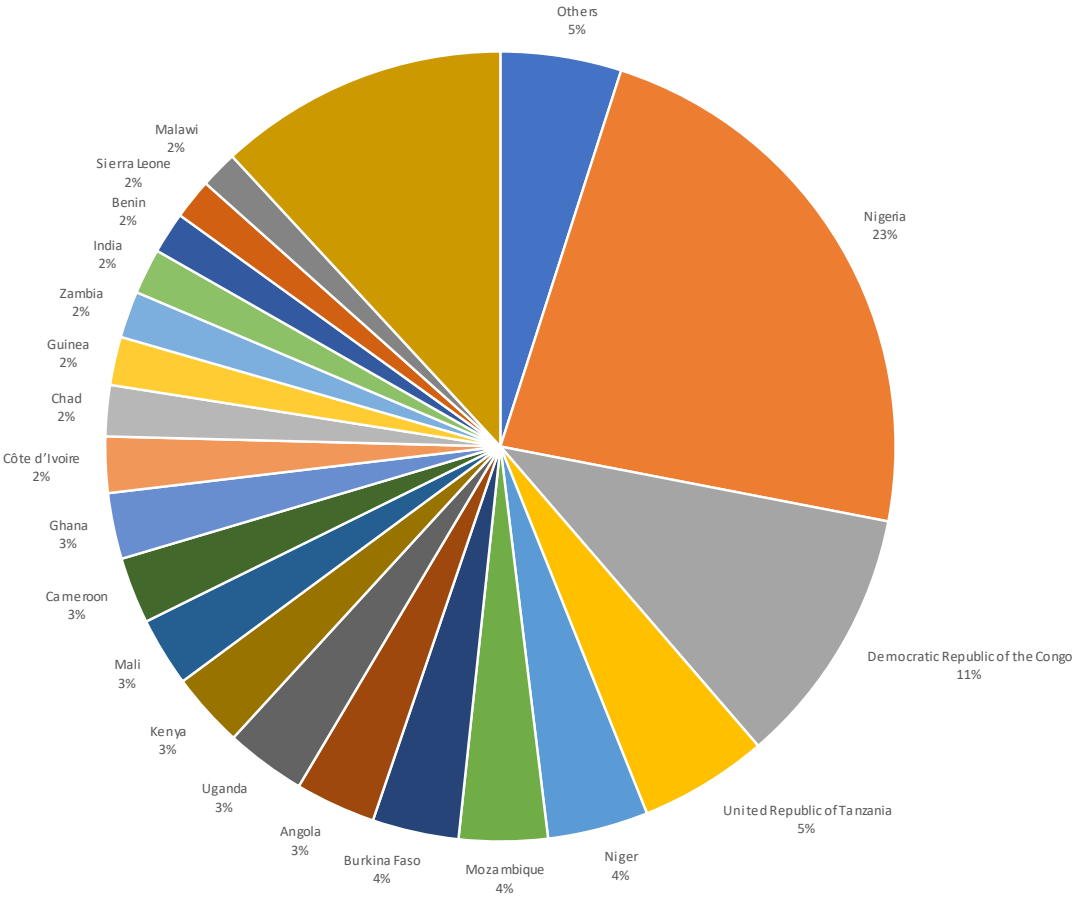
a)



Source: World malaria report 2020 *(18)*.

Fig. 2.10. Global distribution of a) malaria cases and b) deaths, by country, 2019

b)



Source: World malaria report 2020 *(18)*.

Fig. 2.10. Global distribution of a) malaria cases and b) deaths, by country, 2019

Neglected tropical diseases

One in five people in the world require prevention, treatment and care for neglected tropical diseases (NTDs)

The 20 WHO-defined NTDs mostly affect populations living in poverty in tropical areas. In 2019, 1.74 billion people were reported to require mass or individual treatment and care for NTDs: down from 2.19 billion people in 2010. Approximately half of those still requiring such interventions live in the South-East Asia Region and about a third in the African Region. The majority require mass treatment for the diseases targeted with preventive chemotherapy: lymphatic filariasis, onchocerciasis, soil-transmitted helminthiases, schistosomiasis and trachoma.

All regions have made progress in reducing the proportion of their populations requiring treatment and care for NTDs between 2010 and 2019, and since the first WHO roadmap for the prevention and control of NTDs was launched in 2012 *(19)*.

Advancement has been paralleled by elimination of at least one disease in each of 42 countries, territories and areas since 2010. Dracunculiasis is on the verge of eradication, with 27 human cases reported in six countries in 2020; lymphatic filariasis and trachoma have been eliminated as public health problems 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 fell from more than 7000 in 2012 to fewer than 1000 in 2019, halving the original target of 2000 cases by 2020; and the number of new leprosy cases reported globally has continued to decline since 2010 at an average of 1% per year after most endemic countries achieved elimination as a public health problem, defined as less than one case on treatment per 10 000 population. While substantial improvements have been made, not all of the 2020 targets have been met. The new WHO global roadmap for NTDs (2021–2030) *(12)* underlines, in addition to disease-specific 2030 targets and intermediate milestones, four overarching and 10 cross-cutting 2030 targets, aligned both with the SDGs and with the WHO GPW 13, and the multisectoral actions required to reach them.

Hepatitis B

Only one in 10 people with hepatitis B are aware of their infection

WHO estimates that in 2019, 295.8 million people were living with chronic hepatitis B infection (defined as hepatitis B surface antigen positive); among them, 30.4 million people living with hepatitis B knew their hepatitis B status and 6.6 million people diagnosed with hepatitis B received treatment *(20)*. In 2019, hepatitis B resulted in an estimated 820 000 (UI 450 000 to 950 000) deaths, mostly from cirrhosis and hepatocellular carcinoma (i.e. primary liver cancer). It is estimated that 1.5 million people were newly infected with chronic hepatitis B infection in 2019.

Hepatitis B prevalence is highest in the African Region and the Western Pacific Region, where 7.5% and 5.9% of the adult population, respectively, are estimated to be infected. In the South-East Asia Region, the Eastern Mediterranean Region and the European Region, an estimated 3.0%, 2.5% and 1.46% of the general population are thought to be infected, respectively. In the Region of the Americas, prevalence is lower at 0.53%.

Hepatitis B can be prevented by vaccines that are safe, available and effective. The global proportion of children under 5 years of age chronically infected with hepatitis B virus dropped to 0.94% in 2019, down from around 5% in the pre-vaccine era ranging from the 1980s to the early 2000s.

Poliovirus

Wild poliovirus is still classified as endemic in only two countries

Of the three strains of wild poliovirus (i.e. type 1, type 2 and type 3), wild poliovirus type 2 was eradicated in 1999 and no case of wild poliovirus type 3 has been found since the last reported case in Nigeria in November 2012. Both strains have officially been certified as globally eradicated with type 3 status declared as of October 2019 *(21)*.

As of 2020, wild poliovirus type 1 affects two countries globally: Pakistan and Afghanistan, with 84 and 56 reported cases, respectively. No cases of wild poliovirus type 1 have been reported in Nigeria since August 2016 and the WHO African Region was certified free in 2020 *(22)*.

Antimicrobial resistance

Antimicrobial resistance is a global health and development threat

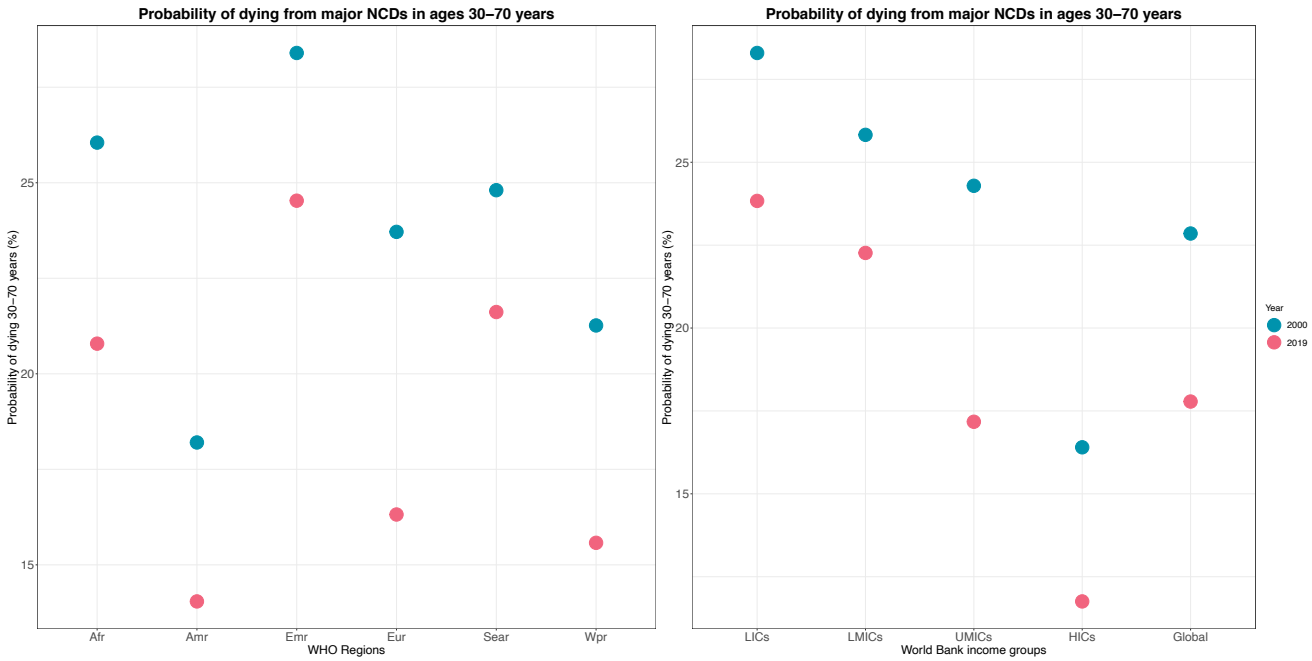
Antimicrobial resistance (AMR) threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi. WHO launched the Global Antimicrobial Resistance and Use Surveillance System (GLASS) *(23)* in 2015 to continue filling knowledge gaps and to inform strategies at all levels.

In 2020, two pathogens responsible for bloodstream infections were added to the SDG indicators. The first measure included in the indicator is the proportion of bloodstream infections due to Escherichia coli that is resistant to third 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 but lower values are observed in HICs. National representativeness of the reported data remains problematic particularly in low-resourced countries generally still at an early stage of antimicrobial resistance surveillance *(23)*.

Noncommunicable diseases

The world has seen progress in combating NCDs since 2000. However, the progress is not comparable to that made for curbing communicable diseases and is unequal across regions and income groups.

Global premature NCD mortality – as measured by the probability of dying from one of the four major NCDs (cancer, cardiovascular diseases (CVD), diabetes and chronic respiratory diseases (CRD)) between the ages 30 and 70 years (SDG indicator 3.4.1) – dropped over one fifth from 22.9% in 2000 to 17.8% in 2019. This is below the approximately 30% decline seen in HICs and UMICs, but far exceeds the progress made in LICs and LMICs, where the decline was from 13% to 16% over the same 20-year period. The South-East Asia Region and the Eastern Mediterranean Region had the slowest 20-year declines at about 13%, less than half of that seen in the European Region (31%) and the Western Pacific Region (27%). The African Region and the Region of the Americas had similar reductions, at 20% and 23%, respectively (Fig. 2.11).



Source: WHO Global Health Estimates, 2019 *(1)*.

Fig. 2.11. Probability of premature mortality from major noncommunicable diseases, by WHO regions and World Bank income group, 2000–2019

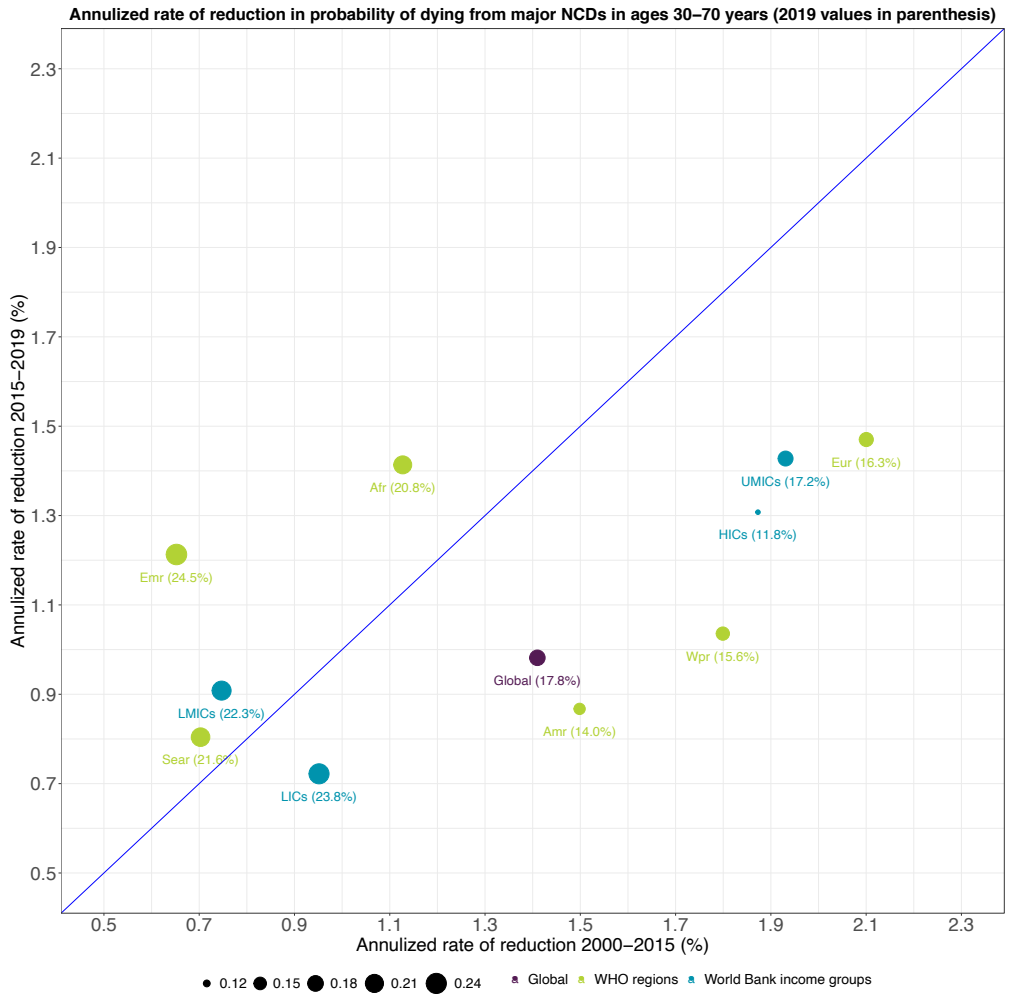
The global ARR in premature NCD mortality has decreased by 30% since 2015, to just below 1% (from the 1.4% ARR observed between 2000–2015). Without effective acceleration strategies to bring the ARR back in line with the required 2.7% annual decrease from 2015, the world is destined to fall short of the SDG target with few countries on track to meet it.

But regional trends belie mixed underlying situations: WHO regions that had already achieved relatively low premature NCD mortality by 2019 tended to show the most marked declines in ARR since 2015. In the Region of the Americas and the Western Pacific Region, for example, the ARR declines were up to 40%, and 30% in the European Region. In contrast, those with the persistently highest premature NCD mortalities by 2019 saw more rapid decreases in mortality during 2015–2019, as demonstrated by increases in ARR ranging from 14% in the South-East Asia Region to 86% in the Eastern Mediterranean Region (Fig 2.12).

When examined according to World Bank income groups, the underlying variations were less distinct, with the ARRs in LICs, UMICs and HICs slowing at similar rates (24%, 26% and 30%, respectively). Acceleration was seen in LMICs, however, with ARRs rising by 22% in 2015–2019 compared to 2000–2015. Despite the acceleration in a handful of regions, if the current rates of decline continue, meeting the SDG target in these regions would remain a remote possibility.

Trends in deaths due to the four major NCDs in all ages (i.e. not only premature mortality) were driven by diverse changes across regions in 2000–2019. Globally, the greatest decline in mortality was seen for CRD, with a 37% decline in age-standardized rates (ASR) for all ages, followed by CVD and cancer at 27% and 16% respectively. However, the ASR for diabetes has shown an unfavourable trend with a 3% increase in ASR. The greatest success in lowering mortality from CRD occurred in the Western Pacific Region, showing a decline of about 55%. In the Region of the Americas and the European Region, CVD declines led to the greatest reduction in mortality by up to 43%, followed by cancer with a decline of around 20%. The mortality from diabetes, however, has worsened in some parts of the world, ranging from an increase in ASR of less than 5% in the Region of the Americas and the South-East Asia Region, to over 20% in the Eastern Mediterranean Region. Similar increases were seen when diabetes mortality was assessed according to income groups, increasing ASR by approximately 5% in UMICs and by 13% in LMICs.

Although the overall trends in mortality for the four major NCDs are heading downwards, as indicated by the ASRs for all age groups, the total number of deaths generally attributed to these causes have gone up because of population growth and ageing. Those four diseases alone killed a total of 33.2 million people in 2019, a 28% increase compared to 2000. The greatest



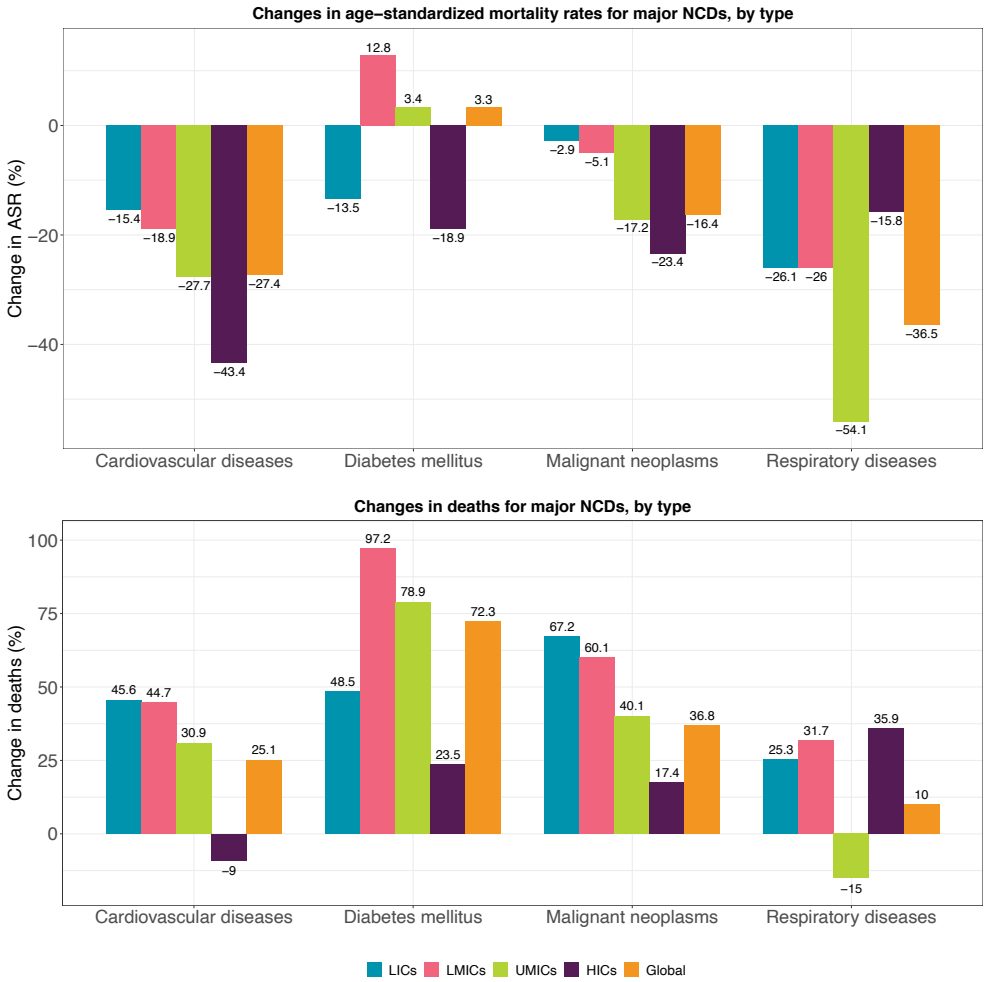
Source: WHO Global Health Estimates, 2019 *(1)*.

Fig. 2.12. Annualized rate of reduction in noncommunicable disease mortality, by WHO regions and World Bank income group, 2000–2015 and 2015–2019

burden was borne by the Western Pacific Region with 14.6 million deaths, and by UMICs (10.0 million) and LMICs (10.5 million).

By disease, the total global CVD deaths grew by one quarter since 2000, reaching 17.9 million in 2019; cancer deaths grew 37% to 9.3 million; CRD grew 10% to 4.1 million; and diabetes by 72% to 2.0 million. The greatest increase in absolute number of deaths was from CVD with a rise of 1.8 million in the Western Pacific Region (and 1.9 million in UMICs) compared to 2000. Increases in cancer were also highest from these parts of the world, at 1.2 and 1.0 million respectively. Although deaths from diabetes and its increase between 2000 and 2019 were lower, the greatest percentage increases were seen for this disease in the South-East Asia Region and the Eastern Mediterranean Region (and LMICs) with a doubling of deaths in 2019 relative to 2000. In contrast, the only observed declines were CVD in the European Region (and HICs), and CRD in the Western Pacific Region (and UMICs) and for which the mortality rates across the age span have dropped sufficiently to lead to an over 10% reduction in the total number of deaths (Fig. 2.13).

In summary, notwithstanding some reductions in the premature mortality risk from NCDs, progress is insufficient to attain the corresponding SDG target. The COVID-19 pandemic is an additional wake-up call for intensified NCD intervention, as patients with existing NCD conditions and comorbidities suffer from increased risk of severe illness and death from COVID-19. Populations that are already affected by NCDs now become additionally vulnerable to a life-threatening condition that could cost their lives in a matter of days, potentially shortening the population level LE and erasing the hard-won progress made worldwide in the past 20 years. Accelerated progress calls for more effective and cost-effective policies and actions for NCD prevention and control, through investments in health promotion, reducing the prevalence of risk factors and improving diagnosis, treatment, rehabilitation and palliation with strengthened health systems.



Source: WHO Global Health Estimates, 2019 *(1)*.

Fig. 2.13. Changes in age-standardized mortality rate and deaths for major noncommunicable diseases, by World Bank income group, 2000–2019

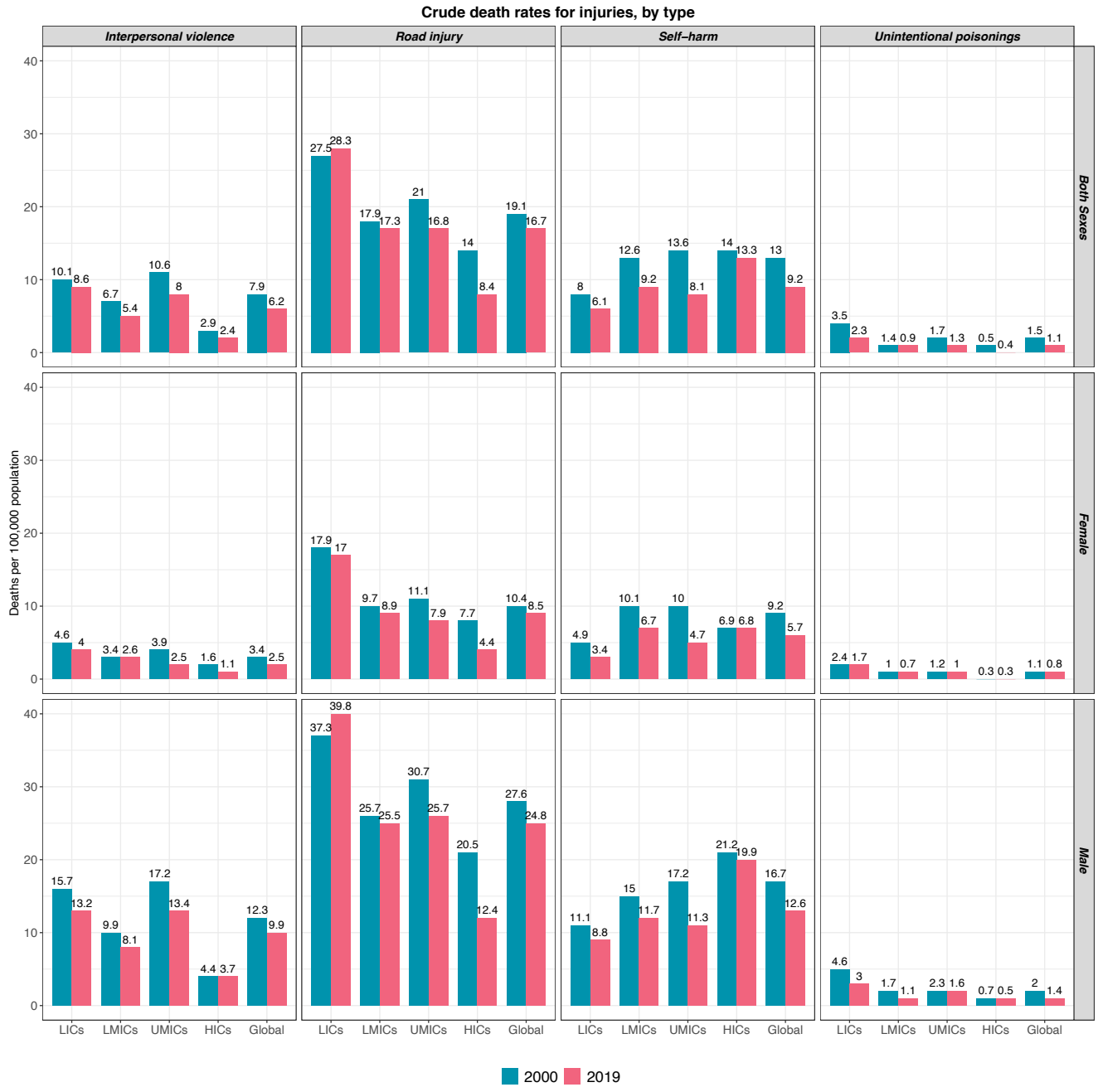
Injuries

Injuries account for 8% of global deaths *(1)*. More than 4 million people died because of injuries in 2019. Whether intentional or unintentional, these deaths can be prevented.

Although there have been some spikes in death rates from injuries in certain areas of the world due to natural disasters and armed conflicts, the overall trend for injury deaths has been slightly declining since 2000. Deaths from four specific types of injuries that are addressed by the SDGs – homicide, road injury, suicide and unintentional poisoning – have seen downward trends in general from 2000 to 2019 (Fig. 2.14).

Nearly 475 000 (UI 337 000 to 668 000) people were killed by others in 2019: 80% of them were men. Corresponding crude death rates (CDRs) were in decline, falling by 20% from 7.9 (UI 6.5 to 9.7) per 100 000 population in 2000 to 6.2 (UI 4.4 to 8.7) per 100 000 population in 2019. The rates were highest in UMICs with male homicide mortality of 13.4 (UI 10.8 to 16.7) per 100 000 population, followed by LICs with 13.2 (UI 6.7 to 23.0) male homicide mortality.

The WHO Region of the Americas reached the highest male homicide mortality with 34.0 (UI 28.0 to 41.5) per 100 000 population, 250% higher than the global male mortality rate. Homicide mortality has shown a strong age pattern, with age-specific mortality rates peaking at ages 20–29 years, at over 10 deaths per 100 000 population globally.



Source: WHO Global Health Estimates, 2019 *(1)*.

Fig. 2.14. Crude death rate by injury type, by sex, 2000–2019

Unintentional poisoning

A total of over 84 000 (UI 48 000 to 137 000) people, equivalent to 1.1 (UI 0.6 to 1.7) per 100 000 population died from unintentional poisoning in 2019. Men were dying from poisoning at a rate that was 66% higher than women, and the population at both ends of the age span succumb to the highest mortality rates. Among World Bank income groups, the highest CDRs were observed in LICs at 2.3 (UI 0.9 to 5.1) per 100 000 population. The CDR in the WHO African Region was even higher at 2.5 (UI 1.2 to 5.0). This, however, represents significant progress compared to 2000, decreasing by one third and one quarter, respectively. Countries of the South-East Asia Region and European Region showed the largest decline, dropping by approximately half and two thirds, respectively.

Road injury

CDR for road injury deaths declined by nearly 13% globally to 16.7 (UI 13.1 to 20.2) per 100 000 population, even though the total number of road injury deaths increased slightly from 1.2 (UI 1.0 to 1.4) million in 2000 to 1.3 (UI 1.0 to 1.6) million in 2019. The greatest decline occurred in the European Region with a 50% reduction since 2000, attaining the lowest values worldwide at approximately 7.4 (UI 5.9 to 9.2) deaths per 100 000 population. The decline in other regions was slower. For example, the African Region had the highest CDR in 2000 and the rates only decreased by less than 9% in 2019. The HICs CDR reduced by 40% in the same period, attaining 8.4 (e 7.2 to 9.6) deaths per 100 000 population, while the LICs CDR increased by 3%.

Suicide

Global suicide deaths amounted to over 700 000 (UI 516 000 to 966 000) in 2019 with men dying at about twice the rates among women. Older adults are the population at the highest risk of suicide deaths. The corresponding CDR declined by 29% from 13.0 (UI 10.4 to 16.0) deaths to 9.2 (UI 6.7 to 12.6) deaths per 100 000 population between 2000 and 2019. Unlike many other causes of death for which higher resourced settings are in a relatively favourable position, suicide mortality has resulted in considerable life losses but has seen little progress in many higher resourced settings since 2000. In that time, the CDR for suicide mortality in HICs declined by less than 5%.

Notably, the suicide rate in the Region of the Americas increased by 28% in this period, and the European Region started and ended with the highest CDR for suicide among all WHO regions at 21.9 (UI 20.0 to 24.2) per 100 000 population in 2000 and 12.8 (UI 10.1 to 16.4) per 100 000 population in 2019, despite having the most dramatic decline by over 40% during the past two decades.

Deaths due to each of these causes are preventable. More effective and targeted multisectoral interventions are vital for addressing related mortality and their respective underlying risk factors, including mental health issues, road safety and access to hazardous pesticides, as well as social determinants that are driving the inequalities in the related health outcomes across regions and income groups. Political commitment and long-term investments are also essential to sustain and accelerate the existing progress for meeting the SDG targets.

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3 RISKS TO HEALTH

Childhood malnutrition (stunting, wasting and overweight), anaemia, intimate partner violence (IPV), tobacco use, alcohol consumption, obesity, physical inactivity, trans-fatty acids (TFA), safely managed water and sanitation, outdoor air pollution and household (indoor) air pollution and hypertension (raised blood pressure) all contribute to a considerable fraction of burden of disease and result in premature and preventable deaths. Addressing these health risks constitutes one of the priorities of SDG health-related targets and the WHO Triple Billion targets, and WHO and partners have collaboratively developed multisectoral policies and action plans to accelerate progress in achieving these targets. However, inequalities hinder the progress towards minimizing exposure to these risk factors, as the most vulnerable populations tend to be exposed at a higher rate to these health risks yet are less likely to have access to and benefit from effective interventions.

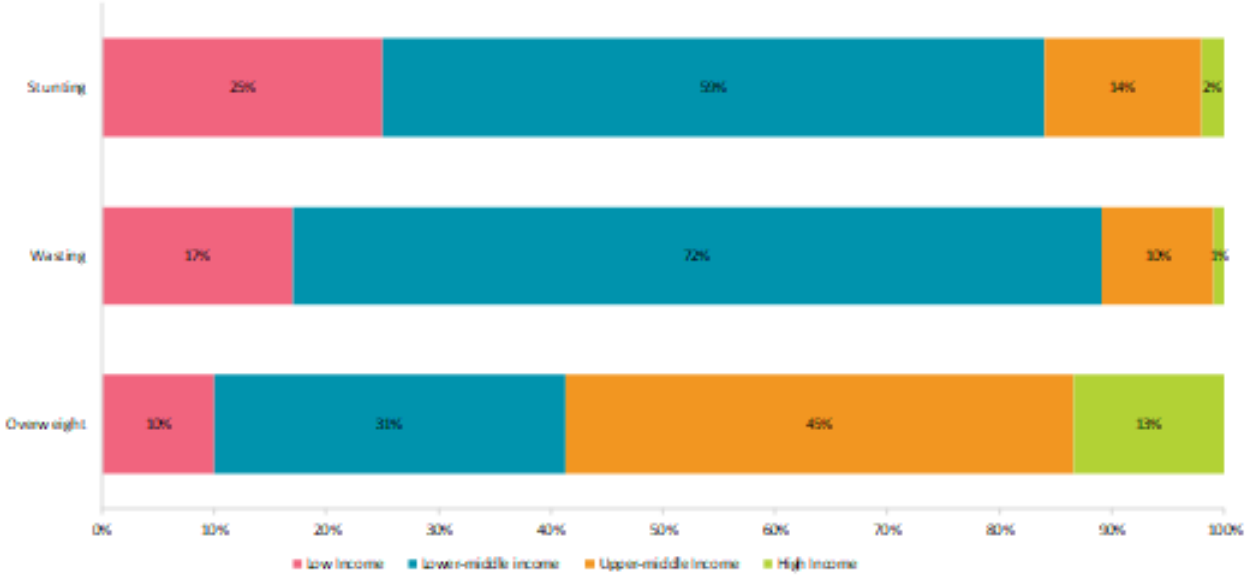
Child malnutrition

No progress to decrease the rate of overweight while stunting and wasting are concentrated in low- and lower middle-income countries

In 2020, an estimated 149.2 million children under 5 years of age were stunted (i.e. low height-for-age) and 45.4 million were wasted (i.e. low weight-for-height) while 38.9 million were overweight or obese. With nearly two thirds of the world's stunted children and three quarters of the world's wasted children, LMICs bore the highest share of malnourished children in 2020, while having less than half of the world's under 5-year-old population. In turn, approximately half of all overweight children live in UMICs, which contribute to less than one third of the global under 5-year-old population (Fig. 3.1).

The global prevalence of stunting, wasting and overweight in 2020 were respectively 22.0% (UI 21.3 to 22.7), 6.7% (UI 5.5 to 7.9) and 5.7% (UI 5.3 to 6.3). The lowest prevalence of overweight was in LICs (3.7%), while UMICs reported the highest (8.8%).

Between 2000 and 2020, the prevalence of stunting declined globally from 33.1% in 2000 to 22.0% in 2020. The fastest declining countries were UMICs (49% reduction) followed by LMICs (35% reduction). In contrast, overweight increased across all income groups, and globally from 5.4% to 5.7%.



Notes: Share is relative to the total number affected across the four country-income groups; this varies from the global totals because the populations are based on the FY2021 World Bank income classification. The differences are as follows: Stunting official global estimate of 149.2 million; sum of four country-income groups = 148.8 million. Wasting official global estimate of 45.4 million; sum of four country-income groups = 41.9 million. Overweight official global estimate of 38.9 million; sum of four country-income groups = 38.7 million.

Source: UNICEF–WHO–The World Bank: Joint child malnutrition estimates –levels and trends – 2021 edition *(1)*.

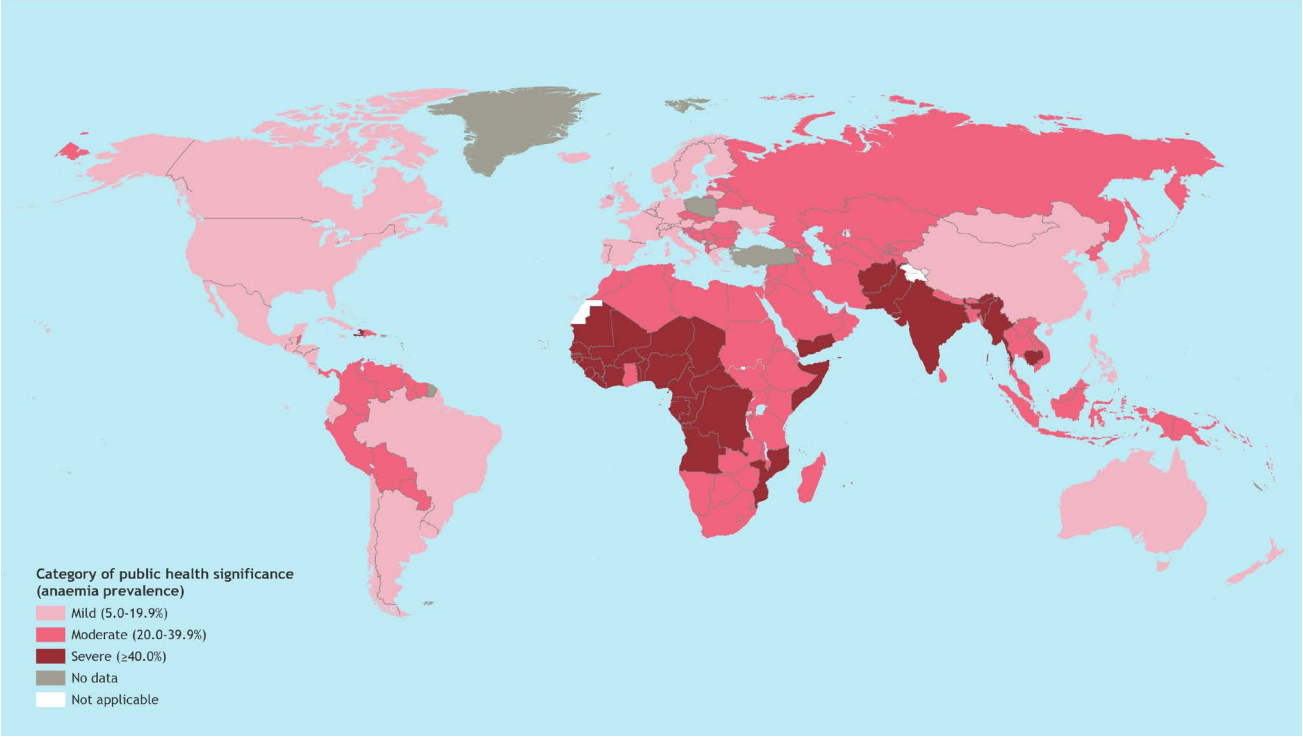
Fig. 3.1. Proportion of stunted, wasted and overweight children under 5 years of age, by World Bank income group, 2020

Anaemia in women

Limited and mixed progress

In 2019, the global prevalence of anaemia was 29.9% (UI 27.0, 32.8) among reproductive age women, 36.5% (UI 34.0, 39.1) among pregnant women and 29.6% (UI 26.6, 32.5) among non-pregnant women. Prevalence varied considerably between countries and regions (Fig. 3.2). Among women of reproductive age, the prevalence was highest in the SDG regions of Central Asia and Southern Asia (47.5%; UI 40.5, 54.0) and sub-Saharan Africa (40.7%; UI 37.0, 44.5) and lowest in Northern America and Europe (14.6%; UI 11.1–19.0).

The global decline in anaemia has been slow in pregnant women and stagnant in reproductive age women, from the 2000 benchmarks of 40.9% and 31.2%, respectively. SDG regional trends varied from a modest decline in the prevalence in women of reproductive age in sub-Saharan Africa (from 46.8% (UI 43.0 to 50.5) in 2000 to 40.7% (UI 37.0 to 44.5) in 2019), Latin America and the Caribbean (from 25.6% (UI 20.9 to 30.6) in 2000 to 17.2% (UI 12.7 to 23.1) in 2019) and Western Asia and Northern Africa (from 36.7% (UI 31.7 to 42.4) in 2000 to 31.8% (UI 25.5 to 38.7) in 2019) to a slight in increase in other SDG regions. To achieve the global target of halving the prevalence of anaemia in women of reproductive age by 2030, multisectoral efforts need to be accelerated.



Source: Global Health Observatory (GHO) data *(2)*.

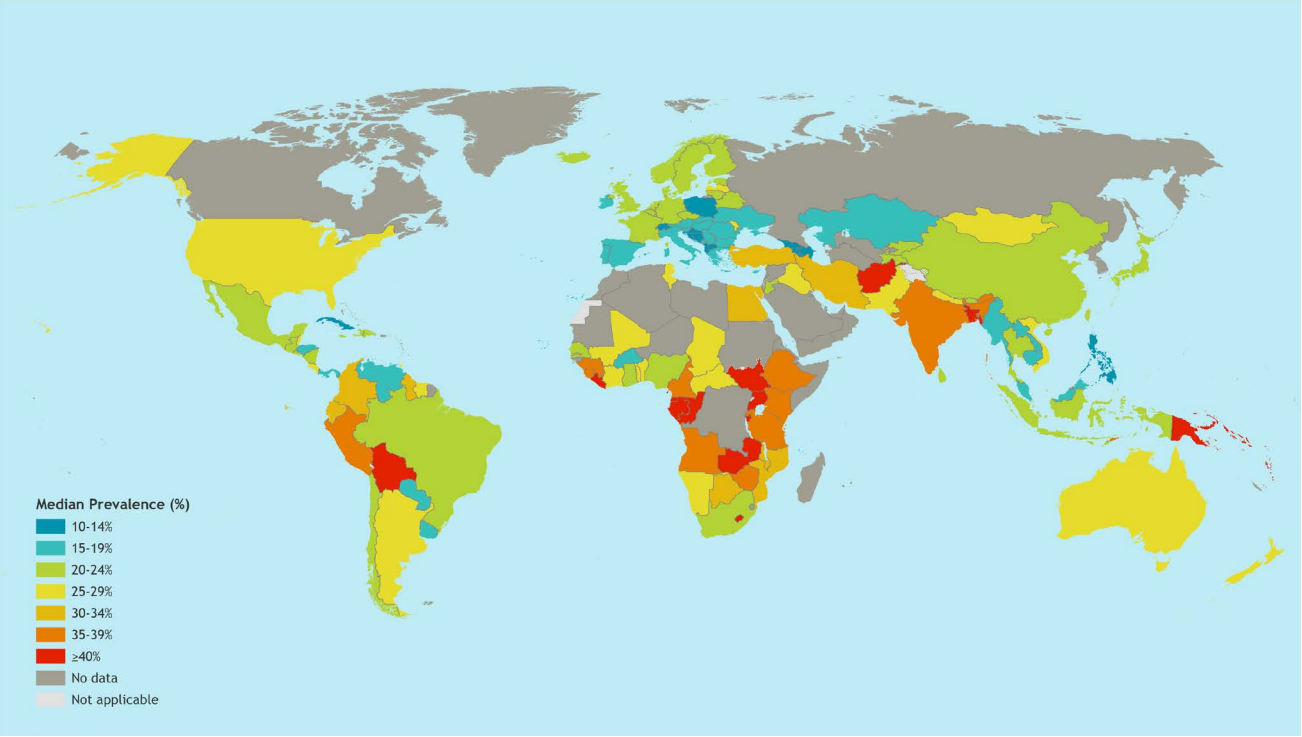
Fig. 3.2. Prevalence of anaemia among reproductive age women (15–49 years), 2019

Intimate partner violence

Alarming levels and distribution

Globally in 2018, about one in three women of reproductive age (15–49 years) had experienced physical and/or sexual intimate partner violence (IPV) at least once in their lifetime since the age of 15 (27%, UI 24 to 32), while 1 in 10 have experienced it in the past 12 months (13%, UI 10 to 16). The prevalence of lifetime IPV varied by country and region (Fig. 3.3), with the highest burden being in least developed countries with a lifetime IPV prevalence of 37% (UI 33 to 42). SDG regions with the highest prevalence were the three subregions of Oceania (Melanesia (51%, UI 38 to 63), Micronesia (42%, UI 32 to 52) and Polynesia (39%, UI 30 to 49)) followed by sub-Saharan Africa (33%, UI 29 to 38) and the subregion of Southern Asia (35%, UI 26 to 45).

IPV starts early in age, with nearly 1 in 4 (24%, UI 21 to 28) adolescent girls 15–19 years old and 26% (UI 23 to 30) of young women aged 20–24 years who have ever had a partner or been married being subjected already to this violence. Sixteen per cent of adolescent girls and young women (15–24 years old) have been subjected to current/recent physical and/or sexual violence, or both, by a male partner (i.e. within the past 12 months).



Source: Violence against women prevalence estimates, 2018 *(3)*.

Fig. 3.3. Prevalence estimates of lifetime physical and/or sexual intimate partner violence among ever-married/-partnered women aged 15–49 years, 2018

Noncommunicable disease risk factors

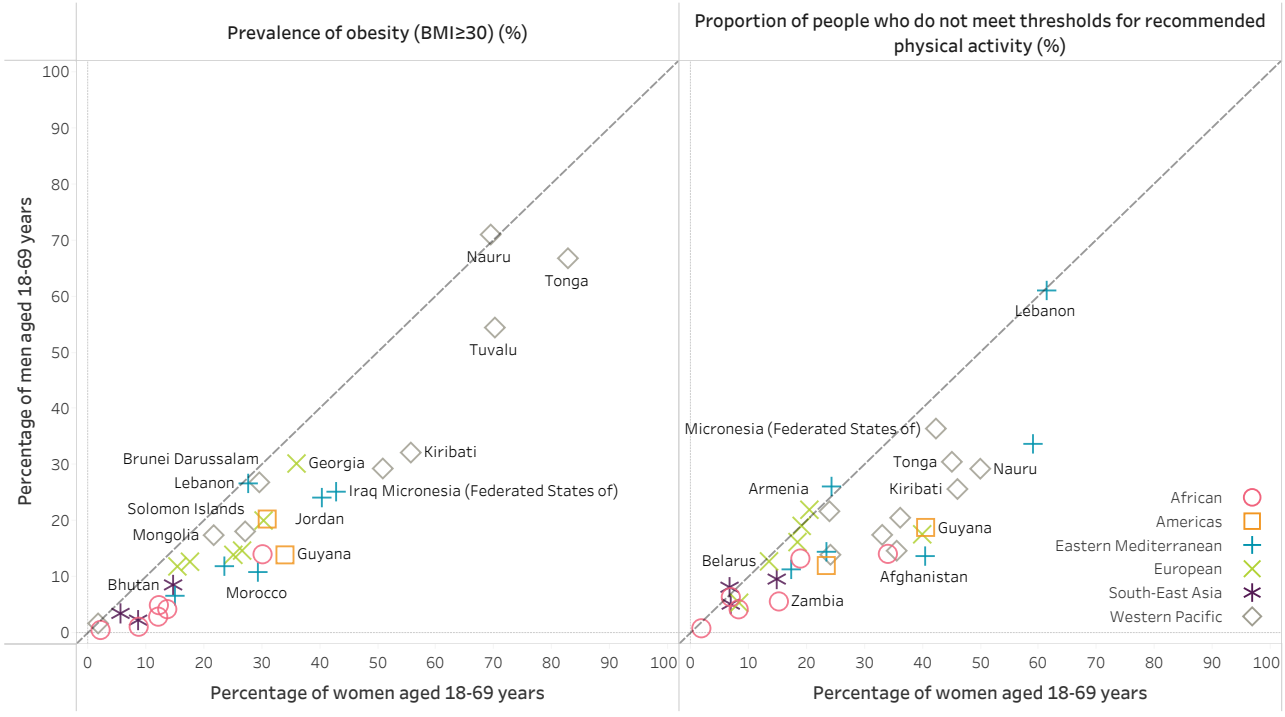
Noncommunicable diseases now account for most causes of premature death and disability worldwide, with most deaths concentrated in low- and middle-income countries. Hypertension, obesity, physical inactivity, tobacco use, harmful alcohol consumption and TFA intake are among the key risk factors underlying NCDs. Global estimates by WHO regions and World Bank income groups are presented for the indicators where applicable.

