WORLD HEALTH STATISTICS

2019

MONITORING HEALTH FOR THE

SDGs

SUSTAINABLE
DEVELOPMENT GOALS

World Health Organization

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FOREWORD

For 71 years, the World Health Organization (WHO) has had one vision: the highest attainable standard of health for all people in all countries. Reliable data are vital for assessing whether we are making progress towards that vision, for highlighting areas of progress and for exposing where we need to change course.

Health trends are constantly evolving, and so are health systems. No health system is perfect, and all countries have people who are left behind. It is therefore important to accurately document the state of global health and how it is changing.

The *World health statistics*, published annually since 2005, is WHO's annual snapshot of the state of the world's health. Since 2016, the World Health Statistics series has focused on monitoring progress toward the Sustainable Development Goals (SDGs), and the 2019 edition contains the latest available data for the health-related SDG indicators.

The SDGs address inequality wherever it exists. The 2019 edition reports on trends over time and disaggregates data by WHO region, World Bank income group, and sex to identify key inequalities. The report reveals that in low-income countries, health is frequently compromised by diseases and conditions that are preventable or treatable. Many premature deaths are associated with environmental factors or the leading underlying causes of death, such as tobacco use, unhealthy diet, physical inactivity and unhealthy consumption of alcohol.

Although the *World health statistics 2019* tells its story with numbers, the consequences are human. In low-income countries, one woman in 41 dies from maternal causes, and each maternal death greatly affects the health of surviving family members and the resilience of the community. Not only are the risks of maternal deaths elevated by poverty, but their occurrence perpetuates the cycle of poverty in poor communities from one generation to the next.

We must be relentless in our pursuit of solutions to such human tragedies, and our responses must be informed by robust, reliable data on health risks, access to services and health outcomes. At present, many countries lack the health information systems they need to accurately monitor health trends and inform decision-making. That is why WHO is creating an entirely new process for strategic policy dialogue with countries, using evidence and information strategically to drive change.

We will continue to work with countries to strengthen their information systems for health and generate better data. We will also build a modern data backbone that allows sharing and analysis of data among the three levels of WHO and countries. And we will make investments to strengthen analytical capacity at all levels, to identify trends, make projections and support acceleration of progress toward achieving health targets.

Behind every number in these pages is a person, a family, a community and a nation. My hope is that governments, health providers, academics, civil society organizations, the media and others use these numbers to promote health, keep the world safe and serve the vulnerable.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

ABBREVIATIONS

AFR	WHO African Region
AIDS	acquired immunodeficiency syndrome
AMR	WHO Region of the Americas
COPD	chronic obstructive pulmonary disease
COSI	Childhood Obesity Surveillance Initiative
CRD	chronic respiratory disease
CRVS	civil registration and vital statistics
CVD	cardiovascular disease
DHS	demographic and health surveys
DTP3	diphtheria-tetanus-pertussis third dose
EMR	WHO Eastern Mediterranean Region
EUR	WHO European Region
FGM	female genital mutilation
GGE	general government expenditure
GHO	Global Health Observatory
HALE	healthy life expectancy
HBV	hepatitis B virus
HES	health examination survey
HI	high income
HIV	human immunodeficiency virus
IHR	International Health Regulations
ITN	insecticide-treated mosquito net
LAC	Latin America and the Caribbean
LI	low income
LMI	lower-middle income
LMIC	low- and middle-income countries
M/F	male to female (ratio)
MCV2	measles-containing vaccine second dose
MIS	malaria indicator surveys
MMR	maternal mortality ratios
NCD	noncommunicable disease
NTD	neglected tropical disease
ODA	official development assistance
PAHO	Pan American Health Organization
PCV3	pneumococcal conjugate vaccine third dose
PPP	purchasing power parity
PrEP	pre-exposure prophylaxis
SCI	service coverage index
SDG	Sustainable Development Goal
SEAR	WHO South-East Asia Region
TB	tuberculosis
UHC	universal health coverage
UMI	upper-middle income
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene for all
WB	World Bank
WHO	World Health Organization
WPR	WHO Western Pacific Region

INTRODUCTION

The World Health Statistics series is the World Health Organization's (WHO's) annual compilation of health statistics for its 194 Member States. The series is produced by WHO's Division for Data, Analytics and Delivery, in collaboration with WHO technical departments and regional offices.

World health statistics 2019 summarizes recent trends and levels in life expectancy and causes of death (Section 1) and reports on the health and health-related Sustainable Development Goals (SDGs) and associated targets (Sections 2–8). It then summarizes the major findings, including the availability of underlying data for monitoring progress towards the health-related SDGs (Section 9), and concludes by briefly discussing the implications for health policy and the planning of programmes (Section 10). Annex 1 provides regional level statistics, Annex 2 presents country-level statistics for selected health-related SDG indicators and Annex 3 summarizes WHO regional groupings.

The 2019 report disaggregates data by WHO region, World Bank income group[1] and sex where possible, and it discusses differences in health status and access to preventive and curative services, particularly in relation to differences between men and women. Where possible, it indicates the roles of sex, as a biological determinant, and gender, as a social construct, in accounting for the observed differences as shown in the table below. Because the focus of *World health statistics* is on life expectancy, causes of death and SDG indicators, it does not capture some important health differences between men and women such as anaemia or other morbidities. In addition, the report summarizes national data and differences between countries, but does not undertake subnational analysis of the interaction between sex differences in health-related indicators and other factors such as household wealth, ethnicity and geographical location. Finally, there have been gaps in the datasets available for analysis, meaning that the analyses presented are not exhaustive. Nonetheless, it is hoped that the report will raise awareness of some critical sex and gender differences in health outcomes, highlight the importance of those differences in the attainment of the SDGs, and encourage the roles of sex and gender to be systematically taken into account when collecting data, analysing health situations, formulating policies and designing health programmes.

The statistics presented in *World health statistics 2019* are official WHO statistics based on data available for global monitoring in March 2019. They have been compiled primarily using publications and databases produced and maintained by WHO or by United Nations (UN) groups of which WHO is a member, such as the UN Interagency Group for Child Mortality Estimation. Additionally, a number of statistics have been derived from data produced and maintained by other international organizations, such as the UN Department of Economic and Social Affairs and its Population Division.

The statistics presented are of two types:

- **primary data** – data compiled by international agencies from routine reporting by countries or publicly available sources such as demographic and health surveys (DHS); statistics are presented as they were reported or with modest adjustment; and

- **comparable estimates** – country data adjusted or modelled to allow comparisons between countries or over time. Comparable estimates are produced for countries with underlying primary data and, in some cases, also for those without.

In constructing estimates, Member States were asked to review the methodology, data input and the resulting estimates before the estimates were finalized. Comparable estimates are subject to considerable uncertainty, especially for countries where the availability and quality of the underlying primary data are limited. However, to ensure readability, the printed and online versions of the World Health Statistics series do not include the margins of uncertainty, which are instead made available through online WHO databases such as the Global Health Observatory (GHO).

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[1] Unless otherwise noted, the World Bank Income groupings used in this report refers to the World Bank's classification of economies based on the gross national income (GNI) per capita corresponding to the year of the data or estimates.

This report also considers the extent to which underlying data are available for use by WHO or other UN agencies or interagency groups. In *World health statistics 2019,* attention has been given to the availability of data by sex. More details on the indicators and statistics presented here are available from the GHO.

Definitions of sex and gender

Sex	Gender
Sex refers to the biological characteristics that define humans as female or male. These sets of biological characteristics are not mutually exclusive, because there are individuals who are born with physical or biological sex characteristics who do not fit the traditional definitions of female or male (intersex).	Gender refers to the socially constructed norms, roles and relations of and among women, men, boys and girls. Gender also refers to expressions and identities of women, men, boys, girls and gender-diverse people. Gender is inextricable from other social and structural determinants shaping health and equity, and can vary across time and place.
Sex differences can be observed at the level of chromosomes, gene expression, hormones, immune system and anatomy (e.g. body size, and sexual and reproductive anatomy).	Gender differences and inequalities influence exposure to risk factors, health-seeking and risk-taking behaviours; access to and use of health information, and to promotive, preventive, curative, rehabilitative and palliative health services; and experience with health care, including in terms of access to and control over resources and power relations.
Examples of sex-specific conditions: • cervical cancer (women); • prostate cancer (men); and • X-linked immune regulators may enhance immune responses in female children.	Examples of gender-related factors resulting in differential health outcomes: • early pregnancy, including as a result of child marriage, increases girls' risk of adverse health outcomes; • due to the gender-based division of labour, men and women may be exposed to different risks for work-related injuries or illnesses; • gender norms related to masculinity promote smoking and alcohol use among men, while gender norms associating smoking with women's freedom and liberation are being targeted to young women by the tobacco industry; • women's access to health services may be limited by lack of access to and control of household financial resources, caregiving roles, and restrictions on their mobility, whereas men's use of health services may be influenced by masculinity norms in which seeking health care is not seen as manly; and • in addition to gender norms and roles, intersecting discrimination based on gender identity contributes to transgender people experiencing high rates of stigma and discrimination including in health care settings, and a lack of appropriate services responding to their needs.

1

LIFE EXPECTANCY AND CAUSES OF DEATH

Women live longer than men, but the additional years are not always healthy

In 2019, more than 141 million children will be born: 73 million boys and 68 million girls *(1)*. Based on recent mortality risks the boys will live, on average, 69.8 years and the girls 74.2 years – a difference of 4.4 years. Life expectancy at age 60 years is also greater for women than men: 21.9 versus 19.0 years.

Women have a longer life expectancy than men at all ages (Fig. 1.1). Although the absolute difference in life expectancy decreases with age, the proportional difference increases from age 1 year up to age 80 years before it declines. Thus, women can expect to live 7.6% longer than men at age 20 years, and 14% longer at age 80 years. Differences in global life expectancy between men and women increased between 1950 and 1990 but have subsequently decreased (Table 1.1).

Fig. 1.1
Global life expectancy at different ages for men and women, 2016
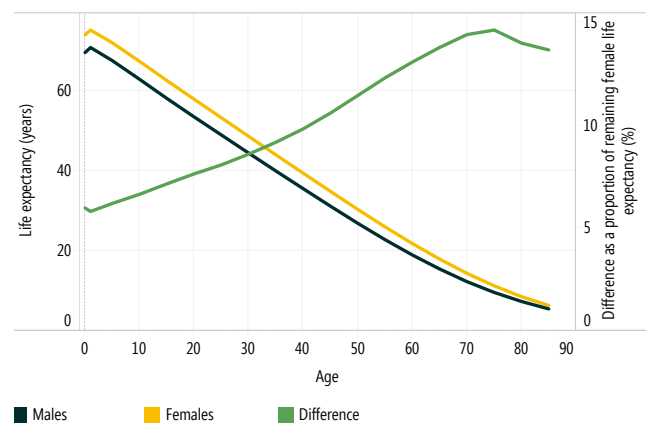
Source: WHO (2018) *(2)*.

Table 1.1
Male deficit in life expectancy as a proportion of remaining female life expectancy, 1950–2015

Age	1950–1955	1955–1960	1960–1965	1965–1970	1970–1975	1975–1980	1980–1985	1985–1990	1990–1995	1995–2000	2000–2005	2005–2010	2010–2015
0–4	6%	6%	6%	7%	6%	7%	7%	7%	7%	7%	6%	6%	6%
5–9	5%	6%	6%	6%	6%	6%	7%	7%	7%	7%	6%	6%	6%
10–14	6%	6%	6%	6%	7%	7%	7%	7%	7%	7%	7%	7%	7%
15–19	6%	7%	7%	7%	7%	7%	8%	8%	8%	8%	7%	7%	7%
20–24	7%	7%	7%	7%	8%	8%	9%	8%	9%	9%	8%	8%	8%
25–29	7%	8%	8%	8%	8%	9%	9%	9%	9%	9%	9%	8%	8%
30–34	8%	9%	9%	9%	9%	9%	10%	9%	10%	10%	9%	9%	9%
35–39	9%	10%	10%	10%	10%	10%	11%	10%	11%	11%	10%	10%	9%
40–44	10%	11%	12%	11%	11%	11%	12%	11%	12%	11%	11%	10%	10%
45–49	12%	13%	13%	12%	12%	13%	13%	12%	13%	12%	11%	11%	11%
50–54	13%	14%	14%	13%	14%	14%	14%	13%	14%	13%	12%	12%	12%
55–59	13%	15%	15%	15%	15%	15%	15%	15%	15%	14%	13%	13%	12%
60–64	13%	15%	16%	16%	16%	16%	16%	16%	16%	16%	14%	14%	13%
65–69	13%	15%	16%	16%	17%	17%	17%	17%	17%	16%	15%	15%	14%
70–74	13%	14%	15%	16%	17%	18%	18%	17%	17%	17%	16%	15%	15%
75–79	13%	14%	15%	15%	16%	18%	18%	18%	18%	17%	16%	16%	15%
80–84	12%	12%	13%	14%	15%	17%	18%	18%	18%	17%	16%	16%	15%
85–89	10%	10%	11%	12%	13%	16%	17%	18%	17%	16%	15%	16%	15%
90–94	8%	8%	9%	9%	11%	14%	15%	17%	15%	15%	14%	15%	13%
95–99	6%	5%	6%	6%	8%	11%	13%	15%	13%	12%	12%	13%	12%
100+	4%	3%	4%	3%	5%	8%	10%	12%	10%	9%	9%	10%	9%

Source: World population prospects: the 2017 revision *(1)*.

The ratio of the number of men alive to the number of women alive changes through the life course

Globally, the male to female (M/F) sex ratio at birth has been in the range of 105–110 males to every 100 females *(1)*; however, because male mortality rates are higher across the life course, the sex ratio decreases throughout life (Fig. 1.2). Globally, it reaches 1.00 in the age group 50–54 and 0.95 in the age group 60–64 years, falling sharply thereafter. There are notable variations in sex ratios around the world, with some countries having higher M/F sex ratios that are partly associated with preference for male children.

Fig. 1.2
Global male to female (M/F) sex ratio by age, 2016
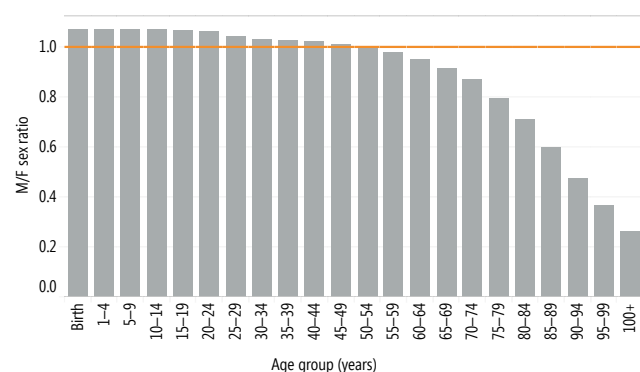
Source: World population prospects: the 2017 revision *(1)*.

Because the incidence of different diseases varies with age, and women live longer than men, some diseases can be more common in women; for example, the lifetime risk for Alzheimer disease is greater in women than men, partly because more women survive to ages at which the disease most commonly occurs, although they also appear to be more susceptible in some locations *(3)*.

Healthy life expectancy is greater for women than men

Between 2000 and 2016 global life expectancy at birth, for both sexes combined, increased by 5.5 years, from 66.5 to 72.0 years. Healthy life expectancy (HALE) also increased, from 58.5 years in 2000 to 63.3 years in 2016; however, so did the number of equivalent years of full health lost through living in unhealthy states, increasing from 8.0 to 8.6 years. In 2016, an adult aged 60 years could expect to live another 20.5 years, while HALE at 60 years was 15.8 – that is, the equivalent years of full health lost was almost a quarter of the remaining life expectancy (4.7 years or 23%).

Women not only have a longer life expectancy than men at birth but also a longer HALE at birth (64.8 years versus 62.0) and at age 60 years (16.8 versus 14.8 years). However, the number of equivalent years of full health lost through living in unhealthy states is also larger (9.5 versus 7.8 years) (Fig. 1.3).

Fig. 1.3
Global life expectancy and HALE, 2000–2016

At birth

Males | Females

At age 60 years

Males | Females

Legend: Lost HALE | HALE
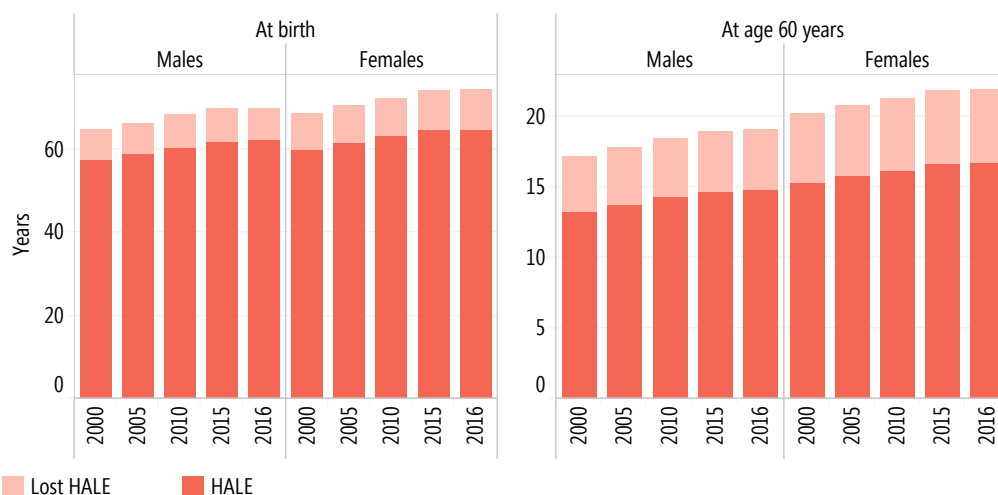
Source: WHO (2018) *(2)*.

Several conditions contribute to differences in life expectancy between men and women

Men's reduced life expectancy compared with women is not due to a single or a small number of causes. Of the 40 leading causes of death, 33 causes contribute more to reduced life expectancy in men than in women (Fig. 1.4). The causes of death that most contribute to a lower

Fig. 1.4
Causes of death that most contribute to differences in life expectancy at birth globally for men and women, 2016

■ Male life expectancy reduced more than female
■ Female life expectancy reduced more than male

Cause of death

Ischaemic heart disease
Road injury
Trachea, bronchus, lung cancers
COPD
Stroke
Breast cancer
Cirrhosis of the liver
Maternal conditions
Tuberculosis
Prostate cancer
Interpersonal violence
Liver cancer
Cervix uteri cancer
Stomach cancer
Lower respiratory infections
Self-harm
Alzheimer
Oesophagus cancer
HIV/AIDS
Kidney diseases

-0.8 -0.4   0.0   0.2 0.4 0.6 0.8

(Years)

Sources: WHO (2018) *(2)* and see *(4)* for decomposition of life expectancy.

life expectancy for men than women are ischaemic heart disease (0.84 years), road injuries (0.47), lung cancer (0.40), chronic obstructive pulmonary disease (0.36), stroke (0.32), cirrhosis of the liver (0.27), tuberculosis (TB) (0.23), prostate cancer (0.22) and interpersonal violence (0.21). Breast cancer (0.30 years), maternal conditions (0.23 years) and cervical cancer (0.15) are the causes of death that have the strongest effect in lowering female global life expectancy in comparison with male global life expectancy *(3, 4)*. These conditions are not necessarily the most important causes of death globally; rather, they are the conditions that show the greatest differences between men and women; for example, malaria is an important cause of death, but is ranked low because most deaths occur in children, and death rates in male and female children are similar.

Both sex and gender contribute to differences in life expectancy

Some of the differences in life expectancy between men and women are due to biological sex differences. Some causes of death occur in one sex only; for example, those related to sexual and reproductive anatomy (e.g. cervical cancer in women or prostate cancer in men). Other conditions can occur in both women and men, but their prevalence is influenced by biological sex differences; for example, death rates from ischaemic heart disease are thought to be lower in women, partly because of higher levels of the hormone estrogen *(5)* whereas TB infection rates may be higher in men, partly due to immunological reasons *(6)*. For some conditions, death rates are similar in men and women if they are exposed to the same risk, but exposures to risk differ as a result of gender-related factors, such as occupation (e.g. road injury). Gender can also influence health outcomes

through differences in health literacy, availability of and access to health information and services, and provider knowledge and attitude. The exact contributions of sex and gender to health disparities are often hard to separate because they do not operate independently *(7)*.

The age of death varies greatly by country income group

Life expectancy at birth in low-income countries (62.7 years) is 18.1 years lower than in high-income countries (80.8 years) (Table 1.2). In high-income countries, the majority of people who die are old; however, in low-income countries almost one in three deaths are in children aged under 5 years (Fig. 1.5) *(2)*.

Table 1.2
Life expectancy and HALE by sex, WHO region and World Bank income group, 2016

		Life expectancy	HALE	Life expectancy	HALE
		At birth (years)		At 60 years (years)	
Global	Male	69.8	62.0	19.0	14.8
	Female	74.2	64.8	21.9	16.8
	Both sexes	72.0	63.3	20.5	15.8
WHO region (both sexes)	AFR	61.2	53.8	16.6	12.5
	AMR	76.8	67.5	22.7	17.6
	SEAR	69.5	60.4	18.2	13.3
	EUR	77.5	68.4	22.3	17.4
	EMR	69.1	59.7	18.2	13.3
	WPR	76.9	68.9	21.0	16.6
World Bank income group (both sexes)	LI	62.7	54.9	17.1	12.9
	LMI	67.9	59.1	18.0	13.2
	UMI	75.2	67.0	20.2	15.8
	HI	80.8	71.2	24.3	19.0

Darker shading represents lower values of life expectancy.
Source: WHO (2018) *(2)*.

Differences in life expectancy between men and women are greater in higher-income countries

The differences in life expectancy between men and women are smaller in low-income countries than in high-income countries (Fig. 1.6). This should not necessarily be interpreted as meaning that there is greater gender equality in health in low-income countries.

Fig. 1.6
Male deficit in life expectancy as a proportion of remaining female life expectancy by World Bank income group, 2016

- Low income
- Lower-middle income
- Upper-middle income
- High income
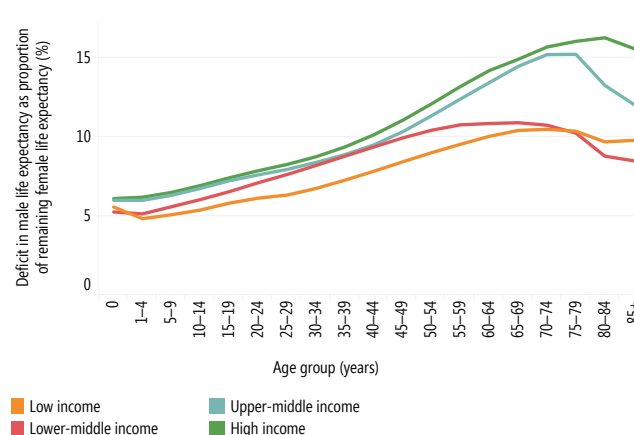
Source: WHO (2018) *(2)*.

Fig. 1.5
Proportion of deaths by age and World Bank income group, 2016 (%)
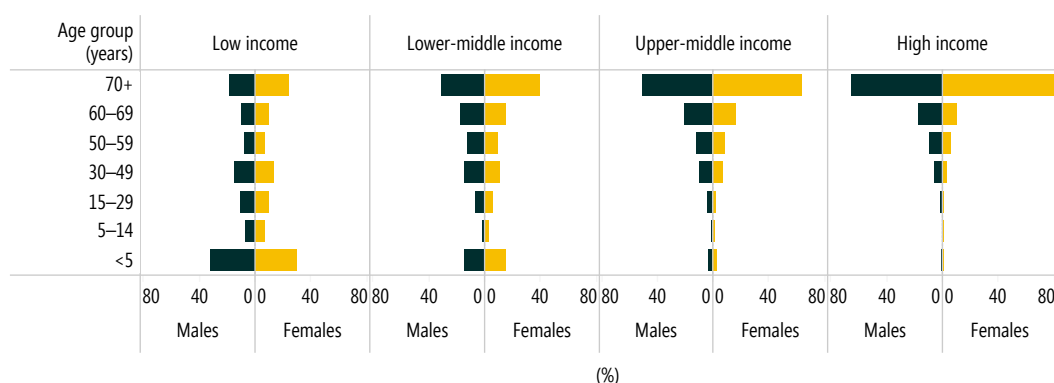
Source: WHO (2018) *(2)*.

The causes of death responsible for differences in life expectancy differ according to the wealth of countries

Communicable diseases, injuries and maternal conditions contribute most to differences in life expectancy between men and women in low-income countries, while noncommunicable diseases (NCDs) contribute most to life expectancy differences in high-income countries (Fig. 1.7) *(2, 4)*.

Maternal conditions contribute more to differences in life expectancy at birth between men and women than any other cause. They are concentrated in low-income countries, being related primarily to lack of access to essential health services. Although the life expectancy of men is reduced in comparison with that of women from most causes of death, and more so than in higher-income countries, the net effect of maternal conditions, breast and cervical cancer is to produce lower differences in life expectancy between men and women in low-income countries than in high-income countries.

Differences in life expectancy related to the wealth of countries are greater than those between men and women

Life expectancy at birth in low-income countries (62.7 years) is 18.1 years lower than in high-income countries (80.8 years) compared with a global difference of 4.4 years between men and women. The 10 conditions contributing most to the reduced life expectancy in low-income countries are, for both sexes, as follows: lower respiratory infections (life expectancy reduced by 2.09 years), diarrhoeal diseases (1.97 years), stroke (1.45 years), HIV/AIDS (1.45 years), TB (1.35 years), ischaemic heart disease (1.35 years), malaria (0.96 years), road injury (0.75 years), birth asphyxia and birth trauma (0.63 years), and protein-energy malnutrition (0.62 years) (Fig. 1.8) *(2, 4)*.

For lower respiratory diseases, the life expectancy of men and women is reduced by equal amounts if they live in a low-income country compared with a high-income

Fig. 1.7
Causes of death responsible for differences in life expectancy between men and women and World Bank income group, 2016
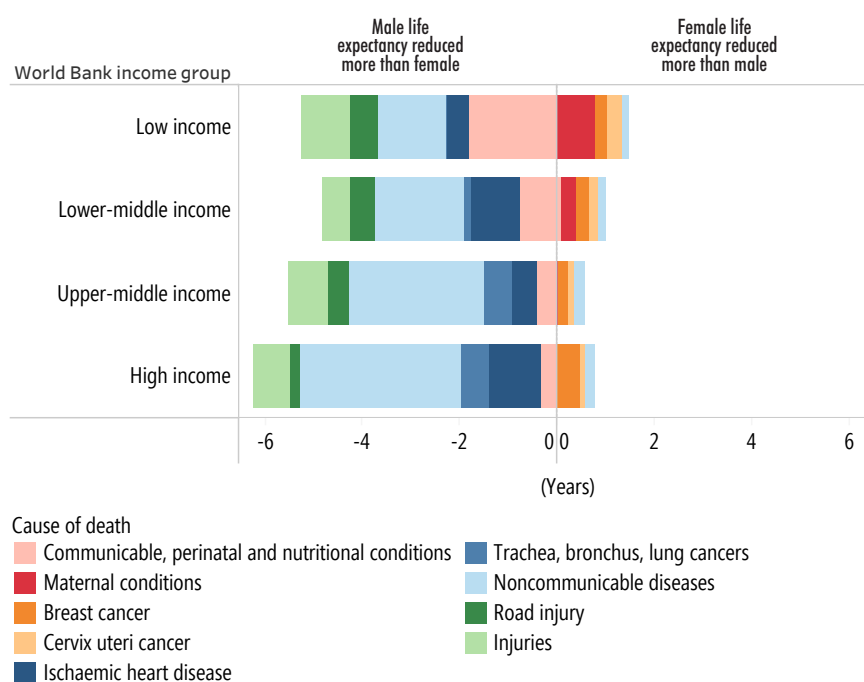
Sources: WHO (2018) *(2)* and see (4) for decomposition of life expectancy.

country. Women's life expectancy is particularly reduced in low-income countries through maternal conditions and cervical cancer. Men's life expectancy in low-income countries is reduced more than women's for road injuries, TB, interpersonal violence, prostate cancer, self-harm and drowning.

Fig. 1.8
Causes of death responsible for differences in life expectancy between women in high-income countries and men and women in low-income countries, 2016

Legend: ■ Life expectancy reduced for both sexes ■ Additional reduction for females ■ Additional reduction for males

Reduction in life expectancy (years)

Categories (top to bottom):
Lower respiratory infections
Diarrhoeal diseases
Ischaemic heart disease
Stroke
HIV/AIDS
Tuberculosis
Road injury
Maternal conditions
Malaria
Birth asphyxia and birth trauma
Protein-energy malnutrition
Preterm birth complications
Chronic obstructive pulmonary disease
Cirrhosis of the liver
Meningitis
Diabetes mellitus
Cervix uteri cancer
Neonatal sepsis and infections
Hypertensive heart disease
Interpersonal violence
Asthma
Falls
Prostate cancer
Drowning
Congenital anomalies
Self-harm
Kidney diseases
Alzheimer disease and other dementias
Oesophagus cancer
Liver cancer
Rheumatic heart disease
Mouth and oropharynx cancers
Cardiomyopathy, myocarditis, endocarditis
Stomach cancer
Lymphomas, multiple myeloma
Breast cancer
Leukaemia
Pancreas cancer
Colon and rectum cancers
Trachea, bronchus, lung cancers
All other communicable diseases
All other injuries
All other NCDs

Sources: WHO (2018) *(2)*, and see *(4)* for decomposition of life expectancy.

The responses to sex differences in health status will vary according to the circumstances of countries

In low-income countries, differences in life expectancy between men and women are due to causes that are frequently preventable or treatable through access to basic health services. In higher-income countries, premature deaths are frequently associated with environmental factors or poor lifestyle (Fig. 1.9).

