

The Sustainable Development Goals Extended Report 2023

3 GOOD HEALTH AND WELL-BEING



Note: This unedited 'Extended Report' includes all indicator storyline contents as provided by the SDG indicator custodian agencies as of 30 April 2023. For instances where the custodian agency has not submitted a storyline for an indicator, please see the custodian agency focal point information for further information. The 'Extended Report' aims to provide the public with additional information regarding the SDG indicators and is compiled by the Statistics Division (UNSD) of the United Nations Department of Economic and Social Affairs.

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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

A woman dies every two minutes due to pregnancy or childbirth

Every day in 2020, approximately 800 women died from preventable causes related to pregnancy and childbirth - meaning that a woman dies around every two minutes. The global maternal mortality ratio (maternal deaths per 100 000 live births - MMR) in 2020 was estimated at 223 maternal deaths per 100 000 live births (uncertainty interval (UI) 202 to 255), down from 227 in 2015 (UI 211 to 246). During the Millennium Development Goal era – from 2000 to 2015 – the global average annual rate of reduction was 2.7% (UI 2.0% to 3.2%), but this fell to -0.04% (UI -1.6% to 1.1%) during the first five years of the Sustainable Development Goal (SDG) era, between 2016 and 2020. In 2020, about 70% of all maternal deaths were in sub-Saharan Africa followed by Central and Southern Asia which accounted for almost 17%. Three countries – all in sub-Saharan Africa – were estimated to have extremely high MMR in 2020 (over 1000): South Sudan (1223; UI 746 to 2009), Chad (1063; UI 772 to 1586) and Nigeria (1047; UI 793 to 1565). Ten other countries, all except one of which (Afghanistan) are also in sub-Saharan Africa, were estimated to have very high MMR in 2020 (500–999). In contrast, the pace of progress between 2016 and 2020 in least developed countries and landlocked developing countries was positive and significant, with an average ARR of 2.8% (UI 1.4% to 3.9%) and 3.0% (UI 1.4% to 4.4%), respectively, for these groups of countries. However, in small island developing States, the MMR stagnated during this period, with a non-significant 1.2% change in MMR (UI -9.0% to 9.2%). 15-year-old girl in sub-Saharan Africa in 2020 has the highest lifetime risk (1 in 40) – approximately 400 times higher than in Australia and New Zealand (1 in 16 000). In nine countries facing severe humanitarian crises, maternal mortality ratios were more than double the world average (551 maternal deaths per 100 000 live births, compared to 223 globally).

The COVID-19 pandemic may have further held back progress on maternal health. Noting the current data series ends in 2020, more data will be needed to show the true impacts of the pandemic on maternal deaths.

Most maternal deaths are preventable, as the health-care solutions to prevent or manage complications are well known. All women need access to timely high-quality care in pregnancy, and during and after childbirth. To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at both health system and societal levels which require a multi-sectoral approaches to build health system resilience.

Additional resources, press releases, etc. with links:

- Report: Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023.
- Report, data, model codes and country profiles are accessible at: <https://www.who.int/publications/i/item/9789240068759>
- Press release: [A woman dies every two minutes due to pregnancy or childbirth](#)

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Custodian agency(ies): WHO

Indicator 3.1.2 Proportion of births attended by skilled health personnel

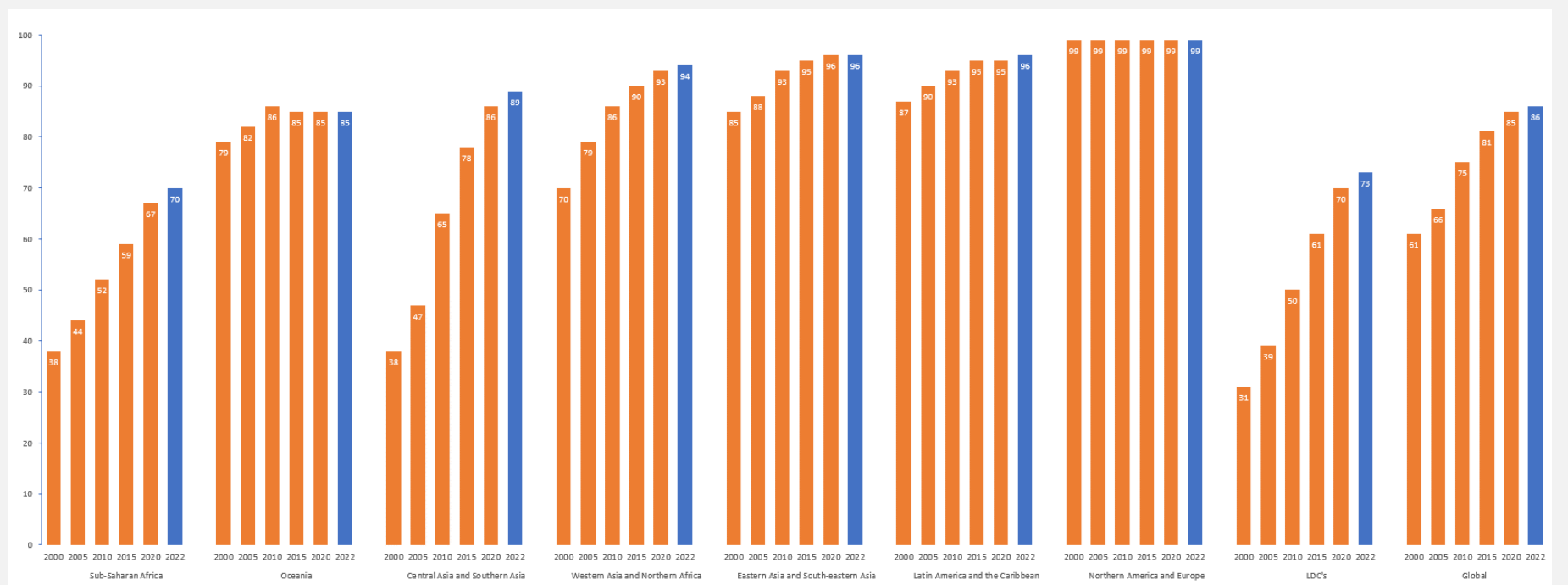
Accelerating progress towards universal coverage of assisted childbirth by skilled health personnel is essential to achieving the SDGs and ensuring that no woman is left behind.

The assistance of skilled health personnel during childbirth is crucial for the lives of women, newborns, and their families. While there has been progress in increasing coverage of assisted childbirth by skilled health personnel, access remains limited in many countries, particularly in sub-Saharan Africa and Southern Asia, where mortality rates are highest. In 2022, 86% of births globally were assisted by skilled health personnel, but only 70% in sub-Saharan Africa. The COVID-19 pandemic has negatively affected maternal health services globally, hindering access to childbirth services for pregnant women. The lack of access to skilled health personnel during childbirth is a significant contributing factor to maternal and newborn mortality. Many deaths could have been prevented with access to skilled health personnel during childbirth, as they are equipped to handle complications and provide appropriate medical care to ensure safe childbirth. The Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM) initiatives have established new coverage targets and milestones that need to be achieved by 2025 to meet the SDGs. The global target for the indicator of birth attended by skilled health personnel is to reach a 90% coverage by 2025, but sub-Saharan Africa is not on pace to meet this target.

To accelerate progress towards universal coverage of assisted childbirth by skilled health personnel, it is essential to prioritize investments in health systems and workforce development. This includes ensuring that there are enough skilled health personnel available to meet the needs of pregnant women and newborns, particularly in underserved areas. It also involves improving the quality of care provided during childbirth and ensuring that all women, regardless of their socioeconomic status, have access to these services.

In conclusion, ensuring access to skilled health personnel during childbirth is critical to reducing maternal and newborn mortality rates. While progress has been made globally, more work needs to be done to ensure universal coverage, particularly in sub-Saharan Africa and Southern Asia. Investments in health systems and workforce development are essential to accelerate progress towards universal coverage, and to meet the SDGs by 2030.

Proportion of Births Attended by Skilled Health Personnel, 2000-2022 (percentage)



Additional resources, press releases, etc. with links:

- Source: Joint UNICEF/WHO database 2023 of skilled health personnel, based on population based national household survey data and routine health systems.
- Note: Includes data on institutional births for countries in which data on skilled attendance at birth was not available.

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Custodian agency(ies): UNICEF, WHO

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

Indicator 3.2.1 Under-5 mortality rate

Indicator 3.2.2 Neonatal mortality rate

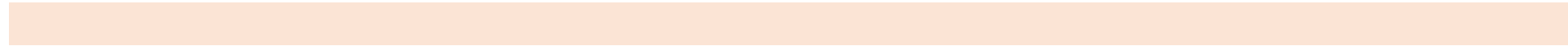
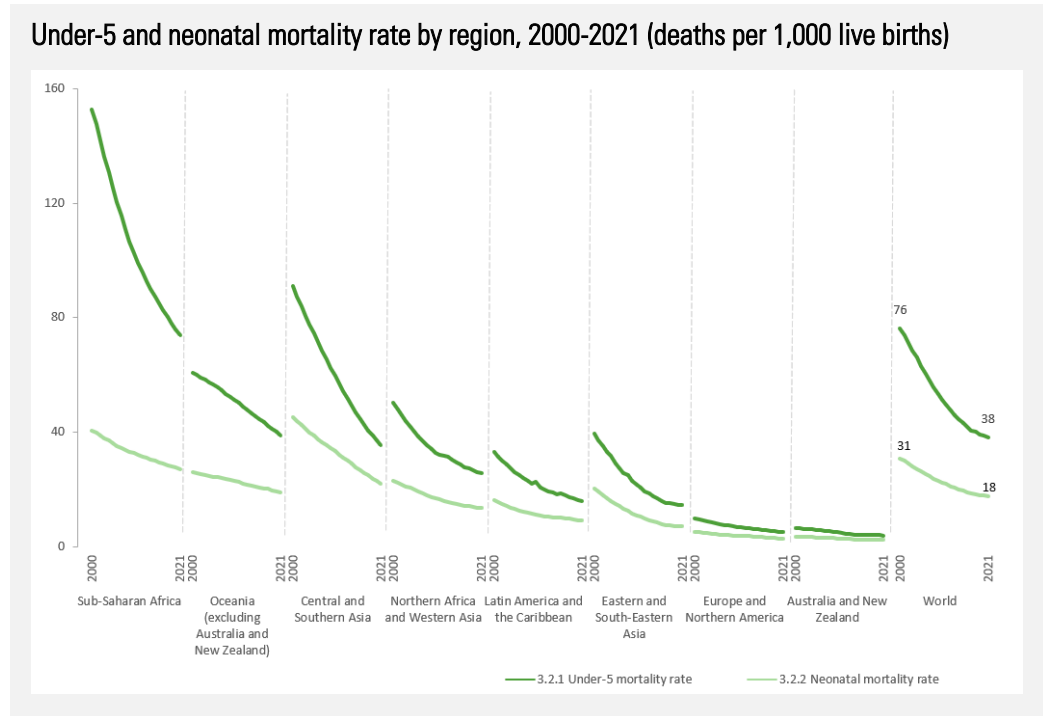
Nearly 10 million under-5 deaths could be averted between 2022 and 2030 if all countries reached the SDG under-5 mortality target