The sex of an individual carries a range of biological, behavioural, social and economic consequences for health that results in marked differences in exposure to risk factors between sexes. As such, sex-related inequalities in hypertension, overweight and obesity, and physical inactivity are explored using comparable data from WHO STEPS surveys conducted between 2015 and 2019 in 32 countries *(4)*.

Adult obesity and physical inactivity

The age-standardized prevalence of obesity among adults aged 18 and older (defined as body mass index (BMI) >30 kg/m^2) has been rising globally over the past few decades with 650 million obese adults in 2016. The prevalence of obesity has increased 50% from 8.7% in 2000 to 13.1% (UI 12.4 to 13.9) in 2016 *(5)*. In men, obesity reached 11.1% in 2016, which is a 66% increase from 6.7% in 2000. The prevalence of obesity in women was 15.1% in 2016, a 70% increase from 10.6% in 2000. The prevalence of obesity has also risen in all World Bank income groups, reaching the highest levels in HICs (24.7% in women and 24.5% in men) where gender differences were the smallest (male-to-female ratio of 0.99). This contrasts with the lowest levels in LICs (9.9% in women and 3.6% in men) where the gender differences were the largest (male-to-female ratio of 0.36).

The age-standardized prevalence of insufficient physical activity (hereafter physical inactivity, defined as not meeting the 2010 Global recommendations on physical activity for health) among adults aged 18 and older *(6)* was 27.5% (UI 25.0 to 32.2) in 2016, with over 8% difference between sexes, males: 23.4% (UI 21.1 to 30.7), females 31.7% (UI 28.6 to 39.0) *(7)*. Over the past 15 years, levels of physical inactivity have only marginally and insignificantly decreased from the global prevalence at 28.5% (UI 23.9 to 33.9) in 2001. HICs showed levels of physical inactivity increasing over time in both males and females, reaching a level in 2016 that was more than double the prevalence seen in LICs: from 31.6% (UI 27.1 to 37.2) in 2001 to 36.8% (UI 35.0 to 38.0) in 2016 in HICs vs 16.0% (UI 12.0 to 19.6) in 2001 to 16.2% (UI 14.2 to 17.9) in 2016 in LICs.



Note: The further from the diagonal line, the more sex-related inequality.

Source: WHO STEPwise Approach to NCD Risk Factor Surveillance (STEPS) 2015–2019 *(4)*.

Fig. 3.4. Sex-related inequality in prevalence of obesity and the proportion of people who do not meet thresholds for recommended physical activity in 32 countries, 2015–2019

Within country inequality

In 32 study countries, 58% of women were overweight (having a BMI equal to or greater than 25 kg/m^2) and 27% were obese (with a BMI greater than or equal to 30 kg/m^2). In contrast, the proportions among men were 50% and 14%, respectively. In parallel, overall, more women did not meet the recommended weekly physical activity threshold compared to men, with a large variation in this proportion across countries with available data.

The sex inequality in obesity at global level also holds true in almost all of the 32 study countries (Fig. 3.4). Guyana, Kiribati and the Federated States of Micronesia are among the countries with the largest sex gaps in obesity, with an absolute difference between females and males equal or larger than 20 percentage points. A similar pattern can be observed for the indicator of physical inactivity: in most countries, the proportion who do not meet the recommended threshold for physical activity was higher for women than for men.[1] In Afghanistan and Iraq, the sex difference was around 25 percentage points.

Hypertension (raised blood pressure)

Hypertension or raised blood pressure[2] is a known risk factor for cardiovascular morbidity and mortality *(8)*. The age-standardized prevalence of hypertension among adults aged 18 and older was 22.1% (UI 20.4 to 24.1) in 2015 (20.1% in women and 24.1% in men) *(9)*. Hypertension was higher in men in HICs (male-to-female ratio 1.54), UMICs (1.26) and LMICs (1.07). However, in LICs, prevalence in women was slightly higher than in men (male-to-female ratio 0.98). Between 2000 and 2015, hypertension generally declined in both women and men in all World Bank income groups. The exception was in LICs, where the prevalence of hypertension increased slightly from 27.7% in 2000 to 28.4% in 2015.

Within country inequality

Across 32 study countries, similar proportions of women and men had hypertension at the time of the STEPS survey (medians of 25% and 28% respectively) *(4)* (Fig. 3.5). However, overall, only 37% of men and 51% of women with hypertension had been previously diagnosed. Among those who had hypertension, women were also more likely to be receiving treatment: overall, 33% of women were taking medication for hypertension, compared to 19% of men. Moreover, 12% of women and 6% of men with hypertension had their blood pressure controlled.

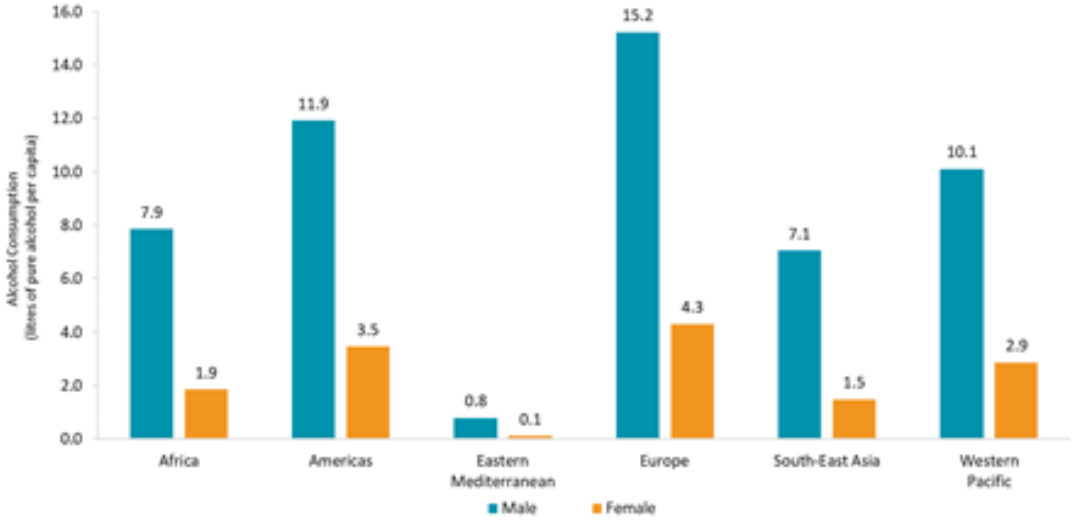
Notes: sbp= systolic blood pressure; dbp= diastolic blood pressure. Circles indicate countries – each country is represented by multiple circles (one for each subgroup). Horizontal black lines indicate the median value (middle point of estimates).

Source: WHO STEPwise Approach to NCD Risk Factor Surveillance (STEPS) 2015–2019 *(4)*.

Fig. 3.5. Sex-related inequality in the diagnosis and treatment cascade for hypertension in 32 countries, 2015–2019

[1] Insufficient physical activity is defined as less than 150 minutes of moderate-intensity activity per week, or equivalent *(6)*.

[2] Defined as systolic blood pressure ≥140 mmHg, diastolic blood pressure ≥90 mmHg, or taking medication for raised blood pressure.



Source: Global Health Observatory (GHO) data *(10)*.

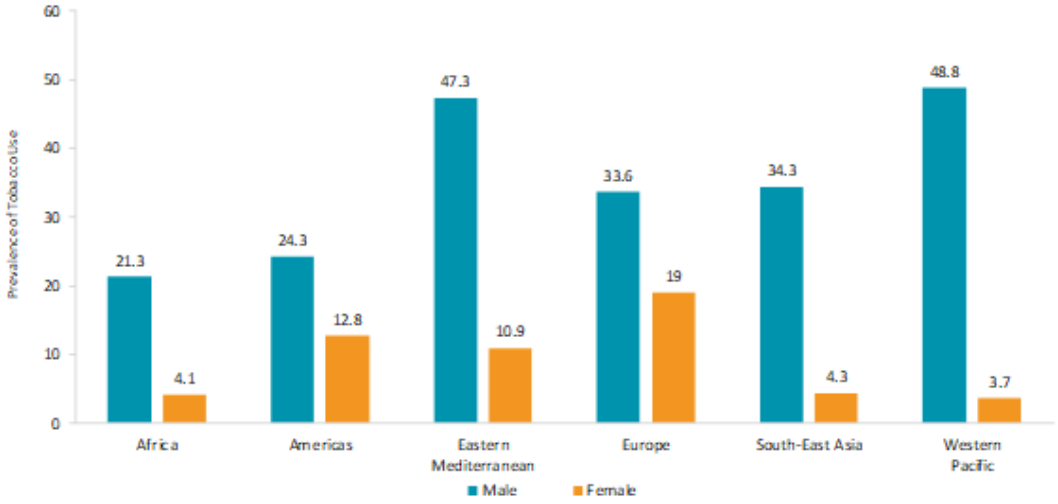
Fig. 3.6. Annual alcohol consumption (litres pure alcohol per capita), by sex and WHO region, 2019

Harmful use of alcohol

In 2019, the global annual consumption of alcohol was equivalent to 5.8 litres (UI 5.5 to 6.2) of pure alcohol per capita (persons aged 15 and older). On average, men consumed 9.2 litres per capita, which is about 3.7 times the amount women consumed (2.5 litres per capita). There has been an increase in alcohol consumption since 2000 and a plateau from 2010 to 2015, followed by a recent decline. The WHO regions with the highest consumption among men and women in 2019 were the European Region (15.2 litres per capita in men and 4.3 litres in women), the Region of the Americas (11.9 litres in men and 3.5 litres in women), and the Western Pacific Region (10.1 litres in men and 2.9 litres in women), while the lowest consumption was in the Eastern Mediterranean Region (0.8 litres in men and 0.1 litres in women) (Fig. 3.6).

Tobacco use

Tobacco continues to be one of the leading risk factors for premature deaths globally *(11)*. Smoking cessation before age 40 reduces the risk of death by about 90% *(12)*. In 2018, 23.6% of the global adult population (15 years of age and older) were current tobacco users, down from 33.3% in 2000 and projected to decline further to 20.9% by 2025. Among women, the worldwide prevalence of tobacco use has declined from 16.7% in 2000 to 8.5% in 2018, and among men from 50% to 38.6% over the same period. The sex differentials (male-to-female ratio) have been increasing noticeably with the proportion of men using tobacco three times higher than women in 2000, 4.5 times higher in 2015 and projected to be 5.2 times higher in 2025, highlighting the slower decline among men in relative terms. The male-to-female ratio varies by region and in 2018 ranged from 1.8 in the European Region to 13.2 in the Western Pacific Region (Fig. 3.7).



Sources: WHO Global Health Observatory (GHO) data *(13)*; WHO global report on trends in prevalence of tobacco use 2000–2025, third edition *(14)*.

Fig. 3.7. Prevalence of tobacco use, by sex and WHO region, 2018

The age-standardized prevalence of tobacco use has declined for men and women across all World Bank income groups. Nevertheless, prevalence among men is still on average over 30% in all income groups except LICs. Prevalence among women in HICs is showing the slowest decline of all income groups and was on average three times the average rate among women in LMICs in 2018. About 1.3 billion adults continued to use tobacco in 2018. Countries should strengthen their implementation of the WHO Framework Convention on Tobacco Control (FCTC), which is a key SDG target to be able to reduce tobacco use and prevent premature deaths and disabilities.

Trans-fatty acids

Intake of trans-fatty acids (TFA) is linked to higher risk of heart attacks and death from coronary heart disease *(15,16)*. In 2018, WHO called for the global elimination of industrially produced TFA by 2023 and released the REPLACE action framework and also six REPLACE action modules to support governments in taking actions to eliminate industrially produced TFA from the food supply *(17)*. WHO recommends that countries implement one of two best-practice policy options: mandatory national limit of 2 g of industrially produced TFA per 100 g of total fat in all foods; or, mandatory national ban on the production or use of partially hydrogenated oils as an ingredient in all foods.

Countries are taking various measures to reduce and eliminate TFA, but there were only 14 countries that have implemented the best-practice TFA policy as of 2020. However, the number of countries that are implementing the best-practice TFA policy is increasing rapidly and, as of April 2021, the number has increased to 37. Inequalities by World Bank income group exist, as best-practice TFA policies were passed or took effect in 35 HICs, seven UMICs, and one LMIC *(18)*.

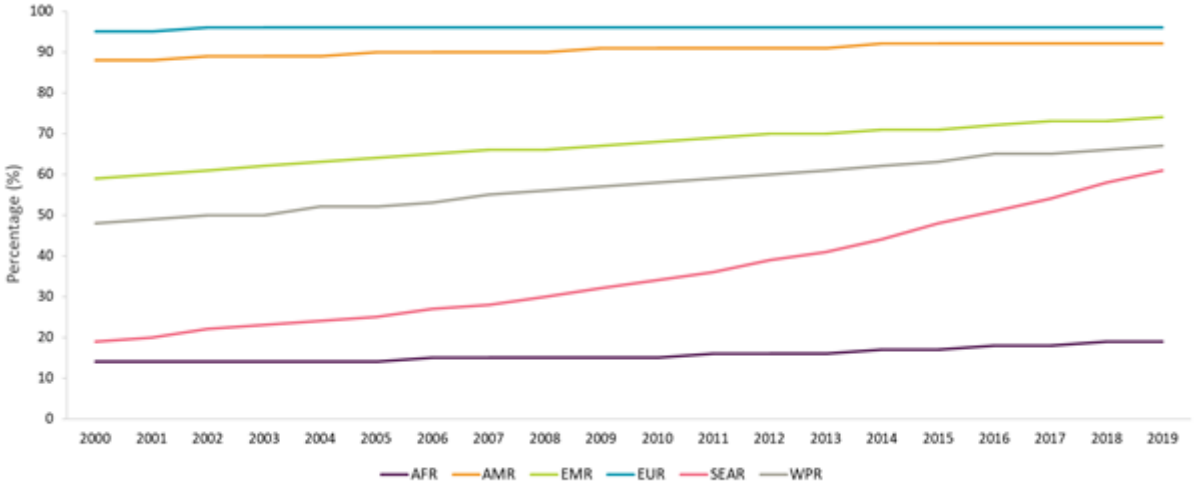
Environmental risk factors

Regional inequalities are stark

Outdoor and household (indoor) air pollution are environmental risk factors that have been linked to several health conditions including cardiovascular illness, stroke, respiratory disease and cancer, leading to approximately 7 million deaths globally in 2016. Of these deaths, 4 million occurred in sub-Saharan Africa, most of Asia and Oceania (excluding Australia and New Zealand), where the highest attributable mortality rates were concentrated.

Globally, in 2016, the concentration of fine particulate matter $PM_{2.5}$ (particulate matter 2.5 micrometres or less in diameter; an indicator of ambient or outdoor air pollution exposure) was 34.7 μg/m^3 (31.2 μg/m^3 in urban settings), which is several times higher than the annual mean WHO air quality safety standard of 10 μg/m^3. Regional variation is extensive with the lowest annual mean $PM_{2.5}$ concentrations reported in the Region of the Americas (11.6 μg/m^3) and the European Region (12.8 μg/m^3) and the highest being in the South-East Asia Region (54.3 μg/m^3) and the Eastern Mediterranean Region (51.1 μg/m^3).

In 2019, about two thirds of the global population (84% urban and 42% rural) relied primarily on clean fuels and technologies, which is about a 30% increase from 50% (76% urban and 25% rural) in 2000. Despite this gain, however, over 2.6 billion people – mainly from low- and middle-income countries – continue to be exposed to household air pollution because of inefficient and polluting cooking systems. In the SDG region of sub-Saharan Africa, population growth has outpaced the increase in clean cooking access, leaving it the region with the largest number of people without access to clean fuels and technologies. Although the annual rate of increase in access to clean fuel and technologies has been 1.0% per year between 2010 and 2019, coverage levels and trends vary considerably by WHO region (Fig. 3.8). The European Region and Region of Americas have reached more than 90%, while the level was markedly lower in the African Region (19% in 2019) and seeing little progress. Coverage of clean fuels and technologies has increased in the Western Pacific Region and most notably in the South-East Asia Region where the increase has been considerable from 20% in 2000 to 67% in 2019.



Source: Global Health Observatory (GHO) data *(19)*.

Fig. 3.8. Trends in the percentage of the population with primary reliance on clean fuels and technologies, by WHO region, 2000–2019

Water, sanitation and hygiene

Clean water, sanitation and hygiene (WASH) are essential to human health and well-being and are especially important in the context of infectious disease outbreaks, such as the current COVID-19 pandemic. Unsafe drinking water, unsafe sanitation and lack of hygiene also remain important causes of death, with an estimated 870 000 associated deaths occurring in 2016.[1] The African Region suffered a disproportionate burden from such deaths, with a mortality rate four times higher than the global average. Available data from 98 countries indicate that safely managed drinking-water services – that is, located on premises, available when needed and free from contamination – were enjoyed by only 71% of the global population (5.3 billion people) in 2017. Safely managed sanitation services – with excreta safely disposed of in situ or treated off-site – were available to only 45% of the global population (3.4 billion people).

In the same year, two in five households globally (40%) lacked basic handwashing facilities with soap and water in their home. Untreated household wastewater contaminates drinking-water sources, posing risks to public health and the environment. Preliminary estimates from 74 countries (excluding much of Africa and Asia) show that, in about a third of countries, less than 50% of all household wastewater flows are safely treated.

Data compiled in 2020 highlighted the inadequate WASH status within many health care facilities, a potentially critical factor in the control of COVID-19 *(20)*. In 2019, a quarter of health care facilities lacked basic water services, exposing 1.8 billion people – including health care workers and patients – to greater risk of infections. One in three health care facilities did not have hand hygiene facilities at the point of care, and 10% of facilities had no sanitation service at all. One third did not segregate waste safely.

Ensuring water and sanitation for all requires financial resources and technical capacity to support and sustain investments in infrastructure. From 2015 to 2019, official development assistance (ODA) *disbursements* to the water sector increased slightly by 3% from US$ 9.0 to US$ 9.2 billion. In the same period, ODA *commitments* to the water sector rose 11%. A 2018 survey found that more than 80% of countries reported insufficient financing to meet national WASH targets *(21)*.

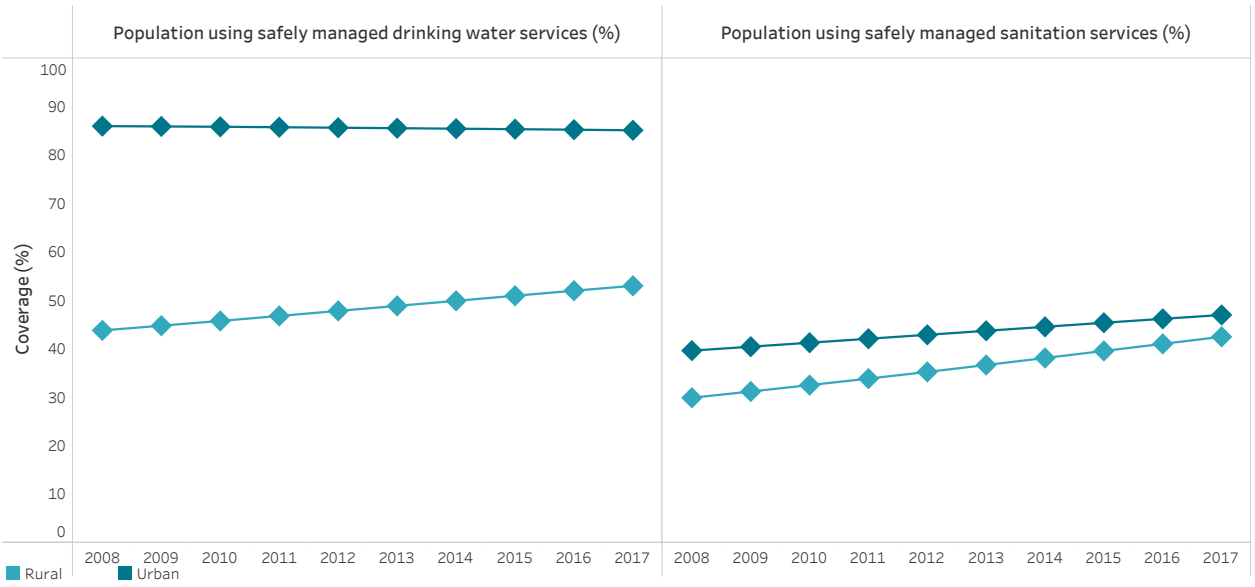
Inequitable access to WASH impedes progress towards equitable recovery and building back better

Access to WASH services varies substantially across countries *(21)*. Data for 98 countries from surveys over the period of 2008–2017 show that while globally more than nine out of 10 people use safely managed drinking-water services (median of 92% across 98 countries), in two countries less than one out of 10 people have access (Sierra Leone and Uganda). Similarly, while globally almost 80% of the population have access to safely managed sanitation services (median of 78% across 88 countries), coverage is below 20% in seven countries. Access to basic hygiene services varies from 1% to 100% across 77 countries with available data, with less than half of the population using these services overall (median of 46% across 78 countries).

[1] Deaths associated with diarrhoeal disease, soil-transmitted helminth infections and malnutrition.

Within countries, not all population groups have equal access to WASH services. Use of safely managed drinking-water and sanitation services is higher among urban than rural populations, however the gap between urban and rural areas narrowed between 2008 and 2017 due to faster improvements among rural areas (Fig. 3.9).

Availability of WASH services in health care facilities also varies between and within countries *(22)*. Overall, the proportion of health care facilities with basic water services is higher among urban than rural areas (median of 82% vs 58% across 28 countries), more common among hospital than non-hospital facilities (median of 86% vs 65% across 34 countries) and more likely among private than public facilities (median of 73% vs 57% across 18 countries) (Fig. 3.10).



Source: WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) *(23)*.

Fig. 3.9. Drinking-water and sanitation services by rural/urban place of residence: change over time

Note: Circles indicate countries – each country is represented by multiple circles (one for each subgroup). Horizontal black lines indicate the median value (middle point of estimates).
Source: WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) *(22)*.

Fig. 3.10. Health care facilities with basic water services by multiple dimensions of inequality: latest situation

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4 UNIVERSAL HEALTH COVERAGE

Universal health coverage (UHC) is firmly based on the 1948 WHO constitution that declares health a fundamental human right and commits to ensuring the highest attainable level of health for all. Achieving UHC is a global commitment that is embodied in the SDG agenda and is a major component of reducing inequalities and fighting poverty worldwide. In addition, in the context of the Triple Billion targets, WHO works with partners in supporting countries to develop and strengthen their health systems to advance and sustain UHC around the world, which stresses not only the coverage of health services, but also how they are funded, managed and delivered.

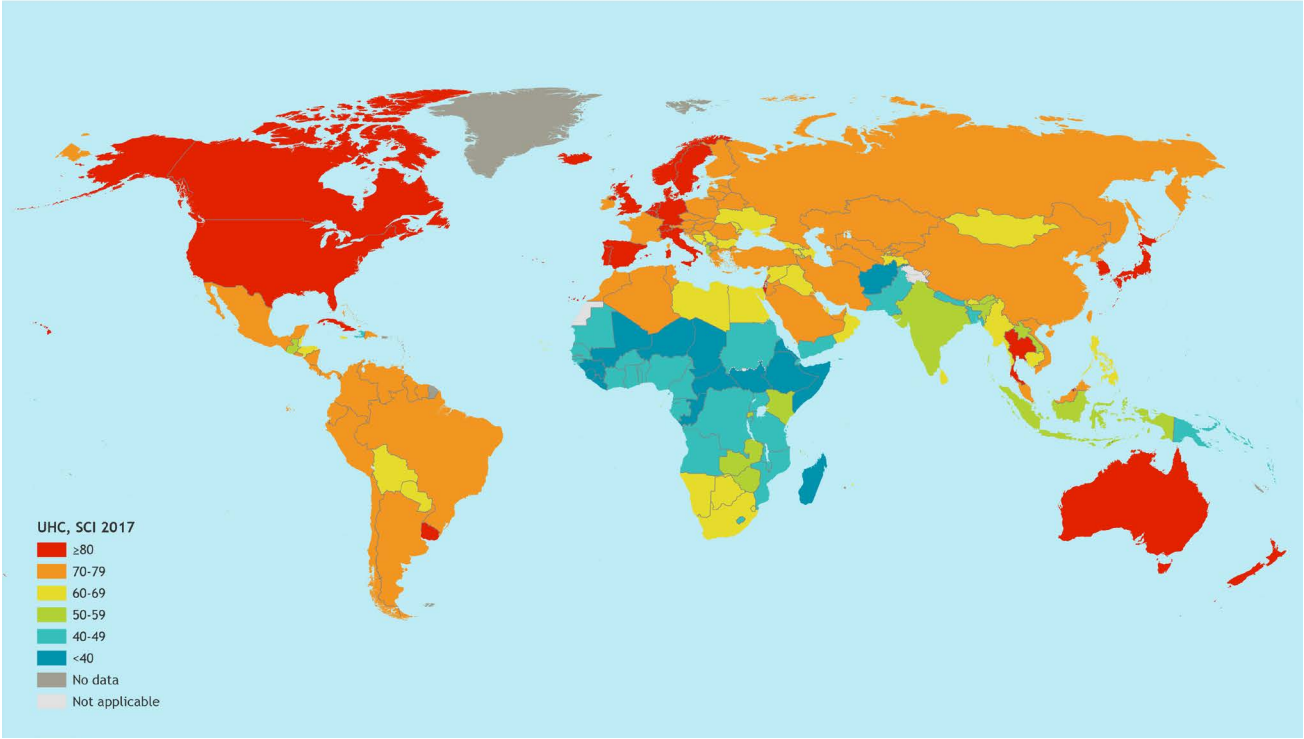
While considerable progress has been made in recent decades, almost half of the world's population still does not benefit from a complete coverage of essential health services and millions of people are still being pushed into extreme poverty, because they have to pay for health care. Progress towards the UHC Billion by 2023 is predicted to be the slowest of all the billions (section 5). There is an urgent need to remove remaining barriers, to allow access to health care for all. This section presents the latest data on service coverage and financial protection, the two pillars of the UHC SDG indicator.

Service coverage

Improvements in coverage of essential health services have been recorded in all regions and all income groups, with the UHC service coverage index (UHC SCI) increasing from a global average of 45 (of 100) in 2000 to 66 in 2017 (Fig. 4.1). Greatest progress has been in LICs, mainly driven by interventions for infectious diseases and, to some extent, for improved reproductive, maternal, newborn and child health (RMNCH) services.

Globally and for many countries, however, the pace of progress has slowed since 2010, and the poorest countries and those affected by conflict generally lag furthest behind. In the midst of the COVID-19 pandemic, health care systems are experiencing increased resource constraints and conflicting priorities. This imposes challenges for the anticipated continuity of progress and represents a heavier load to those countries with weaker systems.

Achieving UHC requires multiple approaches. The primary health care approach and life course approaches are critical. As a first point of entry between patients and health systems, primary health care allows all people to benefit from basic health services while reducing financial and geographic barriers. It is considered one of the most effective means to guarantee equitable progress on access to health care. Its reinforcement at the community level is a key aspect for the realization of UHC, and needs to be increasingly supported. Applying a life course approach optimizes people's health by addressing their needs and maximizing opportunities across all phases of life so that they can be and do what they justifiably value at all ages, always guided by principles that promote human rights and gender equality.



Source: Primary health care on the road to universal health coverage: 2019 monitoring report *(1)*.

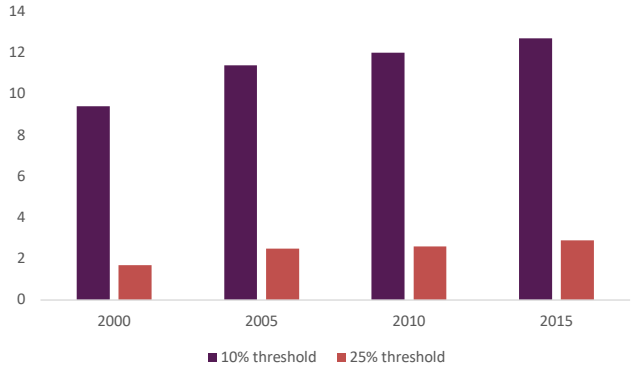
Fig. 4.1. Variation of universal health coverage service index (UHC SCI), 2017

Financial protection

Financial protection is achieved when out-of-pocket payments for health services do not cause financial hardship. Unfortunately, the gains in service coverage have come at a major cost to some individuals and their families. The incidence of catastrophic health expenditures – defined as large out-of-pocket spending in relation to household consumption or income – increased continuously between 2000 and 2015. The proportion of the population with out-of-pocket health spending exceeding 10% of their household budget rose from 9.4% to 12.7% over this period, and the proportion with out-of-pocket spending exceeding 25% rose from 1.7% to 2.9% (Fig. 4.2). Overall, financial protection prior to COVID-19 has been deteriorating not improving. The world cannot afford health systems without financial protection.

For HICs and UMICs, with high service coverage and low financial hardship, the major challenge is to continue to make efficiency, quality and equity gains. For LMICs, with high service coverage but also high levels of financial hardship, ensuring inclusive, universal mechanisms to protect against high out-of-pocket spending is the key challenge. Countries with low service coverage and high financial hardship need comprehensive reform of both their service delivery and health financing arrangements, giving priority to addressing inequities. Countries with low service coverage and low financial hardship – mainly highly vulnerable and conflict-affected states – need to build the foundations of their health systems, including human resources, supply chains and infrastructure.

The impact of COVID-19 on the number of households spending a large share of their budgets on health care remains uncertain, as there is evidence of income shrinking, poverty increasing and households forgoing health care *(2,3)*. But if household spending on health is shown to have decreased, the reduction cannot be interpreted as genuinely improved financial protection. It must be analysed alongside changes in service coverage, because many essential services may become unavailable due to COVID-19-related disruptions, and people may be simply delaying or avoiding seeking care due to diminished ability to pay or fear of contracting COVID-19 in health care settings.



Source: Primary health care on the road to universal health coverage: 2019 monitoring report *(1)*.

Fig. 4.2. Percentage of population with out-of-pocket health spending exceeding 10% or 25% of the household budget, 2000 to 2015

A closer look at the coverage of essential health services

In the SDGs framework, UHC is measured by the coverage of tracer interventions that include RMNCH, infectious diseases, NCDs and service capacity and access, among the general and the most disadvantaged populations. Some of the corresponding indicators – such as WASH and prevalence of hypertension and tobacco use – have already been described and this section will therefore focus on the remaining and other related areas including RMNCH, communicable diseases, health workforce (HWF), health security and the implications of population ageing.

Reproductive, maternal, newborn and child health

The proportion of women of reproductive age who have their need for family planning satisfied with modern methods has only moderately increased worldwide between 2000 and 2021 from 73.7% to 76.8%. The African Region has the lowest coverage at 57.1% in 2021. The region has nevertheless progressed, increasing coverage by 52% in the past 21 years compared to a global increase of 4%. Some of the entrenched causes of this gradual progress are: limited choice of contraceptive methods; inadequate access to services, particularly among young, poorer and unmarried people; perceptions and experience of contraceptive side-effects; cultural or religious opposition; poor service quality and acceptability; bias against some methods among users as well as providers; and gender-based barriers to accessing services *(4)*.

According to the data available for 2014–2020, 83% of global births were assisted by skilled birth attendants, including medical doctors, nurses and midwives: an increase of about 30% compared to data from 2000–2006. Despite this remarkable progress, regional inequalities remain and the COVID-19 pandemic may be undermining these advances. Evidence is emerging that access to competent and quality care during childbirth may be negatively impacted by national lockdown measures, transportation disruptions, resources being diverted away from essential health services, and due to safety fears associated with health centres and hospitals *(5–7)*. Future data collection and analysis may reveal such indirect consequences of the COVID-19 pandemic.

Adolescent girls, especially younger girls, are particularly vulnerable because they face the additional risks of premature pregnancy and childbirth. Adolescent fertility rates are an indicator of effectiveness of measures to ensure universal access to sexual and reproductive health care services. Maternal complications were the second leading cause of death among girls aged 15–19 globally in 2019 *(8)*. The adolescent birth rate has fallen worldwide from 56.4 births per 1000 adolescents aged 15–19 years in 2000 to 41.2 per 1000 in 2020. Adolescent births have generally decreased globally and in individual WHO regions, except for the Western Pacific Region.

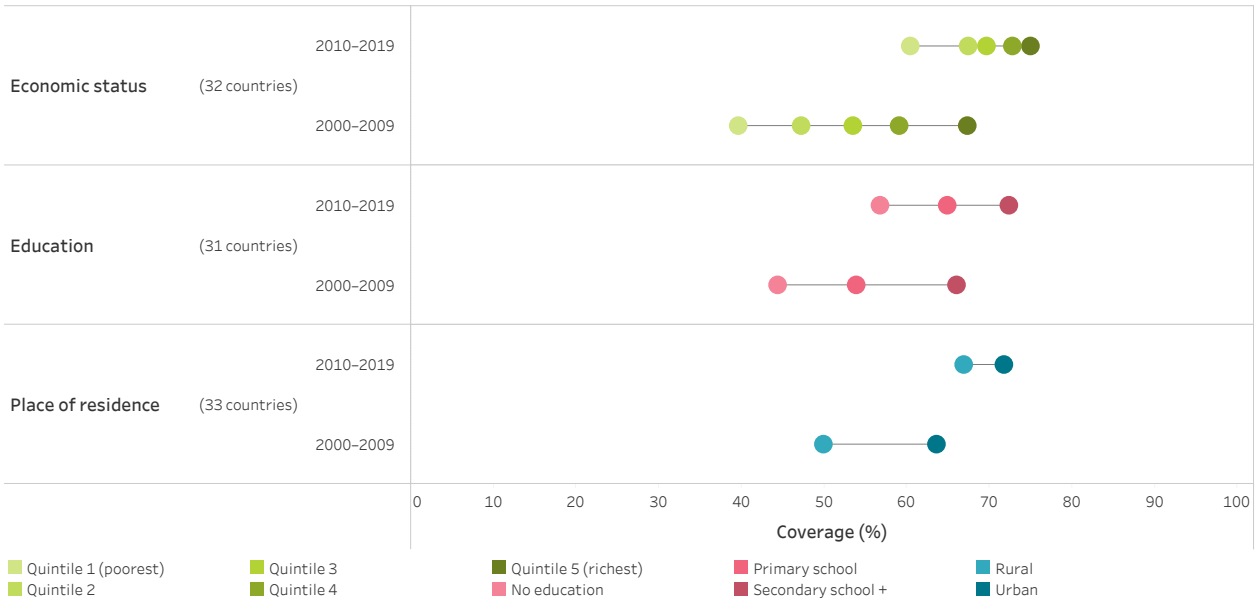
Inequalities in the area of RMNCH

The RMNCH composite coverage index *(9,10)* summarizes the level of coverage across the spectrum of RMNCH interventions. It is calculated as a weighted average of eight indicators in four stages of the continuum of care: reproductive health (demand for family planning satisfied); maternal health (antenatal care coverage, and skilled birth attendance); child immunization (Bacillus

Notes: Circles indicate countries – each country is represented by multiple circles (one for each subgroup). Horizontal black lines indicate the median value (middle point of estimates). DHS: demographic and health survey; MICs: multiple indicator cluster survey.

Source: WHO Health Equity Monitor database, 2020 *(11)*.

Fig. 4.3. RMNCH composite coverage index by multiple dimensions of inequality: latest situation, demographic and health survey (DHS) and multiple indicator cluster survey (MICS), 2010–2019



Notes: Circles indicate median values across countries – one circle for each subgroup. DHS: demographic and health survey; MICs: multiple indicator cluster survey.
Source: WHO Health Equity Monitor database, 2020 *(11)*.

Fig. 4.4. RMNCH composite coverage index by multiple dimensions of inequality: change over time, DHS and MICS, 2000–2009 and 2010–2019

Calmette–Guérin (BCG), measles and diphtheria, tetanus and pertussis (third dose) (DTP3) immunization coverage); and management of childhood illnesses (oral rehydration therapy for diarrhoea and care-seeking for suspected childhood pneumonia symptoms).

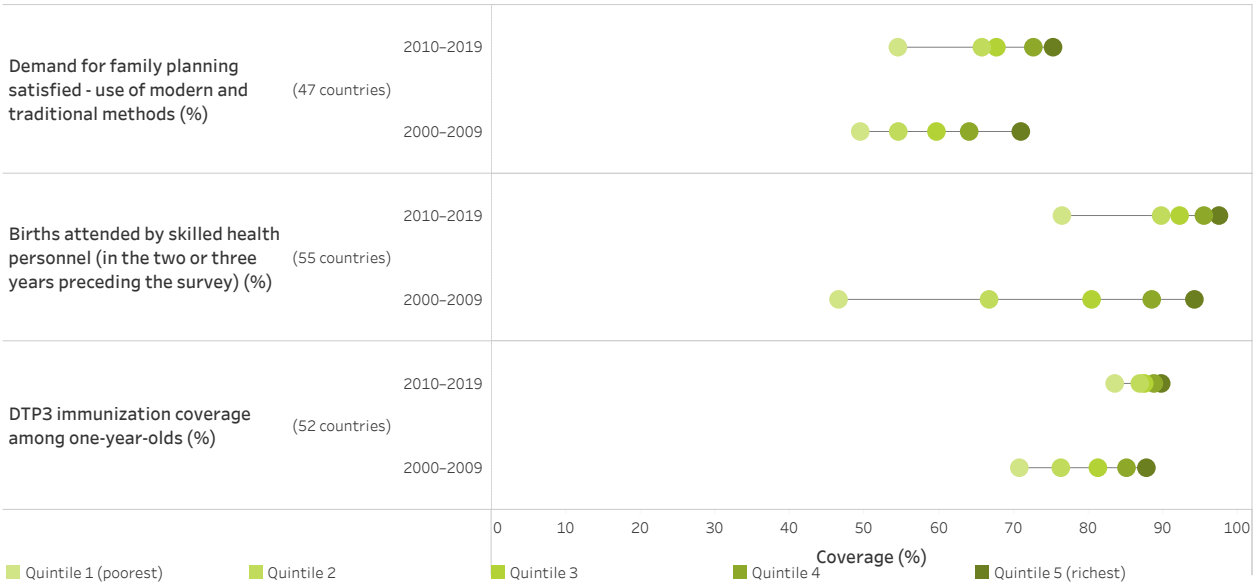
The coverage of RNMCH interventions varies substantially across countries, with the composite coverage index ranging across 71 countries from 28% in Chad to 90% in Cuba (with a global median of 69%). Within countries, coverage also varies between population subgroups, with a common pattern of higher coverage among advantaged groups. It increases with increasing economic status and education levels and is higher in urban than rural areas.

However, data from 33 countries shows that the situation has improved over time, with overall coverage increasing and inequalities between population subgroups reducing in the past decade. For instance, the gap between median coverage in the richest and the poorest population subgroups reduced from 27 percentage points in 2000–2009 to 15 percentage points in 2010–2019. The pace of change of these improvements have tended to favour the disadvantaged subgroups more; that is, the changes were for the most part pro-poor, pro-less educated and pro-rural.

The situation varies for different component indicators of the composite coverage index (Fig. 4.5). Overall, coverage increased and economic-related inequality decreased for all indicators, albeit at varying degrees. While the gap between the richest and poorest did not change much in relation to demand for family planning satisfied, the poorest quintile is nevertheless increasingly left behind. Great improvements can be observed for skilled birth attendance, with coverage increasing fastest among the poorest quintile and leading to a large reduction in economic-related inequality over time (difference between the richest and poorest quintile of 48 percentage points in 2000–2009 compared with 21 percentage points in 2010–2019). Coverage of DTP3 immunization also increased over time and inequalities reduced, leading to very little economic-related inequality in 2010–2019 (gap between the richest and poorest quintile of 6 percentage points).

Immunization

During 2019, about 85% of infants worldwide (116 million infants) received three doses of DTP3 vaccine, protecting them against three infectious diseases that can cause serious illness, disability or death. By 2019, 125 countries had reached at least 90% coverage of DTP3 vaccine. However, an estimated 19.7 million children under the age of one year did not receive DTP3 vaccine in 2019. By the end of 2019, 85% of children had received one dose of measles vaccine by their second birthday and 178 countries had included a second dose as part of routine immunization, with 71% of children receiving two doses of measles vaccine according to national immunization schedules. Global coverage levels of more recently recommended vaccines such as rotavirus vaccine and pneumococcal-conjugated vaccine were still under 50%. Human papillomavirus vaccine was introduced in 103 countries by the end of



Notes: Circles indicate median values across countries – one circle for each subgroup. DHS: demographic and health survey; MICs: multiple indicator cluster survey; RHS: reproductive health survey.
Source: WHO Health Equity Monitor database, 2020 *(11)*.

Fig. 4.5. RMNCH indicators by economic status: change over time, DHS, MICS and reproductive health survey (RHS), 2000–2009 and 2010–2019

2019, not counting three countries where it was only partially introduced. Nearly a third of these Member States *(33)* also started to vaccinate boys.

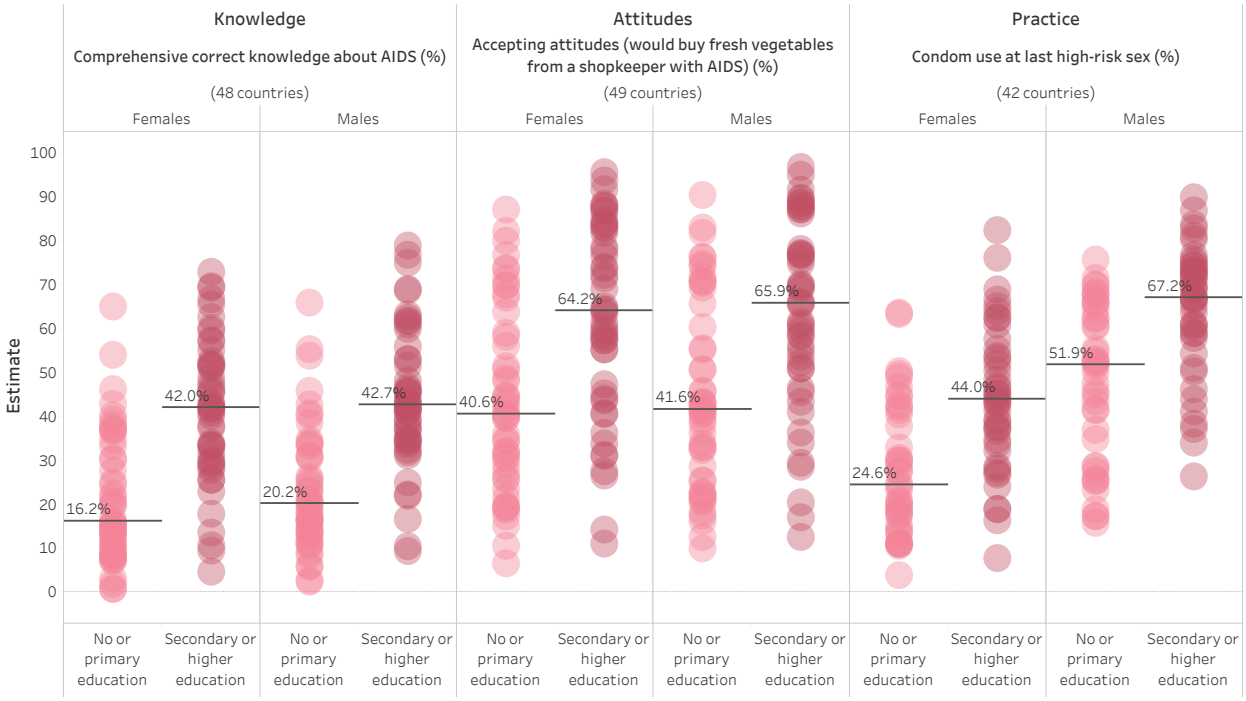
Despite encouraging progress, improvements and expansions in immunization coverage may be under threat: preliminary data for the four months to April 2020 indicate a substantial drop in DTP3 coverage for the first time in almost three decades *(12)*. According to the second round of the WHO "pulse survey"' of 135 countries (April 2021), three quarters of 82 responding countries reported various reasons for COVID-19 related disruptions in their immunization programmes. Even when immunization services are offered, people are either unable to access them because of reluctance to leave home, transport interruptions, economic hardships, restrictions on movement, or fear of being exposed to COVID-19. Many health workers are also unavailable to provide routine vaccination due to restrictions on travel or redeployment to COVID response duties, as well as a lack of protective equipment.

Inequalities in the area of communicable diseases

Socioeconomic inequalities exist in all countries and have important impacts on health. There are systemic differences in infectious diseases between social groups that differ by dimensions such as economic status, education, place of residence, occupation and so on. Poor, more disadvantaged populations tend to suffer from a higher burden of communicable diseases, for instance due to low knowledge of protective behaviours, increased exposure due to living and working conditions, poor health-seeking behaviours and barriers to accessing health services, all of which inhibit rapid detection and treatment.

HIV/AIDS

Overall, HIV knowledge, attitudes and practices (KAP) tend to be better among the richest and most educated. For instance, in over half of countries with data available between 2010–2019, there was a gap of at least 20 percentage points between the richest and poorest for KAP indicators. Knowledge about HIV was also at least 20 percentage points higher among the most educated than the least-educated (Fig. 4.6).



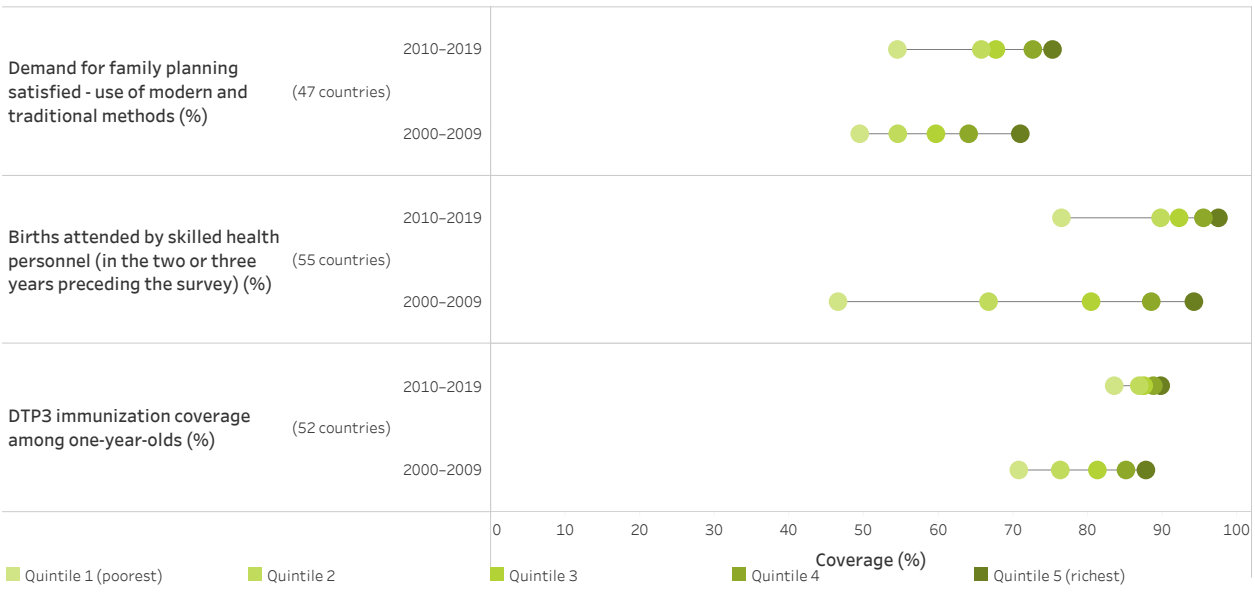
Notes: Circles indicate countries – each country is represented by multiple circles (one for each indicator and subgroup). Horizontal black lines indicate the median value (middle point of estimates). DHS: demographic and health survey; AIS: AIDS indicator survey.

