

# 3 GOOD HEALTH AND WELL-BEING



## The Sustainable Development Goals Extended Report 2022

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

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

### Indicator 3.1.1: Maternal mortality ratio

#### The unequitable decline in maternal mortality

Between 2000 and 2017 the global maternal mortality ratio (MMR) fell by 38%, from 342 deaths to 211 deaths per 100 000 live births; this represents an average annual rate of reduction (ARR) of 2.9%. This progress is positive news. Nonetheless, it falls substantially short of an ARR of 6.1%, the rate required between 2016 and 2030 to achieve the global maternal mortality target of reducing the global maternal mortality ratio to less than 70 maternal deaths per 100 000 live births by 2030. To date, only 16 countries have achieved an ARR of 6.1% or faster. In 2017, the global lifetime risk of maternal mortality was estimated at one in 190; there lifetime risk of maternal death was one in 37 in sub-Saharan Africa compared to one in 7800 in Australia and New Zealand. It is important to ensure progress is truly for all, with no one left behind.

The COVID-19 pandemic has caused disruptions to health services and systems globally and presents further challenges to achieving the SDG target. The COVID-19 pandemic can impact upon maternal mortality levels via two routes: first, as indirect obstetric deaths where COVID-19 was aggravated by the physiologic effects of pregnancy; and second, from maternal deaths from other causes due to challenges in accessing timely high-quality maternity care due to pandemic-related disruptions.

Also of concern, the 10 countries with the highest maternal mortality ratios in 2017 (South Sudan, Chad, Sierra Leone, Nigeria, Central African Republic, Somalia, Mauritania, Guinea-Bissau, Liberia, and Afghanistan) all have stagnant or slowing annual rates of reduction, and therefore remain at greatest risk. As other regions of the world make progress, it is important to take action to ensure that fragile and conflict-affected settings are not left behind, leading to a growing equity gap. Continued support to health system resilience to maintain quality services is paramount for maternal health outcomes.

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**Custodian agency(ies):** WHO

### Indicator 3.1.2: Proportion of births attended by skilled health personnel

#### Despite continued progress towards universal coverage of skilled health personnel, inequities in coverage remain across regions with highest maternal mortality

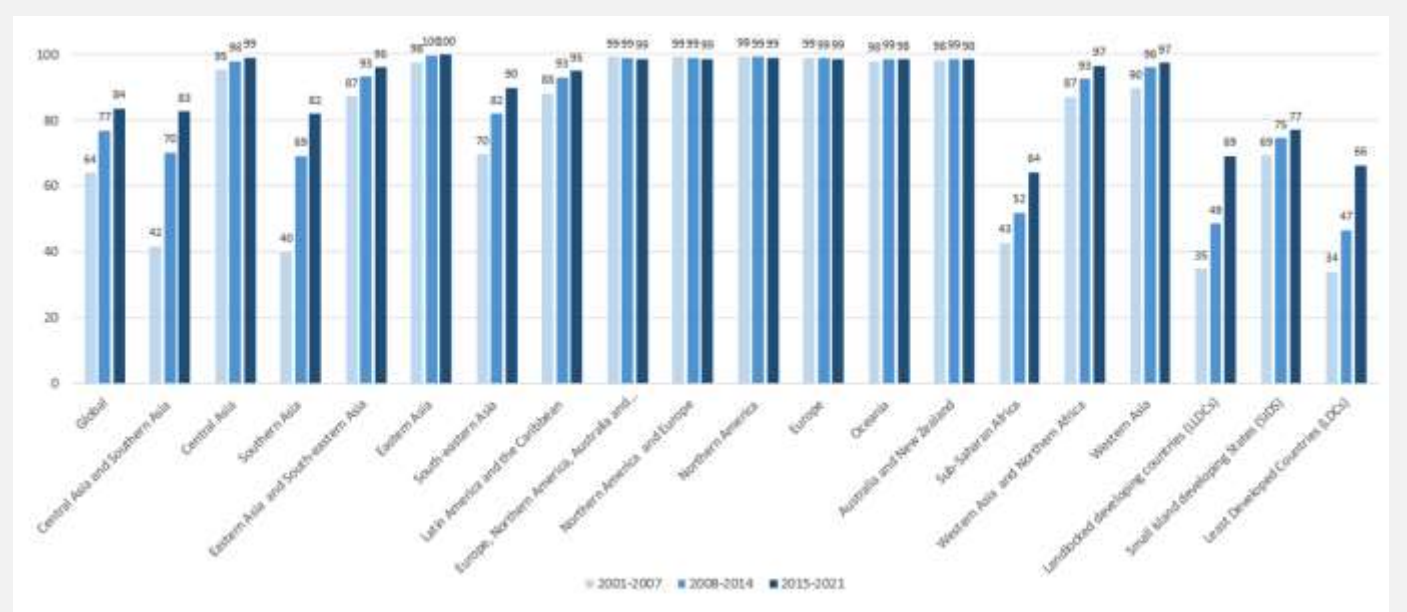
Childbirth attended by skilled health personnel, also known as skilled birth attendants, including doctors, nurses and midwives is paramount to the lives of women, newborns and their families. Competent skilled health personnel are trained to perform normal childbirth safely, recognize and manage warning signs for complications, and refer those in need to emergency care, all of which is key to reducing maternal and newborn morbidity and mortality. Globally, an estimated 84 per cent of births were attended by skilled health personnel for countries with data from 2015-2021, which is an increase of about 20 percentage points compared to countries with data from the period around 2000.

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

Although more than 80% of live births were attended by skilled health personnel in recent years, discrepancies in coverage continue to exist around the world. While regions like Northern America and Europe, Oceania, Eastern and South-eastern Asia and Latin America and the Caribbean have achieved universal or nearly universal coverage, only 64 per cent of births in sub-Saharan Africa are attended by skilled health personnel.

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

Births attended by skilled health personnel by SDG regions (% , 2001-2021)



#### Additional resources, press releases, etc. with links:

- Fore, H. A wake-up call: COVID-19 and its impact on children's health and wellbeing. *The Lancet Global Health* 8, 7 (2020).
- Kotlar, B. et al. The Impact of the COVID-19 Pandemic on Maternal and Perinatal Health: A Scoping Review. *Reprod Health* 18, 10 (2021).
- Robertson, T. et al. Early Estimates of the Indirect Effects of the COVID-19 Pandemic on Maternal and Child Mortality in Low-Income and Middle-Income Countries: A Modelling Study. *The Lancet Global Health* 8, 7 (2020).

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**Custodian agency(ies):** UNICEF, WHO

<sup>1</sup> Fore 2020, Kotlar et al 2021, Robertson et al 2020 (see "Additional resources.." section).

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

### Indicator 3.2.1: Under-5 mortality rate

### Indicator 3.2.2: Neonatal mortality rate

#### 10 million under-5 deaths could be averted between 2021 and 2030 if all countries reached the SDG under-5 mortality target

The world has made tremendous progress in reducing child mortality over the past two decades, and millions of children under 5 years of age are more likely to survive today than in 2000. The global under-5 mortality rate has fallen by 52 per cent from 76 deaths per 1,000 live births in 2000 to 37 deaths in 2020, and the global neonatal mortality rate fell by 44 per cent from 30 deaths per 1,000 live births in 2000 to 17 deaths in 2020. Still, the burden of child deaths remains immense—5.0 million children died before reaching age five in 2020 alone, with almost half of those deaths (2.4 million) occurring within the first 28 days of life.

Even though under-5 and neonatal mortality declined in all regions, children continue to face extensive regional disparities in their chances of survival. Sub-Saharan Africa remains the region with the highest under-five mortality rate in the world at 74 deaths per 1,000 live births in 2020—14 times higher than the risk for children in the region of Europe and Northern America and 19 times higher than the risk in the region of Australia and New Zealand.

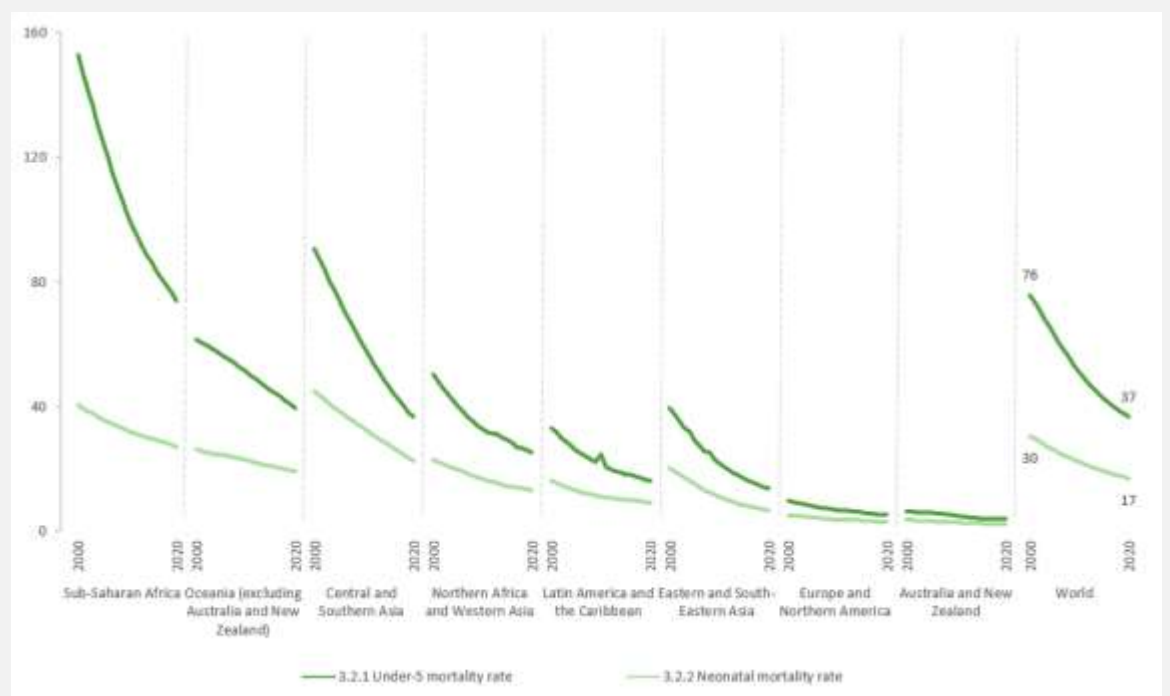
By 2020, 125 countries had already met the SDG target on under-five mortality, and 16 countries are expected to do so by 2030, if current trends continue. But the pace of mortality decline must

quicken if the remaining 54 countries—75 per cent of which are in sub-Saharan Africa—are to meet the target on time. Of these 54, 38 countries will need to more than double their current rate of progress to achieve the SDG target by 2030, without considering the additional challenges brought on by the COVID-19 pandemic or other emergencies. If these countries were to achieve the SDG under-five target, the number of under-five deaths between 2021 and 2030 would be cut by nearly 10 million.