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 50 per cent from 76 deaths per 1,000 live births in 2000 to 38 deaths in 2021, and the global neonatal mortality rate fell by 43 per cent from 31 deaths per 1,000 live births in 2000 to 18 deaths in 2021. Still, the burden of child deaths remains immense—5.0 million children died before reaching age five in 2021 alone, with almost half of those deaths (2.3 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 and economic 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 2021. That is equivalent to 1 child in 14 dying before reaching age 5, 19 times higher than the rate of 1 in 257 in the region of Australia and New Zealand and two decades behind the world average, which achieved a 1 in 14 rate by 2001.

By 2021, 133 countries had already met the SDG target on under-five mortality, and 13 countries are expected to do so by 2030, if current trends continue. However, progress will need to accelerate in 54 countries, nearly 75 per cent of which are located sub-Saharan Africa, to meet the target by 2030. If these countries were to achieve the SDG under-five target, the number of under-five deaths between 2022 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, 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.



Additional resources, press releases, etc. with links:

- United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 'Levels & Trends in Child Mortality: Report 2022, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation', United Nations Children's Fund, New York, 2023. Link: <https://childmortality.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022.pdf>
- Website: <https://childmortality.org/>

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Custodian agency(ies): UNICEF

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

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

Inequalities are stopping the world from ending AIDS

The world has shown tremendous progress on decreasing new HIV infections, particularly in the highest burden regions. The estimated 1.5 million [1.1 million–2.0 million] new HIV infections globally in 2021 were fewer than at any point since the late 1980s and almost one third fewer (32%) than in 2010. Success in providing effective HIV treatment to increasing numbers of people living with HIV has reduced global AIDS-related deaths by almost 55% since 2010 (from 1.4 million [1.1 – 1.8 million] to 650 000 [510 000 – 860 000] in 2021).

The region with the largest HIV burden, sub-Saharan Africa, has achieved a 44% decline in annual new HIV infections since 2010, the steepest reduction in the world. Not everyone is benefiting equally, however, and multiple vulnerabilities—including unequal power dynamics between men and women and harmful gender, social, and economic norms—continue to put women and adolescent girls in all their diversity in this region at heightened risk of HIV infection. Since 2010, the decline in new HIV infection has been much sharper among adolescent boys and young men (56%) than among adolescent girls and young women (42%) or older women (aged 25–49 years) (29%).

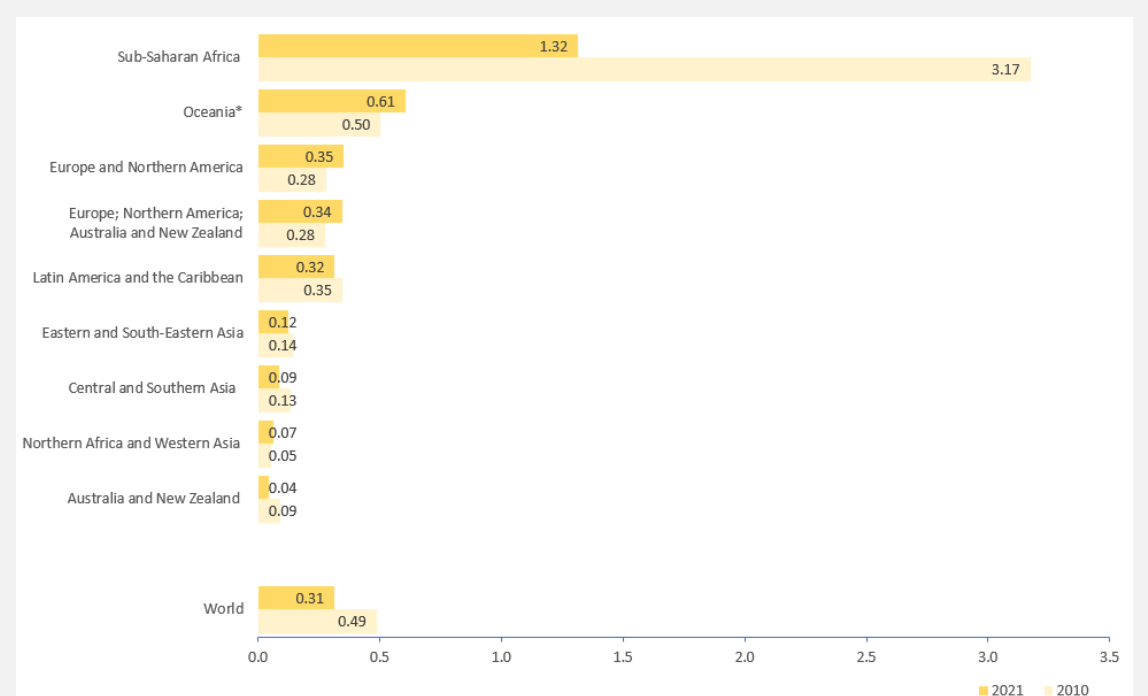
Progress in reducing new infections and AIDS-related deaths is slower in other regions, which together account for a growing share of people acquiring HIV. The vast majority of infections in those regions are in key populations who are subject to stigma and discrimination, criminalization, violence and social exclusion. Urgent efforts are needed to eliminate these inequalities, including through community-led responses, accelerated scale-up of pre-exposure prophylaxis and immediate action to close access gaps for harm reduction services.

Extensive provision of antiretroviral therapy to pregnant and breastfeeding women living with HIV continues to reduce new child infections, the vast majority (about 85%) of which occur in sub-Saharan Africa. New infections among children (aged 0–14 years) globally declined by 52% since 2010, to 160 000 [110 000–230 000]. Nonetheless, the world continues to fail children in the AIDS response: while 81% of pregnant women living with HIV and 76% of adults (aged 15 years and older) were receiving antiretroviral therapy overall in 2021, only 52% of children were accessing treatment, with this gap in coverage continuing to grow since 2010.

Inequalities such as those above and other among key populations at increased risk to HIV have to be removed if the world is to achieve the HIV targets for 2025 and change the current trajectory of infections and deaths. The cost of missing those targets will be huge. Given current trends, at least 1.2 million people will acquire HIV in 2025 (three times more than the target of 370 000 new infections) and some 460 000 people are projected to die of AIDS-related causes globally in 2025 (80% more than the 2025 target of 250 000 deaths).

The colliding AIDS and COVID-19 pandemics—along with economic and humanitarian crises—have placed the global HIV response under increasing threat. Many major bilateral donors are reducing international assistance for AIDS; meanwhile, low- and middle-income countries struggle under the greater fiscal burdens caused by the COVID-19 pandemic. Overall, major gains are being made, but renewed urgency is needed to ensure the progress reaches the populations and places that are still being left behind, a reminder that inequalities undermine the AIDS response for all. In some parts of the world and for some communities, the response to the AIDS pandemic has shown remarkable resilience in adverse times, with HIV treatment and prevention programmes adapting to COVID-19 mitigation efforts. If there is one lesson that the COVID-19 pandemic has taught us, it is that pandemics can't be ended anywhere until they are ended everywhere.

HIV incidence rates, 2010 and 2021 (new cases per 1,000 uninfected adults aged 15 to 49 years)



Additional resources, press releases, etc. with links:

- 2022 World AIDS Day report (<https://www.unaids.org/en/resources/documents/2022/dangerous-inequalities>)
- 2022 UNAIDS Global AIDS Update (<https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update>)
- AIDSinfo (<https://aidsinfo.unaids.org/>)

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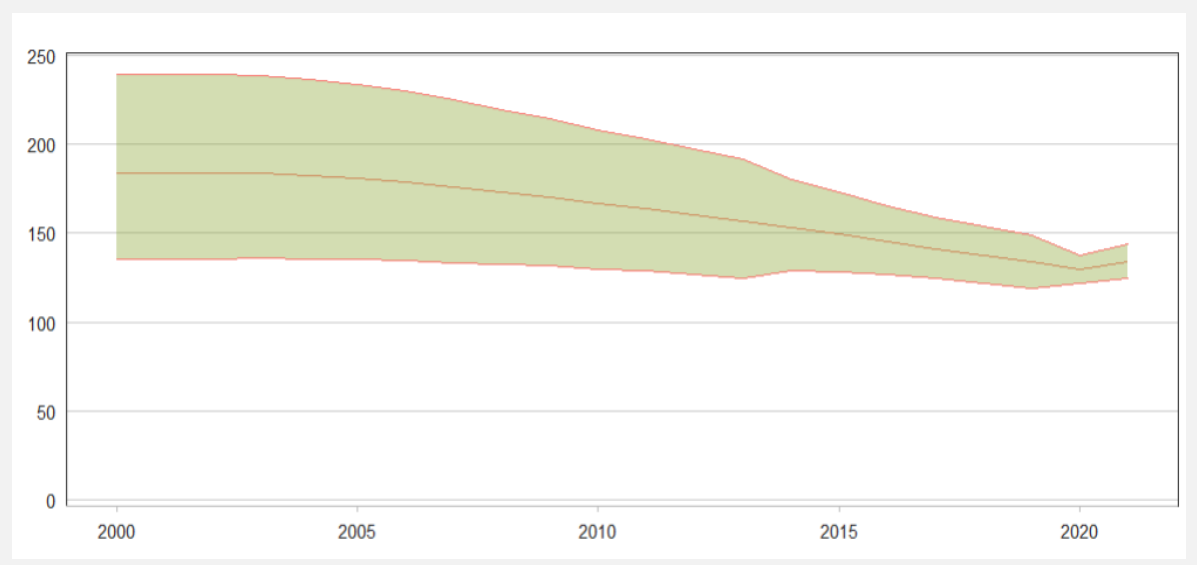
Custodian agency(ies): UNAIDS