Source: DHS and AIS 2010–2019 *(11)*.

Fig. 4.6. Education-related inequalities in HIV knowledge, attitudes and practice among females and males: latest situation, DHS and AIDS indicator survey (AIS) 2010–2019

Tuberculosis

Overall, half of people affected by TB face catastrophic costs (exceeding 20% of the household's income) as a result of the disease, ranging in 16 countries between 19% and 83%. For people with drug resistant TB, this proportion rises to 80%. Probability of facing catastrophic costs was over 20 percentage points higher among the poorest households in most countries surveyed (Fig. 4.7). TB is a disease of poverty; those most at risk tend to be those with the most problems accessing care services and would be most adversely affected by high out-of-pocket expenditures on health. Without strong mitigation measures (including social protection), an even higher proportion of people with TB and their households will be at risk of facing catastrophic costs.



Source: TB patient cost surveys 2016–2019 *(13)*.

Fig. 4.7. Percentage of TB-affected households facing catastrophic costs due to TB by economic status in six countries: latest situation, TB patient cost surveys 2016–2019

Notes: Circles indicate countries – each country is represented by multiple circles (one for each subgroup). Horizontal black lines indicate the median value (middle point of estimates). DHS: demographic and health survey; AIS: AIDS indicator survey; MIS: malaria indicator survey.

Source: DHS and MIS 2010–2019 *(11)*.

Fig. 4.8. Prompt care-seeking for children aged <5 years with fever by multiple dimensions of inequality in 28 countries: latest situation, DHS and malaria indicator survey (MIS) 2010–2019

Malaria

Fever is the main symptom for suspecting malaria and triggering diagnostic testing of the patient in most malaria-endemic settings. A history of fever and subsequent steps taken to seek treatment have been the basis of measuring access to malaria case management. Overall, there are large inequalities in care-seeking behaviour for children with fever, which tend to be lower among the poor, uneducated and rural subpopulations. Prompt care-seeking for children aged under 5 years with fever was at least 20 percentage points higher in the richest quintile than in the poorest quintile in over half of study countries (Fig. 4.8). This inequality in access has remained persistent, with no or little apparent overall change in the past 10 years.

Demographic transition to ageing population

Globally, population ageing continues at an unprecedented pace. In 2020, the share of older persons aged 65 years or over in the world population (9.3%) was already greater than that of children under the age of five (8.7%). By 2050, the proportion of people who are 65 years and older (15.9%) will be more than twice that of children under five (7.1%) and will also surpass the share of youth aged 15 to 24 (13.7%) *(14)*. The health challenges of an older person can include multimorbidity and complex care needs. Their declining physical and functional capacities also create service accessibility barriers and require considerably more attention in provision of health service coverage for ageing populations. In this context, UHC monitoring is important to prepare health systems to respond to people's needs to maintain autonomy through the life course as they age *(15)*.

The WHO Study on global ageing and adult health (SAGE) *(16)* showed varying rates of self-reported unmet health care needs among people aged 65 and older across low- and middle-income countries. Health systems may not be responding to the needs of older people, partly because their perceptions of need are influenced by services available to them. In some settings, this may also be a question of financial protection. Data from SAGE showed that among uninsured persons aged 65 and older who reported a health care need, the levels of unmet need are larger compared to insured populations. These figures only refer to unmet need for health care and do not incorporate unmet needs for social care, which is also vital to the well-being of older people.

Inequity in distribution of health workers

The inequitable distribution of the HWF – in terms of age, gender, place of employment – hinders national capacities to achieve UHC .

A study on gender equity analysed data from 104 countries and revealed that 70% of those employed in the health and social sector are women, indicating a significant increase over time of women's representation in the health sector, even though gender pay gaps remain *(17)*. The *State of the world nursing report 2020* highlights that nurses constitute the biggest single occupation among health workers (59% of total) *(18)*. Although about 90% of the nursing workforce are women, they are often underrepresented at senior management levels *(17)*. Gender inequalities within the HWF remain a critical issue and are further uncovered by the COVID-19 pandemic. The lack of PPEs adapted for female bodies and an average gender pay gap of 28% are only some of them.

The maldistribution of health workforces is central to the existing inequalities in health service coverage and burden of disease for populations in need. Striking variations in health worker availability are demonstrated by recent National Health Workforce Accounts (NHWAs) *(19)*. For example, there is a 366-fold difference in the density of medical doctors between the countries with the highest and lowest densities. There is also a 194-fold difference in the density of nursing and midwifery personnel between countries with the highest and lowest densities. Variations are also marked at the regional level, with on average one medical doctor per 232 people in the European Region compared to one medical doctor per 3619 people in the African Region; for nursing and midwifery personnel there is one per 121 people in the Region of Americas and one per 973 people in the African Region.

The inequity in distribution of health workers observed globally and regionally also exists within individual countries. Fifty-eight countries have reported subnational nursing personnel distribution data for the most recent years. Among these countries, the average staffing disparity (as measured by the Gini coefficient) for nursing personnel density at the subnational level is 0.12;[1] this value varied from an average of 0.05 in the European Region to 0.21 in the African Region. In these 58 countries, an average maximum/minimum ratio (i.e. between the region with the highest density and the region with the lowest density) of 16 (ranging from 1.1 to 352) was observed. This indicated that countries already suffering from low HWF density also had more extensive within-country inequality in health worker distribution.

WHO recommendations focus on strategies to increase the availability of health workers in remote and rural areas through improved attraction, recruitment and retention. Critical to ensuring equitable deployment of health workers are the selection of trainees from, and delivery of training in, rural and underserved areas, financial and non-financial incentives, and regulatory measures of service delivery reorganization.

Access and delivery of health technologies

Access to and delivery of medicines, vaccines and diagnostic tools are vital to addressing most established and emerging health issues, and to recovering overall momentum towards the health-related SDGs. A sample of 25 countries, surveyed between 2008 and 2019, shows substantial variation in access, with a range of 0 to 69.2% (median of 14.6%) of health facilities providing an available and affordable (accessible) set of core essential medicines for treatment, prevention and management of acute and chronic, communicable and noncommunicable diseases in primary health care settings. Specifically, in 28% of countries none of the facilities provided accessible medicines.

Worldwide, the need to reduce face-to-face consultations without compromising the quality and access of essential health services has revitalized telemedicine and brought it to the forefront in the era of COVID-19. Discussions on the necessity and feasibility of telemedicine have pervaded across a range of medical specialties and care settings. Health systems have introduced regulatory flexibilities and incentives to encourage adoption and implementation, with coordination from providers and technology companies. Each year, billions of dollars are spent on research and development into new or improved health products, technologies and processes, ranging from medicines and vaccines to diagnostics and assistive devices. But the way research priorities are selected and funds distributed are often poorly aligned with global public health needs, and access and delivery considerations are typically only included as an afterthought. Countries with comparable levels of income and health needs receive different levels of ODA for medical research and for maintaining basic health sectors. In 2018, LICs received only 0.2% of all direct grants for biomedical research by major funders *(20)*.

Globally, the average national percentage of domestic government expenditure devoted to health was 10% in 2018, ranging from 7% in the African Region to 14% in the Region of the Americas. Most regional and global proportions of investment have increased slightly in the past decade.

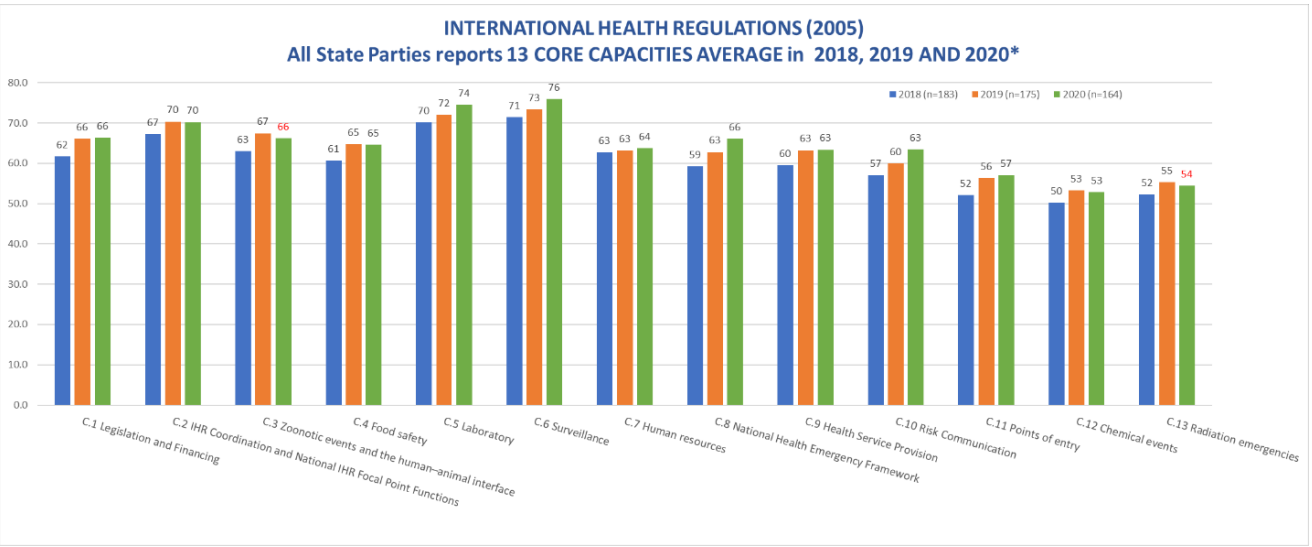
[1] A Gini coefficient of zero represents equality and an increasing coefficient reflects greater inequality.

Health security

Health security is another important and indispensable component of UHC and is assessed as one of the 14 sub-indicators in UHC SCI. The COVID-19 pandemic underlined that health security is a fundamental prerequisite to ensure basic health, achieve UHC, and consolidate the hard-earned health gains. The *International Health Regulations (2005)* (IHR) require that all 196 signatory countries and territories (State Parties) work together for global health security and build their capacities to detect, assess, report and respond to public health emergencies.

WHO had supported IHR State Parties to assess, evaluate and monitor their IHR capacities and developed a Monitoring and Evaluation Framework (IHR MEF), consisting of the compulsory annual reporting to the World Health Assembly, using the IHR State Party self-assessment and reporting tool (SPAR) and other complementary and voluntary instruments: The Joint External Evaluation, Simulation Exercises and After Action Reviews (AAR).[1]

Based on the SPAR annual reporting from the 164 State Parties that reported their data for 2020 – and considering averages of all of reports received from 2018 to 2020 – trends show constancy and steady progress since 2018 in almost every core capacity. The exception is a small reduction in capacities related to zoonotic events and human–animal health interface and chemical events observed in 2020 compared to 2019 (Fig. 4.9). Considering only the 146 countries that reported each year from 2018 to 2020, there is a verified increase in all capacities, with stable scores from 2019 and 2020 in only two capacities: zoonotic events and human–animal health interface, and also chemical events (Fig. 4.10). In general, despite the verified variation in 2020, the 13 capacities average level are above 50% and three capacities reached the level near or above 70%: IHR Coordination and National IHR Focal Point Functions; Laboratory; and surveillance. Covid-19 experience shows the clear need for a coordinated multisectoral health emergency surge capacity and preparedness at all levels nationally. The 2020 IHR SPAR reports provided clear evidence of the strong political commitment to fulfil IHR obligations. They also showed that continuing efforts are needed to improve and maintain early warning systems, to mitigate and manage public health risks within national contexts, and to consider worldwide pandemic context for national health emergency operational preparedness planning.

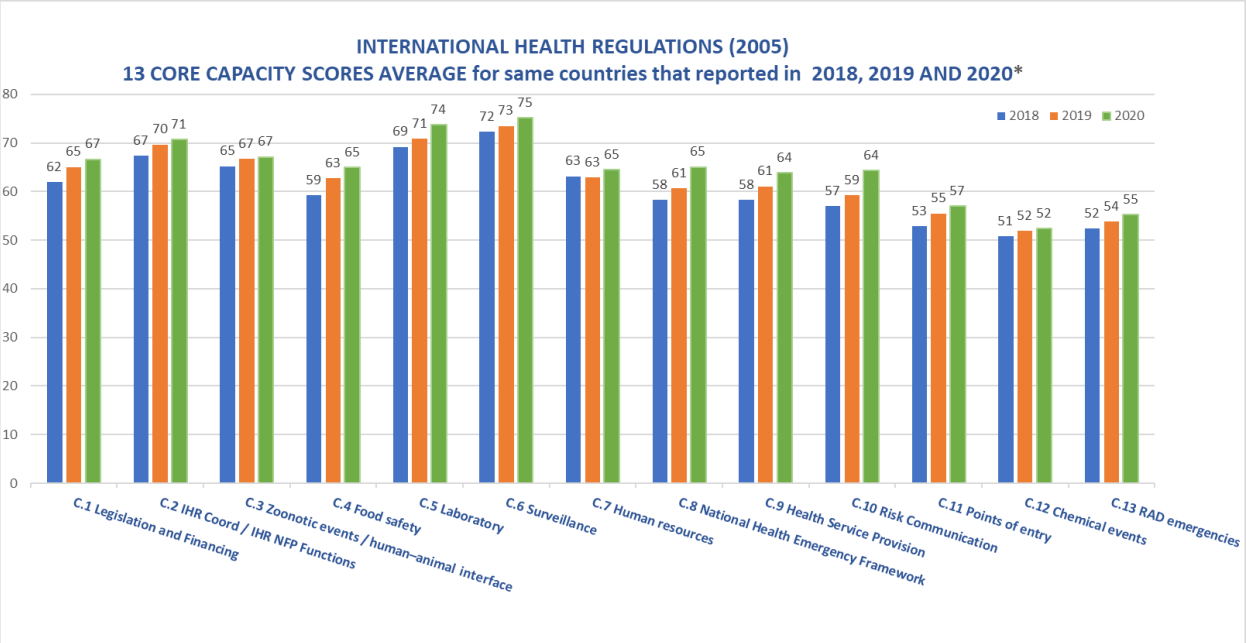


Note: *Based on information of 146 States Parties reporting in 2018 (n=183), 2019 (n=175) and 2020 (n=164).

Source: As of 16 of April, 164 State Parties reported for SPAR 2020 IHR annual report. For the latest update see: https://extranet.who.int/e-spar.

Fig. 4.9. International Health Regulations State Parties SPAR reports, 2018 to 2020

[1] Activities from IHR MEF are disseminated regularly on weekly updates and also available at the Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal. See: https://extranet.who.int/sph/home.



Note: *Based on information of 146 States Parties reporting in 2018 (n=183), 2019 (n=175) and 2020 (n=164).

Source: As of 16 of April, 164 State Parties reported for SPAR 2020 IHR annual report. For the latest update see: https://extranet.who.int/e-spar.

Fig. 4.10. SPAR reports for 146 countries reporting for 2018, 2019 and 2020

The IHR reviews, SPAR, the report of the Independent Panel, and the Global Preparedness Monitoring Board (GPMB) continue to inform avenues for improvement and next steps. It will be important to ensure that the Prevent vaccination indicators continue to express positive hard-earned gains due to COVID-related disruptions to essential health services, and to ensure equitable roll-out of COVID vaccines. The current pandemic offers a tangible opportunity to have a substantial impact on protecting more lives through the roll-out of COVID-related vaccines, to refocus efforts on other priority vaccine-preventable diseases; and also, to address key factors of overall health systems readiness to prepare for, respond to, and ultimately protect more lives from health emergencies

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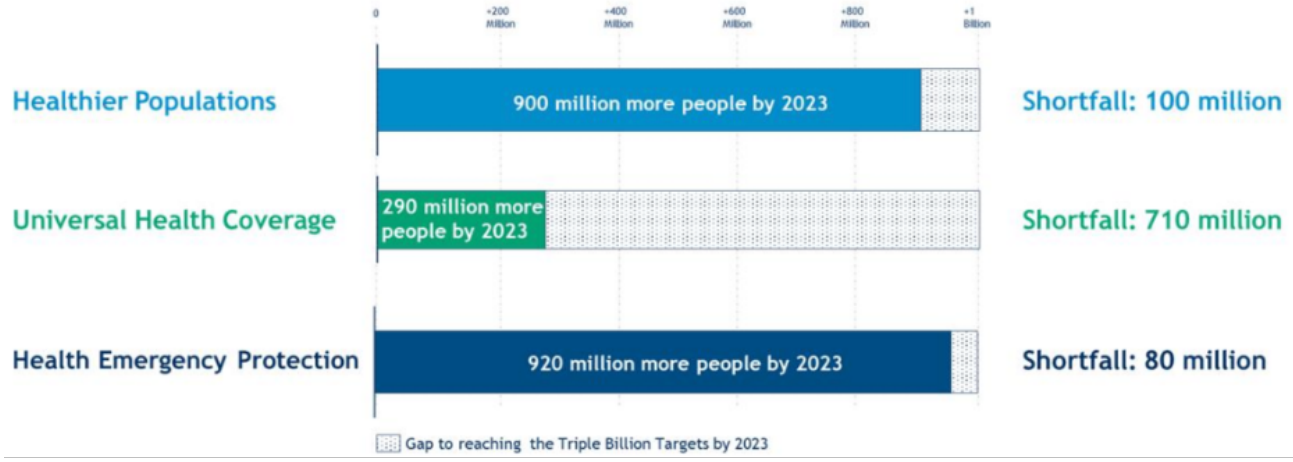
5 ACCELERATING PROGRESS TOWARDS HEALTH-RELATED SDGS AND TRIPLE BILLION TARGETS

The world was already off-track to meet the SDGs and the WHO Triple Billions, and COVID-19 has upended recent progress. Delivering on the WHO Triple Billion targets is imperative to get back on track, be better prepared and recover equitably.



Source: Triple Billion dashboard https://www.who.int/data/triple-billion-dashboard *(1)*.

Fig. 5.1. Projected shortfall in reaching WHO Triple Billion targets by 2023, compared to 2018

Triple Billion targets

The WHO Triple Billion targets are a shared vision among WHO and Member States, which help countries to accelerate the delivery of the SDGs. They aim to improve the health of billions of people by 2023 through achieving: 1) One billion more people enjoying better health and well-being; 2) One billion more people benefiting from universal health coverage (UHC); 3) One billion more people better protected from health emergencies. These targets are aligned closely with the SDGs and are the foundation of the WHO Thirteenth General Programme of Work (GPW 13), acting as both a measurement tool and a policy roadmap to accelerate progress towards health related SDGs. The ongoing COVID-19 pandemic underscores the importance of investing in health to have populations that are healthier and are able to withstand or recover quickly from health risks; to have resilient health systems that deliver to all people essential health services of good quality without incurring financial hardship; and to have well-functioning mechanisms to efficiently and effectively prepare for, prevent, detect and respond to health emergencies.

Healthier Population Billion

One billion more people enjoying better health and well-being

The Healthier Population Billion target aims for one billion more people to live in better health by 2023 by encouraging healthier behaviours, lifestyles and environments. Progress towards this target is measured using the Healthier Population Index, which consists of 17 tracers from the GPW 13 outcome indicators mainly derived from the SDGs. These indicators cover clean air, safe water, sanitation and roads, tobacco and alcohol use, obesity, domestic violence, child nutrition and child development, trans-fats, and mental health *(2)*.

The current projected number of people living healthier lives by 2023 is about 900 million more than the 2018 baseline value, still 100 million short of the one billion target *(1)*. Economic development affects progress towards the target across countries. Just 2% more of the population in LICs is projected to live a healthier life by 2023, compared to 12% more among other countries and 11% more globally. However, the majority of global progress occurs in just a few countries. If the current trend continues without intentional intervention, there is risk of deepening inequalities between LICs and other countries.

The impact of the COVID-19 pandemic is not reflected in this projection but will be accounted for in future work. The pandemic may have reversed some of the progress and worsened existing health inequalities, with increases in reported substance and alcohol use, domestic violence and mental illness *(3–5)*. Moreover, people with noncommunicable diseases and other underlying risk factors have been reported to be at higher risk of severe illness and death since the pandemic began in 2020 *(6–7)*. Multisectoral action must be strengthened at the global, regional and national levels to mitigate the impacts of COVID-19, and address social, behavioural, metabolic and environmental determinants of health.

UHC Billion

One billion more people benefiting from universal health coverage (UHC)

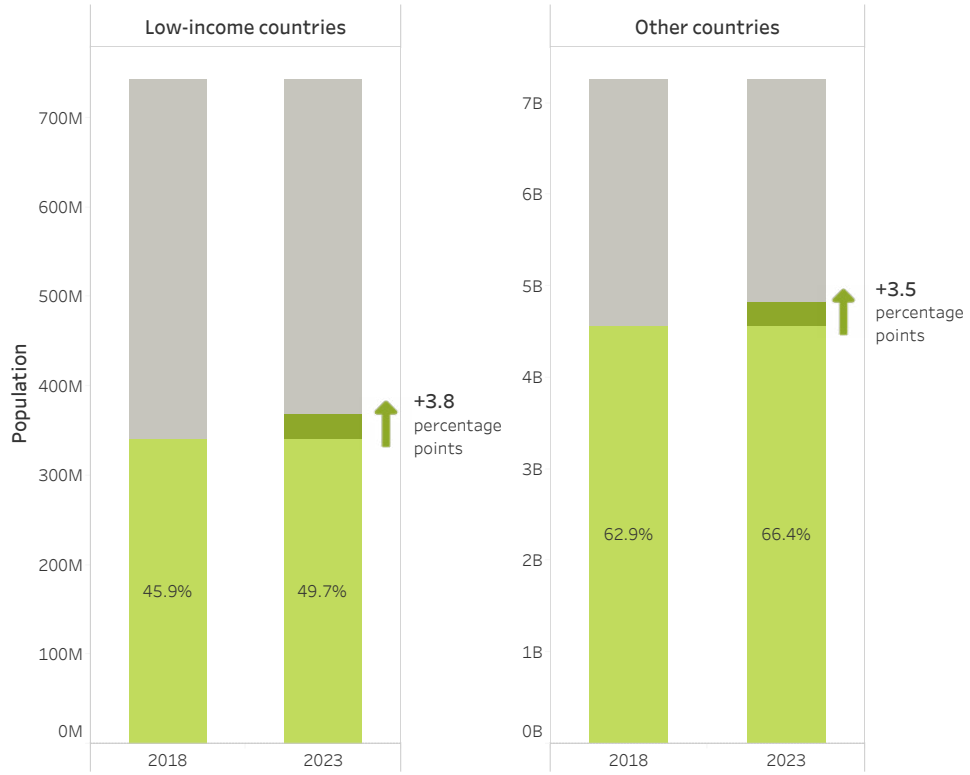
The UHC Billion target is assessed with a set of 14 health service coverage (SDG 3.8.1) and financial hardship tracer indicators (SDG 3.8.2). Between 2018 and 2023, both LICs and other countries are projected to have similar progress towards the UHC target with 4% more of the population with UHC *(1)*. However, the percentage of population with UHC in LICs overall is projected to be 50% in 2023, remaining low compared to the projection of 66% among other countries.

At the current rate of progress, it is projected that 290 million more people would be covered by health services without experiencing financial hardship by 2023, compared to the 2018 baseline value, leaving a gap of 710 million until the UHC Billion is reached *(1)*. This projection does not account for the impact of COVID-19. Given reported disruptions in health services and global economic contraction due to the pandemic, progress towards the UHC Billion is very likely under threat, and urgent investment is necessary to maintain the progress *(8,9)*.

Health Emergencies Billion

One billion more people better protected from health emergencies

The Health Emergencies Billion target is based on SDG 3 and accounts for the need to prepare for, prevent, detect and respond to health emergencies. It is measured through the Health Emergencies Protection Index (HEPI) that comprises three component indicators – Prepare, Prevent, Detect and Respond – representing the key elements of WHO health emergencies activities. Prior to the onset of COVID-19, early estimates showed that the world was on track to achieve one billion people better protected from health emergencies by 2023 with a positive trend across all three component indicators. Although the full impact of the COVID-19 pandemic is yet to be determined, latest estimates that include observed data from 2020 suggest that the current trajectory will result in 920 million people better protected from health emergencies by 2023 – just 80 million short of the target *(1)*. In LICs, 23% more of the population are projected to be protected from health emergencies from 2018 to 2023, compared to 10% among other countries.



Notes: M= million; B= Billion.

Fig. 5.2. Increase in proportion of population projected to have universal health coverage by 2023 in comparison to 2018

The ongoing COVID-19 pandemic suggests that the world was not prepared for health emergencies of such a scale. Further monitoring and analysis are required to determine the longer-term consequences of COVID-19 for the attainment of the Health Emergencies billion target.

However, investments driven by the response to COVID-19, and particularly those related to country preparedness, disease surveillance and COVID-19 vaccination roll-out, may be leveraged to accelerate progress towards achieving the target of 1 billion people better protected from health emergencies.

Monitoring health inequality: an essential step to achieve health equity

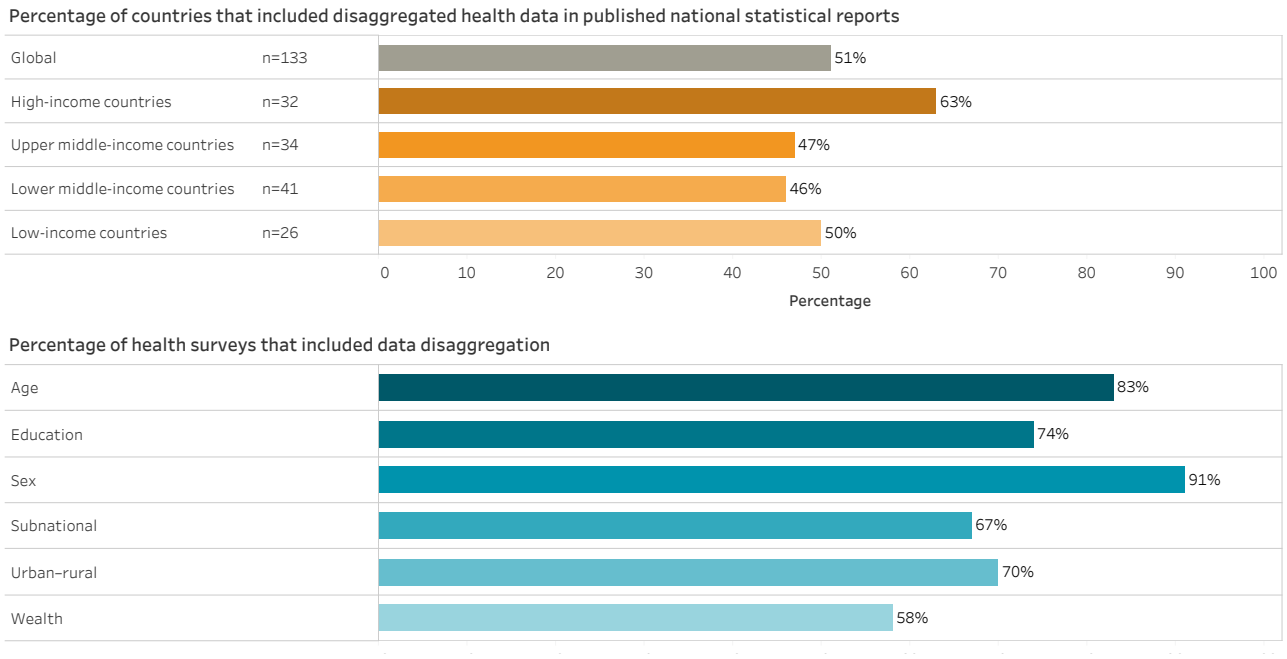
"Leaving no one behind" is the overarching refrain of the SDGs. The 2030 Agenda for Sustainable Development recognizes that high and rising inequalities, both within countries and between countries, are not only an impediment to growth and human development, but are also a violation of shared norms, values and fairness.

Relying solely on national level data to monitor health may lead to biased conclusions and some subpopulations being overlooked. Inequality monitoring is the process of generating evidence on how various subpopulations within a country are performing regarding health, in order to inform equity-oriented policies, programmes and practices that ensure that disadvantaged or hard-to-reach populations are not left behind. This relies on the collection, analysis and reporting of health data disaggregated by inequality dimensions, such as sex, age, economic status, education, place of residence, ethnicity and other context-specific population subgroups. In this light, health information systems are the foundation for monitoring health inequality.

Global data availability on health inequality

A WHO global assessment found that only 51% of the 133 participating countries included data disaggregation in their published national health statistical reports (ranging from 63% of HICs to 46–50% of countries in other income groups) (Fig. 5.3) *(10)*. Household surveys are one of the main sources of data for assessing health inequality. Of the 673 conducted in these countries between 2013 and 2018, 91% collected data disaggregated by sex, 83% by age, and only 74% by education, 70% by urban–rural place of residence and 58% by wealth.

Data disaggregation continues to be lacking in many countries and inequality data are often not being made accessible to the decision-makers who need them. Investment in robust health information systems is vital to ensure that health service access and uptake, and ultimately health outcomes, are equitable.



Source: SCORE for health data technical package: global report on health data systems and capacity, 2020 *(10)*.

Fig. 5.3. Availability and reporting of disaggregated health data in 133 countries, 2013–2018

Availability of disaggregated data for GPW 13 outcome indicators

Out of the 46 outcome indicators defined by WHO GPW 13 impact measurement, 38 can be disaggregated by nature. Based on data that were recently published (survey data conducted within the past 10 years and estimates from latest year(s) available), and comparable across countries, only 22 of the 38 indicators have data disaggregated by at least one dimension of inequality (i.e. age, economic status, education level, place of residence or sex) available in the public domain.

Of the 22 GPW 13 outcome indicators, six had data disaggregated by age, eight by economic status, eight by level of education, 11 by place of residence (urban–rural) and 17 by sex (Annex 4, Table 1). Sex-disaggregated data are available for the largest number of countries in general, largely because these are based on data that are estimated or modelled by organizations including WHO. Population-based household surveys are the main data source for data disaggregated by economic status, education and place of residence. However, the frequency and timeliness of this data vary considerably across countries. Of the eight outcome indicators with disaggregation by economic status or education, data are only available for 64 to 93 countries for at least one year between 2010 and 2019.

Data disaggregation is also not available for many of the indicators used to calculate progress against the Triple Billion targets (Annex 4, Table 2).

Building capacity for monitoring inequality

Disaggregated data enable policy-makers to identify populations that are vulnerable to being left behind, and direct resources and design programmes accordingly. The availability of high-quality disaggregated data continues to be a challenge in many countries, hindering the monitoring of health inequalities both within and between countries. This requires great efforts to enhance country health information systems that collect data to produce disaggregated data by multiple inequality dimensions through various data sources including civil registration and vital statistics (CRVS), population-based surveys, routine health facility data and administrative data.

Countries' capacity to analyse and report health inequality data also needs to be strengthened. WHO has developed a package of tools and resources to support countries for developing inequality monitoring capacities, including a step-by-step manual *(11)*, a handbook *(12)*, statistical codes to facilitate the calculation of disaggregated estimates from household survey data *(13)*, the Health Equity Monitor database (one of the largest databases of disaggregated health data), and the *Health Equity Assessment Toolkit* (HEAT and HEAT Plus) *(14)*, an interactive software application that enables countries to assess inequalities at national and subnational levels.

WORLD HEALTH SURVEY PLUS (A): A NEW DATA COLLECTION PLATFORM

WHS+ is a versatile multi-topic, multi-modal health data collection platform to fill the essential data gaps in progressing towards health-related SDGs and new health priorities with the flexibility to adapt to countries' unique data needs *(19)*. It enables rapid high frequency surveys with the application of mobile technologies. In line with the UN and WHO's position for data transparency and data sharing, WHS+ will include an open data repository to make data available for the broadest audience for maximized data usage. Countries and partners can first use the SCORE package to assess and identify critical data gaps, then strategically select survey modules to obtain data that are lacking but would be most impactful. In conjunction with SCORE package, WHS+ can form the foundation of a sustainable strategy to strengthen health information system for informed public health policy and programmes.

WHO also provides direct support to build country capacity to conduct and interpret health inequality analysis at national and regional levels. For example, WHO supported Indonesia's first national report on the state of health inequality *(15,16)*.

Health inequality data are useful only when they are used to inform national policies and programmes to effectively reduce and eliminate health inequalities. This is a highly context-dependent and iterative process, requiring in-depth knowledge about local settings as well as intersectoral collaboration and strong political commitment. The Innov8 approach *(17)* helps countries to identify ways to take concrete and evidence-based actions to make health programmes more equitable. Continuous monitoring of inequalities is needed to assess the impact of actions taken and make course-adjustment accordingly.

Strengthening health information systems

Timely, reliable, disaggregated and actionable data, comparable statistics and country-specific evidence are critical to driving strategic policy changes. Assessable information is essential to monitor and accelerate progress towards the health-related SDGs, GPW 13 Triple Billion targets, and national and subnational health priorities. The COVID-19 pandemic has highlighted the importance of health data and health information systems in guiding all stages of policy response to the crisis, with life and death consequences. It has magnified many long-standing and acute gaps in country data and information systems. Essential data are often absent, and the dire consequences are well displayed even in the most prepared countries.

Without high-quality data, it will not be possible to have a swift recovery from the COVID-19 pandemic and to fulfil the promise of the United Nations 2030 SDG agenda. For every Member State, a strong health information system is crucial for measuring and tracking population health determinants and outcomes, as well as health inequalities. Decision-makers need timely data to better prepare, develop and implement policies and allocate resources effectively.

SCORE for Health Data Technical Package

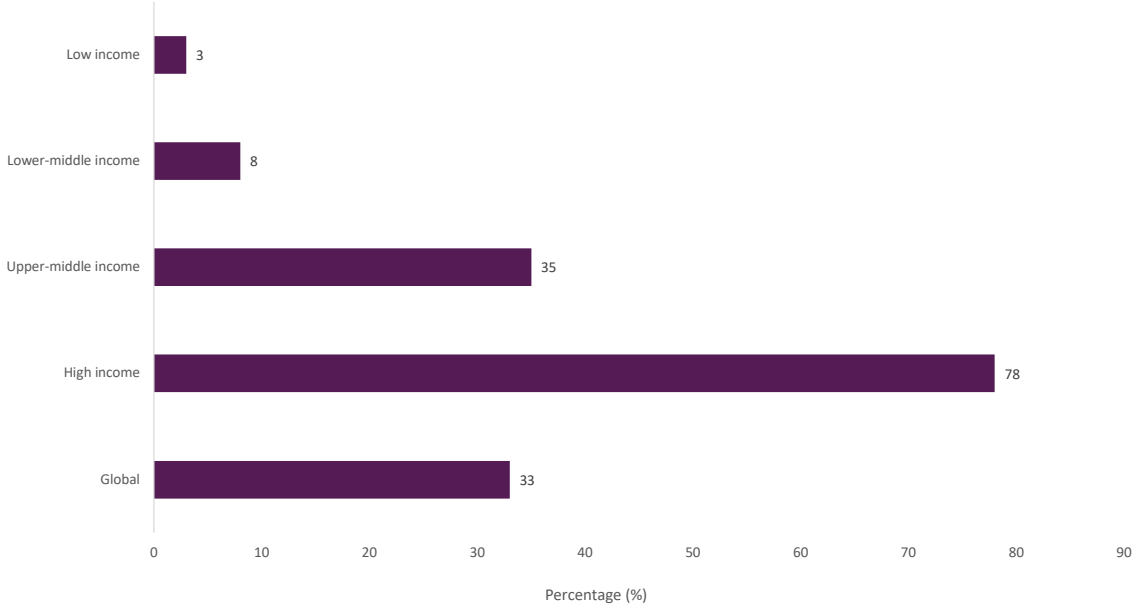
The WHO SCORE for Health Data Technical Package provides a one-stop solution for assessment, interventions and tools to help countries strengthen their health information systems. It covers five essential interventions of a functioning health information system: Survey populations and health risks; Count births, deaths and report causes of death; Optimize health service data; Review progress and performance; and Enable data use for policy and action *(18)*. It can guide investments in the areas that can produce most impact, and track progress towards the SDGs and other national and subnational health priorities.

SCORE assessment identifies data gaps and tracks progress

The COVID-19 pandemic has highlighted the importance of identifying public health threats. SCORE reviewed countries' capacities to use data from international health regulation reports before the pandemic started. The result showed that only 27% of countries have sustainable capacity to survey public health threats *(10)*. The SCORE assessment also indicated that about 40% of the world's deaths remain unregistered, 50% of countries have limited or less capacity for systematic monitoring of health care quality, and only 59% of countries have good capacity to use data to drive policy and planning.

ENHANCING CIVIL REGISTRATION AND VITAL STATISTICS SYSTEMS (CRVS)

Multiple health-related SDG indicators require reporting of causes of death. CRVS is the primary data source for fertility and mortality statistics. The new *WHO CRVS strategic implementation plan* supports countries to improve the registry of births, deaths and report of causes of death with minimal time lags and sufficient details to better inform decision-making *(20)*. In response to the demand to support reporting of weekly death counts arising from the COVID-19 pandemic, WHO and partners have developed guidelines on rapid mortality surveillance and calculation of excess mortality *(21)*. WHO has also developed standards for the medical certification and coding of causes of death attributable to COVID-19 *(22)*, and established an online data portal for Member States to report total and COVID-19 attributable deaths on a weekly basis as medically-certified reports by age and sex *(23)*. In addition, a technical advisory group on COVID-19 mortality assessment has been formed to determine the excess deaths that can be directly and/or indirectly attributed to the pandemic *(24)*.

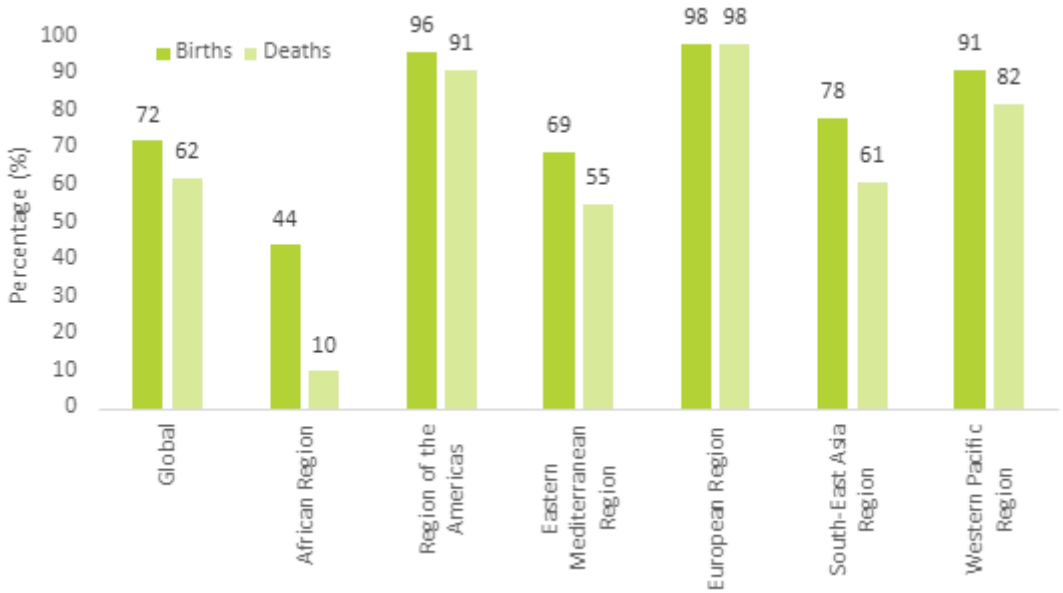


Source: SCORE for health data technical package: global report on health data systems and capacity, 2020 *(10)*.

Fig. 5.4. Percentage of health surveys that are fully funded by government, by World Bank income group, 2013–2018

Population-based surveys are one of the essential tools to measure population health and health-related trends. However, many countries rely heavily on external support for implementing health surveys. SCORE results indicated that only 8% of the surveys in LMICs and 3% in LICs were fully funded by the respective national government (Fig. 5.4). This would very likely cause data disruption in tracking health-related SDGs and other health priorities when external support is not available or insufficient.

A well-functioning civil registration and vital statistics (CRVS) system is vital as accurate birth and death registration provide essential data for service planning and resource allocation. SCORE data showed that 44% of the countries have only poor capacity or no capacity at all to fully register the births, deaths and report causes of death (Fig. 5.5). In the African Region, less than half of the births and only 10% of deaths were registered annually. Causes of death were reported for only 8% of deaths registered in LICs. These findings were echoed by reports of many governments struggling to compile accurate counts of COVID-19-related deaths since the start of the pandemic.



Source: SCORE for health data technical package: global report on health data systems and capacity, 2020 *(10)*.

Fig. 5.5. Percentage of births and deaths registered, by WHO region

Health service data are essential for patient monitoring, facility management and evaluating service delivery as well as ensuring quality of care. UHC and global health security are only possible when people in need have access to services provided by skilled health workers. SCORE evaluated the density and distribution for five of the most common health occupations including physicians, pharmacists, dentists, nurses and midwives. It showed that for all five occupations combined, national data were available in 71% of countries, while data disaggregated by subnational units were available in only 55% of countries *(10)*. The number is even lower when disaggregated by public and private sector, at only 34%. The lack of data on health workforce limits the development of effective plans and policies to ensure sufficient health worker capacity.

Data are only useful when they are applied to informing change. Effective use of data and evidence ensures accountability and transparency at all levels and enables policy actions that deliver impact. SCORE data showed that only 5% of countries have sustainable capacity to enable data for policy and action *(10)*. It was reported by news outlets that government offices in some of the most technologically advanced countries still used fax machines to report time-sensitive COVID-19 data. A strong country-led data governance system would have accelerated the changes by establishing necessary legal frameworks, regulations and inter-agency mechanisms to ensure the most effective data exchange, sharing and access.

WHO is currently developing the World Health Data Hub – a one-stop source for global health data that brings together data across WHO regions and Member States. The hub will support data collection, storage, analysis and dissemination. It will be the WHO corporate solution to reducing countries' reporting burden, facilitating data exchange, and creating a collaborative workspace for all stakeholders. In addition, a data governance mechanism has been formed; data governance principles and policies on data sharing and privacy protection have been established for both emergency and non-emergency contexts. A global data governance summit is planned for 2021 to review these data principles and policies and make recommendations for international communities.

The COVID-19 pandemic exposed the weakness of existing health information systems. Every country deserves a strong health information system that can inform policies to save lives and allow people to live a healthier life without the burden of excessive health care costs. Countries need to increase their investments in such systems in order to build strong and robust health information systems that can prevent the next pandemic and stride towards the health-related SDGs and Triple Billion targets.

SYNTHESIZING HEALTH SERVICE DATA

Health service data can be generated through routine health facility and community reporting systems, health facility assessments and health resource data including on health financing and the health workforce. These systems should be integrated and interoperable to ensure synergized monitoring, analysis and management of health services to support patient care, facility management and health sector planning to improve primary health care and UHC. The WHO *Harmonized facility and community data toolkit* and related digital packages – such as the District Health Information Software 2 – provide reliable and actionable data to improve the access to quality of health care *(25)*.

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ANNEX 1

Regional highlights of health-related SDG indicators

Explanatory notes

Unless otherwise noted, the statistics shown below represent official World Health Organization (WHO) statistics for selected health-related Sustainable Development Goal (SDG) indicators and selected Thirteenth General Programme of Work (GPW 13) indicators, based on evidence available in early 2021. They have been compiled primarily from publications and databases produced and maintained by WHO or by United Nations (UN) groups of which WHO is a member. Unless otherwise noted, all statistics presented here are available in Annex 2. Owing to limited space, indicators are often referred to using SDG targets, along with a shorter indicator name (Annex 2 has a full summary of indicator names and relevant references).

Comparable estimates are subject to considerable uncertainty, especially for countries where the availability and quality of the underlying primary data are limited *(1)*. Uncertainty intervals and other details on the indicators and statistics presented here can be found at the WHO Global Health Observatory[1].

Reference

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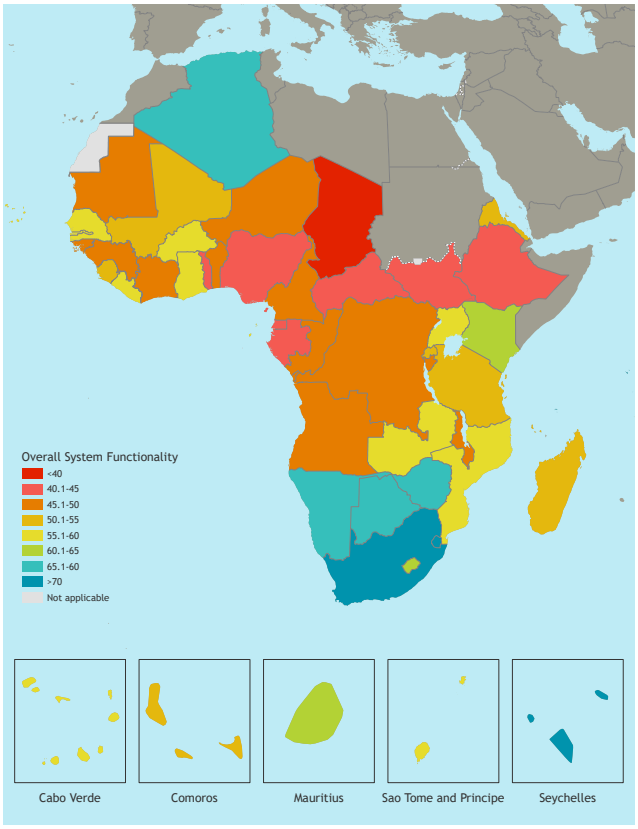
Innovating to generate evidence for policy with limited data – understanding and guiding health system functionality

Countries are making efforts to attain essential health gains in the context of changing social, economic, environmental, political and cultural situations. To achieve this, health sectors are grappling with providing services in constantly shifting environments, where disease, economic and environmental shocks occur frequently. As a result, determining where and what to focus on is complex, with countries required to make varying investments to overcome their most immediate challenges and ensure effective, efficient and equitable achievement of specific health-related goals. Determining and meeting the information needs of this process, and adjusting to changing and unique country needs in a manner that ensures appropriate evidence available, is an equally complex challenge.

The WHO Regional Office for Africa is focusing on use of functional indices constructed from multiple related indicators to generate this essential information, focusing on understanding ongoing contexts and where effort needs to be concentrated *(1,2)*. The approach determines and assesses the level of functionality of systems in the region, as important predictors of health outcomes. Functionality is based on understanding relative capacities to ensure access to the quality essential services demanded by a given population, in a manner resilient to shocks and similar events. Based on indices for various functional capacities, succinct guidance is available to countries on where efforts need to be placed to continue momentum towards their health goals. Emerging evidence on the relative status of different functional capacities is both valid and sensitive to country specificities, even in contexts of limited data availability, and the average of the four combined indices in the areas of access, quality, demand and resilience shows a high correlation with the current status of health outcomes (r=0.778, P<0.005) (Fig. A1.1).