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

Even as evidence began to emerge in 2020 showing COVID-19's very modest direct impact on child mortality, numerous governments, aid organizations, and medical and scientific institutions grew concerned with the possible increase in indirect deaths among children and youth due to disruption of economies and various interventions and services that have proven to be critical in saving children and women's lives in low- and middle-income countries. Some early scenario-based modelling warned that economic contractions or sustained and severe reduction in the coverage of live saving interventions like vaccinations could substantially increase under-five deaths, reversing the decades-long decline in global child mortality. A greater availability of empirical mortality data now makes it possible to assess more directly, albeit partially, the mortality situation of children in 2020, the most recent year available in these estimates. Thus far, these data do not show evidence of significant excess mortality among children in 2020 or the feared reversal in child mortality gains. Still, as more quality data become available for 2020, further monitoring is needed for a more complete picture of child mortality as well as the relevant contributing factors.

Under-5 and neonatal mortality rate by region, 2000-2020 (deaths per 1,000 live births)



#### Additional resources, press releases, etc. with links:

- United Nations Inter-agency Group for Child Mortality Estimation (UNIGME), 'Levels & Trends in Child Mortality: Report 2021, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation', United Nations Children's Fund, New York, 2021.
- Link: <https://childmortality.org/wp-content/uploads/2021/12/UNICEF-2021-Child-Mortality-Report.pdf>
- Website: <http://childmortality.org/>

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

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

#### Societal barriers slow progress against AIDS pandemic

The AIDS pandemic continues to cause enormous morbidity and mortality, undermining efforts to achieve global health targets and the Sustainable Development Goals. An estimated 1.5 million new HIV infections and 680 000 deaths from AIDS-related causes occurred in 2020.

Trend data show that HIV infections are not falling fast enough to reach global targets. The incidence of HIV infections globally declined by 39% between 2010 and 2020, far less than the 75% target agreed by the UN General Assembly in 2016. Progress was strongest in the region most affected by HIV, sub-Saharan Africa, where the incidence of HIV declined by 56% between 2010 and 2020. By contrast, epidemics in Northern Africa and Western Asia, Oceania (excluding Australia and New Zealand) and Europe and Northern America grew over the 10-year period, with increases in the number of new infections especially large in parts of eastern Europe.

The disempowered and the marginalized struggle to access the services they need to prevent HIV infection and AIDS-related illnesses. Depending on the place and context, these populations include women and girls, gay men and other men who have sex with men, transgender people, sex workers, people who use drugs, prisoners, migrants, refugees and other displaced persons.

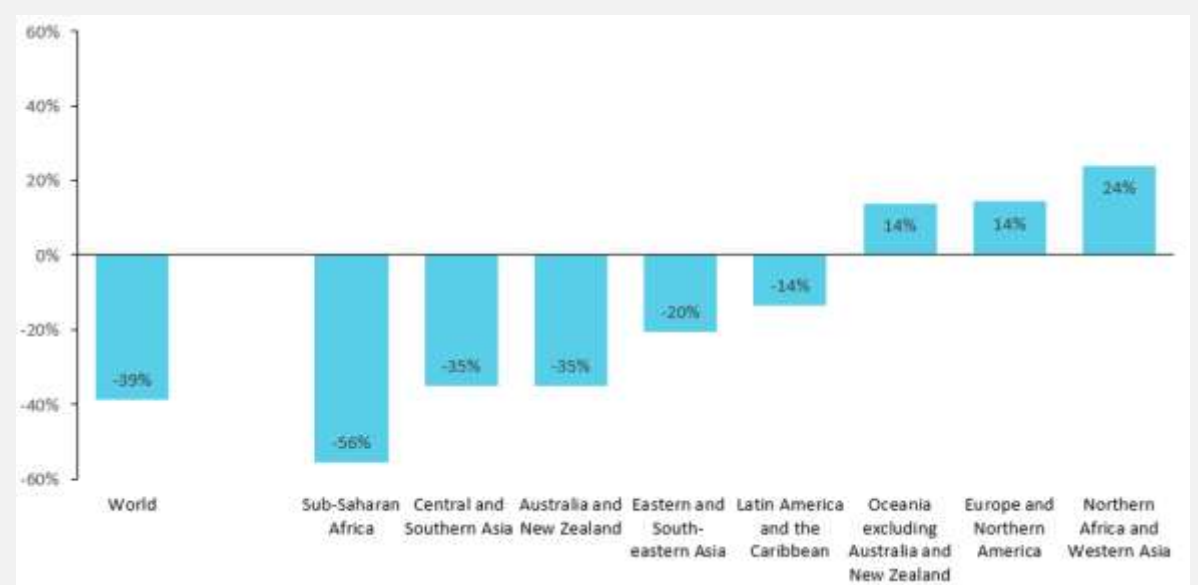
Discriminatory attitudes towards people living with HIV remain common, and a majority of countries continue to criminalize HIV transmission, non-disclosure or exposure. Restrictive legal and policy frameworks that criminalize key populations lead to the denial or limitation of their access to HIV services. Gender inequality and discrimination deny women and girls their fundamental human rights—including the rights to education and health—and increase their risk of HIV infection and their ability to mitigate the impact of HIV. Laws that require parental permission to access services for sexual and reproductive health and HIV prevention, testing and treatment limit the health-seeking behaviours of adolescents and young people.

The General Assembly agreed within its 2021 Political Declaration on HIV and AIDS to address inequalities and re-energize the global AIDS response. The urgent need to address societal barriers to HIV services faced by marginalized populations is expressed through the 10–10–10 societal enabler targets of the Declaration.

AIDS is colliding with COVID-19 to deadly effect because much of the world remains dangerously under-prepared and under-resourced to confront the pandemics of today and tomorrow. Measures to slow the spread of SARS-CoV-2 and the significant additional strain the new pandemic has placed on health systems has disrupted HIV services, schooling, violence-prevention programmes and other efforts to address the inequalities that drive disparate health outcomes.

In many countries, however, the upheaval caused by COVID-19 has summoned the inventiveness and resilience that have become hallmarks of the HIV response. COVID-19 movement restrictions necessitated an acceleration of multimonth dispensing of antiretroviral medicines for people living with HIV and substitution therapy for people with opioid dependence. The approach has been a success, enabling people to continue taking their medications despite service disruptions. HIV treatment and other critical services were preserved by differentiating service delivery, most notably community-led services. Community pick-up schemes and sites were set up, home delivery services were arranged, and treatment support was shifted to telehealth and virtual platforms. By the end of 2020, most HIV testing and treatment programmes had rebounded from COVID-19 disruptions. Other services, such as voluntary medical male circumcision, have been slower to recover.

Change in HIV incidence between 2010 and 2020 (percentage)



Source: UNAIDS 2021 epidemiological estimates. ([www.aidsinfo.unaids.org](http://www.aidsinfo.unaids.org))

#### Additional resources, press releases, etc. with links:

- 2021 World AIDS Day report ([https://www.unaids.org/sites/default/files/media\\_asset/2021\\_WAD\\_report\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2021_WAD_report_en.pdf))
- 2021 UNAIDS Global AIDS Update ([https://www.unaids.org/sites/default/files/media\\_asset/2021-global-aids-update\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf))
- AIDSinfo (<https://aidsinfo.unaids.org/>)

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### Indicator 3.3.2: Tuberculosis incidence per 100,000 population

Progress towards the SDG target 3.3.2 of ending the TB epidemic by 2030 is off-track.

Tuberculosis (TB) remains a leading cause of ill-health and death. In 2020, an estimated 10 million people fell ill with TB: 56% were adult men, 33% adult women and 11% children. Overall, 8% were people living with HIV, but the proportion was much higher in Africa (24% overall and exceeding 50% in parts of southern Africa). Eight countries accounted for two thirds of the global number of incident cases: India (26%), China (8.5%), Indonesia (8.4%), the Philippines (6.0%), Pakistan (5.8%), Nigeria (4.6%), Bangladesh (3.6%) and South Africa (3.3%).