Indicator 3.3.2 Tuberculosis incidence per 100,000 population

Global targets for ending the TB epidemic are off-track

The COVID-19 pandemic has had a negative impact on access to TB diagnosis and treatment in many countries, in turn resulting in global increases in TB disease burden. Global targets for reductions in TB incidence (new cases per 100 000 population per year) and the number of people dying from TB are off-track. In 2021, an estimated 10.6 million people (95% uncertainty interval [UI]: 9.9–11 million) fell ill with TB, an increase of 4.5% from 10.1 million (95% UI: 9.5–10.7 million) in 2020. The TB incidence rate rose by 3.6% between 2020 and 2021, reversing declines of about 2% per year for most of the previous two decades. The net reduction from 2015 to 2021 was 10%, only one fifth of the way to the 2025 milestone of WHO's End TB Strategy. Globally, the estimated number of deaths from TB increased in 2020 and 2021, reversing years of decline between 2005 and 2019. In 2021, there were an estimated 1.4 million deaths among HIV-negative people (95% UI: 1.3–1.5 million) and 187 000 deaths (95% UI: 158 000–218 000) among HIV-positive people, for a combined total of 1.6 million. The net reduction in the number of people dying from TB between 2015 and 2021 was only 5.9%, less than one tenth of the way to the 2025 milestone of the End TB Strategy.

Incidence rate of tuberculosis, 2000-2021



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Custodian agency(ies): WHO

Indicator 3.3.3 Malaria incidence per 1,000 population

Malaria cases and deaths remained stable in 2021, but progress towards the SDG 2030 malaria target is off course

Despite COVID-related disruptions to malaria prevention, testing and treatment services, and the often-devastating impacts of the pandemic on health, social and economic systems, national malaria programmes and their partners largely held the line against further setbacks to malaria control in 2021.

According to the latest *World malaria report*, published in December 2022, there were an estimated 619 000 malaria deaths globally in 2021 compared to 625 000 in the first year of the pandemic. In 2019, before the pandemic struck, the number of deaths stood at 568 000.

Malaria cases continued to rise between 2020 and 2021, but at a slower rate than in the period 2019 to 2020. The global tally of malaria cases reached 247 million in 2021, compared to 245 million in 2020 and 232 million in 2019.

National-level commitment to malaria control was key to success. In 2021, distributions of insecticide-treated nets (ITNs) – the primary vector control tool used in most endemic countries – was strong overall and reached similar levels to the pre-pandemic years: of the 171 million ITNs planned for distribution 128 million (75%) reached their target destination.

In 15 African countries, about 45 million children were treated, on average, per seasonal malaria chemoprevention (SMC) cycle, a major increase from 33.4 million in 2020 and about 22 million in 2019. The preventive therapy is recommended for children living in areas with highly seasonal malaria transmission in Africa.

Despite supply chain and logistical challenges during the pandemic, malaria-endemic countries distributed 223 million malaria rapid diagnostic tests in 2021, a similar level reported before the onset of COVID-19. At the same time, countries succeeded in maintaining the delivery of malaria drug regimens, with an estimated 242 million ACT treatment courses distributed worldwide in 2021 compared to 239 million in 2019.

However, too many people at high risk of malaria are still missing out on the services they need to prevent, detect and treat the disease. In 2021, just over half (53%) of pregnant women and children under 5 years of age in sub-Saharan Africa slept under an insecticide-treated net (ITN).

Only one third (35%) of pregnant women in Africa received the WHO-recommended 3-dose regimen of preventive malaria therapy in 2021 – a figure that has remained largely unchanged in recent years. And, in the period 2015 to 2021, about one third of children with a fever (35%) were not taken to a health provider for treatment.

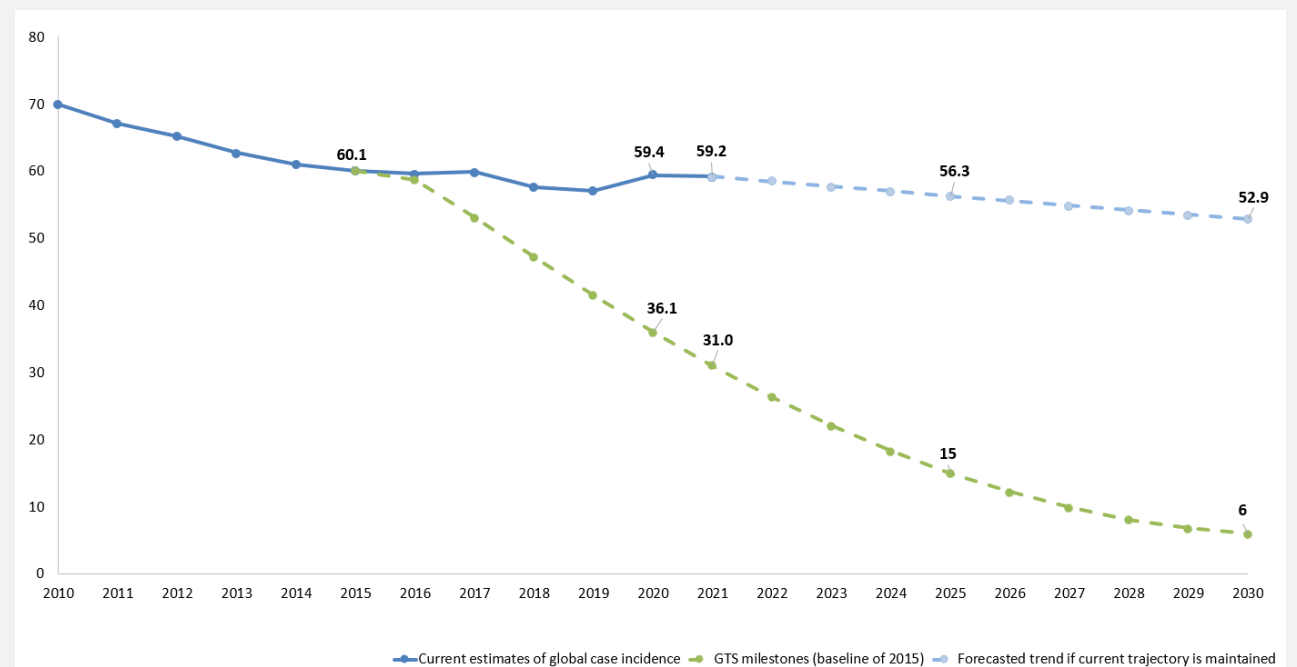
Challenges in expanding access to malaria services have been compounded, particularly in Africa, by the ongoing COVID-19 pandemic, converging humanitarian crises, restricted funding, weak surveillance systems, and declines in the effectiveness of the most commonly used ITNs. Other threats to the malaria response in the African continent include growing parasite resistance to antimalarial drug regimens and an invasive mosquito that adapts easily to urban environments.

Progress towards key global malaria targets remains off course. Urgent and concerted action is needed to set the world back on a trajectory towards achieving the case incidence and mortality targets of WHO's *Global technical strategy for malaria 2016-2030* (GTS) and the SDG target of ending malaria by 2030.

To support countries in building more resilient malaria programmes, WHO recently published new guidance, including: a new strategy to contain antimalarial drug resistance in Africa; a new initiative to stop the spread of the *Anopheles stephensi* mosquito in urban environments; a new framework to guide city leaders in urban malaria control; and a new toolkit to help countries assess their malaria surveillance systems and identify areas for investment.

To support malaria-endemic countries, WHO has also increased the transparency, flexibility and access to its malaria recommendations. WHO encourages countries to tailor the recommendations to local disease settings, using local data, for maximum impact.

Comparison of global progress in malaria case incidence (per 1000 population at risk) considering two scenarios: current trajectory maintained (blue) and targets of the GTS achieved (green)



Additional resources, press releases, etc. with links:

- [Strategy to respond to antimalarial drug resistance in Africa \(who.int\)](#)
- [WHO initiative to stop the spread of Anopheles stephensi in Africa](#)
- [Global framework for the response to malaria in urban areas \(who.int\)](#)
- Malaria surveillance assessment toolkit : [Global Malaria Programme \(who.int\)](#)
- WHO's consolidated malaria guidelines: [Global Malaria Programme \(who.int\)](#)

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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: tackling the disease burden and progress achieved in 2021

In 2021, 1.65 billion people were reported to require mass or individual treatment and care¹ for neglected tropical diseases (NTDs), down from 2.19 billion in 2010, representing a reduction of 25%. The majority of these individuals continued to require mass treatment for diseases amenable to preventive chemotherapy (lymphatic filariasis, onchocerciasis, soil-transmitted helminthiases, schistosomiasis and trachoma), while the numbers requiring other NTD services such as individual disease management or care were much smaller, approximating a few million. Global progress in reducing the number of people requiring interventions against NTDs, which is one of the NTD road map's overarching indicators², was driven by three main factors: first, a number of countries have eliminated at least one NTD (as of December 2022, 47 countries, territories and areas had eliminated at least one NTD); secondly, although not yet certified, verified or validated, several countries have reached the post-intervention surveillance phase for at least one NTD; thirdly, remapping for a number of NTDs has led to the reclassification from endemic to nonendemic status of several geographical areas within a few countries. Improved livelihoods and living conditions may have also contributed, although in uneven and varying ways, as several countries endemic for NTDs are affected by social instability, entailing destruction and population displacement.