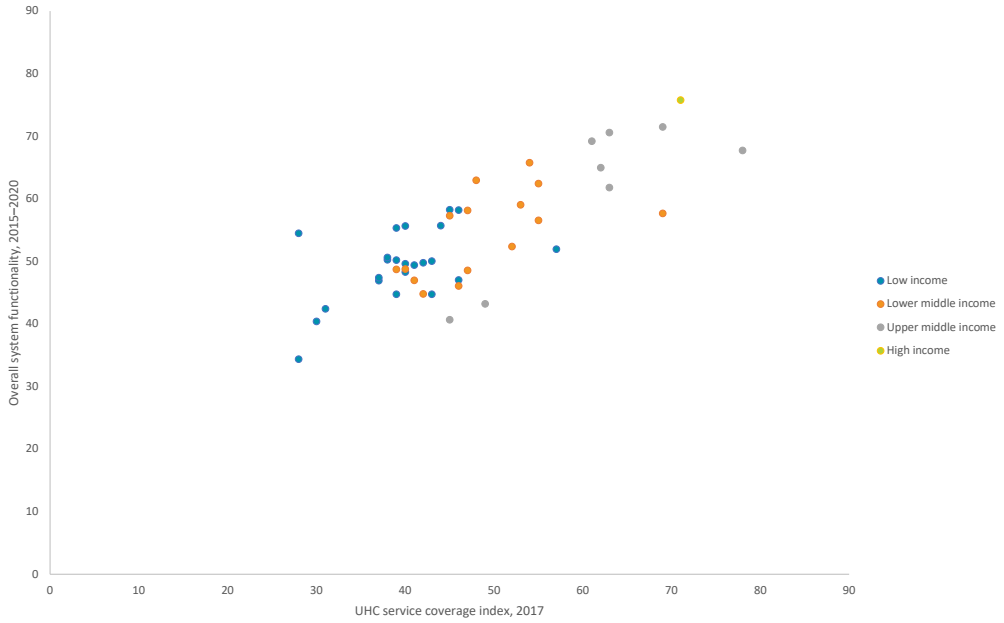
Relative functionality is distinct by country, allowing for specific prioritization and actions (Fig. A1.2).

The system provides countries with the evidence to guide where focused investments are needed across the health system to attain UHC and other health outcomes given current contexts. The evidence is specific for overall functionality and in relation to the status of contributing capacities. Relevant capacities include: ensuring better access (overcoming physical, financial or cultural barriers); strengthening quality of care (improving user experiences, care processes and effectiveness of outcomes); demand for services (improving healthy actions and health-seeking behaviours); and resilience to shocks. Each country can therefore focus its health systems development by focusing on addressing the most essential capacity gaps.



Source: Report on the performance of health systems in the WHO African Region *(1)*.

Fig. A1.2. Relative functionality of health systems across countries of the WHO African Region, 2015–2020



Note: UHC service coverage index does not include the service capacity and access components. Income groups are according to World Bank Income Groups (July 2020).

Sources: Report on the performance of health systems in the WHO African Region *(1)* and Primary health care on the road to universal health coverage: 2019 Monitoring report *(3)*.

Fig. A1.1. Functionality index correlation with UHC service coverage index in countries of the WHO African Region, by income group

Summary of SDG 3 indicators for which country-level values are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2017	3.2.1 Under-five mortality rate[c] 2019	3.2.2 Neonatal mortality rate[c] 2019	3.3.1 New HIV infections[d] 2019	3.3.2 Tuberculosis incidence[e] 2019	3.3.3 Malaria incidence[f] 2019	3.3.4 Hepatitis B prevalence[g] 2019	3.4.1 Probability of dying from the four major NCDs.. 2019	3.4.2 Suicide mortality rate[e] 2019	3.5.2 Alcohol consumption[i] 2019	3.6.1 Road traffic mortality rate[e] 2019	3.8.1 UHC service coverage index 2017	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[e] 2016	3.9.3 Unintentional poisoning mortality rate.. 2019	3.a.1 Tobacco use prevalence[k] 2018	3.b.1 DTP3 immunization[l] 2019	3.b.1 MCV2 immunization[m] 2019	3.b.1 PCV3 immunization[l] 2019	3.b.1 HPV vaccine[n] 2019
Algeria	112	23	16	0.05	61	0.0	0.08	13.9	2.5	0.6	20.9	78	49.7	1.9	0.7	18.8	91	77	91	
Angola	241	75	28	0.84	351	235.2	4.57	22.2	6.1	7.8	26.1	40	118.5	48.8	2.0		57	45	53	
Benin	397	90	31	0.31	55	406.7	2.87	22.6	7.8	2.2	26.8	40	205.0	59.7	2.6	7.2	76		73	
Botswana	144	42	18	4.78	253	0.2	0.18	27.0	16.1	6.6	26.4	61	101.3	11.8	1.8	23.7	95	76	92	47
Burkina Faso	320	88	26	0.14	47	386.7	1.66	23.9	7.5	11.0	31.0	40	206.2	49.6	3.1	16.0	91	71	91	
Burundi	548	56	21	0.17	107	296.0	1.35	25.0	6.2	7.5	35.5	42	179.9	65.4	3.2	12.6	93	80	93	
Cabo Verde	58	15	9	0.19	46	0.0	0.26	17.4	12.9	6.4	26.8	69	99.5	4.1	0.4		96	91		
Cameroon	529	75	26	0.69	179	243.1	1.75	23.9	9.0	5.5	30.2	46	208.1	45.2	2.6	9.3	67		67	
Central African Republic	829	110	40	1.10	540	345.0	3.75	36.0	12.3	1.7	37.7	33	211.9	82.1	2.8		47		47	
Chad	1140	114	33	0.34	142	202.1	10.79	22.7	6.4	1.3	32.4	28	280.1	101.0	3.5	11.8	50			
Comoros	273	63	30	<0.01	35	20.7	1.16	20.6	5.4	1.1	26.6	52	172.4	50.7	2.4	19.5	91			
Congo	378	48	19	1.55	373	230.8	2.56	22.6	6.5	9.2	29.7	39	130.7	38.7	1.3	16.1	79	9	68	
Cote d'Ivoire	617			0.51	137	300.6		21.7	8.9	3.0	24.1	47	269.1	47.2	2.5	13.0	84		84	
Democratic Republic of the Congo	473	85	27	0.22	320	325.8	3.28	24.0	6.7	1.1	34.9	41	163.9	59.8	2.0		57		58	
Equatorial Guinea	301	82	29	4.06	181	237.1	6.07	22.1	7.9	6.9	27.2	45	177.7	22.3	1.6		53			
Eritrea	480	40	18	0.11	86	57.3	1.02	26.8	10.9	2.1	37.9	38	173.7	45.6	3.3	7.2	95	88	95	
Eswatini	437	49	18	4.90	363	0.7		35.2	29.4	8.8	33.5	63	137.0	27.9	3.3	10.7	90	75	87	
Ethiopia	401	51	28	0.16	140	34.3	1.59	17.1	5.4	2.2	28.2	39	144.4	43.7	3.3	4.6	69	41	63	84
Gabon	252	42	20	0.74	521	211.9	2.12	21.3	8.4	8.1	23.9	49	76.0	20.6	1.3		70			
Gambia	597	52	27	1.06	158	50.5	1.60	21.1	4.8	3.4	29.6	44	237.0	29.7	1.8	14.4	88	61	87	
Ghana	308	46	23	0.70	144	161.5	2.13	22.5	6.6	2.8	25.7	47	203.8	18.8	1.7	3.7	97	83	97	
Guinea	576	99	30	0.39	176	296.9	6.07	24.9	7.0	1.1	29.7	37	243.3	44.6	2.3		47			
Guinea-Bissau	667	78	35	1.15	361	86.9	2.11	24.9	7.0	5.5	32.2	40	214.7	35.3	2.3		84		84	
Kenya	342	43	21	0.92	267	57.0	0.40	21.0	6.1	2.1	28.3	55	78.1	51.2	2.4	11.8	92	45	92	
Lesotho	544	86	43	6.43	654		1.22	42.7	72.4	5.1	31.9	48	177.6	44.4	5.2	29.7	87	82	87	
Liberia	661	85	32	0.46	308	366.6	4.66	17.8	4.4	5.4	38.9	39	170.2	41.5	1.7	8.4	74	13	74	
Madagascar	335	51	20	0.23	233	76.1	2.13	26.0	5.5	2.0	29.2	28	159.6	30.2	2.1	28.9	79		79	
Malawi	349	42	20	1.94	146	207.7	1.39	22.6	5.4	4.1	33.4	46	115.0	28.3	1.7	12.8	95	75	95	
Mali	562	94	32		52	333.7	4.62	22.3	4.1	1.3	22.7	38	209.1	70.7	2.9	12.0	77	4	74	
Mauritania	766	73	32		89	43.4	3.35	16.1	3.1	0.0	25.6	41	169.5	38.6	1.5		81		77	
Mauritius	61	16	10	0.57	12		0.41	23.2	9.5	4.8	12.2	63	38.3	0.6	0.8	26.9	96	99	97	80
Mozambique	289	74	29	4.68	361	308.4	0.59	30.6	13.6	2.7	30.0	46	110.0	27.6	3.7	14.4	88	85	80	
Namibia	195	42	19	3.10	486	2.8	0.36	22.6	9.7	3.1	34.8	62	145.0	18.3	1.9	17.9	87	56	57	
Niger	509	80	24	0.06	84	343.2	3.44	21.0	5.3	0.5	25.5	37	251.8	70.8	3.3	8.6	81	58	81	
Nigeria	917	117	36	0.52	219	303.3	2.94	16.9	3.5	6.2	20.7	42	307.4	68.6	3.3	4.8	57	9	57	
Rwanda	248	34	16	0.44	57	366.1	0.49	20.2	5.6	8.0	29.4	57	121.4	19.3	1.7	13.3	98	92	98	94
Sao Tome and Principe	130	30	14		114	11.4	1.31	21.0	1.5	5.8	27.9	55	162.4	11.4	0.7	5.4	95	81	95	
Senegal	315	45	22	0.09	117	50.5	0.93	19.5	6.0	0.7	23.5	45	160.7	23.9	1.9	9.1	93	78	92	25
Seychelles	53	14	9		16		0.09	21.1	8.1	8.8	11.3	71	49.3	0.2	0.5	21.1	99	99	92	68
Sierra Leone	1120	109	31	0.65	295	334.8	1.98	23.5	6.7	5.3	33.0	39	324.1	81.3	2.8	19.8	95	72	94	
South Africa	119	34	11	3.98	615	0.5	3.10	24.1	23.5	9.5	22.2	69	86.7	13.7	1.7	31.4	77	54	76	56
South Sudan	1150	96	39	1.50	227	272.0	13.03	16.8	3.8		36.7	31	165.1	63.3	2.3		49			
Togo	396	67	25	0.59	37	225.0	3.27	23.9	8.8	2.7	28.7	43	249.6	41.6	1.9	7.6	84	67	83	
Uganda	375	46	20	1.38	200	262.7	0.96	21.2	4.6	12.5	29.4	45	155.7	31.6	1.7	9.8	93		92	64
United Republic of Tanzania	524	50	20	1.46	237	111.2		17.4	4.3	12.0	31.1	43	139.0	38.4	2.0	13.3	89	72	83	49
Zambia	213	62	23	3.17	333	147.7	1.32	24.6	7.3	4.5	20.5	53	127.2	34.9	2.6	14.7	88	66	89	
Zimbabwe	458	55	26	2.81	199	67.9	2.74	28.4	14.1	4.5	41.2	54	133.0	24.6	3.5	13.9	90	75	90	67

[a] Comparable estimates refer to country values of the same reference year, which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Refer to Annex 2 for the full set of SDG 3 indicators. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators. Each indicator is graphed on an individual scale.

[b] per 100 000 live births
[c] per 1000 live births
[d] per 1000 uninfected population
[e] per 100 000 population
[f] per 1000 population at risk
[g] among children under 5 years (%)
[h] betwe en ages 30-69 (%)
[i] litres of pure alcohol per capita ≥15 years
[j] age-standardized, per 100 00 population
[k] age-standardized, among adults 18+ (%)
[l] among 1-year-olds (%)
[m] by the nationally recommended age (%)
[n] among 15 year-old girls (%)

Regional trends and income-related inequalities in the incidence of tuberculosis in the Region of the Americas

The Region of the Americas experienced a steady decline in tuberculosis (TB) from 1990 to 2015, cutting its prevalence and mortality by half over that period. It was the first region in the world to meet the Millennium Development Goal (MDG) target for halting the spread of TB.[1] However, progress in closing gaps in the prevention, detection and reporting of incident TB cases, multidrug-resistant TB (MDR-TB) and TB/HIV coinfection has been slow, and the disease remains a serious public health problem, posing a critical challenge to meeting the SDG 3.3.2 target *(5)*.

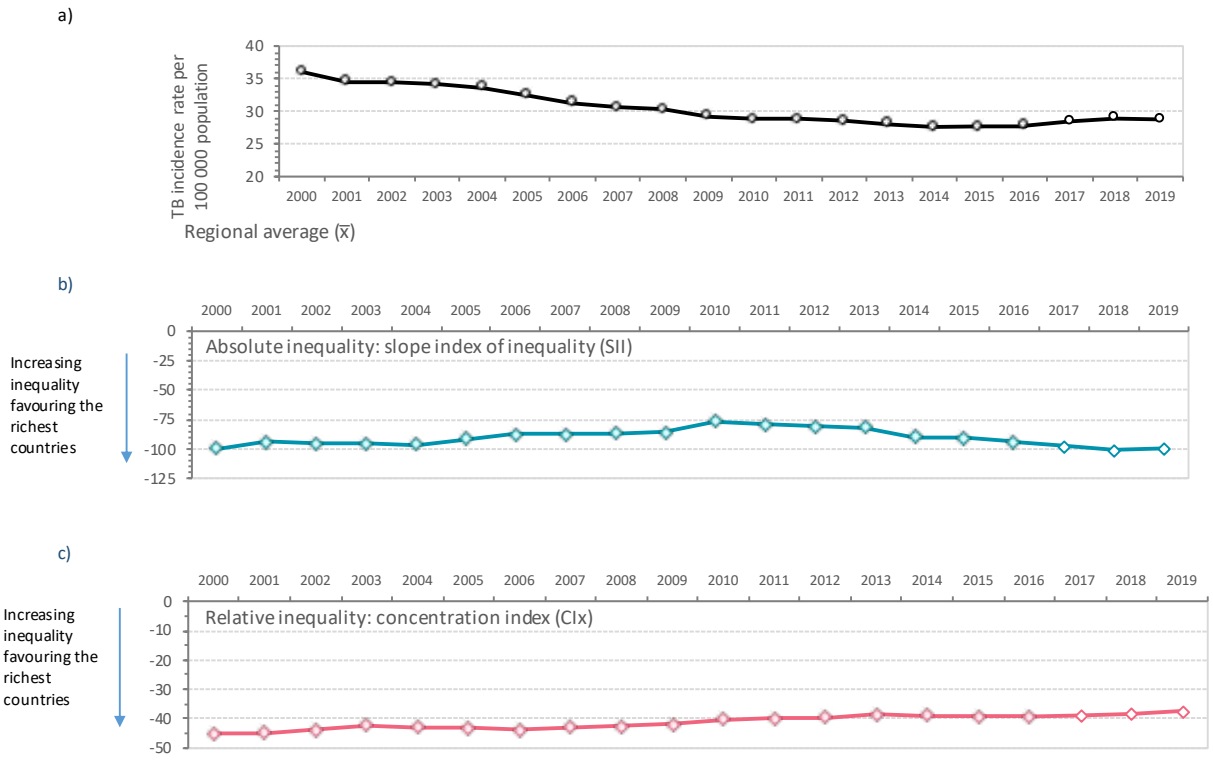
In 2019, the regional TB incidence rate (all forms, both sexes) was 28.6 per 100 000 population [95% CI: 26.6 to 30.7], up from 27.5 per 100 000 population [25.5 to 29.5] in 2015, representing an annual average increase of almost 1%. Despite an apparent 2018–19 stabilization, this unwanted trend contrasts with the one observed from 2000 to 2015, during which a steady –1.9% annual average reduction was observed (Fig. A1.3a).

Income-related inequalities in TB incidence between countries in the Region of the Americas continue to be extremely high. The extra TB burden associated with this social gradient, as measured by the slope index of inequality (SII), went from –99.5 excess TB incident cases per 100 000 population (between the richest and poorest countries) in 2000 to –77.0 in 2010 and back to –99.6 in 2019 (Fig. A1.3b). This means that the favourable downward trend (i.e. towards zero) observed in the first decade of the century (corresponding to a 2.9% annual average reduction in absolute between-country inequality) has been reversed (averaging a 2.6% annual increase from 2011 onwards). The corresponding relative inequality, as measured by the concentration index (CIx), showed a slightly better prospect, with a steady 1% annual average reduction in between-country relative inequality in the period observed (Fig. A1.3c). This change in CIx equates to a reduction from 81% to 76% in the TB incidence burden among the poorest half of countries in the Americas from 2000 to 2019, respectively.

The observed deceleration of the regional efforts to reduce TB incidence in the past five years, along with its sizeable income-related inequalities across countries, will no doubt be amplified by the multidimensional impacts of the COVID-19 pandemic in the region. Attaining SDG 3.3.2 will demand, therefore, truly stepped-up efforts with an explicit focus on inequality, including territories and populations living under conditions of social and health vulnerability. To enhance accountability for the 2030 Agenda for Sustainable Development's overarching pledge that *no one will be left behind*, the Region of the Americas is implementing a health inequality monitoring system for all its SDG 3 related indicators,[2] informing the adoption of equity-sensitive targets, policies and interventions. This approach is critical for a region with extreme wealth-related inequality, and especially for the post-COVID-19 scenario.

[1] Unless otherwise noted the data found here are from the Global tuberculosis report 2020. Geneva: World Health Organization; 2020 (https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2020) *(4)*.

[2] For information regarding PAHO's SDG 3 related health inequality monitoring, please visit: https://www.paho.org/ods3.



Notes: The slope index of inequality (SII) represents an estimate of the difference in TB incidence rates between the richest and the poorest countries, while taking into consideration the other countries in the region. The Concentration Index (CIx) indicates the extent to which TB incidence is concentrated among the richest or the poorest countries. In the lower two panels, SII and CIx negative values account for negative inequality (i.e. TB incidence disproportionately concentrated among the most socially disadvantaged (i.e. poorest) countries: the closer to zero (0), the lower the inequality).[3]

Sources: Global tuberculosis report 2020 *(4)*; Gross domestic product per capita 2000–2019 estimates *(6)*.

Fig. A1.3. Regional trends (a) and cross-country income-related inequalities (b and c) in the incidence of tuberculosis (SDG 3.3.2) in the Region of the Americas, 2000–2019

[3] Cross-country inequalities in TB incidence (all forms, both sexes) were measured across the social hierarchy defined by the gross domestic product per capita (in 2018 constant, international dollars). For information regarding the calculation of the SII and the CIx as summary measures of absolute and relative inequality, please refer to the WHO's Handbook for health inequality monitoring https://www.who.int/gho/health_equity/handbook/en/).

Summary of SDG 3 indicators for which country-level values are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2017	3.2.1 Under-five mortality rate[c] 2019	3.2.2 Neonatal mortality rate[c] 2019	3.3.1 New HIV infections[d] 2019	3.3.2 Tuberculosis incidence[e] 2019	3.3.3 Malaria incidence[f] 2019	3.3.4 Hepatitis B prevalence[g] 2019	3.4.1 Probability of dying from the four major NCDs.. 2019	3.4.2 Suicide mortality rate[e] 2019	3.5.2 Alcohol consumption[i] 2019	3.6.1 Road traffic mortality rate[e] 2019	3.8.1 UHC service coverage index 2017	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[e] 2016	3.9.3 Unintentional poisoning mortality rate.. 2019	3.a.1 Tobacco use prevalence[k] 2018	3.b.1 DTP3 immunization[l] 2019	3.b.1 MCV2 immunization[m] 2019	3.b.1 PCV3 immunization[l] 2019	3.b.1 HPV vaccine[n] 2019
Antigua and Barbuda	42	7	4		0.0		0.19	17.5	0.4	9.4	0.0	73	29.9	0.1	0.7		95	95		
Argentina	39	9	6	0.13	29	0.0	0.01	15.7	8.4	9.5	14.1	76	26.6	0.4	0.4	21.8	86	89	88	59
Bahamas	70	13	7		15		0.16	19.9	3.5	4.8	7.7	75	19.9	0.1	0.2	10.9	86	82	86	9
Barbados	27	13	8	0.18	0.0		0.18	16.0	0.6	10.4	8.2	77	31.1	0.2	0.7	8.7	90	77	93	29
Belize	36	12	8		27	0.0	0.60	16.5	7.1	6.4	22.6	64	68.6	1.0	0.4		98	95		63
Bolivia (Plurinational State of)	155	26	15	0.08	106	2.4	0.14	17.9	6.2	3.9	21.1	68	63.7	5.6	0.6		75	44	75	70
Brazil	60	14	8	0.23	46	4.2	0.03	15.5	6.9	7.3	16.0	79	29.9	1.0	0.1	16.5	73	54	84	69
Canada	10	5	3		5.5		0.34	9.6	11.8	8.8	5.3	89	7.0	0.4	0.3	17.5	91	87	81	83
Chile	13	7	5	0.27	18		0.03	10.0	9.0	8.9	14.9	70	25.3	0.2	0.4	44.7	96	91	95	82
Colombia	83	14	7	0.25	35	10.7	0.15	9.7	3.9	5.5	15.4	76	37.0	0.8	0.1	7.9	92	88	94	39
Costa Rica	27	9	6	0.19	10.0	0.1	0.02	9.5	8.1	4.1	14.8	77	23.3	0.9	0.1	9.8	95	93	95	39
Cuba	36	5	2	0.14	6.5		0.03	16.6	14.5	6.3	8.9	83	49.5	1.0	0.2	27.1	99	99		
Dominica		35	28		16					7.2							99	92		
Dominican Republic	95	28	19	0.27	42	0.3	0.10	19.1	4.9	6.7	64.6	74	43.0	2.2	0.4	9.4	89	60	70	7
Ecuador	59	14	7	0.14	46	3.6	0.09	11.0	7.6	3.3	20.1	77	24.5	0.6	0.3		85	76	83	54
El Salvador	46	13	7	0.14	58	0.0	0.02	10.7	6.1	4.1	20.9	76	41.9	2.0	0.2	12.7	81	87	82	
Grenada	25	17	11		3.1		0.12	23.3	0.7	9.0	8.0	72	45.3	0.3	0.1		92	82		41
Guatemala	95	25	12	0.07	26	0.2	0.03	16.5	5.9	1.6	22.9	55	73.8	6.3	1.6		85	78	88	24
Guyana	169	29	19	0.42	79	33.7	0.40	29.2	40.3	5.3	22.3	72	107.8	3.6	0.1	12.2	99	92	98	13
Haiti	480	63	25	0.52	170	1.4	1.04	31.3	9.6	3.0	18.8	49	184.3	23.8	1.4	8.3	51	41	42	
Honduras	65	17	9	0.11	31	0.1	0.03	18.7	2.1	3.9	16.1	65	60.7	3.6	0.5		87	85	87	59
Jamaica	80	14	10	0.58	3.2		0.55	16.9	2.4	4.2	15.1	65	25.4	0.6	0.1	11.0	96	92		9
Mexico	33	14	9		23	0.2	0.03	15.6	5.3	5.0	12.8	76	36.7	1.1	0.4	13.9	82	73	86	95
Nicaragua	98	17	10	0.06	43	5.9	0.09	15.3	4.3	5.1	16.9	73	55.7	2.2	0.3		98	99	98	
Panama	52	15	9		37	0.4	0.07	10.7	2.9	7.8	13.9	79	25.8	1.9	0.1	6.9	88	97	96	73
Paraguay	84	19	11	0.16	46	0.0	0.42	16.0	6.0	7.0	22.0	69	57.5	1.5	0.2	12.8	86	83	89	61
Peru	88	13	6	0.10	119	3.6	0.06	9.7	2.8	6.8	13.6	77	63.9	1.3	0.4	9.6	88	66	80	76
Saint Kitts and Nevis		15	10		1.5					6.3							96	98		
Saint Lucia	117	22	13		3.8		0.22	17.7	7.9	9.6	29.8	68	30.0	0.6	0.1		92	75		46
Saint Vincent and the Grenadines	68	15	9		4.2		0.15	20.7	1.0	7.2	7.4	71	47.6	1.3	0.0		97	99		10
Suriname	120	18	11	0.45	29	1.1	0.07	22.7	25.4	7.4	15.3	71	56.7	2.0	0.3		77	58		38
Trinidad and Tobago	67	18	12	0.07	18		0.19	17.1	8.7	6.5	9.3	74	38.6	0.1	0.1		93	92	93	9
United States of America	19	6	4		3.0		0.01	13.6	16.1	10.0	12.7	84	13.3	0.2	0.5	25.1	94	95	92	39
Uruguay	17	7	4		35		0.15	16.5	21.2	6.9	14.8	80	17.5	0.4	0.5	21.8	94	99	95	38
Venezuela (Bolivarian Republic of)	125	24	15	0.19	45	32.8	0.15	14.8	2.1	3.6	39.0	74	34.6	1.4	0.2		64	13		

[a] Comparable estimates refer to country values of the same reference year, which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Refer to Annex 2 for the full set of SDG 3 indicators. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators. Each indicator is graphed on an individual scale.

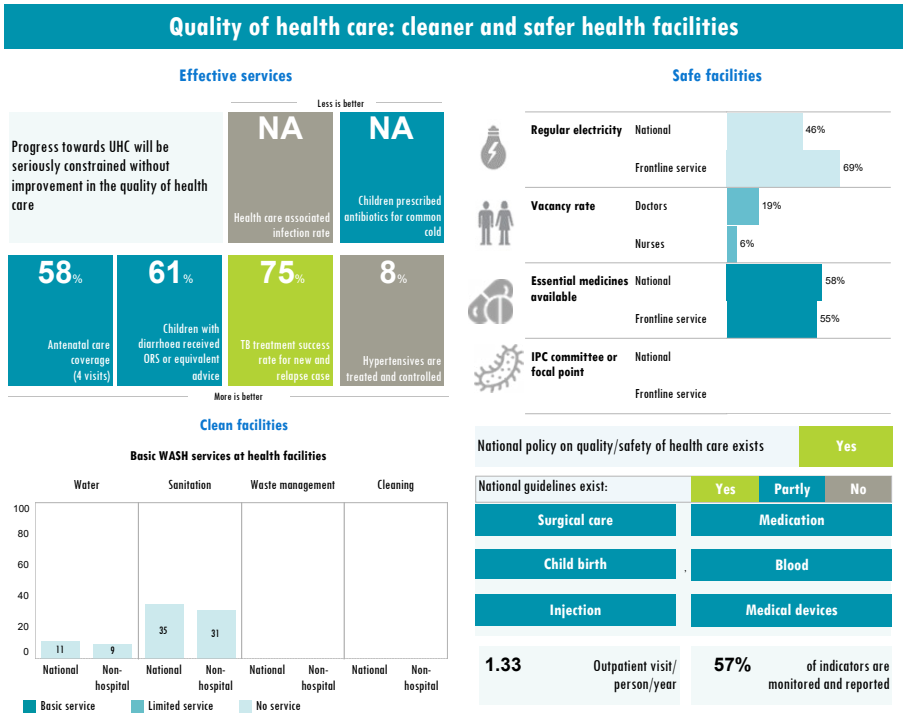
[b] per 100 000 live births
[c] per 1000 live births
[d] per 1000 uninfected population
[e] per 100 000 population
[f] per 1000 population at risk
[g] among children under 5 years (%)
[h] betwe en ages 30-69 (%)
[i] litres of pure alcohol per capita ≥15 years
[j] age-standardized, per 100 00 population
[k] age-standardized, among adults 18+ (%)
[l] among 1-year-olds (%)
[m] by the nationally recommended age (%)
[n] among 15 year-old girls (%)

Maintaining high quality essential health services during the COVID-19 crisis and recovery

The WHO South-East Asia Region is home to 2.02 billion people – more than one quarter of the world's population *(7)* – and is central to global health improvement. With the region prone to natural disasters, disease outbreaks and health risks associated with climate change, a key WHO priority is to strengthen emergency risk management for sustainable development. Committed to building a better, healthier future in the region, WHO is working with the 11 Member States to address persistent and emerging epidemiological and demographic challenges in the wake of the COVID-19 pandemic.

COVID-19 has brought increased focus to the importance of maintaining functioning and quality essential health services during a crisis and recovery. Poor-quality health care remains common, especially in developing countries, and exacts a heavy toll on health and the economy. Progress towards UHC and the health-related SDGs will be seriously constrained without improvement in the quality of health care delivery at all levels. Disadvantaged groups are particularly affected by poor quality of health care. Monitoring service quality is beginning to get more attention. Assessments of quality of care involve many dimensions, all of which suffer from severe data limitations in low- and middle-income countries. A regional fit-for-service dashboard of quality of health care indicators has been developed to address various dimensions of effective services, and cleaner and safer health facilities (Fig. A1.4).

Avoidable maternal, newborn and child mortality and stillbirths are one of many ongoing priorities in the region. Between 2000 and 2017, the region experienced the largest decline in maternal deaths, witnessing a 57.3% reduction in maternal mortality ratio (MMR) compared with a global decline of 38% *(9)*. From 2000 to 2019, stillbirths were reduced by 50% *(10)*, and both under-five mortality and neonatal mortality continued to decline *(11)*. The under-five mortality rate in the region reduced from 36 per 1000 live births in 2018 to 34 in 2019, while neonatal mortality further declined to 20 per 1000 live births. Table A1.1 highlights the progress of all 11 Member States towards achieving targets in reducing maternal, newborn and child mortality and stillbirths.



Note: Data shown in the dashboard are for 2018–2019.

Source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2020 update *(8)*.

Fig. A1.4. Quality of care: Summary of effective services, cleaner and safer health facilities in the South-East Asia region

Table A1.1. Status of maternal, newborn and child mortality and stillbirths in the South-East Asia Region, 2019

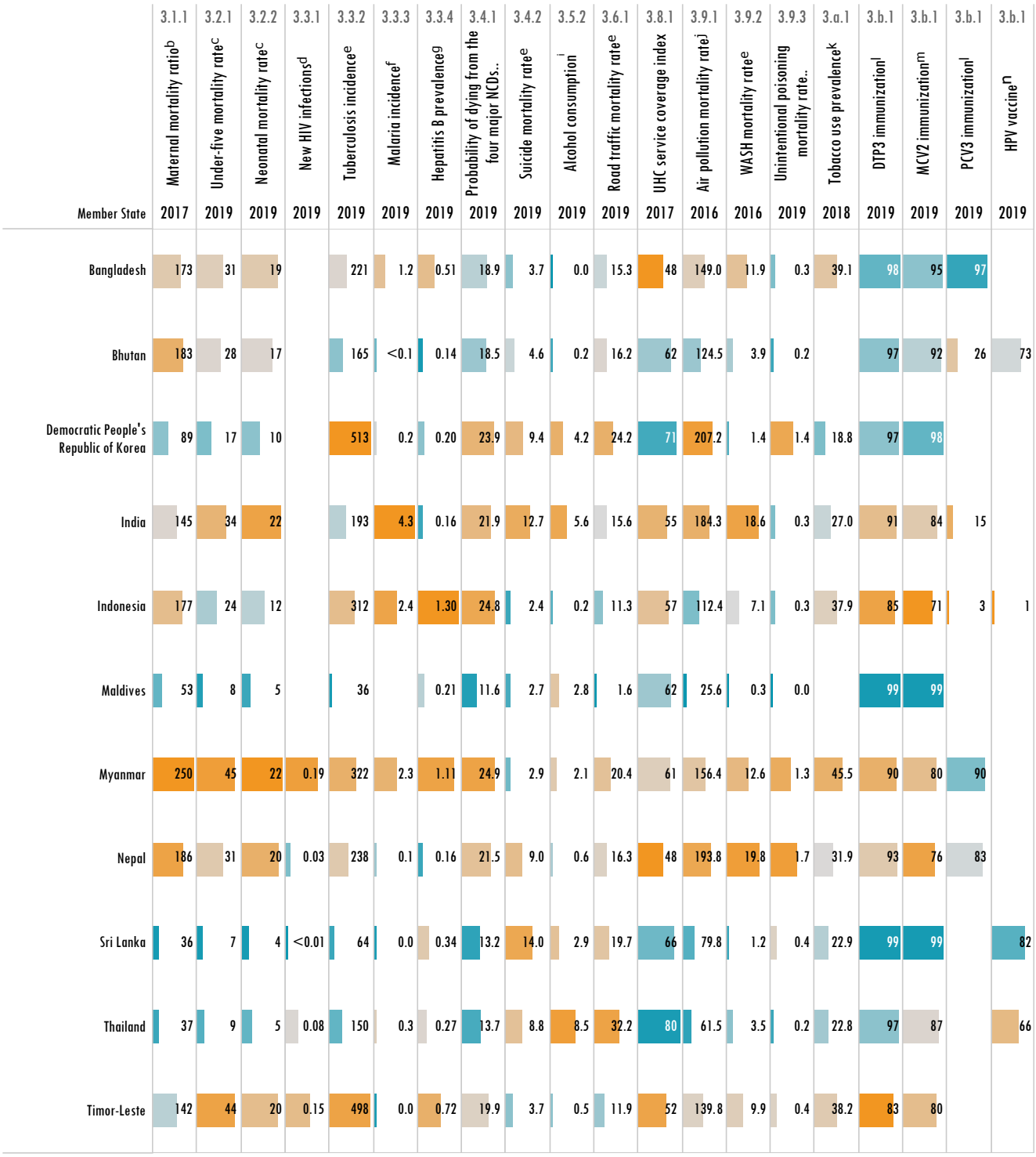
- Achieved the SDG/EPMM/ENAP/Global Strategy Target in 2018
- Expected to achieve the SDG/EPMM/ENAP/Global Strategy Target in 2030
- Need to increase current efforts and attain faster annualized rate of reduction (ARR)

	Maternal mortality ratio* (per 100 000 live births)	Stillbirth rate (deaths per 1000 births)	Neonatal mortality rate (deaths per 1000 live births)	Under-five mortality rate (deaths per 1000 live births)
Bangladesh	173	24	19	31
Bhutan	183	10	17	28
DPR Korea	89	8	10	17
India	145	14	22	34
Indonesia	177	9	12	24
Maldives	53	6	5	8
Myanmar	250	14	22	45
Nepal	186	17	20	31
Sri Lanka	36	6	4	7
Thailand	37	6	5	9
Timor-Leste	142	13	20	44
SEA Region	**152**	**14**	**20**	**32**

* Data are for 2017.

Sources: Maternal mortality report *(9)*; WHO MNCAH data portal *(10)*; Levels and trends in child mortality *(11)*.

Summary of SDG 3 indicators for which country-level values are reported as comparable estimates[a]



Member State	3.1.1 Maternal mortality ratio[b] 2017	3.2.1 Under-five mortality rate[c] 2019	3.2.2 Neonatal mortality rate[c] 2019	3.3.1 New HIV infections[d] 2019	3.3.2 Tuberculosis incidence[e] 2019	3.3.3 Malaria incidence[f] 2019	3.3.4 Hepatitis B prevalence[g] 2019	3.4.1 Probability of dying from the four major NCDs.. 2019	3.4.2 Suicide mortality rate[e] 2019	3.5.2 Alcohol consumption[i] 2019	3.6.1 Road traffic mortality rate[e] 2019	3.8.1 UHC service coverage index 2017	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[e] 2016	3.9.3 Unintentional poisoning mortality rate.. 2019	3.a.1 Tobacco use prevalence[k] 2018	3.b.1 DTP3 immunization[l] 2019	3.b.1 MCV2 immunization[m] 2019	3.b.1 PCV3 immunization[l] 2019	3.b.1 HPV vaccine[n] 2019
Bangladesh	173	31	19		221	1.2	0.51	18.9	3.7	0.0	15.3	48	149.0	11.9	0.3	39.1	98	95	97	
Bhutan	183	28	17		165	<0.1	0.14	18.5	4.6	0.2	16.2	62	124.5	3.9	0.2		97	92	26	73
Democratic People's Republic of Korea	89	17	10		513	0.2	0.20	23.9	9.4	4.2	24.2	71	207.2	1.4	1.4	18.8	97	98		
India	145	34	22		193	4.3	0.16	21.9	12.7	5.6	15.6	55	184.3	18.6	0.3	27.0	91	84	15	
Indonesia	177	24	12		312	2.4	1.30	24.8	2.4	0.2	11.3	57	112.4	7.1	0.3	37.9	85	71	3	1
Maldives	53	8	5		36		0.21	11.6	2.7	2.8	1.6	62	25.6	0.3	0.0		99	99		
Myanmar	250	45	22	0.19	322	2.3	1.11	24.9	2.9	2.1	20.4	61	156.4	12.6	1.3	45.5	90	80	90	
Nepal	186	31	20	0.03	238	0.1	0.16	21.5	9.0	0.6	16.3	48	193.8	19.8	1.7	31.9	93	76	83	
Sri Lanka	36	7	4	<0.01	64	0.0	0.34	13.2	14.0	2.9	19.7	66	79.8	1.2	0.4	22.9	99	99		82
Thailand	37	9	5	0.08	150	0.3	0.27	13.7	8.8	8.5	32.2	80	61.5	3.5	0.2	22.8	97	87		66
Timor-Leste	142	44	20	0.15	498	0.0	0.72	19.9	3.7	0.5	11.9	52	139.8	9.9	0.4	38.2	83	80		

[a] Comparable estimates refer to country values of the same reference year, which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Refer to Annex 2 for the full set of SDG 3 indicators. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators. Each indicator is graphed on an individual scale.

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[k] age-standardized, among adults 18+ (%)
[l] among 1-year-olds (%)
[m] by the nationally recommended age (%)
[n] among 15 year-old girls (%)

How countries are using equity-sensitive data to build back more healthy and equitable societies

Over the past year, the impacts of COVID-19 have set back the mission of levelling up health and closing inequities in health and well-being in countries around the world. The pandemic has disproportionately impacted already vulnerable communities and may have widened pre-existing health and socioeconomic inequities (Fig. A1.5). These include inequities in physical and mental health, and in the essential conditions needed for good health and well-being, such as access to and quality of health care services, income security and social protection, living and neighbourhood conditions, opportunities for social and human capital building, and decent employment and working conditions.

In the WHO European Region, collection of data disaggregated by demographic and socioeconomic status during the pandemic has made it possible to monitor and assess its impacts on inequities. Using a four-step approach, policy-makers can use this data to identify and prioritize policies and investments for recovery that mitigate the most pressing equity gaps, both in health and in the essential conditions needed for good health and well-being. The steps comprise: 1) assessing the pre-COVID trends or baseline status of inequities between socioeconomic groups, using disaggregated indicators of health and the essential conditions for health; 2) identifying pathways of health, social and economic impact from COVID-19 and its containment measures; 3) mapping these impacts to relevant disaggregated indicators to assess changes in inequities over the period of the pandemic; 4) identifying and prioritizing policy actions that reduce the most severe impacts on inequities from the assessment.

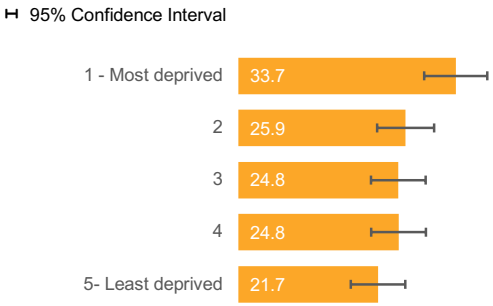
For example, equity-sensitive data from Wales prior to and since the COVID-19 pandemic on income security – one of the essential conditions for health – has allowed monitoring of existing and newly emerging inequities, helping to inform policies aimed at supporting those most negatively impacted. Data disaggregated as part of the Welsh Index of Multiple Deprivation show that 1.6 times more Welsh residents in the most deprived quintile reported a worsening of their financial situation due to the impacts of COVID-19 compared to those in the least deprived quintile (Fig. A1.6) *(12)*. The financial impact of COVID-19 has additionally affected gender and age inequities, since women and young people were more likely to work in a sector that was shut down (18% of women compared to 14% of men, and 27% of young people compared to 12% of the general workforce).

Recognizing that these newly emerging inequities compound baseline inequities that existed prior to COVID-19, the United Kingdom and Welsh Governments have implemented an extensive support framework to address the loss of income to individuals and businesses. This support has protected more than 500 000 jobs in Wales through job retention and self-employed schemes, and over 40 000 businesses in Wales through more than £1.4 billion in loans.

Identifying directly comparable data since the onset of the COVID-19 pandemic can be a challenge in many countries. In the absence of directly comparable data, drawing from different data sources can still provide meaningful comparisons and crucial insights about the impact of COVID-19 and its containment measures on inequities.

Combining the assessments of baseline status with COVID-19 impacts, this strategy provides quantitative evidence supporting the need for both short-term emergency income support as well as longer-term wage and social protection policies to close these inequities, to enable all people in society to meet their basic needs for a healthy life irrespective of demographic or socioeconomic status.

Fig. A1.5. Socioeconomic inequities that contribute to inequities in health and well-being



Source: Placing health equity at the heart of the COVID-19 sustainable response and recovery: Building prosperous lives for all in Wales *(12)*.

Fig. A1.6. Proportion of Welsh residents (18+) reporting being in a worse financial situation as a result of COVID-19 restrictions, by Welsh Index of Multiple Deprivation quintiles, 15 June to 25 July 2020

Summary of SDG 3 indicators for which country-level values are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2017	3.2.1 Under-five mortality rate[c] 2019	3.2.2 Neonatal mortality rate[c] 2019	3.3.1 New HIV infections[d] 2019	3.3.2 Tuberculosis incidence[e] 2019	3.3.4 Hepatitis B prevalence[f] 2019	3.4.1 Probability of dying from the four major NCDs[g] 2019	3.4.2 Suicide mortality rate[e] 2019	3.5.2 Alcohol consumption[h] 2019	3.6.1 Road traffic mortality rate[e] 2019	3.8.1 UHC service coverage index 2017	3.9.1 Air pollution mortality rate[i] 2016	3.9.2 WASH mortality rate[e] 2016	3.9.3 Unintentional poisoning mortality rate[e] 2019	3.a.1 Tobacco use prevalence[j] 2018	3.b.1 DTP3 immunization[k] 2019	3.b.1 MCV2 immunization[l] 2019	3.b.1 PCV3 immunization[k] 2019	3.b.1 HPV vaccine[m] 2019
Albania	15	10	8	0.03	16	0.29	11.4	4.3	6.8	11.7	59	68.0	0.2	0.3	29.2	99	96	96	
Andorra		3	1		7.5				12.3						33.8	99	95	96	64
Armenia	26	12	6	0.05	26	0.06	19.9	3.3	4.7	20.0	69	54.8	0.2	0.7	26.7	92	96	92	7
Austria	5	3	2		6.2	0.16	10.4	14.6	11.9	4.9	79	15.3	0.1	0.2	29.1	85	84		
Azerbaijan	26	20	11	0.06	60	0.06	27.2	4.1	1.0	6.7	65	63.9	1.1	0.9	19.6	94	97	95	
Belarus	2	3	1	0.20	29	0.29	23.8	21.2	11.0	7.6	76	60.7	0.1	3.3	26.6	98	98		
Belgium	5	3	2		8.9	0.09	10.6	18.3	10.8	5.8	84	15.7	0.3	0.4	25.0	98	85	94	67
Bosnia and Herzegovina	10	6	4		27	0.63	18.7	10.9	7.8	13.5	61	79.8	0.1	0.4	38.3	73	76		
Bulgaria	10	7	3	0.04	21	0.09	24.2	9.7	12.5	9.2	66	61.8	0.1	0.5	38.9	92	87	88	4
Croatia	8	5	3	0.02	8.0	0.12	16.1	16.4	8.7	7.9	71	35.5	0.1	0.4	36.6	94	95		
Cyprus	6	2	1		5.3	0.34	8.2	3.6	10.8	5.8	78	20.1	0.3	0.3	36.7	96	88	81	64
Czechia	3	3	2		4.9	0.13	14.3	12.2	14.3	5.9	76	29.6	0.2	0.4	31.5	97	84		
Denmark	4	4	3		5.0	0.68	10.8	10.7	10.1	3.7	81	13.2	0.3	0.1	18.6	97	90	97	62
Estonia	9	2	1		13	0.29	14.9	14.9	10.8	4.5	75	25.0	<0.1	0.6	30.5	91	90		45
Finland	3	2	1		4.7	0.81	9.6	15.3	10.7	3.9	78	7.2	<0.1	0.4	19.7	91	93	89	60
France	8	4	3		8.7	0.15	10.6	13.8	12.2	5.1	78	9.7	0.3	0.3	34.6	96	83	92	24
Georgia	25	10	5		74	0.06	24.9	9.2	9.5	12.4	66	101.8	0.2	0.6	29.7	94	97	84	11
Germany	7	4	2		5.8	0.21	12.1	12.3	12.8	3.8	83	16.0	0.6	0.3	28.0	93	93	84	43
Greece	3	4	2		4.3	0.14	12.5	5.1	10.5	8.3	75	27.6	<0.1	0.2	39.1	99	83	96	
Hungary	12	4	2		6.3	0.90	22.1	16.6	11.1	7.7	74	38.8	0.2	0.5	30.6	99	99	99	78
Iceland	4	2	1		4.4	0.15	8.7	11.9	9.2	2.0	84	8.7	0.1	1.0	13.8	91	95	90	93
Ireland	5	3	2		5.8	0.04	9.7	9.6	12.7	3.1	76	11.9	0.1	0.3	23.6	94		86	69
Israel	3	4	2		2.9	0.05	8.8	5.3	4.4	3.9	82	15.4	0.2	0.0	25.5	98	96	95	52
Italy	2	3	2	0.04	7.1	0.33	9.0	6.7	8.0	5.3	82	15.0	0.1	0.3	23.4	95	88	92	40
Kazakhstan	10	10	5	0.20	68	0.15	22.4	17.6	5.0	12.7	76	62.7	0.4	1.9	24.4	97	98	89	
Kyrgyzstan	60	18	12	0.14	110	0.15	20.3	7.4	4.9	12.7	70	110.7	0.8	0.9	27.9	95	98	96	
Latvia	19	4	2	0.19	26	0.27	21.6	20.1	13.2	8.1	71	41.3	<0.1	1.2	36.7	99	96	84	54
Lithuania	8	4	2	0.09	42	0.05	19.3	26.1	12.8	8.1	73	34.0	0.1	1.7	27.1	92	93	79	66
Luxembourg	5	3	1		9.0	0.06	9.7	11.3	12.4	4.1	83	11.6	<0.1	0.2	21.7	99	90	96	14
Malta	6	7	5		14	0.20	10.5	6.1	8.3	4.1	82	20.2	<0.1	0.1	25.1	98	95		81
Monaco		3	2		0.0											99	79		
Montenegro	6	2	1	0.05	15	0.67	22.3	21.0	12.2	7.6	68	78.6	<0.1	0.6		86	86		
Netherlands	5	4	3	0.02	5.0	0.08	10.3	11.8	9.7	4.0	86	13.7	0.2	0.1	23.4	94	90	93	53
North Macedonia	7	6	4		12		22.7	9.4	6.4	5.1	72	82.2	0.1	0.5		92	94		40
Norway	2	2	1		3.3	0.02	8.7	11.8	7.1	2.1	87	8.6	0.2	0.3	18.4	97	95	95	91
Poland	2	4	3		15	0.01	17.0	11.3	11.9	9.4	75	37.9	0.1	0.5	26.0	95	92	60	
Portugal	8	4	2		19	0.02	11.0	11.5	12.1	8.2	82	9.8	0.2	0.3	27.9	99	96	98	81
Republic of Moldova	19	14	11	0.23	80	0.20	24.1	14.7	12.9	7.3	69	78.3	0.1	5.5	25.3	91	95	80	31
Romania	19	7	3	0.04	66	0.29	21.0	9.7	12.3	10.3	74	59.3	0.4	1.9	25.5	88	76	88	
Russian Federation	17	6	3		50	0.55	24.2	25.1	10.5	12.0	75	49.4	0.1	3.8	28.3	97	97	85	
San Marino		2	1		0.0											88	79	76	50
Serbia	12	5	3	0.02	14	0.04	22.0	11.4	8.9	7.5	65	62.5	0.7	0.3	40.6	97	91	93	
Slovakia	5	6	3		4.5	0.31	15.5	12.1	11.1	6.1	77	33.5	<0.1	0.5	32.3	97	98	96	
Slovenia	7	2	1		5.4	1.12	11.4	19.8	12.1	5.1	79	22.6	<0.1	0.2	22.7	95	94	65	59
Spain	4	3	2	0.06	9.3	0.13	9.6	7.7	12.7	3.9	83	9.9	0.2	0.4	27.9	96	94	95	79
Sweden	4	3	1		5.5	0.13	8.4	14.7	9.0	3.1	86	7.2	0.2	0.2	28.8	98	95	97	80
Switzerland	5	4	3	0.03	5.4	0.16	7.9	14.5	11.2	2.2	83	10.1	0.1	0.2	25.1	96	90	84	59
Tajikistan	17	34	15	0.17	83	0.18	28.3	4.3	0.9	15.7	68	129.3	2.7	0.4		97	97		
Turkey	17	10	5		16	0.11	15.6	2.4	1.8	6.7	74	46.6	0.3	0.4	29.3	99	88	97	
Turkmenistan	7	42	24		45	0.07	27.7	5.7	3.1	13.5	70	79.3	4.0	0.6		99	99		99
Ukraine	19	8	5	0.28	77	0.25	25.5	21.6	8.3	10.2	68	70.7	0.3	2.5	25.5	80	92		
United Kingdom	7	4	3		8.0	0.41	10.3	7.9	11.4	3.2	87	13.8	0.2	0.3	19.2	93	87	91	82
Uzbekistan	29	17	10	0.13	67	0.16	25.3	8.0	2.6	11.7	73	81.1	0.4	0.8	12.3	96	99	99	

[a] Comparable estimates refer to country values of the same reference year, which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Malaria incidence is not included in the this graph because all countries in this region are certified malaria free, or considered to have eliminated malaria. Refer to Annex 2 for the full set of SDG 3 indicators. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators. Each indicator is graphed on an individual scale.