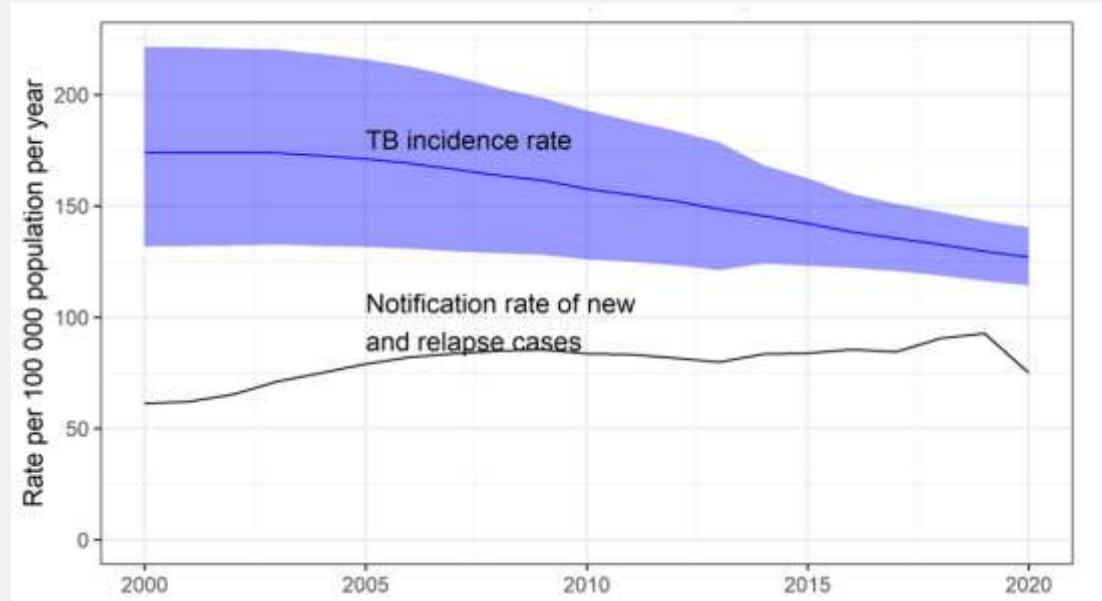
Globally, TB incidence declined from 174 new and relapse cases per 100 000 population in 2000 to 127 per 100 000 population in 2020 (a 27% decline in the 19-year period) and the TB mortality rate among HIV-negative people fell by 42% in the same period. However, large gaps in detection and treatment remain, which widened substantially in 2020 as a result of disruptions associated with the COVID-19 pandemic. The number of people diagnosed with TB and reported to national authorities fell from 7.1 million in 2019 to 5.8 million in 2020 (-18%). The two countries with the largest absolute reductions in notifications between 2019 and 2020, India and Indonesia, had previously been the main contributors to a large global increase between 2013 and 2019. Their combined annual total number of notifications increased by 1.2 million in that period, but then fell by 0.7 million between 2019 and 2020.

Globally, these negative trends meant that TB treatment coverage (approximated as notifications divided by incidence) fell to 59% (95% UI: 53–56%) in 2020, down from 72% (UI: 65–80%) in 2019. In turn, this caused a noticeable rise in the global number of TB deaths, from 1.2 (95% UI: 1.1 – 1.3) million in 2019 to 1.3 (95% UI: 1.2 – 1.4) million in 2020 (excluding TB deaths in people with HIV). This is the first year-on-year increase in TB deaths since 2005 and took the world back to the level of 2017. The decline in TB incidence also slowed in 2020, to less than 2% per year. Modelling suggests that impacts on TB incidence and mortality could worsen, especially in 2021 (when ongoing disruptions to access to TB diagnosis and treatment were evident) and 2022. Drug-resistant TB also remains a continuing public health threat.

Many new cases of TB are attributable to five risk factors: undernutrition, HIV infection, alcohol use disorders, smoking (especially among men) and diabetes. In the context of the COVID-19 pandemic, multisectoral action to address these and other determinants of TB and its consequences, including GDP per capita, poverty and social protection, is more important than ever.

Progress towards the SDG target of ending the TB epidemic by 2030 is off-track. The COVID-19 pandemic has reversed recent progress in reducing the global burden of TB disease and is likely to have long-lasting negative effects, particularly among populations most affected by the economic consequences of the pandemic.

Global trends in TB incidence rate (2000-2020)



#### Additional resources, press releases, etc. with links:

- Additional sources/documents: Global TB Report 2021 [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/)

Storyline author(s)/contributor(s): Philippe Glaziou, WHO; Katherine Floyd, WHO; Tereza Kasaeva, WHO

Custodian agency(ies): WHO

### Indicator 3.3.3: Malaria incidence per 1,000 population

#### More malaria cases and deaths in 2020 linked to COVID-19 disruptions

In the early days of the COVID-19 pandemic, WHO had projected that – with severe service disruptions – malaria deaths in sub-Saharan Africa could potentially double in 2020. According to the latest World malaria report, many countries took urgent action to shore up their malaria programmes, averting this worst-case scenario.

Still, the findings of the report are sobering. In 2020, there were an estimated 241 million malaria cases and 627 000 malaria deaths worldwide. This represents about 14 million more cases compared to the previous year, and 69 000 more deaths. Approximately two-thirds of the additional deaths (47 000) were linked to disruptions in the provision of malaria prevention, diagnosis and treatment during the pandemic.

The WHO African Region continues to shoulder the heaviest burden of the disease. In 2020, the region accounted for 95% of all malaria cases (228 million) and 96% of all deaths (602 000). Approximately 80% of malaria deaths in the region were among children under the age of five.

Even before the emergence of COVID-19, global gains against malaria were levelling off, and the world was not on track to reach the 2020 milestones of the WHO Global technical strategy for malaria 2016-2030. By 2020, the global malaria case incidence rate was 59 cases per 1000 people at risk against a target of 35 — off track by 40%. The global mortality rate was 15.3 deaths per 100 000 people at risk against a target of 8.9 — off track by 42%.

Urgent and concerted action is needed to set the world back on a trajectory towards achieving the case incidence and mortality targets of the WHO global malaria strategy and the SDG target of ending malaria by 2030.

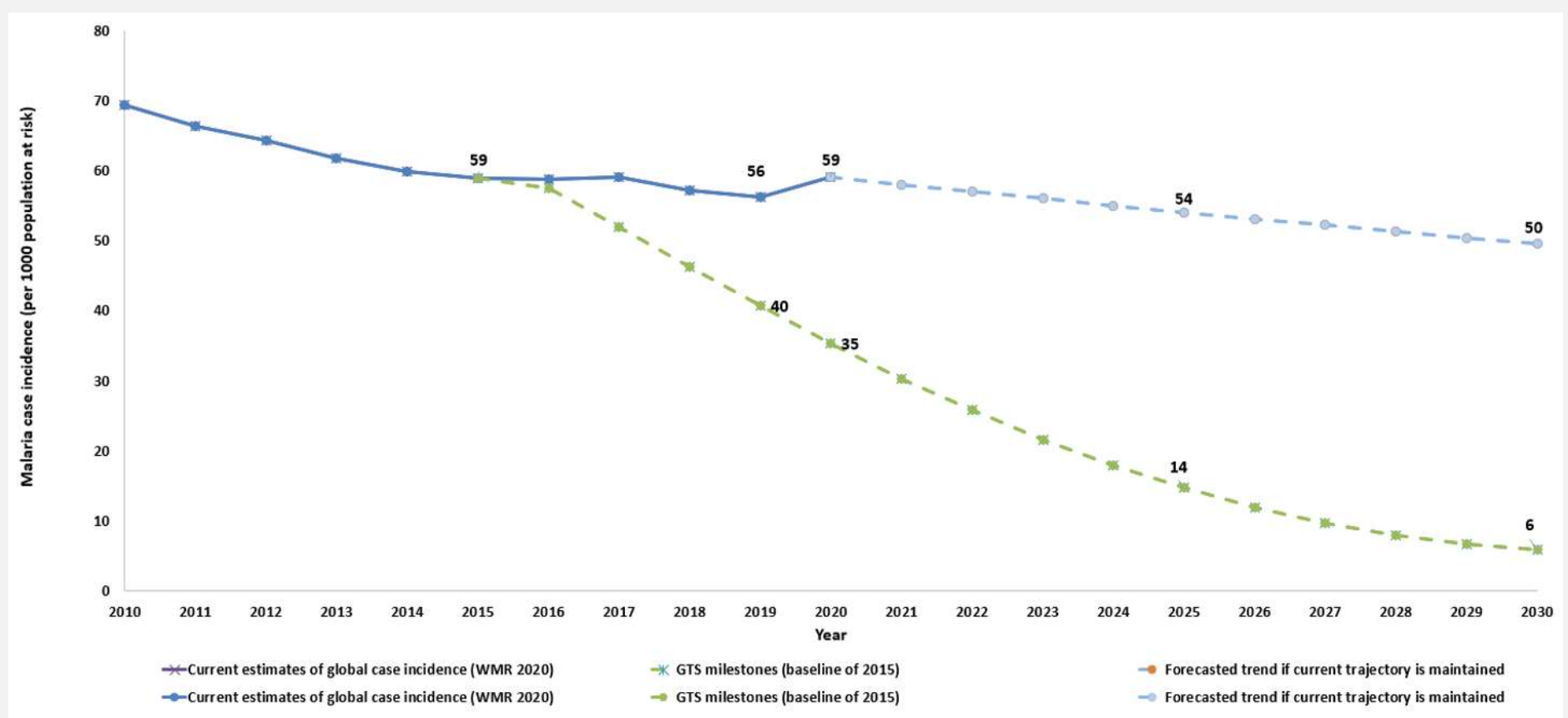
The situation remains precarious – especially in sub-Saharan Africa, where a convergence of threats poses a challenge to disease control efforts. In 2020 and 2021, about 122 million people in 21 malaria-endemic countries needed assistance due to health and humanitarian emergencies, not including the COVID-19 pandemic – from Ebola outbreaks to conflicts and flooding.

Other threats converging in African countries include the emergence of partial resistance to the most commonly used drug treatment; the spread of *P. falciparum* parasite mutations that are undermining the effectiveness of rapid diagnostic tests; mosquitoes that are resistant to the insecticides used in key vector control tools; and the emergence of an invasive malaria vector that thrives in urban and rural areas.

Insufficient funding, at both the international and domestic levels, poses an added threat to future progress. In 2020, global funding for malaria control and elimination totalled US\$ 3.3 billion against a target of US \$6.8 billion. Funding gaps have resulted in gaps in access to proven, WHO-recommended malaria control tools.

Reaching the 2030 WHO and SDG malaria targets will require new approaches, new malaria control tools, and the better implementation of the tools that are available today. WHO's malaria strategy emphasizes the need to carefully tailor existing prevention, diagnostic and treatment approaches to local disease settings, and to strengthen health systems overall, with a view to achieving universal health coverage.