Where there are differences in health outcomes between men and women, further analysis to disentangle determinants of outcomes for women and for men can help shape gender-sensitive responses that aim to take into account specific needs of women. The development of such responses requires better information on differences between men and women in exposure and responses to risk factors, access to and use of health services, and the effectiveness of interventions. Qualitative research is also needed to reveal factors underlying gender norms, roles, relations and expectations that lead to poor health outcomes.

Many of the factors that influence exposure to risks and access to health services are beyond the traditional remit of ministries of health. They require a multisectoral approach that addresses the underlying causes of gender and socioeconomic inequalities.

Fig. 1.9
Concentration of deaths according to national income of countries and sex, 2016

Points represent the 40 leading causes of death globally, with their areas being proportional to the number of deaths in 2016. Selected causes are labelled; space does not permit labelling of all causes. The concentration index is used to summarize the extent to which deaths from a disease are concentrated in high- or low-income countries, or in males or females. The index ranges from −1 to 1: a value of 0 indicates no association with national income or sex, and a value of −1 or 1 indicates that a disease occurs exclusively in males or females or in low-income or high-income countries (e.g. maternal deaths occur exclusively in women and are concentrated in low-income countries, whereas lung cancer is concentrated in high-income countries and occurs more in males).

Sources: WHO (2018) *(2)* and see *(8)* for calculation of concentration index.

2

REPRODUCTIVE AND MATERNAL HEALTH

The main targets of the SDGs relating to reproductive and maternal health reported in *World health statistics* are Targets 3.1, 3.2, and 3.7. Target 5.6 is also highly pertinent but is not discussed further here because data for Indicator 5.6.1 are only available for 41 countries since 2010; they are not currently available for Indicator 5.6.2.

In 2015, an estimated 303 000 women died during pregnancy and childbirth. In 2016, maternal mortality was the second leading cause of death for women of reproductive age, after HIV/AIDS, and was the leading cause among women aged 15–29 years (Fig. 2.1). Almost all maternal deaths (95%) occurred in low-income and lower-middle-income countries, and almost two thirds (65%) occurred in the World Health Organization (WHO) African Region (Fig. 2.2).

The risk of dying from maternal causes is related to the risk of getting pregnant and to the obstetric risk of developing a complication and dying while pregnant, during childbirth or within 42 days postpartum. In resource-poor settings, fertility rates are higher and the risks of dying in labour are greater *(10)*, so the lifetime risk of dying from maternal causes is greatly amplified; in 2015, one woman in 41 in low-income countries died from maternal causes (Fig. 2.3).

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

INDICATORS

3.1.1 Maternal mortality ratio

3.1.2 Proportion of births attended by skilled health personnel

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

INDICATORS

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

3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group

TARGET 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

INDICATORS

5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education

Fig. 2.1
Leading causes of death among women aged 15–49 years, 2016

Crude death rate per 100 000 population

Cause of death

- Maternal conditions
- Tuberculosis
- HIV/AIDS
- Diarrhoeal diseases
- Breast cancer
- Ischaemic heart disease
- Stroke
- Cirrhosis of the liver
- Road injury
- Self-harm
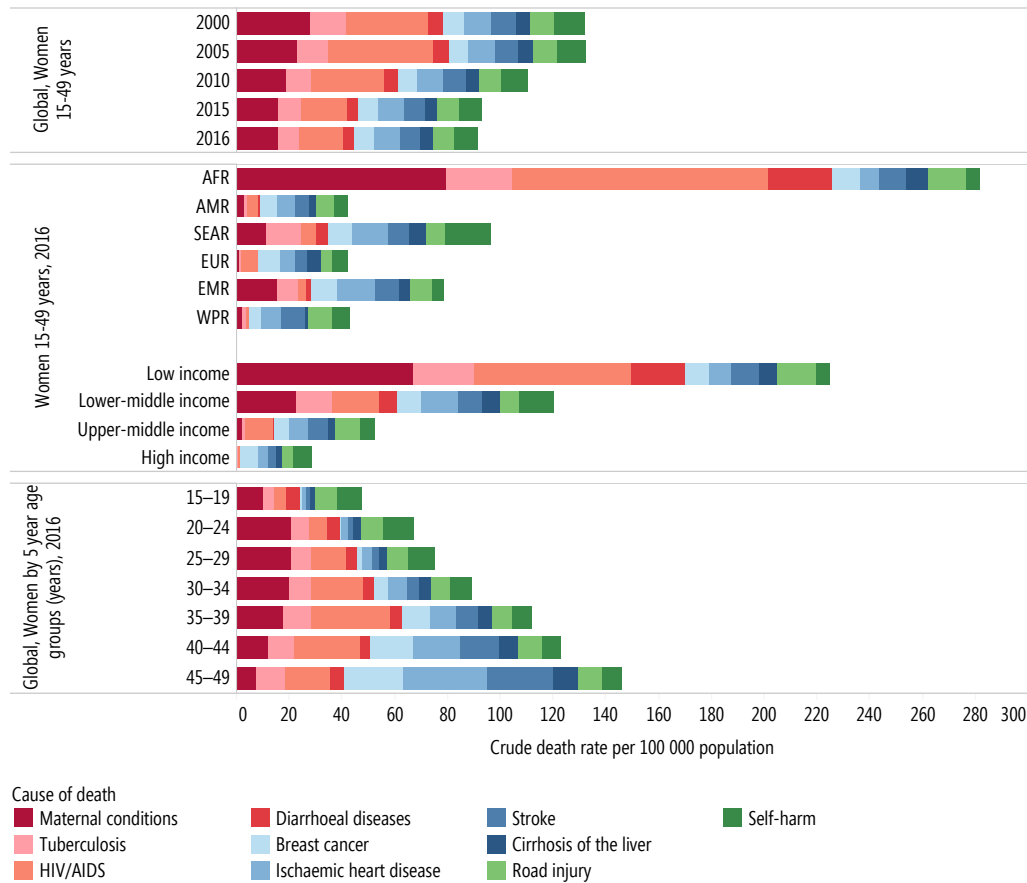
Source: WHO (2018) *(2)*.

Fig. 2.2
Maternal mortality ratio (maternal deaths per 100 000 live births), 2015

- 1–19
- 20–99
- 100–299
- 300–499
- 500–999
- ≥1000
- Population <100 000 not included in the assessment
- Data not available
- Not applicable
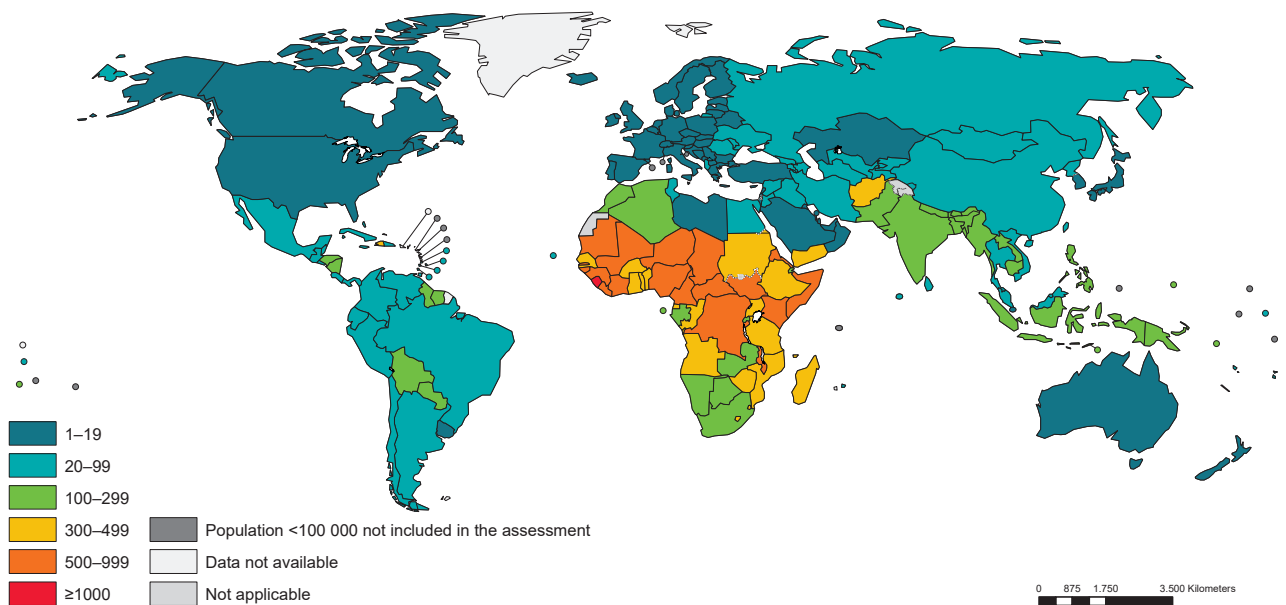
Source: WHO (2015) *(9)*.

Fig. 2.3
Lifetime risk of dying from maternal causes, 2015[a]

AFR — 1 in 37
AMR — 1 in 920
SEAR — 1 in 240
EUR — 1 in 3400
EMR — 1 in 170
WPR — 1 in 1400

Low income — 1 in 41
Lower-middle income — 1 in 130
Upper-middle income — 1 in 970
High income — 1 in 3300

0%   1%   2%   3%
Lifetime risk of dying of maternal causes (%)
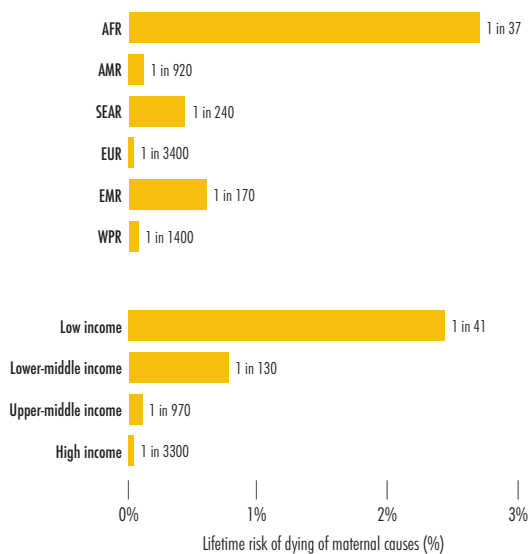
[a] The life time risk of dying from maternal causes is the probability of a 15-year-old girl eventually dying from a maternal cause, assuming that she is subjected throughout her lifetime to the fertility and maternal mortality risks, as estimated for 2015.

Source: WHO (2015) *(9)*.

The risk of maternal death can be reduced through better access to modern methods of contraception, and by ensuring that women have access to high-quality care before, during and after childbirth. It is estimated that 76% of women of reproductive age have their family planning needs met with a modern contraceptive method. Globally between 2013 and 2018, 81% of births took place with the assistance of a skilled birth attendant. However, there are wide disparities across regions. Coverage of deliveries by a skilled birth attendant ranges from 59% in the WHO African Region to over 90% in the Region of the Americas, and in the European and Western Pacific regions.

There is an inverse association between maternal mortality ratios (MMRs) and the proportion of women aged 15–49 years with their contraception needs met with modern methods; similarly, there is an inverse correlation between MMRs and the proportion of women receiving quality care from a skilled health professional (Fig. 2.4). Thus, critical services are least available, or least used, where MMRs are highest.

In 2018 there were an estimated 12.8 million births among adolescent girls aged 15–19 years, representing 44 births per 1000 adolescent girls. Adolescent birth rates are lowest in high-income countries (12 births per 1000 adolescent girls) and highest in low-income countries (97 births per 1000). Regionally, adolescent birth rates are lowest in the WHO Western Pacific Region (14 births per 1000) and highest in the African Region (99 births per 1000).

Adolescent girls (aged 10–19 years) face higher risks of eclampsia, systemic infections and complications during childbirth than women aged 20–24 years *(12)*. Early childbearing can also have a negative effect on the health of newborn children, and on the health of the young mothers and pregnant adolescents, who may encounter stigma and stress and thus be less likely to complete schooling – in turn

Fig. 2.4
Maternal mortality ratios are highest where (a) the need for family planning is least met and (b) the proportion of births delivered by a skilled attendant is lowest[a]

■ Low income ■ Lower-middle income ■ Upper-middle income ■ High income

(a)

Maternal mortality ratio (per 100 000 births), 2015

1000
100
10
1

0   10   20   30   40   50   60   70   80   90   100
Women 15–49 with family planning need met, 2009–2018 (%)

(b)

Maternal mortality ratio (per 100 000 births), 2015

1000
100
10
1

100   10   1
Proportions of births without skilled birth attendant, 2009–2018 (%)
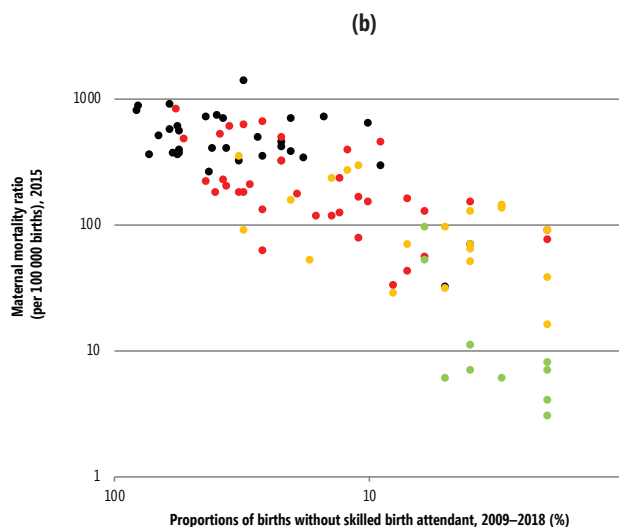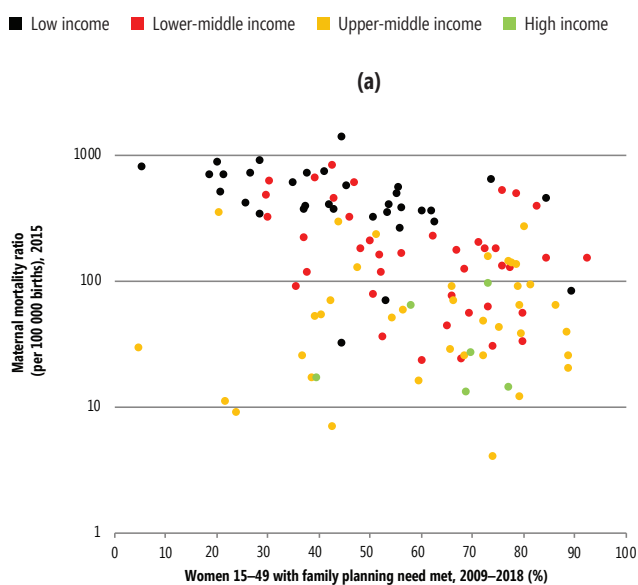
[a] Six upper-middle-income countries and one high-income country deviate from the overall trend in 2.4a and have low values of met need for family planning with low MMRs. These are Albania, Armenia, Bosnia and Herzegovina, Libya, Montenegro, Oman and Serbia *(11)*.

Source: WHO (2015) *(9)*.

this reduces their lifetime opportunities and weakens their control over resources and their lives *(13, 14)*.

There is an inverse association between adolescent birth rates and the proportion of women aged 15–49 years with their contraceptive needs met, which is also related to the wealth of countries (Fig. 2.5). Similarly, there is an inverse association between adolescent birth rates and the proportion of women receiving quality care from a skilled health professional. Thus, not only do adolescents giving birth have less access to methods to prevent high-risk birth, the high-risk birth is less likely to be delivered by a skilled birth attendant.

In addition to the tragic loss of life, a maternal death can have negative effects on families, including on the physical and mental health of family members *(15, 16)*. Studies have shown greatly increased mortality among children whose mothers had died *(17–19)*. Other documented effects include catastrophic payments and reduced household income *(20–22)*; thus, not only are the risks of maternal deaths elevated by poverty, but their occurrence may perpetuate the cycle of poverty in poor communities from one generation to the next.

Many women, and their children, could be saved by increasing availability and use of modern methods of contraception, and high-quality pregnancy and childbirth care. However, most maternal deaths are also influenced by other factors associated with poverty, lack of freedom over reproductive health choices and lack of command of resources. Programmes to address upstream risk factors for maternal death, including women's economic empowerment and increased educational attainment, are also important for the well-being of women and their families.

The design and monitoring of maternal health programmes is impaired by incomplete information on the frequency and causes of death, and data are scarcest in countries where MMRs are highest. Investments are needed in monitoring systems that can, for example, investigate maternal deaths (without penalizing those who report maternal deaths), and survey the availability and quality of essential obstetric care. Such systems would supplement routine health information systems and household surveys.

Fig. 2.5
Adolescent birth rates are highest where (a) the need for family planning is least met and (b) the proportion of births delivered by a skilled attendant is lowest[a]

■ Low income ■ Lower-middle income ■ Upper-middle income ■ High income
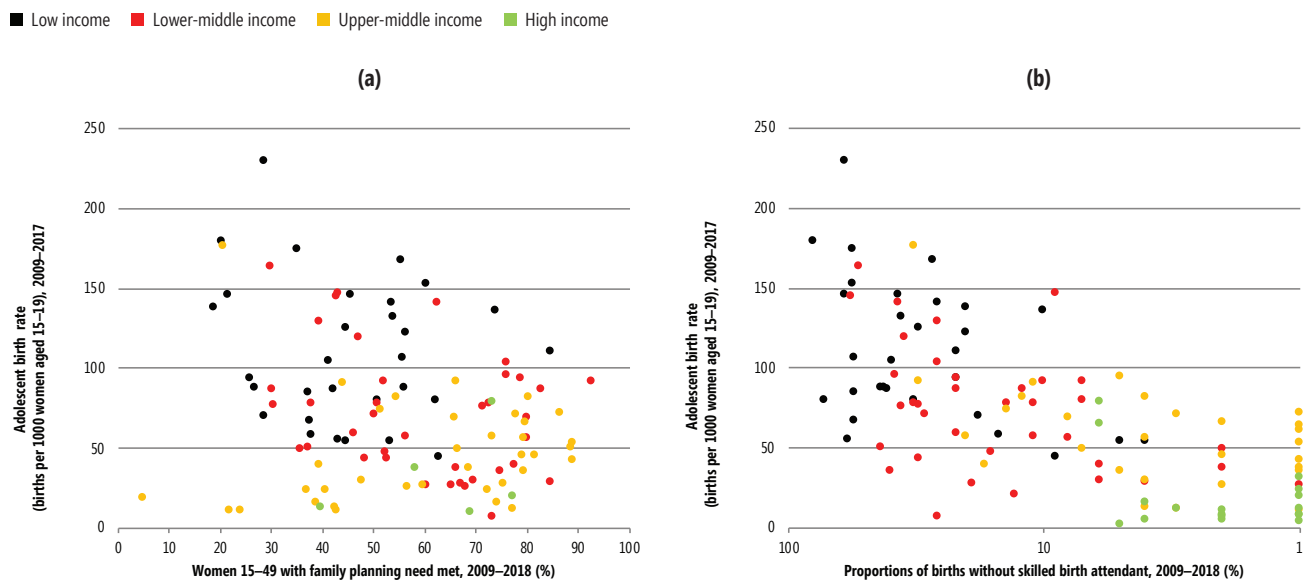
[a] Individual points represent the latest available survey results for a country since 2009 *(11)*.

Indicator 3.1.1 Maternal mortality ratio (per 100 000 live births)

TREND
Globally, the MMR fell by 37% during 2000–2015. Even so, in 2015, 303 000 deaths occurred – more than one woman died for every 500 births.

GEOGRAPHICAL DISTRIBUTION
MMRs are highest in the WHO African Region where one woman dies for every 185 children born.

NATIONAL INCOME
MMRs are highest in low-income countries where one woman dies for every 202 children born compared to one woman in 5900 in high-income countries – a 29-fold difference.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
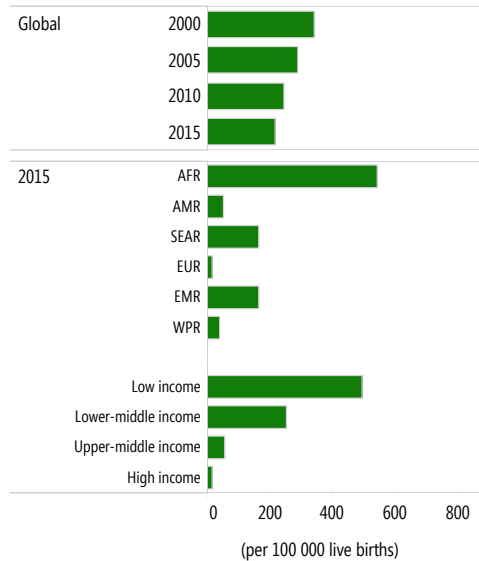
Indicator 3.1.2 Proportion of births attended by skilled health personnel (%)

TREND
The proportion of births attended by skilled health personnel increased from 62% in 2000–2005 to 81% in 2013–2018.

GEOGRAPHICAL DISTRIBUTION
The proportion of births attended by skilled health personnel is lowest in the WHO African, Eastern Mediterranean and South-East Asia regions.

NATIONAL INCOME
Just 60% of births are attended by skilled health personnel in low-income countries compared to nearly 100% in upper-middle-income and high-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
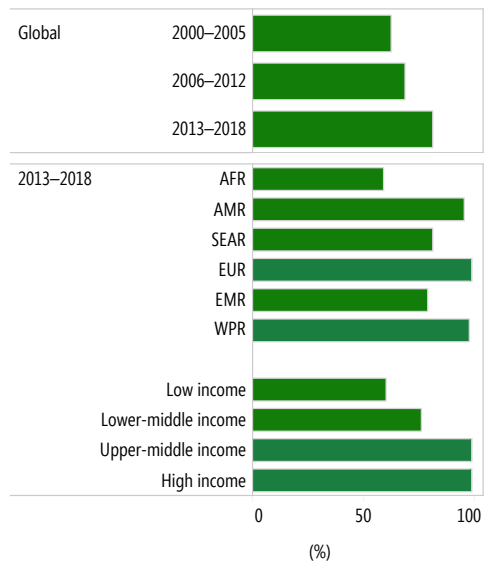
Indicator 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods (%)

TREND
The proportion of women of reproductive age who have their need for family planning satisfied with modern methods of contraception increased between 2000–2015.

GEOGRAPHICAL DISTRIBUTION
The proportion of women who have their need for family planning satisfied with modern methods is lowest in the WHO African Region and highest in the Western Pacific Region.

NATIONAL INCOME
Not available.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not applicable because the denominator for Indicator 3.7.1 is women 15–49. However, information on method of contraception, including female and male methods, is collected in DHS. In the latest nationally representative DHS results from 39 countries for 2010–2017, condom use was the most common method reported in 26 countries, oral contraceptive pills in 9 countries, injections in 2 countries, female sterilization in 1 country and intrauterine devices in 1 country. Such surveys are undertaken predominantly in low- and middle-income countries (LMIC). Condoms may also be used to prevent transmission of sexually transmitted diseases.
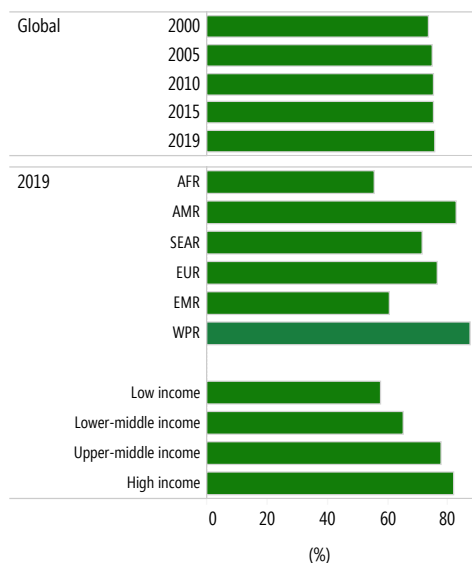
Indicator 3.7.2 Adolescent birth rate (per 1000 women aged 15–19 years)

TREND
Globally, adolescent birth rates have fallen from 53 per 1000 women aged 15–19 years in 2000–2005 to 44 in 2015–2020.

GEOGRAPHICAL DISTRIBUTION
Adolescent birth rates are highest in the WHO African Region where one in 10 adolescent girls give birth each year.

NATIONAL INCOME
Adolescent birth rates are eight times higher in low-income countries (97 per 1000) than in high-income countries (12 per 1000).

AGE DISTRIBUTION
Adolescent birth rates are only available for adolescents aged 15–19 years, not for those aged 10–14 years.

SEX DISTRIBUTION
Not available.

3 NEWBORN AND CHILD HEALTH

This section discusses some of the SDG targets that focus on child health: those for nutrition (Target 2.2), child mortality (Target 3.2) and vaccines (Target 3.b). Other SDG targets critical for child health are those concerning reproductive and maternal health (Targets 3.7 and 3.1), safe drinking-water (Target 6.1), and sanitation and hygiene (Target 6.2); those targets are discussed in Sections 2 and 7 of this report.

Substantial progress has been made in reducing child deaths since 2000, with the global under-5 mortality rate dropping by 49%, from 77 deaths per 1000 live births in 2000 to 39 in 2017. This is the equivalent of 1 in 14 children dying before reaching age 5 in 2017, compared with 1 in 13 dying before age 5 in 2000. An estimated 5.4 million children aged under 5 years died in 2017, of whom 2.5 million were female and 2.9 million male. Of these deaths, 2.5 million occurred during the first 28 days of life. Globally, death rates in the first month of life fell by 41%, from 31 per 1000 live births in 2000 to 18 in 2017, a smaller reduction in mortality compared with the 54% reduction in mortality for children aged 1–59 months. Under-5 mortality rates are highest in the WHO African Region and in low-income countries, where one child dies out of 14 born.

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 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births

INDICATORS

3.2.1 Under-5 mortality rate

3.2.2 Neonatal mortality rate

TARGET 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

INDICATORS

2.2.1 Prevalence of stunting (height for age <–2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

2.2.2 Prevalence of malnutrition (weight for height >+2 or <–2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight).

TARGET 3.b: Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines

INDICATOR

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

More than half of under-5 child deaths are due to diseases that are preventable and treatable through simple, affordable interventions (Fig. 3.1). The leading causes of death in young children over 28 days of age remain pneumonia, diarrhoea, birth defects and malaria (in malaria endemic countries). Rates of death from all conditions are higher in low-income countries, but children in low-income countries are more than 100 times more likely to die from infectious diseases than those in high-income countries.

Children who die within the first 28 days of birth (neonatal mortality) suffer from conditions and diseases associated with lack of quality care at birth, or skilled care and treatment immediately after birth and in the first days of life. Preterm birth, intrapartum-related complications (birth asphyxia or lack of breathing at birth), infections and birth defects caused the most neonatal deaths in 2017. Most newborn deaths take place in low- and middle-income countries (LMIC), and two regions accounted for almost 70% of newborn deaths in 2017 – the WHO African Region and South-East Asia Region. It is possible to improve the survival and health of newborns by achieving high coverage of quality antenatal care, skilled care at birth, postnatal care for mother and baby, and care of small and sick newborns.

In 2017, male children were 11% more likely to die before the age of 5 years. Boys have a higher probability of dying before reaching the age of 5 years than girls for biological reasons, including less lung maturity at birth and less resistance to infectious diseases (24, 25). Newborn boys often weigh more at birth, but have higher perinatal mortality and more frequent congenital malformations. Immunoregulatory genes linked to the X-chromosome confer greater resistance to infectious diseases on girls, who have two X-chromosomes compared with boys, who have one X-chromosome.

Because boys have a higher biological risk of death than girls, an assessment of gender bias in health outcomes cannot be based on equality of the under-5 mortality rate. Rather, mortality rates close to unity are indicative of female disadvantage. The risk of dying before the age of 5 years is higher in boys in all income groups set by the World Bank and in all regions. However, in the WHO South-East Asia Region, the risk is almost equal, indicating high rates of avoidable mortality among females aged under 5 years.

Nutrition-related factors contribute to about 45% of deaths in children aged under 5 years. Malnourished children, particularly those with severe acute malnutrition, have a higher risk of death from common childhood illnesses such as diarrhoea, pneumonia and malaria. In most countries, a higher proportion of boys are malnourished than girls in the age group 0–5 years (this refers to overweight, stunting and wasting) (Fig. 3.2). Sex differences in nutritional status have been attributed to biological differences in morbidity between boys and girls in early life (24, 26). In addition, boys grow faster during infancy, resulting in greater energy needs.

Fig. 3.1
Number of deaths (thousands) among children under 5 years by cause, 2017

Acute respiratory infections 653	Diarrhoeal diseases 424	Other communicable diseases 395			Prematurity 878		Birth asphyxia and birth trauma 610
Injuries 304	Other noncommunicable diseases 242	Meningitis 95	Measles 92		Sepsis and other infectious conditions of the newborn 350		Other causes 255
Malaria 263	Congenital anomalies 191	Prematurity 65	HIV/AIDS 75		Congenital anomalies 284		Acute respiratory infections 155
		Birth asphyxia 61					

Age group
■ Neonatal (0–28 days)
■ Postneonatal (1–59 months)

Source: WHO-MCEE (2018) (23).