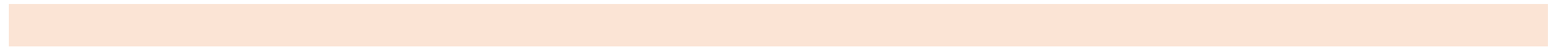
Notably, between 2020 and 2021, the global reduction of about 80 million was largely attributable to a revision of the number of children requiring preventive chemotherapy for soil-transmitted helminthiases in India, which is the country with the largest population requiring this intervention globally. This decrease was based on impact assessment surveys conducted in the past few years, which changed the endemicity status of some districts.

Some 505 million people required treatment and care for NTDs in the least developed countries (LDCs), representing 46% of those countries' populations, down from 79% in 2010. More than 1.14 billion people living outside the group of LDCs still required treatment and care for NTDs.

In 2021, across the entire spectrum of essential health services, NTD services were found to be among those most severely affected by the coronavirus disease (COVID-19) pandemic; notably, preventive chemotherapy interventions were the most frequently affected among NTD services. Nevertheless, in 2021–2022 efforts continued to mitigate the impact of the pandemic and implement the road map, which resulted in improved performance of NTD programmes. For example, 1.805 billion treatments were delivered through preventive chemotherapy in 2019, 1.137 billion in 2020 (–37%) and 1.355 billion in 2021 (–25%); compared with 2020, about 218 more million treatments were distributed in 2021 (+19%).

The number of people receiving NTD treatments, both through preventive chemotherapy and through individual treatment and care, has also bounced back after the major disruptions caused by COVID-19. Although the difference from the pre-COVID-19 era is still substantial (more than one billion people had been treated every year for four consecutive years between 2016 and 2019), the trend registered in 2021 (888 million people treated, +11% from 798 million treated in 2020) is positive and likely to continue in 2022.

The pandemic has also presented opportunities for innovation and synergies. For example, hand-washing and other WASH-related measures were promoted and enforced during the pandemic in accordance with WHO guidance, which is expected to have generated a positive impact on transmission of several NTDs as well.



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Custodian agency(ies): WHO

¹ Preventive, curative, surgical or rehabilitative interventions.

² 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 2 February 2023)

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

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

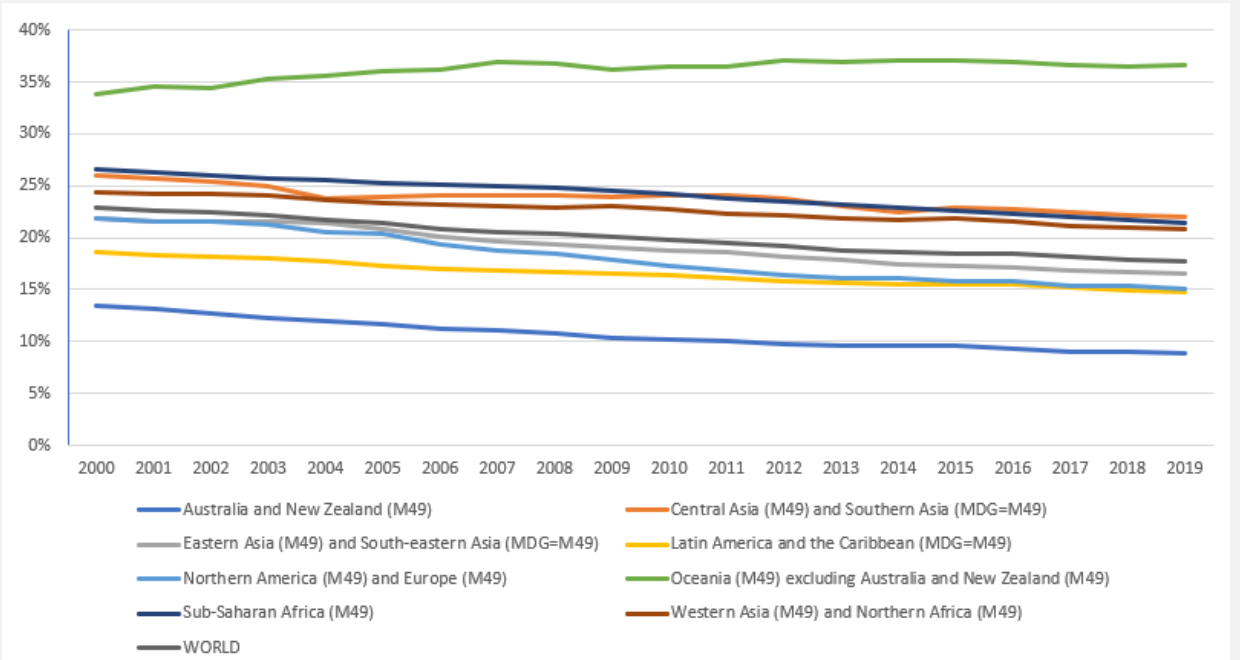
Most of the world is not on track to meet the SDG target on noncommunicable diseases

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

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

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

Probability of dying from any of the four main NCDs between ages 30 and 70, 2000 to 2019 (%)



Storyline authors(s)/contributor(s): Melanie Cowan, World Health Organization; Leanne Riley, World Health Organization

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

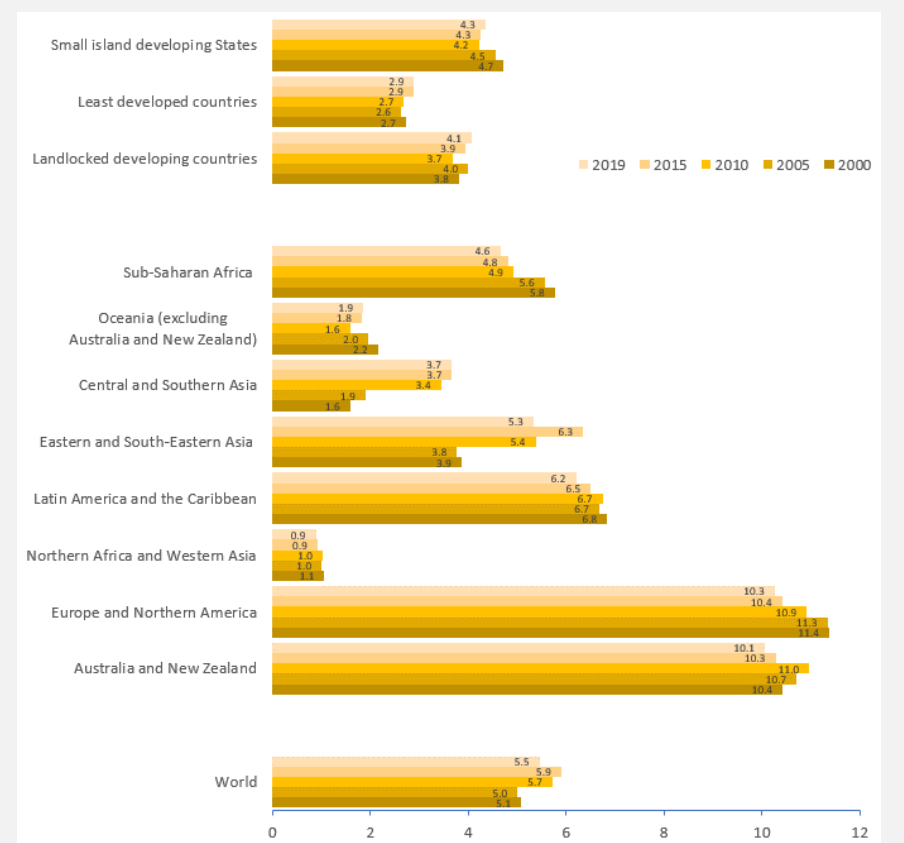
The level of drinking in populations is highest in Europe and Northern America, and is increasing in Central and Southern Asia

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

In 2019, alcohol consumption in the world, measured in litres of pure alcohol per person of 15 years of age or older, was 5.5 litres, which is a 4.7% relative decrease from 5.7 litres in 2010. Europe and Northern America has the highest per capita consumption in the world (10.3 litres per capita in 2019), and its per capita consumption has decreased by 6.0% since 2010. In all (SDG) regions, fewer women drink alcohol than men, and when they drink, they drink less. In 2019, 56% of the world population aged 15 years or older (65% of women; 48% of men) abstained from drinking alcohol in the past 12 months.