[b] per 100 000 live births
[c] per 1000 live births
[d] per 1000 uninfected population
[e] per 100 000 population
[f] among children under 5 years (%)
[g] between ages 30-69 (%)
[h] litres of pure alcohol per capita ≥15 years
[i] age-standardized, per 100 000 population
[j] age-standardized, among adults 18+ (%)
[k] among 1-year-olds (%)
[l] by the nationally recommended age (%)
[m] among 15 year-old girls (%)

Monitoring mortality and cause of death in Lebanon

The Lebanese Republic began interventions to improve civil registration and vital statistics (CRVS) systems in the 1990s, with several initiatives involving the Ministry of Interior and Municipalities (the authority mandated by law to issue death certificates) and the Ministry of Public Health (MoPH). WHO has been supporting the MoPH to enhance its CRVS system to generate timely and reliable data on birth and deaths, including causes of death. This is important because 15 out of 17 SDG targets require vital registration data for measurement of indicators. Current efforts are also focusing on supporting statistical capacity-building in line with the WHO Thirteenth General Programme of Work (GPW 13) goal of better supporting countries to strengthen information systems for health at all levels and the use of data for evidence-based decision-making.

A first review of death certificates took place in 1999 as part of the Burden of disease study and preparatory work for health sector reforms. The review showed: most death certificates were incomplete in some way (e.g. address, year of birth and/or underlying cause of death); cardiac arrest was the immediate cause of death in the majority of cases; and reporting forms were not unified. Lebanon conducted a CRVS assessment in 2013, and its recommendations led to implementation of activities aimed at building national capacities in adaptation and use of global standardized death certificate, training of physicians and medical staff in identifying and reporting cause of death, as well as using electronic approaches to automating death registration, selecting the underlying cause of death and improving data quality.

Building on those previous efforts, recent initiatives included development of a national hospital mortality system (HMS) in 2016 covering 150 hospitals (more than 90% of functioning hospitals). This consists of death notification and registration of basic demographic information for deaths that occur among nationals and non-nationals in hospital settings. Such reports are submitted, compiled, cleaned and utilized at the central MoPH level.

After almost 17 years of incomplete reporting of cause of death data – with the last report published in 2000 without reliable medically certified causes of death – Lebanon produced cause of death data from 2017–2019, disaggregated by age and sex. One of the major related achievements was the development of an electronic death registration system through a collaboration between the MoPH and hospitals. The comprehensive and decentralized system allows coding of all causes of death to be done in individual hospitals in addition to using the Analysing mortality levels and causes-of-death (ANACoD) tool for assessment of data quality and automatic coding and IRIS to facilitate accurate selection of underlying cause of death.

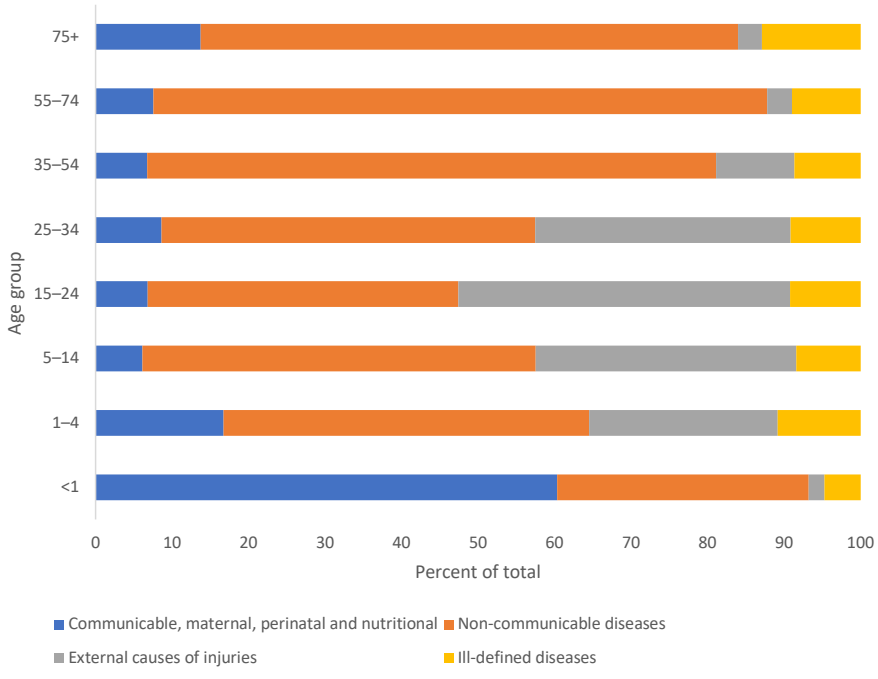
In 2019, the number of recorded deaths was 18 544, of which 70% were due to noncommunicable diseases, 14% to communicable, maternal, perinatal and nutritional conditions, 6% to external causes of injury and 10% to ill-defined conditions (Fig A1.7) *(13)*.

The death registration system that the MoPH is implementing covers more than 80% of registered deaths according to national sources *(13)*. Efforts are being made to address the remaining gaps and increase reporting to include the remaining 20%, believed to have occurred outside health facilities. In collaboration with the Order of Physicians, a doctor in each district will be contracted to notify the underlying cause of death on all deaths occurring outside health facilities.

To improve quality of cause of death data, ongoing training workshops have also been conducted for doctors from all hospitals in collaboration with WHO and the Order of Physicians.

During the COVID-19 pandemic, investments in the cause of death registration system were highly effective and timely in facilitating and supporting the surveillance system for COVID-19-related deaths. The system contributes to better understanding and monitoring of the pandemic situation in Lebanon.

Collaborative initiatives between MoPH and WHO for system improvement are aimed at scaling up system coverage, reporting of non-national mortality rates by age and cause of death, responding to data needs for monitoring of epidemic diseases through integration with surveillance systems and regular data updates, in addition to data quality improvement and feedback at the national, regional and global levels. The country is planning a phased implementation of the International classification of diseases (ICD-11) as part of a broad agenda to enhance the functionality of the national health information system in line with latest standards and guidelines.



Source: Based on data reported by the Ministry of Public Health Lebanon to the WHO mortality database *(13)*.

Fig. A1.7. Major causes of death in Lebanon, 2019

Summary of SDG 3 indicators for which country-level values are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2017	3.2.1 Under-five mortality rate[c] 2019	3.2.2 Neonatal mortality rate[c] 2019	3.3.1 New HIV infections[d] 2019	3.3.2 Tuberculosis incidence[e] 2019	3.3.3 Malaria incidence[f] 2019	3.3.4 Hepatitis B prevalence[g] 2019	3.4.1 Probability of dying from the four major NCDs.. 2019	3.4.2 Suicide mortality rate[e] 2019	3.5.2 Alcohol consumption[i] 2019	3.6.1 Road traffic mortality rate[e] 2019	3.8.1 UHC service coverage index 2017	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[e] 2016	3.9.3 Unintentional poisoning mortality rate.. 2019	3.a.1 Tobacco use prevalence[k] 2018	3.b.1 DTP3 immunization[l] 2019	3.b.1 MCV2 immunization[m] 2019	3.b.1 PCV3 immunization[l] 2019	3.b.1 HPV vaccine[n] 2019
Afghanistan	638	60	36	0.04	189	14.5	0.39	35.3	4.1	<0.1	15.9	37	211.1	13.9	1.0		66	39	65	
Bahrain	14	7	3		12		0.03	16.1	8.9	1.1	5.2	77	40.1	<0.1	0.3	25.1	99	99	97	
Djibouti	248	57	31	0.14	234	67.7	0.26	22.0	9.6	0.4	23.5	47	159.0	31.3	2.5		85	81	85	
Egypt	37	20	11	0.05	12	0.0	0.20	28.0	3.0	0.1	10.1	68	108.9	2.0	0.2	21.4	95	94		
Iran (Islamic Republic of)	16	14	9	0.05	13	0.0	0.05	14.8	5.2	1.0	21.5	72	50.9	1.0	1.0	14.0	99	98		
Iraq	79	26	15		41	0.0	0.29	23.5	3.6	0.4	27.3	61	75.1	3.0	0.2	22.2	84	86	37	
Jordan	46	16	9		5.5		0.56	15.3	1.6	0.5	17.0	76	51.2	0.6	0.5		89	96		
Kuwait	12	8	5		22		0.03	11.9	2.9	0.0	15.4	76	103.8	<0.1	0.4	22.1	91	94	91	
Lebanon	29	7	4	0.03	13		0.07	19.9	2.8	1.5	16.4	73	51.4	0.8	0.6	42.6	83	63	82	
Libya	72	12	6	0.07	59		0.43	18.6	4.5	<0.1	21.3	64	71.9	0.6	0.8		73	72	73	
Morocco	70	21	14	0.02	97	0.0	0.16	24.1	7.2	0.5	17.0	70	49.1	1.9	0.7	14.7	99	99	98	
Oman	19	11	5	0.04	8.5	0.0	0.13	21.5	4.9	0.9	10.6	69	53.9	<0.1	0.9	9.6	99	99	99	
Pakistan	140	67	41	0.12	263	3.3	0.91	29.4	8.9	0.3	13.0	45	173.6	19.6	1.6	20.0	75	71	75	
Qatar	9	7	3		35		0.05	10.7	5.8	1.5	7.3	68	47.4	<0.1	0.3	14.0	98	95	98	
Saudi Arabia	17	7	4		9.9	<0.1	0.00	20.9	6.0	0.0	35.9	74	83.7	0.1	0.8	16.6	96	96	96	
Somalia	829	117	37	0.03	258	49.1	6.32	30.4	7.9	0.0	27.4	25	212.8	86.6	4.9		42			
Sudan	295	58	27	0.08	67	55.4	1.66	22.8	3.8		26.8	44	184.9	17.3	1.7		93	74	93	
Syrian Arab Republic	31	22	11	<0.01	19	0.0	0.69	22.1	1.9	0.2	14.9	60	75.2	3.7	0.6		54	54		
Tunisia	43	17	12	0.05	35		0.12	15.7	3.3	2.0	16.5	70	56.1	1.0	0.7	26.0	92	93		
United Arab Emirates	3	7	4		1.0	0.0	0.02	18.5	6.4	3.8	8.9	76	54.7	<0.1	0.4	18.2	99	99	99	27
Yemen	164	58	27	0.04	48	46.4	1.76	27.6	5.8	<0.1	29.4	42	194.2	10.2	1.8	20.9	73	46	72	

[a] Comparable estimates refer to country values of the same reference year, which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Refer to Annex 2 for the full set of SDG 3 indicators. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators. Each indicator is graphed on an individual scale.

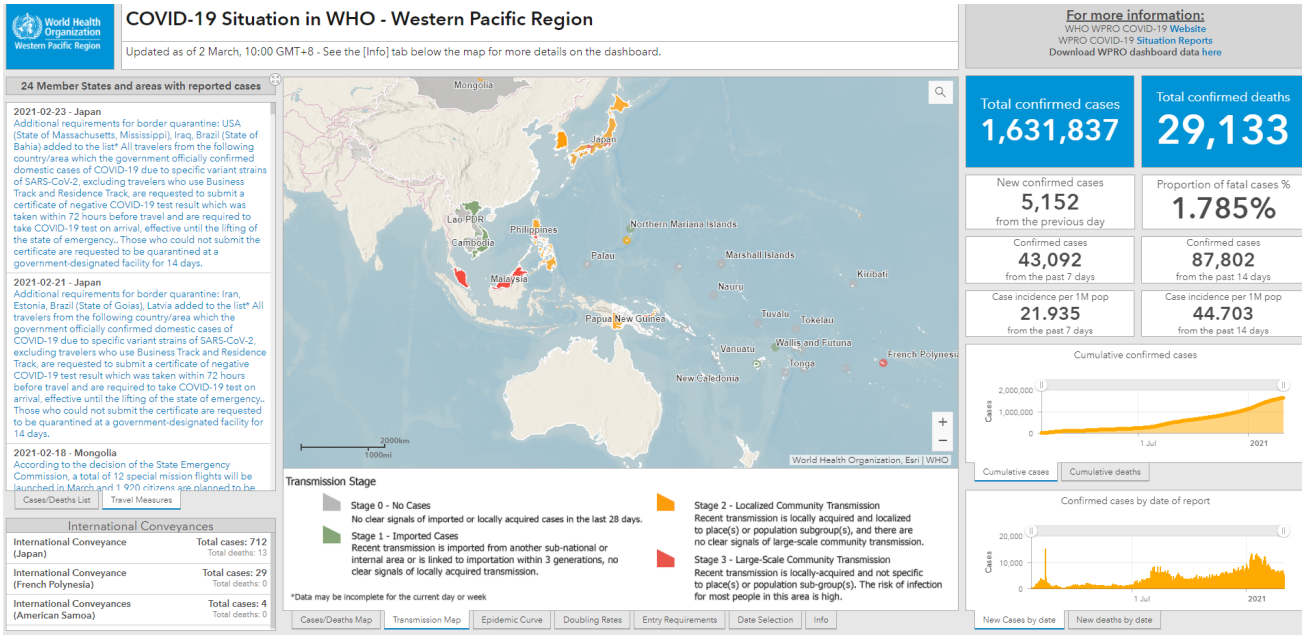
[b] per 100 000 live births
[c] per 1000 live births
[d] per 1000 uninfected population
[e] per 100 000 population
[f] per 1000 population at risk
[g] among children under 5 years (%)
[h] betwe en ages 30-69 (%)
[i] litres of pure alcohol per capita ≥15 years
[j] age-standardized, per 100 00 population
[k] age-standardized, among adults 18+ (%)
[l] among 1-year-olds (%)
[m] by the nationally recommended age (%)
[n] among 15 year-old girls (%)

Impact measurement using systematic surveillance combining data from multiple sources

The Western Pacific Region vision for managing future health challenges is laid out in *For the Future: towards the healthiest and safest region*. Grounded in an operational shift towards driving and measuring country impact, the vision contextualizes the SDGs and GPW 13 to the Western Pacific Region. Over the past few decades, Member States have made significant investments in improving their strategic health information systems, reorienting them progressively from simply measuring inputs and processes to documenting results. The ongoing challenge remains that systems lack cohesive measurement frameworks and struggle with maximizing data use for strategic dialogue and decision-making.

The complexities of the COVID-19 pandemic have highlighted the pre-existing demands for new data analytic approaches. Flexible measurement frameworks that can efficiently generate and integrate data across sources and sectors are needed to accurately measure population impact and to inform the pursuit of national goals. The Universal Health Coverage Technical Advisory Group, during its fourth meeting in August 2020, recommended that WHO should accelerate its support to countries on data collection, reporting and analysis. This should also include equity-focused analysis of disaggregated data to support monitoring and policy decision-making on regional UHC enhancements for reaching the unreached.

Currently, WPRO has combined data from multiple COVID-19 surveillance sources for rapid and concrete COVID-19 responses. A multi-source COVID-19 dashboard has been developed for a broader set of users for aiding COVID-19 responses in countries (Fig. A1.8). Meanwhile, a comprehensive data analysis approach has also been adopted in health-related SDG monitoring in the region. The ongoing regional country-focused SDG analysis is integrating health information from multiple sources with estimates generated within countries, as well as at the global or regional levels, to strategically link different health areas and programmes in a cohesive measurement framework and to draw a systematic picture of country progress for policy decision-making.



Source: COVID-19 Situation in WHO – Western Pacific Region *(14)*.

Fig. A1.8. Multi-source COVID-19 surveillance dashboard for Western Pacific Region

Summary of SDG 3 indicators for which country-level values are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2017	3.2.1 Under-five mortality rate[c] 2019	3.2.2 Neonatal mortality rate[c] 2019	3.3.1 New HIV infections[d] 2019	3.3.2 Tuberculosis incidence[e] 2019	3.3.3 Malaria incidence[f] 2019	3.3.4 Hepatitis B prevalence[g] 2019	3.4.1 Probability of dying from the four major NCDs.. 2019	3.4.2 Suicide mortality rate[e] 2019	3.5.2 Alcohol consumption[i] 2019	3.6.1 Road traffic mortality rate[e] 2019	3.8.1 UHC service coverage index 2017	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[e] 2016	3.9.3 Unintentional poisoning mortality rate.. 2019	3.a.1 Tobacco use prevalence[k] 2018	3.b.1 DTP3 immunization[l] 2019	3.b.1 MCV2 immunization[m] 2019	3.b.1 PCV3 immunization[l] 2019	3.b.1 HPV vaccine[n] 2019
Australia	6	4	2	0.03	6.9		0.13	8.6	12.5	10.4	4.9	87	8.4	0.1	0.1	16.2	95	94	96	79
Brunei Darussalam	31	11	6		64		0.10	18.5	2.7	0.5	7.5	81	13.3	<0.1	0.0	15.5	99	98		90
Cambodia	160	27	14	0.05	287	12.0	0.19	22.5	4.9	7.8	19.6	60	149.8	6.5	0.5	21.8	92	82	89	
China	29	8	4		58	0.0	0.22	15.9	8.1	6.0	17.4	79	112.7	0.6	1.8	24.7	99	98		
Cook Islands		8	4		13					10.9						26.6	98	98		73
Fiji	34	26	11	0.14	66		0.13	37.7	9.0	3.7	13.5	64	99.0	2.9	0.3	26.7	99	94	99	56
Japan	5	2	1		13		0.96	8.3	15.3	10.1	3.6	83	11.9	0.2	0.2	21.9	98	93	97	0
Kiribati	92	51	22		436		1.57	50.8	28.3	2.3	1.9	41	140.2	16.7	2.6	52.0	97	91	97	
Lao People's Democratic Republic	185	46	22	0.11	155	2.8	0.68	26.8	5.4	12.1	17.9	51	188.5	11.3	0.6	37.8	68	57	56	
Malaysia	29	9	5	0.20	92	0.0	0.06	18.4	5.7	0.9	22.5	73	47.4	0.4	0.7	21.8	98	87		85
Marshall Islands		32	15		483												79	64	63	24
Micronesia (Federated States of)	88	29	16		100		0.40	46.3	28.2	2.5	0.2	47	151.8	3.6	0.9		78	52	73	57
Mongolia	45	16	8	0.01	428		0.47	35.0	17.9	5.9	21.0	62	155.9	1.3	2.8	27.6	98	98	49	
Nauru		31	20		182					4.2						52.1	96	95		
New Zealand	9	5	3	0.03	7.5		0.77	10.3	11.0	10.7	9.6	87	7.2	0.1	0.2	14.8	92	90	91	67
Niue		23	13		0.0					9.9							99	99	99	
Palau		17	9		38											23.7	97	88	74	67
Papua New Guinea	145	45	22	0.38	432	156.4	1.36	36.0	2.9	2.1	12.6	40	152.0	16.3	1.4		35	20	35	
Philippines	121	27	13	0.14	554	0.7	0.38	24.5	2.2	7.0	12.0	61	185.2	4.2	0.2	24.3	65	40	43	0
Republic of Korea	11	3	2		59	0.1	0.09	7.3	28.6	8.5	8.6	86	20.5	1.8	0.2	22.0	98	96	98	52
Samoa	43	15	8		11		0.34	31.2	12.6	2.8	13.0	58	85.0	1.5	0.4	28.9	58	44		
Singapore	8	3	1	0.03	41		0.13	9.5	11.2	2.0	2.1	86	25.9	0.1	0.0	16.5	96	84	82	0
Solomon Islands	104	20	8		66	247.9	0.87	39.2	14.7	1.7	16.5	47	137.0	6.2	2.3	37.9	94	54	94	
Tonga	52	17	7		11		0.89	24.8	3.8	0.4	33.0	58	73.3	1.4	1.1	30.2	99	99		
Tuvalu		24	16		296					1.3						48.7	92	92		
Vanuatu	72	26	11		41	3.5	2.25	39.7	18.0	2.1	14.9	48	135.6	10.4	0.7	24.1	90			
Viet Nam	43	20	10	0.05	176	0.1	0.64	21.2	7.5	7.9	30.6	75	64.5	1.6	0.9		89	92		

[a] Comparable estimates refer to country values of the same reference year, which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Refer to Annex 2 for the full set of SDG 3 indicators. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators. Each indicator is graphed on an individual scale.

[b] per 100 000 live births
[c] per 1000 live births
[d] per 1000 uninfected population
[e] per 100 000 population
[f] per 1000 population at risk
[g] among children under 5 years (%)
[h] betwe en ages 30-69 (%)
[i] litres of pure alcohol per capita ≥15 years
[j] age-standardized, per 100 00 population
[k] age-standardized, among adults 18+ (%)
[l] among 1-year-olds (%) ..
[n] among 15 year-old girls (%)

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ANNEX 2

Tables of health statistics by country, WHO region and globally

Explanatory notes

The statistics shown below represent official (WHO) statistics for selected health-related Sustainable Development Goal (SDG) indicators and selected Thirteenth General Programme of Work (GPW 13) indicators, based on evidence available in early 2021. In addition, summary measures of health, such as (healthy) life expectancy and total population, are included to provide a general indication of the current situation.

These statistics have been compiled primarily from publications and databases produced and maintained by WHO, or United Nations (UN) groups of which WHO is a member. Some statistics have been derived from data produced and maintained by other international organizations and in each instance the source of the data series is provided.

The type of data used for each data series (comparable estimate or primary data) is also provided *(1)*. Comparable estimates are subject to considerable uncertainty, especially for countries where the availability and quality of the underlying primary data are limited. Uncertainty intervals and other details on the indicators and statistics presented here can be found at the WHO Global Health Observatory.[1]

Although every effort has been made to maximize the comparability of statistics across countries and over time, data series based on primary data may differ in terms of the definitions, data collection methods, population coverage and estimation methods used. For indicators with a reference period expressed as a range, country values refer to the latest available year in the range unless otherwise noted; the accompanying footnotes provide more details. In some cases, as SDG indicator definitions are being refined and baseline data are being collected, proxy indicators have been presented in this annex; where this is the case, proxy indicators have been clearly indicated as such through accompanying footnotes.

Unless otherwise stated, the WHO regional and global aggregates for rates and ratios are presented as weighted averages when relevant, whereas for absolute numbers they are the sums. Aggregates are shown only if data are available for at least 50% of the population (or other denominator) within an indicated group. For indicators with a reference period expressed as a range, aggregates are for the reference period shown in the corresponding table column heading above the WHO regional values. Some WHO regional and global aggregates may include country estimates that are not individually reported.

Changes in the values shown for indicators reported in previous editions of the *World Health Statistics* Series should not be assumed to accurately reflect underlying trends. This applies to all data types (comparable estimates and primary data) and all reporting levels (country, regional and global). The data presented here may also differ from, and should not be regarded as, the official national statistics of individual WHO Member States.

Note: – indicates that data is not applicable or not available.

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[1] The Global Health Observatory (GHO) is a WHO online portal that provides access to data and analyses for monitoring the global health situation (available at https://www.who.int/gho/en/).

ANNEX 2
Part 1

										3.1
	Total population[a] (000s)			Life expectancy at birth[b,c] (years)			Healthy life expectancy at birth[b,c] (years)			Maternal mortality ratio[d] (per 100 000 live births)
Data type	Comparable estimates			Comparable estimates			Comparable estimates			Comparable estimates
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
Member State	2019			2019			2019			2017
Afghanistan	19 530	18 512	38 042	63.3	63.2	63.2	54.7	53.2	53.9	638
Albania	1 467	1 414	2 881	76.3	79.9	78.0	68.0	70.3	69.1	15
Algeria	21 750	21 303	43 053	76.2	78.1	77.1	66.7	66.1	66.4	112
Andorra	–	–	77	–	–	–	–	–	–	–
Angola	15 745	16 081	31 825	60.7	65.5	63.1	53.6	56.2	54.8	241
Antigua and Barbuda	47	50	97	74.9	78.0	76.5	66.2	67.7	67.0	42
Argentina	21 841	22 939	44 781	73.5	79.5	76.6	65.4	68.8	67.1	39
Armenia	1 391	1 566	2 958	72.5	79.2	76.0	64.9	69.1	67.1	26
Australia	12 551	12 652	25 203	81.3	84.8	83.0	70.2	71.7	70.9	6
Austria	4 409	4 546	8 955	79.4	83.8	81.6	69.9	71.9	70.9	5
Azerbaijan	5 016	5 032	10 048	68.8	74.1	71.4	62.1	65.2	63.6	26
Bahamas	189	200	389	69.9	76.6	73.2	62.3	66.5	64.4	70
Bahrain	1 055	586	1 641	75.0	77.0	75.8	66.0	65.5	65.9	14
Bangladesh	82 474	80 572	163 046	73.0	75.6	74.3	64.2	64.4	64.3	173
Barbados	139	148	287	74.3	77.7	76.0	66.2	67.7	67.0	27
Belarus	4 400	5 052	9 452	69.7	79.6	74.8	62.3	69.4	66.0	2
Belgium	5 711	5 828	11 539	79.3	83.5	81.4	69.8	71.3	70.6	5
Belize	194	196	390	71.4	77.8	74.4	63.5	67.3	65.3	36
Benin	5 891	5 910	11 801	61.2	65.7	63.4	54.5	56.6	55.5	397
Bhutan	405	358	763	72.0	74.4	73.1	63.2	63.5	63.4	183
Bolivia (Plurinational State of)	5 780	5 733	11 513	71.1	73.1	72.1	63.2	63.3	63.3	155
Bosnia and Herzegovina	1 617	1 684	3 301	74.4	79.1	76.8	65.7	68.7	67.2	10
Botswana	1 114	1 190	2 304	58.9	65.5	62.2	51.9	55.8	53.9	144
Brazil	103 733	107 316	211 050	72.4	79.4	75.9	63.4	67.4	65.4	60
Brunei Darussalam	225	208	433	73.4	75.4	74.3	65.2	66.1	65.6	31
Bulgaria	3 400	3 600	7 000	71.6	78.6	75.1	63.9	68.7	66.3	10
Burkina Faso	10 148	10 174	20 321	60.1	65.2	62.7	53.4	56.3	54.9	320
Burundi	5 719	5 812	11 531	61.5	66.1	63.8	54.0	57.2	55.6	548
Cabo Verde	276	274	550	69.9	77.9	74.0	62.2	67.2	64.8	58
Cambodia	8 047	8 439	16 487	67.2	72.7	70.1	59.8	63.0	61.5	160
Cameroon	12 940	12 936	25 876	60.3	64.5	62.4	53.5	55.6	54.5	529
Canada	18 564	18 848	37 411	80.4	84.1	82.2	70.5	72.0	71.3	10
Central African Republic	2 352	2 393	4 745	50.2	56.3	53.1	44.5	48.4	46.4	829
Chad	7 961	7 986	15 947	58.0	61.3	59.6	51.3	52.8	52.0	1140
Chile	9 342	9 610	18 952	78.1	83.2	80.7	69.0	71.1	70.0	13
China	739 350	702 510	1 441 860	74.7	80.5	77.4	67.2	70.0	68.5	29
Colombia	24 713	25 626	50 339	76.7	81.9	79.3	67.4	70.5	69.0	83
Comoros	429	422	851	65.9	68.9	67.4	58.3	59.6	58.9	273
Congo	2 687	2 693	5 381	63.8	65.6	64.7	56.4	56.1	56.2	378
Cook Islands	–	–	18	–	–	–	–	–	–	–
Costa Rica	2 523	2 525	5 048	78.3	83.4	80.8	68.6	71.3	70.0	27
Côte d'Ivoire	12 974	12 742	25 717	60.5	65.8	62.9	53.4	56.5	54.8	617
Croatia	1 990	2 140	4 130	75.5	81.6	78.6	66.7	70.5	68.6	8
Cuba	5 628	5 706	11 333	75.4	80.3	77.8	66.6	69.2	67.8	36
Cyprus	599	599	1 199	81.1	85.1	83.1	71.8	73.0	72.4	6
Czechia	5 261	5 429	10 689	76.3	81.9	79.1	67.0	70.6	68.8	3
Democratic People's Republic of Korea	12 553	13 113	25 666	69.3	75.7	72.6	63.3	66.6	65.0	89
Democratic Republic of the Congo	43 319	43 471	86 791	60.0	64.8	62.4	52.8	55.4	54.1	473
Denmark	2 870	2 902	5 772	79.6	83.0	81.3	70.7	71.4	71.0	4
Djibouti	512	462	974	64.1	67.8	65.8	57.2	58.9	58.0	248
Dominica	–	–	72	–	–	–	–	–	–	–
Dominican Republic	5 366	5 373	10 739	69.8	76.2	72.8	62.1	66.1	64.0	95
Ecuador	8 690	8 683	17 374	76.4	80.5	78.4	67.7	69.3	68.5	59
Egypt	50 723	49 665	100 388	69.6	74.1	71.8	62.3	63.7	63.0	37
El Salvador	3 023	3 430	6 454	70.6	79.1	75.0	61.6	67.8	64.9	46

3.1	3.2		3.3					
Proportion of births attended by skilled health personnel[e] (%)	Under-five mortality rate[f] (per 1000 live births)	Neonatal mortality rate[f] (per 1000 live births)	New HIV infections[g] (per 1000 uninfected population)	Tuberculosis incidence[h] (per 100 000 population)	Malaria incidence[i] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years[j] (%)	Reported number of people requiring interventions against NTDs[k]	
Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
2011–2020	2019	2019	2019	2019	2018	2019	2019	**Member State**
59	60	36	0.04	189	14.5	0.39	16 222 053	Afghanistan
100	10	8	0.03	16	–	0.29	0	Albania
99	23	16	0.05	61	0.0	0.08	10 339	Algeria
100 [ai]	3	1	–	7.5	–	–	0	Andorra
50	75	28	0.84	351	235.2	4.57	15 362 008	Angola
100 [ai]	7	4	–	0.0	–	0.19	1 223	Antigua and Barbuda
100	9	6	0.13	29	0.0	0.01	160 777	Argentina
100 [ai]	12	6	0.05	26	0.0	0.06	17	Armenia
97 [aj]	4	2	0.03	6.9	–	0.13	13 700	Australia
98 [aj]	3	2	–	6.2	–	0.16	29	Austria
99 [ai]	20	11	0.06	60	0.0	0.06	686 000	Azerbaijan
99 [ai]	13	7	–	15	–	0.16	27	Bahamas
100 [ai]	7	3	–	12	–	0.03	5	Bahrain
59	31	19	–	221	1.2	0.51	56 339 394	Bangladesh
99 [ai]	13	8	0.18	0.0	–	0.18	44	Barbados
100	3	1	0.20	29	–	0.29	0	Belarus
–	3	2	–	8.9	–	0.09	22	Belgium
94 [ai]	12	8	–	27	0.0	0.60	13 317	Belize
78	90	31	0.31	55	406.7	2.87	6 070 676	Benin
96 [ai]	28	17	–	165	<0.1	0.14	229 846	Bhutan
81 [ai]	26	15	0.08	106	2.4	0.14	190 910	Bolivia (Plurinational State of)
100	6	4	–	27	–	0.63	0	Bosnia and Herzegovina
100 [aj]	42	18	4.78	253	0.2	0.18	238 203	Botswana
99 [aj]	14	8	0.23	46	4.2	0.03	9 560 959	Brazil
100 [ai]	11	6	–	64	–	0.10	0	Brunei Darussalam
100	7	3	0.04	21	–	0.09	193	Bulgaria
80	88	26	0.14	47	386.7	1.66	3 652 080	Burkina Faso
85	56	21	0.17	107	296.0	1.35	3 418 124	Burundi
97 [ai]	15	9	0.19	46	0.0	0.26	137 073	Cabo Verde
89 [ai]	27	14	0.05	287	12.0	0.19	5 068 956	Cambodia
69 [ai]	75	26	0.69	179	243.1	1.75	16 891 418	Cameroon
98 [aj]	5	3	–	5.5	–	0.34	0	Canada
40 [ai]	110	40	1.10	540	345.0	3.75	4 442 825	Central African Republic
24 [ai]	114	33	0.34	142	202.1	10.79	6 270 047	Chad
100	7	5	0.27	18	–	0.03	33	Chile
100 [ai]	8	4	–	58	0.0	0.22	22 841	China
99	14	7	0.25	35	10.7	0.15	3 186 736	Colombia
82	63	30	<0.01	35	20.7	1.16	788 813	Comoros
91	48	19	1.55	373	230.8	2.56	1 407 153	Congo
–	8	4	–	13	–	–	0	Cook Islands
99	9	6	0.19	10	0.1	0.02	10 011	Costa Rica
74	–	–	0.51	137	300.6	–	21 713 670	Côte d'Ivoire
100	5	3	0.02	8.0	–	0.12	1	Croatia
100	5	2	0.14	6.5	–	0.03	3 445	Cuba
99 [aj]	2	1	–	5.3	–	0.34	0	Cyprus
100 [aj]	3	2	–	4.9	–	0.13	0	Czechia
100	17	10	–	513	0.2	0.20	5 418 928	Democratic People's Republic of Korea
85	85	27	0.22	320	325.8	3.28	53 320 501	Democratic Republic of the Congo
95 [aj]	4	3	–	5.0	–	0.68	0	Denmark
87 [ai]	57	31	0.14	234	67.7	0.26	110 561	Djibouti
100 [ai]	35	28	–	16	–	–	1 066	Dominica
100 [aj]	28	19	0.27	42	0.3	0.10	2 749 409	Dominican Republic
96	14	7	0.14	46	3.6	0.09	9 608	Ecuador
92	20	11	0.05	12	0.0	0.20	6 894 411	Egypt
100	13	7	0.14	58	0.0	0.02	1 443 743	El Salvador

ANNEX 2
Part 1

	Total population[a] (000s)			Life expectancy at birth[b,c] (years)			Healthy life expectancy at birth[b,c] (years)			3.1 Maternal mortality ratio[d] (per 100 000 live births)
Data type	Comparable estimates			Comparable estimates			Comparable estimates			Comparable estimates
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
Member State	2019			2019			2019			2017
Equatorial Guinea	754	602	1 356	60.9	63.6	62.2	53.4	54.1	53.9	301
Eritrea	1 753	1 744	3 497	61.3	67.1	64.1	53.9	57.7	55.7	480
Estonia	627	699	1 326	74.7	82.6	78.9	66.4	71.7	69.2	9
Eswatini	563	585	1 148	53.4	63.2	57.7	47.1	53.8	50.1	437
Ethiopia	56 069	56 010	112 079	66.9	70.5	68.7	59.0	60.8	59.9	401
Fiji	451	439	890	65.9	70.3	68.0	58.5	60.7	59.6	34
Finland	2 727	2 805	5 532	79.2	84.0	81.6	69.9	72.0	71.0	3
France	31 524	33 605	65 130	79.8	85.1	82.5	71.1	73.1	72.1	8
Gabon	1 106	1 066	2 173	63.6	69.7	66.5	56.0	59.3	57.6	252
Gambia	1 164	1 183	2 348	63.4	67.7	65.5	56.4	57.7	57.0	597
Georgia	1 906	2 091	3 997	68.8	77.8	73.3	61.4	67.9	64.7	25
Germany	41 249	42 268	83 517	78.7	84.8	81.7	69.7	72.1	70.9	7
Ghana	15 416	15 002	30 418	63.7	69.2	66.3	56.5	59.6	58.0	308
Greece	5 141	5 333	10 473	78.6	83.6	81.1	69.9	71.9	70.9	3
Grenada	56	56	112	70.6	75.3	72.9	62.6	65.4	63.9	25
Guatemala	8 660	8 922	17 581	69.0	75.0	72.0	60.5	64.1	62.3	95
Guinea	6 166	6 605	12 771	59.5	62.3	61.0	52.9	53.7	53.3	576
Guinea–Bissau	939	982	1 921	57.4	63.0	60.2	51.1	54.1	52.6	667
Guyana	393	390	783	62.5	69.4	65.7	55.1	59.7	57.2	169
Haiti	5 558	5 705	11 263	63.3	64.8	64.1	55.9	55.8	55.8	480
Honduras	4 869	4 877	9 746	70.7	73.2	71.9	62.7	63.3	63.0	65
Hungary	4 608	5 076	9 685	73.1	79.6	76.4	65.0	69.3	67.2	12
Iceland	170	169	339	80.8	83.9	82.3	71.7	72.3	72.0	4
India	710 130	656 288	1366 418	69.5	72.2	70.8	60.3	60.4	60.3	145
Indonesia	136 270	134 356	270 626	69.4	73.3	71.3	61.9	63.8	62.8	177
Iran (Islamic Republic of)	41 890	41 024	82 914	75.7	79.1	77.3	66.0	66.5	66.3	16
Iraq	19 892	19 418	39 310	69.9	75.0	72.4	61.6	63.7	62.7	79
Ireland	2 422	2 460	4 882	80.2	83.5	81.8	70.7	71.4	71.1	5
Israel	4 237	4 282	8 519	80.8	84.4	82.6	72.0	72.7	72.4	3
Italy	29 461	31 089	60 550	80.9	84.9	83.0	71.2	72.6	71.9	2
Jamaica	1 464	1 485	2 948	74.4	77.7	76.0	65.9	67.3	66.6	80
Japan	61 950	64 910	126 860	81.5	86.9	84.3	72.6	75.5	74.1	5
Jordan	5 113	4 988	10 102	77.0	78.8	77.9	68.1	67.2	67.6	46
Kazakhstan	9 000	9 552	18 551	70.0	77.6	74.0	62.4	67.4	65.0	10
Kenya	26 122	26 452	52 574	63.7	68.4	66.1	56.4	58.9	57.7	342
Kiribati	58	60	118	56.1	62.8	59.4	50.5	54.9	52.6	92
Kuwait	2 563	1 644	4 207	79.3	83.9	81.0	69.5	71.1	70.1	12
Kyrgyzstan	3 174	3 242	6 416	70.7	77.3	74.2	63.6	67.7	65.8	60
Lao People's Democratic Republic	3 599	3 570	7 169	66.2	70.9	68.5	59.2	61.9	60.5	185
Latvia	878	1 029	1 907	70.6	79.8	75.4	62.9	69.3	66.2	19
Lebanon	3 449	3 406	6 856	74.0	79.2	76.4	65.1	67.0	66.0	29
Lesotho	1 048	1 077	2 125	47.7	54.2	50.7	42.3	46.4	44.2	544
Liberia	2 481	2 456	4 937	63.2	65.0	64.1	54.9	55.0	54.9	661
Libya	3 423	3 355	6 777	74.2	77.3	75.8	64.9	65.5	65.2	72
Lithuania	1 276	1 483	2 760	71.2	80.4	76.0	63.4	69.7	66.7	8
Luxembourg	311	305	616	80.6	84.2	82.4	71.1	72.0	71.6	5
Madagascar	13 453	13 516	26 969	64.1	66.6	65.3	56.9	57.7	57.3	335
Malawi	9 185	9 443	18 629	62.3	68.9	65.6	55.1	59.0	57.1	349
Malaysia	16 423	15 527	31 950	72.6	77.1	74.7	64.5	66.9	65.7	29
Maldives	336	195	531	78.6	80.8	79.6	69.7	70.0	70.0	53
Mali	9 845	9 813	19 658	62.2	63.4	62.8	54.8	54.5	54.6	562
Malta	221	220	440	79.9	83.8	81.9	70.9	71.9	71.5	6
Marshall Islands	–	–	59	–	–	–	–	–	–	–
Mauritania	2 272	2 254	4 526	68.1	68.7	68.4	60.2	59.4	59.8	766
Mauritius	627	643	1 270	71.0	77.3	74.1	62.0	65.9	63.9	61

3.1	3.2		3.3					
Proportion of births attended by skilled health personnel[e] (%)	Under-five mortality rate[f] (per 1000 live births)	Neonatal mortality rate[f] (per 1000 live births)	New HIV infections[g] (per 1000 uninfected population)	Tuberculosis incidence[h] (per 100 000 population)	Malaria incidence[i] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years[j] (%)	Reported number of people requiring interventions against NTDs[k]	
Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
2011–2020	2019	2019	2019	2019	2018	2019	2019	**Member State**
68 [ai]	82	29	4.06	181	237.1	6.07	429 326	Equatorial Guinea
–	40	18	0.11	86	57.3	1.02	427 112	Eritrea
100	2	1	–	13	–	0.29	0	Estonia
88	49	18	4.90	363	0.7	–	406 184	Eswatini
50	51	28	0.16	140	34.3	1.59	76 238 251	Ethiopia
100 [ai]	26	11	0.14	66	–	0.13	919 387	Fiji
100 [aj]	2	1	–	4.7	–	0.81	8	Finland
98 [aj]	4	3	–	8.7	–	0.15	55	France
89 [ai]	42	20	0.74	521	211.9	2.12	937 923	Gabon
84	52	27	1.06	158	50.5	1.60	168 211	Gambia
100	10	5	–	74	0.0	0.06	48	Georgia
99 [aj]	4	2	–	5.8	–	0.21	113	Germany
79	46	23	0.70	144	161.5	2.13	17 220 101	Ghana
100 [ai]	4	2	–	4.3	–	0.14	0	Greece
100 [ai]	17	11	–	3.1	–	0.12	106	Grenada
70 [ai]	25	12	0.07	26	0.2	0.03	4 957 871	Guatemala
55 [ai]	99	30	0.39	176	296.9	6.07	7 480 197	Guinea
54	78	35	1.15	361	86.9	2.11	1 232 549	Guinea–Bissau
96 [ai]	29	19	0.42	79	33.7	0.40	685 176	Guyana
42	63	25	0.52	170	1.4	1.04	5 921 717	Haiti
74 [aj]	17	9	0.11	31	0.1	0.03	2 214 843	Honduras
100 [ai]	4	2	–	6.3	–	0.90	0	Hungary
98 [aj]	2	1	–	4.4	–	0.15	0	Iceland
81 [ai]	34[ak]	22[ak]	–	193	4.3	0.16	733 660 997	India
95	24	12	–	312	2.4	1.30	98 728 063	Indonesia
99 [ai]	14	9	0.05	13	0.0	0.05	8 251	Iran (Islamic Republic of)
96	26	15	–	41	0.0	0.29	2 170 486	Iraq
100 [aj]	3	2	–	5.8	–	0.04	0	Ireland
–	4	2	–	2.9	–	0.05	0	Israel
100 [aj]	3	2	0.04	7.1	–	0.33	1	Italy
100	14	10	0.58	3.2	–	0.55	7 560	Jamaica
100 [aj]	2	1	–	13	–	0.96	8	Japan
100	16	9	–	5.5	–	0.56	70	Jordan
100 [aj]	10	5	0.20	68	0.0	0.15	55	Kazakhstan
70	43	21	0.92	267	57.0	0.40	8 321 398	Kenya
92 [ai]	51	22	–	436	–	1.57	122 769	Kiribati
100 [aj]	8	5	–	22	–	0.03	0	Kuwait
100	18	12	0.14	110	0.0	0.15	2 169 854	Kyrgyzstan
64	46	22	0.11	155	2.8	0.68	2 256 885	Lao People's Democratic Republic
100 [aj]	4	2	0.19	26	–	0.27	5	Latvia
–	7	4	0.03	13	–	0.07	2	Lebanon
87	86	43	6.43	654	–	1.22	382 336	Lesotho
84 [ai]	85	32	0.46	308	366.6	4.66	3 175 460	Liberia
100 [ai]	12	6	0.07	59	–	0.43	6 774	Libya
100 [ai]	4	2	0.09	42	–	0.05	51	Lithuania
–	3	1	–	9.0	–	0.06	1	Luxembourg
46 [ai]	51	20	0.23	233	76.1	2.13	21 125 732	Madagascar
90 [ai]	42	20	1.94	146	207.7	1.39	12 393 153	Malawi
100 [ai]	9	5	0.20	92	0.0	0.06	127 602	Malaysia
100	8	5	–	36	–	0.21	5 013	Maldives
67	94	32	–	52	333.7	4.62	7 735 946	Mali
100 [aj]	7	5	–	14	–	0.20	1	Malta
92	32	15	–	483	–	–	19 594	Marshall Islands
69	73	32	–	89	43.4	3.35	826 827	Mauritania
100	16	10	0.57	12	–	0.41	0	Mauritius