Comparison of global progress in malaria case incidence considering two scenarios: current trajectory maintained (blue) and GTS targets achieved (green)



#### Additional resources, press releases, etc. with links:

- Global technical strategy for malaria 2016-2030, 2021 update: <https://www.who.int/publications/i/item/9789240031357>
- World malaria report 2021 <https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2021>

Storyline author(s)/contributor(s): Abdisalan Noor, WHO; Saira Stewart, WHO

Custodian agency(ies): WHO

### Indicator 3.3.4: Hepatitis B incidence per 100,000 population

Custodian agency(ies): WHO

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

### Neglected tropical diseases: progress achieved in 2020 despite COVID-19 disruptions

In 2020, 1.73 billion people were reported to require mass or individual treatment and care<sup>2</sup> for neglected tropical diseases (NTDs), down from 2.19 billion in 2010, and about 9.5 million people fewer than in 2019. The majority of them continued to require mass treatment for five diseases amenable to preventive chemotherapy: lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, schistosomiasis and trachoma.

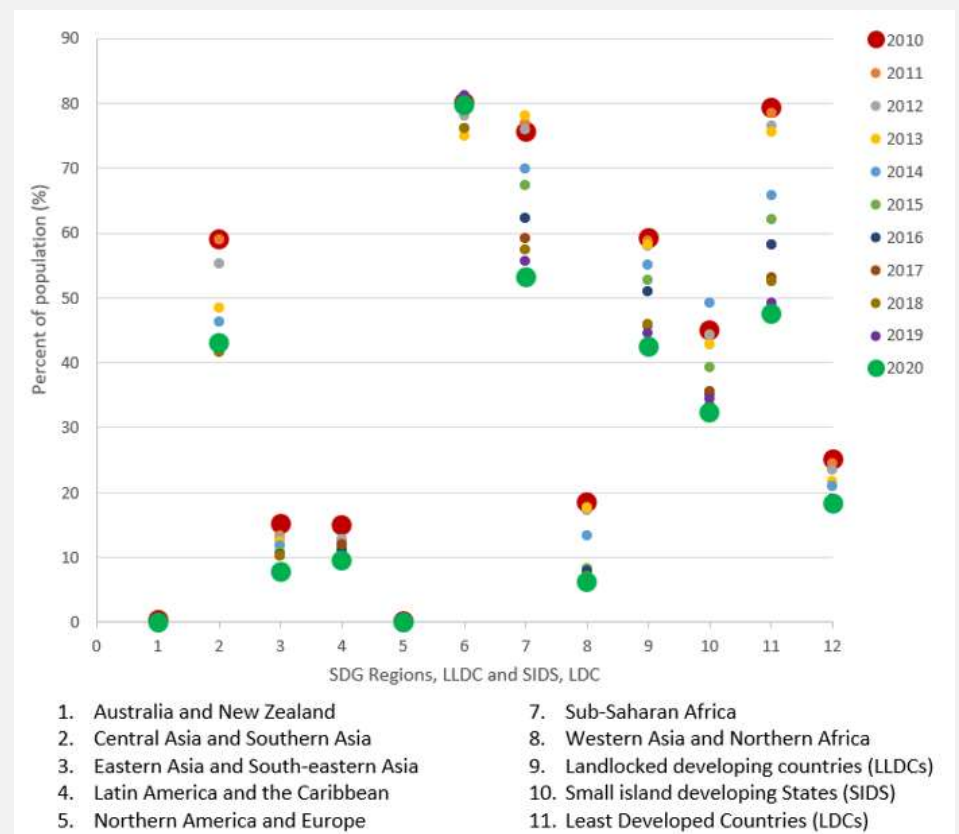
Progress in reducing the number of people requiring the above interventions against NTDs was driven largely because by the end of 2020 at least one NTD had been eliminated in 42 countries, as acknowledged by WHO. Lymphatic filariasis and trachoma had been eliminated as a public health problem in 17 and 10 countries, respectively; onchocerciasis had been eliminated in four countries in the Region of the Americas; three countries had been classified as no longer requiring preventive treatment for soil-transmitted helminthiasis after multiple treatment rounds with high coverage; the annual number of cases of human African trypanosomiasis had fallen from more than 7000 in 2012 to just 663; and the number of new leprosy cases reported globally had continued to decline since 2010 at on average 1% per year, after most endemic countries had reached elimination as a public health problem in 2000. Additionally, dracunculiasis was on the verge of eradication, with 27 human cases reported in five countries in 2020.

Some 502 million people required treatment and care for NTDs in the least developed countries (LDCs), representing 48% of those countries' populations, down from 79% in 2010. More than 1.2 billion people living outside the group of LDCs still required treatment and care for NTDs.

In 2020, across the entire spectrum of essential health services, NTD services were found to be among those most frequently and most severely affected by the COVID-19 pandemic. Disruptions impacted several programmatic areas including mass treatment, active case-finding, vector control, veterinary public health, awareness and health education campaigns, support for self-care, rehabilitation and psychosocial services, monitoring and evaluation activities, and supply chain. Since the beginning of the pandemic, WHO has taken normative and operational action to tackle and mitigate the impact of COVID-19 on NTD services.<sup>3</sup>

In January 2021, the World Health Organization (WHO) launched the new NTD road map 2021–2030,<sup>4</sup> which sets global targets to prevent, control, eliminate and eradicate 20 diseases and disease groups by 2030; 10 cross-cutting targets focused on integration, multisectoral coordination, universal health coverage and country ownership; and four overarching targets aligned with the Sustainable Development Goals (SDGs). One of the overarching global targets set for 2030 matches SDG indicator 3.3.5, and provides for a 90% reduction in people requiring interventions against NTDs.

Proportion of number people requiring interventions against neglected tropical diseases out of total population



#### Additional resources, press releases, etc. with links:

- Neglected tropical diseases: impact of COVID-19 and WHO's response – 2021 update. Geneva: World Health Organization, Weekly Epidemiological Record, 2021; 96(38):461–8 <http://apps.who.int/iris/bitstream/handle/10665/345382/WER9638-eng-fre.pdf>
- Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2021 <https://apps.who.int/iris/handle/10665/338565>

Storyline author(s)/contributor(s): Alexei Mikhailov, WHO; Albis Francesco Gabrielli, WHO; Ashok Moloo, WHO

Custodian agency(ies): WHO

<sup>2</sup> Preventive, curative, surgical or rehabilitative interventions.

<sup>3</sup> Neglected tropical diseases: impact of COVID-19 and WHO's response – 2021 update. Geneva: World Health Organization, Weekly Epidemiological Record. 2021; 96(38):461–8 (<http://apps.who.int/iris/bitstream/handle/10665/345382/WER9638-eng-fre.pdf>, accessed 4 February 2022).

<sup>4</sup> Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/338565>, accessed 4 February 2022).



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

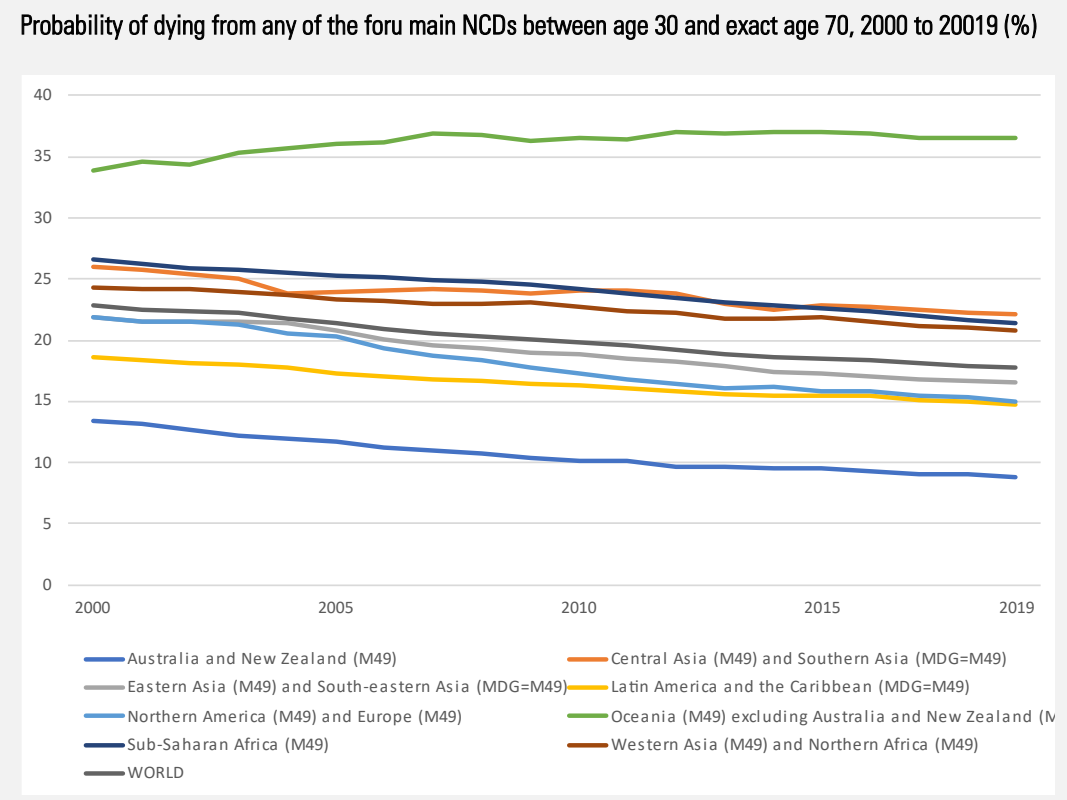
**Indicator 3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease**

**Most of the world is not on track to meet the SDG target on noncommunicable diseases**

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

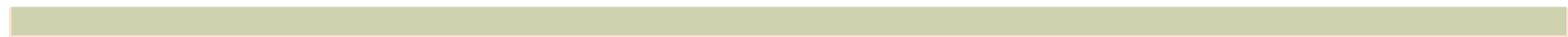
While the risk remains markedly higher for men globally (27.5% compared to 18.2% for women), some regions have seen the gender gap close considerably from 2000 to 2019. In Australia and New Zealand, Northern America and Europe and even Sub-Saharan Africa, where the gap has been historically small, the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

Even if the rates of decline in premature NCD mortality since 2000 could be sustained, no region and just 14 countries would be on track to reach the SDG 3.4.1 target. However, preventive, diagnostic and treatment services for NCDs have been disrupted since the COVID-19 pandemic began in early 2020, threatening progress made in the last two decades. At the same time, the COVID-19 pandemic underscores the need for further attention to NCD interventions, as people with underlying NCD conditions have higher risks of severe illness and death from COVID-19.