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

Adult per capita consumption (litres/year)



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[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

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

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

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

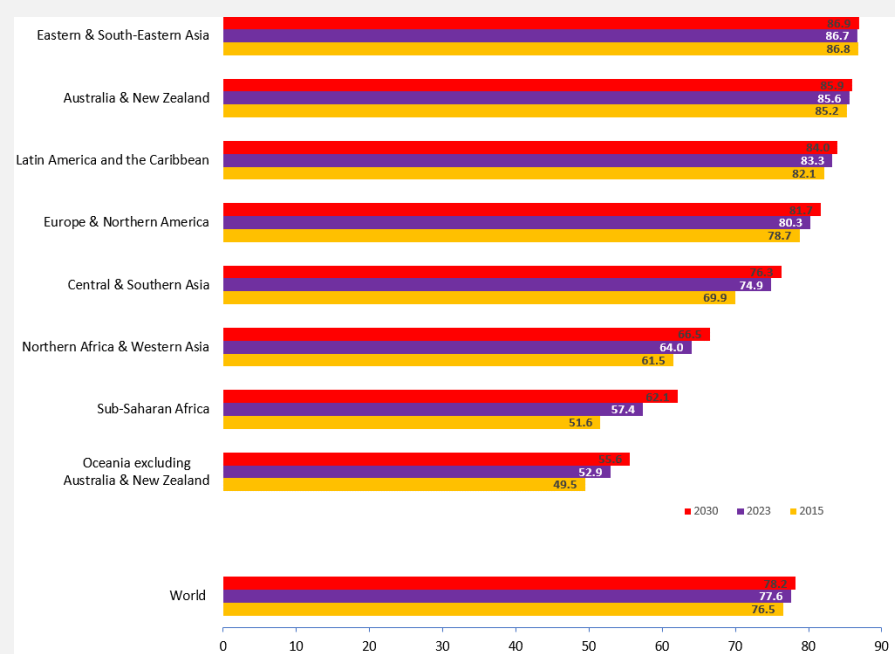
More women among those who want to avoid pregnancy use modern contraceptive methods

Access to and use of modern contraceptive methods enable individuals and couples to exercise their right to decide the number and spacing of their children. Globally, the proportion of women of reproductive age (aged 15-49) who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1) increased slightly from 76.5 per cent to 77.6 per cent between 2015 and 2023 and is projected to reach 78.2 per cent by 2030. Slow global progress in meeting the need for family planning with modern contraception conceals the advances made in all regions, with the largest increases observed in regions where modern contraceptive use among women who want to avoid pregnancy was lower than the global value in 2015 (Figure 1). In sub-Saharan Africa, the proportion of women using modern contraception among those who want to avoid a pregnancy increased from 51.6 per cent to 57.4 per cent between 2015 and 2023 and is projected to rise further to 62.1 per cent by 2030. Three other regions with low use of modern contraception are expected to experience slower increases in the proportion of women of reproductive age who have their need for family planning satisfied with modern methods between 2015 and 2030 – in Oceania excluding Australia and New Zealand from 49.5 to 55.6 per cent, in Northern Africa and Western Asia from 61.5 to 66.5 per cent and in Central and Southern Asia from 69.9 to 76.3 per cent.

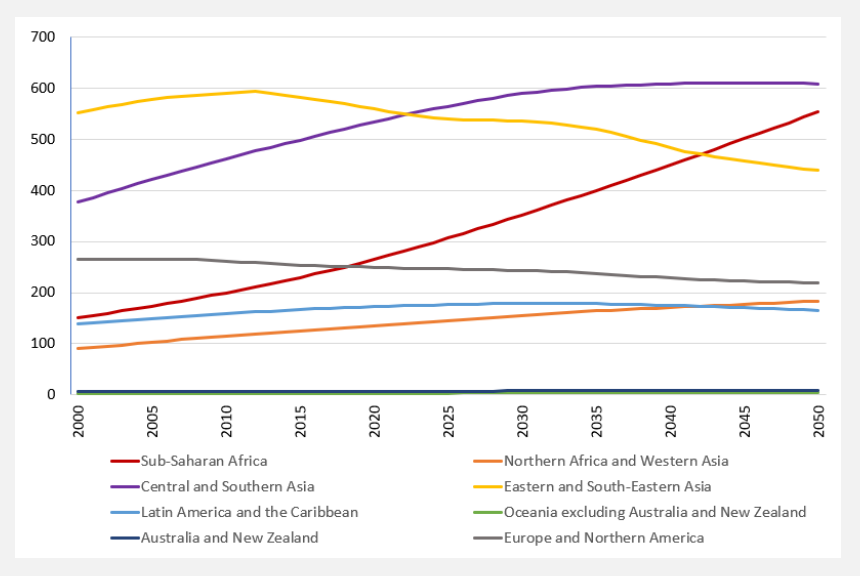
Notably, progress in these regions has been achieved against a background of rapid growth in the number of women of reproductive age, which heightens the challenges of ensuring adequate coverage of reproductive health-care services, including family planning. In sub-Saharan Africa, the population of women of reproductive age, which was 230 million in 2015, is projected to number 352 million by 2030, an increase of more than half (53.0 per cent) (Figure 2). Similarly, over the same period, the population of women of reproductive age is projected to increase by 18.2 per cent in Central and Southern Asia, by 24.2 per cent in Northern Africa and Western Asia, and by 30.9 per cent in Oceania excluding Australia and New Zealand. These four regions together are home to an increasing percentage of reproductive-age women globally – rising from 45.9 per cent of the total in 2015 to 53.2 per cent in 2030.

Future global progress will be driven by trends in regions and countries where the use of modern contraceptive methods among women who want to avoid pregnancy is still low and the number of women of reproductive age will continue to grow rapidly. In addition to its impact on global progress, an accelerated increase in meeting family planning needs in regions with the largest gaps would help to reduce global inequality in access to reproductive health-care services, including for family planning.

Proportion of women of reproductive age (aged 15-49) who have their need for family planning satisfied by modern methods (SDG indicator 3.7.1), by SDG regions (percentage)



Population of women of reproductive age (aged 15-49), by SDG regions, 2000-2050 (millions)



Additional resources, press releases, etc. with links:

- United Nations Department of Economic and Social Affairs, Population Division (2022). World Family Planning 2022. Meeting the changing needs for family planning: Contraceptive use by age and method (UN DESA/POP/2022/TR/NO. 4)
 - (2020). World Family Planning 2020. Accelerating action to ensure universal access to family planning (ST/ESA/SER.A/450)
 - (2022). World Population Prospects 2022 (UN DESA/POP/2021/TR/NO. 3)
 - (n.d.). SDG Indicator 3.7.1. Available at <https://www.un.org/development/desa/pd/data/sdg-indicator-371-contraceptive-use>.

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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

Adolescent fertility continues to decline

Reducing adolescent pregnancies and adolescent birth rates (the number of births per 1,000 women aged 10-14 and women aged 15-19), continues to be an important priority for the international community. Pregnancy complications are a known leading cause of death among girls and young women aged 15-19 and these risks are only exacerbated among younger girls. The adolescent birth rate is also an indicator of the effectiveness of measures taken to prevent unintended pregnancies and to ensure universal access to sexual and reproductive health-care services.

This year's data submission presents, for the first time, a comprehensive global dataset on adolescent birth rates for young adolescents ages 10-14 years. These new data can help the international community to shine a light on young girls, often those who are the most vulnerable and most at risk of being left behind.

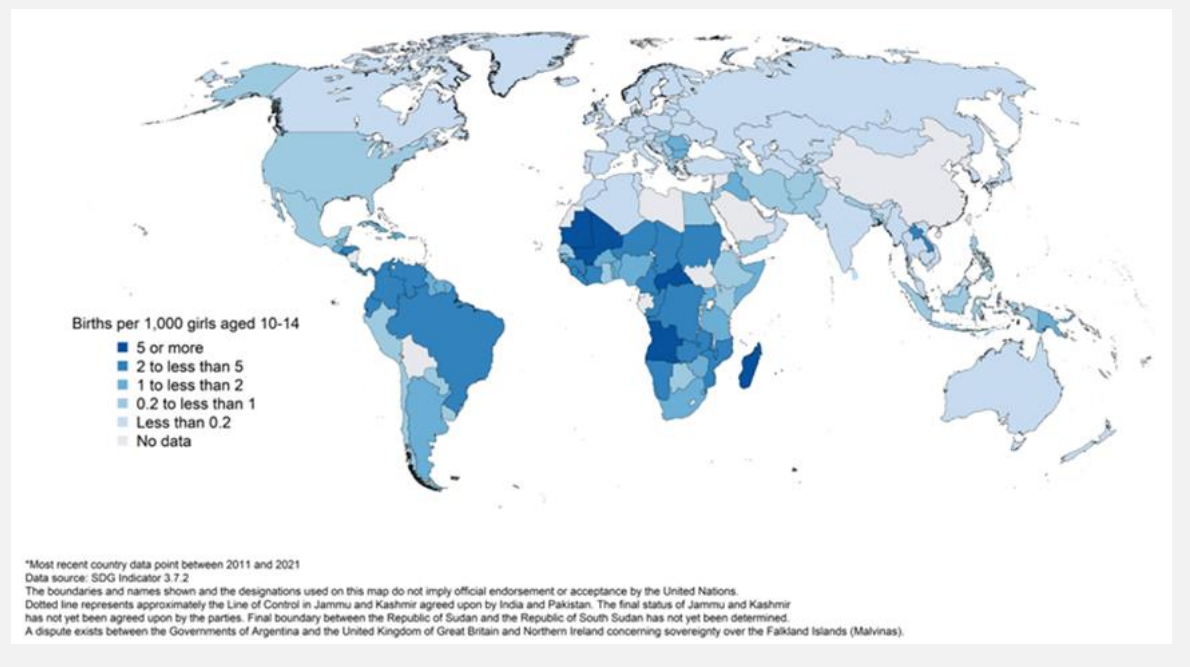
Pregnancy among young girls aged 10-14 is generally rather uncommon when compared with pregnancy among older girls aged 15-19. In 2021, the global adolescent birth rate for women ages 15-19 was 42.5 births per 1,000 women in that age group, down from 47.2 in 2015 and 64.5 in 2000; a remarkable decline of one third since 2000. The global adolescent birth rate for girls aged 10-14 has also declined, from 3.3 births per 1,000 girls in that age group in 2000 to 1.8 births in 2015 and to 1.6 births in 2021; a total reduction of more than 50 percent over the past 20 years.

While progress is uneven, the decline in the adolescent birth rate for both age-groups has been almost universal since 2000 across major regions and countries. The largest declines are reported for Central and South-Eastern Asia, from 96.2 births for 1,000 women aged 15-19 years in 2000 to 34.5 in 2015 and 28.8 in 2021 (a reduction of 70 per cent) and from 4.8 births per 1,000 girls aged 10-14 in 2000 to 0.7 in 2015 and 0.5 in 2021 (a reduction of 89 per cent).