Fig. 3.2
Malnutrition rates in male and female children[a]: (a) stunting, low height for age, (b) wasting, low weight for height, and (c) overweight
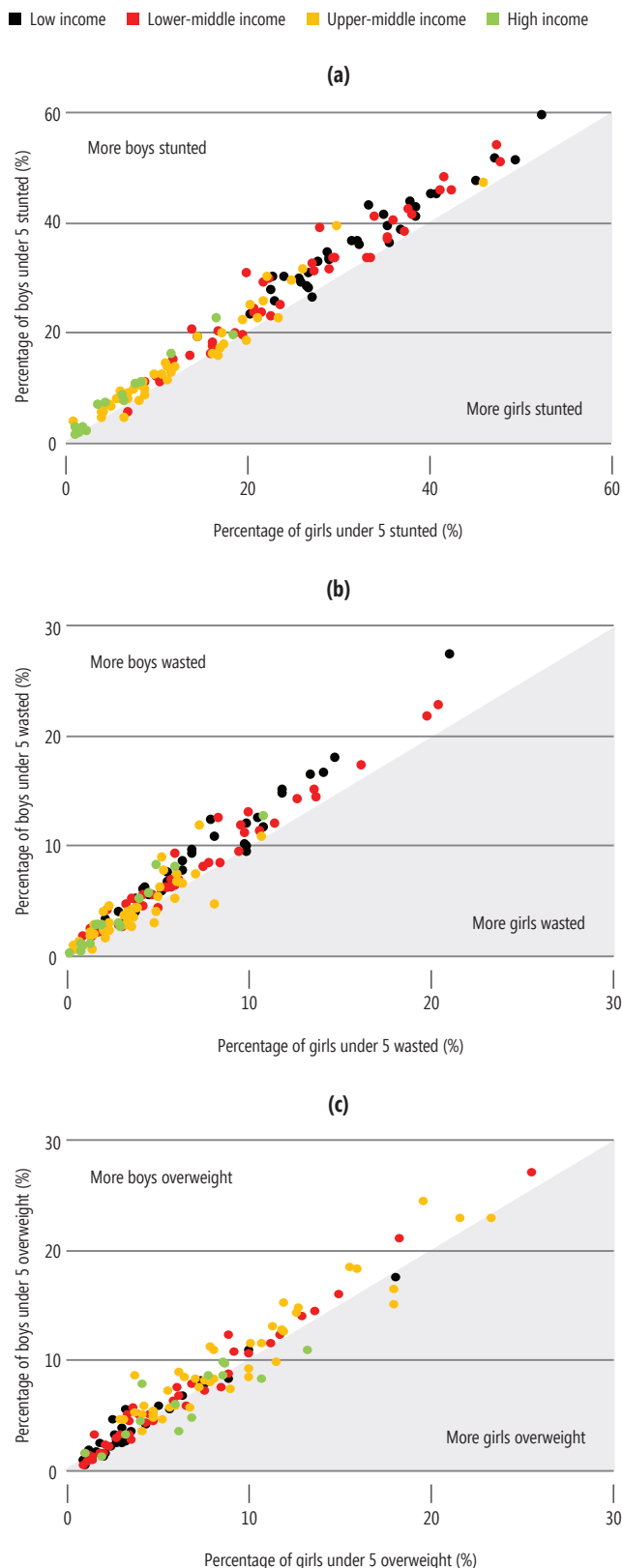
■ Low income ■ Lower-middle income ■ Upper-middle income ■ High income

(a)

(b)

(c)

[a] Individual points represent the latest available survey results for a country since 2000 *(11)*.

Use of health care services can contribute to differences in mortality rates between boys and girls. However, most studies find that boys and girls are equally likely to be taken for care when ill *(27)*, although a bias is observed in some locations. In a United Nations Children's Fund (UNICEF) review, a higher proportion of boys were taken to treatment centres for pneumonia in six countries out of 67 with data, whereas a higher proportion of girls were taken to treatment centres in one of those 67 countries *(28)*. Hospitalizations for pneumonia, diarrhoea and fever were found to be higher in boys than in girls, whereas case fatality rates were higher in girls than in boys, perhaps as a result of greater delays in care-seeking or poorer quality of care. Gender-based discrimination in health care affecting girls is reported mainly from South Asia and China, with sporadic reports from Africa and South America *(29)*.

Vaccines are available for some of the most deadly childhood diseases, such as measles, polio, diphtheria, tetanus, pertussis, pneumonia due to *Haemophilus influenzae* type B and *Streptococcus pneumonia* and diarrhoea due to rotavirus. Vaccination rates are similar between boys and girls (Fig. 3.3). Use of pneumococcal conjugate and rotavirus vaccines is lagging, especially in middle-income countries without donor support. Vaccination against both these diseases has the potential to substantially reduce deaths of children aged under 5 years, because pneumonia and diarrhoea are the leading causes of death in this age group.

Fig. 3.3
Vaccination rates in male and female children, 2000–2015[a]

[a] Individual points represent the latest available survey results for a country since 2000.
Source: Health equity assessment toolkit *(30)*.

Globally, countries with a low under-5 mortality rate have high M/F mortality ratios *(31, 32)*, partly because congenital diseases predominate when mortality is low. Countries with a high under-5 mortality rate have low M/F mortality ratios. Both high under-5 mortality rate and low M/F mortality ratios are associated with low socioeconomic status and gender inequality *(33)*. Progress in reducing the under-5 mortality rate since 2000 was accompanied by an increase in the M/F mortality ratio from 1.06 in 2000 to 1.11 in 2017, indicating that the decline in the female under-5 mortality rate was faster than that for males.

Reductions in the under-5 mortality rate are accompanied not only by higher M/F mortality ratios but also by reductions in fertility. Smaller families reduce the chances of a couple having a child of any given sex. In societies with a preference for male children, reductions in the under-5 mortality rate have been accompanied by another type of female disadvantage – that is, a disadvantage in natality – through selective abortion of female fetuses. Increases in the M/F sex ratio at birth have been seen in parts of East Asia, South Asia and the South Caucuses. M/F sex ratios at birth have been seen to be higher if a couple's previous children have been female; also, multiparous women are more likely to have prenatal knowledge of the sex of their fetus, resulting in sex selection and more male births than in primiparous women *(34)*.

A number of actions can be envisaged to address female disadvantage in populations with an atypically high female under-5 mortality rate, including policies to discourage sex-selective abortions, financial incentives to have female children, and policies that address the marginalized status of women or the provision of social protection in old age *(35)*. The development of policies that will improve child health requires better information on sex differentials in child morbidity and mortality, and more qualitative research that can reveal the harmful gender norms and expectations that result in discriminatory treatment of boys or girls.

Female disadvantage is of widespread concern and must be tackled. In addition, the specific needs of boys should be addressed. Boys experience higher rates of mortality than girls in most of the world, and as the under-5 mortality rate falls globally, the M/F mortality ratio is increasing. In countries that have achieved large reductions in the under-5 mortality rate, additional actions may need to be taken to improve health outcomes for boys, to ensure continued progress towards SDG Target 3.2.

Indicator 3.2.1: Under-5 mortality rate (per 1000 live births)

TREND
Under-5 mortality rates fell by 49% since 2000; nevertheless, in 2017, one child in every 14 born died before his or her fifth birthday, amounting to 5.4 million deaths.

GEOGRAPHICAL DISTRIBUTION
Higher under-5 mortality rates are seen in the WHO African Region and Eastern Mediterranean Region. The risk of death before the age of 5 years is eight times higher in the WHO African Region than in the European Region.

NATIONAL INCOME
Higher under-5 mortality rates are seen in low-income and lower-middle-income countries. The risk of death in low-income countries is more than 13 times higher than that in high-income countries.

AGE DISTRIBUTION
See Indicator 3.2.2 for neonatal mortality rate (first 28 days after birth).

SEX DISTRIBUTION
In 2017, male children were 11% more likely to die before the age of 5 years than female children. Progress in reducing the under-5 mortality rate since 2000 has been accompanied by an increase in the M/F mortality ratio from 1.06 in 2000 to 1.11 in 2017 (i.e. the decline in the female under-5 mortality rate has been faster than the male rate).

The risk of dying before the age of 5 years is higher in boys in all income groups from the World Bank and all WHO regions, but is almost equal in the WHO South-East Asia Region. Because boys have a higher biological risk of death than girls, mortality ratios close to unity are indicative of female disadvantage and are of concern.

(per 1000 live births)

Indicator 3.2.2: Neonatal mortality rate (per 1000 live births)

TREND
Globally, the neonatal mortality rate fell by 41% between 2000 and 2017; nevertheless, in 2017, 2.5 million deaths occurred in children aged under 1 month: one child in every 55 born.

GEOGRAPHICAL DISTRIBUTION
Neonatal mortality rates are highest in the WHO African Region and Eastern Mediterranean Region; regions where one child in 37 born dies before they are 1 month old.

NATIONAL INCOME
Neonatal mortality rates are highest in low-income and lower-middle-income countries, where approximately one child in 20 born dies before they are 1 month old. The risk of death before a child reaches the age of 1 month is seven times higher in low-income and lower-middle-income countries than in high-income countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that neonatal mortality rates are higher in boys than girls.

Indicator 2.2.1: Prevalence of stunting in children under 5 (%)

TREND
Globally, the proportion of children aged under 5 years who are stunted fell by nearly a third between 2000 and 2018; nevertheless, in 2018, more than a fifth of children were shorter than global standards for their age.

GEOGRAPHICAL DISTRIBUTION
Rates of stunting are highest in the WHO African Region and South-East Asia Region, where about one in three children are stunted.

NATIONAL INCOME
Rates of stunting are highest in low-income and lower-middle-income countries, where the risk of stunting is five times higher than in upper-middle-income countries, and more than 10 times higher than in high-income countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that rates of stunting are generally higher in boys than girls.
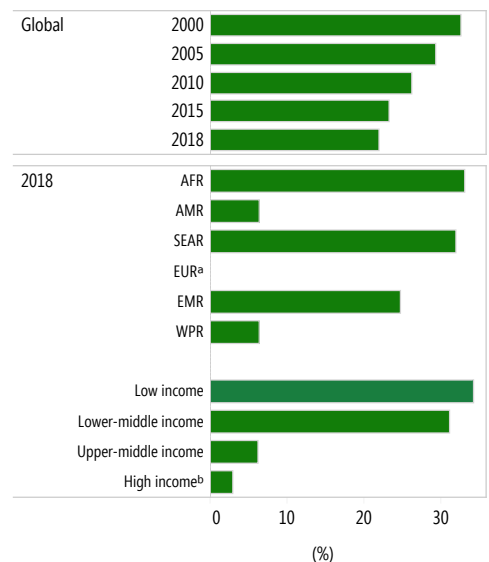
[a] Not available.
[b] Low coverage, interpret with caution.

Indicator 2.2.2.a: Prevalence of wasting in children under 5 (%), 2018

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
Rates of wasting are highest in the WHO South-East Asia Region where one in seven children are considered to be too light (thin) for their height.

NATIONAL INCOME
Rates of wasting are highest in low-income and lower-middle-income countries. The greater proportion of children that are wasted in lower-middle-income countries reflects large inequalities in nutritional status within countries, as well as between countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that rates of wasting are generally higher in boys than girls.
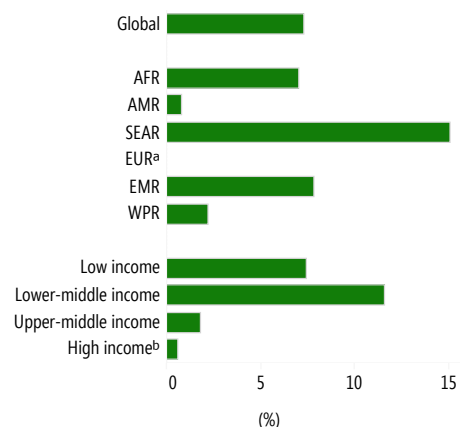
a Not available.
b Low coverage, interpret with caution.

Indicator 2.2.2.b: Prevalence of overweight in children under 5 (%)

TREND
Globally, the proportion of children aged under 5 years who are overweight increased by 20% between 2000 and 2018; in 2018, one in 17 children were heavier than global standards for their height.

GEOGRAPHICAL DISTRIBUTION
The proportion of children considered overweight is highest in the WHO Region of the Americas where one child in 14 is overweight.

NATIONAL INCOME
The proportion of children considered overweight is highest in upper-middle-income countries, where one child in 14 is overweight. In low-income countries, one child in 32 is considered to be heavier than global standards for their height.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that the proportion of children overweight is higher in boys than in girls.
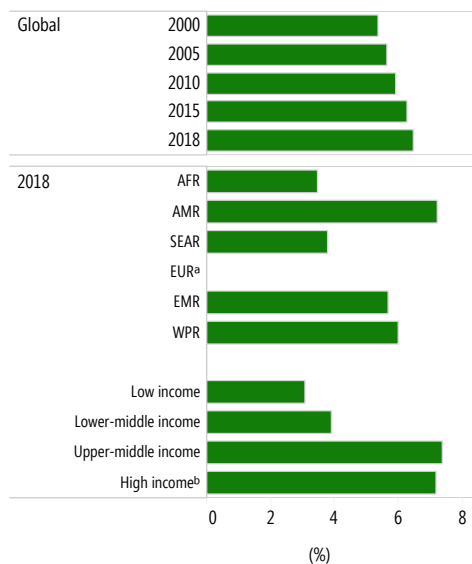
a Not available.
b Low coverage, interpret with caution.

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

Indicator 3.b.1 is tracked using the coverage of three vaccine doses: the third dose of diphtheria-tetanus-pertussis (DTP3), the measles-containing vaccine second dose (MCV2) and the pneumococcal conjugate vaccine third dose (PCV3). These are reported separately below.

DIPHTHERIA-TETANUS-PERTUSSIS (DTP3) IMMUNIZATION COVERAGE AMONG 1-YEAR-OLDS (%)

TREND
Global coverage rose from 72% in 2000 to 85% in 2017, representing a 15% increase. All countries are using DTP-containing vaccines for the administration of the three primary doses. Most countries are using vaccines combined with other antigens such as hepatitis B or *Haemophilus* type b.

GEOGRAPHICAL DISTRIBUTION
The WHO African Region has had the highest increase in coverage since 2000 (38%), but the coverage level in 2017 was still the lowest among WHO regions, at 72%. The WHO Western Pacific Region had the highest level of coverage in 2017, at 97%.

NATIONAL INCOME
Low-income countries have lower vaccine coverage rates. The gap between low- and high-income countries has decreased since 2000, but was still 17 percentage points in 2017.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that vaccination rates are similar between boys and girls.
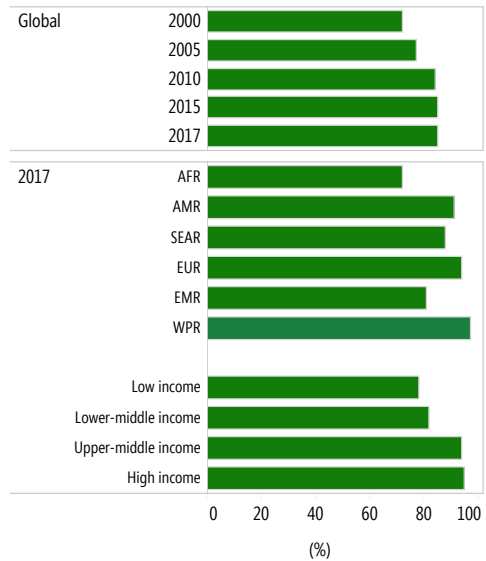
MEASLES-CONTAINING-VACCINE SECOND-DOSE (MCV2) IMMUNIZATION COVERAGE BY THE NATIONALLY RECOMMENDED AGE (%)

TREND
Global coverage has increased more than fourfold since 2000; two thirds of children received two doses of measles vaccine according to national immunization schedules in 2017. In 2017, 167 of the 194 WHO Member States had introduced a second dose of measles-containing vaccine in their national immunization schedules.

GEOGRAPHICAL DISTRIBUTION
In 2017, just 26 of the 47 countries in the WHO African Region had introduced the second dose in their national immunization schedule, translating to vaccination coverage of 25%, the lowest of all WHO regions. The WHO Eastern Mediterranean Region had the second lowest coverage among WHO regions, despite 95% of the Member States already having introduced MCV2 in their national immunization schedules. The WHO Western Pacific Region had the highest coverage in 2017, at 94%, followed by the European Region at 90%.

NATIONAL INCOME
Nine in 10 children in high-income countries received two doses of measles vaccine according to national immunization schedules in 2017, yet only about three in 10 children in low-income countries received two doses.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that vaccination rates are similar between boys and girls.
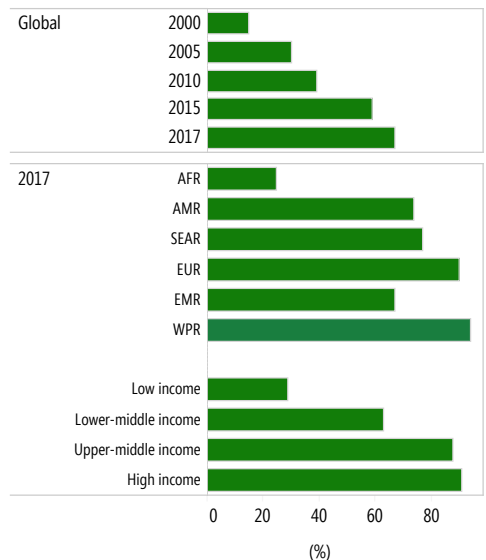
PNEUMOCOCCAL CONJUGATE 3RD DOSE (PCV3) IMMUNIZATION COVERAGE AMONG 1-YEAR-OLDS (%)

TREND
Global coverage has increased 4-fold since 2010, reaching 44% in 2017. By 2017, 141 countries had introduced PCV in their national immunization schedules, the WHO South-East Asia Region being the region with the fewest number of introductions (proportionally).

GEOGRAPHICAL DISTRIBUTION
In 2017, coverage ranged from 12% in the WHO South-East Asia Region to 82% in the Region of the Americas.

NATIONAL INCOME
Middle-income countries are lagging in the uptake of pneumococcal vaccine, with 33% estimated coverage in 2017, compared with 68% in low-income countries and 85% in high-income countries. Most middle-income countries do not benefit from donor support, and Gavi gives preferential pricing to newer and more expensive vaccines.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global estimates are not available, but individual country surveys suggest that vaccination rates are similar between boys and girls.
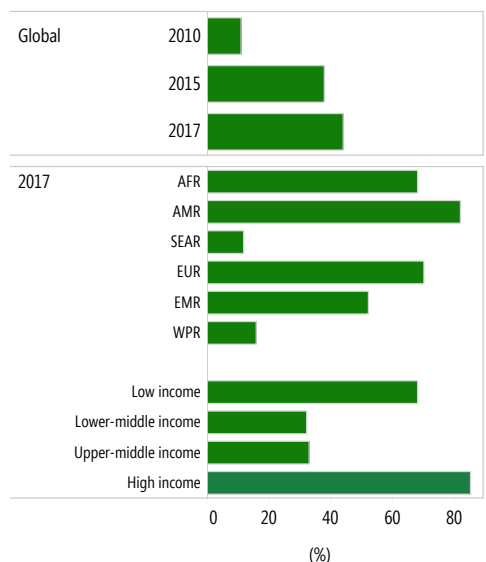
4

INFECTIOUS DISEASES

The main SDG target concerning infectious diseases is Target 3.3. Indicators of progress consider HIV, TB, malaria, hepatitis and neglected tropical diseases (NTDs).[1] Collectively, these diseases accounted for an estimated 4.3 million deaths in 2016 (1.7 million female and 2.7 million male), down from 5.3 in 2000 (2.2 million female and 3.1 million male) (Fig. 4.1).

The risk of dying from these infectious diseases is highest in the WHO African Region and South-East Asia Region, and in low-income and lower-middle-income countries.

The risk of death varies across the life course by disease. The risk of death from malaria is greatest in children aged under 5 years. Deaths from HIV peak in reproductive years, whereas the risk of death from TB, hepatitis B and NTDs increases with age (Fig. 4.2).

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

INDICATORS

3.3.1 Number of new HIV infections per 1000 uninfected population, by sex, age and key populations

3.3.2 Tuberculosis incidence per 1000 population

3.3.3 Malaria incidence per 1000 population

3.3.4 Hepatitis B incidence per 100 000 population

3.3.5 Number of people requiring interventions against neglected tropical diseases

There are two male deaths from TB for every female TB death, and two male deaths from hepatitis for every female hepatitis death. There are also almost 40% more male deaths than female deaths from HIV, but the M/F death rate ratio varies from 1.1 in the WHO African Region to 3.5 in the Western Pacific Region, and from 1.1 in low-income countries to 3.0 in high-income countries, reflecting the different predominant modes of transmission. Deaths from NTDs and malaria are more evenly spread across the sexes.

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[1] Buruli ulcer, Chagas' disease, dengue and chikungunya, dracunculiasis (guinea-worm disease), echinococcosis, foodborne trematodiases, human African trypanosomiasis (sleeping sickness), leishmaniasis, leprosy (Hansen's disease), lymphatic filariasis, mycetoma, chromoblastomycosis and other deep mycoses, onchocerciasis (river blindness), rabies, scabies and other ectoparasites, schistosomiasis, soil-transmitted helminthiases, snake-bite envenoming, taeniasis/cysticercosis, trachoma and yaws (endemic treponematoses).

Fig. 4.1
Deaths per 100 000 population from infectious diseases covered by SDG Target 3.3, 2016[a]

Deaths
per 100 000 population

- <38
- 38–<90
- 90–<162
- 162–<240   Data not available
- ≥240   Not applicable

0   875   1.750   3.500 Kilometers
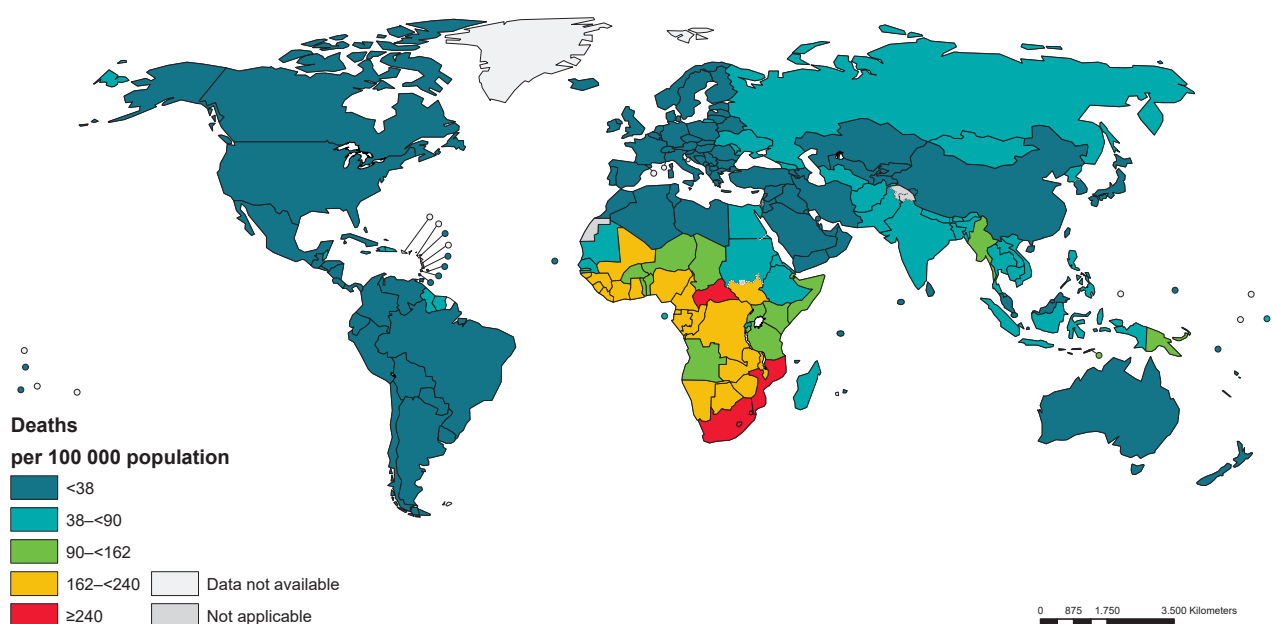
[a] Thresholds based on Jenks natural breaks optimization. Hepatitis includes acute hepatitis, cirrhosis due to hepatitis B and C, and liver cancer secondary to hepatitis B and C.
Source: WHO (2018) *(2)*.

Fig. 4.2
Age distribution of deaths from infectious diseases covered by SDG Target 3.3, 2016

Age group (years)

Crude death rate per 100 000 population

Cause of death
- HIV/AIDS
- Tuberculosis
- Malaria
- NTDs
- Hepatitis[a]
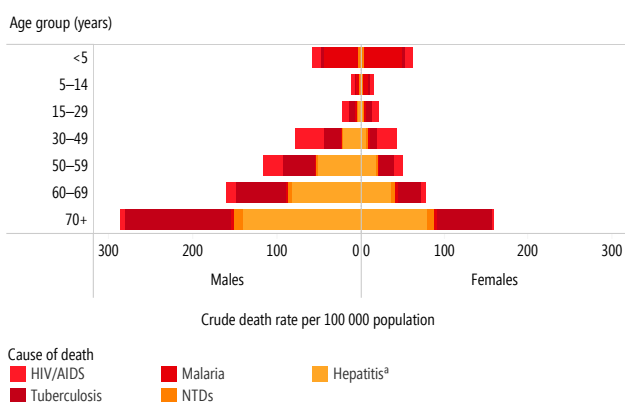
[a] Hepatitis includes acute hepatitis, cirrhosis due to hepatitis B and C, and liver cancer secondary to hepatitis B and C.
Source: WHO (2018) *(2)*.

HIV

Globally, the incidence of HIV infection declined from 0.40 per 1000 uninfected population in 2005 to 0.25 per 1000 uninfected population in 2017. In total, there were an estimated 1.8 million new HIV infections in 2017 – 851 000 in females and 940 000 in males. Sub-Saharan Africa remained the most heavily affected region, where 59% of the 980 000 new adult HIV infections were in women. In other parts of the world, men accounted for 63% of the 650 000 new adult HIV infections.

In 2017, an estimated 47% of new infections occurred among key populations at high risk of HIV infection and their sexual partners. These key populations include gay men and other men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and their clients, and transgender people. Available data suggest that, in 2017, the risk of HIV acquisition among gay men and other men who have sex with men was 28 times higher than it was among heterosexual men. Similarly, the risk of acquiring HIV for people who inject drugs was 22 times higher than for people who do not inject drugs, 13 times higher for female sex workers than for women aged 15–49 years, and 13 times higher for transgender women than for people aged 15–49 years *(36)*. Risk behaviours (e.g. unprotected anal sex, the sharing of injecting equipment and unprotected transactional sex) within these populations are exacerbated by laws and policies that criminalize same-sex sexual relationships, sex work and drug use, which give licence for discrimination, harassment and violence, and hinder affected populations from accessing HIV and health services *(37-42)*.

In sub-Saharan Africa there were three times as many new infections in girls aged 15–19 years as there were in boys aged 15–19 years, and 1.5 times as many infections in women aged 20–24 years as there were in men aged 20–24 years (Fig. 4.3). The pattern of infection in the region reflects gender inequalities and harmful gender norms that create unequal power dynamics in the home and wider society, limit women's and girls' access to education, deny them control over their lives, restrict their access to HIV prevention and sexual and reproductive health services,
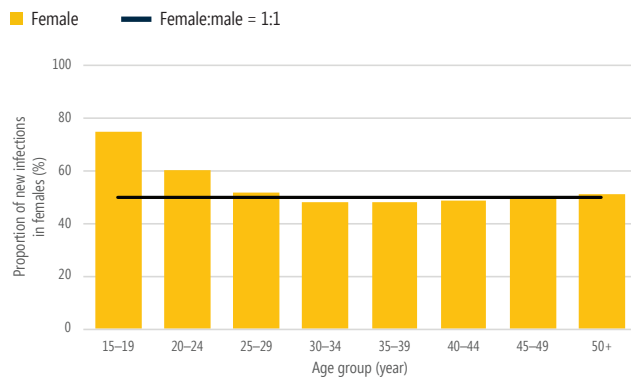
Source: UNAIDS (2018) *(36)*.

expose them to intimate partner and sexual violence, and cause a heightened risk of HIV, other sexually transmitted infections, unwanted pregnancies and maternal mortality *(43-47)*.

Condoms are one of the most effective methods for reducing the sexual transmission of HIV and other sexually transmitted infections. However, in half of the 27 countries in sub-Saharan Africa that had undertaken a recent household survey, condom use among men at last sex with non-regular partners was lower than 60%. Reported condom use among women was even lower, at less than 40% *(36)*. Male circumcision reduces the risk of female-to-male transmission of HIV. Between 2015 and 2017, almost 10 million adolescent boys and men underwent voluntary medical male circumcision in 14 priority countries in eastern and southern Africa, but circumcision rates remained at less than 30% in six of these countries.

Oral pre-exposure prophylaxis (PrEP) is among the most promising recent additions to HIV prevention for people at high risk of infection. The enormous potential of PrEP is already evident in North America, western Europe and Australia, where the addition of PrEP to areas with high coverage of antiretroviral therapy is contributing to declines in new diagnoses of HIV infection among gay men and other men who have sex with men. The impact of PrEP on a broader population within a high-prevalence setting remains to be seen, because large-scale PrEP programmes in eastern and southern Africa are in their early stages.

A record 21.7 million people were receiving antiretroviral therapy by the end of 2017, a net increase of 2.3 million people since the end of 2016. However, 41% of people living with HIV were still not receiving treatment. The uptake of these services can be low if HIV testing and treatment services are difficult to access; for example, where people must travel long distances to a clinic, where clinic hours are not suited to individuals or groups, or where

clinic staff discriminate against people living with HIV and key populations at risk of HIV. Food insecurity, costs associated with HIV and viral load testing (including for the tests themselves), other health care costs, transport costs, lost income and opportunity costs contribute to later treatment initiation, lower treatment adherence and higher rates of AIDS-related mortality. Fear of stigma and discrimination also results in delays in a person seeking an HIV test, and in accessing and adhering to treatment, which can result in poor health outcomes *(48–50)*. Key populations often face multiple barriers to access, including stigma and discrimination in health care settings, and lack of appropriate services provided in a manner that respects confidentiality and privacy.