**Custodian agency(ies):** WHO

**Indicator 3.4.2: Suicide mortality rate**



**Custodian agency(ies):** WHO

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

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



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

Indicator 3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol



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

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

Indicator 3.6.1: Death rate due to road traffic injuries



<a href="#">Custodian agency(ies):</a> WHO
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Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

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



[Custodian agency\(ies\):](#) DESA Population Division

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



[Custodian agency\(ies\):](#) DESA Population Division

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

### Indicator 3.8.1: Coverage of essential health services

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

Even before COVID-19 struck, the world was far short of reaching universal health coverage (SDG target 3.8) as health services coverage was improving but not fast enough and at an undue cost to too many people.

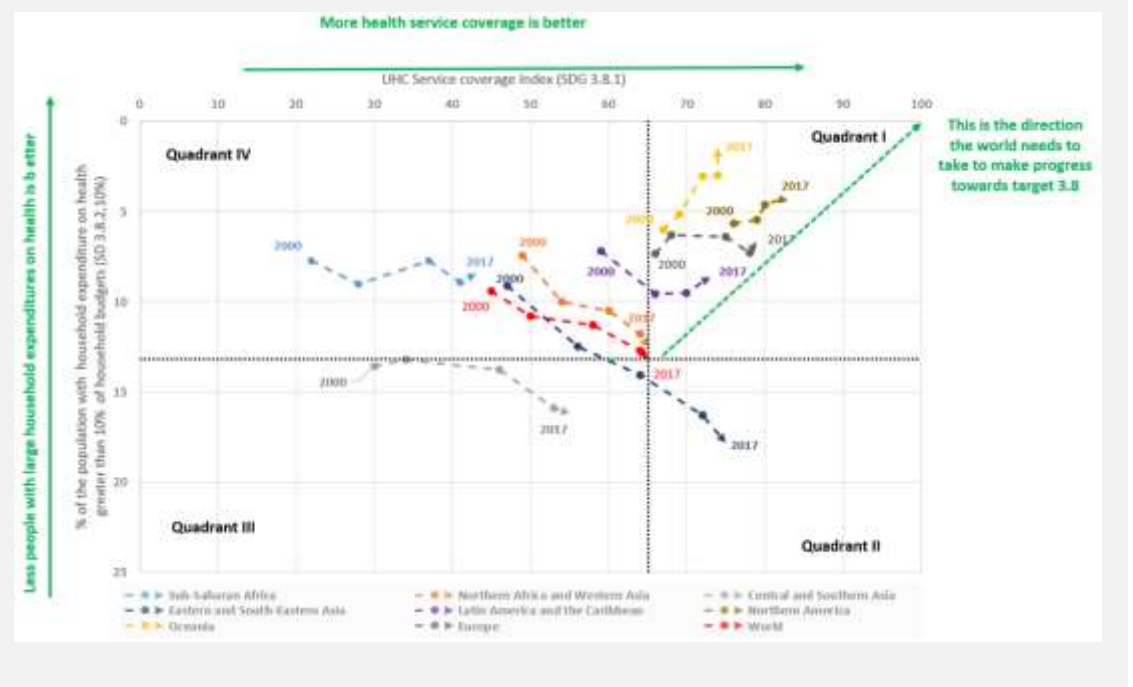
Universal health coverage (UHC) means that all people can get the health services they need, of good quality, and without facing financial hardship from the need to pay for those services. Even before COVID-19 struck, the latest available data confirms alarming and diverging trends in SDG UHC indicators, with service coverage (SDG indicator 3.8.1) improving from an index of 64 in 2015 to 67 in 2019, while the proportion of the population spending more than 10% of their household budget on health out of pocket (SDG indicator 3.8.2) worsened from 12.7% in 2015 (940 million people) to 13.2% in 2017 (996 million people). In addition, in 2017, 6.7% of the global population (505 million people) were pushed or further pushed into extreme poverty due to out-of-pocket payments for health.

The divergence in trends between SDG indicators 3.8.1 and 3.8.2 occurred across all regions between 2000-2017 (the period for which data are available for both indicators) but actual levels and trajectories varied substantially (Figure 1):

Four regions achieved relatively high levels of service coverage and low rates of people with large household budgets dedicated to health spending (Quadrant I). In almost all regions in Asia, the population with large portions of household budgets dedicated to health increased fast but service coverage levels achieved remained relatively low (Quadrants III and IV) except in the Eastern and South-Eastern Asian region (Quadrant II). In Sub-Saharan Africa, service coverage levels reached also remained relatively low but the fraction of the population with large portions of household budgets dedicated to health remained pretty stable around 8%-9% (Quadrant IV).

Against this backdrop, the COVID-19 pandemic is likely to slow down the progress made in health service coverage (SDG 3.8.1) over the past 20 years and exacerbate the financial hardship experienced by those paying out-of-pocket for health. Lack of data currently precludes a detailed and comprehensive assessment of the impact of COVID-19 on the path to UHC; nevertheless, there is evidence that the COVID-19 pandemic has led to significant disruptions in the delivery of essential health services. Additional patient load caused by the COVID-19 pandemic has strained health systems and threatened their ability to provide all essential health services leading to a stagnation or even a decrease in service coverage. The combined macroeconomic, fiscal, and health impacts of COVID-19 point towards the strong likelihood of a significant worsening of financial protection globally – higher rates of foregone care due to financial barriers as poverty grows, and, for those seeking care, a higher proportion of the population with large health spending and worsening impoverishment. This worsening of financial protection will probably be sustained in the medium term unless proactive policy efforts are made, for example, pro-poor focused increases in public spending to reduce out of pocket spending on health, enhanced social protection support, removal of co-payments and other fees when seeking care, cash transfer payments to enable poor and vulnerable households to meet their basic needs (including for health services), expansion in coverage and strengthening of primary health care – not just to recover but also to accelerate progress towards UHC.

Figure 1: Progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2000–2017



#### Additional resources, press releases, etc. with links:

- World Health Organization and World Bank, 2021. Tracking Universal Health Coverage : 2021 Global Monitoring Report
- World Health Organization and World Bank, 2021. Global monitoring report on financial protection in health 2021
- Links: <https://www.who.int/teams/health-systems-governance-and-financing/global-monitoring-report>
- Website: <https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major>
- <http://datatopics.worldbank.org/universal-health-coverage/>

**Storyline author(s)/contributor(s):** Gabriela Flores, World Health Organization; Nelly Biondi, World Health Organization; Susan Sparkes, World Health Organization; Rouselle Lavado, Tessa Tan-Torres Edejer, Joe Kutzin (World Health Organization); Patrick Hoang-Vu Eozenou, Ajay Tandon, Marc-Fra

**Custodian agency(ies):** WHO

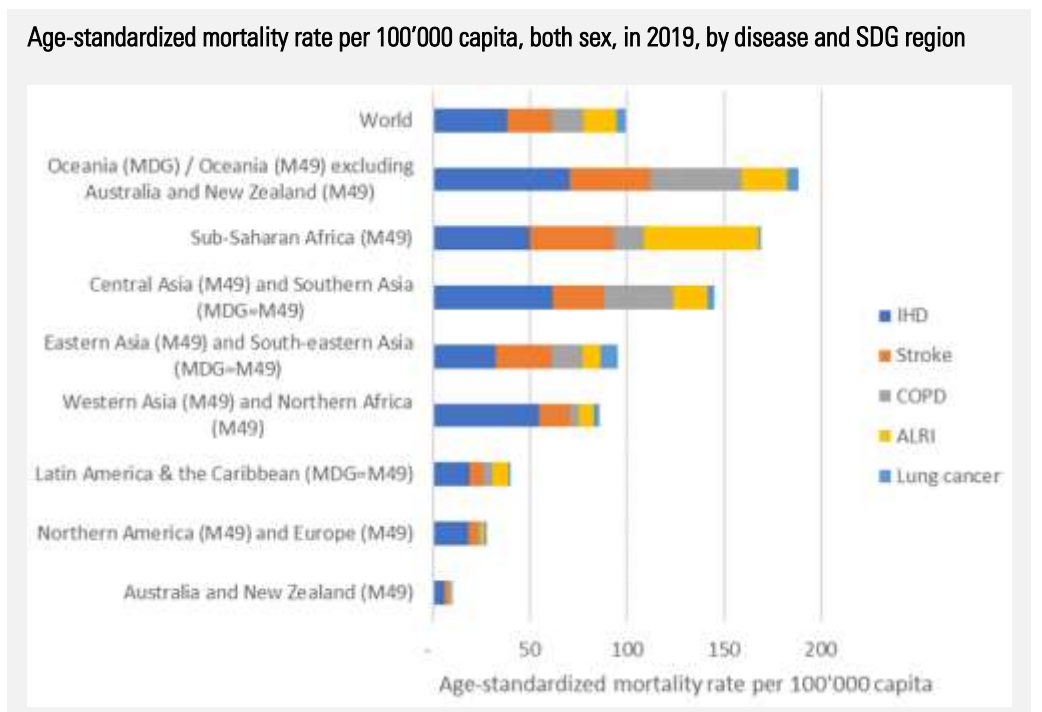
## Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

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

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

Air pollution from particulate matter, whether household or ambient increases the risk of cardiovascular disease, stroke, chronic obstructive pulmonary disease, lung cancer and acute lower respiratory infections, leading to some 6.7 million deaths worldwide. Non-communicable diseases such as chronic obstructive pulmonary disease (COPD, 16%), ischaemic heart disease (IHD, 40%), lung cancer (5%) and stroke (23%) account together for 84% of the total deaths due to air pollution, the remaining 16% are due to acute lower respiratory infection (ALRI).