For the first time available global and regional estimates on early adolescent fertility (for girls between 10-14 years) show (Figure 1) that becoming a mother at such young ages varies considerably across the world, and it is quite common in sub-Saharan Africa, in Latin America and the Caribbean and in Oceania. It occurs mostly in sub-Saharan Africa, with nearly 5 births per 1,000 girls aged 10 to 14 years in 2021. The highest rates are observed in countries of Western and Middle Africa, and parts of Eastern Africa. Birth rates to girls below age 15 are also high in Latin America and the Caribbean at 2.4 births per 1,000 girls aged 10 to 14 years and in Oceania (excluding Australia and New Zealand) at 2.2 births per 1,000 girls aged 10 to 14 years. While in other regions childbearing below age 15 is relatively uncommon, selected countries such as Afghanistan, Bangladesh and Lao People's Democratic Republic still have more than 2 births per 1,000 girls aged 10 to 14 years.

Becoming a mother below the age of 15 is a rare experience in Australia and New Zealand, Europe and Northern America (less than 0.1 births per 1,000 girls aged 10 to 14 years in 2021). Data to assess the impact of COVID-19 on adolescent fertility in a systematic manner are not yet available.

Adolescent birth rate per 1,000 girls ages 10-14, 2021*



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

Indicator 3.8.1 Coverage of essential health services

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

Halfway through the SDG period, the world is far short of reaching universal health coverage (SDG target 3.8) as improvements to health services coverage have stagnated and financial hardship resulting from the need to pay out-of-pocket for health services and products worsened for too many people.

Universal health coverage (UHC) means that all people can access needed health services of good quality without facing financial hardship. The latest data confirms alarming trends in SDG UHC indicators. After massive global efforts to alleviate the burden of infectious diseases, especially HIV, TB, and malaria, drove rapid expansions of service coverage (SDG 3.8.1) between 2000 and 2015, progress markedly slowed, with the UHC Service Coverage Index (SCI) rising by only two points to 67 between 2015 and 2021. Key components of UHC service coverage without similar global commitments, such as those related to non-communicable diseases (NCDs) and health service capacity and access, continue to see minimal or no progress. There hasn't been any significant progress in reducing financial hardship. The proportion of the population spending more than 10% of their household budget on health out of pocket (OOP) (SDG 3.8.2) worsened since 2015 at 0.04 percentage points on average per year to reach 12.8% in 2019 (about 1 billion people). In addition, in 2019, 6% of the global population (about 480 million people) were pushed or further pushed into extreme poverty due to OOP payments for health. Failure to reduce financial hardship globally pre-pandemic is due to the combination of people getting richer, gaps in coverage policies in particular for medicines which are mostly paid out-of-pocket and health systems heavy relying on their OOP health spending, especially in low and lower middle-income countries.

Lack of data currently precludes a comprehensive assessment of COVID-19 impacts on UHC but the available evidence points towards a deterioration. The SCI stagnated globally, but sub-regional and country level decreases were observed, alongside significant disruptions in the delivery of essential health services not captured by the index. The disruptions occurred thru a mix of demand and supply side factors, with the absorption of significant health system resources for COVID-19-related services. Importantly, the pandemic has had cascading impacts on other health-related issues, driven by the diminished capacities of health systems to provide, and people's ability to receive, effective preventive, curative, rehabilitative and palliative services not directly related to COVID-19. The combined macroeconomic, fiscal, and health impacts of the pandemic and emerging evidence on rising poverty point to a significant worsening of financial protection globally with higher rates of foregone care due to financial barriers, and more people incurring financial hardship due to relatively high and impoverishing OOP spending. The economic outlook, including increasing debt burdens and inflation rates, will continue to pressure government and household budgets alike,

indicating sustained worsening of financial protection in the medium-term without targeted policy action.

While there was substantial regional variation in the levels of SDGs 3.8.1 and 3.8.2 when the SDGs began in 2015, all regions have since shown the same pattern of stagnating service coverage and worsening financial hardship (Figure 1). Causes of this lack of progress vary by region and country and addressing them requires context-specific policies. But in general, significant advances towards UHC by 2030 require an acceleration in the expansion of all essential health services, especially those with minimal progress to date. Proactive policy efforts are needed to decrease financial hardship from OOP payments – specifically, public health funding needs to further increased and used more efficiently, coverage for medicines extended, and co-payments for the poor removed.

Progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2000–2019



Additional resources, press releases, etc. with links:

- <https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major>
- https://www.who.int/health-topics/financial-protection#tab=tab_1
- <http://datatopics.worldbank.org/universal-health-coverage/>
- <https://www.who.int/teams/health-systems-governance-and-financing/global-monitoring-report>

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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

Low- and middle-income countries are more susceptible to the deadly threat of air pollution

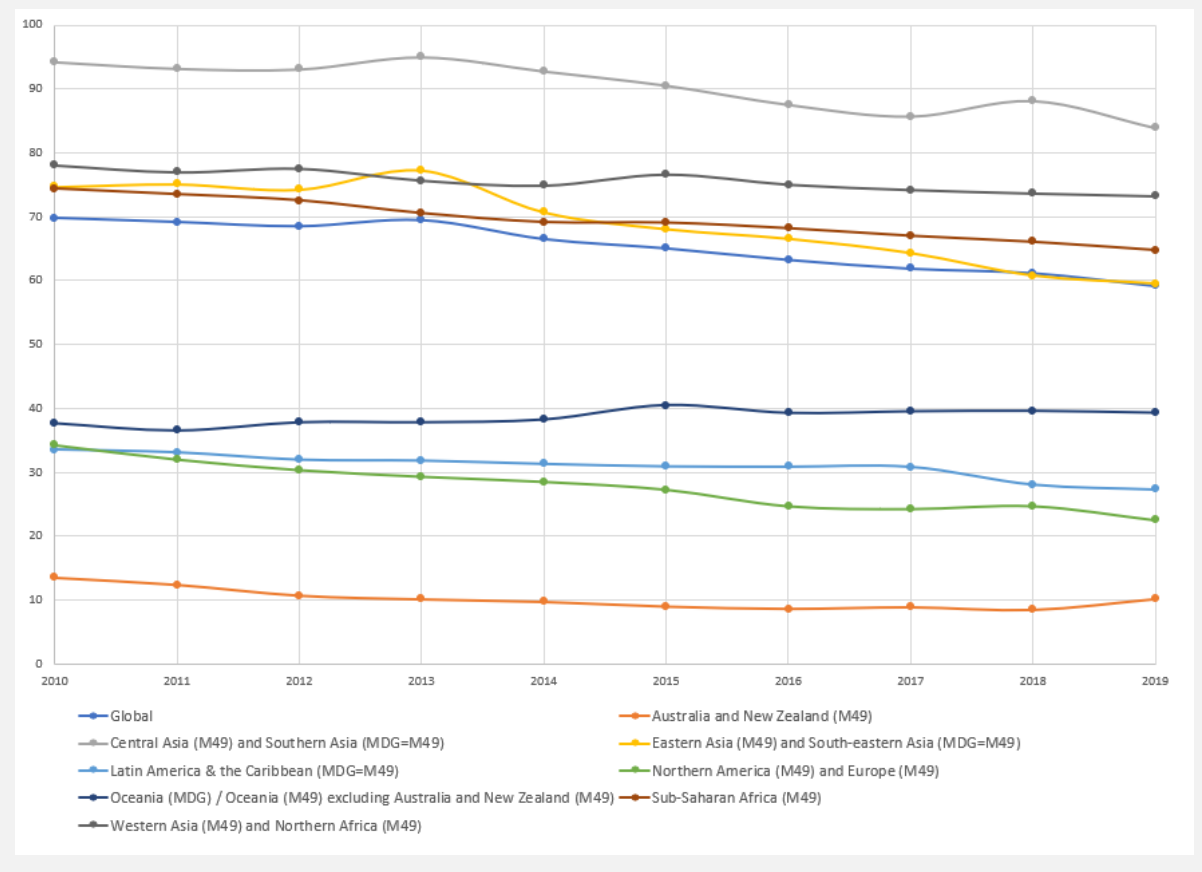
Particulate air pollution, whether household or ambient increases the risk of cardiovascular diseases (i.e., Ischaemic heart disease and stroke), respiratory diseases (i.e., chronic obstructive pulmonary disease and acute lower respiratory infections) and lung cancer; leading to some 6.7 million deaths worldwide which represents an age-standardized mortality rate of 103.6 cases per 100'000 capita in 2019. 93% of these deaths occurs in low-and middle-income countries, mainly from Asia (Central Asia (M49) and Southern Asia (MDG=M49), Eastern Asia (M49) and South-eastern Asia (MDG=M49)) and Sub-Saharan Africa.

Non-communicable diseases such as ischaemic heart disease (IHD, 41%), stroke (23%), chronic obstructive pulmonary disease (COPD, 16%) and lung cancer (5%) account together for 85% of the total deaths due to air pollution. The remaining 15% are due to acute lower respiratory infection (ALRI) in general population, of which 31% occurs in children under five years old.

The differences in the age-standardized 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 mortality 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 causes of death. 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 rates from air pollution. This is largely due to the high levels of household air pollution exposure 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, which is equivalent to an age-standardized mortality rate of 59.2 cases per 100'000 capita. As shown in the figure, the 2010-2019 tendency of these rates has decreased globally and almost for all the SDG regions except for Oceania (excluding Australia/New Zealand).

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. Moreover, current scientific evidence suggests that air pollution weakens the immune system against infectious diseases. Since particulate matter induces inflammation in lung cells, the exposure to this air pollutant could increase the susceptibility and severity of the COVID-19 patient symptoms. Hence it is critical to pursue efforts to mitigate air pollution levels and reduce exposure for the most vulnerable individuals.