In countries with generalized HIV epidemics, men are less likely than women to take an HIV test, less likely to access antiretroviral therapy and more likely to die of AIDS-related illnesses than women *(51)*. Men have fewer entry points to health care services compared with women who often access HIV services through maternal health services; also, men are less likely to seek care for many illnesses, and are thus less likely to be diagnosed and treated. When men living with HIV are not diagnosed, do not start on HIV treatment or fail to remain on treatment, it jeopardizes both their own health, and the well-being and prospects of their partners, households, extended families and communities.

Tuberculosis

The higher estimated incidence and death rates of TB among men may be partly explained by men being more likely to smoke or drink *(52, 53)*; however, other risk factors, such as exposure to indoor air pollution and HIV infection, are more common in women. Immunological reasons for an excess of TB disease in men have also been proposed *(6)*.

Male TB patients appear to be less likely to seek care than female TB patients, as reflected in lower rates of case notification compared with the estimated total of cases (Fig. 4.4) *(54)*. As a consequence, male patients remain infectious in the community longer than female patients. Combined with a higher disease burden, and their social mixing patterns, men are considered to generate a greater number of secondary infections than women *(55)*. Hence, there is a need for strategies to improve access to and use of health services among men, not only to address gender inequities but also to maximize reductions in disease incidence. Potential strategies include the more active targeting of men with routine diagnostic and screening services, with risk reduction strategies for tobacco smoking, type 2 diabetes, untreated HIV infection, undernutrition and air pollution.

■ Male notified   ■ Male not notified   ■ Female notified   ■ Female not notified

Incidence per 100 000 population
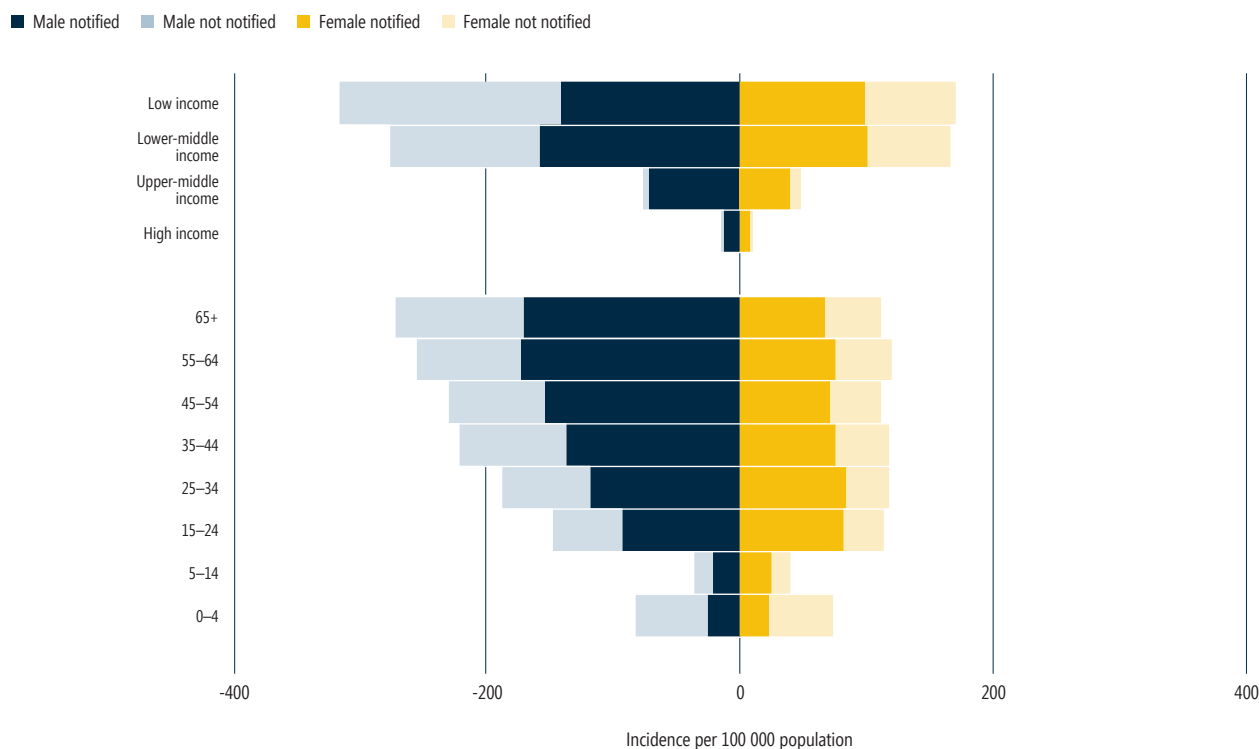
Sources: WHO (2018) *(54)* and World Bank (2018) *(11)*.

Drug-resistant TB is a continuing threat and in 2017 there were 558 000 new cases resistant to rifampicin (the most effective first-line drug), of which 460 000 were multidrug-resistant. There is no evidence of an association between sex of patient and the risk of drug resistance.

Malaria

The biting activity of the anopheline mosquitoes that transmit malaria is independent of the sex of the human host *(56, 57)*, and household surveys suggest that malaria infection rates are similar in male and female children aged under 5 years. However, differences in infection rates emerge in older ages, partly because gender roles influence exposure to mosquitoes. Men may be at high risk of malaria if they work in forests or fields at peak biting times, or if they migrate to areas of high endemicity for work. Women may be at increased risk if they perform household chores before dawn. Pregnant women are also more susceptible to malaria owing to their reduced immunity, with infection rates highest in the first and second pregnancies *(58)*. Malaria in pregnancy increases the risk of abortion, stillbirth, premature delivery and low-birthweight infants.

An effective intervention to reduce the risk of malaria infection is to sleep under a mosquito net *(59)*, and increased use of insecticide-treated mosquito nets (ITNs) since 2000 is estimated to account for half of the decline

in parasite prevalence among children aged 2–10 years in sub-Saharan Africa between 2000 and 2015 *(60)*. Initially, bednet campaigns were targeted to children aged under 5 years and pregnant women (Fig. 4.5) *(61)*, but in 2008, WHO recommended that ITNs should be used by all people at risk. Nonetheless, coverage rates have remained highest in children aged under 5 years and in women of reproductive age. Coverage rates are lowest among children and young people aged 5–19 years and men aged 20–24 years, which is of concern given that parasite prevalence rates frequently peak between ages 5–15 years *(62)*, and infected school children are a source of infection for other household and community members *(63)*. Coverage rates are higher in young women, partly because they tend to marry and form new households at a younger age than men; smaller, newly formed households are more likely to have enough ITNs for all occupants compared with larger households (from which the young women moved), which generally have lower ITN to person ratios.

Evidence on the extent to which malaria patients seek treatment derives mostly from household surveys. These indicate that the proportion of febrile children for whom advice or treatment was sought is equal between boys and girls. The indicator's measurement is largely confined to sub-Saharan Africa and children aged under 5 years; further information on care-seeking in other age groups and outside of Africa is needed.

Fig. 4.5
Proportion of population sleeping under an ITN, sub-Saharan Africa, by age and sex, 2000–2015
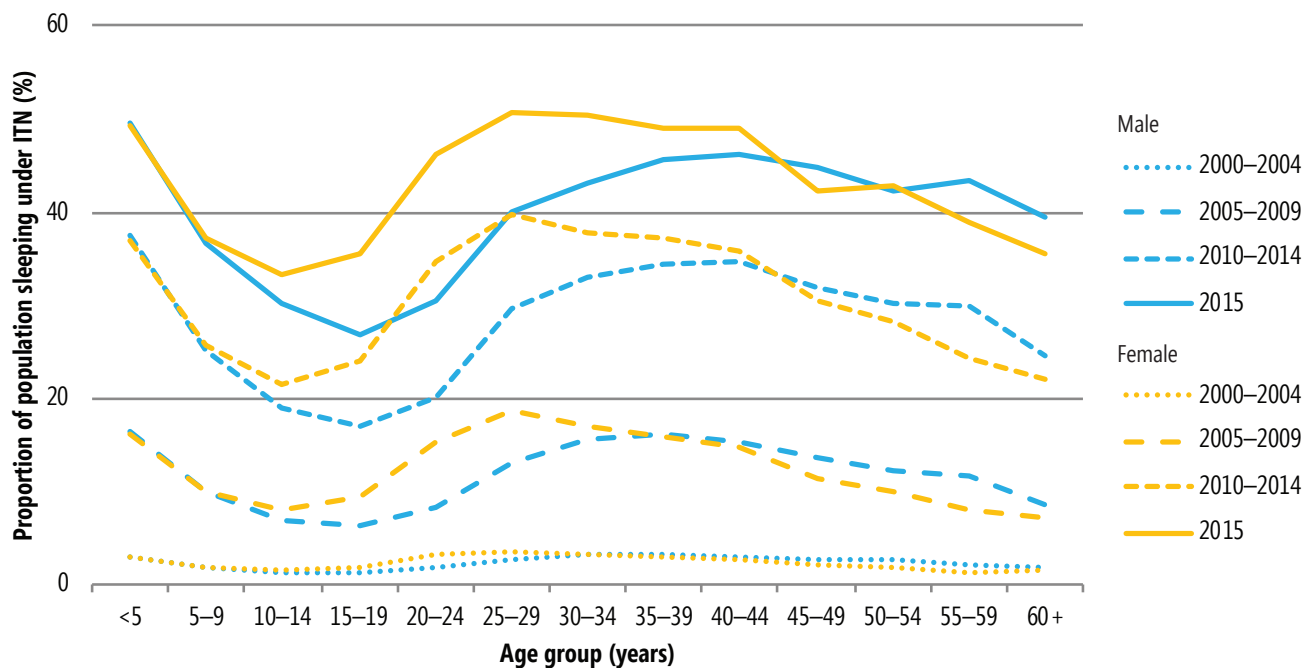
Source: DHS and malaria indicator surveys (MIS) 2000–2015 *(61)*.

Hepatitis B

Most of the burden of disease from infection with hepatitis B virus (HBV) comes from infections acquired before the age of 5 years. A person may be infected with HBV for 30 years or more before developing any clinical symptoms of disease. Unless people are tested and diagnosed, they are not aware of their disease. Untreated viral hepatitis can progress to life-threatening complications. Depending on life expectancy, 20% or more of those with chronic infection develop end-stage chronic liver disease, such as cirrhosis or hepatocellular carcinoma. Mortality rates are similar in men and women aged below 30 years, but mortality rates among men aged 30–59 years are 2 times higher than in women. The incidence of HBV-related hepatocellular carcinoma is higher in men than women, and in postmenopausal females compared with other females, which may be related to levels of the hormones androgen and estrogen *(64)*. Cofactors (e.g. alcohol and HIV infection) can also accelerate progression towards end-stage liver disease.

NTDs

Sex differences in mortality rates for NTDs are slight compared with other infectious diseases covered by SDG Target 3.3, but mortality rates are 30% higher in men than in women aged 15–29 years. Interventions against NTDs largely rely on mass drug administration (to prevent disease) and early detection and treatment. Males are reported to face more barriers to accessing treatment than women owing to occupational roles that keep them away from households or villages for long periods, and they may be more distrustful of treatment *(65)*. Pregnant and breastfeeding women may also miss treatment if community distributors are unaware of which medicines can be safely used. Programmes often employ a higher proportion of men as community drug distributors than women. Some studies have identified underuse of female community drug distributors as being a factor that limits the effectiveness of ivermectin interventions against onchocerciasis in sub-Saharan Africa, but large-scale evaluations have not been undertaken *(66)*.

Indicator 3.3.1: New HIV infections (per 1000 uninfected population)

TREND
Between 2000 and 2017, the incidence of new HIV infections fell by 49% to 0.25 per 100 000, resulting in an estimated 1.8 million cases of HIV in 2017.

GEOGRAPHICAL DISTRIBUTION
The highest incidence rates are seen in the WHO African Region.

NATIONAL INCOME
The highest incidence rates are seen in low-income countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Global new HIV infection rates in women were 1.02 times higher than in men in 2000 but fell more rapidly between 2000–2017 so that they were 0.92 times that of men in 2017. Nonetheless, HIV adult infection rates were 1.3 times higher among women than men in the WHO African Region in 2017, though lower in women in other WHO regions.

(per 1000 uninfected population)
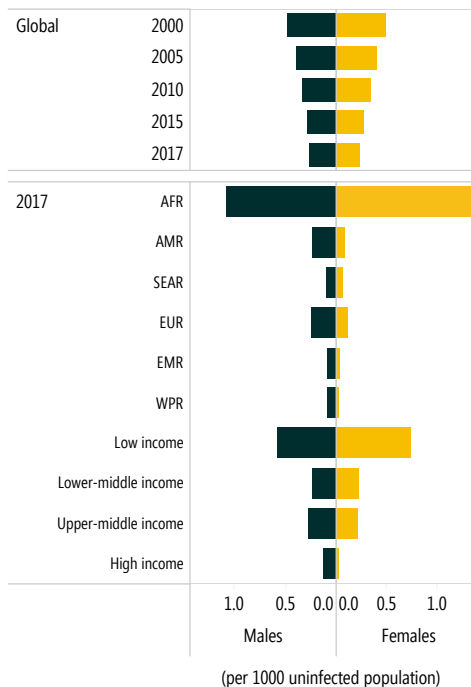
Indicator 3.3.2: Tuberculosis incidence (per 100 000 population)

TREND
Between 2000 and 2017, the TB incidence rate fell by 21% to 134 per 100 000, resulting in an estimated 10 million cases of TB in 2017.

GEOGRAPHICAL DISTRIBUTION
Higher incidence rates are seen in the WHO African Region and South-East Asia Region.

NATIONAL INCOME
Higher incidence rates are seen in low-income and lower-middle-income countries.

AGE DISTRIBUTION
In 2017, 90% of cases were in those aged over 15 years.

SEX DISTRIBUTION
In 2017, 64% of cases were estimated to be in men and boys, and 36% in women and girls. Incidence rates in men increased with age while those in women aged over 15 years remained constant. The M/F ratio was 1.1 in children aged under 15 years but exceeded 2 from the age of 45 years.

Cases per 100 000 population
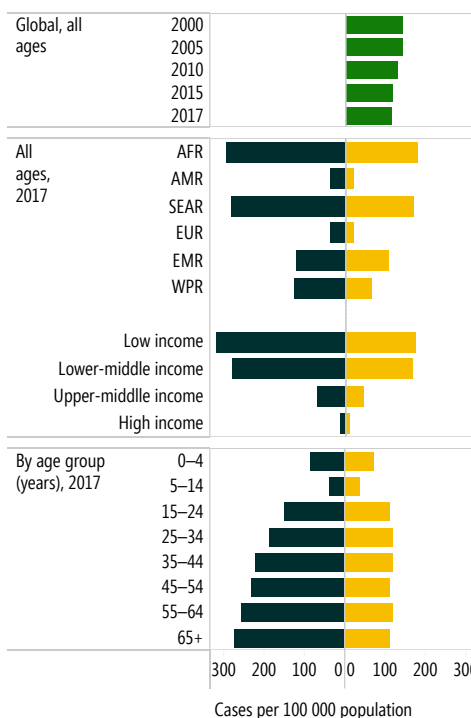
Indicator 3.3.3: Malaria incidence (per 1000 population at risk)

TREND
Global malaria incidence has remained at 59 per 1000 since 2015, after previously showing annual average reductions in incidence of 2.1% since 2000. An estimated 219 million cases of malaria occurred in 2017, leading to 435 000 deaths.

GEOGRAPHICAL DISTRIBUTION
The highest incidence rates are seen in the WHO African Region.

NATIONAL INCOME
Higher incidence rates are seen in low-income and lower-middle-income countries.

AGE DISTRIBUTION
An age breakdown of malaria incidence is not available; however, 61% of deaths and hence a similar proportion of cases are estimated to occur in children aged under 5 years. The percentage of deaths in children aged under 5 years is higher where case incidence rates are higher.

SEX DISTRIBUTION
Global estimates are not available. Nationally representative household surveys suggest that malaria infection rates are similar between male and female children, but that differences emerge in older age groups.
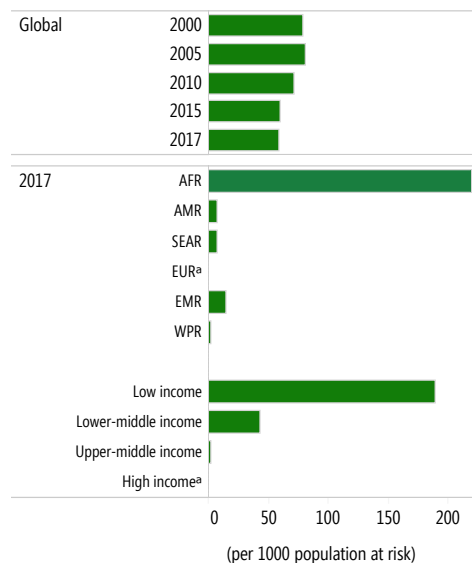
[a] The WHO European Region has reported zero indigenous malaria cases since 2015.

Indicator 3.3.4: Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years (%)

TREND
Hepatitis B prevalence among children aged under 5 years fell from 4.7% in the pre-vaccine era to 0.8% in 2017.

GEOGRAPHICAL DISTRIBUTION
Prevalence rates of hepatitis B are highest in the WHO African Region and the Eastern Mediterranean Region.

NATIONAL INCOME
The hepatitis B prevalence rate in low-income countries is 14 times that of high-income countries.

AGE DISTRIBUTION
Most hepatitis infections are acquired before the age of 5 years, although the most severe manifestations of the disease may not be noticed until late adulthood.

SEX DISTRIBUTION
Not available.
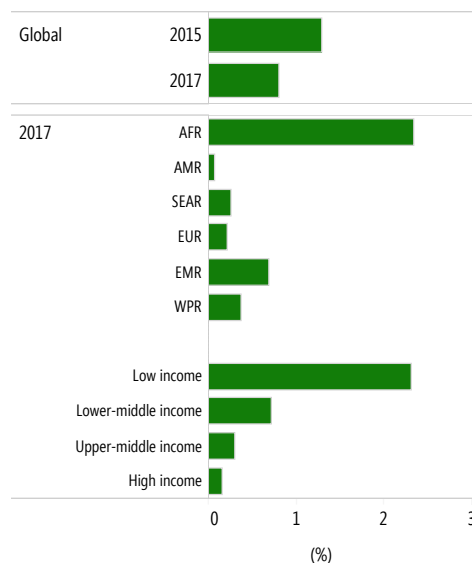
Indicator 3.3.5: Reported number of people requiring interventions against neglected tropical diseases

TREND
The number of people requiring interventions fell from 2.03 billion in 2010 to 1.58 billion in 2017.

GEOGRAPHICAL DISTRIBUTION
About 85% of people that require interventions are located in the WHO African Region and South-East Asia Region.

NATIONAL INCOME
Two thirds of those that require interventions live in lower-middle-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
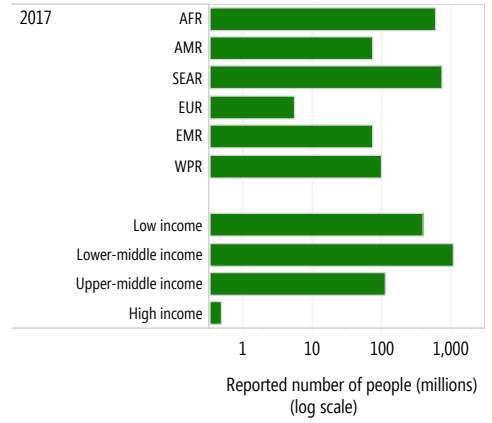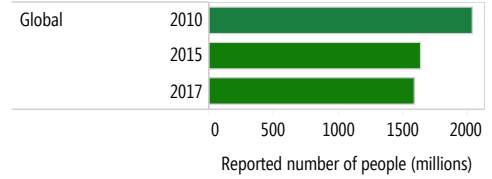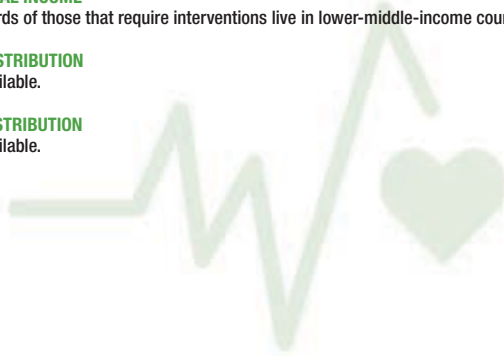
5 NONCOMMUNICABLE DISEASES

The SDG targets concerning noncommunicable diseases (NCDs) are twofold; namely, improving health outcomes (Target 3.4) and lowering the exposure to NCD risk factors (Targets 3.5 and 3.A). Target 3.4 is assessed on the reduction in risk of premature death between the ages of 30 and 70 years from cardiovascular disease (CVD), cancer, diabetes and chronic respiratory disease (Indicator 3.4.1), and reduction in suicide mortality rates (Indicator 3.4.2).

NCDs collectively caused 41 million deaths worldwide in 2016, equivalent to 71% of all global deaths. Additionally, there were nearly 800 000 deaths from suicide.

Globally in 2016, the risk of a 30-year-old person dying from any of the four major NCDs before reaching the age of 70 years was 21.6% for men and 15.0% for women. The highest risks of premature death from NCDs by WHO region were seen in the WHO South-East Asia Region for men (26.5%) and in the WHO African Region for women (20.1%), whereas the highest risks by national income were in lower-middle-income countries for both sexes (26.6% for men and 19.9% for women). The risk of death from NCDs increased with age.

At a global level, CVD causes more premature deaths than cancer; however, for women in the WHO European Region

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

INDICATORS

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

3.4.2 Suicide mortality rate

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

INDICATORS

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

3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

TARGET 3.a: Strengthen the implementation of the WHO 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

and the Region of the Americas, cancer is the predominant cause of NCD premature deaths. Overall, in 2016, men were more likely than women to die from all four major NCDs, except in the WHO African Region and the Eastern Mediterranean Region, where women had higher age-standardized rates of premature death from cancer than men, and in the Western Pacific Region and the Eastern

Fig. 5.1
Age-standardized rates (per 100 000 population) of premature death from the four major NCDs covered by SDG Target 3.4, 2016
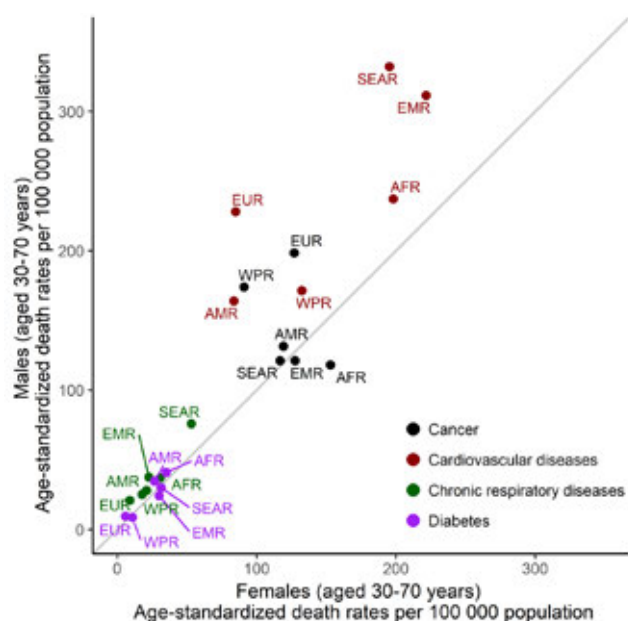
Source: WHO (2018) *(2)*.

Mediterranean Region, where female death rates from diabetes were higher (Fig. 5.1).

From 2000 to 2016, the risks of premature NCD death decreased; the relative declines were slightly larger for women (19%) than for men (18%).

Worldwide, the crude suicide mortality rates dropped between 2000 and 2016, by 16% in men and 20% in women. In 2016, nearly 800 000 deaths were due to suicide, equivalent to an annual global crude suicide mortality rate of 10.6 per 100 000 population. Globally, for every female suicide death, there are nearly two male deaths (13.5 and 7.7 deaths per 100 000 population in men and women, respectively). Although suicide attempts are about two to four times more frequent among females *(67)*, men are more likely to use lethal means, partly explaining the reversed pattern in suicide mortality rates.

Men in the WHO European Region and in high-income countries suffer from the highest crude suicide mortality rates (24.7 and 21.0 per 100 000 population, respectively). The rates in women in these settings are substantially lower (6.6 and 7.6 per 100 000 population, respectively), yielding the largest M/F ratios (3.7 in the WHO European Region and 2.7 in high-income countries). The highest female suicide mortality rates were seen in the WHO South-East Asia Region (11.6 per 100 000 population) and in lower-middle-income countries (8.8 per 100 000 population). The lowest were seen in the WHO Eastern Mediterranean Region, and in low-income countries, for both men and women.

Biological differences between men and women are the main reasons for variation in the risk of death from some NCDs, such as cancers of organs associated with reproduction (e.g. cervical, breast, prostate and testicular cancer). Death rates may also be influenced by access to diagnosis and treatment; for example, cervical cancer rates are higher in low-income countries with poor access to health services *(68)*. However, for many NCDs, death rates in men and women are driven by exposure to the same major modifiable risk factors – for example, tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity – all of which vary by sex. Among these factors, tobacco use and harmful use of alcohol are currently of concern for the SDG targets, and are being assessed using Indicators 3.A.1 and 3.5.2, respectively.

Exposures to risk factors vary geographically, across income levels and between sexes (because gender roles and social norms expose men and women to different risks at different levels). Until the late 20th century, tobacco use and alcohol consumption were widely viewed as desired masculine norms in most of the world. In 2016, the worldwide age-standardized prevalence of tobacco smoking among persons aged 15 years and older was 34% in men and 6% in women, compared with 2000, when the prevalence was higher, at 43% and 11% in men and women, respectively. This corresponds to the historical trends and sex difference observed in many countries and the higher male mortality rates from smoking-related diseases, such as lung cancer (31.3 and 14.4 per 100 000 population in men and women in 2016, respectively) *(2)*.

A decline in smoking rate has been observed for both sexes in many high-income countries, but the decline has been slower among women, and the female smoking rate in some countries may even have increased owing to women having a greater control of resources, association of smoking with women's liberation , and the tobacco industry's marketing strategies that target women, particularly young women (resulting in M/F ratios of <2 in the WHO Region of the Americas and European Region) *(69)*. In contrast, in low- and middle-income settings, smoking prevalence in men is substantially higher than in women, reaching a M/F ratio of 15.5 in the WHO Eastern Mediterranean Region, where gender roles and social norms pose barriers for women to smoke.

Findings for alcohol are similar to those for smoking. On average, men consumed far more alcohol than women worldwide in 2016 (10.1 versus 2.7 L of pure alcohol per person), with the largest consumption for both sexes being in the WHO European Region and in high-income countries, and the smallest in the WHO Eastern Mediterranean Region and low-income countries. The largest M/F ratios were observed in the WHO Eastern Mediterranean, South-East Asia and African regions.

As a major type of substance abuse, the implication of harmful use of alcohol goes beyond the control of major NCDs, because it is also a modifiable risk factor for suicide, especially for young people at risk. The high average alcohol consumption in men is likely to be one of the drivers of men's excess rates of suicide mortality relative to women *(70)*. Yet, data for interventions for substance use disorders (Indicator 3.5.1) are currently unavailable and its methodology is still under development.

In addition to the unhealthier lifestyles and risk-taking behaviours among men compared with women, in many settings men tend to underuse health services and visit a doctor less frequently, due to norms of masculinity and other socioeconomic factors. However, some NCD risk factors are less in favour of women. For example, women are more likely to have insufficient physical activity (31.7% versus 23.4% of men) *(71)*, because women are often subject to financial restraint, lack of decision-making power and extra household workload, making it difficult for them to allocate adequate resources and time for physical activity *(72)*. In particular, a large proportion of the female population have to fulfil multiple roles – such as childrearing, household care-giving and professional duties – which consume women's time and energy. Moreover, many communities lack the exercise space and facilities that are intended for and accessible to women, giving women less motivation to undertake physical activity. The lack of physical activity interacts with sex-related biological factors (e.g. women generally are more likely to store fat subcutaneously, but have lower metabolism than men); hence, the prevalence of obesity is higher in women (15.3% versus 11.1% in men) *(73)*. The higher prevalence of obesity leads to women having greater vulnerability to some NCDs; for example, for diabetes, the M/F ratio in risks of premature death is nearly unity at global level, substantially lower than the ratios for other NCDs. Women with lower education or socioeconomic status are even more likely to suffer from these NCDs, because they also tend to have limited access to a healthy diet. Because physical activity could potentially reduce levels of stress and depression, the lack of it would also put women at greater risk of suffering mental health issues.

Women may also manifest different symptoms of some NCDs than men, and hence be more likely to experience delayed diagnosis and treatment. This delay occurs in part because, historically, male patients have been more widely used as the reference in medical research while female patients have been understudied. For example, women's symptoms for coronary heart disease – including back pain, nausea or fatigue – are usually considered "atypical", leading to underdiagnosis and under-treatment *(74)*. Moreover, women, particularly those in low-resourced settings, are likely to face increased economic burdens for the prevention and treatment of NCDs and mental health issues, while having less decision-making power for health expenditures. This situation means that women are more vulnerable than men once the diseases have developed, and it offsets their lower exposure to the risk factors relative to men. For example, the M/F ratio of premature NCD mortality in 2016 was lowest in the WHO African Region (M/F: 1.1) where women have the lowest access to quality health care, and was over 40% lower than the highest ratio, which was seen in the WHO European Region (M/F: 1.9).

To meet the SDG target for NCDs by 2030, more research is needed to better understand the differences between men and women in susceptibility, vulnerability and exposure to risk factors, presentation of symptoms, disease progression, access to diagnosis and treatment, and treatment response, in addition to other gender-related factors related to inequity in health systems. Policies and strategies must recognize the sex and gender differences, and address the different needs of men and women with better targeted measures to reduce exposure to risk factors, improve early diagnosis, and increase access to affordable and effective treatment.