The differences in the mortality rates attributable to air pollution, across the regions are not only due to different concentrations (population weighted) of ambient and household PM2.5 but also to the different age distribution and underlying disease prevalence. Furthermore, the relative contribution of the different diseases to the overall mortality due to air pollution related diseases varies by region, due to different population structure and main cause of deaths. Ambient and household have also different contributions to the overall burden due to air pollution, in the different regions. Oceania (excluding Australia/New Zealand), Sub-Saharan Africa, and most of Asia have the highest mortality rate from air pollution. This is largely due to the high levels of household air pollution exposure in these regions where a large proportion of the population still rely on polluting fuels and technologies for cooking, leading to about 3.2 million deaths worldwide. Health risks from household air pollution are particularly high among women and children, who tend to spend more time in and around the stove. In 2019, ambient air pollution from traffic, industry, power generation, waste burning and residential fuel combustion resulted in 4.2 million deaths.



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

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**Custodian agency(ies):** WHO

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

**Custodian agency(ies):** WHO

### Indicator 3.9.3: Mortality rate attributed to unintentional poisoning

**Custodian agency(ies):** WHO

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

### Indicator 3.a.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older

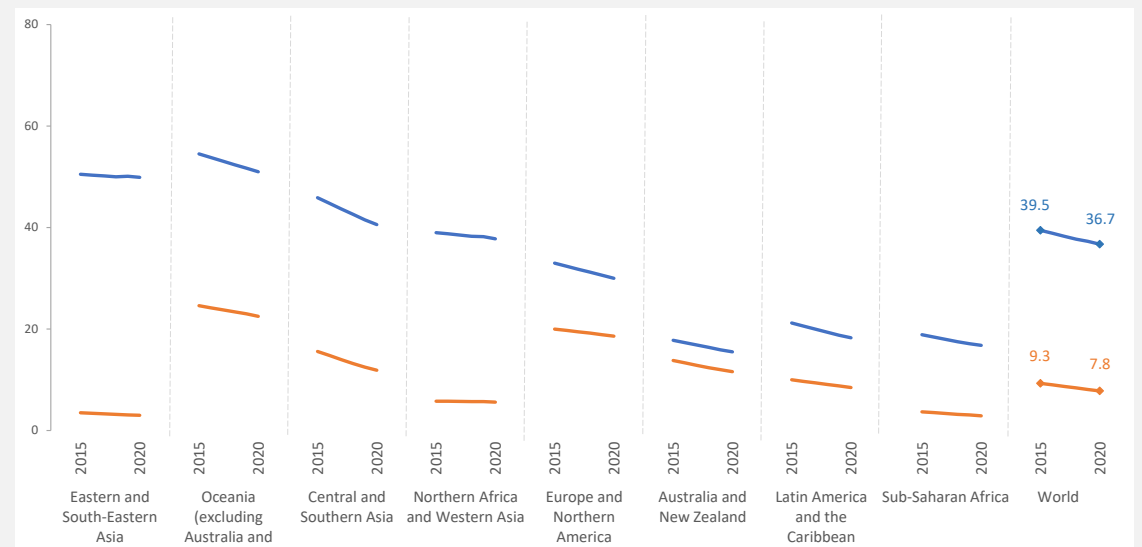
#### Tobacco use is a dying habit in 150 countries

The global average rate of tobacco use among people aged 15 year or more has declined to 22.3% in 2020 (latest data year), down from 24.4% in 2015. Countries are achieving these reductions in tobacco use largely by implementing the specific measures of the WHO Framework Convention on Tobacco Control (WHO FCTC). 180 countries are Parties to the WHO FCTC. 165 countries have collected enough national data on the use of tobacco in the adult population to measure the trend in prevalence over time. 150 countries are recording a decreasing trend in tobacco use prevalence. The tobacco use rate among males aged 15+ globally has declined from an average of 39.5% in 2015 to 36.7% in 2020. Among females aged 15+, the global average rate has declined from 9.3% to 7.8% over the same period.

Among males, the SDG region with the highest average rate of tobacco use in 2020 is Oceania excluding Australia and New Zealand, at 51.0%. The SDG region with the lowest average rate among males is Australia and New Zealand, at 15.5% in 2020. The SDG region seeing the fastest rate of decline in tobacco use among males over the period 2015-2020 is Latin America and the Caribbean, down from an average rate of 21.2% in 2015 to 18.3% in 2020 – a relative reduction of 13% over 5 years. Among females, the SDG region with the highest average rate of tobacco use in 2020 is Oceania excluding Australia and New Zealand, at 22.5%. The SDG region with the lowest average rate among females is Sub-Saharan Africa, at 2.9% in 2020. The SDG region seeing the fastest rate of decline in tobacco use among females over the period 2015-2020 is Central and Southern Asia, down from an average rate of 15.6% in 2015 to 11.9% in 2020 – a relative reduction of 24% over 5 years.

The Conference of the Parties (COP), in its Ninth Session in November 2021, emphasized that “governments, in the context of the coronavirus disease 2019 (COVID-19) pandemic, face a heavier, more sustained toll from the tobacco epidemic, which already claims 8 million lives every year”. The COP also noted that “against the backdrop of the COVID-19 pandemic, unsubstantiated and inappropriate information had been disseminated with regard to the positive impact of tobacco and nicotine consumption, creating among consumers an illusion of protection and decreased risk of developing COVID-19 and undermining the efforts of national responses to combat the pandemic”. In this regard, the COP called on the Parties “to include actions to achieve SDG Target 3.a on implementation of WHO FCTC and SDG Target 3.4 on NCDs as an integral component of national recovery from the COVID-19 pandemic, including in national SDG plans.”

Prevalence of current tobacco use among males and females aged 15 years and older



#### Additional resources, press releases, etc. with links:

- WHO FCTC Implementation database <https://untobaccocontrol.org/impldb/>
- WHO global report on trends in prevalence of tobacco use 2000-2025, fourth edition <https://www.who.int/publications/i/item/9789240039322>
- 2021 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2022. <https://fctc.who.int/publications/i/item/9789240041769>
- Guide for WHO FCTC Parties on including SDG target 3.a in voluntary national reviews. Geneva: World Health Organization; 2020. <https://fctc.who.int/publications/i/item/guide-for-who-fctc-parties-on-including-sdg-target-3.a-in-voluntary-national-reviews>

**Storyline author(s)/contributor(s):** Vinayak Prasad, WHO; Alison Commar, WHO; Tibor Szilagyi, WHO FCTC Secretariat; Leticia Martínez López, WHO FCTC Secretariat  
**Custodian agency(ies):** WHO, WHO FCTC Secretariat

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

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

**The COVID-19 pandemic causes more children to miss out on essential vaccines**

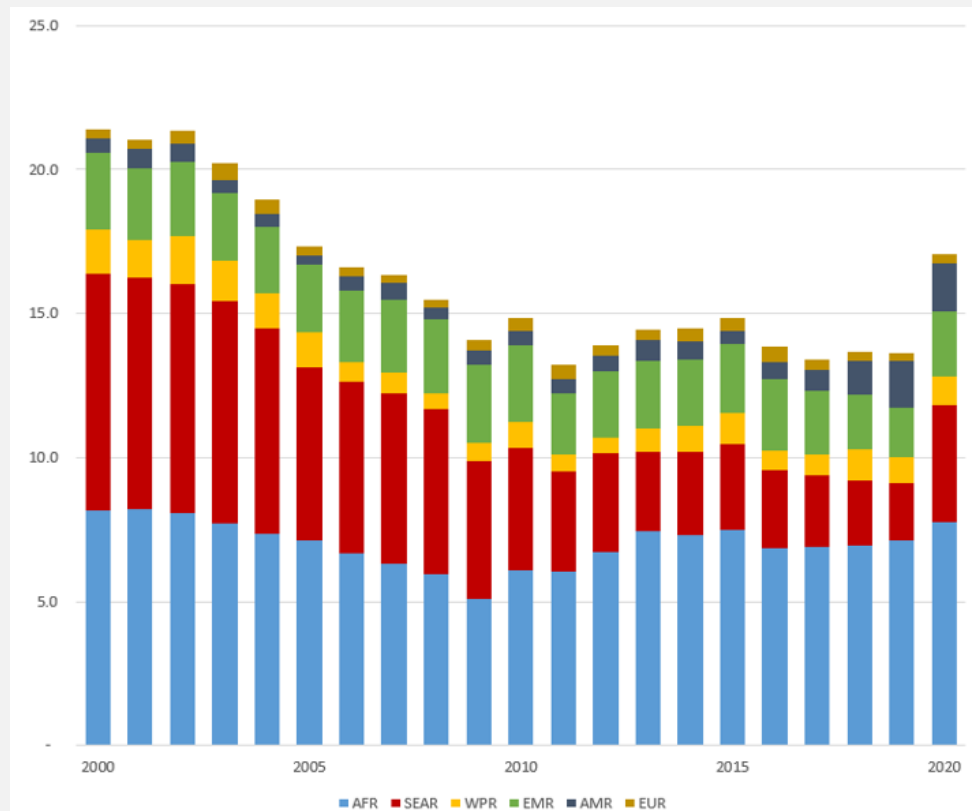
Sustainable Development Goal 3 tracks the coverage of four vaccines given to infants, young children, and adolescent girls to signal that immunization is important at all ages. However, for people to benefit from all vaccines that will protect them from more than 20 diseases over the course of their life, starting soon after birth is the most important step. In 2020, this step was missed by 17 million children.

The Immunization Agenda aspires to leave no one behind and aims to halve the number of ‘zero-dose’ children globally by 2030. Zero-dose children are those left completely unvaccinated in their first year of life. Their number had steadily declined as immunization programmes progressed, then plateaued over the last decade.