Age-standardized mortality rate trends per 100'000 capita 2010-2019, attributable to ambient air pollution due to five causes of death, by SDG region



Additional resources, press releases, etc. with links:

- For further information on the SDG 3.9.1 please refer to the WHO Global Health Observatory, Air pollution data portal, available at: <https://www.who.int/data/gho/data/themes/air-pollution>

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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

Unintentional poisonings were responsible for more than 84 000 deaths in 2019 – of which 73% (around 62,000 deaths) are thought to be preventable through sound chemical management. Although the number of deaths from unintentional poisonings has steadily declined since 2000, mortality rates continue to be relatively high in low-income countries (over two times the global average). A third of all deaths from unintentional poisonings occurred in Sub-Saharan Africa alone. Due to occupational exposures, deaths rates from unintentional poisonings are lower in females compared to males – more than 40% lower on a global basis. Unintentional poisoning can be caused by household chemicals, pesticides, kerosene, carbon monoxide and medicines or can be the result of environmental contamination or occupational chemical exposure. Lead recycling, for example, is an important source of environmental contamination and human exposure. As of 1 January 2023, only 47% of WHO Member States had a poison centre, which have an important role in implementation of the International Health Regulations (2005) requiring countries to have the capacity for surveillance, detection and response to public health events caused by chemicals.

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[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

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

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

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

Measles outbreaks continue to occur as immunization programmes struggle to recover from the COVID-19 pandemic

Sustainable Development Goal 3.b.1 tracks the coverage of four vaccines given to infants, young children, and adolescent girls to signal that immunization is important at all ages. All six World Health Organization (WHO) regions are committed to eliminating measles. These regional targets are part of the core impact indicators of the Immunization Agenda 2021–2030 (IA2030) and position measles as the tracer of a health system’s ability to deliver essential childhood vaccines.

Measles elimination requires a population coverage of 95% with 2 doses of measles containing vaccine to interrupt circulation of the virus. While vaccination data are essential to monitor overall population immunity, rigorous measles surveillance also helps to document specific immunity gaps.

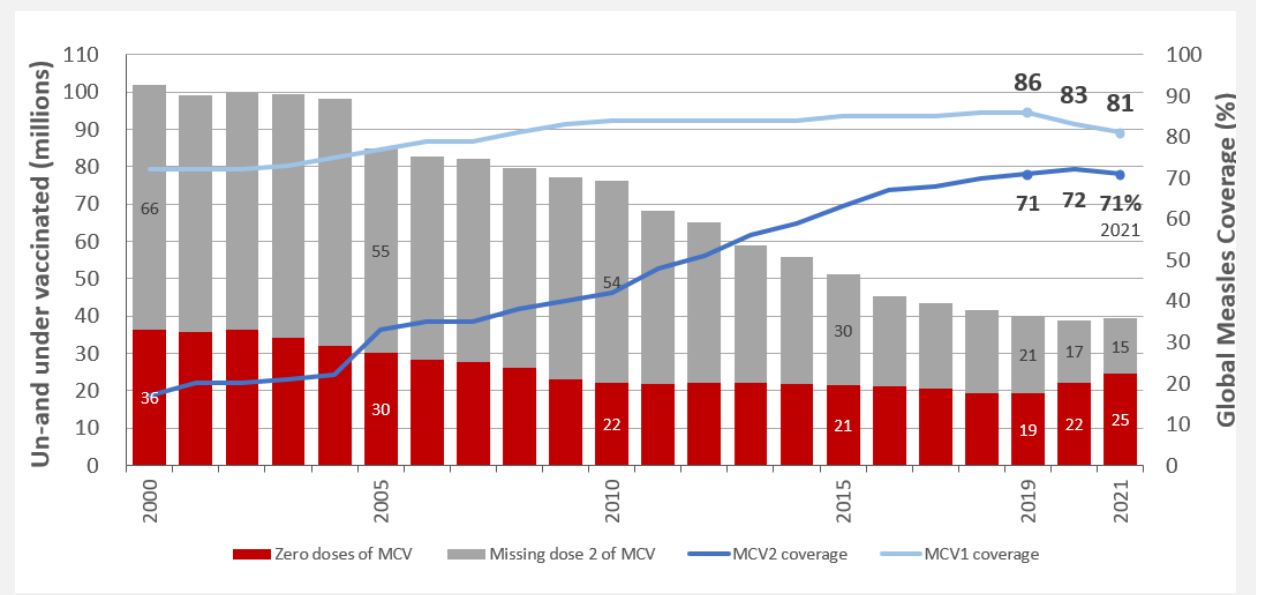
The COVID-19 pandemic caused a historic backsliding in immunization rates of measles and other life-saving vaccines in all WHO Regions, creating a large pool of individuals susceptible to measles and other diseases. In parallel, strained surveillance systems failed to maintain the levels of performance required for the accurate and timely detection of measles cases and outbreaks. This created an alarming situation favorable to the spread of measles, particularly in low- and middle-income countries.

Measles incidence decreased in 2020 and 2021, but this should be considered in the context of a global resurgence of measles in 2017-2019 which might have temporarily increased overall population immunity. Public health measures implemented to control COVID-19 may have also limited the ability of other pathogens, including measles, to spread in the population. Finally, the repurposing of measles surveillance resources for COVID-19 activities increased the likelihood of missing cases.

In 2022, an increased number (33) of large and disruptive outbreaks, defined as showing an incidence rate of more than 20 cases per million population, occurred in four of the six WHO regions as compared to the 19 large outbreaks documented in 2021. This upward trend continues in early 2023.

To avoid a larger spread of the disease and to achieve regional measles elimination goals, it is essential that health systems recover from the effects of the COVID-19 pandemic, accelerate efforts to identify immunity gaps and reach unvaccinated children while implementing robust measles surveillance to detect outbreaks

Measles coverage (percentage) and estimated number of children (millions) who did not receive 2 doses of measles containing vaccination



Additional resources, press releases, etc. with links:

- Immunization Agenda 2030 <https://www.immunizationagenda2030.org/>
- <https://www.who.int/news/item/15-07-2022-covid-19-pandemic-fuels-largest-continued-backslide-in-vaccinations-in-three-decades>
- Progress towards regional measles elimination – worldwide, 2000–2021 <https://apps.who.int/iris/handle/10665/364733>
- Coverage <https://data.unicef.org/topic/child-health/immunization>

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Custodian agency(ies): WHO, UNICEF

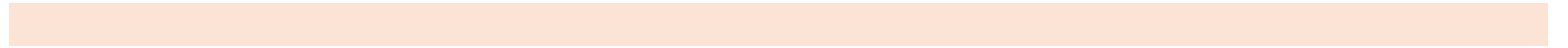
Indicator 3.b.2 Total net official development assistance to medical research and basic health sectors

ODA for basic health from all donors doubled in real terms since 2015

ODA for basic health from all donors doubled in real terms since 2015, from USD 10.2 billion (constant 2021 prices) and reached USD 20.4 billion in 2021. Approximately USD 2.7 billion was spent on basic health care, USD 2.4 billion on malaria control, and USD 2.0 billion on infectious disease control. The United States, the Global Fund, Germany and GAVI accounted for almost 40 percent of this total, providing, USD 2.2 billion, USD 2.1 billion, USD 2.1 billion, and USD 1.6 billion respectively.

In 2021, 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 9.6 billion of which USD 6.3 billion were for vaccine donations.

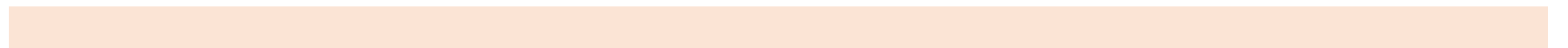
Preliminary data for 2022 indicate that within total ODA, DAC countries spent USD 11.2 billion on COVID-19 related activities³, down by 45% compared to 2021. Within this total, USD 7.0 billion were to provide support related to COVID-19 control (e.g. prevention; treatment, care and vaccines). Vaccine donations from DAC member countries amounted to USD 1.53 billion, a fall of 74.1% in real terms compared to 2021. Cumulated for the period 2020-2022, COVID-19 control represented USD 21.2 billion (constant 2021 prices).



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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

³ The figures in 2022 on COVID-19 related activities are preliminary and partial, as several donors are still in the process of collecting detailed information, especially sector-related data.