Indicator 3.4.1 Probability of dying from any of CVD, cancer, diabetes, chronic respiratory disease between age 30 years and exact age 70 years (%)

TREND
BThe global risk of premature NCD deaths declined by 18% for both sexes in 2000–2016, with the decline being slightly higher among women.

GEOGRAPHICAL DISTRIBUTION
The highest risk of premature NCD death occurred in the WHO South-East Asia Region for men and in the African Region for women.

NATIONAL INCOME
The highest risk of premature NCD deaths was seen in lower-middle-income countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Men face a greater risk of premature death from NCDs than women in all geographical regions and income groups. In 2016, the probability of a man aged 30 years dying from an NCD before the age of 70 years was 21.6% compared with 15.0% in women.
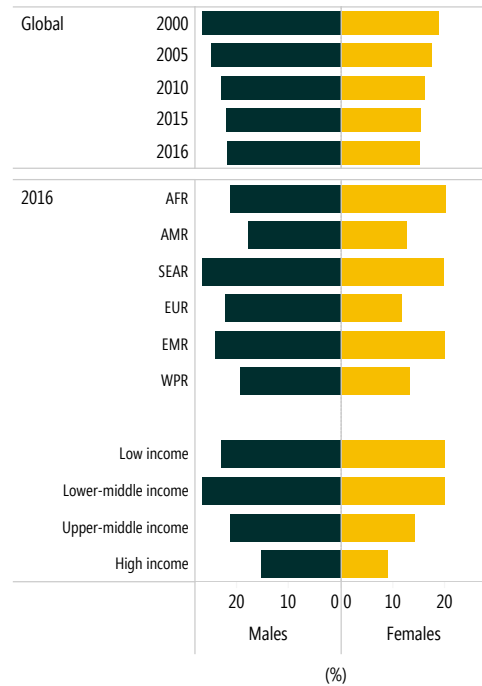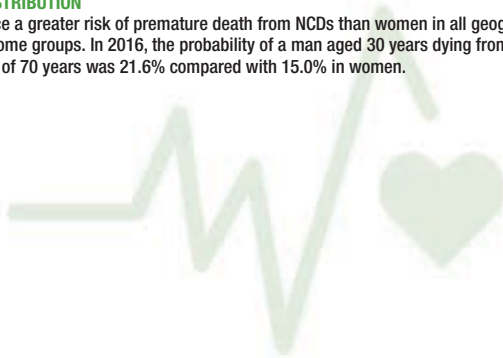
Indicator 3.4.2 Suicide mortality rate (per 100 000 population)

TREND
Global suicide mortality rates decreased in 2000–2016 by 16% in men and 20% in women.

GEOGRAPHICAL DISTRIBUTION
The highest suicide mortality rates were seen in the WHO European Region for men and in the South-East Asia Region for women.

NATIONAL INCOME
Higher suicide mortality rates were seen in high-income countries (for men) and lower-middle-income countries (for women).

AGE DISTRIBUTION
In men, suicide rates increased with age. In women, suicide rates increased with age from 30 years but peaked among those aged 15–29 years.

SEX DISTRIBUTION
Globally, suicide mortality rates were twice as high in men than in women (13.5 and 7.7 deaths per 100 000 population, respectively) in 2016.

Crude death rate per 100 000 population
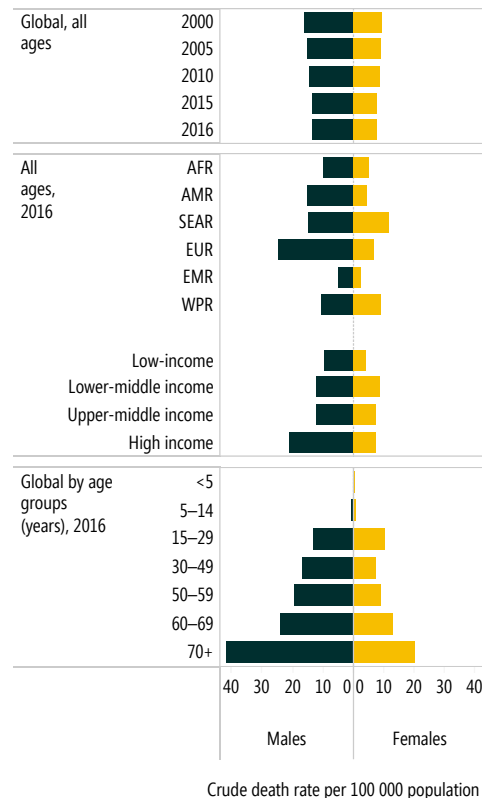
Indicator 3.5.2 Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol), 2016

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
The highest alcohol consumption was seen in the WHO European Region, and the lowest in the Eastern Mediterranean Region.

NATIONAL INCOME
Alcohol consumption increased with national income of countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Globally in 2016, per capita alcohol consumption was five times higher in men than in women (10.1 versus 2.7 L of pure alcohol per capita). The largest M/F ratios were observed in the WHO Eastern Mediterranean, South-East Asia and African regions.

per capita consumption (litres of pure alcohol)
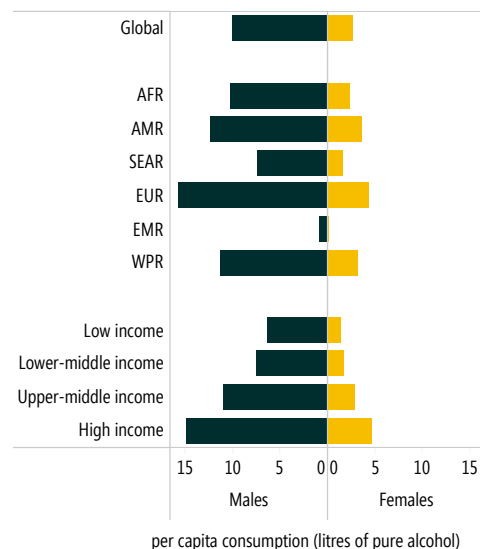
Indicator 3.a.1 Age-standardized prevalence of tobacco smoking among persons 15 years and older (%)

TREND
Globally, age-standardized prevalence decreased in 2000–2016 by 9 percentage points in men and 5 percentage points in women.

GEOGRAPHICAL DISTRIBUTION
Among men, the highest prevalence of tobacco smoking was seen in the WHO Western Pacific Region. Among women, the highest rates were seen in the WHO European Region.

NATIONAL INCOME
Among men, the highest rates of tobacco smoking were seen in upper-middle-income countries. Among women, the highest rates were seen in high-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Globally in 2016, the age-standardized prevalence of current tobacco smoking was five times higher in men than in women (33.7% versus 6.2%). The largest M/F ratio was observed in the WHO Eastern Mediterranean Region (M/F: 15).

(%)

6
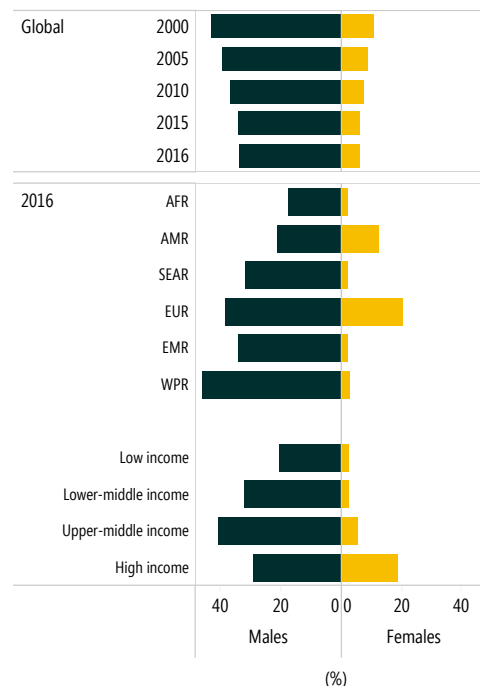
INJURIES AND VIOLENCE

This section focuses on road traffic injuries (SDG 3.6.1) and interpersonal violence including homicide (SDG 16.1.1). Other key target areas are violence against women (SDGs 5.2.1 and 5.2.2) and harmful practices (SDGs 5.3.1 and 5.3.2). Injuries related to self-harm are addressed in the sections on NCDs and mental health, and unintentional poisonings in the environmental section.

There is a specific target for road traffic deaths, Target 3.6, which is to halve the number of global deaths and injuries from road traffic. The crude death rates due to road traffic have stabilized relative to the global population, yet the number continues to climb, and the SDG target will not be met in 2020. The number of annual road traffic deaths reached 1.35 million in 2016 and road traffic caused up to 50 million injuries. The burden of road traffic injuries and deaths largely falls on those living in LMIC, where 93% of the road traffic deaths occur, even though those countries have only 60% of the registered vehicles.

In 2016, there were an estimated 477 000 deaths globally due to homicides. Men are almost four times more likely to be murdered than women. Population structure is a key risk factor for homicide. Areas with a higher proportion of young people, especially young males, see higher crude death rates from homicide. The proportion of males aged 15–29

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

TARGET 16.1: Significantly reduce all forms of violence and related death rates everywhere

INDICATOR

16.1.1 Number of victims of intentional homicide per 100 000 population, by sex and age

TARGET 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

INDICATORS

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

5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

TARGET 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

INDICATORS

5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18

5.3.2 Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age

Fig. 6.1
Population distribution by age and sex of the lowest and highest homicide rates countries, 2016
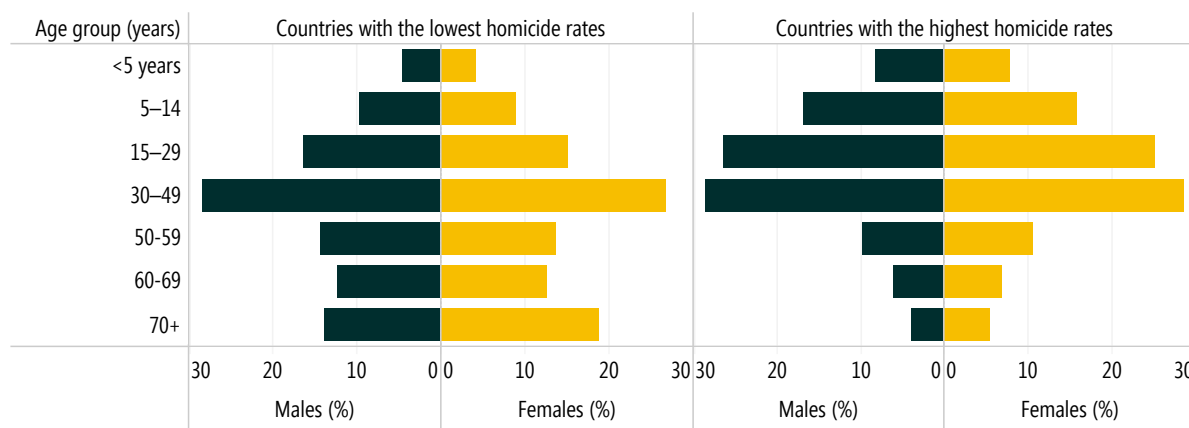
Sources: WHO (2018) *(2)* and World population prospects: the 2017 revision *(1)*.

years in the 10 countries with the highest homicide rates was 26%, compared with 16% in the 10 countries with the lowest homicide rate (Fig. 6.1). Other risk factors for homicide include poverty, availability of guns and alcohol.

Globally, one in five homicides is committed by an intimate partner or family member, with women making up the majority of those deaths *(75)*. In 2013, an estimated 38% of homicides among women were committed by their intimate partners as compared to 6% of homicides among men *(76)*.

Together, road traffic and homicide represented 38% of global deaths due to injuries in 2016 (43% among males and 28% among females). Road injury is the leading cause of injury death among both males and females, although the crude death rate among males is still 2.8 times higher than that among females, and in the age group of 15–29 years is almost four times higher (Fig. 6.2).

Fig. 6.2
Ratio of global M/F crude death rates by age and cause, 2016

Cause of death
🟧 Homicide   🟩 Road traffic injury
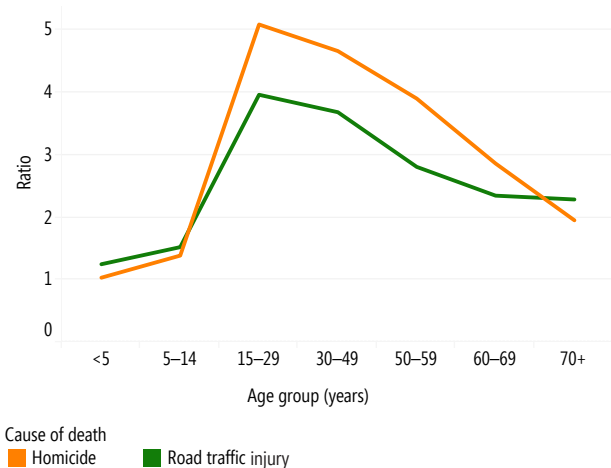
Source: WHO, 2018 *(2)*.
Note: death rates for road traffic injury from this source may differ from figures presented elsewhere in report, but are used here for comparison with other causes of injury.

Beyond mortality and injuries, violence against women is not only widespread, but carries a high burden of morbidity and ill health more broadly. Unlike the violence experienced by men, violence against women is largely experienced in private spaces and mostly by people the women know. It includes intimate partner violence (the most common form of violence experienced by women), sexual violence, trafficking, femicide and acid attacks. Women also experience harmful practices such as female genital mutilation and child, early and forced marriages. Worldwide, one in three (35%) women and girls aged 15–49 years report physical or sexual intimate partner violence or non-partner sexual violence in their lifetime. Most of this is intimate partner violence, which affects 30% of women (aged 15–49 years) and 30% of adolescent girls (aged 15–19 years). Estimates of the proportion of women who have experienced intimate partner violence range from 23.2% in high-income countries and 24.6% in the WHO Western Pacific Region LMIC, to 37% in the Eastern Mediterranean Region LMIC and 37.7% in the South-East Asia Region LMIC *(76)*.

SDG 5 includes two specific targets on the elimination of violence against women and girls, and on ending harmful practices against women and girls. WHO estimates in 2013 show that violence against women increases the risk of adverse physical health outcomes including those related to sexual and reproductive health as well as mental health outcomes *(76)*.

Globally, the practice of child marriage of girls has continued to decline; for example, during the past decade, the proportion of young women who were married as children decreased from 25% to 21%. Nevertheless, about 650 million girls and women alive today were married before their 18th birthday *(77)*. Although the exact number of girls and women worldwide who have undergone female genital mutilation remains unknown, at least 200 million girls and women have been cut in 30 countries that have

representative data on prevalence *(78)*. Data for these indicators currently are from either stand-alone surveys or DHS. Work is ongoing to improve measures of child marriage, and data collection and reporting, to enhance comparability across studies.

Preventing homicide and nonfatal violence requires a multisectoral approach that addresses underlying causes, such as gender, social and economic inequalities; cultural norms that support violence; and easy access to and misuse of alcohol, drugs and firearms. The health sector has an important role to play in addressing violence against women and girls. Thus, in May 2016, the Member States of WHO endorsed a global plan of action on strengthening the response of health systems in addressing interpersonal violence, in particular, against women and girls and against children. The plan of action urges Member States to demonstrate leadership in speaking

out against violence; provide comprehensive services and train health care providers; contribute to prevention; and improve data collection including through surveillance, health management information systems and surveys. WHO has published clinical and policy guidelines and implementation tools for health care professionals and health managers, to strengthen capacities to respond to violence against women and to child and adolescent sexual abuse. Prevention of violence against women and girls requires gender inequalities to be addressed, including by transforming harmful gender norms that privilege men over women, empowering women, creating safe environments, and enforcing laws and policies that promote gender equality. WHO has also developed the technical package *INSPIRE: seven strategies for ending violence against children*; the package includes evidence-based strategies that have shown success in reducing violence *(79)*.

Indicator 3.6.1: Road traffic mortality rate (per 100 000 population), 2016

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
The rates of road traffic deaths are highest in the WHO African Region (26.6/100 000 people) and South-East Asia Region (20.7/100 000 people).

NATIONAL INCOME
Death rates in low-income countries are three times higher than those in high-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.

Crude death rate per 100 000 population

Indicator 16.1.1: Mortality rate due to homicide (per 100 000 population)

TREND
Globally, homicide rates fell from 8.1 to 6.4 (per 100 000 population) between 2000 and 2016, a reduction of 21%, which is twice the overall rate of decrease in all mortality.

GEOGRAPHICAL DISTRIBUTION
Higher death rates are seen in the WHO Region of the Americas and African Region. The male death rate in the WHO Region of the Americas is twice as high as that of the second highest region, the African Region.

NATIONAL INCOME
Female death rates decrease with an increase in income. Surprisingly, males in the upper-middle-income countries have higher death rates than those in the lower-middle-income countries; this is largely attributed to the high death rates in the WHO Region of the Americas which are mostly upper-middle-income countries (20 compared with five in the lower-middle-income countries).

AGE DISTRIBUTION
Deaths peaked at ages 15–29 years for both males and females.

SEX DISTRIBUTION
Males were almost four times as likely as females to be a victim of homicide. Males deaths rates are declining more slowly than female death rates, so the proportion of deaths occurring in males increased between 2000 and 2016.

Crude death rate per 100 000 population

7
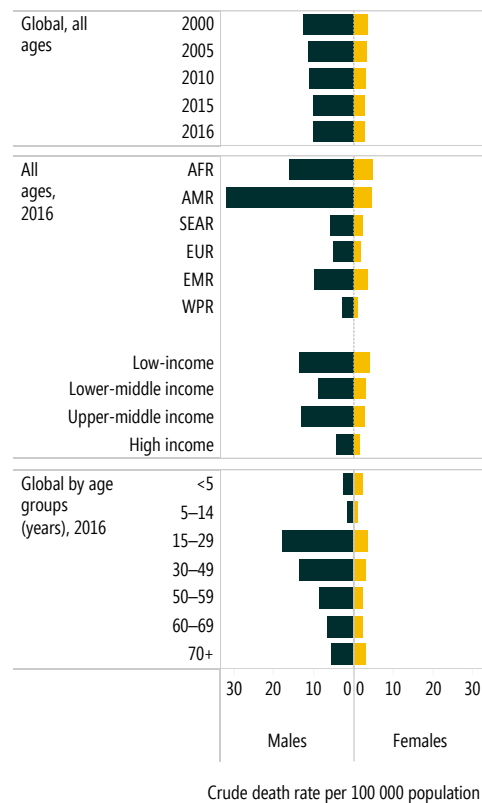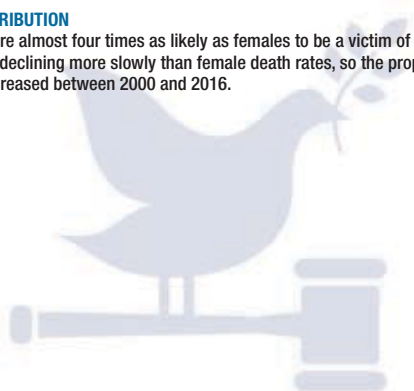
ENVIRONMENTAL RISKS

The SDG targets principally focus on three types of environmental risk: air pollution (assessed with Indicators 3.9.1, 7.1.2 and 11.6.2), water and sanitation (assessed with Indicators 3.9.2, 6.1.1 and 6.2.1) and poisoning (assessed with Indicator 3.9.3).

TARGET 11.6: By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management

INDICATOR

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

TARGET 7.1: By 2030, ensure universal access to affordable, reliable and modern energy services

INDICATOR

7.1.2 Proportion of population with primary reliance on clean fuels and technology

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

INDICATORS

3.9.1 Mortality rate attributed to household and ambient air pollution

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)

3.9.3 Mortality rate attributed to unintentional poisoning

TARGET 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking-water for all

INDICATOR

6.1.1 Proportion of population using safely managed drinking-water services

TARGET 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

INDICATOR

6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water

TARGET 6.a: By 2030, expand international cooperation and capacity-building support to developing countries in water- and sanitation-related activities and programmes, including water harvesting, desalination, water efficiency, wastewater treatment, recycling and reuse technologies

INDICATOR

6.a.1 Amount of water and sanitation related official development assistance for water and sanitation related activities and programmes that is part of a government-coordinated spending plan

It is estimated that, globally, 9 out of 10 people dwelling in urban areas are exposed to air pollution from PM2.5 (i.e. particulate matter 2.5 micrometres in diameter) levels that are above the annual mean WHO air quality guideline levels of 10 μg/m^3, with the highest annual mean levels of urban PM2.5 concentration being in the WHO South-East Asia Region (57.3 μg/m^3) and Eastern Mediterranean Region (54.0 μg/m^3). Regarding household air pollution, the proportion of the global population with primary reliance on clean fuels and technologies has been increasing progressively, and in 2017 it nearly reached full coverage in the WHO European Region (>95%) and Region of the Americas (92%). Nevertheless, 3 billion people still cook with polluting fuels and technologies, putting their health at risk, especially in the WHO African Region (where only 17% have primary reliance on clean fuels) – a situation that has changed little in 3 decades.

Poor air quality is associated with increasing risk of stroke, heart disease, lung cancer, and chronic and acute respiratory diseases. Household and ambient air pollution were jointly responsible for 7 million deaths in 2016. Globally in 2016, men had nearly 30% higher age-standardized mortality rates attributed to household and ambient air pollution than women (128.5 and 101.1 per 100 000 population, respectively). High-income countries and the WHO European Region had the highest M/F mortality ratio, at about 1.8, whereas countries in the WHO African Region had the lowest M/F ratio, at only 1.1. The highest mortality burdens fall in the WHO African Region and LMIC, and the lowest in the WHO Region of the Americas and high-income countries, for both sexes.

In 2015, 71% of the world population used safely managed drinking-water services, and 39% used safely managed sanitation services; these percentages have increased progressively since 2000, when the figures were 61% and 29%, respectively. The WHO African Region again fell far behind other parts of the world, with only 44% of the rural population having at least basic drinking-water and only 21% having basic sanitation services. Globally in 2016, unsafe drinking-water, unsafe sanitation and lack of hygiene were responsible for nearly 0.9 million deaths, including over 470 000 deaths of children aged under 5 years from diarrhoea. Crude death rates decline substantially with increasing level of national income and level of development; for example, in 2016, the rates were nearly 150 times higher in low-income countries and the WHO African Region (42.4 and 45.8 per 100 000 population, respectively) than in high-income countries and the WHO European Region (0.3 per 100 000 population for both). The rates were slightly higher for women than men (12.1 compared with 11.4 per 100 000 population globally) in most parts of the world, except in the WHO African Region and Region of the Americas, and in low-income countries, where the rates for males were higher than those for females.

Similar geographical and economic trends were observed for crude death rates due to unintentional poisoning at global level in 2016, with the WHO African Region and low-income countries having the highest rates (2.7 and 2.8 per 100 000 population, respectively), and the WHO Region of the Americas and high-income countries the lowest (0.6 and 0.5 per 100 000 population, respectively). Infants and the elderly are more likely to die from exposure to chemicals such as pesticides and carbon monoxide. Children aged under 5 years and those aged over 70 years account for 37% of the estimated 107 000 deaths caused by unintentional poisonings. The WHO Eastern Mediterranean Region and Western Pacific Region and upper-middle-income countries have M/F ratios below 1 (0.68, 0.83 and 0.96, respectively); globally, males are more likely than females to succumb to unintentional poisoning. The decrease in unintentional poisonings has been faster globally in males than in females, and the global M/F ratio fell from 1.7 in 2000 to 1.3 in 2016.

Scaling up financial resources and technical capacity with increased external aid is required for ensuring water, sanitation and hygiene for all (WASH), which has been included as SDG Target 6.a, and is measured with Indicator 6.a.1. According to OECD data, official development assistance (ODA) disbursements to the water sector declined by 3% from 2016 to 2017, perhaps reflecting the fall in ODA commitments from US$ 12 billion in 2012 to US$ 9 billion in 2016, partly owing to donor stocktaking in the transition from Millennium Development Goals (MDGs) to SDGs. However, donors have renewed their focus on the water sector, with commitments jumping by 37% in 2016–2017.

For both social and biological reasons, men and women are at different levels of risk for negative health effects from environmental exposures. The differences include the level, frequency and duration of exposures, as well as the types of pollutants and chemicals to which they are exposed. For example, men constitute a majority of the workforce in many industries (e.g. mining and manufacturing) that expose workers to toxic chemicals. In contrast, women are more likely to be responsible for household work that involves direct contact with the natural environment and some pollution sources; for example, women are more likely to cook with polluting energy systems, manage household waste and use water sources or pesticides containing pollutants and chemicals on a daily basis for an extended time. Due to their caring and domestic roles, women, particularly those in low-resource settings, are more reliant on natural resources and more vulnerable to environmental risks, because alternative opportunities and sources of livelihood are limited. For example, women and children in rural areas bear the greatest burden of death due to high levels of black carbon produced by the inefficient burning of solid fuels in unventilated homes *(80)*.

Disadvantaged men are also at greater environmental risks compared with men and women in high-resource settings. Disadvantaged women often face an additional lack of ownership and negotiating power over natural resources in the household, making them more vulnerable to detrimental environmental effects. These negative health impacts could be readily mitigated by the adoption of clean natural resources and technologies, and by ensuring that women are in a better financial situation, with their own source of income or savings and stronger decision-making power to enable the household to upgrade to improve technologies. Women's participation in community and local decision-making in relation to water and sanitation policy should be further promoted, to help meet the targets under SDG 6, through measures such as gender parity for participation in public authorities, inclusive consultation processes, and the introduction of gender-specific objectives in national action plans and legislation in relation to WASH policy. Indeed, SDG Target 6b calls for supporting and strengthening the participation of local communities, including both women and men, in improving water and sanitation management.

The susceptibility to the health impact from exposure to environmental risks varies between men and women, and between children and adults, because it is influenced by many biological factors (e.g. physiological, hormonal and enzyme differences) and by body size. Depending on the types of polluting substance, the detoxifying capacity of men may be better than that of women, or vice versa *(81)*. Another key difference is that the percentage of body fat is generally higher in women, leaving them at higher risk of storing environmental pollutants in their tissues. However, evidence is still inadequate, given that data are not systematically disaggregated by sex, age and other factors, and meaningful gender analysis to understand the underlying causes of the observed differences is rarely undertaken. For example, critical data are missing on the gender dynamics of household energy use and the gender determinants of related health risks *(82)*. Most data – including those for SDG Indicators 6.1.1, 6.2.1, 7.1.2 and 11.6.2, discussed in this section – are currently limited, with surveys measuring across household instead of individuals. This limitation highlights the need for dedicated surveys and studies *(83)*. Even if disaggregated data are available, research gaps still need to be closed, because gender analyses for environmental risks are lacking.

Everyone should have equal opportunity for a healthy environment and access to clean energy and resources; hence, the lack of disaggregated data should not impede the actions to reduce environment risks. Disadvantaged groups should be equally covered by policies and measures to reduce environment risks, and to ultimately attain sustainable and equitable use of resources for better health. In particular, more disaggregated data should be collected, and analyses should be conducted to facilitate the formulation and implementation of environmental, health, economic and social policies that jointly tackle the inequity in the health impact of the environment, and in the distribution of resources and power at household, regional, national and global levels.

Indicator 3.9.1 Age-standardized mortality rate attributed to household and ambient air pollution (per 100 000 population), 2016

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
The WHO African Region has the highest age-standardized mortality rates (180.9 per 100 000 population), over six times as high as the lowest rates, which are seen in the WHO Region of the Americas (29.7 per 100 000 population).

NATIONAL INCOME
Low- and middle-income countries had the highest mortality rates (131.7 per 100 000 population), whereas high-income countries had the lowest (17.8 per 100 000 population).

AGE DISTRIBUTION
Limited availability.

SEX DISTRIBUTION
The global age-standardized death rate in men was about 27% higher than the rate in women.

Indicator 3.9.2 Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population), 2016

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
The WHO African Region had crude death rates three times that of the second highest region (the WHO South-East Asia Region) and 150 times that of the WHO European Region.

NATIONAL INCOME
Low-income countries had the greatest mortality burden, with crude death rates twice those of lower-middle-income countries and 145 times those of high-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Globally, this is one of only a few indicators where females are more likely than men to die (12.1 versus 11.4 deaths per 100 000 population), but the sex ratio varies. Only in low-income countries and the WHO African Region is the crude death rate higher in men than women, but elsewhere females are more likely to die from unsafe WASH (e.g. F/M ratios are 1.5 in high-income countries and 1.3 in the WHO Eastern Mediterranean Region and the South-East Asia Region).

Crude death rate per 100 000 population
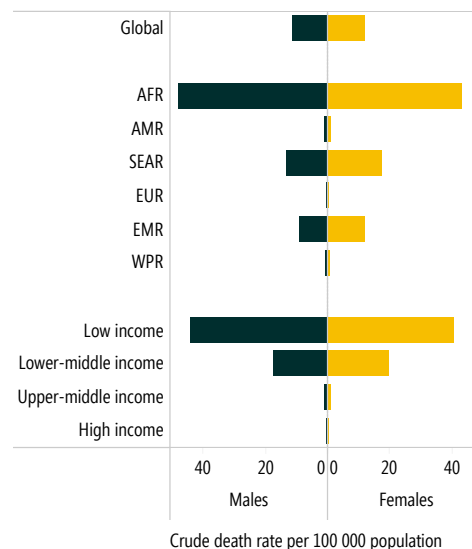
Indicator 3.9.3 Mortality rate from unintentional poisoning (per 100 000 population)

TREND
Crude death rates from unintentional poisonings decreased 36% from 2000 to 2016, which was faster than the decrease in injuries overall (12%).

GEOGRAPHICAL DISTRIBUTION
The crude death rates were highest in the WHO African Region (2.7 per 100 000 population), and lowest in the Region of the Americas (0.6 per 100 000 population).

NATIONAL INCOME
Low-income countries had the highest crude death rates (2.8 per 100 000 population), and high-income countries had the lowest (0.5 per 100 000 population).

AGE DISTRIBUTION
Children aged under 5 years and the elderly (those aged over 70 years) have the highest death rates.