ANNEX 2
Part 1

	Total population[a] (000s)			Life expectancy at birth[b,c] (years)			Healthy life expectancy at birth[b,c] (years)			3.1 Maternal mortality ratio[d] (per 100 000 live births)
Data type	Comparable estimates			Comparable estimates			Comparable estimates			Comparable estimates
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
Member State	2019			2019			2019			2017
Mexico	62 403	65 172	127 576	73.1	78.9	76.0	64.3	67.2	65.8	33
Micronesia (Federated States of)	58	56	114	60.3	66.0	63.0	54.4	57.8	56.0	88
Monaco	–	–	39	–	–	–	–	–	–	–
Mongolia	1 590	1 635	3 225	63.8	72.8	68.1	57.1	63.8	60.3	45
Montenegro	311	317	628	73.2	78.7	75.9	65.2	68.7	67.0	6
Morocco	18 093	18 379	36 472	71.7	74.3	73.0	63.7	63.7	63.7	70
Mozambique	14 746	15 620	30 366	54.5	61.7	58.1	47.9	52.8	50.4	289
Myanmar	26 045	28 001	54 045	65.9	72.2	69.1	58.8	62.8	60.9	250
Namibia	1 209	1 286	2 495	60.6	68.4	64.6	53.4	58.6	56.1	195
Nauru	–	–	11	–	–	–	–	–	–	–
Nepal	13 047	15 562	28 609	68.9	72.7	70.9	60.6	62.1	61.3	186
Netherlands	8 515	8 582	17 097	80.4	83.1	81.8	71.3	71.5	71.4	5
New Zealand	2 351	2 432	4 783	80.4	83.5	82.0	69.6	70.8	70.2	9
Nicaragua	3 226	3 320	6 546	72.1	77.9	75.0	63.7	67.2	65.5	98
Niger	11 714	11 596	23 311	62.1	64.6	63.3	55.3	55.8	55.5	509
Nigeria	101 832	99 132	200 964	61.2	64.1	62.6	53.9	54.9	54.4	917
Niue	–	–	2	–	–	–	–	–	–	–
North Macedonia	1 042	1 041	2 083	72.8	76.9	74.8	65.1	67.3	66.1	7
Norway	2 717	2 662	5 379	81.1	84.1	82.6	71.0	71.6	71.4	2
Oman	3 284	1 691	4 975	73.0	75.3	73.9	64.5	64.5	64.7	19
Pakistan	111 448	105 118	216 565	64.6	66.7	65.6	56.9	56.8	56.9	140
Palau	–	–	18	–	–	–	–	–	–	–
Panama	2 126	2 120	4 246	76.6	82.1	79.3	67.4	70.0	68.7	52
Papua New Guinea	4 480	4 296	8 776	63.4	67.4	65.3	56.2	58.1	57.1	145
Paraguay	3 581	3 464	7 045	73.1	78.8	75.8	64.5	67.3	65.8	84
Peru	16 148	16 362	32 510	78.5	81.3	79.9	69.2	69.8	69.5	88
Philippines	54 316	53 801	108 117	67.4	73.6	70.4	60.1	63.9	62.0	121
Poland	18 361	19 527	37 888	74.5	81.9	78.3	65.9	71.3	68.7	2
Portugal	4 837	5 390	10 226	78.6	84.4	81.6	69.6	72.2	71.0	8
Qatar	2 134	699	2 832	78.0	76.6	77.2	68.1	65.1	67.1	9
Republic of Korea	25 649	25 576	51 225	80.3	86.1	83.3	71.3	74.7	73.1	11
Republic of Moldova	1 938	2 105	4 043	69.3	77.1	73.3	61.9	67.1	64.5	19
Romania	9 418	9 946	19 365	72.0	79.3	75.6	64.3	69.4	66.8	19
Russian Federation	67 603	78 269	145 872	68.2	78.0	73.2	60.7	67.5	64.2	17
Rwanda	6 206	6 421	12 627	66.9	71.2	69.1	59.0	61.4	60.2	248
Saint Kitts and Nevis	–	–	53	–	–	–	–	–	–	–
Saint Lucia	90	93	183	71.3	77.7	74.3	63.0	66.6	64.7	117
Saint Vincent and the Grenadines	56	54	111	71.3	75.3	73.2	62.9	65.1	64.0	68
Samoa	102	95	197	69.2	71.8	70.5	61.8	62.5	62.1	43
San Marino	–	–	34	–	–	–	–	–	–	–
Sao Tome and Principe	108	107	215	68.8	72.0	70.4	60.9	62.2	61.6	130
Saudi Arabia	19 784	14 485	34 269	73.1	76.1	74.3	63.8	64.4	64.0	17
Senegal	7 946	8 350	16 296	66.8	70.1	68.6	58.8	59.9	59.4	315
Serbia	4 297	4 475	8 772	73.5	78.3	75.9	65.4	68.4	66.9	12
Seychelles	50	48	98	70.0	77.1	73.3	61.9	66.4	64.0	53
Sierra Leone	3 898	3 915	7 813	59.6	61.9	60.8	52.5	53.3	52.9	1120
Singapore	3 038	2 766	5 804	81.0	85.5	83.2	72.4	74.7	73.6	8
Slovakia	2 657	2 800	5 457	74.8	81.4	78.2	66.2	70.8	68.5	5
Slovenia	1 035	1 044	2 079	78.6	84.1	81.3	69.0	72.5	70.7	7
Solomon Islands	341	329	670	62.9	67.9	65.2	56.5	59.1	57.8	104
Somalia	7 700	7 743	15 443	54.0	59.2	56.5	48.3	51.3	49.7	829
South Africa	28 859	29 699	58 558	62.2	68.3	65.3	54.6	57.7	56.2	119
South Sudan	5 537	5 526	11 062	60.8	64.8	62.8	52.9	54.5	53.7	1150
Spain	22 961	23 776	46 737	80.7	85.7	83.2	71.3	72.9	72.1	4
Sri Lanka	10 233	11 090	21 324	73.8	79.8	76.9	65.1	69.0	67.0	36

3.1	3.2		3.3					
Proportion of births attended by skilled health personnel[e] (%)	Under-five mortality rate[f] (per 1000 live births)	Neonatal mortality rate[f] (per 1000 live births)	New HIV infections[g] (per 1000 uninfected population)	Tuberculosis incidence[h] (per 100 000 population)	Malaria incidence[i] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years[j] (%)	Reported number of people requiring interventions against NTDs[k]	
Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
2011–2020	2019	2019	2019	2019	2018	2019	2019	**Member State**
97	14	9	–	23	0.2	0.03	19 900 177	Mexico
–	29	16	–	100	–	0.40	70 736	Micronesia (Federated States of)
–	3	2	–	0.0	–	–	0	Monaco
99 [ai]	16	8	0.01	428	–	0.47	0	Mongolia
99	2	1	0.05	15	–	0.67	0	Montenegro
87	21	14	0.02	97	0.0	0.16	5 576	Morocco
73	74	29	4.68	361	308.4	0.59	21 517 399	Mozambique
60 [ai]	45	22	0.19	322	2.3	1.11	23 748 613	Myanmar
88	42	19	3.10	486	2.8	0.36	1 094 020	Namibia
–	31	20	–	182	–	–	10 774	Nauru
77 [ai]	31	20	0.03	238	0.1	0.16	14 118 850	Nepal
–	4	3	0.02	5.0	–	0.08	0	Netherlands
96 [aj]	5	3	0.03	7.5	–	0.77	6	New Zealand
96 [ai]	17	10	0.06	43	5.9	0.09	1 611 101	Nicaragua
39 [aj]	80	24	0.06	84	343.2	3.44	14 046 246	Niger
43 [ai]	117	36	0.52	219	303.3	2.94	134 545 208	Nigeria
100 [ai]	23	13	–	0.0	–	–	0	Niue
100	6	4	–	12	–	–	0	North Macedonia
99 [aj]	2	1	–	3.3	–	0.02	3	Norway
99	11	5	0.04	8.5	0.0	0.13	80	Oman
71 [ai]	67	41	0.12	263	3.3	0.91	25 234 450	Pakistan
100	17	9	–	38	–	–	3	Palau
93	15	9	–	37	0.4	0.07	51 175	Panama
56 [ai]	45	22	0.38	432	156.4	1.36	6 982 087	Papua New Guinea
98 [aj]	19	11	0.16	46	0.0	0.42	1 974 836	Paraguay
94	13	6	0.10	119	3.6	0.06	342 185	Peru
84	27	13	0.14	554	0.7	0.38	47 496 283	Philippines
100	4	3	–	15	–	0.01	46	Poland
100	4	2	–	19	–	0.02	11	Portugal
100	7	3	–	35	–	0.05	22	Qatar
100 [aj]	3	2	–	59	0.1	0.09	4	Republic of Korea
100	14	11	0.23	80	–	0.20	0	Republic of Moldova
95	7	3	0.04	66	–	0.29	0	Romania
100 [ai]	6	3	–	50	–	0.55	1	Russian Federation
94 [ai]	34	16	0.44	57	366.1	0.49	5 015 979	Rwanda
100 [aj]	15	10	–	1.5	–	–	46	Saint Kitts and Nevis
100 [ai]	22	13	–	3.8	–	0.22	26	Saint Lucia
99 [ai]	15	9	–	4.2	–	0.15	702	Saint Vincent and the Grenadines
89	15	8	–	11	–	0.34	191 219	Samoa
–	2	1	–	0.0	–	–	0	San Marino
97	30	14	–	114	11.4	1.31	201 114	Sao Tome and Principe
99 [ai]	7	4	–	9.9	<0.1	0.00	1 113	Saudi Arabia
75	45	22	0.09	117	50.5	0.93	8 815 619	Senegal
100	5	3	0.02	14	–	0.04	0	Serbia
99 [ai]	14	9	–	16	–	0.09	0	Seychelles
87	109	31	0.65	295	334.8	1.98	6 910 107	Sierra Leone
100 [ai]	3	1	0.03	41	–	0.13	15 998	Singapore
98	6	3	–	4.5	–	0.31	11	Slovakia
100 [aj]	2	1	–	5.4	–	1.12	1	Slovenia
86 [ai]	20	8	–	66	247.9	0.87	493 611	Solomon Islands
32 [ai]	117	37	0.03	258	49.1	6.32	2 286 299	Somalia
97	34	11	3.98	615	0.5	3.10	18 807 465	South Africa
–	96	39	1.50	227	272.0	13.03	8 472 338	South Sudan
100	3	2	0.06	9.3	–	0.13	7	Spain
100	7	4	<0.01	64	0.0	0.34	106 353	Sri Lanka

ANNEX 2
Part 1

										3.1
	Total population[a] (000s)			Life expectancy at birth[b,c] (years)			Healthy life expectancy at birth[b,c] (years)			Maternal mortality ratio[d] (per 100 000 live births)
Data type	Comparable estimates			Comparable estimates			Comparable estimates			Comparable estimates
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
Member State	2019			2019			2019			2017
Sudan	21 388	21 425	42 813	67.6	70.8	69.1	59.6	60.3	59.9	295
Suriname	292	289	581	68.5	74.6	71.5	60.7	64.2	62.4	120
Sweden	5 026	5 011	10 036	80.8	84.0	82.4	71.7	72.1	71.9	4
Switzerland	4 261	4 331	8 591	81.8	85.1	83.4	72.2	72.8	72.5	5
Syrian Arab Republic	8 555	8 516	17 070	71.2	74.3	72.7	62.5	63.3	62.9	31
Tajikistan	4 698	4 623	9 321	67.6	71.5	69.5	60.9	63.2	62.0	17
Thailand	33 905	35 721	69 626	74.4	81.0	77.7	65.9	70.6	68.3	37
Timor-Leste	654	640	1 293	67.9	71.4	69.6	59.8	62.0	60.9	142
Togo	4 021	4 062	8 082	61.5	67.2	64.3	54.7	57.8	56.2	396
Tonga	52	52	104	69.8	75.6	72.6	62.7	65.5	64.0	52
Trinidad and Tobago	689	706	1 395	72.5	79.9	76.1	64.0	68.6	66.2	67
Tunisia	5 798	5 897	11 695	74.9	79.2	77.0	66.1	67.7	66.9	43
Turkey	41 174	42 256	83 430	76.4	80.7	78.6	67.8	69.0	68.4	17
Turkmenistan	2 926	3 016	5 942	66.5	73.0	69.7	59.9	64.3	62.1	7
Tuvalu	–	–	12	–	–	–	–	–	–	–
Uganda	21 807	22 462	44 270	63.2	70.1	66.7	56.0	60.4	58.2	375
Ukraine	20 379	23 615	43 994	68.0	77.8	73.0	60.6	67.8	64.3	19
United Arab Emirates	6 767	3 004	9 771	75.1	78.4	76.1	65.8	66.2	66.0	3
United Kingdom	33 351	34 179	67 530	79.8	83.0	81.4	69.6	70.6	70.1	7
United Republic of Tanzania	28 981	29 025	58 005	65.4	69.3	67.3	57.6	59.3	58.5	524
United States of America	162 826	166 239	329 065	76.3	80.7	78.5	65.2	67.0	66.1	19
Uruguay	1 672	1 790	3 462	73.5	80.6	77.1	65.4	69.5	67.5	17
Uzbekistan	16 450	16 532	32 982	70.8	75.2	73.0	63.5	65.8	64.7	29
Vanuatu	152	148	300	62.7	68.3	65.3	56.4	59.4	57.8	72
Venezuela (Bolivarian Republic of)	14 045	14 471	28 516	69.9	78.2	73.9	61.9	67.1	64.4	125
Viet Nam	48 151	48 311	96 462	69.6	78.1	73.7	62.4	68.3	65.3	43
Yemen	14 692	14 470	29 162	64.4	68.9	66.6	56.9	58.2	57.5	164
Zambia	8 843	9 018	17 861	59.5	65.4	62.5	52.5	56.3	54.4	213
Zimbabwe	6 983	7 662	14 645	57.5	63.6	60.7	51.2	54.8	53.1	458
WHO region	2019			2019			2019			2017
African Region	545 008	546 751	1 091 759	62.4	66.6	64.5	55.0	57.1	56.0	525
Region of the Americas	497 928	511 897	1 009 950	74.5	79.8	77.2	64.8	67.5	66.2	57
South-East Asia Region	1 026 050	975 896	2 001 946	69.9	73.1	71.4	61.1	61.9	61.5	152
European Region	451 018	478 998	930 167	75.1	81.3	78.2	66.6	70.0	68.3	13
Eastern Mediterranean Region	367 791	344 485	712 276	68.3	71.3	69.7	60.2	60.7	60.4	164
Western Pacific Region	982 936	947 812	1 930 867	74.8	80.8	77.7	67.0	70.2	68.6	41
Global	3 870 732	3 805 840	7 676 965	70.8	75.9	73.3	62.5	64.9	63.7	211

3.1	3.2		3.3					
Proportion of births attended by skilled health personnel[e] (%)	Under-five mortality rate[f] (per 1000 live births)	Neonatal mortality rate[f] (per 1000 live births)	New HIV infections[g] (per 1000 uninfected population)	Tuberculosis incidence[h] (per 100 000 population)	Malaria incidence[i] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years[j] (%)	Reported number of people requiring interventions against NTDs[k]	
Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
2011–2020	2019	2019	2019	2019	2018	2019	2019	**Member State**
78 [ai]	58	27	0.08	67	55.4	1.66	12 015 065	Sudan
98 [ai]	18	11	0.45	29	1.1	0.07	241	Suriname
–	3	1	–	5.5	–	0.13	28	Sweden
–	4	3	0.03	5.4	–	0.16	0	Switzerland
–	22	11	<0.01	19	0.0	0.69	2 440 286	Syrian Arab Republic
95	34	15	0.17	83	0.0	0.18	3 161 746	Tajikistan
99 [ai]	9	5	0.08	150	0.3	0.27	129 102	Thailand
57 [ai]	44	20	0.15	498	0.0	0.72	1 327 038	Timor-Leste
69 [ai]	67	25	0.59	37	225.0	3.27	4 311 460	Togo
98 [ai]	17	7	–	11	–	0.89	37 131	Tonga
100 [ai]	18	12	0.07	18	–	0.19	442	Trinidad and Tobago
100	17	12	0.05	35	–	0.12	7 085	Tunisia
99 [aj]	10	5	–	16	0.0	0.11	0	Turkey
100 [ai]	42	24	–	45	0.0	0.07	105	Turkmenistan
–	24	16	–	296	–	–	11 500	Tuvalu
74	46	20	1.38	200	262.7	0.96	24 639 995	Uganda
100 [ai]	8	5	0.28	77	–	0.25	0	Ukraine
100 [ai]	7	4	–	1.0	0.0	0.02	55	United Arab Emirates
–	4	3	–	8.0	–	0.41	5	United Kingdom
64 [ai]	50	20	1.46	237	111.2	–	27 086 592	United Republic of Tanzania
99	6	4	–	3.0	–	0.01	1 158	United States of America
100 [ai]	7	4	–	35	–	0.15	13	Uruguay
100 [ai]	17	10	0.13	67	0.0	0.16	405 951	Uzbekistan
89 [ai]	26	11	–	41	3.5	2.25	291 481	Vanuatu
99 [ai]	24	15	0.19	45	32.8	0.15	8 062 142	Venezuela (Bolivarian Republic of)
94	20	10	0.05	176	0.1	0.64	7 368 702	Viet Nam
45 [ai]	58	27	0.04	48	46.4	1.76	10 471 813	Yemen
80 [ai]	62[al]	23[al]	3.17	333	147.7	1.32	12 032 435	Zambia
86	55	26	2.81	199	67.9	2.74	10 660 813	Zimbabwe

2014–2020	2019	2019	2019	2019	2019	2019	2019	**WHO region**
65	74	27	0.94	226	225.2	2.53	590 380 426	African Region
96	13	7	0.17	29	6.4	0.07	63 062 825	Region of the Americas
81	32	20	0.08	217	3.9	0.38	933 812 197	South-East Asia Region
99	8	4	0.21	26	0.0	0.26	6 424 369	European Region
81	46	25	0.07	114	10.4	0.84	77 874 457	Eastern Mediterranean Region
98	11	6	0.06	93	2.3	0.30	71 521 277	Western Pacific Region

83	38	17	0.22	130	56.8	0.94	1 743 075 551	**Global**

ANNEX 2
Part 2

	3.4		3.5	3.6	3.7		3.8
	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70[c,l] (%)	Suicide mortality rate[c,l] (per 100 000 population)	Total alcohol per capita (≥ 15 years of age) consumption[m] (litres of pure alcohol)	Road traffic mortality rate[c,l] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods[n] (%)	Adolescent birth rate[o] (per 1000 women aged 15–19 years)	UHC: Service coverage index[p]
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Comparable estimates
Member State	**2019**	**2019**	**2019**	**2019**	**2011–2020**	**2011–2020**	**2017**
Afghanistan	35.3	4.1	<0.1	15.9	42.2[am]	62.0	37
Albania	11.4	4.3	6.8	11.7	6.3	14.2	59
Algeria	13.9	2.5	0.6	20.9	77.2[am]	12.0	78
Andorra	–	–	12.3	–	–	2.7	–
Angola	22.2	6.1	7.8	26.1	29.8	163.0	40
Antigua and Barbuda	17.5	0.4	9.4	0.0	–	27.7	73
Argentina	15.7	8.4	9.5	14.1	–	49.9	76
Armenia	19.9	3.3	4.7	20.0	40.2[am]	18.9	69
Australia	8.6	12.5	10.4	4.9	–	9.4	87
Austria	10.4	14.6	11.9	4.9	–	5.5	79
Azerbaijan	27.2	4.1	1.0	6.7	–	48.1	65
Bahamas	19.9	3.5	4.8	7.7	–	29.0	75
Bahrain	16.1	8.9	1.1	5.2	–	12.5	77
Bangladesh	18.9	3.7	0.0	15.3	77.4[am]	74.0	48
Barbados	16.0	0.6	10.4	8.2	69.9[am]	–	77
Belarus	23.8	21.2	11.0	7.6	73.0[am]	11.7	76
Belgium	10.6	18.3	10.8	5.8	–	5.5	84
Belize	16.5	7.1	6.4	22.6	64.9	58.2	64
Benin	22.6	7.8	2.2	26.8	28.0	108.0	40
Bhutan	18.5	4.6	0.2	16.2	–	–	62
Bolivia (Plurinational State of)	17.9	6.2	3.9	21.1	50.3[am]	71.0	68
Bosnia and Herzegovina	18.7	10.9	7.8	13.5	21.9[am]	10.1	61
Botswana	27.0	16.1	6.6	26.4	–	51.9	61
Brazil	15.5	6.9	7.3	16.0	–	49.1	79
Brunei Darussalam	18.5	2.7	0.5	7.5	–	9.9	81
Bulgaria	24.2	9.7	12.5	9.2	–	38.9	66
Burkina Faso	23.9	7.5	11.0	31.0	52.6	132.3	40
Burundi	25.0	6.2	7.5	35.5	39.6	58.2	42
Cabo Verde	17.4	12.9	6.4	26.8	–	12.0	69
Cambodia	22.5	4.9	7.8	19.6	56.5	30.0	60
Cameroon	23.9	9.0	5.5	30.2	44.9	122.2	46
Canada	9.6	11.8	8.8	5.3	–	6.6	89
Central African Republic	36.0	12.3	1.7	37.7	27.6	–	33
Chad	22.7	6.4	1.3	32.4	17.5[am]	179.4	28
Chile	10.0	9.0	8.9	14.9	–	22.6	70
China	15.9	8.1	6.0	17.4	–	9.2	79
Colombia	9.7	3.9	5.5	15.4	86.6	57.9	76
Comoros	20.6	5.4	1.1	26.6	28.8	70.3	52
Congo	22.6	6.5	9.2	29.7	43.2	111.3	39
Cook Islands	–	–	10.9	–	–	41.9	–
Costa Rica	9.5	8.1	4.1	14.8	80.8	40.9	77
Côte d'Ivoire	21.7	8.9	3.0	24.1	43.5	123.3	47
Croatia	16.1	16.4	8.7	7.9	–	8.6	71
Cuba	16.6	14.5	6.3	8.9	86.9	53.3	83
Cyprus	8.2	3.6	10.8	5.8	–	7.8	78
Czechia	14.3	12.2	14.3	5.9	–	10.8	76
Democratic People's Republic of Korea	23.9	9.4	4.2	24.2	89.6[am]	1.0	71
Democratic Republic of the Congo	24.0	6.7	1.1	34.9	33.0	109.0	41
Denmark	10.8	10.7	10.1	3.7	–	2.0	81
Djibouti	22.0	9.6	0.4	23.5	–	21.0	47
Dominica	–	–	7.2	–	–	–	–
Dominican Republic	19.1	4.9	6.7	64.6	81.7	53.5	74
Ecuador	11.0	7.6	3.3	20.1	79.4[am]	63.5	77
Egypt	28.0	3.0	0.1	10.1	80.0[am]	51.8	68
El Salvador	10.7	6.1	4.1	20.9	80.0	69.7	76

3.8		3.9			3.a	
Population with household expenditures on health > 10% of total household expenditure or income[q] (%)	Population with household expenditures on health > 25% of total household expenditure or income[q] (%)	Age-standardized mortality rate attributed to household and ambient air pollution[c,r] (per 100 000 population)	Mortality rate attributed to exposure to unsafe WASH services[c,r] (per 100 000 population)	Mortality rate from unintentional poisoning[c,l] (per 100 000 population)	Age-standardized prevalence of tobacco use among persons 15 years and older[s] (%)	
Primary data	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	
2011–2018	2011–2018	2016	2016	2019	2018	**Member State**
14.6	2.0	211.1	13.9	1.0	–	Afghanistan
16.7	5.0	68.0	0.2	0.3	29.2[an]	Albania
–	–	49.7	1.9	0.7	18.8	Algeria
–	–	–	–	–	33.8[an]	Andorra
–	–	118.5	48.8	2.0	–	Angola
–	–	29.9	0.1	0.7	–	Antigua and Barbuda
–	–	26.6	0.4	0.4	21.8	Argentina
16.1	4.9	54.8	0.2	0.7	26.7[an]	Armenia
–	–	8.4	0.1	0.1	16.2	Australia
–	–	15.3	0.1	0.2	29.1[an]	Austria
–	–	63.9	1.1	0.9	19.6[an]	Azerbaijan
2.7	0.2	19.9	0.1	0.2	10.9[an]	Bahamas
–	–	40.1	<0.1	0.3	25.1	Bahrain
24.7	9.5	149.0	11.9	0.3	39.1	Bangladesh
16.4	3.8	31.1	0.2	0.7	8.7	Barbados
9.2	0.7	60.7	0.1	3.3	26.6[an]	Belarus
–	–	15.7	0.3	0.4	25.0[an]	Belgium
–	–	68.6	1.0	0.4	–	Belize
10.9	5.4	205.0	59.7	2.6	7.2	Benin
1.8	0.4	124.5	3.9	0.2	–	Bhutan
6.0	1.1	63.7	5.6	0.6	–	Bolivia (Plurinational State of)
8.2	1.4	79.8	0.1	0.4	38.3[an]	Bosnia and Herzegovina
–	–	101.3	11.8	1.8	23.7	Botswana
–	–	29.9	1.0	0.1	16.5	Brazil
–	–	13.3	<0.1	0.0	15.5[an]	Brunei Darussalam
–	–	61.8	0.1	0.5	38.9[an]	Bulgaria
3.1	0.4	206.2	49.6	3.1	16.0	Burkina Faso
3.3	0.4	179.9	65.4	3.2	12.6	Burundi
–	–	99.5	4.1	0.4	–	Cabo Verde
15.3	5.2	149.8	6.5	0.5	21.8	Cambodia
10.8	3.0	208.1	45.2	2.6	9.3	Cameroon
–	–	7.0	0.4	0.3	17.5	Canada
–	–	211.9	82.1	2.8	–	Central African Republic
–	–	280.1	101.0	3.5	11.8	Chad
14.6	2.1	25.3	0.2	0.4	44.7[an]	Chile
19.7	5.4	112.7	0.6	1.8	24.7	China
8.2	2.2	37.0	0.8	0.1	7.9[an]	Colombia
8.8	1.6	172.4	50.7	2.4	19.5	Comoros
4.6	0.7	130.7	38.7	1.3	16.1	Congo
–	–	–	–	–	26.6[an]	Cook Islands
9.8	1.7	23.3	0.9	0.1	9.8[an]	Costa Rica
12.4	3.4	269.1	47.2	2.5	13.0	Côte d'Ivoire
–	–	35.5	0.1	0.4	36.6[an]	Croatia
–	–	49.5	1.0	0.2	27.1[an]	Cuba
–	–	20.1	0.3	0.3	36.7[an]	Cyprus
–	–	29.6	0.2	0.4	31.5[an]	Czechia
–	–	207.2	1.4	1.4	18.8[an]	Democratic People's Republic of Korea
4.8	0.6	163.9	59.8	2.0	–	Democratic Republic of the Congo
–	–	13.2	0.3	0.1	18.6[an]	Denmark
–	–	159.0	31.3	2.5	–	Djibouti
–	–	–	–	–	–	Dominica
–	–	43.0	2.2	0.4	9.4[an]	Dominican Republic
10.3	2.4	24.5	0.6	0.3	–	Ecuador
26.2	3.9	108.9	2.0	0.2	21.4	Egypt
1.7	0.3	41.9	2.0	0.2	12.7	El Salvador

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	3.4		3.5	3.6	3.7		3.8
	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70[c,l] (%)	Suicide mortality rate[c,l] (per 100 000 population)	Total alcohol per capita (≥ 15 years of age) consumption[m] (litres of pure alcohol)	Road traffic mortality rate[c,l] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods[n] (%)	Adolescent birth rate[o] (per 1000 women aged 15–19 years)	UHC: Service coverage index[p]
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Comparable estimates
Member State	**2019**	**2019**	**2019**	**2019**	**2011–2020**	**2011–2020**	**2017**
Equatorial Guinea	22.1	7.9	6.9	27.2	20.7[am]	–	45
Eritrea	26.8	10.9	2.1	37.9	–	–	38
Estonia	14.9	14.9	10.8	4.5	–	9.6	75
Eswatini	35.2	29.4	8.8	33.5	82.9	87.1	63
Ethiopia	17.1	5.4	2.2	28.2	63.6	79.5	39
Fiji	37.7	9.0	3.7	13.5	–	23.1	64
Finland	9.6	15.3	10.7	3.9	–	4.3	78
France	10.6	13.8	12.2	5.1	–	8.6	78
Gabon	21.3	8.4	8.1	23.9	44.0	91.0	49
Gambia	21.1	4.8	3.4	29.6	39.7[am]	67.5	44
Georgia	24.9	9.2	9.5	12.4	50.5[am]	29.4	66
Germany	12.1	12.3	12.8	3.8	–	7.2	83
Ghana	22.5	6.6	2.8	25.7	40.4	78.0	47
Greece	12.5	5.1	10.5	8.3	–	8.6	75
Grenada	23.3	0.7	9.0	8.0	–	35.9	72
Guatemala	16.5	5.9	1.6	22.9	66.1	77.4	55
Guinea	24.9	7.0	1.1	29.7	37.7	120.0	37
Guinea–Bissau	24.9	7.0	5.5	32.2	60.0[am]	84.0	40
Guyana	29.2	40.3	5.3	22.3	51.5	73.7	72
Haiti	31.3	9.6	3.0	18.8	45.4	54.8	49
Honduras	18.7	2.1	3.9	16.1	76.0	88.7	65
Hungary	22.1	16.6	11.1	7.7	–	22.0	74
Iceland	8.7	11.9	9.2	2.0	–	5.3	84
India	21.9	12.7	5.6	15.6	72.8	12.2	55
Indonesia	24.8	2.4	0.2	11.3	77.0	36.0	57
Iran (Islamic Republic of)	14.8	5.2	1.0	21.5	68.6[am]	31.1	72
Iraq	23.5	3.6	0.4	27.3	53.7[am]	70.0	61
Ireland	9.7	9.6	12.7	3.1	–	6.2	76
Israel	8.8	5.3	4.4	3.9	–	8.2	82
Italy	9.0	6.7	8.0	5.3	–	4.1	82
Jamaica	16.9	2.4	4.2	15.1	–	51.7	65
Japan	8.3	15.3	10.1	3.6	–	3.1	83
Jordan	15.3	1.6	0.5	17.0	56.7[am]	27.0	76
Kazakhstan	22.4	17.6	5.0	12.7	73.2[am]	23.2	76
Kenya	21.0	6.1	2.1	28.3	74.4	96.0	55
Kiribati	50.8	28.3	2.3	1.9	53.1[am]	50.6	41
Kuwait	11.9	2.9	0.0	15.4	–	5.0	76
Kyrgyzstan	20.3	7.4	4.9	12.7	64.6	37.7	70
Lao People's Democratic Republic	26.8	5.4	12.1	17.9	72.3	83.4	51
Latvia	21.6	20.1	13.2	8.1	–	12.1	71
Lebanon	19.9	2.8	1.5	16.4	–	11.7	73
Lesotho	42.7	72.4	5.1	31.9	82.8	90.8	48
Liberia	17.8	4.4	5.4	38.9	41.0[am]	128.0	39
Libya	18.6	4.5	<0.1	21.3	24.0[am]	10.9	64
Lithuania	19.3	26.1	12.8	8.1	–	11.2	73
Luxembourg	9.7	11.3	12.4	4.1	–	4.6	83
Madagascar	26.0	5.5	2.0	29.2	65.9	150.8	28
Malawi	22.6	5.4	4.1	33.4	73.9	137.6	46
Malaysia	18.4	5.7	0.9	22.5	–	8.8	73
Maldives	11.6	2.7	2.8	1.6	29.2	8.9	62
Mali	22.3	4.1	1.3	22.7	41.2	164.0	38
Malta	10.5	6.1	8.3	4.1	–	12.1	82
Marshall Islands	–	–	–	–	–	84.5	–
Mauritania	16.1	3.1	0.0	25.6	30.4[am]	84.0	41
Mauritius	23.2	9.5	4.8	12.2	40.8[am]	23.2	63
Mexico	15.6	5.3	5.0	12.8	79.8	62.0	76

3.8		3.9			3.a	
Population with household expenditures on health > 10% of total household expenditure or income[q] (%)	Population with household expenditures on health > 25% of total household expenditure or income[q] (%)	Age-standardized mortality rate attributed to household and ambient air pollution[c,r] (per 100 000 population)	Mortality rate attributed to exposure to unsafe WASH services[c,r] (per 100 000 population)	Mortality rate from unintentional poisoning[c,l] (per 100 000 population)	Age-standardized prevalence of tobacco use among persons 15 years and older[s] (%)	
Primary data	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	
2011–2018	2011–2018	2016	2016	2019	2018	**Member State**
–	–	177.7	22.3	1.6	–	Equatorial Guinea
–	–	173.7	45.6	3.3	7.2	Eritrea
–	–	25.0	<0.1	0.6	30.5[an]	Estonia
–	–	137.0	27.9	3.3	10.7	Eswatini
4.9	1.4	144.4	43.7	3.3	4.6	Ethiopia
–	–	99.0	2.9	0.3	26.7[an]	Fiji
–	–	7.2	<0.1	0.4	19.7[an]	Finland
–	–	9.7	0.3	0.3	34.6[an]	France
–	–	76.0	20.6	1.3	–	Gabon
0.2	<0.1	237.0	29.7	1.8	14.4	Gambia
29.2	9.0	101.8	0.2	0.6	29.7[an]	Georgia
–	–	16.0	0.6	0.3	28.0[an]	Germany
1.1	0.1	203.8	18.8	1.7	3.7	Ghana
16.9	1.6	27.6	<0.1	0.2	39.1[an]	Greece
–	–	45.3	0.3	0.1	–	Grenada
1.4	<0.1	73.8	6.3	1.6	–	Guatemala
7.0	1.3	243.3	44.6	2.3	–	Guinea
–	–	214.7	35.3	2.3	–	Guinea–Bissau
–	–	107.8	3.6	0.1	12.2[an]	Guyana
11.5	4.0	184.3	23.8	1.4	8.3[an]	Haiti
–	–	60.7	3.6	0.5	–	Honduras
–	–	38.8	0.2	0.5	30.6[an]	Hungary
–	–	8.7	0.1	1.0	13.8[an]	Iceland
17.3	3.9	184.3	18.6	0.3	27.0	India
2.7	0.5	112.4	7.1	0.3	37.9	Indonesia
15.8	3.8	50.9	1.0	1.0	14.0	Iran (Islamic Republic of)
3.3	0.4	75.1	3.0	0.2	22.2	Iraq
–	–	11.9	0.1	0.3	23.6[an]	Ireland
6.7	1.0	15.4	0.2	0.0	25.5[an]	Israel
–	–	15.0	0.1	0.3	23.4[an]	Italy
–	–	25.4	0.6	0.1	11.0	Jamaica
4.4	0.6	11.9	0.2	0.2	21.9[an]	Japan
–	–	51.2	0.6	0.5	–	Jordan
2.6	0.1	62.7	0.4	1.9	24.4[an]	Kazakhstan
5.4	1.5	78.1	51.2	2.4	11.8	Kenya
–	–	140.2	16.7	2.6	52.0[an]	Kiribati
–	–	103.8	<0.1	0.4	22.1	Kuwait
3.5	0.7	110.7	0.8	0.9	27.9	Kyrgyzstan
–	–	188.5	11.3	0.6	37.8	Lao People's Democratic Republic
–	–	41.3	<0.1	1.2	36.7[an]	Latvia
–	–	51.4	0.8	0.6	42.6	Lebanon
–	–	177.6	44.4	5.2	29.7	Lesotho
–	–	170.2	41.5	1.7	8.4	Liberia
–	–	71.9	0.6	0.8	–	Libya
–	–	34.0	0.1	1.7	27.1[an]	Lithuania
–	–	11.6	<0.1	0.2	21.7[an]	Luxembourg
–	–	159.6	30.2	2.1	28.9	Madagascar
4.2	0.9	115.0	28.3	1.7	12.8	Malawi
2.0	0.2	47.4	0.4	0.7	21.8[an]	Malaysia
10.3	4.1	25.6	0.3	0.0	–	Maldives
6.5	1.1	209.1	70.7	2.9	12.0	Mali
–	–	20.2	<0.1	0.1	25.1[an]	Malta
–	–	–	–	–	–	Marshall Islands
11.7	3.0	169.5	38.6	1.5	–	Mauritania
8.9	1.8	38.3	0.6	0.8	26.9	Mauritius
1.6	0.2	36.7	1.1	0.4	13.9[an]	Mexico

ANNEX 2
Part 2

	3.4		3.5	3.6	3.7		3.8
	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70[c,l] (%)	Suicide mortality rate[c,l] (per 100 000 population)	Total alcohol per capita (≥ 15 years of age) consumption[m] (litres of pure alcohol)	Road traffic mortality rate[c,l] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods[n] (%)	Adolescent birth rate[o] (per 1000 women aged 15–19 years)	UHC: Service coverage index[p]
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Comparable estimates
Member State	**2019**	**2019**	**2019**	**2019**	**2011–2020**	**2011–2020**	**2017**
Micronesia (Federated States of)	46.3	28.2	2.5	0.2	–	–	47
Monaco	–	–	–	–	–	–	–
Mongolia	35.0	17.9	5.9	21.0	63.6	30.5	62
Montenegro	22.3	21.0	12.2	7.6	32.9[am]	10.0	68
Morocco	24.1	7.2	0.5	17.0	72.0[am]	19.0	70
Mozambique	30.6	13.6	2.7	30.0	55.5	180.0	46
Myanmar	24.9	2.9	2.1	20.4	74.9	28.0	61
Namibia	22.6	9.7	3.1	34.8	80.4	63.9	62
Nauru	–	–	4.2	–	–	94.0	–
Nepal	21.5	9.0	0.6	16.3	61.9[am]	63.0	48
Netherlands	10.3	11.8	9.7	4.0	–	2.6	86
New Zealand	10.3	11.0	10.7	9.6	–	13.3	87
Nicaragua	15.3	4.3	5.1	16.9	89.8[am]	102.6	73
Niger	21.0	5.3	0.5	25.5	45.5[am]	154.0	37
Nigeria	16.9	3.5	6.2	20.7	35.6	106.0	42
Niue	–	–	9.9	–	–	20.0	–
North Macedonia	22.7	9.4	6.4	5.1	29.6[am]	15.1	72
Norway	8.7	11.8	7.1	2.1	–	2.6	87
Oman	21.5	4.9	0.9	10.6	39.6[am]	8.1	69
Pakistan	29.4	8.9	0.3	13.0	48.6[am]	54.0	45
Palau	–	–	–	–	–	33.8	–
Panama	10.7	2.9	7.8	13.9	65.2	74.1	79
Papua New Guinea	36.0	2.9	2.1	12.6	49.2	68.0	40
Paraguay	16.0	6.0	7.0	22.0	78.9	72.0	69
Peru	9.7	2.8	6.8	13.6	66.6[am]	44.0	77
Philippines	24.5	2.2	7.0	12.0	56.0	36.4	61
Poland	17.0	11.3	11.9	9.4	–	10.3	75
Portugal	11.0	11.5	12.1	8.2	–	7.3	82
Qatar	10.7	5.8	1.5	7.3	68.9[am]	7.2	68
Republic of Korea	7.3	28.6	8.5	8.6	–	0.9	86
Republic of Moldova	24.1	14.7	12.9	7.3	63.9	21.4	69
Romania	21.0	9.7	12.3	10.3	–	36.4	74
Russian Federation	24.2	25.1	10.5	12.0	72.4[am]	21.5	75
Rwanda	20.2	5.6	8.0	29.4	62.9	41.0	57
Saint Kitts and Nevis	–	–	6.3	–	–	–	–
Saint Lucia	17.7	7.9	9.6	29.8	72.0[am]	25.3	68
Saint Vincent and the Grenadines	20.7	1.0	7.2	7.4	–	52.3	71
Samoa	31.2	12.6	2.8	13.0	39.4[am]	39.2	58
San Marino	–	–	–	–	–	1.4	–
Sao Tome and Principe	21.0	1.5	5.8	27.9	57.7	86.0	55
Saudi Arabia	20.9	6.0	0.0	35.9	–	–	74
Senegal	19.5	6.0	0.7	23.5	53.2	68.0	45
Serbia	22.0	11.4	8.9	7.5	38.4[am]	12.0	65
Seychelles	21.1	8.1	8.8	11.3	–	68.3	71
Sierra Leone	23.5	6.7	5.3	33.0	53.0	102.0	39
Singapore	9.5	11.2	2.0	2.1	–	2.1	86
Slovakia	15.5	12.1	11.1	6.1	–	26.3	77
Slovenia	11.4	19.8	12.1	5.1	–	3.8	79
Solomon Islands	39.2	14.7	1.7	16.5	38.0[am]	78.0	47
Somalia	30.4	7.9	0.0	27.4	2.1[am]	118.0	25
South Africa	24.1	23.5	9.5	22.2	79.7	40.9	69
South Sudan	16.8	3.8	–	36.7	–	–	31
Spain	9.6	7.7	12.7	3.9	–	6.2	83
Sri Lanka	13.2	14.0	2.9	19.7	74.3[am]	21.0	66
Sudan	22.8	3.8	–	26.8	30.1[am]	86.8	44
Suriname	22.7	25.4	7.4	15.3	57.5	53.9	71

3.8		3.9			3.a	
Population with household expenditures on health > 10% of total household expenditure or income[q] (%)	Population with household expenditures on health > 25% of total household expenditure or income[q] (%)	Age-standardized mortality rate attributed to household and ambient air pollution[c,r] (per 100 000 population)	Mortality rate attributed to exposure to unsafe WASH services[c,r] (per 100 000 population)	Mortality rate from unintentional poisoning[c,l] (per 100 000 population)	Age-standardized prevalence of tobacco use among persons 15 years and older[s] (%)	
Primary data	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	
2011–2018	2011–2018	2016	2016	2019	2018	**Member State**
–	–	151.8	3.6	0.9	–	Micronesia (Federated States of)
–	–	–	–	–	–	Monaco
2.4	0.5	155.9	1.3	2.8	27.6	Mongolia
10.3	0.8	78.6	<0.1	0.6	–	Montenegro
–	–	49.1	1.9	0.7	14.7	Morocco
1.6	0.4	110.0	27.6	3.7	14.4	Mozambique
14.4	2.8	156.4	12.6	1.3	45.5	Myanmar
–	–	145.0	18.3	1.9	17.9	Namibia
–	–	–	–	–	52.1	Nauru
10.7	2.4	193.8	19.8	1.7	31.9	Nepal
–	–	13.7	0.2	0.1	23.4[an]	Netherlands
–	–	7.2	0.1	0.2	14.8[an]	New Zealand
14.8	3.0	55.7	2.2	0.3	–	Nicaragua
6.6	1.9	251.8	70.8	3.3	8.6	Niger
15.1	4.1	307.4	68.6	3.3	4.8	Nigeria
–	–	–	–	–	–	Niue
–	–	82.2	0.1	0.5	–	North Macedonia
–	–	8.6	0.2	0.3	18.4[an]	Norway
–	–	53.9	<0.1	0.9	9.6	Oman
4.5	0.5	173.6	19.6	1.6	20.0	Pakistan
–	–	–	–	–	23.7	Palau
–	–	25.8	1.9	0.1	6.9	Panama
–	–	152.0	16.3	1.4	–	Papua New Guinea
7.1	1.9	57.5	1.5	0.2	12.8[an]	Paraguay
9.2	1.3	63.9	1.3	0.4	9.6[an]	Peru
6.3	1.4	185.2	4.2	0.2	24.3[an]	Philippines
14.1	1.3	37.9	0.1	0.5	26.0[an]	Poland
–	–	9.8	0.2	0.3	27.9[an]	Portugal
–	–	47.4	<0.1	0.3	14.0	Qatar
21.8	3.9	20.5	1.8	0.2	22.0[an]	Republic of Korea
18.7	3.6	78.3	0.1	5.5	25.3[an]	Republic of Moldova
13.4	2.2	59.3	0.4	1.9	25.5[an]	Romania
4.9	0.6	49.4	0.1	3.8	28.3[an]	Russian Federation
1.2	0.1	121.4	19.3	1.7	13.3	Rwanda
–	–	–	–	–	–	Saint Kitts and Nevis
–	–	30.0	0.6	0.1	–	Saint Lucia
–	–	47.6	1.3	0.0	–	Saint Vincent and the Grenadines
–	–	85.0	1.5	0.4	28.9[an]	Samoa
–	–	–	–	–	–	San Marino
–	–	162.4	11.4	0.7	5.4	Sao Tome and Principe
–	–	83.7	0.1	0.8	16.6	Saudi Arabia
3.3	0.2	160.7	23.9	1.9	9.1	Senegal
8.1	0.5	62.5	0.7	0.3	40.6[an]	Serbia
3.5	1.6	49.3	0.2	0.5	21.1	Seychelles
54.2	22.2	324.1	81.3	2.8	19.8	Sierra Leone
9.0	1.5	25.9	0.1	0.0	16.5[an]	Singapore
–	–	33.5	<0.1	0.5	32.3[an]	Slovakia
2.9	0.3	22.6	<0.1	0.2	22.7[an]	Slovenia
–	–	137.0	6.2	2.3	37.9[an]	Solomon Islands
–	–	212.8	86.6	4.9	–	Somalia
–	–	86.7	13.7	1.7	31.4	South Africa
–	–	165.1	63.3	2.3	–	South Sudan
–	–	9.9	0.2	0.4	27.9[an]	Spain
5.4	0.9	79.8	1.2	0.4	22.9	Sri Lanka
–	–	184.9	17.3	1.7	–	Sudan
4.9	1.4	56.7	2.0	0.3	–	Suriname

ANNEX 2
Part 2

	3.4		3.5	3.6	3.7		3.8
	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70[c,l] (%)	Suicide mortality rate[c,l] (per 100 000 population)	Total alcohol per capita (≥ 15 years of age) consumption[m] (litres of pure alcohol)	Road traffic mortality rate[c,l] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods[n] (%)	Adolescent birth rate[o] (per 1000 women aged 15–19 years)	UHC: Service coverage index[p]
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Comparable estimates
Member State	**2019**	**2019**	**2019**	**2019**	**2011–2020**	**2011–2020**	**2017**
Sweden	8.4	14.7	9.0	3.1	86.7[am]	4.2	86
Switzerland	7.9	14.5	11.2	2.2	–	2.3	83
Syrian Arab Republic	22.1	1.9	0.2	14.9	–	–	60
Tajikistan	28.3	4.3	0.9	15.7	52.1[am]	54.3	68
Thailand	13.7	8.8	8.5	32.2	88.2	23.0	80
Timor-Leste	19.9	3.7	0.5	11.9	45.9	41.9	52
Togo	23.9	8.8	2.7	28.7	39.6	79.0	43
Tonga	24.8	3.8	0.4	33.0	49.9[am]	30.0	58
Trinidad and Tobago	17.1	8.7	6.5	9.3	58.2[am]	32.0	74
Tunisia	15.7	3.3	2.0	16.5	62.7[am]	7.0	70
Turkey	15.6	2.4	1.8	6.7	60.1[am]	19.2	74
Turkmenistan	27.7	5.7	3.1	13.5	79.6[am]	22.0	70
Tuvalu	–	–	1.3	–	–	26.6	–
Uganda	21.2	4.6	12.5	29.4	55.1	111.4	45
Ukraine	25.5	21.6	8.3	10.2	68.0[am]	18.0	68
United Arab Emirates	18.5	6.4	3.8	8.9	–	3.8	76
United Kingdom	10.3	7.9	11.4	3.2	86.5[am]	11.9	87
United Republic of Tanzania	17.4	4.3	12.0	31.1	55.1	138.9	43
United States of America	13.6	16.1	10.0	12.7	78.4[am]	17.4	84
Uruguay	16.5	21.2	6.9	14.8	–	35.8	80
Uzbekistan	25.3	8.0	2.6	11.7	–	18.9	73
Vanuatu	39.7	18.0	2.1	14.9	50.7[am]	51.2	48
Venezuela (Bolivarian Republic of)	14.8	2.1	3.6	39.0	–	94.5	74
Viet Nam	21.2	7.5	7.9	30.6	69.6	35.0	75
Yemen	27.6	5.8	<0.1	29.4	40.5	67.2	42
Zambia	24.6	7.3	4.5	20.5	65.9	135.0	53
Zimbabwe	28.4	14.1	4.5	41.2	84.8	107.9	54
WHO region	**2016**	**2016**	**2018**	**2016**	**2020**	**2015–2020**	**2017**
African Region	20.8	6.9	4.8	27.2	57.1	102.1	46
Region of the Americas	14.0	9.6	7.6	15.3	82.4	49.9	79
South-East Asia Region	21.6	10.1	4.3	15.8	75.3	26.1	56
European Region	16.3	12.8	9.5	7.4	76.9	17.1	77
Eastern Mediterranean Region	24.5	5.9	0.5	17.8	61.6	46.5	57
Western Pacific Region	15.6	8.7	6.5	16.4	87.2	14.4	77
Global	17.8	9.2	5.8	16.7	76.8	42.5	66