In 2020, however, as governments locked down and health systems struggled, more children were left out than in any other year since 2005 (Figure 1). The pandemic affected the South-East Asian and Eastern Mediterranean WHO regions most acutely, but the impact in other regions may yet be reassessed when more data become available.

Disruptions to programmes continued after 2020. People remained wary to seek healthcare. The COVID-19 response and vaccination diverted health system resources away from other essential health services. It is therefore likely that in 2021 and beyond, too many children continue to miss out on immunization as well as on other healthcare services. Recovering these to pre-pandemic levels is an urgent priority.

Estimated number of children who didn't receive a first dose of DTP containing vaccine by WHO region, 2000-2020



**Additional resources, press releases, etc. with links:**

- Immunization Agenda 2030 <https://www.immunizationagenda2030.org/>
- <https://www.who.int/news-room/fact-sheets/detail/immunization-coverage><https://data.unicef.org/topic/child-health/immunization/>

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**Custodian agency(ies):** WHO, UNICEF

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

**COVID-19 control largest share of basic health services in 2020**

ODA for basic health from all donors has increased by 113.2% in real terms since 2010 and reached USD 14.9 billion in 2020. The Global Fund, the United States, GAVI, and Germany accounted for almost half of this total, providing, USD 2.0 billion, USD 1.8 billion, USD 1.8 billion, and USD 1.6 billion respectively.

In 2020, COVID-19 control (e.g. information, education and communication; testing; prevention; immunisation, treatment and care) represented the largest share of ODA for basic health, totaling USD 4.4 billion. Approximately USD 3.0 billion was spent on infectious disease control, USD 2.2 billion on basic health care, and USD 2.2 billion on malaria control.



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



**Custodian agency(ies):** WHO



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

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

#### The pandemic has taken a heavy toll on health and care workers

Health and care workers (HCW) remain at the fore front of the COVID-19 pandemic response. For more than two years running, health systems at the national and subnational levels have undertaken unprecedented measures to handle the pandemic including the unmeasured impact on HCWs. Of rising concern is the health and well-being of HCWs. A global estimate of 115 500 HCW deaths (ranging between 80 000 to 180 000) portrays an alarming picture of the impact of the pandemic on HCWs who need to be provided with better protection (including access to vaccines, personal protective equipment, training, testing and psychosocial support) and decent work conditions (including adequate remuneration and protection against excessive workloads). (1)(2)

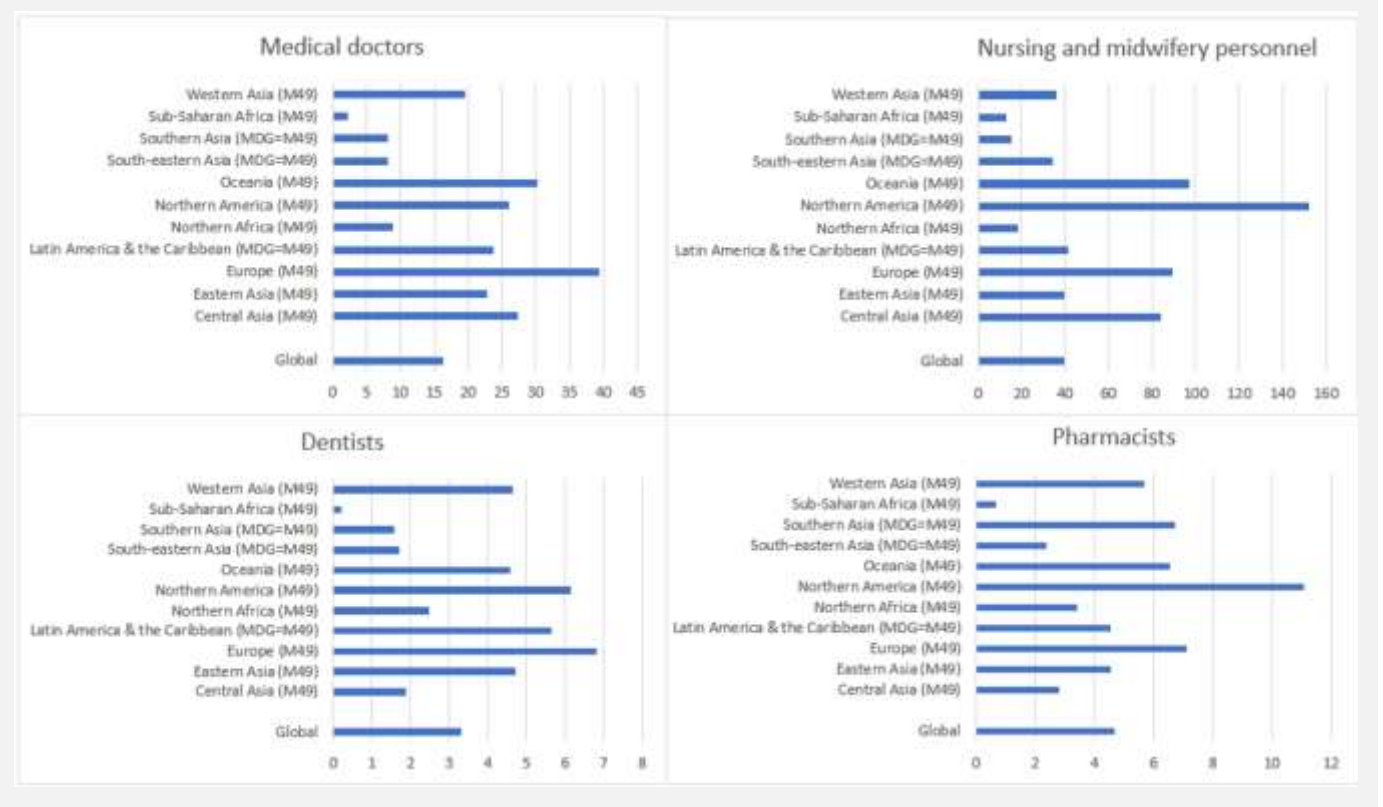
Greater efforts are needed for equitable distribution of COVID-19 vaccines to ensure that HCWs have access to vaccination and protection. Countries are called upon to make a firm commitment to the 'Global Health and Care Worker Compact', called for in the International Year of Health and Care Workers in order to protect HCWs rights, decent work and practice environments (3)

According to National Health Workforce Accounts (NHWA) data from 2014-2020, the density of nursing and midwifery personnel in Northern America remains the highest, over 152 per 10,000 people—almost 4 times the global average, over 15 times that of sub-Saharan Africa and 8 times that of Northern Africa and Southern Asia. The disparity in density of medical doctors is striking with 40 per 10,000 people in Europe, ranging from 20 to 26 in Western Asia, Eastern Asia, Latin America & the Caribbean, Northern America, and as low as 2 per 10,000 in sub-Saharan African. However, there seems to be a steady increase in the medical doctors' density in the countries.

Countries with medical doctors' density less than 1 per 10 000 population, have narrowed to the Sub-Saharan region and Oceania region, compared to 2018 estimates when all regions except Australia and New Zealand and Northern America and Europe, had countries with medical doctors' density less than 1. (4)

The progressive implementation of the NHWA has also brought to bear more data on dentists (ranging from less than 1 per 10 000 population in Sub-Saharan Africa to close to 7 in Europe) and pharmacists (ranging from less than 1 per 10 000 population in Sub-Saharan Africa to 7 in Northern America).

Density of select health professionals per 10,000 population, 2014-2020 (latest available)



#### Additional resources, press releases, etc. with links:

- The impact of COVID-19 on health and care workers: a closer look at deaths. Health Workforce Department – Working Paper 1. Geneva: World Health Organization; September 2021(WHO/HWF/WorkingPaper/2021.1). Licence: CC BY-NC-SA 3.0 IGO.
- [1] International Labour Conference.109/Resolution I (Jun 2021). Resolution concerning a global call to action for a human-centred recovery from the COVID-19 crisis that is inclusive, sustainable and resilient ( [https://www.ilo.org/wcmsp5/groups/public/---ed\\_norm/---relconf/documents/meetingdocument/wcms\\_806092.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_806092.pdf); accessed 7 July 2021).
- Decision WHA73(30). Human resources for health. In: Seventy third World Health Assembly, Geneva, resumed 9-14 November 2020 (WHA73/2020/REC/1, [https://apps.who.int/gb/ebwha/pdf\\_files/WHA73/A73\(30\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73(30)-en.pdf)); WHO (Departmental News, November 2020). 2021 designated as the International Year of Health and Care Workers. <https://www.who.int/news/item/1111-2020-2021-designated-as-the-international-year-ofhealth-and-care-workers>; accessed 7 July 2021).
- The Sustainable Development Goals Report 2018