SEX DISTRIBUTION
The global M/F ratio is 1.3, and ranges from 0.7 to 2.3 across WHO regions.

Crude death rate per 100 000 population
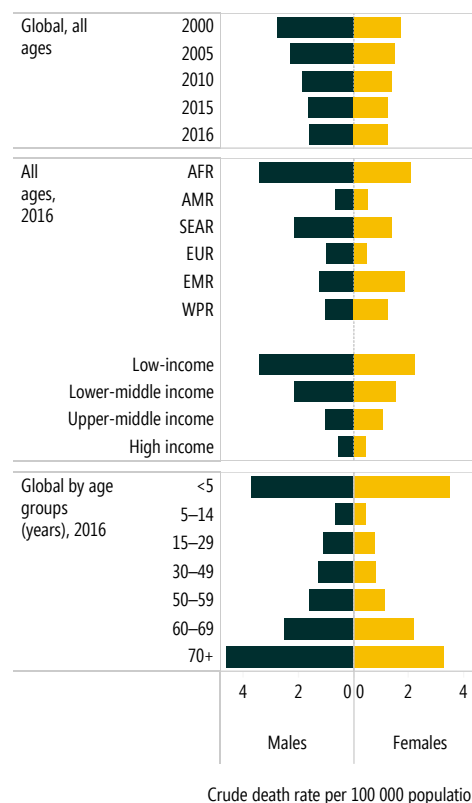
Indicator 6.1.1 Proportion of population using safely managed drinking-water services (%)

TREND
The proportion slowly increased, from 61% in 2000 to 71% in 2015.

GEOGRAPHICAL DISTRIBUTION
Among regions with available data, the proportion was lowest in the WHO African Region (26%) and highest in the European Region (91%).

NATIONAL INCOME
Low-income countries had the lowest proportion (23%), and upper-middle-income and high-income countries had the highest (92% and 98%, respectively).

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.

a Not available.

(%)
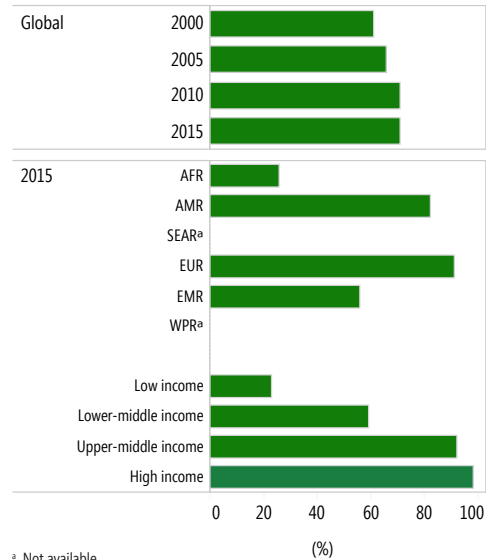
Indicator 6.2.1 Proportion of population using safely managed sanitation services (%)

TREND
Proportion slowly increased, from 29% in 2000 to 39% in 2015.

GEOGRAPHICAL DISTRIBUTION
Among regions with available data, the proportion was lowest in the WHO Region of the Americas (43%) and highest in the European Region (67%).

NATIONAL INCOME
Data are only available for upper-middle-income (50%) and high-income countries (81%).

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.

a Not available.

(%)

Indicator 6.a.1 Amount of water and sanitation related official development assistance (ODA) for water and sanitation related activities and programmes that is part of a government-coordinated spending plan

TREND
Water sector ODA increased by nearly 270% from 3.2 billion USD in 2000 to 8.7 billion USD in 2017, but dropped by 3% from 2016 to 2017.

GEOGRAPHICAL DISTRIBUTION
In 2017, the WHO African Region received the largest water sector ODA to the water sector (2.5 billion USD), nearly four times higher than that in the WHO Region of the Americas (677 million USD).

NATIONAL INCOME
Lower-middle-income countries received the largest water sector ODA to the water sector (4.3 billion USD), more than two times of that in low-income countries (2.0 billion USD) and upper-middle-income countries (1.8 billion USD).

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.

[a] Not applicable.

(millions US$)
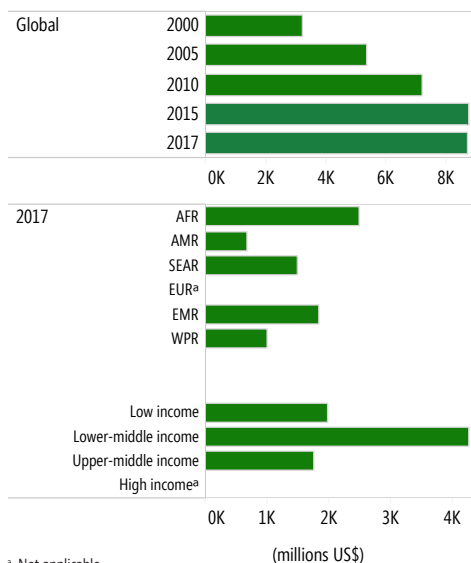
Indicator 7.1.2 Proportion of population with primary reliance on clean fuels (%)

TREND
The proportion slowly increased, from 49% in 2000 to 61% in 2017.

GEOGRAPHICAL DISTRIBUTION
The proportion was highest in the WHO European Region and the Region of the Americas (>95% and 92%, respectively), and lowest in the African Region (17%).

NATIONAL INCOME
Only about half the population in LMIC have primary reliance on clean fuels, but the proportion is nearly 100% in high-income countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Not applicable.

(%)
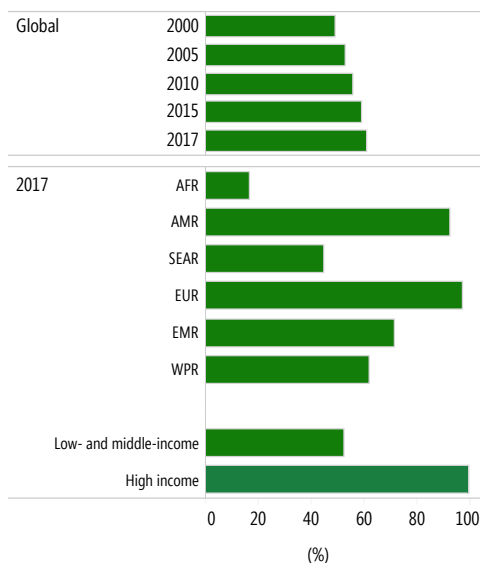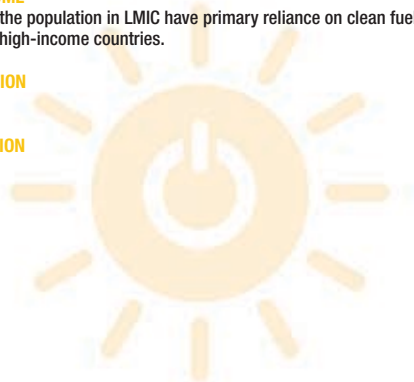
Indicator 11.6.2 Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m³), 2016

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
Particulate matter was highest in the WHO South-East Asia Region (57.3 µg/m³) and the Eastern Mediterranean Region (54.0 µg/m³), and lowest in the Region of the Americas (13.4 µg/m³).

NATIONAL INCOME
The mean level of fine particulate matter was more than 40 µg/m³ in LMIC, three times as high as that of high-income countries.

AGE DISTRIBUTION
Not applicable.

SEX DISTRIBUTION
Not applicable.

µg/m³

8
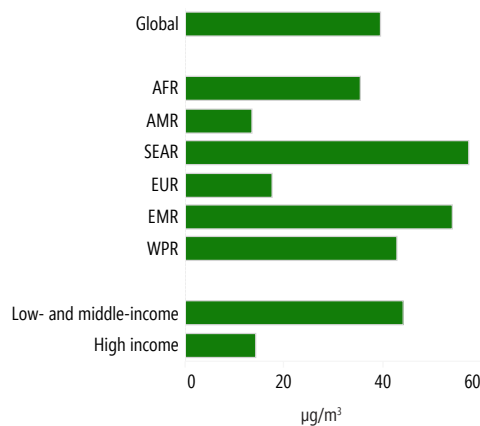
UNIVERSAL HEALTH COVERAGE AND HEALTH SYSTEMS

The main SDG targets relating to universal health coverage (UHC) and health systems are Targets 3.8 (UHC), 1.a (resource mobilization), 3.b (research and development, and access to essential medicines and vaccines), 3.c (health workforce), 3.d (international health regulations) and 17.19 (statistical capacity-building).

The indicators for UHC track whether people in need of health services receive them (service coverage) and whether they incur financial hardship in doing so (financial protection) *(84)*. Service coverage is tracked using 16 tracer indicators, which are compiled into an index that ranges between 0 and 100.[1] Service coverage is lowest in the WHO African Region and in lower-income countries (Fig. 8.1). In 2015, the number of people with full coverage of essential services was estimated to range from 2.3 to 3.5 billion (Fig. 8.2). This implies that at least half of the world's 7.3 billion people are not receiving the essential health services they need. Using currently available data and methods, it is not possible to disaggregate the service coverage index by sex; also, two of the included tracer conditions are female specific.

TARGET 3.b: Support the research and development of vaccines and medicines for the communicable and noncommunicable 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

INDICATORS

3.b.1 Proportion of the target population covered by all vaccines included in their national programme (see Section 3)

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

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

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

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

TARGET 17.19: By 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement gross domestic product, and support statistical capacity-building in developing countries

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[1] Covering areas of reproductive, maternal, newborn and child health, infectious disease control, NCDs, and service capacity and access.

Fig. 8.1
UHC service coverage index by country for 2015

Index value by quintile

- ≤45
- 46–61
- 62–69
- 70–76 Not applicable
- ≥77 Data not available

0 850 1,700 3,400 Kilometers
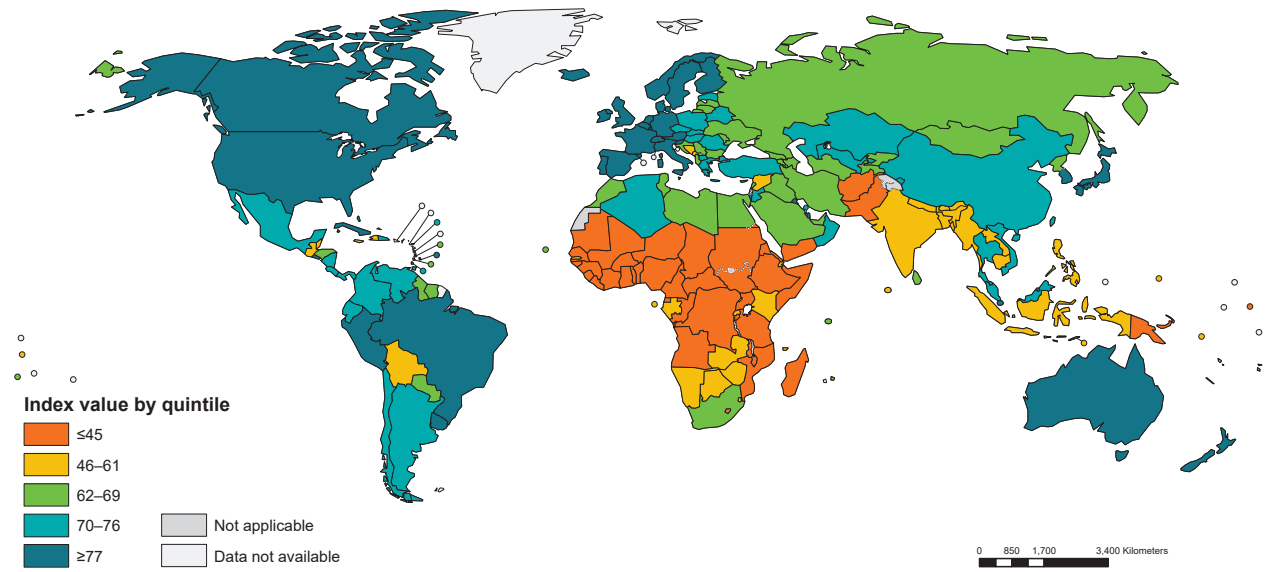
Source: WHO (2017) *(84)*.

Fig. 8.2
Number of people in need of but not receiving a selected essential health service

Millions of people (log scale)
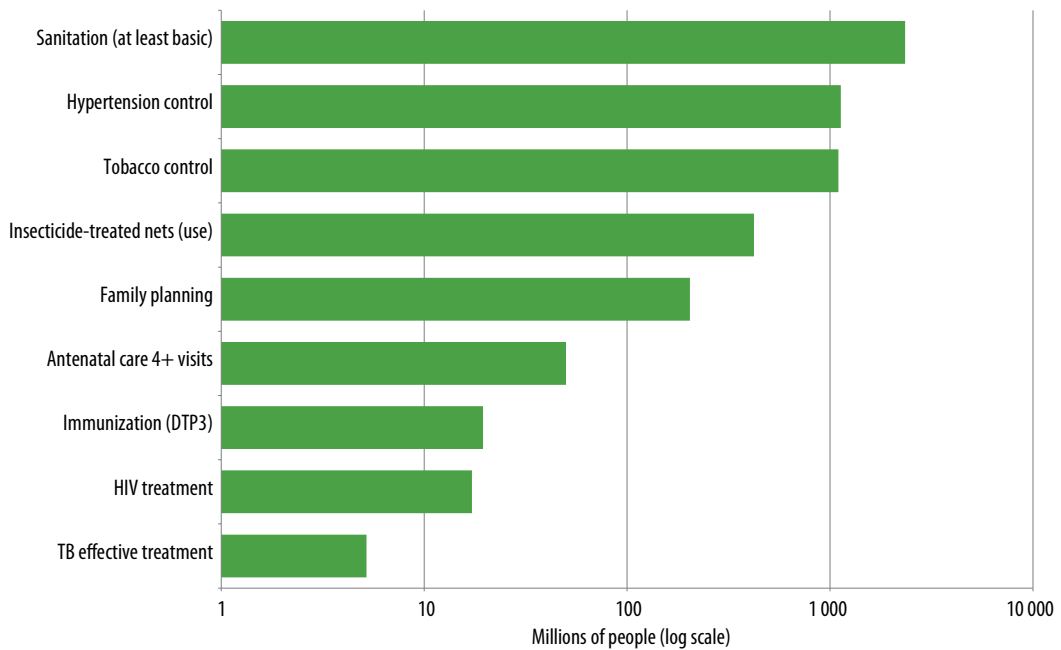
DTP3: third dose of diphtheria-tetanus-pertussis containing vaccine; HIV: human immunodeficiency virus; TB: tuberculosis.
ᵃ 2016 estimates: TB effective treatment, HIV treatment, Immunization (DTP3), Family planning, Insecticide-treated nets (use); 2015 estimates: Tobacco control, Hypertension control, Sanitation (at least basic); 2013 estimates: Antenatal care 4+ visits.

Source: WHO (2017) *(84)*.

Fig. 8.3
Proportion of population falling below the 2011 PPP US$ 1.90-a-day poverty line as a result of paying for health care, latest year

Percent of population*

- 0.00
- 0.01–0.54
- 0.55–0.80
- 0.81–1.27
- 1.28–1.72 — Not applicable
- 1.73–6.15 — Data not available

* with impoverishing health spending at the 2011 PPP $1.90-a-day poverty line

0   850   1,700   3,400 Kilometers
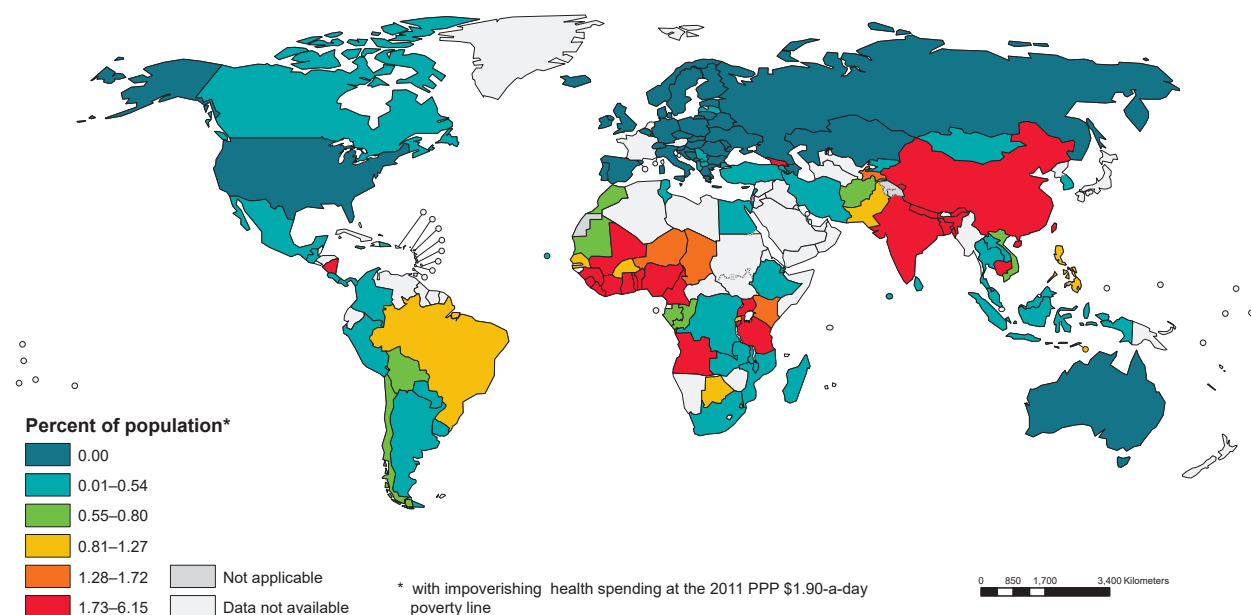
Source: WHO (2017) *(84)*.

Regarding financial protection, in 2010, an estimated 808 million people (11.7% of the world's population) spent at least 10% of their household budget paying out of their own pocket for health services; for 179 million people these payments exceeded a quarter of their household budget *(84)*. An estimated 97 million people (1.4% of the world's population) fell below the poverty line as a result of out-of-pocket health care spending in 2010[1] (Fig. 8.3). The proportion of the population that suffers catastrophic health expenditures (>10% or >25% of total household expenditures or income) is higher in middle-income countries than in low- or high-income countries. However, at all income levels people can suffer catastrophic health expenditures, even in high-income countries and in countries where most of the out-of-pocket health spending is on medicines. Further work is needed to investigate differences in financial protection between men and women.

Globally in 2016, the mean proportion of total government expenditure from domestic sources devoted to health was 10.6%, varying from less than 2% in some countries to over 20% in others. The proportion was lowest in low-income countries (around 6.6%) and highest in high-income countries (above 14%). External funding (aid) represents less than 1% of global health expenditure, and is a small and declining proportion of health spending in middle-income countries, but it is increasing in low-income countries *(85)*.

A qualified health workforce that is available, equitably distributed and accessible by the population is essential for

a well-functioning health system. In general, the number of health workers available for the size of population increases with country income. Data for 2013–2018 show that almost 40% of all countries have fewer than 10 medical doctors per 10 000 people: 90% of low-income countries suffer from such shortages, whereas only 5% of high-income countries do *(86)*. The average global density of medical doctors in 2017 was 15 per 10 000 people. Up to 93% of low-income countries have fewer than 40 nursing and midwifery personnel per 10 000 people, whereas only 19% of high-income countries do. In terms of dentists and pharmacists, 64% and 60% of countries have fewer than five of these health workers, respectively, per 10 000 people (Fig. 8.4).

WHO's study of the cost of health SDGs in low- and lower-middle income countries found that about one third of the additional investment required to achieve the health SDGs is for the cost of health workers' employment, not including the necessary education and training *(87)*. The WHO Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH) estimates a global shortfall of almost 18 million health workers by 2030, primarily in low-income and lower-middle-income countries. The health and social sector, with its 234 million workers, is one of the biggest and fastest growing employers in the world, particularly of women *(88)*. Women represent the majority of workers in the health and social sector at around 70%, and contribute US$ 3 trillion annually to global health, nearly half in the form of unpaid care work *(88–90)*. More recent analysis shows that 67% of the health workforce is female, although the percentage varies among regions. However, fewer women are employed in high-skill health occupations; also, women are more likely to have part-time jobs and may earn less *(91)*. Gender inequities in the health workforce are the result of

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[1] At the international US$ 1.90-a-day poverty line measured in terms of 2011 purchasing power parity (PPP). For each country, this poverty line is converted to local currency units of the relevant year using PPP conversion factors and consumer index prices, to take into account inflation or deflation since 2011.

Fig. 8.4
Proportion of countries with insufficient health care professionals, 2013–2018

- Fewer than 10 medical doctors per 10 000 population
- Fewer than 40 nursing and midwifery personnel per 10 000 population
- Fewer than 5 dentists per 10 000 population
- Fewer than 5 pharmacists per 10 000 population
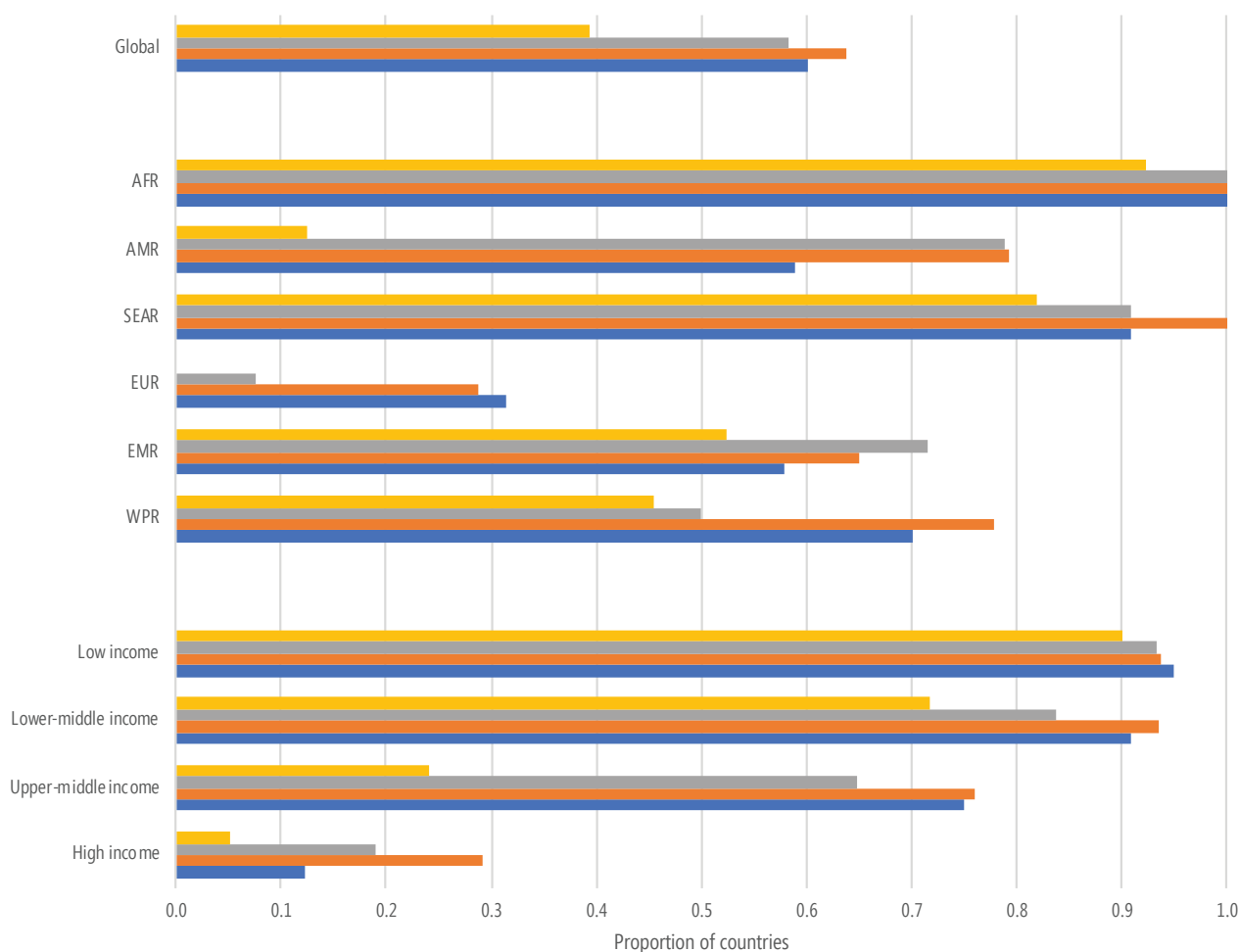
Source: WHO (2018) *(86)*.

gender norms affecting occupational entry, gender-based discrimination in earnings, barriers to access to full-time employment, and constraints to accessing professional development and leadership roles. Power and pay gaps between men and women in the health sector need to be urgently closed, by pursuing deliberate strategies to level the playing field for women *(92)*.

Health system functioning also relies on access to affordable essential medicines of assured quality that are available at all times in adequate amounts and in the appropriate dosage forms. Indicator 3.b.3 (Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis) makes it possible to assess both the availability and affordability of medicines by combining them into a single indicator, while allowing a separate analysis to identify the main driver of poor performance. The index is computed based on 32 tracer essential medicines for the treatment, prevention and management of acute and chronic diseases, communicable diseases and NCDs in a primary health care setting. Preliminary analysis from 16 countries (eight

from the WHO African Region, seven from the Region of the Americas and one from the European Region) found that only 15.5% of surveyed facilities provided available and affordable (i.e. accessible) medicines in 2016, with accessibility being higher in public sector facilities than in private sector facilities (24.5% and 9.2%, respectively). The analysis also found that the issue lies with the price of the tracer medicines; that is, if the selected tracer essential medicines were provided at affordable prices, overall access to medicines across 16 analysed countries would be 20.5%, with accessibility in public sector facilities reaching 30% and in private sector facilities 15.4%.

Research and development into new or improved health products and processes (e.g. medicines, vaccines and diagnostics) is critical for improving health outcomes. However, allocation of funds for research and development is often poorly aligned with global public health needs. The latest available data from OECD indicate that only 18 of 139 countries (13%) that received ODA for medical research and basic health sectors met their target for the percentage of such ODA allocated to medical research *(93)*.

All countries need to have a strong capacity for early warning, risk reduction and management of national and global health risks, including disease outbreaks, natural disasters, and deliberate or accidental events. Under the International Health Regulations (IHR) (2005) *(94)*, all States Parties are required to have or to develop minimum core public health capacities for surveillance, response and reporting of an event that may constitute a public health emergency of international concern. The IHR monitoring and evaluation framework includes annual self-assessment reporting by State Parties, and voluntary joint external evaluations. Preliminary analysis of the 2018 reports from 181 States Parties show that States Parties are generally reporting better performance in the detection capacities (e.g. surveillance and laboratory, with the average scores of around 70% globally), than in response capacities (such as emergency preparedness and response, with a global average score of 59%). Gaps in capacities at the points of entry (ports, airports and ground crossings) and for

chemical safety and radiation emergencies are reported, with the global average scores of about 50%.

It is estimated that only half of the 194 Member States register at least 80% of the deaths in their population of those aged 15 years and over, with associated information on cause of death. In addition, data-quality problems (e.g. the high proportion of deaths being assigned a "garbage code") mean that it is difficult to obtain precise and meaningful information on causes of death, which in turn further limits the use of cause-of-death information to inform public health actions. The latest assessment suggests that less than one third of countries have high-quality data on cause of death.[1] Further research is needed to investigate sex differences in the completeness of death registration and possible biases in reporting causes of death. Monitoring of 11 health-related SDG indicators relies on good-quality cause-of-death data from countries; hence, investments in death registration systems need to be improved.

_____

[1] Unpublished, updated assessment from WHO (2018) *(2)*.

Indicator 3.8.1 UHC service coverage index, 2015

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
Values of the service coverage index varied widely across countries and across regions, with the WHO Region of the Americas having the highest score in 2015 (78 out of a maximum score of 100), followed by the Western Pacific Region (75) and the European Region (73).

NATIONAL INCOME
Low-income countries had the lowest score (40) and high-income countries had the highest score (80).

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.

Indicators 3.8.2 Population with household expenditures on health exceeding 10% and 25% of total household expenditure or income

TREND
The proportion of the world's population who spent a considerable share of their household budget paying out of their own pocket for health services increased in the decade from 2000 (at least a 10% share: from 9.7% to 11.7%; at least a 25% share: from 1.9% to 2.6%).

GEOGRAPHICAL DISTRIBUTION
Out-of-pocket health payments are a source of financial hardship everywhere for all countries across all regions. The WHO South-East Asia Region and Western Pacific Region are the regions with the highest proportion of their population spending at both thresholds, whereas the WHO European Region and Eastern Mediterranean Region are the regions with the lowest incidence. However, in-depth country-specific analyses are needed to understand what is behind these aggregate numbers for relevant evidence-based policy analysis.

NATIONAL INCOME
At all national income levels people can suffer financial hardship. Middle-income countries have the highest proportion of the population spending a large share of the household budget on health out-of-pocket; low-income and high-income countries have smaller shares. In low-income countries, financial barriers to access might be preventing people from spending anything on health. In high income countries, out-of-pocket spending on medicines can be a major source of financial hardship.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.

Percentage of total household expenditure or income
■ >25%   ■ >10%

Indicator 3.b.2 Total net ODA to medical research and basic health sectors per capita (US$), by recipient country, 2017

TREND (not shown here)
The global absolute amount of total net ODA increased from 2.1 billion constant 2016 US$ in 2010 to 9.4 billion constant 2016 US$ in 2016.

GEOGRAPHICAL DISTRIBUTION
Net ODA per capita in 2017 was greatest in the WHO African Region.