3.8		3.9			3.a	
Population with household expenditures on health > 10% of total household expenditure or income[q] (%)	Population with household expenditures on health > 25% of total household expenditure or income[q] (%)	Age-standardized mortality rate attributed to household and ambient air pollution[c,r] (per 100 000 population)	Mortality rate attributed to exposure to unsafe WASH services[c,r] (per 100 000 population)	Mortality rate from unintentional poisoning[c,l] (per 100 000 population)	Age-standardized prevalence of tobacco use among persons 15 years and older[s] (%)	
Primary data	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	
2011–2018	2011–2018	2016	2016	2019	2018	**Member State**
–	–	7.2	0.2	0.2	28.8	Sweden
–	–	10.1	0.1	0.2	25.1[an]	Switzerland
–	–	75.2	3.7	0.6	–	Syrian Arab Republic
–	–	129.3	2.7	0.4	–	Tajikistan
2.2	0.4	61.5	3.5	0.2	22.8	Thailand
2.9	0.5	139.8	9.9	0.4	38.2	Timor-Leste
–	–	249.6	41.6	1.9	7.6	Togo
–	–	73.3	1.4	1.1	30.2[an]	Tonga
3.9	1.9	38.6	0.1	0.1	–	Trinidad and Tobago
18.4	2.7	56.1	1.0	0.7	26.0	Tunisia
3.2	0.4	46.6	0.3	0.4	29.3[an]	Turkey
–	–	79.3	4.0	0.6	–	Turkmenistan
–	–	–	–	–	48.7	Tuvalu
15.3	3.8	155.7	31.6	1.7	9.8	Uganda
7.8	0.9	70.7	0.3	2.5	25.5[an]	Ukraine
–	–	54.7	<0.1	0.4	18.2	United Arab Emirates
1.6	0.5	13.8	0.2	0.3	19.2[an]	United Kingdom
3.8	1.2	139.0	38.4	2.0	13.3	United Republic of Tanzania
4.8	0.8	13.3	0.2	0.5	25.1	United States of America
–	–	17.5	0.4	0.5	21.8[an]	Uruguay
–	–	81.1	0.4	0.8	12.3[an]	Uzbekistan
–	–	135.6	10.4	0.7	24.1	Vanuatu
–	–	34.6	1.4	0.2	–	Venezuela (Bolivarian Republic of)
9.4	1.9	64.5	1.6	0.9	–	Viet Nam
15.8	4.2	194.2	10.2	1.8	20.9	Yemen
–	–	127.2	34.9	2.6	14.7	Zambia
–	–	133.0	24.6	3.5	13.9	Zimbabwe
2015	2015	2016	2016	2016	2018	**WHO region**
7.3	1.8	180.9	45.8	2.5	12.7	African Region
11.3	1.8	29.7	1.1	0.4	18.6	Region of the Americas
16.0	3.8	165.8	15.4	0.3	29.1	South-East Asia Region
7.4	1.2	36.3	0.3	1.1	26.3	European Region
11.7	1.9	125.0	10.6	1.1	19.3	Eastern Mediterranean Region
15.9	4.2	102.8	1.0	1.4	26.3	Western Pacific Region
12.7	2.9	114.1	11.7	1.1	23.6	**Global**

ANNEX 2
Part 3

	3.b						3.c		
	Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds[t] (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age[t] (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year-olds[t] (%)	Human papillomavirus (HPV) immunization coverage estimates among 15-year-old girls[t] (%)	Total net official development assistance to medical research and basic health sectors per capita[u] (US$), by recipient country	Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis[v] (%)	Density of medical doctors[w] (per 10 000 population)	Density of nursing and midwifery personnel[w] (per 10 000 population)	Density of dentists[w] (per 10 000 population)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Primary data	Primary data	Primary data
Member State	**2019**	**2019**	**2019**	**2019**	**2019**	**2011–2019**	**2010–2019**	**2010–2019**	**2010–2019**
Afghanistan	66	39	65	–	6.90	–	2.8	4.5	0.7
Albania	99	96	96	–	2.21	–	16.5	50.9	10.3
Algeria	91	77	91	–	0.02	–	17.2	15.5	3.7
Andorra	99	95	96	64[aq]	–	–	33.3	40.1	8.2
Angola	57	45	53	–	1.35	–	2.1	4.1	–
Antigua and Barbuda	95	95	–	–	0.03	–	27.7	90.8	0.4
Argentina	86	89	88	59	0.06	–	39.9	26.0	15.3
Armenia	92	96	92	7	1.89	–	44.0	43.7	5.6
Australia	95	94	96	79	–	–	37.6	132.4	6.0
Austria	85	84	–	–	–	–	52.1	70.9	5.7
Azerbaijan	94	97	95	–	0.40	–	34.5	64.3	2.7
Bahamas	86	82	86	9[ar]	–	–	19.4	45.7	2.6
Bahrain	99	99	97	–	–	–	9.3	24.9	1.0
Bangladesh	98	95	97	–	1.75	–	6.4	3.9	0.6
Barbados	90	77	93	29	–	–	24.9	5.1	3.1
Belarus	98	98	–	–	0.65	–	51.9	110.0	6.2
Belgium	98	85	94	67[at]	–	–	59.6	118.1	10.8
Belize	98	95	–	63	5.02	–	10.8	23.4	1.4
Benin	76	–	73	–	6.28	–	0.6	3.0	–
Bhutan	97	92	26	73	7.54	–	4.6	18.3	0.9
Bolivia (Plurinational State of)	75	44	75	70	1.53	23.1[as]	10.3	15.6	1.8
Bosnia and Herzegovina	73	76	–	–	2.57	–	21.6	57.3	2.4
Botswana	95	76	92	47	4.88	–	2.9	54.6	0.7
Brazil	73	54	84	69	0.03	–	23.1	74.0	6.4
Brunei Darussalam	99	98	–	90	–	–	16.1	59.0	2.5
Bulgaria	92	87	88	4	–	–	42.1	47.9	14.0
Burkina Faso	91	71	91	–	9.19	0.0[as]	0.9	9.3	–
Burundi	93	80	93	–	14.06	0.0[as]	1.0	6.6	–
Cabo Verde	96	91	–	–	2.87	–	7.8	13.0	2.2
Cambodia	92	82	89	–	5.26	–	1.9	10.1	0.9
Cameroon	67	–	67	–	4.14	–	0.9	0.1	0.1
Canada	91	87	81	83[at]	–	–	24.4	118.1	5.2
Central African Republic	47	–	47	–	12.80	–	0.7	2.1	–
Chad	50	–	–	–	5.90	–	0.5	1.4	–
Chile	96	91	95	82	–	36.4[as]	51.8	133.2	12.5
China	99	98	–	–	0.06	–	19.8	26.6	4.5
Colombia	92	88	94	39	0.07	8.3[as]	38.4	13.9	10.1
Comoros	91	–	–	–	5.57	–	1.7	6.3	0.4
Congo	79	9	68	–	3.35	0.0[as]	1.1	9.3	0.1
Cook Islands	98	98	–	73	10.79	–	14.1	80.0	3.4
Costa Rica	95	93	95	39[0]	0.09	–	28.9	9.0	1.4
Côte d'Ivoire	84	–	84	–	5.14	–	1.6	6.6	0.1
Croatia	94	95	–	–	–	–	30.0	81.2	12.2
Cuba	99	99	–	–	0.11	–	84.2	75.6	16.7
Cyprus	96	88	81	64[at]	–	–	19.5	2.8	8.0
Czechia	97	84	–	–	–	–	41.2	84.2	7.4
Democratic People's Republic of Korea	97	98	–	–	0.63	–	36.8	44.5	2.2
Democratic Republic of the Congo	57	–	58	–	7.47	–	0.9	11.1	–
Denmark	97	90	97	62	–	–	42.2	105.5	7.2
Djibouti	85	81	85	–	4.84	–	2.2	7.3	0.2
Dominica	99	92	–	–	–	–	11.0	61.0	1.1
Dominican Republic	89	60	70	7	0.38	–	14.5	14.6	2.3
Ecuador	85	76	83	54	0.21	50.0[as]	22.2	25.1	3.0

3.c	3.d			1.a	2.2			
Density of pharmacists[w] (per 10 000 population)	Average of 13 International Health Regulations core capacity scores[x]	Percentage of bloodstream infections due to methicillin-resistant Staphylococcus aureus[y] (MRSA) (%)	Percentage of bloodstream infections due to Escherichia coli resistant to 3rd-generation cephalosporin (e.g., ESBL- E. coli)[y] (%)	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE)[z] (%)	Prevalence of stunting in children under 5[aa] (%)	Prevalence of wasting in children under 5[aa] (%)	Prevalence of overweight in children under 5[aa] (%)	
Primary data	Primary data	Primary data	Primary data	Comparable estimates	Comparable estimates	Primary data	Comparable estimates	
2010–2019	2020	2019	2019	2018	2020	2011–2020	2020	**Member State**
0.3	47	–	–	1.8	35.1	5.1[ao,ap]	3.9	Afghanistan
10.8	73	–	–	9.7	9.6	1.6	14.6	Albania
4.5	68	–	–	10.7	9.3	2.7	12.9	Algeria
10.1	41	–	–	18.6	–	–	–	Andorra
–	65	–	–	5.4	37.7	4.9	3.5	Angola
–	–	–	–	11.7	–	–	–	Antigua and Barbuda
–	64	42	19	15.2	7.8	1.6	12.9	Argentina
0.5	84	–	–	5.3	9.1	4.4	10.8	Armenia
8.9	92	18	13	17.9	2.1	–	18.5	Australia
7.1	67	5	9	15.5	–	–	–	Austria
2.0	86	–	–	2.8	16.3	3.2[ap]	9.4	Azerbaijan
5.6	65	–	–	15.9	–	–	–	Bahamas
1.6	–	40	54	7.2	5.1	–	6.4	Bahrain
1.8	70	–	93	3.0	30.2	9.8	2.1	Bangladesh
–	–	–	–	9.9	6.6	6.8	11.4	Barbados
3.6	–	–	–	10.6	3.9	–	6.8	Belarus
19.4	81	–	–	15.0	2.3	0.4[ap,au]	5.1	Belgium
6.8	48	–	–	12.5	13.3	1.8	8.0	Belize
0.3	35	–	–	3.0	31.3	5.0	2.2	Benin
0.6	71	21	57	7.6	22.4	–	5.2	Bhutan
2.2	58	–	–	12.1	12.7	2.0	8.8	Bolivia (Plurinational State of)
1.3	–	11	20	15.1	9.1	2.3	12.8	Bosnia and Herzegovina
2.1	43	–	–	14.3	22.8	–	11.0	Botswana
6.8	92	21	28	10.3	6.1	–	7.3	Brazil
1.7	–	12	17	7.1	12.7	–	9.3	Brunei Darussalam
8.4	–	–	–	11.6	6.4	6.3[av]	5.7	Bulgaria
0.2	51	–	–	8.8	25.5	8.1[ao]	2.6	Burkina Faso
–	53	–	–	8.5	57.6	4.8[ao]	3.1	Burundi
0.1	52	–	–	10.4	9.7	–	–	Cabo Verde
0.3	48	–	71	5.2	29.9	9.7	2.1	Cambodia
0.1	50	–	–	1.1	27.2	4.3	9.6	Cameroon
11.7	100	–	–	19.5	–	–	11.8	Canada
–	32	–	–	4.2	40.1	5.2[ao,aw]	2.6	Central African Republic
–	39	–	–	5.2	35.0	13.9	3.4	Chad
5.3	76	–	–	18.3	1.6	0.3	9.8	Chile
3.2	94	–	–	8.9	4.7	1.9	8.3	China
–	75	–	–	19.6	11.5	1.6[ao]	5.8	Colombia
0.2	41	–	–	2.6	22.6	11.2	9.6	Comoros
0.1	37	–	–	3.5	18.0	8.2	5.1	Congo
0.6	59	–	–	7.8	–	–	–	Cook Islands
7.3	77	–	–	27.8	8.6	1.8	8.1	Costa Rica
0.4	44	–	–	5.1	17.8	6.1	2.8	Côte d'Ivoire
7.2	78	25	16	12.3	–	–	–	Croatia
–	–	–	–	15.2	7.0	2.0	10.0	Cuba
6.5	67	100	20	6.6	–	–	–	Cyprus
6.9	–	13	15	15.5	2.5	–	6.6	Czechia
4.0	70	–	–	–	18.2	2.5	1.9	Democratic People's Republic of Korea
0.1	52	–	–	4.5	40.8	6.4	4.2	Democratic Republic of the Congo
5.4	–	–	–	16.6	–	–	–	Denmark
2.3	31	–	–	4.3	34.0	21.5	7.2	Djibouti
–	–	–	–	7.0	–	–	–	Dominica
1.2	60	–	–	15.4	5.9	2.4	7.6	Dominican Republic
0.4	70	–	–	11.4	23.1	3.7	9.8	Ecuador

ANNEX 2
Part 3

	3.b						3.c		
	Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds[t] (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age[t] (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year-olds[t] (%)	Human papillomavirus (HPV) immunization coverage estimates among 15-year-old girls[t] (%)	Total net official development assistance to medical research and basic health sectors per capita[u] (US$), by recipient country	Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis[v] (%)	Density of medical doctors[w] (per 10 000 population)	Density of nursing and midwifery personnel[w] (per 10 000 population)	Density of dentists[w] (per 10 000 population)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Primary data	Primary data	Primary data
Member State	**2019**	**2019**	**2019**	**2019**	**2019**	**2011–2019**	**2010–2019**	**2010–2019**	**2010–2019**
Egypt	95	94	–	–	0.10	–	7.5	19.3	2.0
El Salvador	81	87	82	–	0.44	–	28.7	18.3	8.7
Equatorial Guinea	53	–	–	–	0.84	–	4.0	5.0	–
Eritrea	95	88	95	–	7.16	–	–	14.4	–
Estonia	91	90	–	45[at]	–	–	34.6	66.3	9.7
Eswatini	90	75	87	–	11.97	–	1.0	41.4	0.1
Ethiopia	69	41	63	84	3.46	–	0.8	7.1	0.2
Fiji	99	94	99	56	4.97	–	8.6	39.6	1.2
Finland	91	93	89	60[ax]	–	–	46.4	13.1	8.1
France	96	83	92	24[at]	–	–	65.3	114.7	6.7
Gabon	70	–	–	–	2.26	–	6.8	29.5	0.2
Gambia	88	61	87	–	14.55	–	1.1	6.1	0.1
Georgia	94	97	84	11[ay]	1.47	–	70.8	52.2	7.7
Germany	93	93	84	43[at]	–	–	43.0	134.9	8.6
Ghana	97	83	97	–	6.45	12.5[as]	1.1	27.1	0.1
Greece	99	83	96	–	–	–	62.3	37.0	12.6
Grenada	92	82	–	41	2.09	–	14.4	62.8	2.0
Guatemala	85	78	88	24	1.10	–	3.5	12.8	0.1
Guinea	47	–	–	–	7.58	12.5[as]	0.8	1.2	–
Guinea–Bissau	84	–	84	–	12.86	–	1.3	6.9	–
Guyana	99	92	98	13	2.38	–	18.2	10.4	1.2
Haiti	51	41	42	–	6.34	0.0	2.3	4.0	0.2
Honduras	87	85	87	59	1.23	–	3.1	7.3	0.3
Hungary	99	99	99	78	–	–	34.1	52.6	7.1
Iceland	91	95	90	93	–	–	41.4	171.9	8.4
India	91	84	15	–	0.22	–	9.3	23.9	2.0
Indonesia	85	71	3	1[az]	0.36	–	4.7	38.1	0.6
Iran (Islamic Republic of)	99	98	–	–	0.01	–	15.8	20.8	4.5
Iraq	84	86	37	–	1.02	–	7.1	20.4	2.6
Ireland	94	–	86	69	–	–	33.5	130.1	6.9
Israel	98	96	95	52[at]	–	–	54.7	66.0	11.6
Italy	95	88	92	40[at]	–	–	80.1	58.9	8.0
Jamaica	96	92	–	9	0.78	–	4.5	9.4	0.9
Japan	98	93	97	0	–	–	24.8	127.0	8.0
Jordan	89	96	–	–	3.44	–	23.2	33.5	7.1
Kazakhstan	97	98	89	–	0.38	–	39.8	72.9	2.9
Kenya	92	45	92	–	4.51	–	1.6	11.7	0.2
Kiribati	97	91	97	–	14.28	–	2.0	38.3	0.7
Kuwait	91	94	91	–	–	–	26.5	74.1	6.7
Kyrgyzstan	95	98	96	–	3.23	0.0[as]	22.1	56.0	1.9
Lao People's Democratic Republic	68	57	56	–	6.70	25.3	3.7	7.2	0.6
Latvia	99	96	84	54	–	–	33.0	46.2	7.1
Lebanon	83	63	82	–	5.41	52.5	21.0	16.7	10.2
Lesotho	87	82	87	–	12.96	–	–	32.6	0.2
Liberia	74	13	74	–	13.38	–	0.4	5.3	–
Libya	73	72	73	–	0.42	–	20.9	65.3	8.8
Lithuania	92	93	79	66	–	–	50.4	94.5	13.9
Luxembourg	99	90	96	14[at]	–	–	30.1	121.7	9.8
Madagascar	79	–	79	–	2.72	–	1.8	3.0	0.5
Malawi	95	75	95	–	15.39	–	0.4	4.4	–
Malaysia	98	87	–	85	0.11	–	15.4	34.8	3.1
Maldives	99	99	–	–	4.00	–	17.1	64.3	2.0
Mali	77	4	74	–	7.35	0.0[as]	1.3	4.4	0.1
Malta	98	95	–	81	–	–	28.6	94.8	4.8

3.c	3.d			1.a	2.2			
Density of pharmacists[w] (per 10 000 population)	Average of 13 International Health Regulations core capacity scores[x]	Percentage of bloodstream infections due to methicillin-resistant Staphylococcus aureus[y] (MRSA) (%)	Percentage of bloodstream infections due to Escherichia coli resistant to 3rd-generation cephalosporin (e.g., ESBL- E. coli)[y] (%)	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE)[z] (%)	Prevalence of stunting in children under 5[aa] (%)	Prevalence of wasting in children under 5[aa] (%)	Prevalence of overweight in children under 5[aa] (%)	
Primary data	Primary data	Primary data	Primary data	Comparable estimates	Comparable estimates	Primary data	Comparable estimates	
2010–2019	2020	2019	2019	2018	2020	2011–2020	2020	**Member State**
4.6	86	–	88	4.7	22.3	9.5	17.8	Egypt
6.5	100	–	–	18.8	11.2	2.1	6.6	El Salvador
–	26	–	–	3.2	19.7	3.1	9.3	Equatorial Guinea
–	57	–	–	2.4	49.1	–	2.1	Eritrea
7.2	72	–	–	12.5	1.2	1.5	5.7	Estonia
0.3	46	–	–	6.0	22.6	2.0	9.7	Eswatini
0.4	67	–	–	4.8	35.3	7.2	2.6	Ethiopia
1.1	–	–	–	7.2	7.5	–	5.2	Fiji
19.2	82	2	8	13.3	–	–	–	Finland
10.6	–	13	9	14.8	–	–	–	France
0.6	40	–	–	9.4	14.4	3.4	7.4	Gabon
–	35	–	–	4.4	16.1	5.1	2.3	Gambia
0.9	59	14	57	10.3	5.7	0.6	7.6	Georgia
6.6	89	7	12	20.0	1.6	0.3[au]	4.1	Germany
0.2	49	–	–	6.4	14.2	6.8	2.9	Ghana
10.4	60	43	22	8.5	2.2	–	13.9	Greece
6.8	–	–	–	7.7	–	–	–	Grenada
–	58	–	–	16.7	42.8	0.8	5.1	Guatemala
0.1	48	–	–	4.1	29.4	9.2	5.7	Guinea
–	35	–	–	3.0	28.0	7.8[ao,ap]	3.4	Guinea–Bissau
0.1	100	–	–	10.7	9.0	6.4	6.6	Guyana
0.3	40	–	–	4.8	20.4	3.7	3.7	Haiti
–	60	–	–	10.7	19.9	1.4	5.7	Honduras
8.1	66	–	–	9.9	–	–	–	Hungary
5.4	–	–	–	16.6	–	–	–	Iceland
8.8	80	61	81	3.4	30.9	17.3	1.9	India
0.8	69	40	70	8.5	31.8	10.2	11.1	Indonesia
2.9	88	39	70	21.8	6.3	–	9.4	Iran (Islamic Republic of)
3.3	74	–	–	6.2	11.6	3.0	9.0	Iraq
10.9	64	15	13	20.2	–	–	–	Ireland
9.9	–	–	–	12.1	–	–	–	Israel
11.4	83	39	30	13.2	–	–	–	Italy
0.2	87	–	–	13.0	8.5	3.3	6.8	Jamaica
18.9	95	36	21	23.6	5.5	–	2.4	Japan
16.0	43	72	66	12.4	7.3	2.4	7.1	Jordan
8.1	81	–	–	9.1	6.7	3.1	8.8	Kazakhstan
0.2	44	–	–	8.5	19.4	4.2	4.5	Kenya
0.3	70	–	–	6.0	14.9	3.5	2.4	Kiribati
4.9	84	–	–	8.9	6.0	2.5[ba]	7.1	Kuwait
0.4	52	–	–	8.4	11.4	2.0	5.8	Kyrgyzstan
2.5	43	6	50	4.4	30.2	9.0	3.0	Lao People's Democratic Republic
8.5	77	8	18	9.6	–	–	–	Latvia
12.9	69	25	56	13.3	10.4	–	19.7	Lebanon
–	40	–	–	11.6	32.1	2.1	7.2	Lesotho
–	54	–	–	5.2	28.0	3.4	4.7	Liberia
6.0	59	–	58	–	43.5	10.2	25.4	Libya
12.4	85	9	13	12.7	–	–	–	Lithuania
7.0	–	6	10	10.7	–	–	–	Luxembourg
–	36	33	41	10.5	40.2	6.4	1.5	Madagascar
0.1	39	–	–	9.8	37.0	0.6[ao,bb]	4.7	Malawi
3.5	86	20	27	8.5	20.9	9.7	6.1	Malaysia
3.5	47	–	–	21.4	14.2	9.1	4.6	Maldives
0.1	50	3	40	5.4	25.7	9.3[ao,bb]	2.1	Mali
12.9	61	22	18	15.6	–	–	–	Malta

ANNEX 2
Part 3

	3.b						3.c		
	Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds[t] (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age[t] (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year-olds[t] (%)	Human papillomavirus (HPV) immunization coverage estimates among 15-year-old girls[t] (%)	Total net official development assistance to medical research and basic health sectors per capita[u] (US$), by recipient country	Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis[v] (%)	Density of medical doctors[w] (per 10 000 population)	Density of nursing and midwifery personnel[w] (per 10 000 population)	Density of dentists[w] (per 10 000 population)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Primary data	Primary data	Primary data
Member State	**2019**	**2019**	**2019**	**2019**	**2019**	**2011–2019**	**2010–2019**	**2010–2019**	**2010–2019**
Marshall Islands	79	64	63	24	4.82	–	4.2	33.4	1.2
Mauritania	81	–	77	–	2.74	–	1.9	9.3	0.5
Mauritius	96	99	97	80	0.45	–	25.3	35.2	2.8
Mexico	82	73	86	95	0.03	–	48.5	23.6	1.4
Micronesia (Federated States of)	78	52	73	57[at]	4.22	–	–	21.5	–
Monaco	99	79	–	–	–	–	75.1	201.6	10.2
Mongolia	98	98	49	–	4.85	26.7	38.5	42.1	4.1
Montenegro	86	86	–	–	0.28	–	27.6	52.3	0.5
Morocco	99	99	98	–	0.40	–	7.3	13.9	1.4
Mozambique	88	85	80	–	7.70	–	0.8	4.7	0.1
Myanmar	90	80	90	–	2.24	–	7.4	10.8	0.7
Namibia	87	56	57	–	5.85	–	5.9	19.5	0.7
Nauru	96	95	–	–	22.95	–	13.5	78.5	3.7
Nepal	93	76	83	–	2.41	–	8.1	33.0	1.1
Netherlands	94	90	93	53[bc]	–	–	37.1	114.9	6.5
New Zealand	92	90	91	67	–	–	34.2	6.8	6.3
Nicaragua	98	99	98	–	6.08	–	16.6	15.5	0.4
Niger	81	58	81	–	5.03	–	0.4	2.2	–
Nigeria	57	9	57	–	3.63	–	3.8	15.0	0.2
Niue	99	99	99	–	26.65	–	–	125.0	–
North Macedonia	92	94	–	40[at]	0.67	–	28.7	37.9	8.8
Norway	97	95	95	91	–	–	48.9	183.5	8.7
Oman	99	99	99	–	–	–	19.3	40.9	3.0
Pakistan	75	71	75	–	1.98	–	11.2	4.8	1.2
Palau	97	88	74	67	8.32	–	14.2	72.6	2.2
Panama	88	97	96	73	0.65	–	16.3	32.1	3.0
Papua New Guinea	35	20	35	–	13.91	–	0.7	4.5	0.1
Paraguay	86	83	89	61	0.80	–	13.5	16.6	1.6
Peru	88	66	80	76	0.49	69.2[as]	8.2	29.8	1.5
Philippines	65	40	43	0[az]	0.68	–	6.0	54.4	2.6
Poland	95	92	60	–	–	–	23.8	68.9	3.5
Portugal	99	96	98	81[aq]	–	–	53.1	69.0	9.6
Qatar	98	95	98	–	–	–	24.9	72.0	6.1
Republic of Korea	98	96	98	52	–	–	24.1	74.6	5.0
Republic of Moldova	91	95	80	31	2.97	21.7	25.6	39.3	1.8
Romania	88	76	88	–	–	–	29.8	73.9	8.0
Russian Federation	97	97	85	–	–	–	44.4	45.3	2.8
Rwanda	98	92	98	94	9.60	–	1.2	9.5	0.2
Saint Kitts and Nevis	96	98	–	–	–	–	27.7	42.2	2.3
Saint Lucia	92	75	–	46	4.30	–	6.4	31.5	1.7
Saint Vincent and the Grenadines	97	99	–	10	3.23	–	9.4	70.1	1.7
Samoa	58	44	–	–	25.61	–	3.4	34.4	1.1
San Marino	88	79	76	50	–	–	61.1	82.1	17.8
Sao Tome and Principe	95	81	95	–	10.16	–	3.2	19.2	–
Saudi Arabia	96	96	96	–	–	–	26.1	58.2	5.0
Senegal	93	78	92	25	5.79	7.7[as]	0.9	5.4	0.1
Serbia	97	91	93	–	3.00	–	31.1	60.9	2.1
Seychelles	99	99	92	68	–	–	24.7	98.5	4.3
Sierra Leone	95	72	94	–	9.18	–	0.7	7.5	–
Singapore	96	84	82	0[at]	–	–	22.9	62.4	4.1
Slovakia	97	98	96	–	–	–	35.2	60.2	5.1
Slovenia	95	94	65	59[aq]	–	–	31.7	102.2	7.2
Solomon Islands	94	54	94	–	9.85	–	1.9	21.6	0.7
Somalia	42	–	–	–	4.13	–	0.2	1.1	–

3.c	3.d			1.a	2.2			
Density of pharmacists[w] (per 10 000 population)	Average of 13 International Health Regulations core capacity scores[x]	Percentage of bloodstream infections due to methicillin-resistant Staphylococcus aureus[y] (MRSA) (%)	Percentage of bloodstream infections due to Escherichia coli resistant to 3rd-generation cephalosporin (e.g., ESBL- E. coli)[y] (%)	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE)[z] (%)	Prevalence of stunting in children under 5[aa] (%)	Prevalence of wasting in children under 5[aa] (%)	Prevalence of overweight in children under 5[aa] (%)	
Primary data	Primary data	Primary data	Primary data	Comparable estimates	Comparable estimates	Primary data	Comparable estimates	
2010–2019	2020	2019	2019	2018	2020	2011–2020	2020	**Member State**
0.7	49	–	–	12.1	32.2	3.5[ao,ap]	4.2	Marshall Islands
0.2	35	–	–	6.1	24.2	11.5[ao,ap]	2.7	Mauritania
4.2	64	–	–	10.0	8.7	–	7.6	Mauritius
–	83	–	–	10.5	12.1	1.4[ap]	6.3	Mexico
–	49	–	–	4.8	–	–	–	Micronesia (Federated States of)
26.3	–	–	–	6.6	–	–	–	Monaco
6.8	85	–	–	7.7	7.1	0.9	10.1	Mongolia
1.9	–	–	–	10.6	8.1	2.2	10.2	Montenegro
2.6	75	–	–	7.2	12.9	2.6	11.3	Morocco
0.1	70	10	28	5.6	37.8	4.4	6.0	Mozambique
0.8	63	56	72	3.5	25.2	6.7[bb]	1.5	Myanmar
2.4	61	–	–	10.7	18.4	7.1	5.0	Namibia
1.9	–	–	–	7.4	15.0	–	3.7	Nauru
1.3	39	–	73	4.6	30.4	12.0	1.8	Nepal
2.1	90	2	7	15.4	1.6	–	5.0	Netherlands
7.3	87	–	–	19.3	–	–	–	New Zealand
1.9	83	–	–	18.8	14.1	2.2	7.5	Nicaragua
–	10	–	–	8.4	46.7	9.8[ao]	1.9	Niger
1.2	54	–	–	4.4	35.3	6.5	2.7	Nigeria
–	–	–	–	5.0	–	–	–	Niue
–	–	–	64	12.4	4.1	3.4	10.0	North Macedonia
8.5	94	1	6	17.4	–	–	–	Norway
5.3	79	–	55	8.0	12.2	9.3[bd]	4.8	Oman
1.5	52	65	89	5.3	36.7	7.1[be]	3.4	Pakistan
–	64	–	–	16.8	–	–	–	Palau
2.2	79	–	–	21.4	14.7	–	10.8	Panama
0.1	–	–	–	7.4	48.4	–	8.9	Papua New Guinea
0.3	65	–	–	15.3	4.6	1.0	12.0	Paraguay
0.5	59	–	–	15.3	10.8	0.4	8.0	Peru
3.3	69	51	40	6.6	28.7	5.6	4.2	Philippines
7.7	50	15	16	10.8	2.3	0.7[ap,bf]	6.7	Poland
9.1	82	–	–	13.4	3.3	0.6[bb]	8.5	Portugal
8.9	92	34	49	6.3	4.6	–	13.9	Qatar
7.4	98	49	37	14.0	2.2	–	8.8	Republic of Korea
4.1	62	–	–	12.0	4.9	1.9[bg]	4.3	Republic of Moldova
9.1	67	–	–	12.7	9.7	–	6.7	Romania
0.5	100	23	58	9.8	–	–	–	Russian Federation
0.7	73	–	–	8.9	32.6	1.1	5.2	Rwanda
–	51	–	–	7.4	–	–	–	Saint Kitts and Nevis
4.4	69	–	–	8.2	2.8	3.7	6.9	Saint Lucia
–	–	–	–	10.1	–	–	–	Saint Vincent and the Grenadines
0.7	–	–	–	11.0	6.8	3.1	7.1	Samoa
6.7	–	–	–	23.4	–	–	–	San Marino
–	31	–	–	10.8	11.8	4.1	4.0	Sao Tome and Principe
8.6	79	49	57	10.9	3.9	–	7.6	Saudi Arabia
0.1	62	–	–	4.3	17.2	8.1	2.1	Senegal
8.1	71	–	–	12.4	5.3	2.6	10.8	Serbia
4.7	56	–	–	10.2	7.4	4.3[bh]	9.8	Seychelles
0.1	49	–	–	7.2	26.8	5.4	4.7	Sierra Leone
5.1	92	29	29	15.3	2.8	–	4.8	Singapore
8.0	72	–	–	12.7	–	–	–	Slovakia
7.1	–	–	–	13.8	–	–	–	Slovenia
1.2	47	–	–	7.9	29.3	8.5	4.0	Solomon Islands
–	–	–	–	–	27.4	–	2.9	Somalia

ANNEX 2
Part 3

	3.b						3.c		
	Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds[t] (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age[t] (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year-olds[t] (%)	Human papillomavirus (HPV) immunization coverage estimates among 15-year-old girls[t] (%)	Total net official development assistance to medical research and basic health sectors per capita[u] (US$), by recipient country	Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis[v] (%)	Density of medical doctors[w] (per 10 000 population)	Density of nursing and midwifery personnel[w] (per 10 000 population)	Density of dentists[w] (per 10 000 population)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Primary data	Primary data	Primary data
Member State	**2019**	**2019**	**2019**	**2019**	**2019**	**2011–2019**	**2010–2019**	**2010–2019**	**2010–2019**
South Africa	77	54	76	56[at]	1.88	–	7.9	13.1	1.1
South Sudan	49	–	–	–	18.90	–	–	–	–
Spain	96	94	95	79[bi]	–	–	40.3	60.8	8.2
Sri Lanka	99	99	–	82	0.76	–	11.5	22.6	1.1
Sudan	93	74	93	–	2.81	41.0	2.6	11.5	2.1
Suriname	77	58	–	38	2.78	–	8.2	39.3	0.6
Sweden	98	95	97	80[aq]	–	–	43.3	216.7	17.9
Switzerland	96	90	84	59[bj]	–	–	43.3	178.9	5.1
Syrian Arab Republic	54	54	–	–	1.88	–	12.9	15.4	7.2
Tajikistan	97	97	–	–	2.89	15.0	17.2	47.5	1.6
Thailand	97	87	–	66	0.35	–	9.2	31.5	2.7
Timor-Leste	83	80	–	–	15.19	–	7.7	17.6	0.1
Togo	84	67	83	–	3.74	–	0.8	4.6	–
Tonga	99	99	–	–	16.79	–	5.4	43.3	1.6
Trinidad and Tobago	93	92	93	9[ar]	–	0.0[as]	44.8	40.7	3.2
Tunisia	92	93	–	–	0.33	–	13.0	25.1	3.1
Turkey	99	88	97	–	0.91	–	18.1	30.0	3.7
Turkmenistan	99	99	–	99[ar,bk]	0.44	–	22.2	44.3	1.2
Tuvalu	92	92	–	–	17.80	–	9.1	42.6	4.5
Uganda	93	–	92	64	6.60	–	1.7	12.4	0.1
Ukraine	80	92	–	–	1.30	–	29.9	66.6	6.0
United Arab Emirates	99	99	99	27[az]	–	–	25.3	57.3	6.5
United Kingdom	93	87	91	82	–	–	58.2	102.9	5.3
United Republic of Tanzania	89	72	83	49	5.17	0.0[as]	0.6	5.8	0.1
United States of America	94	95	92	39[at]	–	–	26.0	156.9	6.1
Uruguay	94	99	95	38	–	–	49.4	72.2	14.5
Uzbekistan	96	99	99	–	1.57	–	23.7	112.8	1.5
Vanuatu	90	–	–	–	14.49	–	1.7	14.2	0.3
Venezuela (Bolivarian Republic of)	64	13	–	–	0.08	–	17.3	20.7	1.4
Viet Nam	89	92	–	–	0.84	–	8.3	14.5	–
Yemen	73	46	72	–	6.24	–	5.3	7.9	0.2
Zambia	88	66	89	–	11.67	16.7[as]	0.9	10.2	0.1
Zimbabwe	90	75	90	67[bm]	8.19	–	2.1	19.3	0.2
WHO region	**2018**	**2018**	**2018**	**2018**	**2018**		**2018**	**2018**	
African Region	74	33	70	–	5.34	–	2.8	10.3	–
Region of the Americas	84	75	83	–	0.36	–	28.4	82.7	–
South-East Asia Region	91	83	23	–	0.48	–	8.7	24.5	–
European Region	95	92	80	–	1.28	–	43.2	77.8	–
Eastern Mediterranean Region	82	75	52	–	1.89	–	10.9	16.4	–
Western Pacific Region	94	91	14	–	0.32	–	18.9	36.9	–
Global	85	71	48	–	1.44	–	17.5	39.0	–

3.c	3.d			1.a	2.2			
Density of pharmacists[w] (per 10 000 population)	Average of 13 International Health Regulations core capacity scores[x]	Percentage of bloodstream infections due to methicillin-resistant Staphylococcus aureus[y] (MRSA) (%)	Percentage of bloodstream infections due to Escherichia coli resistant to 3rd-generation cephalosporin (e.g., ESBL- E. coli)[y] (%)	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE)[z] (%)	Prevalence of stunting in children under 5[aa] (%)	Prevalence of wasting in children under 5[aa] (%)	Prevalence of overweight in children under 5[aa] (%)	
Primary data	Primary data	Primary data	Primary data	Comparable estimates	Comparable estimates	Primary data	Comparable estimates	
2010–2019	2020	2019	2019	2018	2020	2011–2020	2020	**Member State**
2.7	79	21	31	13.3	23.2	3.4[ap,bb]	12.9	South Africa
–	36	–	–	2.1	30.6	–	5.7	South Sudan
11.9	88	–	–	15.2	–	–	–	Spain
0.9	62	56	63	8.3	16.0	15.1	1.3	Sri Lanka
0.3	53	48	–	6.8	33.7	16.3[ao]	2.7	Sudan
0.4	59	–	–	16.8	8.0	5.5	4.0	Suriname
15.7	91	2	8	18.6	–	–	–	Sweden
6.9	–	4	10	11.0	–	–	–	Switzerland
10.7	49	–	–	–	29.6	–	18.2	Syrian Arab Republic
–	–	–	–	6.1	15.3	5.6	3.5	Tajikistan
6.3	85	12	37	15.0	12.3	7.7	9.2	Thailand
2.1	42	–	–	5.4	48.8	9.9[ao]	2.6	Timor-Leste
0.3	45	–	–	4.3	23.8	5.7	2.4	Togo
0.4	65	–	–	7.5	2.6	1.1	12.6	Tonga
6.6	–	–	–	11.0	8.7	6.4	11.0	Trinidad and Tobago
2.3	74	17	36	13.6	8.6	2.1	16.5	Tunisia
3.9	88	–	–	9.3	–	1.7	–	Turkey
1.7	68	–	–	8.7	7.6	4.1	3.8	Turkmenistan
2.7	48	–	–	13.7	9.7	–	6.4	Tuvalu
–	69	–	60	5.1	27.9	3.5	4.0	Uganda
0.3	69	–	–	8.9	15.9	–	17.0	Ukraine
8.8	96	36	46	7.2	–	–	–	United Arab Emirates
8.7	95	10	11	19.2	–	–	–	United Kingdom
0.1	51	–	–	9.4	32.0	3.5[bl]	5.5	United Republic of Tanzania
–	92	–	–	22.5	3.2	0.1	8.8	United States of America
–	80	–	–	20.2	6.5	1.4	10.3	Uruguay
0.4	55	–	–	7.9	9.9	1.8[ao]	5.0	Uzbekistan
1.2	55	–	–	7.0	28.7	4.7[ao]	4.9	Vanuatu
–	74	–	–	3.7	10.6	–	6.7	Venezuela (Bolivarian Republic of)
3.4	72	–	–	9.3	22.3	5.8	6.0	Viet Nam
1.1	49	–	–	–	37.2	16.4	2.7	Yemen
0.4	58	–	–	7.0	32.3	4.2	5.7	Zambia
1.0	52	–	–	7.6	23.0	2.9	3.6	Zimbabwe

	2019			2017	2019	2019	2019	**WHO region**
–	48	–	–	6.8	31.7	5.8	4.2	African Region
–	72	–	–	13.9	8.9	0.7	8.0	Region of the Americas
–	63	–	–	8.1	30.1	14.5	3.3	South-East Asia Region
–	74	–	–	12.5	5.7	–	7.9	European Region
–	67	–	–	8.6	26.2	7.4	7.7	Eastern Mediterranean Region
–	70	–	–	10.0	9.3	2.1	7.5	Western Pacific Region

–	64	25	37	10.0	22.0	6.7	5.7	**Global**

ANNEX 2
Part 4

	2.2 continued	5.2		6.1	6.2		6.3	7.1
	Prevalence of anaemia in women of reproductive age (15–49 years)[ab] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months[ac] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime[ac] (%)	Proportion of population using safely-managed drinking-water services[ad] (%)	Proportion of population using safely-managed sanitation services[ad] (%)	Proportion of population using a hand-washing facility with soap and water[ad] (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan[ae] (current US$ millions)	Proportion of population with primary reliance on clean fuels and technology[af] (%)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Comparable estimates
Member State	**2019**	**2018**	**2018**	**2017**	**2017**	**2017**	**2019**	**2019**
Afghanistan	42.6	35	46	–	–	38	142.90	36
Albania	24.8	6	13	70	40	–	46.55	81
Algeria	33.3	–	–	–	18	84	7.49	99
Andorra	12.1	–	–	91	>99	–	–	100 [bn]
Angola	44.5	25	38	–	–	27	21.65	50
Antigua and Barbuda	17.2	–	–	–	–	–	1.14	100 [bn]
Argentina	11.9	5	27	–	–	–	20.01	100
Armenia	17.3	5	10	86	48	94	6.33	98
Australia	8.5	3	23	–	76	–	–	100 [bn]
Austria	13.0	4	15	99	97	–	–	100 [bn]
Azerbaijan	35.1	5	14	74	–	83	94.57	97
Bahamas	14.5	–	–	–	–	–	–	100 [bn]
Bahrain	35.4	–	–	99	96	–	–	100 [bn]
Bangladesh	36.7	23	50	55	–	35	330.37	23
Barbados	17.0	–	–	–	–	–	–	100 [bn]
Belarus	20.6	6	21	95	81	–	3.05	99
Belgium	13.6	5	22	>99	97	–	–	100 [bn]
Belize	20.5	8	24	–	–	90	1.27	82
Benin	55.2	15	26	–	–	11	52.42	4
Bhutan	38.6	9	22	36	–	–	21.72	79
Bolivia (Plurinational State of)	24.4	18	42	–	23	25	140.30	86
Bosnia and Herzegovina	24.4	3	12	89	22	–	26.67	46
Botswana	32.5	17	34	–	–	–	0.18	53
Brazil	16.1	6	23	–	49	–	42.08	96
Brunei Darussalam	16.7	–	–	–	–	–	–	100 [bn]
Bulgaria	23.6	6	19	97	64	–	–	–
Burkina Faso	52.5	11	19	–	–	12	159.97	10
Burundi	38.5	22	40	–	–	6	86.35	0
Cabo Verde	24.3	11	19	–	–	–	–	78
Cambodia	47.1	9	19	26	–	66	177.01	31
Cameroon	40.6	22	39	–	–	9	148.12	22
Canada	10.4	3	–	99	82	–	–	100 [bn]
Central African Republic	46.8	21	29	–	–	–	6.30	1
Chad	45.4	16	29	–	–	6	21.37	4
Chile	8.7	6	21	99	77	–	–	100 [bn]
China	15.5	8	19	–	72	–	83.15	64
Colombia	21.2	12	30	73	17	65	15.12	94
Comoros	33.8	8	16	–	–	–	9.42	7
Congo	48.8	–	–	45	–	48	12.13	34
Cook Islands	27.1	14	33	–	–	–	1.77	78
Costa Rica	13.7	7	27	94	–	–	13.22	96
Côte d'Ivoire	50.9	16	27	37	–	19	29.56	30
Croatia	21.0	4	13	90	58	–	–	100 [bn]
Cuba	19.3	5	14	–	44	85	16.70	–
Cyprus	13.6	3	16	>99	75	–	–	100 [bn]
Czechia	21.1	4	22	98	94	–	–	100 [bn]
Democratic People's Republic of Korea	33.9	–	–	67	–	–	1.14	11
Democratic Republic of the Congo	42.4	36	47	–	–	4	115.66	5
Denmark	12.2	3	23	97	95	–	–	100 [bn]
Djibouti	32.3	–	–	–	36	–	43.36	9
Dominica	20.8	–	–	–	–	–	0.29	83
Dominican Republic	26.4	10	19	–	–	55	2.34	91
Ecuador	17.2	8	33	75	42	81	48.89	94