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Custodian agency(ies): WHO

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

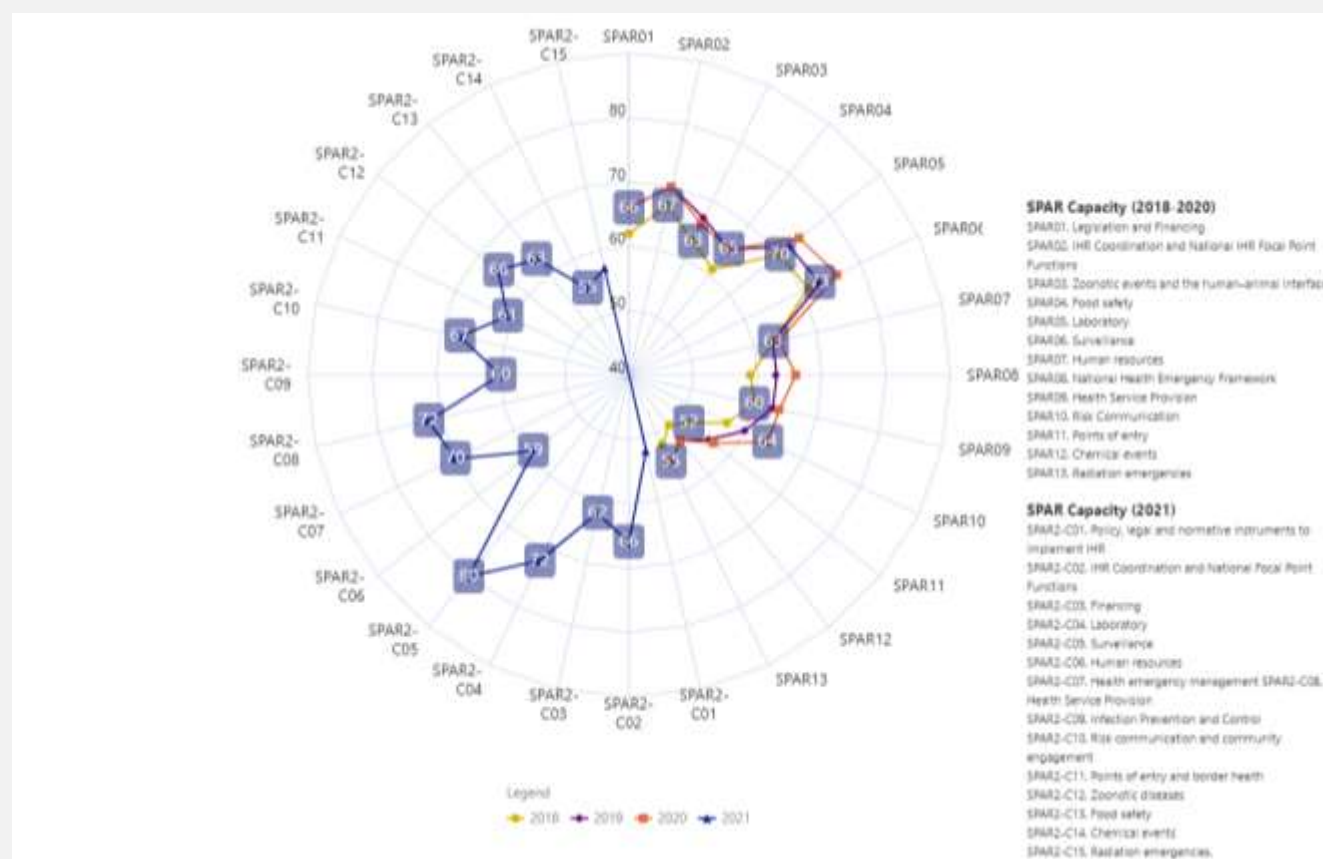
**Indicator 3.d.1: International Health Regulations (IHR) capacity and health emergency preparedness**

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

The current experience with the COVID-19 pandemic continues to show the challenges countries face scaling up existing capacities for public health emergency response at all levels and to maintain the multisectoral coordination and international collaboration. The COVID-19 has also impacted on the activity of national self-assessment and reporting of the status of implementation of the International Health Regulations (2005). As of 28 Jun 2022, 180 countries reported their data for 2021, compare to the 174 countries that reported by October 2021 on their capacities required under the IHR (2005). In 2018, 183 countries reported, and this is the highest so far. The data analysis shows stability and steady progress between 2018 and 2020. In 2021, 196 the state parties reported using the new SPAR (State Party Self-Assessment Annual Reporting) tool which expanded the capacity from 13 to 15, and improved indicators of most capacities. As a result, four capacities had small reduction (i.e, IHR Coordination, National IHR Focal Point functions and advocacy; Laboratory; Human Resources; and Food Safety) compared to one capacity (i.e, Zoonotic events and the human – animal interface) in 2020.

The new changes that also include the split of “Legislation and Financing” capacity into two separate capacities; introduction of “Health emergency management” and “Infection prevention and control (IPC)” were informed by lessons from COVID-19 pandemic. This expected to contribute to improve assessment of IHR capacity and preparedness of State Parties for Health Emergencies.

**IHR State Parties Annual Reports, all regions, all capacities average**



**Additional resources, press releases, etc. with links:**

- SPAR: <https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/states-parties-self-assessment-annual-reporting>

**Custodian agency(ies):** WHO

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

### AMR is a major global public health issue, particularly worrying in low resourced countries

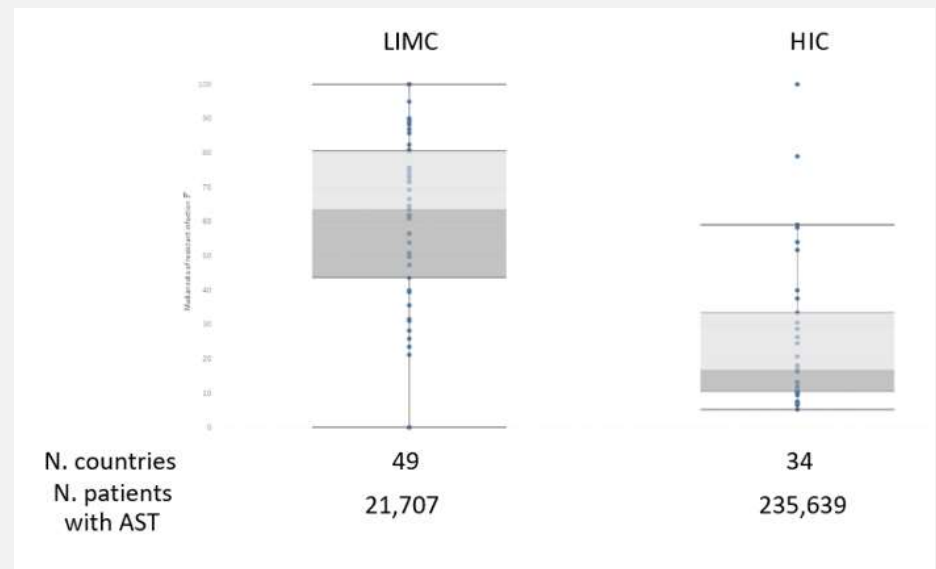
A recent study<sup>5</sup> suggests a high burden of bacterial antimicrobial resistance (AMR) globally. In this study, *Escherichia coli* and *Staphylococcus aureus* were among the leading causes of death, with higher AMR rates in low- and middle-income countries (LMIC). WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) AMR surveillance data presents the same worrisome picture.

The indicator 3.2.d specifically monitors the proportion of bloodstream infections due to methicillin-resistant *Staphylococcus aureus* and *Escherichia coli* resistant to 3rd generation cephalosporins among patients seeking care and whose blood samples were tested. An increasing number of Countries reported 2020 AMR data to WHO, including the indicator 3.2.d. The median proportion of bloodstream infections due to *E. coli* resistant to 3rd generation cephalosporins in 83 countries and the median proportion of methicillin-resistant *Staphylococcus aureus* (MRSA) in 81 countries were 47.5% (IQR 17.3-71.7) and 35.9% (IQR 12.5-50), respectively.

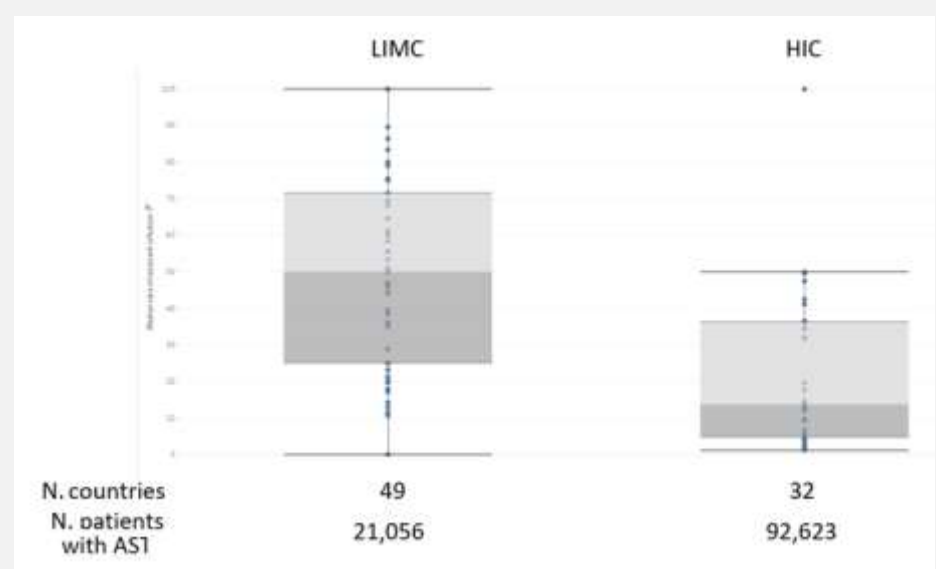
The frequency of resistance for both indicators was significantly higher in LMIC as compared to high-income countries (HIC) (Figure 1). It is important to note that the interpretation of routine surveillance data as reported to WHO remains challenging as many countries, especially LMIC, are still at early stages of antimicrobial resistance surveillance, with limited coverage and quality control. Therefore, these findings require further verification through the introduction of novel AMR surveillance approaches, while at the same time strengthening efforts to improve the representativeness and accuracy of routine surveillance.

Although data limitations do not yet allow for robust country comparisons and trends over time, the high proportions of bloodstream infections due to MRSA and *E. coli* resistant to 3rd generation cephalosporins as reported worldwide confirm that AMR poses as a major public health threat. Urgent actions are needed to prevent and control AMR, and generate more robust AMR data, particularly in LMIC.

Global median rate of bloodstream infections due to *E. coli* resistant to 3rd generation cephalosporins



Global median rate of bloodstream infections due methicillin-resistant *Staphylococcus aureus* (MRSA)



#### Additional resources, press releases, etc. with links:

- Murray et al. Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. Lancet 2022; 399(10325): 629-655. At [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)02724-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02724-0/fulltext)

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**Custodian agency(ies):** WHO

<sup>5</sup> Murray et al. Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. Lancet 2022; 399(10325): 629-655. At [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)02724-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02724-0/fulltext).