NATIONAL INCOME
Net ODA per capita in 2017 was greatest in low-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
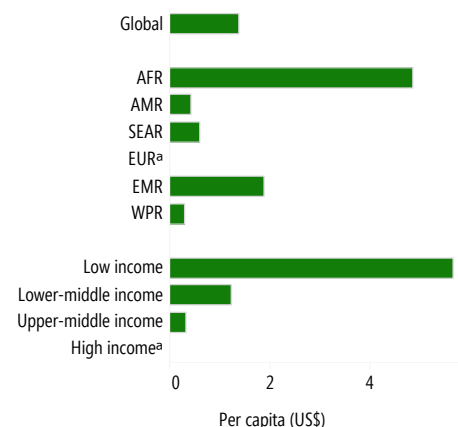
ª Not applicable.
Source: OECD.Stat (95).

Indicator 3.c.1 Density of medical doctors and midwifery personnel (per 10 000 population), 2017

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
The lowest health worker densities are seen in the WHO African Region and the highest in the European Region.

NATIONAL INCOME
The lowest health worker densities are seen in low-income countries and the highest in high-income countries.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Among the health workforce, 67% is female, although the percentage varies among regions. In most countries, male workers make up most of the workforce of physicians, dentists and pharmacists, with female workers making the most of nursing and midwifery personnel (86).
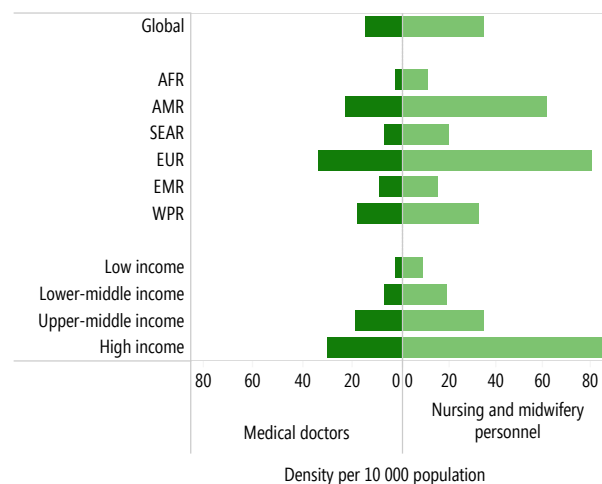
Indicator 3.d.1 Average of 13 International Health Regulations core capacity scores, 2018

TREND
Not available. As a new tool and questionnaire were used in the 2018 annual self-assessment reporting of States Parties, the results are not directly comparable with the reports of previous years.

GEOGRAPHICAL DISTRIBUTION
The average capacity is lowest in WHO Africa Region (42%), and highest in the WHO European Region (74%).

NATIONAL INCOME
The average capacity increases with national income.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
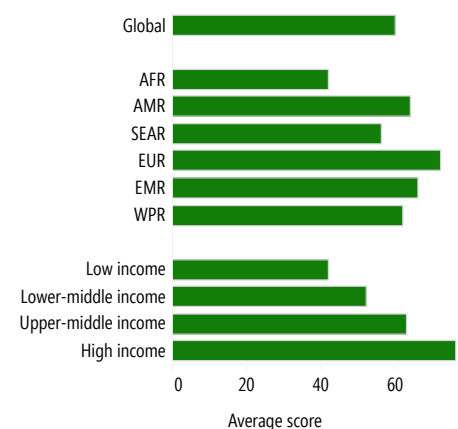
Indicator 1.a.2 Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)

TREND
Globally, the average national percentage of total government expenditure devoted to health increased slightly from around 9% in 2000 to 10.6% in 2016.

GEOGRAPHICAL DISTRIBUTION
The average national percentage of total government expenditure from domestic sources allocated to health ranged from 7% in the WHO African Region and South-East Asia Region, to over 15% in the Region of the Americas in 2016.

NATIONAL INCOME
The level of government spending on health from domestic sources within the total expenditure for public sector operations in a country increased with country income.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
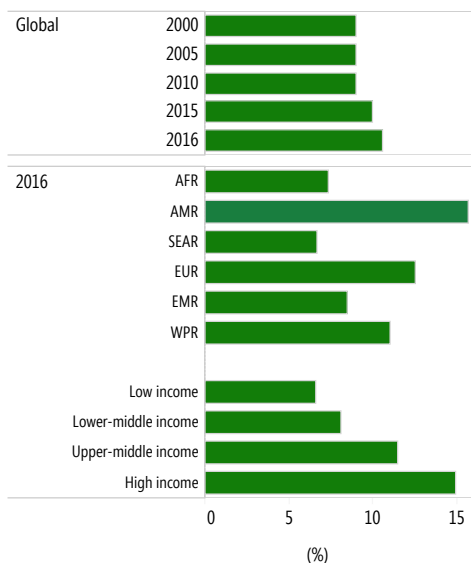
Indicator 17.19.2 Completeness of cause-of-death data (%), 2017

TREND
Not available.

GEOGRAPHICAL DISTRIBUTION
The WHO European Region and Region of the Americas had the most complete cause-of-death registration data in 2017, covering 97% and 94% of deaths, respectively. The WHO African Region and South-East Asia Region had very low completeness (6% and 10%, respectively).

NATIONAL INCOME
Completeness of cause-of-death registration data increased with income group.

AGE DISTRIBUTION
Not available.

SEX DISTRIBUTION
Not available.
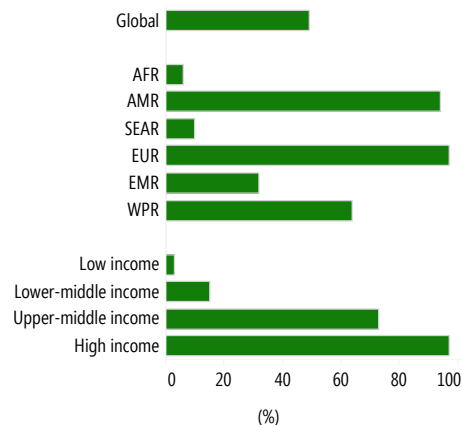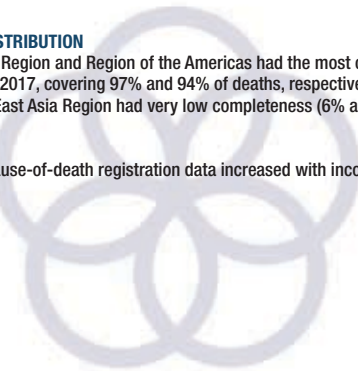
9 SUMMARY OF FINDINGS

Global trends

Life expectancy

Between 2000 and 2016, global life expectancy at birth increased by 5.5 years, from 66.5 to 72.0 years; healthy life expectancy (HALE) also increased over that period, from 58.5 in 2000 to 63.3 in 2016. In 2016, a person aged 60 years could expect to live another 20.5 years, while HALE was 15.8; thus, in a person aged 60 years, the equivalent number of years of full health lost due to living in an unhealthy state is almost a quarter of the remaining life expectancy (i.e. 4.7 years or 23%).

Health-related SDG indicators

Recent years have seen improvements in 24 (56%) of the 43 health-related SDG indicators tracked in this report.[1] However, at a global level, progress has stalled or trends are in the wrong direction for five of those 43 indicators: road traffic mortality, children overweight, malaria incidence, alcohol consumption and water sector ODA (Table 9.1). Trends have not yet been reported in 14 of the 43 indicators (33%). Nine of the health-related SDG indicators have

Table 9.1
Trends in health-related SDG indicators

Programme area
- Reproductive, maternal and child health
- Infectious and noncommunicable diseases
- Injuries, violence and environmental risks
- Health systems and financing

SDG indicators with explicit targets for 2030

Progress stalled or trend in wrong direction	
3.6.1	Road traffic mortality
Progress made but too slow to meet target	
3.1.1	Maternal mortality
3.4.1	NCD mortality
3.4.2	Suicide mortality
6.1.1	Safe drinking-water coverage
6.2.1	Safe sanitation coverage
7.1.2	Clean energy coverage
Progress fast enough to attain target	
3.2.1	Under-5 mortality
3.2.2	Neonatal mortality

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[1] Four of the health-related SDG indicators in the official list of SDG indicators *(7)* have more than one component (Indicators 2.2.2, 3.8.2, 3.b.1, 3.c.1). Where this is the case, each component is treated as a separate indicator in *World health statistics 2019*. The 43 indicators tracked have 36 unique indicator numbers in the official list of SDG indicators.

Table 9.1, continued

SDG indicators with no explicit targets for 2030

Progress stalled or trend in wrong direction	
2.2.2	Children overweight
3.3.3	Malaria incidence
3.5.2	Alcohol consumption
6.a.1	Water sector ODA
Progress made	
3.1.2	Skilled birth attendance
3.7.1	Met need for family planning
3.7.2	Adolescent birth rate
2.2.1	Stunting in children
3.b.1	DTP3 coverage
	MCV2 coverage
	PCV3 coverage
3.3.1	New HIV infections
3.3.2	Tuberculosis incidence
3.3.4	Hepatitis B prevalence
3.3.5	Need for NTD interventions
3.a.1	Tobacco use in persons ≥15 years
16.1.1	Homicide
3.9.3	Poisoning mortality
3.b.2	ODA medical research & basic health sectors
1.a.2	Domestic government health expenditure

Trend not yet reported	
2.2.2	Wasting in children
3.9.1	Air pollution mortality
3.9.2	Unsafe water and sanitation mortality
5.2.1	Intimate partner violence
11.6.2	Fine particulate matter in urban areas
3.8.1	UHC service coverage index
3.c.1	Medical doctor density
	Nurse/midwife density
	Dentist density
	Pharmacist density
3.d.1	International Health Regulations capacity
3.8.2	Household health expenditures >10%
	Household health expenditures >25%
17.9.2	Completeness of cause-of-death data

explicit targets for 2030, but only two of those indicators are on track to meet 2030 targets: those for under-5 mortality rate and neonatal mortality rate. However, it is estimated that on current trends 51 countries will miss the target for under-5 mortality, and more than 60 countries will miss the target for neonatal mortality in 2030.

Underlying data for tracking the health-related SDGs

Monitoring of the health-related SDGs is based on statistics of two types:

- **primary data** – data compiled by international agencies from routine reporting by countries or publicly available sources such as DHS. Statistics are presented as they are reported or with modest adjustment; and

- **comparable estimates** – country data are adjusted or modelled to allow comparisons between countries or over time. Comparable estimates are produced for countries with underlying primary data and, in some cases, also for those without.

Sections 2–8 of this report presented SDG indicator values with respect to trends over time, geographical comparisons and sex disaggregation. Another aspect that needs to be considered is the availability and timeliness of the data underlying each SDG indicator value. Health-related SDG indicators have varying definitions and methodologies; thus, what is considered as underlying data can vary by indicator. Some complex indicators use multiple parameters from multiple data sources from different years. In such cases, the most important parameter (or parameters) was selected as the defining criteria of underlying data. The quality of underlying data may also vary. This assessment is based on the underlying data used as inputs for the SDG indicator, regardless of any adjustments made to the data in the estimation process. The "latest available year of underlying data" refers to the most recent year of the reference period for the available input data that were used to generate an estimate.

For 18 SDG indicators that are reported as primary data, the proportion of countries with available primary data within the past 10 years ranged from 32% for intimate partner violence, to 100% for four indicators (Fig. 9.1). The proportion of countries with available recent primary data, that is, within the past 5 years, ranged from 5% to 100%.

For 25 SDG indicators that are reported as comparable estimates, the availability of underlying data also varies across indicators (Fig. 9.2). Indicators that were adopted for global monitoring before the SDG era – for example, under-5 mortality, TB incidence, and vaccination coverage – tend to have relatively high availability of underlying data, even though such data may not be recent for all countries. In contrast, availability of underlying data tends to be lower for new global indicators such as cause-specific mortality rates, and population using safely managed drinking-water and safely managed sanitation services. The average lag between the year of the estimate and the latest available year of underlying data ranged from 0 for HIV, TB, malaria incidence and immunizations, to 5 years for hepatitis B prevalence. The year of estimates ranges from 2015 for maternal mortality to 2017 for HIV, TB and malaria incidence, vaccination coverage and clean energy coverage.

Of the 43 health and health-related SDG indicators reported in *World health statistics 2019*, sex disaggregation would potentially be informative for 28 indicators (Table 9.2). Sex disaggregation is not possible for the 10 indicators

Fig. 9.1
The availability of underlying data for SDG indicators reported as primary data

Year range: 2009–2013 / 2014–2018
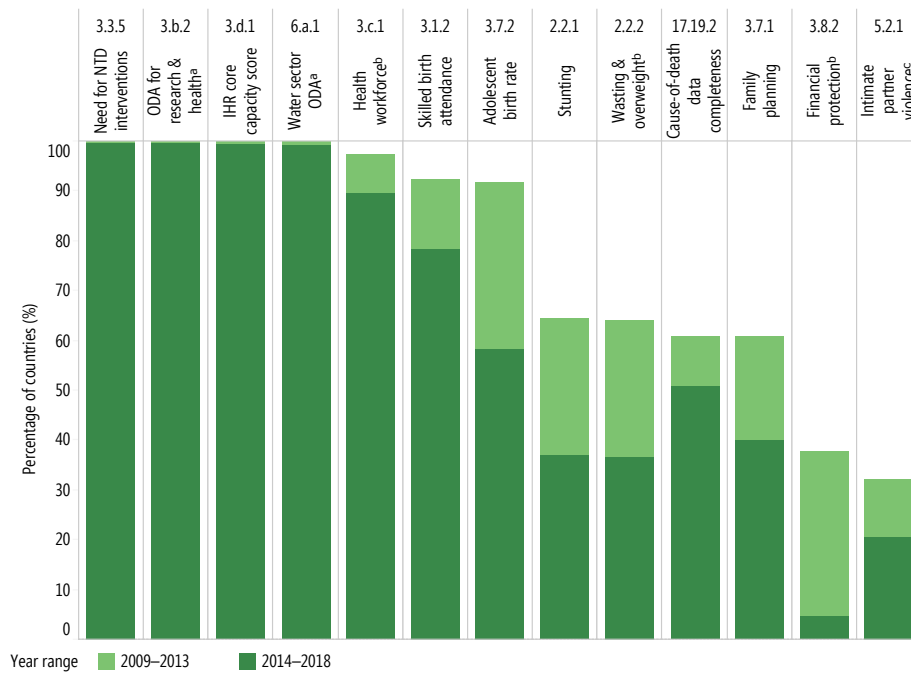
[a] Denominator for 3.b.2 and 6.a.1 reflects the list of official development assistance (ODA) recipients 2014–2017 maintained by the Development Assistance Committee of the Organisation for Economic Co-operation and Development.

[b] Indicator 3.8.2 considers two thresholds (10% and 25% of total household expenditure); availability is the same for both. Indicator 3.c.1, health workforce, includes four components (density of medical doctors, nursing and midwifery personnel, dentists and pharmacists); availability is shown for density of nursing and midwifery personnel. Indicator 2.2.2 includes two components (proportion of children wasted and proportion of children overweight); availability is shown for children wasted.

[c] Includes surveys for women aged 15–49 only.

Fig. 9.2
The availability of underlying data for SDG indicators reported as comparable estimates

Time lag between estimate and underlying data
No underlying data since 2000 / >4 years / ≤4 years / Average lag

[a] Denominator for indicator 3.3.3 is the number of endemic countries in 2000 (107 countries).

[b] For indicator 3.8.1, grey bar indicates "low" data availability and purple bar indicates "medium" and "high" data availability (84).

[c] Includes mortality attributed to household and ambient air pollution, unsafe WASH services and unintentional poisoning.

Table 9.2
Availability of sex-disaggregated values of SDG indicators at global or regional levels

Programme area:
■ Reproductive, maternal and child health   ■ Infectious and noncommunicable diseases   ■ Injuries, violence and environmental risks   ■ Health systems and financing

Sex-disaggregated values reported	
3.2.1	Under-5 mortality
3.3.1	New HIV infections
3.3.2	Tuberculosis incidence
3.4.1	NCD mortality
3.a.1	Tobacco use in persons ≥15 years
3.5.2	Alcohol consumption
3.4.2	Suicide mortality
16.1.1	Homicide
3.9.3	Poisoning mortality
3.9.1	Air pollution mortality
3.9.2	Unsafe water and sanitation mortality

Sex-disaggregated values not currently reported	
3.2.2	Neonatal mortality
2.2.1	Stunting in children
2.2.2	Wasting in children
2.2.2	Overweight children
3.b.1	DTP3 immunization coverage
	MCV2 immunization coverage
	PCV3 immunization coverage
3.3.3	Malaria incidence
3.3.4	Hepatitis B prevalence
3.3.5	Need for NTD interventions
3.6.1	Road traffic mortality
3.8.1	UHC service coverage index
3.c.1	Medical doctor density
	Nurse/midwife density
	Dentist density
	Pharmacist density
17.9.2	Cause-of-death data completeness

Data collected at household or higher level	
6.1.1	Safe drinking-water coverage
6.2.1	Safe sanitation coverage
6.a.1	Water sector ODA
7.1.2	Clean energy coverage
11.6.2	Fine particulate matter in urban areas
3.8.2	Household health expenditure >10%
	Household health expenditure >25%
1.a.2	Domestic government health expenditure
3.b.2	ODA medical research & basic health sectors
3.d.1	International Health Regulations capacity

Female specific	
3.7.1	Met need for family planning
3.7.2	Adolescent birth rate
3.1.1	Maternal mortality
3.1.2	Skilled attendance at birth
5.1.2	Intimate partner violence

for which data are collected at household, subnational or national level, or for the five female-specific indicators. For the 28 SDG indicators for which sex-disaggregated data could be informative, such data at global and regional levels are available for only 11 indicators (though data may be available at country level).

The availability of underlying data for sex-disaggregated estimates for the 11 indicators is shown in Fig. 9.3. When the main data sources for sex-specific and both-sexes estimates are the same, such as cause-of-death registration data for cause-specific mortality, the availability of recent, sex-specific underlying data is similar to that of both-sexes

Fig. 9.3
The availability of underlying data for SDG indicators reported as comparable estimates by sex

Time lag between estimate and underlying data
■ No underlying data since 2000   ■ ≤4 years
■ >4 years   ● Average lag

underlying data. When data sources are different, such as the case for alcohol consumption where underlying data for both-sexes estimates come mainly from administrative sources while underlying data for sex-specific estimates (that is, sex ratio of alcohol consumption) come mainly from surveys, the availability of recent, sex-specific underlying data may be lower than that of both-sexes underlying data.

Country variation in data availability is shown in Fig. 9.4. For 40% of countries, recent primary or underlying data are available for three quarters or more of all indicators included here. However, for about one third of countries, over half of the indicators have no recent primary or underlying data. One in seven indicator country values included in Annex 2 have had no underlying data since 2000. Low-income and lower-middle-income countries in particular lack primary or underlying data.

The results presented above illustrate the need for improved data availability for global health monitoring. Greater investment is needed to improve country health information systems as part of the national statistical system to generate better data, both to inform national decision-making and to reduce reliance on statistical modelling for global monitoring.

The "availability of data" reported here refers to data available to and used by international agencies responsible for global monitoring of the SDGs. More data may be available at country level,[1] but did not reach or was not compiled by the relevant international agencies in time to produce this report, or were not included because of issues with comparability. Better systems are needed to improve data flow, to enable international agencies to capture primary data that are available at country level, and for countries to give feedback to international agencies on the use of both primary data and methodologies to generate comparable estimates.

WHO is committed to promoting the use of sex-disaggregated data and to undertaking gender analysis, in line with the commitment made in its Thirteenth General Programme of Work *(96)* and the World Health Assembly Resolution 60.25 *(97)*. It will support Member States in improving the collection, analysis and use of quantitative data on health, disaggregated by sex, age and other relevant social stratifications. It will also promote quantitative and qualitative research to analyse the complex effects of social and cultural factors on health, and the reduction of gender biases in health information and research.

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[1] A report on the availability of data at country level for health-related SDG indicators is being prepared and scheduled for release later in 2019.

Fig. 9.4
Availability of recent primary or underlying data to inform global SDG monitoring[a]

Percentage of indicators with recent primary or underlying data (%)
- <25
- 25–49
- 50–74 | Data not available
- ≥75 | Not applicable
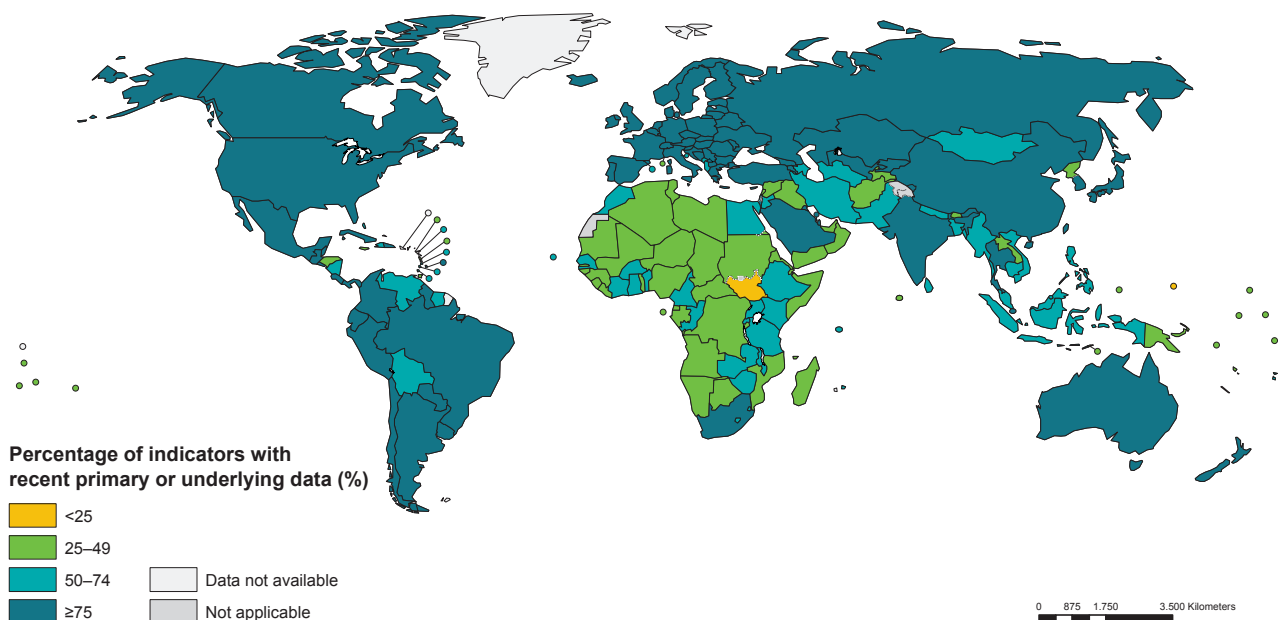
[a] Sex disaggregation is included in the count of indicators. Indicator 3.8.1 (UHC service coverage index) is not included as the availability is assessed differently (see Fig. 9.2).

Differences between countries

Life expectancy

Mortality rates are higher in low-income countries and the WHO African Region. As a consequence, life expectancy in low-income countries (62.7 years) is 18.1 years lower than in high-income countries (80.8 years). The 10 conditions contributing most to the reduced life expectancy in low-income countries are lower respiratory infections (life expectancy reduced by 2.09 years), diarrhoeal diseases (1.97 years), stroke (1.45 years), HIV/AIDS (1.45 years), TB (1.35 years), ischaemic heart disease (1.35 years), malaria (0.96 years), road injury (0.75 years), birth asphyxia and birth trauma (0.63 years), and protein-energy malnutrition (0.62 years).

SDG indicators of health status

The disparities in life expectancy between countries are reflected in many of the health-related SDG indicators. In low-income countries, more than a third of children are stunted (short for their age), reflecting long-term nutritional deprivation, and more than one child out of 14 born will die before his or her fifth birthday. Adolescent birth rates are eight times higher in low-income countries than in high-income countries. In low-income countries, one woman out of 41 dies from maternal causes. The burden of infectious diseases, including HIV, TB, malaria, hepatitis B and neglected tropical diseases (NTDs) is higher in low-income countries than in high-income countries (Table 9.3). Mortality rates attributed to unsafe water, unsafe sanitation and lack of hygiene are also highest in low-income

Table 9.3
Latest values of selected WHS 2019 indicators by sex, WHO region and World Bank income group and globally[a]

SDG indicator (by topic area)	Year	Global Male	Global Female	Both sexes	AFR	AMR	SEAR	EUR	EMR	WPR	LI	LMI	UMI	HI	2030 numeric target
Reproductive and maternal health															
3.1.1 Maternal mortality ratio (per 100 000 live births)	2015	-	216	-	542	52	164	16	166	41	495	253	55	17	<70
3.1.2 Proportion of births attended by skilled health personnel (%)	2013–2018	-	81	-	59	95	81	99	79	97	60	76	99	99	-
3.7.1 Family planning satisfied with modern methods[b] (%)	2019	-	76	-	56	83	71	77	61	87	58	65	78	82	-
3.7.2 Adolescent birth rate (per 1000 women aged 15–19 years)	2015–2020	-	44	-	99	49	33	17	45	14	97	46	29	12	-
Child health															
3.2.1 Under-five mortality rate (per 1000 live births)	2017	41	37	39	74	14	36	9	50	13	69	49	14	5	25
3.2.2 Neonatal mortality rate (per 1000 live births)	2017	-	-	18	27	8	21	5	27	6	48	49	26	7	12
2.2.1 Prevalence of stunting in children under 5[c] (%)	2018	-	-	21.9	33.1	6.5	31.9	-	24.7	6.4	34.2	31.1	6.3	-	-
2.2.2 Prevalence of wasting in children under 5[c] (%)	2018	-	-	7.3	7.0	0.8	15.0	-	7.8	2.2	7.4	11.6	1.8	-	-
2.2.2 Prevalence of overweight in children under 5[c] (%)	2018	-	-	5.9	3.5	7.2	3.8	-	5.7	6.0	3.1	3.9	7.4	-	-
3.b.1 DTP3 immunization coverage among 1-year-olds (%)	2017	-	-	85	72	91	88	94	81	97	78	82	94	95	-
3.b.1 MCV2 immunization coverage by the nationally recommended age (%)	2017	-	-	67	25	74	77	90	67	94	29	63	88	91	-
3.b.1 PCV3 immunization coverage among 1-year olds (%)	2017	-	-	44	68	82	12	70	52	16	68	32	33	85	-
Infectious diseases															
3.3.1 New HIV infections (per 1000 uninfected population)	2017	0.26	0.24	0.25	1.22	0.16	0.08	0.18	0.06	0.06	0.66	0.23	0.24	0.07	-
3.3.2 Tuberculosis incidence (per 100 000 population)	2017	168	99	134	237	28	226	30	113	95	244	223	58	11	-
3.3.3 Malaria incidence (per 1000 population at risk)	2017	-	-	59.1	219.4	7.3	7.0	0.0	14.8	2.5	189.3	42.8	2.5	-	-
3.3.4 Hepatitis B surface antigen prevalence among children under 5 years (%)	2017	-	-	0.80	2.34	0.07	0.26	0.21	0.69	0.38	2.31	0.72	0.30	0.16	-
3.3.5 Reported number of people requiring interventions against NTDs (millions)	2017	-	-	1582.9	594.1	75.5	733.3	5.5	75.4	98.4	398.4	1068.6	114.7	0.5	-
Noncommunicable diseases															
3.4.1 Probability of dying from CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)	2016	21.6	15.0	18.3	20.6	15.1	23.1	16.7	22.0	16.2	21.3	23.3	17.7	12.0	Reduce 1/3
3.4.2 Suicide mortality rate (per 100 000 population)	2016	13.5	7.7	10.6	7.4	9.8	13.2	15.4	3.9	10.2	6.8	10.6	10.0	14.3	Reduce 1/3
3.5.2 Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)	2016	10.1	2.7	6.4	6.3	8.0	4.5	9.8	0.6	7.3	3.8	4.7	7.0	9.8	-
3.a.1 Prevalence of tobacco smoking among persons aged 15 years and older[d] (%)	2016	33.7	6.2	19.9	9.8	16.9	16.9	29.4	18.1	24.5	11.4	17.2	23.1	24.1	-
Injuries and violence															
3.6.1 Road traffic mortality rate (per 100 000 population)	2016	-	-	18.2	26.6	15.6	20.7	9.3	18.0	16.9	27.5	19.2		8.3	Half by 2020
16.1.1 Mortality rate due to homicide (per 100 000 population)	2016	10.1	2.6	6.4	10.4	17.9	4.1	3.3	6.7	1.9	8.7	5.9	7.9	2.9	-
Environmental risks															
3.9.1 Mortality rate attributed to household and ambient air pollution[d] (per 100 000 population)	2016	128.5	101.1	114.1	180.9	29.7	165.8	36.3	125.0	102.8	131.7			17.8	-
3.9.2 Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)	2016	11.4	12.1	11.7	45.8	1.1	15.4	0.3	10.6	1.0	42.4	18.6	1.1	0.3	-
3.9.3 Mortality rate from unintentional poisoning (per 100 000 population)	2016	1.6	1.2	1.4	2.7	0.6	1.8	0.7	1.5	1.1	2.8	1.8	1.1	0.5	-
6.1.1 Proportion of population using safely managed drinking-water services (%)	2015	-	-	71	26	82	-	91	56	-	23	59	92	98	Universal
6.2.1 Proportion of population using safely managed sanitation services (%)	2015	-	-	39	-	43	-	67	-	-			50	81	Universal
6.a.1 WASH-related ODA[e] (constant 2016 US$ millions)	2017	-	-	8698.25	2483.89	676.69	1484.41	-	1836.26	1011.10	1983.59	4262.35	1750.49	-	-
7.1.2 Proportion of population with primary reliance on clean fuels (%)	2017	-	-	61	17	92	45	>95	72	62	54			100	Universal
11.6.2 Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (μg/m³)	2016	-	-	39.6	35.5	13.4	57.3	17.6	54.0	42.9	44.0			14.4	-
UHC and health systems															
3.8.1 UHC service coverage index	2015	-	-	64	44	78	55	73	53	75	40	54	74	80	-
3.8.2 Catastrophic out-of-pocket health spending >10%[f]	2010	-	-	11.7	10.3	11.1	12.8	7.0	9.5	14.8	8.1	12.4	13.8	7.2	-
3.8.2 Catastrophic out-of-pocket health spending >25%[f]	2010	-	-	2.6	2.6	1.9	2.8	1.0	1.4	3.9	1.1	2.8	3.2	1.4	-
1.a.2 Domestic general government health expenditure as percentage of GGE (%)	2016	-	-	10.6	7.3	15.6	6.7	12.5	8.5	11.0	6.6	8.1	11.5	14.9	-
3.c.1 Density of medical doctors (per 10 000 population)	2017	-	-	15.1	2.8	23.3	7.4	33.8	9.9	18.0	3.1	7.5	19.4	30.4	-
3.c.1 Density of nursing and midwifery personnel (per 10 000 population)	2017	-	-	34.8	10.9	61.9	19.9	80.6	15.2	32.6	8.5	18.9	35	85.6	-
3.d.1 Average of 13 International Health Regulations core capacity scores	2018	-	-	60	42	65	56	74	66	64	42	52	64	77	-
3.b.2 Total net ODA to medical research and basic health sectors per capita[g] (US$)	2017	-	-	1.39	4.83	0.42	0.60	-	1.89	0.30	5.64	1.23	0.33	-	-
17.19.2 Completeness of cause-of-death data (%)	2017	-	-	49	6	94	10	97	32	64	3	15	73	97	-

Darker shading represents high values for mortality, incidence, prevalence, risk factor and catastrophic out-of-pocket health spending indicators; and lower values for coverage, ODA, health workforce and health expenditure indicators.