11.6	16.1	GPW 13				
Annual mean concentrations of fine particulate matter ($PM_{2.5}$) in urban areas[af] ($\mu g/m^3$)	Mortality rate due to homicide[c,l] (per 100 000 population)	Number of cases of poliomyelitis caused by wild poliovirus (WPV)[ag]	Age-standardized prevalence of raised blood pressure among persons aged 18+ years[ah] (SBP of >140 mmHg and/or DBP >90 mmHg)	Prevalence of obesity among children and adolescents (5–19 years)[ah] (%)	Age-standardized prevalence of obesity among adults (18+ years)[ah] (%)	
Comparable estimates	Comparable estimates	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	
2016	2019	2020	2015	2016	2016	**Member State**
59.9	8.5	56	30.6	3.1	5.5	Afghanistan
18.2	3.6	0	29.0	7.6	21.7	Albania
34.5	1.7	0	25.1	13.5	27.4	Algeria
11.5	–	–	18.7	12.8	25.6	Andorra
28.4	9.2	0	29.7	2.4	8.2	Angola
18.0	2.4	0	23.4	11.5	18.9	Antigua and Barbuda
11.7	6.1	0	22.6	16.9	28.3	Argentina
32.9	3.8	0	25.5	4.8	20.2	Armenia
7.3	1.0	0	15.2	12.4	29.0	Australia
13.1	0.5	0	21.0	8.6	20.1	Austria
18.5	2.5	0	24.5	4.9	19.9	Azerbaijan
19.0	38.1	0	20.9	17.3	31.6	Bahamas
69.0	0.3	0	21.4	17.2	29.8	Bahrain
58.6	2.8	0	24.7	2.6	3.6	Bangladesh
22.4	11.3	0	24.4	12.3	23.1	Barbados
19.3	2.7	0	27.1	7.6	24.5	Belarus
13.0	1.3	0	17.5	7.0	22.1	Belgium
20.9	37.3	0	22.7	12.2	24.1	Belize
30.4	6.2	0	27.7	2.6	9.6	Benin
35.4	2.4	0	28.1	3.3	6.4	Bhutan
23.3	9.5	0	17.9	9.1	20.2	Bolivia (Plurinational State of)
29.7	1.5	0	30.8	5.4	17.9	Bosnia and Herzegovina
20.9	16.9	0	29.6	6.3	18.9	Botswana
11.8	32.6	0	23.3	10.8	22.1	Brazil
5.8	0.7	0	18.9	14.1	14.1	Brunei Darussalam
20.8	1.2	0	28.4	10.8	25.0	Bulgaria
36.3	9.6	0	32.6	1.0	5.6	Burkina Faso
35.6	6.6	0	29.2	1.9	5.4	Burundi
31.6	13.4	0	29.5	3.1	11.8	Cabo Verde
24.9	2.1	0	26.1	3.2	3.9	Cambodia
65.4	6.4	0	24.8	2.8	11.4	Cameroon
6.7	1.6	0	13.2	12.3	29.4	Canada
51.2	21.3	0	31.2	2.2	7.5	Central African Republic
50.8	9.0	0	32.9	1.5	6.1	Chad
23.1	3.9	0	20.9	15.2	28.0	Chile
51.0	0.8	0	19.2	11.7	6.2	China
17.2	38.3	0	19.2	7.0	22.3	Colombia
18.6	7.4	0	27.9	2.8	7.8	Comoros
36.4	10.0	0	26.2	2.0	9.6	Congo
12.0	–	0	22.3	32.2	55.9	Cook Islands
16.7	12.6	0	18.7	12.3	25.7	Costa Rica
23.9	11.5	0	27.2	3.4	10.3	Côte d'Ivoire
17.6	1.1	0	32.4	10.9	24.4	Croatia
21.6	5.1	0	19.0	11.4	24.6	Cuba
17.1	1.3	0	19.8	12.2	21.8	Cyprus
15.6	0.6	0	27.9	9.7	26.0	Czechia
31.0	4.2	0	18.2	8.5	6.8	Democratic People's Republic of Korea
37.4	12.8	0	28.5	2.2	6.7	Democratic Republic of the Congo
10.3	1.1	0	20.6	7.2	19.7	Denmark
41.0	6.6	0	26.8	5.3	13.5	Djibouti
18.8	–	0	22.5	15.0	27.9	Dominica
13.3	17.8	0	21.5	15.0	27.6	Dominican Republic
15.5	7.0	0	17.9	9.4	19.9	Ecuador

ANNEX 2
Part 4

	2.2 continued	5.2		6.1	6.2		6.3	7.1
	Prevalence of anaemia in women of reproductive age (15–49 years)[ab] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months[ac] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime[ac] (%)	Proportion of population using safely-managed drinking-water services[ad] (%)	Proportion of population using safely-managed sanitation services[ad] (%)	Proportion of population using a hand-washing facility with soap and water[ad] (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan[ae] (current US$ millions)	Proportion of population with primary reliance on clean fuels and technology[af] (%)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Comparable estimates
Member State	**2019**	**2018**	**2018**	**2017**	**2017**	**2017**	**2019**	**2019**
Egypt	28.3	15	30	–	61	90	350.22	100
El Salvador	10.6	6	21	–	–	91	10.20	89
Equatorial Guinea	44.5	29	46	–	–	–	0.00	24
Eritrea	37.0	–	–	–	–	–	3.48	9
Estonia	21.7	4	21	93	97	–	–	100 [bn]
Eswatini	30.7	18	–	–	–	24	2.82	55
Ethiopia	23.9	27	37	11	–	8	264.43	7
Fiji	32.0	23	52	–	–	–	18.31	50
Finland	10.9	8	23	>99	>99	–	–	100 [bn]
France	10.6	5	22	98	88	–	–	100 [bn]
Gabon	52.4	22	41	–	–	–	0.52	88
Gambia	49.5	10	–	–	–	8	1.71	1
Georgia	27.5	3	10	80	27	–	47.19	88
Germany	11.7	5	21	>99	97	–	–	100 [bn]
Ghana	35.4	10	24	36	–	41	62.18	23
Greece	15.1	5	18	>99	90	–	–	100 [bn]
Grenada	19.2	8	28	87	–	–	0.35	89
Guatemala	7.4	7	21	56	–	77	19.52	49
Guinea	48.0	21	37	–	–	17	28.77	2
Guinea–Bissau	48.1	–	–	–	–	6	5.23	1
Guyana	31.7	10	31	–	–	77	4.63	77
Haiti	47.7	12	23	–	–	23	41.28	4
Honduras	18.0	7	17	–	–	–	45.26	45
Hungary	19.7	6	19	90	96	–	–	100 [bn]
Iceland	10.3	3	21	>99	82	–	–	100 [bn]
India	53.0	18	35	–	–	60	373.63	64
Indonesia	31.2	9	22	–	–	64	130.99	82
Iran (Islamic Republic of)	24.1	18	31	92	–	–	2.41	96
Iraq	28.6	–	26	59	41	95	90.79	99
Ireland	12.1	3	16	97	82	–	–	100 [bn]
Israel	12.9	6	–	>99	94	–	–	100 [bn]
Italy	13.6	4	16	95	96	–	–	100 [bn]
Jamaica	19.9	7	24	–	–	–	0.37	83
Japan	19.0	4	20	98	99	–	–	100 [bn]
Jordan	37.7	13	24	94	81	–	300.65	100
Kazakhstan	28.7	6	16	90	–	99	1.09	98
Kenya	28.7	23	38	–	–	25	200.06	17
Kiribati	32.6	25	53	–	–	–	4.96	10
Kuwait	23.7	–	–	>99	>99	–	–	100 [bn]
Kyrgyzstan	35.8	13	23	68	–	89	14.67	77
Lao People's Democratic Republic	39.5	8	19	16	58	50	76.53	8
Latvia	21.6	6	25	95	86	–	–	100 [bn]
Lebanon	28.3	–	–	48	22	–	120.71	–
Lesotho	27.9	16	40	–	–	2	8.19	39
Liberia	42.6	27	43	–	–	1	26.02	0
Libya	29.9	–	–	–	26	–	–	–
Lithuania	19.9	5	22	92	91	–	–	100 [bn]
Luxembourg	10.2	4	20	>99	97	–	–	100 [bn]
Madagascar	37.8	–	–	–	–	–	43.34	1
Malawi	31.4	17	30	–	–	9	87.60	2
Malaysia	32.0	–	19	93	89	–	28.93	96
Maldives	52.2	6	19	–	–	96	7.87	99
Mali	59.0	18	29	–	19	52	122.79	1

11.6	16.1	GPW 13				
Annual mean concentrations of fine particulate matter ($PM_{2.5}$) in urban areas[af] ($\mu g/m^3$)	Mortality rate due to homicide[c,l] (per 100 000 population)	Number of cases of poliomyelitis caused by wild poliovirus (WPV)[ag]	Age-standardized prevalence of raised blood pressure among persons aged 18+ years[ah] (SBP of >140 mmHg and/or DBP >90 mmHg)	Prevalence of obesity among children and adolescents (5–19 years)[ah] (%)	Age-standardized prevalence of obesity among adults (18+ years)[ah] (%)	
Comparable estimates	Comparable estimates	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	
2016	2019	2020	2015	2016	2016	**Member State**
79.6	4.1	0	25.0	17.6	32.0	Egypt
23.8	85.0	0	18.7	11.7	24.6	El Salvador
49.1	3.3	0	28.4	2.3	8.0	Equatorial Guinea
41.1	11.0	0	29.1	2.1	5.0	Eritrea
7.0	2.1	0	27.4	6.3	21.2	Estonia
16.2	18.5	0	29.8	6.0	16.5	Eswatini
34.0	7.2	0	30.3	1.1	4.5	Ethiopia
10.5	2.2	0	21.7	11.5	30.2	Fiji
6.5	1.2	0	19.4	9.1	22.2	Finland
12.4	0.8	0	22.0	8.1	21.6	France
37.8	8.5	0	25.5	4.2	15.0	Gabon
32.3	8.3	0	29.1	2.8	10.3	Gambia
24.0	2.3	0	26.3	6.8	21.7	Georgia
11.9	0.9	0	19.9	8.9	22.3	Germany
31.1	6.1	0	23.7	2.1	10.9	Ghana
16.4	1.0	0	19.1	13.8	24.9	Greece
21.8	6.6	0	24.3	10.7	21.3	Grenada
24.2	25.1	0	21.2	9.9	21.2	Guatemala
22.2	8.8	0	30.3	1.7	7.7	Guinea
26.5	9.0	0	30.3	2.4	9.5	Guinea–Bissau
21.6	24.7	0	23.1	10.0	20.2	Guyana
14.7	20.7	0	24.5	10.9	22.7	Haiti
21.5	66.9	0	21.4	9.6	21.4	Honduras
16.3	1.4	0	30.0	11.1	26.4	Hungary
5.9	1.2	0	19.7	9.9	21.9	Iceland
68.0	3.8	0	25.8	2.0	3.9	India
16.4	4.3	0	23.8	6.1	6.9	Indonesia
34.4	3.1	0	19.7	9.8	25.8	Iran (Islamic Republic of)
60.1	14.4	0	25.2	14.4	30.4	Iraq
8.7	0.8	0	19.7	9.8	25.3	Ireland
19.4	1.2	0	16.6	11.9	26.1	Israel
15.7	0.7	0	21.2	12.5	19.9	Italy
13.6	50.3	0	21.8	13.0	24.7	Jamaica
11.8	0.2	0	17.6	3.3	4.3	Japan
31.7	2.7	0	21.0	12.9	35.5	Jordan
14.5	5.1	0	27.1	6.5	21.0	Kazakhstan
25.8	5.6	0	26.7	2.3	7.1	Kenya
10.9	4.8	0	21.5	23.0	46.0	Kiribati
58.9	1.8	0	23.6	22.9	37.9	Kuwait
17.4	4.6	0	26.7	3.9	16.6	Kyrgyzstan
25.5	6.6	0	24.8	4.7	5.3	Lao People's Democratic Republic
14.4	5.0	0	29.4	7.0	23.6	Latvia
30.7	4.2	0	20.7	13.9	32.0	Lebanon
28.1	43.5	0	29.0	5.0	16.6	Lesotho
17.0	9.7	0	28.3	1.9	9.9	Liberia
41.7	2.1	0	23.7	14.6	32.5	Libya
12.3	4.8	0	29.3	6.8	26.3	Lithuania
10.4	0.5	0	21.9	8.3	22.6	Luxembourg
22.5	6.5	0	28.1	1.8	5.3	Madagascar
21.9	2.2	0	28.9	2.0	5.8	Malawi
17.3	2.7	0	22.9	12.7	15.6	Malaysia
7.7	1.9	0	24.4	7.4	8.6	Maldives
29.0	10.7	0	32.6	2.6	8.6	Mali

ANNEX 2
Part 4

	2.2 continued	5.2		6.1	6.2		6.3	7.1
	Prevalence of anaemia in women of reproductive age (15–49 years)[ab] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months[ac] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime[ac] (%)	Proportion of population using safely-managed drinking-water services[ad] (%)	Proportion of population using safely-managed sanitation services[ad] (%)	Proportion of population using a hand-washing facility with soap and water[ad] (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan[ae] (current US$ millions)	Proportion of population with primary reliance on clean fuels and technology[af] (%)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Comparable estimates
Member State	**2019**	**2018**	**2018**	**2017**	**2017**	**2017**	**2019**	**2019**
Malta	13.7	4	17	>99	93	–	–	100 [bn]
Marshall Islands	30.6	19	38	–	–	83	2.03	65
Mauritania	43.3	–	–	–	–	43	87.96	43
Mauritius	23.5	–	–	–	–	–	3.02	100
Mexico	15.3	10	24	43	50	88	2.33	85
Micronesia (Federated States of)	25.0	21	35	–	–	–	1.51	12
Monaco	12.3	–	–	>99	>99	–	–	100 [bn]
Mongolia	14.5	12	27	24	–	71	23.53	52
Montenegro	17.2	4	16	94	–	–	8.80	62
Morocco	29.9	10	–	70	39	–	229.53	98
Mozambique	47.9	16	30	–	–	–	114.10	5
Myanmar	42.1	11	19	–	–	79	142.00	30
Namibia	25.2	16	27	–	–	45	2.22	46
Nauru	29.6	20	43	–	–	–	0.17	100
Nepal	35.7	11	27	27	–	48	145.17	31
Netherlands	12.8	5	21	>99	97	–	–	100 [bn]
New Zealand	10.4	4	23	>99	89	–	–	100 [bn]
Nicaragua	15.7	6	23	52	–	–	66.07	55
Niger	49.5	13	–	–	10	–	157.30	2
Nigeria	55.1	13	24	20	27	42	193.93	13
Niue	27.3	–	–	97	–	–	0.01	98
North Macedonia	19.3	4	13	81	17	–	–	76
Norway	12.0	4	20	98	76	–	–	100 [bn]
Oman	29.1	–	–	90	–	97	–	100 [bn]
Pakistan	41.3	16	29	35	–	60	176.42	49
Palau	28.5	14	31	–	–	–	7.14	100 [bn]
Panama	21.2	8	16	–	–	–	19.88	100 [bn]
Papua New Guinea	34.4	31	51	–	–	–	26.92	9
Paraguay	23.0	6	18	64	58	80	28.99	68
Peru	20.6	11	38	50	43	–	49.28	83
Philippines	12.3	6	14	47	52	78	92.13	47
Poland	–	3	13	>99	93	–	–	100 [bn]
Portugal	13.2	4	18	95	85	–	–	100 [bn]
Qatar	28.1	–	–	96	96	–	–	100 [bn]
Republic of Korea	13.5	8	–	98	>99	–	–	100 [bn]
Republic of Moldova	26.1	9	27	73	–	–	8.34	96
Romania	22.7	7	18	82	77	–	–	100
Russian Federation	21.1	–	–	76	61	–	–	90
Rwanda	17.2	23	38	–	–	5	48.53	2
Saint Kitts and Nevis	15.4	–	–	–	–	–	–	100 [bn]
Saint Lucia	14.3	–	–	–	–	–	0.21	97
Saint Vincent and the Grenadines	17.0	–	–	–	–	–	0.08	94
Samoa	26.8	18	40	59	48	–	7.77	36
San Marino	12.5	–	–	>99	77	–	–	100 [bn]
Sao Tome and Principe	44.2	18	27	–	–	41	6.23	3
Saudi Arabia	27.5	–	–	–	78	–	–	100 [bn]
Senegal	52.7	12	24	–	21	24	162.05	24
Serbia	22.8	4	17	75	25	–	46.88	66
Seychelles	25.1	–	–	–	–	–	–	100 [bn]
Sierra Leone	48.4	20	36	10	13	19	27.86	1
Singapore	13.0	2	11	>99	>99	–	–	100 [bn]
Slovakia	23.5	6	18	>99	83	–	–	100 [bn]
Slovenia	21.8	3	18	98	83	–	–	100 [bn]

11.6	16.1	GPW 13				
Annual mean concentrations of fine particulate matter ($PM_{2.5}$) in urban areas[af] ($\mu g/m^3$)	Mortality rate due to homicide[c,l] (per 100 000 population)	Number of cases of poliomyelitis caused by wild poliovirus (WPV)[ag]	Age-standardized prevalence of raised blood pressure among persons aged 18+ years[ah] (SBP of >140 mmHg and/or DBP >90 mmHg)	Prevalence of obesity among children and adolescents (5–19 years)[ah] (%)	Age-standardized prevalence of obesity among adults (18+ years)[ah] (%)	
Comparable estimates	Comparable estimates	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	
2016	2019	2020	2015	2016	2016	**Member State**
14.0	1.0	0	19.4	13.4	28.9	Malta
9.4	–	0	21.3	26.6	52.9	Marshall Islands
41.7	10.9	0	31.7	4.0	12.7	Mauritania
13.5	2.3	0	25.0	4.4	10.8	Mauritius
20.9	25.4	0	19.7	14.8	28.9	Mexico
10.5	4.6	0	25.0	20.7	45.8	Micronesia (Federated States of)
12.2	–	–	–	–	–	Monaco
49.5	6.1	0	29.0	4.3	20.6	Mongolia
19.3	2.8	0	29.1	7.6	23.3	Montenegro
31.1	1.7	0	26.1	10.2	26.1	Morocco
18.4	3.7	0	29.1	2.3	7.2	Mozambique
34.6	3.9	0	24.6	3.7	5.8	Myanmar
21.0	18.0	0	28.5	4.9	17.2	Namibia
12.5	–	0	20.5	33.2	61.0	Nauru
99.5	2.5	0	29.4	1.7	4.1	Nepal
12.1	0.6	0	18.7	7.0	20.4	Netherlands
5.8	1.2	0	16.2	16.3	30.8	New Zealand
19.0	9.4	0	20.8	10.8	23.7	Nicaragua
73.0	9.6	0	33.4	1.4	5.5	Niger
46.3	9.2	0	23.9	1.9	8.9	Nigeria
11.5	–	0	24.2	29.5	50.0	Niue
33.0	1.5	0	28.5	9.3	22.4	North Macedonia
7.8	0.6	0	19.7	9.1	23.1	Norway
36.2	0.7	0	24.8	14.9	27.0	Oman
56.2	6.0	84	30.5	3.1	8.6	Pakistan
12.4	–	0	22.9	31.4	55.3	Palau
12.0	17.2	0	19.9	10.5	22.7	Panama
11.5	11.0	0	25.6	9.8	21.3	Papua New Guinea
11.7	8.0	0	24.6	10.5	20.3	Paraguay
29.0	9.3	0	13.7	7.8	19.7	Peru
18.7	13.7	0	22.6	4.3	6.4	Philippines
21.5	0.8	0	28.7	9.1	23.1	Poland
8.1	0.9	0	24.4	10.4	20.8	Portugal
91.7	0.5	0	22.4	19.5	35.1	Qatar
24.7	0.8	0	11.0	8.5	4.7	Republic of Korea
16.5	4.1	0	29.8	4.2	18.9	Republic of Moldova
15.4	1.3	0	30.0	8.1	22.5	Romania
14.7	7.8	0	27.2	7.1	23.1	Russian Federation
40.7	4.3	0	26.7	1.7	5.8	Rwanda
12.3	–	0	25.3	12.3	22.9	Saint Kitts and Nevis
21.2	20.2	0	27.1	8.8	19.7	Saint Lucia
21.4	29.4	0	23.3	12.4	23.7	Saint Vincent and the Grenadines
10.9	2.8	0	24.0	21.7	47.3	Samoa
13.4	–	–	–	–	–	San Marino
25.2	5.6	0	25.8	3.5	12.4	Sao Tome and Principe
86.7	1.9	0	23.3	17.4	35.4	Saudi Arabia
39.7	7.6	0	30.2	1.8	8.8	Senegal
24.7	1.2	0	29.5	9.8	21.5	Serbia
18.6	14.8	0	23.5	10.8	14.0	Seychelles
20.6	7.9	0	30.3	2.5	8.7	Sierra Leone
18.3	0.3	0	14.6	6.8	6.1	Singapore
18.0	1.1	0	28.5	8.1	20.5	Slovakia
16.4	0.9	0	30.5	9.2	20.2	Slovenia

ANNEX 2
Part 4

	2.2 continued	5.2		6.1	6.2		6.3	7.1
	Prevalence of anaemia in women of reproductive age (15–49 years)[ab] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months[ac] (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime[ac] (%)	Proportion of population using safely-managed drinking-water services[ad] (%)	Proportion of population using safely-managed sanitation services[ad] (%)	Proportion of population using a hand-washing facility with soap and water[ad] (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan[ae] (current US$ millions)	Proportion of population with primary reliance on clean fuels and technology[af] (%)
Data type	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Comparable estimates
Member State	**2019**	**2018**	**2018**	**2017**	**2017**	**2017**	**2019**	**2019**
Solomon Islands	37.7	28	50	–	–	36	16.22	9
Somalia	43.1	–	–	–	–	10	16.49	3
South Africa	30.5	13	24	–	–	44	93.76	86
South Sudan	35.6	27	41	–	–	–	34.59	0
Spain	13.4	3	15	98	97	–	–	100 [bn]
Sri Lanka	34.6	4	24	–	–	–	144.23	31
Sudan	36.5	17	–	–	–	23	62.28	53
Suriname	21.0	8	28	–	–	–	1.05	94
Sweden	13.6	6	21	>99	93	–	–	100 [bn]
Switzerland	11.3	2	12	95	>99	–	–	100 [bn]
Syrian Arab Republic	32.8	–	–	–	–	71	25.88	97
Tajikistan	35.2	14	24	48	–	73	61.81	82
Thailand	24.0	9	24	–	–	84	3.07	80
Timor-Leste	29.9	28	38	–	–	28	3.18	13
Togo	45.7	13	25	–	–	10	14.56	9
Tonga	28.5	17	37	–	–	–	1.08	76
Trinidad and Tobago	17.7	7	28	–	–	–	–	100 [bn]
Tunisia	32.1	10	25	93	78	79	110.17	100
Turkey	–	12	32	–	65	–	50.39	95
Turkmenistan	26.6	–	–	94	–	>99	0.01	100
Tuvalu	27.5	20	39	–	6	–	0.03	69
Uganda	32.8	26	45	7	–	21	127.52	1
Ukraine	17.7	9	18	92	68	–	30.96	95
United Arab Emirates	24.3	–	–	–	96	–	–	100 [bn]
United Kingdom	11.1	4	24	>99	98	–	–	100 [bn]
United Republic of Tanzania	38.9	24	38	–	25	48	227.80	4
United States of America	11.8	6	26	>99	90	–	–	100 [bn]
Uruguay	15.0	4	18	–	–	–	–	100 [bn]
Uzbekistan	24.8	–	–	59	–	–	149.89	85
Vanuatu	28.5	29	47	44	–	25	4.73	8
Venezuela (Bolivarian Republic of)	24.2	8	19	–	24	–	0.17	97
Viet Nam	20.6	10	25	–	–	86	405.56	65
Yemen	61.5	–	–	–	–	50	71.18	61
Zambia	31.5	28	41	–	–	14	84.62	16
Zimbabwe	28.9	18	35	–	–	37	11.84	30

WHO region	**2019**	**2018**	**2018**	**2017**	**2017**	**2017**	**2019**	**2019**
African Region	40.4	20	33	29	20	28	2932.34	19
Region of the Americas	15.4	7	25	79	49	–	591.02	92
South-East Asia Region	46.6	17	33	–	–	60	1303.35	61
European Region	18.8	6	21	92	68	–	608.65	96
Eastern Mediterranean Region	34.9	17	31	56	–	66	1859.09	74
Western Pacific Region	16.4	8	20	–	67	–	979.49	67

Global	29.9	10	26	71	45	60	8846.42	66

11.6	16.1	GPW 13				
Annual mean concentrations of fine particulate matter ($PM_{2.5}$) in urban areas[af] ($\mu g/m^3$)	Mortality rate due to homicide[c,l] (per 100 000 population)	Number of cases of poliomyelitis caused by wild poliovirus (WPV)[ag]	Age-standardized prevalence of raised blood pressure among persons aged 18+ years[ah] (SBP of >140 mmHg and/or DBP >90 mmHg)	Prevalence of obesity among children and adolescents (5–19 years)[ah] (%)	Age-standardized prevalence of obesity among adults (18+ years)[ah] (%)	
Comparable estimates	Comparable estimates	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	
2016	2019	2020	2015	2016	2016	**Member State**
11.5	3.9	0	22.0	4.3	22.5	Solomon Islands
28.0	5.4	0	32.9	3.0	8.3	Somalia
24.3	35.9	0	26.9	11.3	28.3	South Africa
40.9	14.3	0	–	–	–	South Sudan
9.8	0.6	0	19.2	10.8	23.8	Spain
15.1	2.3	0	22.4	4.8	5.2	Sri Lanka
46.8	5.8	0	–	–	–	Sudan
25.8	5.8	0	22.4	13.9	26.4	Suriname
6.1	1.1	0	19.3	6.7	20.6	Sweden
10.4	0.5	0	18.0	5.8	19.5	Switzerland
37.4	2.6	0	24.5	11.5	27.8	Syrian Arab Republic
42.8	1.8	0	26.1	3.0	14.2	Tajikistan
26.6	4.3	0	22.3	11.3	10.0	Thailand
18.2	4.7	0	27.6	4.2	3.8	Timor-Leste
31.2	8.9	0	28.9	2.0	8.4	Togo
10.2	3.4	0	23.7	26.7	48.2	Tonga
22.4	39.4	0	25.8	11.1	18.6	Trinidad and Tobago
35.7	3.5	0	23.2	8.5	26.9	Tunisia
41.2	4.8	0	20.3	11.5	32.1	Turkey
24.2	2.8	0	25.4	4.7	18.6	Turkmenistan
11.4	–	0	23.7	27.2	51.6	Tuvalu
48.7	13.9	0	27.3	1.7	5.3	Uganda
19.4	6.3	0	27.1	7.0	24.1	Ukraine
37.2	0.7	0	21.1	17.3	31.7	United Arab Emirates
10.6	1.3	0	15.2	10.2	27.8	United Kingdom
25.1	8.1	0	27.3	2.5	8.4	United Republic of Tanzania
7.6	5.8	0	12.9	21.4	36.2	United States of America
8.7	8.5	0	20.7	13.8	27.9	Uruguay
28.9	1.5	0	25.6	4.0	16.6	Uzbekistan
11.0	2.3	0	24.2	8.3	25.2	Vanuatu
16.8	63.6	0	18.6	14.1	25.6	Venezuela (Bolivarian Republic of)
30.1	1.9	0	23.4	2.6	2.1	Viet Nam
44.3	9.7	0	30.7	7.0	17.1	Yemen
23.8	6.5	0	27.1	2.9	8.1	Zambia
19.1	13.1	0	28.2	4.0	15.5	Zimbabwe

2016	2019	2020	2015	2016	2016	**WHO region**
35.5	10.0	0	27.4	2.8	10.6	African Region
13.4	19.2	0	17.6	14.4	28.6	Region of the Americas
57.3	3.8	0	25.1	3.0	4.7	South-East Asia Region
17.6	2.9	0	23.2	8.6	23.3	European Region
54.0	5.3	140	26.3	8.2	20.8	Eastern Mediterranean Region
42.9	1.6	0	19.2	9.8	6.4	Western Pacific Region

39.6	6.2	140	22.1	6.8	13.1	**Global**

[a] World population prospects: 2019 revision. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2019 (https://population.un.org/wpp/, accessed 1 May 2021). For Member states with a total population less than 90 000, the male, female values are not shown but are included in the regional and global sums. Male and female may not sum to both sexes due to rounding.

[b] Global health estimates 2019: Life expectancy, 2000–2019. Geneva: World Health Organization; 2020 (https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/, accessed 1 May 2021).

[c] WHO Member States with a population of less than 90 000 in 2019 were not included in the analysis.

[d] Trends in maternal mortality: 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019 (https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/, accessed 1 May 2021). WHO Member States with populations less 100 000 in 2019 were not included in the analysis.

[e] Joint WHO/UNICEF Interagency database 2021 of skilled health personnel, based on population-based national household survey data and routine health systems. (https://unstats.un.org/sdgs/indicators/database/, accessed 1 May 2021).

[f] Levels and trends in child mortality. Report 2020. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. United Nations Children's Fund, World Health Organization, World Bank Group and United Nations Population Division. New York: United Nations Children's Fund; 2020 (https://www.unicef.org/reports/levels-and-trends-child-mortality-report-2020, accessed 1 May 2021).

[g] AIDSinfo [online database]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) (http://aidsinfo.unaids.org/, accessed 1 May 2021); and HIV/AIDS [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/new-hiv-infections-(per-1000-uninfected-population), accessed 1 May 2021).

[h] Global tuberculosis report 2020. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/336069/9789240013131-eng.pdf, accessed 1 May 2021).

[i] World malaria report 2020. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240015791, accessed 1 May 2021).

[j] Global progress report on HIV, viral hepatitis and sexually transmitted infections. Geneva: World Health Oganization (https://www.who.int/hiv/strategy2016-2021/progress-report-2019/en/, accessed 1 May 2021). This indicator is used here as a proxy for the SDG indicator.

[k] Neglected tropical diseases [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/neglected-tropical-diseases, accessed 1 May 2021).

[l] Global health estimates 2019: deaths by cause, age, sex, by country and by region, 2000–2019. Geneva: World Health Organization; 2020 (https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/, accessed 1 May 2021).

[m] WHO Global Information System on Alcohol and Health (GISAH) [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/levels-of-consumption/, accessed 1 May 2021).

[n] United Nations, Department of Economic and Social Affairs, Population Division (2020). World Contraceptive Use 2020 (POP/DB/CP/Rev2020). (https://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2020.asp, accessed 1 May 2021). Global and regional aggregates are from the United Nations, Department of Economic and Social Affairs, Population Division (2020). Estimates and Projections of Family Planning Indicators 2020.

[o] Most recent updates provided by the Population Division, DESA to the SDG Indicators United Nations Global SDG Database (https://unstats.un.org/sdgs/indicators/database/, accessed 1 May 2021). Global and regional aggregates are from the World population prospects: the 2019 revision. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2019 (https://population.un.org/wpp/Download/SpecialAggregates/UNrelated/, accessed 1 May 2021).

[p] Primary health care on the road to universal health coverage: 2019 monitoring report. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/fp_gmr_2019.pdf, accessed 1 May 2021). WHO Member States with a population of less than 90 000 in 2015 were not included in the analysis.

[q] The median most recent year within the 2011–2018 period is 2014. Primary health care on the road to universal health coverage: 2019 monitoring report. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/fp_gmr_2019.pdf, accessed 1 May 2021). Global and regional aggregates include country data not shown in the table.

[r] Public health and environment [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/public-health-and-environment/GHO/public-health-and-environment, accessed 1 May 2021).

[s] WHO global report on trends in prevalence of tobacco use 2000-2025, third edition. Geneva: World Health Organization; 2019 (https://www.who.int/publications-detail/who-global-report-on-trends-in-prevalence-of-tobacco-use-2000-2025-third-edition, accessed 1 May 2021).

[t] WHO/UNICEF estimates of national immunization coverage and human papillomavirus (HPV) vaccine coverage estimates [online database]. July 2021 revision for HPV vaccine (last dose in the schedule): percentage of 15 year-old girls who received the recommended doses of HPV vaccine is not yet available due to recent introduction and often targeting girls below 15 years of age. Currently performance of the programme in the previous calendar year based on target age group is used as proxy for the SDG indicator. For HPV, global and regional aggregates include all countries. For more details see: Brunei et al., 2021 (https://doi.org/10.1016/j.ypmed.2020.106399, accessed 1 May 2021).

[u] OECD.Stat [online database]. Paris: Organisation for Economic Co-operation and Development (https://stats.oecd.org/, accessed 1 May 2021).

[v] Data collected with the WHO Essential Medicines and Health Products Price and Availability Monitoring Mobile Application (WHO EMP MedMon): (https://www.who.int/medicines/areas/policy/monitoring/empmedmon/en/, accessed 1 May 2021) and Health Action International Medicine Prices, Availability, Affordability & Price Components Database (HAI/WHO): (https://haiweb.org/what-we-do/price-availability-affordability/price-availability-data/, accessed 1 May 2021).

[w] WHO Global Health Workforce Statistics [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/health-workforce, accessed 1 May 2021). Country comparisons are affected by differences in the occupations included. Please refer to the source for country-specific definitions and other descriptive metadata. The global averages were calculated using countries with values between 2013 and 2019.

[x] International Health Regulations (2005) - States Parties Annual Self-Assessment Reports - Monitoring Framework [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://extranet.who.int/e-spar/, accessed 1 May 2021). Responses received for SPAR 2020 annual report as of 16 April 2021. Regional and global averages include two IHR State Parties not shown in the table (Liechtenstein and Holy See). For full list of IHR States Parties please see https://www.who.int/ihr/legal_issues/states_parties/en/.

[y] Global Antimicrobial Resistance Surveillance System (GLASS). Geneva: World Health Organization; 2020. Global values are median of country figures and are not population weighted averages.

[z] Global Health Expenditure Database. Geneva: World Health Organization (https://apps.who.int/nha/database, accessed 1 May 2021). The WHO regional and global averages are unweighted. This indicator is presented here because it could constitute the health-related portion of the SDG Indicator 1.a.2.

[aa] Levels and trends in child malnutrition. UNICEF/WHO/World Bank Group Joint Child Malnutrition Estimates. New York, Geneva and Washington (DC): United Nations Children's Fund, World Health Organization and the World Bank Group; 2021.

[ab] Prevalence of anaemia in women of reproductive age (Global Health Observatory) [online database]. Geneva: World Health Organization; 2019 (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-anaemia-in-women-of-reproductive-age-(-), accessed 1 May 2021).

[ac] Violence against women prevalence estimates, 2018. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/violence-against-women-prevalence-estimates, accessed 1 May 2021). Given the lack of consensus on the definition and standardized measurement of psychological intimate partner violence, the current estimates only include physical and/or sexual partner violence. As majority of the available survey data on intimate partner violence are for women aged 15-49, with sparse data for women aged 15 years and older, the estimates are presented for the 15-49 age group. This is useful for tracking progress, but we encourage countries to include women 50 years and above in all violence against women surveys.

[ad] Progress on drinking water, sanitation and hygiene – 2017 update and SDG baselines. Geneva and New York: World Health Organization and United Nations Children's Fund; 2017 (https://washdata.org/sites/default/files/documents/reports/2018-01/JMP-2017-report-final.pdf, accessed 1 May 2021); and Water and sanitation [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/water-sanitation-and-hygiene-exposure, accessed 1 May 2021). Comparable estimates are only shown for countries with recent primary data.

[ae] Official development assistance for the water sector (water supply and sanitation, agricultural water resources, and hydro-electric power plants), OECD-CRS, 2019 (https://stats.oecd.org/Index.aspx?DataSetCode=crs1, accessed 1 May 2021). Includes CRS purpose codes for water supply and sanitation (CRS 14000), agricultural water resources (CRS 31140), and hydro-electric power plants (CRS 23220).

[af] Public health and environment [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/public-health-and-environment/GHO/public-health-and-environment, accessed 1 May 2021).

[ag] Data from World Health Organization, Polio Eradication Initiative, as of 17 February 2020. (Updated information can be found at: http://www.who.int/immunization_monitoring/en/diseases/poliomyelitis/case_count.cfm, accessed 1 May 2021).

[ah] Risk factors in noncommunicable diseases [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/noncommunicable-diseases---risk-factors, accessed 1 May 2021).

[ai] Non-standard definition. For more details see the Joint UNICEF/WHO database of skilled health personnel (footnote e).

[aj] Proportion of institutional births (%) used as proxy for the SDG indicator.

[ak] The most recent national official estimates of neonatal, infant and under-five mortality rates in India are from the India Sample Registration System with a rate of 23, 32 and 36 deaths per 1000 live births, respectively, in the year 2018.

[al] The most recent national official estimates of neonatal, infant and under-five mortality rates in Zambia are from the 2018 Zambia Demographic and Health Survey (2018 ZDHS) with a rate of 27, 42 and 61 deaths per 1000 live births, respectively, in the 5-year period before the survey.

[am] Data pertain to a non-standard age or marital status group. For more details, see the World Contraceptive Use 2020 (footnote n).

[an] Estimate refers to smoking only, but expected to be similar to all tobacco use.

[ao] Oedema data was not considered in the analysis.

[ap] Height/length modality (standing/lying) was not collected.

[aq] Estimate based on reported official coverage.

[ar] Proxy estimate based on reported data for both sexes together.

[as] Estimate extrapolated from previous years.

[at] Data for capital city only.

[au] Reduced age range/interval 36–59 months; unadjusted.

[av] Reduced age range/interval 12–60 months; unadjusted.

[aw] Height/length modality (standing/lying) was not collected excluding Haute Kotto.

[ax] Estimate based on reported coverage from the national vaccination registry.

[ay] Reflects population vaccinated before the implementation of the human papillomavirus programme (pilot/demo projects).

[az] Subnational introduction.

[ba] National Surveillance System; Kuwaiti citizens.

[bb] Reduced age range: age 0–5 months not covered; unadjusted.

[bc] Proxy estimate based on reported coverage by age 14 (registry).

[bd] Omani citizens.

[be] Excludes Azad Jammu and Kashmir and Gilgit Baltistan regions.

[bf] Reduced age range: interval 24–59 months; unadjusted.

[bg] Excludes Transnistria.

[bh] Health centres (80% coverage); 0–60 months.

[bi] Proxy estimate based on reported coverage by age 13 (registry).

[bj] Estimate based on survey data. Females 16 years of age at time of the survey.

[bk] Coverage over 100% truncated to 99%. May indicate problems with the accuracy of data.

[bl] Oedema data was considered in the analysis.

[bm] Survey data (subnational) indicate 80% coverage.

[bn] For high-income countries with no information on clean fuel use, usage is assumed to be 100%.

ANNEX 3

WHO regional groupings

WHO African Region: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

WHO Region of the Americas: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of).

WHO South-East Asia Region: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

WHO European Region: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan.

WHO Eastern Mediterranean Region: Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen.

WHO Western Pacific Region: Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Viet Nam.

ANNEX 4

Availability of disaggregated data for GPW13 outcome indicators

Disaggregated data for GPW 13 impact measurement– including outcome indicators as well as indicators used to monitor HALE and the Triple Billion targets– were compiled from a range of data sources. These included:

- Data from publicly available datasets based on demographic and health surveys (DHS), multiple indicator cluster surveys (MICS) and reproductive health surveys (RHS). The disaggregated data are published in the Health Equity Monitor database, with the re-analysis done by the International Center for Equity in Health in the Federal University of Pelotas, Brazil, a WHO Collaborating Centre for Health Equity Monitoring.

- WHO estimates from the Global Health Estimates (GHE) as well as estimates produced by WHO programmes and published in the WHO Global Health Observatory.

- Water supply, sanitation and hygiene (WASH) estimates from the WHO/UNICEF Joint Monitoring Programme (JMP).

- UNICEF-WHO-World Bank Joint Malnutrition Estimates from the WHO Global Database on Child Growth and Malnutrition.

The availability of disaggregated data was assessed across five inequality dimensions: age, economic status, education, place of residence and sex (Tables A4.1 and A4.2). The number of WHO Member States with disaggregated data available was calculated by indicator and inequality dimension. Estimates from the latest year available and survey data collected between 2010 and 2019 were used for the calculation.

Table A4.1. Number of WHO Member States with publicly available disaggregated data, by dimension of inequality and GPW 13 outcome indicators

SDG/WHA	Indicator	Data source (year)*	Age	Economic status	Education	Place of residence	Sex
SDG 2.2.1	Stunting prevalence in children aged <5 years (%)	Surveys	84	86	71	85	86
SDG 2.2.2	Overweight prevalence in children aged <5 years (%)	Surveys	84	86	71	85	86
SDG 2.2.2	Wasting prevalence in children aged <5 years (%)	Surveys	84	86	71	85	86
SDG 3.1.1	Maternal mortality ratio (per 100 000 live births)						
SDG 3.1.2	Births attended by skilled health personnel (in the two or three years preceding the survey) (%)	Surveys		93	74	95	
SDG 3.2.1	Under-five mortality rate (deaths per 1000 live births)	Surveys/ Estimates (2019)**		76	64	76	193
SDG 3.2.2	Neonatal mortality rate (deaths per 1000 live births)	Surveys		76	64	76	76
SDG 3.3.1	Number of new HIV infections (per 1000 uninfected population)	Estimates (2019)					107
SDG 3.3.2	Tuberculosis incidence (per 100 000 population)	Estimates (2019)	182				182
SDG 3.3.3	Malaria incidence (per 1000 population at risk)						
SDG 3.3.4	Hepatitis B incidence (per 100 000 population)						
SDG 3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease (%)	Estimates (2019)					183
SDG 3.4.2	Suicide mortality rate (per 100 000 population)	Estimates (2016)	183				183
SDG 3.5.1	Coverage of treatment interventions for substance-use disorders (%)						
SDG 3.5.2	Total alcohol per capita consumption in adults aged 15+ (litres of pure alcohol)	Estimates (2018)					188
SDG 3.6.1	Road traffic mortality rate (per 100 000 population)						
SDG 3.7.1	Demand for family planning satisfied – use of modern methods (%)	Surveys	85	90	78	91	
SDG 3.8.1	UHC service coverage index						
SDG 3.8.2	Proportion of population with >10% household expenditures on health (%)	Surveys				96	
SDG 3.9.1	Mortality rate attributed to household and ambient air pollution (per 100 000 population)	Estimates (2016)					183
SDG 3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (per 100 000 population)	Estimates (2016)					183
SDG 3.9.3	Mortality rate attributed to unintentional poisoning (per 100 000 population)	Estimates (2016)					183
SDG 3.a.1	Prevalence of tobacco use among persons over 15 (%)	Estimates (2018)					149
SDG 3.b.1	DTP3 immunization coverage among 1-year-olds (%)	Surveys		87	69	89	90
SDG 3.b.1	Measles immunization coverage among 1-year-olds (%)	Surveys		88	69	89	90
SDG 3.b.1	Polio immunization coverage among 1-year-olds (%)	Surveys		88	69	89	90
SDG 3.d.2	Proportion of bloodstream infections due to antimicrobial resistant organisms (%)						
SDG 4.2.1	Proportion of children aged <5 years developmentally on track (health, learning and psychosocial well-being) (%)						
SDG 5.2.1	Proportion of women (15–49) subjected to violence by current or former intimate partner (%)						
SDG 5.6.1	Proportion of women (15–49) who make their own decisions regarding sexual relations, contraceptive use and reproductive health care (%)						

Table A4.1. Number of WHO Member States with publicly available disaggregated data, by dimension of inequality and GPW 13 outcome indicators, continued

SDG/WHA	Indicator	Data source (year)*	Age	Economic status	Education	Place of residence	Sex
SDG 6.1.1	Proportion of population using safely managed drinking-water services (%)	Estimates (2017)				32	
SDG 6.2.1	Proportion of population using safely managed sanitation services (%)	Estimates (2017)				39	
SDG 7.1.2	Proportion of population with primary reliance on clean fuels (%)						
SDG 11.6.2	Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (μg/m^3)						
SDG 16.2.1	Proportion of children (aged 1–17) experiencing physical or psychological aggression (%)						
WHA 66.10	Prevalence of raised blood pressure among persons aged 18+ years (age-standardized) (%)	Estimates (2015)					190
WHA 66.10	Prevalence of obesity among adults (%)	Estimates (2016)					190
WHA 66.10	Prevalence of obesity among children and adolescents (5–19) (%)	Estimates (2016)					190
WHA 68.3	Number of cases of poliomyelitis caused by wild poliovirus (WPV)						
	Proportion of health facilities with essential medicines available and affordable on a sustainable basis (%)						
	Vaccine coverage for epidemic-prone diseases						

* For indicators with data from surveys, a country is counted if data are available for at least one survey year between 2010–2019.
** Data disaggregated by sex for under-five mortality rate is based on estimates.

Source: HEAT Plus Data Repository, Health Equity Monitor (https://www.who.int/data/gho/health-equity/assessment_toolkit/heat-plus-data-repository, accessed 30 April 20121).

Table A4.2. Number of WHO Member States with publicly available disaggregated data, by dimension of inequality and indicators used to monitor HALE and the Triple Billion targets

Triple Billion target	SDG/WHA	Indicator	Data source (year)*	Age	Economic status	Education	Place of residence	Sex
HALE		**Healthy life expectancy (HALE) at birth (years)**	**Estimates (2019)**					183
Universal health coverage	SDG 3.8.1	**UHC service coverage index**						
		Antenatal care coverage – at least four visits (in the two or three years preceding the survey) (%)	**Surveys**		94	74	95	
		Children aged <5 years with pneumonia symptoms taken to a health facility (%)	**Surveys**		62	55	82	89
	SDG 3.b.1	DTP3 immunization coverage among 1-year-olds (%)	**Surveys**		87	69	89	90
		Mean fasting plasma glucose for adults 25+ years (age-standardized) (%)	**Estimates (2014)**					191
		Percentage of population who slept under an insecticide-treated net (%)	**Surveys**	30	30		30	30
	WHA 66.10	Prevalence of raised blood pressure among persons aged 18+ years (age-standardized) (%)	**Estimates (2015)**					190
		Proportion of people living with HIV currently receiving antiretroviral therapy (%)	**Estimates (2019)**	42				117
		Proportion of population using at least basic sanitation services (%)	**Estimates (2017)**				165	
		Proportion of tuberculosis cases that are treated (%)						
	SDG 3.7.1	**Demand for family planning satisfied – use of modern methods (%)**	**Surveys**	85	90	78	91	
	SDG 3.8.2	**Proportion of population with >10% household expenditures on health (%)**	**Surveys**				96	
Healthier populations	SDG 11.6.2	**Annual mean concentrations of fine particulate matter ($PM_{2.5}$) in urban areas (μg/m³)**						
	SDG 3.9.1	**Mortality rate attributed to household and ambient air pollution (per 100 000 population)**	**Estimates (2016)**					183
	SDG 2.2.2	**Overweight prevalence in children aged <5 years (%)**	**Surveys**	84	86	71	85	86
	WHA 66.10	**Prevalence of obesity among adults (%)**	**Estimates (2016)**					190
	WHA 66.10	**Prevalence of obesity among children and adolescents (5–19) (%)**	**Estimates (2016)**					190
	SDG 3.a.1	**Prevalence of tobacco use among persons over 15 years (%)**	**Estimates (2018)**					149
	SDG 16.2.1	**Proportion of children (aged 1–17 years) experiencing physical or psychological aggression (%)**						
	SDG 4.2.1	**Proportion of children <5 years developmentally on track (health, learning and psychosocial well-being) (%)**						
	SDG 6.1.1	**Proportion of population using safely managed drinking-water services (%)**	**Estimates (2017)**				32	
	SDG 6.2.1	**Proportion of population using safely managed sanitation services (%)**	**Estimates (2017)**				39	
	SDG 5.2.1	**Proportion of women (15–49) subjected to violence by current or former intimate partner (%)**						
	SDG 3.6.1	**Road traffic mortality rate (per 100 000 population)**						
	SDG 2.2.1	**Stunting prevalence in children aged <5 years (%)**	**Surveys**	84	86	71	85	86
	SDG 3.4.2	**Suicide mortality rate (per 100 000 population)**	**Estimates (2016)**	183				183
	SDG 3.5.2	**Total alcohol per capita consumption in adults aged 15+ (litres of pure alcohol)**	**Estimates (2018)**					188
	SDG 2.2.2	**Wasting prevalence in children aged <5 years (%)**	**Surveys**	84	86	71	85	86
Health emergencies protection	SDG 3.b.1	**Measles immunization coverage among 1-year-olds (%)**	**Surveys**		88	69	89	90
	SDG 3.b.1	**Polio immunization coverage among 1-year-olds (%)**	**Surveys**		88	69	89	90

* For indicators with data from surveys, a country is counted if data are available for at least one survey year between 2010–2019.

Note: Not all indicators used to monitor the Triple Billion targets are GPW 13 outcome indicators.

Source: HEAT Plus Data Repository, Health Equity Monitor (https://www.who.int/data/gho/health-equity/assessment_toolkit/heat-plus-data-repository, accessed 30 April 20121).

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