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

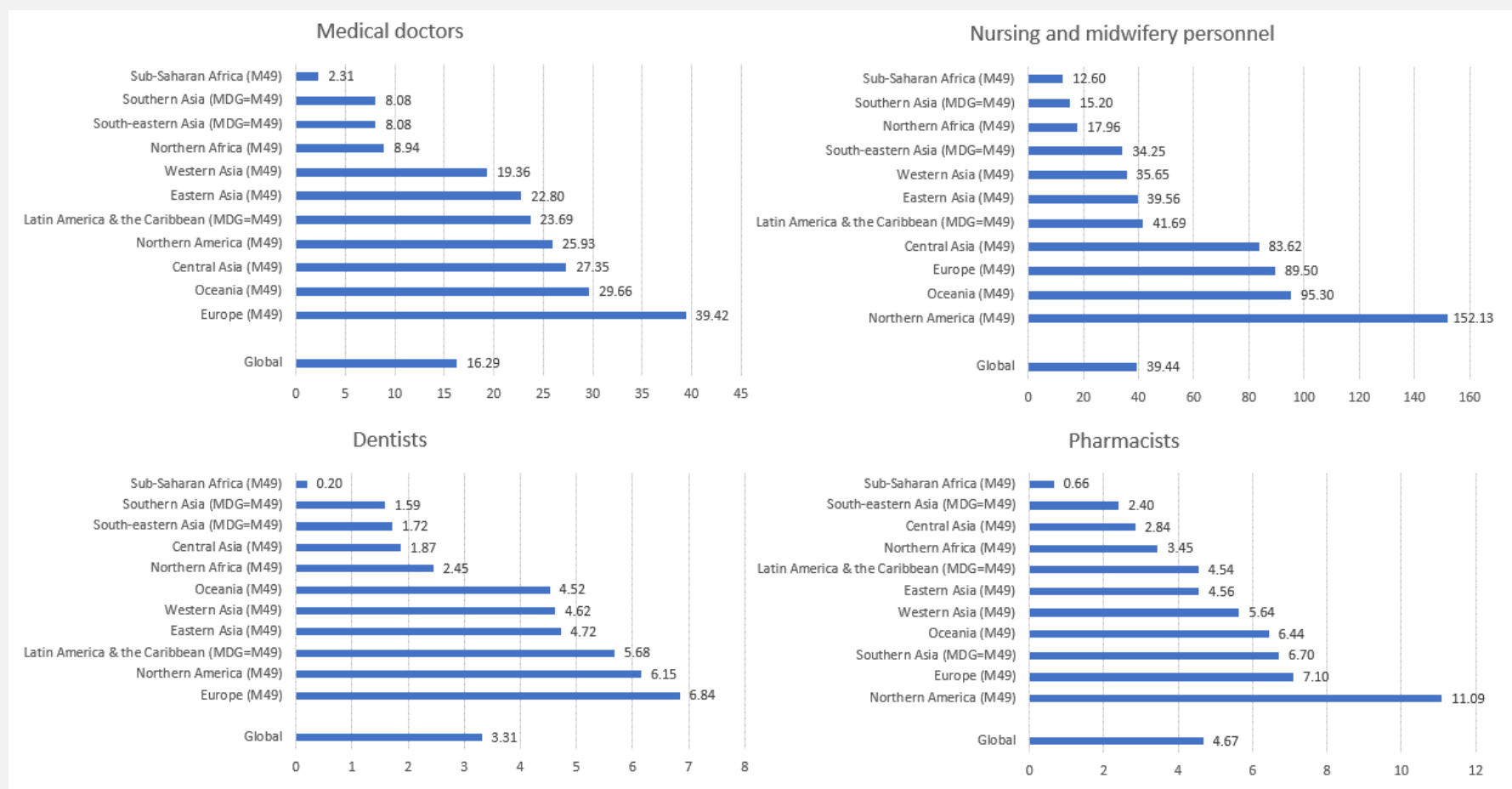
2030 global health workforce shortage reduced from 18 million to 10 million health workers

Achieving Universal Health Coverage, health security and the Sustainable Development Goals requires an adequate, well distributed, motivated and competent health workforce. The COVID-19 pandemic further exacerbated the weaknesses in the health systems of countries across the world, resulting in renewed interest to strengthen health systems and enhance national workforce capacity to deliver the essential public health functions including emergency preparedness and response.

In 2016, the Global Strategy on Human Resources for Health (GSHRH)⁴ estimated the shortage of health workers to exceed 18 million by 2030. The adoption of the GSHRH and through it the progressive implementation of National Health Workforce Accounts (NHWA)⁵, has facilitated reliable and annually updated information on the stock, demographics, distribution and mobility patterns of health workers to address national, regional and global level health workforce challenges. A recent assessment⁶ shows that the global shortage reduced from 20 million in 2013 to 15 million health workers in 2020, with a projected decrease to 10 million by 2030. Though there has been a tremendous increase in health workforce globally, regions with the highest burden of disease continue to have the lowest proportion of health workforce to deliver the health services. Data from 2014-2021 show that the highest health worker densities for medical doctors and dentists are in Europe at 39.4 and 6.8 per 10,000 population respectively, and for nursing and midwifery personnel and pharmacists in North America at 152 and 11 per 10,000 population respectively. The lowest health worker density, however, remains in Sub – Saharan Africa with 2.3 medical doctors per 10,000 population, 12.6 nursing and midwifery personnel per 10,000 population, and less than 1 per 10,000 population for both dentists and pharmacists. Even when national densities seem adequate, disparities in densities persist between rural, remote, subnational⁷ and hard to reach areas compared to capital cities and urban centers.

To plan and build an adequate health workforce requires, among others, detailed information on the stock, demographics, distribution and migration of health workers. Implementing NHWA enables countries to strengthen their national human resources for health information systems and produce the data required for evidence-based health workforce planning and policy-making.

Density of select health professionals per 10,000 population, 2014-2021 (latest available)



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Custodian agency(ies): WHO

⁴ WHO 2016 - Global strategy on human resources for health (GSHRH) <https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf>

⁵ National Health Workforce Accounts <https://apps.who.int/iris/handle/10665/259360>

⁶ The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage? <https://pubmed.ncbi.nlm.nih.gov/35760437/>

⁷ <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-022-00720-5>

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

Custodian agency(ies): WHO

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

Laboratory testing coverage impact on the assessment of SDG antimicrobial resistance indicator.

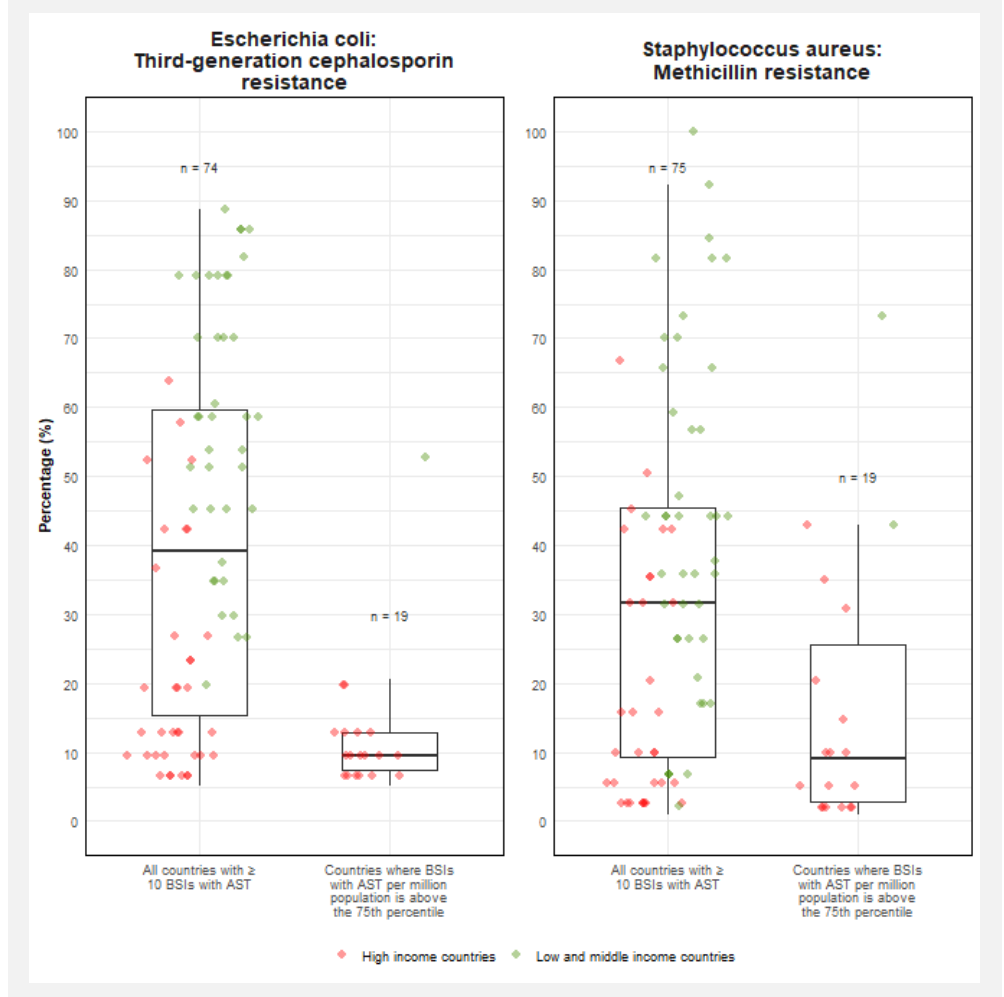
Global surveillance of antimicrobial resistance (AMR) is critical and forms the basis of country-level action and international cooperation on preventing and mitigating a top global health threat. Such information must build upon nationally representative prevalence estimates obtained using standardised methods. The SDG indicator on AMR (3.d.2) monitors the proportion of bloodstream infections (BSIs) due to *Escherichia coli* resistant to third-generation cephalosporins and methicillin-resistant *Staphylococcus aureus* (MRSA). This indicator is considered a building block to help drive the establishment of national AMR programmes for monitoring and tracking the impact of interventions.

Considering settings reporting at least 10 BSIs with antimicrobial susceptibility test results (AST) in 2021, the median proportion of BSIs due to *E. coli* resistant to third-generation cephalosporins in 74 countries and the median proportion of BSIs due to MRSA in 75 countries are 39.2% (IQR 15.3-59.7) and 31.6% (IQR 9.2-45.3), respectively. These rates are much lower (9.6% [IQR 7.4-12.8] and 9.0% [IQR 2.7-25.6], respectively) in 19 countries with better testing coverage (that is, where the number of BSIs with AST per million population is above the 75th percentile). See Figure 1. Currently, global surveillance of AMR relies on voluntary reporting of AMR data from clinical specimens in selected healthcare facilities, and most low- and middle-income countries present lower testing coverage compared to high-income countries. Consequently, the observations are in part consistent with bias resulting from the convenient selection of healthcare facilities in settings where the capacity for routine surveillance is still nascent. For instance, a convenience sample of referral hospitals and/or financial barriers to laboratory testing may result in selecting the most severely ill patients who may have been exposed to antibiotics previously to laboratory testing.

Although lower resistance in settings with high coverage could be due to potentially better diagnostic practices, more robust health systems to combat AMR, and fewer testing biases, conclusions of any genuine differences in resistance prevalence in settings with less established surveillance networks are limited by the vast differences in surveillance coverage and representativeness.

Complementary surveillance approaches are needed to generate representative data and trends to evaluate and inform the AMR response, especially in low-resource countries with weak routine surveillance.

Percentage resistance to third-generation cephalosporins in *E. coli* and percentage methicillin resistance in *S. aureus* in countries reporting ≥ 10 BSIs with AST results compared to countries where the reported numbers per million population were above the 75th percentile in 2021.



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Custodian agency(ies): WHO