[a] Excludes SDG 5.2.1 and density of dentists and pharmacists in SDG 3.c.1 which have low coverage or are not available across most regions.
[b] Women of reproductive age.
[c] High income figure has low coverage, interpret with caution.
[d] Age-standardized.
[e] Amount that is part of a government-coordinated spending plan, refers to water sector only.
[f] Population with household expenditures on health greater than 10% or 25% of total household expenditure or income.
[g] Recipient countries.

countries, as are mortality rates for road traffic injuries and unintentional poisoning. Although NCDs are often associated with a more prosperous lifestyle, the probability of dying prematurely from CVD, cancer, diabetes and chronic respiratory disease is highest in low-income and lower-middle-income countries.

There are some exceptions to poor health being primarily associated with low-income countries, and in locations where geography also has an influence. Highest wasting rates are observed in the WHO South-East Asia Region (15%) and Eastern Mediterranean Region (7.8%). Mortality rates from homicide are highest in the WHO Region of the Americas. Suicide mortality rates are highest in the WHO European Region, and lowest in the Eastern Mediterranean Region.

SDG indicators of health service coverage and financing
Populations in low-income countries generally have poorer coverage of essential health services and values of the UHC service coverage index are lower. The proportion of women who had their family planning needs met with a modern contraceptive method, and the skilled birth attendance rate were lowest in low-income and lower-middle-income countries, where 95% of maternal deaths occur. Immunization coverage rates are also generally lower in low-income countries. Health workforce densities are lower in low-income countries, and domestic government health expenditure as a proportion of total general government expenditures is lower (despite lower absolute levels of general government expenditure and greater health needs). The proportion of the population that suffer catastrophic health expenditures (>10% or >25% of total household expenditures or income) is higher in middle-income countries than in low- or high-income countries. However, at all income levels people can suffer catastrophic health expenditures, even in high-income countries and in countries where most of the out-of-pocket health spending is due to medicines.

SDG indicators of exposure to risk factors
Populations in lower-income countries are less likely to use safely managed drinking-water, and clean fuels and technology; also, they have greater exposure to fine particulate matter in cities. In contrast, tobacco use and alcohol consumption are the highest in high-income countries, although the health impact of alcohol is greater among disadvantaged populations for the same levels of alcohol consumption.

Differences between men and women

Life expectancy
Globally, women have a longer life expectancy than men: 74.2 versus 69.8 years at birth, and 21.9 versus 19.0 years at age 60 years. HALE is also greater in women than men

at birth (64.8 versus 62.0 years) and at age 60 years (16.8 versus 14.8 years). However, the number of equivalent years of full health lost through living in unhealthy states is also greater in women than men (9.5 versus 7.8 years). Globally, the sex ratio at birth has ranged between 105–110 males to every 100 females; however, because mortality rates are higher in men, the number of men for every 100 women decreases to 100 in the age group 50–54 years and to 95 by the age group 60–64 years, falling sharply thereafter.

Some of the differences in mortality rates and life expectancy are due to biological sex differences between men and women. For example, X-linked immune regulators may enhance immune responses in female children, resulting in reduced mortality among girls aged under 5 years. Others are linked to gender differences; that is, the socially constructed roles, norms, behaviours, activities and attributes that a given society considers appropriate for men, women boys and girls. For example, child marriage increases the risks related to early pregnancy among girls whereas higher rates of male employment in the transport industry expose men to higher risks of death on the roads. The exact contributions that biological differences and gender roles make to health status are often difficult to separate because they do not operate independently.

Men's reduced life expectancy compared with that of women is not due to a single or a small number of causes. Of the 40 leading causes of death, 33 causes contribute more to reduced life expectancy in men than in women. The main causes of death that contribute to a lower life expectancy for men than for women are ischaemic heart disease (0.84 years), road injuries (0.47), lung cancer (0.40), chronic obstructive pulmonary disease (0.36), stroke (0.32), cirrhosis of the liver (0.27), TB (0.23), prostate cancer (0.22) and interpersonal violence (0.21). Breast cancer (0.30 years), maternal conditions (0.23) and cervical cancer (0.15) are the causes of death that have the most effect on female rather than male global life expectancy.

SDG indicators of health status
The differences between men and women in health status are reflected in the majority of health-related SDG indicators, where sex disaggregation has been possible. In 2017, male children were 11% more likely to die than female children before the age of 5 years, compared with only 6% in 2000, indicating that the decline in under-5 mortality rate since 2000 has been faster in females than in males. Given that boys generally have a higher under-5 mortality rate than girls for biological reasons, the similarity of the under-5 mortality rate between boys and girls in the WHO South-East Asia Region is indicative of high rates of avoidable mortality among female children. Although global estimates are not available, household surveys indicate that rates of stunting and wasting are generally higher in boys than girls. Similarly, the proportion of boys overweight is higher than girls.

Globally in 2017, the incidence rate of new HIV infections was 1.09 times higher in men than in women. In the WHO African Region, the incidence rate was 1.28 times higher in women than in men; however, in all other WHO regions, the incidence rates were higher in men than women. The incidence rate of TB was 1.7 higher in men than in women globally in 2017. In 2016, the probability of a man aged 30 years dying from an NCD before 70 years of age was 1.44 times higher than for a woman aged 30 years. Globally in 2016, suicide mortality rates were 1.75 times higher in men than in women.

Deaths rates from road injury are more than twice as high in men as in women from age 15 years, and mortality rates due to homicide are four times higher in men than in women. One in five of all homicides is committed by an intimate partner or family member, with women making up most of the victims *(75)*. Beyond mortality, violence against women is not only widespread, but carries a high burden of morbidity and ill health. Worldwide in 2013, it was estimated that 35% of women and girls aged 15–49 years reported physical or sexual intimate partner violence or non-partner sexual violence in their lifetime. Women and girls may also experience harmful practices, such as female genital mutilation (FGM) and early and forced marriage. As of 2017, at least 200 million girls and women had undergone FGM in the 30 countries where the practice is concentrated *(78)*. Globally, 21% of women aged between 20 and 24 years reported that they were married or in an informal union before age 18 years *(77)*. Also, it is estimated that in 2015–2020 more than one in 25 adolescent girls aged 15–19 years will give birth *(1)*.

Mortality rates attributed to household and ambient air pollution are 1.27 times higher in men than in women.

In contrast, the global mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene is 1.06 higher in women than in men, although there is much regional variation.

SDG indicators of health service coverage
Access to many services for prevention or treatment of infectious diseases and NCDs is not part of the SDG monitoring framework, except as part of the UHC service coverage index, which cannot be sex-disaggregated using currently available data and methodologies. Nevertheless, some relevant observations have been made through other global health reports. Household surveys suggest that vaccination rates are similar in boys and girls. The risk of not using a condom during sex with a non-regular partner appears to be higher in women than in men. However, in countries with generalized HIV epidemics, men are less likely than women to take an HIV test and less likely to access antiretroviral therapy; also, men are more likely than women to die of an AIDS-related illness *(51)*. Similarly, male TB patients appear to be less likely to seek care than female TB patients *(52–55, 98)*, as reflected in lower rates of case notification compared with the estimated total of cases. Death rates for some NCDs may also be influenced by access to diagnosis and treatment; for example, cervical cancer mortality rates are higher in low-income countries that have poorer access to health services.

SDG indicators of exposure to risk factors
Age-standardized prevalence of tobacco smoking was five times higher in men than in women in 2016, with the largest M/F ratio observed in the WHO Eastern Mediterranean Region. Globally, per capita alcohol consumption was almost 4 times higher in men than in women in 2016.

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HIGHLIGHTS AND WAYS FORWARD

What has improved

- Global life expectancy increased by 5.5 years to 72.0 years between 2000 and 2016, and healthy life expectancy increased by 4.8 years to 63.3 years.
- Of 29 health-related SDG indicators for which global trends are reported, 24 have shown improvements in recent years. More births are attended by skilled health personnel, and women are less likely to die in childbirth. Global targets to reduce neonatal deaths and deaths in children aged under 5 years are on track, and childhood stunting is in decline. Nonetheless, it is estimated that 303 000 maternal deaths occurred globally in 2015 and that 5.4 million children aged under 5 years died in 2017.
- Vaccination coverage rates have increased while incidence rates for several infectious diseases, prevalence of tobacco smoking, exposure to environmental risks and premature NCD mortality have decreased.

What has not improved

- Progress has stalled or trends are in the wrong direction for five of the 29 health-related SDG indicators for which trends are reported: the proportion of children aged under 5 years overweight, malaria incidence, harmful use

of alcohol, deaths from road traffic injuries, and water-sector official development assistance.

Disparities in health outcomes

- Life expectancy at birth in low-income countries is 18.1 years lower than in high-income countries. Much of this difference is attributable to easily preventable and treatable conditions.
- In low-income countries, one in 41 women die from maternal causes. Such deaths rarely occur in upper-middle and high-income countries. Maternal deaths contribute more to differences in life expectancy between men and women than any other single cause.
- In low-income countries, more than a third of children are stunted (short for their age), reflecting long-term nutritional deprivation, and one child out of every 14 born will die before his or her fifth birthday.
- In 2016, life expectancy in men was 4.4 years lower than for women, with higher death rates for multiple causes, especially cardiovascular diseases, road injuries, lung cancer, chronic obstructive pulmonary disease and stroke. Men are generally exposed to increased occupational risks, and have higher prevalence of tobacco use and higher per capita consumption of alcohol. In

many settings, men use health services less than women, even after taking into account reproductive-related consultations. The health gap between men and women is widest in high-income countries.

Data availability

The *World health statistics 2019* report reviews, for the first time, the availability of country data for global SDG reporting. This review suggests that major improvements are needed to country data systems:

- one in seven indicator country values included in this report have had no underlying data since 2000; low-income and lower-middle-income countries in particular lack underlying data;
- for about one third of countries, over half of the indicators have no recent primary or underlying data;
- 11 health-related SDG indicators require cause-of-death data, yet only around half of countries are able to register more than 80% of adult deaths, and less than one third of countries have good-quality data on cause of death; and
- sex disaggregation is currently available for less than half (11/28) of relevant SDG indicators at global level where it would be of interest.

Ways forward

Some key actions are suggested based on the findings of this report; these actions are outlined below.

1. Improve access to health services

For many conditions, particularly in low-income countries, premature deaths can be averted by improving access to and use of preventive and curative health services. Efforts in support of UHC must focus on reaching those whom services are not reaching, such as marginalized, stigmatized and geographically isolated people of all ages and genders. This may require a strengthened health workforce and increased provision of health facilities, equipment, medicines and vaccines. It will also require removing barriers to accessing services including economic barriers (as a consequence of out-of-pocket expenses and insufficient public financing) and cultural barriers (where the workforce providing services does not have the necessary cultural sensitivity). In some circumstances it will be necessary to address societal barriers to accessing care and this may require actions that lie beyond the traditional remit of ministries of health. Nonetheless, the health sector

can play a key role in raising awareness and catalysing the development of multisectoral policies and programmes to reduce barriers to access. In some countries, health and social systems are strained by natural disasters or conflict, and the populations affected can account for a large proportion of unmet SDG need. Stronger and more resilient national health systems need to be backed by the regional and global alert and response mechanisms that will mitigate the impact of health emergencies.

2. Address risks to health

The health of populations can also be improved by reducing exposure to risk factors such as unsafe water and sanitation, air pollution, violence, unsafe roads, tobacco use and alcohol consumption. The health sector also has a key role to play in raising awareness and catalysing the development of multisectoral policies and programmes to reduce exposure to these risk factors.

3. Make health systems responsive to sex and gender

Health planning needs to allow for the different needs of men and women, regarding exposure to risk factors, barriers to access and use of services and health outcomes. In many circumstances, men experience poorer health outcomes than women do. Although some of these poorer health outcomes may have a biological basis, they may be amplified by gender roles. Gender analysis and health policies should consider women, men and gender-diverse population groups, to ensure equitable health outcomes. It is also necessary to formulate gender-responsive human-resource policies and regulations, ensure equal pay for work of equal value, and address barriers faced by women in progressing to leadership roles.

4. Invest in data systems for health, including disaggregated data

Progress in achieving the SDG goals is inhibited by incomplete or outdated information on several health-related indicators. The countries lacking underlying data are often those with limited resources and the greatest health need. Collecting, analysing and utilizing data of good quality is an important step to progressing health care, allowing better allocation of resources and timely interventions, and reducing costs while also improving the health care received. By ensuring that data can be disaggregated by sex, place of residence and other dimensions, there is potential to act to reduce inequality. Routine information systems, health facility or household surveys, and civil registration and vital statistics systems must be designed to provide relevant, timely and accurate data.

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ANNEX 1

Regional highlights of health-related SDG indicators

Explanatory notes

The statistics shown below represent official World Health Organization (WHO) statistics for selected health-related Sustainable Development Goal (SDG) indicators, based on evidence available in early 2019. They have been compiled primarily from publications and databases produced and maintained by WHO or by United Nations (UN) groups of which WHO is a member. Unless otherwise noted, all statistics presented here are available in Annex 2. Owing to limited space, indicators are often referred to here using SDG targets, along with a shorter indicator name (Annex 2 has the full indicator names and references).

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

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[1] The Global Health Observatory (GHO) is WHO's portal providing access to data and analyses for monitoring the global health situation (available at https://www.who.int/gho/en/, accessed 28 March 2019).

Key statistics (2016)

Age distribution of population and deaths by sex

(%)

Life expectancy at birth
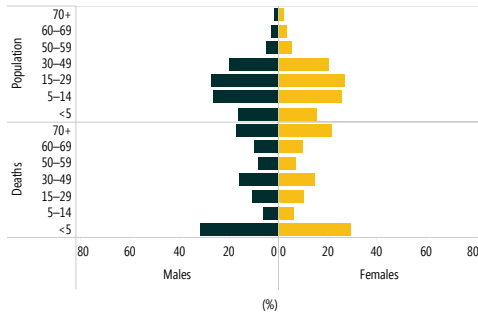
Years
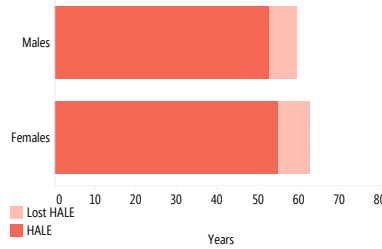
Lost HALE
HALE

Lost healthy life expectancy (HALE) represents equivalent year(s) of full health lost through years lived with morbidity and disability. This ranged within the region from 9.3 to 15.6 years by country (5.7–11.8% of life expectancy). Although females live longer, lost HALE is longer as well; on average 0.8 years or 0.8% more than males.

Current health expenditure per capita
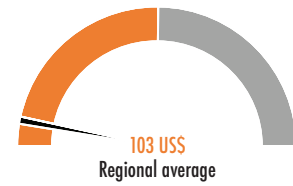
103 US$
Regional average

Range of gauge is the maximum value among WHO regions; orange portion is the global average.

Underlying data availability

Primary data

Year range 2009–2013 2014–2018   See Fig. 9.1 for further details.

Comparable estimates with sex disaggregation

Time lag between estimate and underlying data
No underlying data since 2000   ≤4 years
>4 years   Average lag
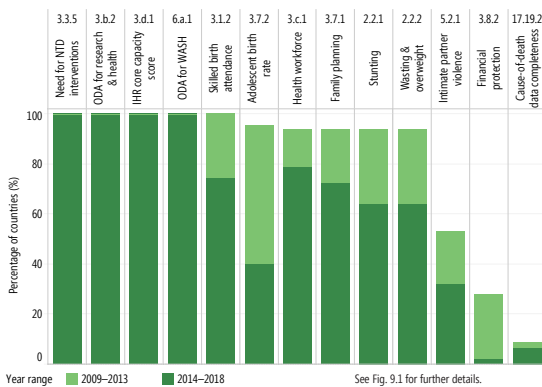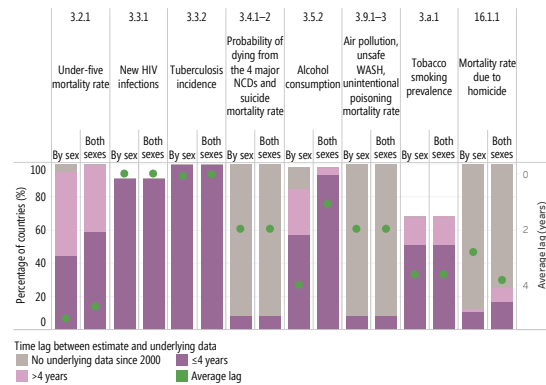
Road safety[1]

SDG Target 3.6 is to halve the number of global deaths and injuries from road traffic accidents by 2020. At the 1st African Road Safety Forum, held in November 2018, African ministers of transport made a commitment to improving road safety in the WHO African Region by increasing funding, enhancing legislative and regulatory frameworks, creating lead agencies to manage road safety, and prioritizing the development of their systems for civil registration and vital statistics (CRVS).[2]

There is a crucial need for reliable data to monitor the impact of such interventions. More than 65% of African countries rely on police records alone for road traffic death data, and only 25% use a combination of police records, health facilities records and vital registration data. The lack of a fully functioning CRVS system is a major obstacle to monitoring progress. Currently, there are several global and regional initiatives on strengthening CRVS that could bring together various national institutions (e.g. civil registration, health sector, justice sector and police) to collaborate for the benefit of all sectors.

The number of deaths from road traffic crashes was estimated to be 1.35 million worldwide in 2016. The WHO African Region has only 2% of the world's registered vehicles but accounts for up to 20% of the world's road traffic related deaths; this is the highest rate for any WHO region, with death rates 1.5 times the global average. Road traffic injuries are the leading cause of death among men aged 15–29 years

Fig. A1. Road user deaths (%), 2016
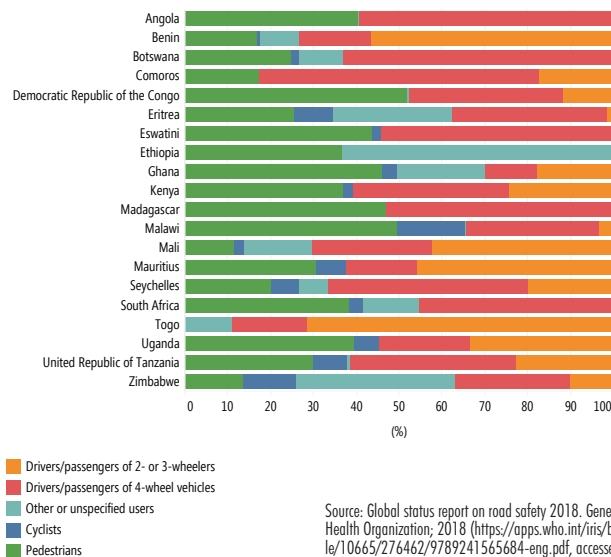
(%)

Drivers/passengers of 2- or 3-wheelers
Drivers/passengers of 4-wheel vehicles
Other or unspecified users
Cyclists
Pedestrians

Source: Global status report on road safety 2018. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/276462/9789241565684-eng.pdf, accessed 21 March 2019).

in the WHO African Region. Data have been available for 20 of the 47 countries in the WHO African Region for the past 5 years. The data suggest that about half (54%, range: 27–83%) of road user deaths in these countries occurred among pedestrians, cyclists and motorcyclists (Fig. A1). Protecting such vulnerable road users starts in part with strengthening legislation and safety standards.

Currently, few countries in the WHO African Region have laws that meet best practice for behavioural risk

factors. For drink-driving, only one country, Burkina Faso, has best practice laws, but enforcement of those laws is a major issue (the enforcement score provided by the country was 0 out of 10). For helmet use for motorcyclists, eight countries have laws meeting best practice, but compliance with the law varies across countries; for example, Eritrea reports that 95% of motorcyclists use a helmet, whereas Mali reports that only 6% of motorcyclists use a helmet.

[1] Unless noted otherwise, all data presented here are from Global status report on road safety 2018. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/276462/9789241565684-eng.pdf, accessed 21 March 2019).

[2] 1st African Road Safety Forum 13–15 November 2018, Marrakech: Declaration (https://arsforum2018.ma/storage/app/media/pdf/Marrakech-declaration.pdf, accessed 21 March 2019).

Summary of SDG 3 indicators that are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] (2015)	3.2.1 Under-five mortality rate[c] (2017)	3.2.2 Neonatal mortality rate[c] (2017)	3.3.1 New HIV infections[d] (2017)	3.3.2 Tuberculosis incidence[e] (2017)	3.3.3 Malaria incidence[f] (2017)	3.3.4 Hepatitis B prevalence[g] (2015)	3.4.1 Probability of dying from the 4 major NCDs[g] (2016)	3.4.2 Suicide mortality rate[h] (2016)	3.5.2 Alcohol consumption[i] (2016)	3.6.1 Road traffic mortality rate[h] (2016)	3.8.1 UHC service coverage index (2015)	3.9.1 Air pollution mortality rate[j] (2016)	3.9.2 WASH mortality rate[h] (2016)	3.9.3 Poisoning mortality rate[h] (2016)	3.a.1 Tobacco smoking prevalence[g] (2016)	3.b.1 DTP3 immunization[g] (2017)	3.b.1 MCV2 immunization[g] (2017)	3.b.1 PCV3 immunization[g] (2017)
Algeria	140	24	15	0.03	70	0.0	0.22	14.2	3.2	0.9		76	49.7	1.9	0.8	15.6	91	92	89
Angola	477	81	29	0.99	359	155.0	4.85	16.5	4.7	6.4	23.6	36	118.5	48.8	2.7		52	30	59
Benin	405	98	33	0.37	58	367.9	5.55	19.6	9.9	3.0	27.5	41	205.0	59.7	3.5	6.5	82		75
Botswana	129	38	25	7.47	300	2.0	0.19	20.3	9.3	8.4	23.8	60	101.3	11.8	1.1	20.1	95	74	89
Burkina Faso	371	81	25	0.23	49	412.0	4.29	21.7	7.7	8.2	30.5	39	206.2	49.6	3.0	12.8	91	50	91
Burundi	712	61	22	0.29	114	194.5	2.59	22.9	9.1	7.5	34.7	43	179.9	65.4	5.2		91	75	91
Cabo Verde	42	17	10	0.24	134	3.0	0.71	17.2	11.3	5.7	25.0	62	99.5	4.1	0.5	9.3	96	85	
Cameroon	596	84	26	1.24	194	303.8	1.90	21.6	12.2	8.9	30.1	44	208.1	45.2	3.1		86		84
Central African Republic	882	122	42	1.71	423	387.3	6.62	23.1	7.7	3.3	33.6	33	211.9	82.1	3.2		47		47
Chad	856	123	35	0.41	154	188.6	3.08	23.9	8.8	1.6	27.6	29	280.1	101.0	3.6		41		
Comoros	335	69	32	0.01	35	4.0	1.96	22.9	6.8	0.9	26.5	47	172.4	50.7	2.4	14.0	91		
Congo	442	48	19	1.59	376	197.6	4.11	16.7	5.9	7.8	27.4	38	130.7	38.7	1.2	27.0	69		66
Cote d'Ivoire	645	89	34	1.29	148	138.9	3.04	29.1	14.5	8.4	23.6	44	269.1	47.2	3.9		84		99
Democratic Republic of the Congo	693	91	29	0.17	322	307.6	1.43	19.4	5.7	2.6	33.7	40	163.9	59.8	3.2		81		79
Equatorial Guinea	342	90	31	3.45	191	343.3	8.66	22.0	16.4	11.3	24.6	45	177.7	22.3	1.9		25		
Eritrea	501	43	18	0.16	67	22.9	0.74	23.9	7.9	1.3	25.3	38	173.7	45.6	4.2	5.8	95	88	95
Eswatini	389	54	17	8.02	308	1.9	0.85	26.7	13.3	9.9	26.9	58	137.0	27.9	3.3	9.1	90	89	87
Ethiopia	353	59	29	0.17	164	37.4	2.61	18.3	7.2	2.9	26.7	39	144.4	43.7	2.9	4.5	73		68
Gabon	291	48	22	1.60	529	168.9	4.16	14.4	7.1	11.5	23.2	52	76.0	20.6	0.9		75		
Gambia	706	64	28	0.68	174	56.7	1.17	20.4	5.1	3.8	29.7	46	237.0	29.7	1.9	16.0	92	68	90
Ghana	319	49	24	0.68	152	270.7	3.61	20.8	5.4	2.7	24.9	45	203.8	18.8	1.7	4.0	99	83	99
Guinea	679	86	24	0.66	176	336.7	7.47	22.4	6.3	1.3	28.2	35	243.3	44.6	3.0		45		
Guinea-Bissau	549	84	37	1.31	374	58.0	2.12	20.0	4.0	4.8	31.1	39	214.7	35.3	2.2		87		87
Kenya	510	46	21	1.21	319	70.8	0.86	13.4	3.2	3.4	27.8	57	78.1	51.2	1.8	10.8	82	35	71
Lesotho	487	86	38	9.07	665		1.64	26.6	21.2	5.0	28.9	45	177.6	44.4	3.1	27.2	93	82	93
Liberia	725	75	25	0.51	308	192.6	7.75	17.6	6.8	5.8	35.9	34	170.2	41.5	1.8	9.8	86		86
Madagascar	353	44	18	0.22	238	90.9	4.36	22.9	3.9	1.9	28.6	30	159.6	30.2	3.3		74		74
Malawi	634	55	23	2.39	131	231.1	3.03	16.4	3.7	3.7	31.0	44	115.0	28.3	2.0	14.6	88	67	88
Mali	587	106	35	0.55	55	386.2	4.88	24.6	4.8	1.3	23.1	32	209.1	70.7	3.3	12.3	66		57
Mauritania	602	79	34	0.06	97	53.9	4.29	18.1	4.4	0.0	24.7	33	169.5	38.6	1.9		81		77
Mauritius	53	13	8		12		0.61	22.6	7.8	3.6	13.7	64	38.3	0.6	0.1	22.0	94	95	84
Mozambique	489	72	27	4.75	551	337.9	3.67	18.4	4.9	2.4	30.1	42	110.0	27.6	2.9	17.1	80	45	80
Namibia	265	44	18	3.49	423	44.6	0.66	21.3	8.7	9.8	30.4	59	145.0	18.3	1.5	22.0	88	32	67
Niger	553	85	26	0.08	90	358.6	6.01	20.0	4.6	0.5	26.2	33	251.8	70.8	4.2	7.8	81	38	80
Nigeria	814	100	33		219	281.1	2.61	22.5	9.5	13.4	21.4	39	307.4	68.6	3.0	5.7	42		36
Rwanda	290	38	16	0.61	57	505.6	1.74	18.2	6.7	9.0	29.7	53	211.4	19.3	2.4	12.9	98	95	98
Sao Tome and Principe	156	32	14		118	11.0	1.36	18.5	2.3	6.8	27.5	54	162.4	11.4	0.9		95	76	95
Senegal	315	45	21	0.10	122	64.6	3.48	18.1	6.0	0.7	23.4	41	160.7	23.9	2.3	8.5	93	70	92
Seychelles		14	9		19		0.15	21.2	9.3	12.0	15.9	68	49.3	0.2	0.6	21.4	97	99	
Sierra Leone	1360	111	34	0.44	301	379.7	8.18	30.5	9.7	5.7		36	324.1	81.3	4.1	25.1	90	55	90
South Africa	138	37	11	5.46	567	4.0	1.74	26.2	11.6	9.3	25.9	67	86.7	13.7	1.2	20.7	66	60	60
South Sudan	789	96	40	1.17	146	141.7	21.13	19.8	3.7		29.9	30	165.1	63.3	4.0		26		
Togo	368	73	25	0.65	41	370.9	3.36	23.6	9.6	3.1	29.2	42	249.6	41.6	2.4	7.6	90		90
Uganda	343	49	20	1.37	201	200.7	3.16	21.9	9.9	9.5	29.0	44	155.7	31.6	3.2	10.1	85		81
United Republic of Tanzania	398	54	21	1.36	269	113.0	1.69	17.9	5.4	9.4	29.2	39	139.0	38.4	2.7	15.0	97	79	97
Zambia	224	60	22	3.60	361	203.3	1.84	17.9	6.1	4.8		56	127.2	34.9	2.9	13.9	94	64	94
Zimbabwe	443	50	22	3.08	221	95.2	4.38	19.3	10.7	4.8	34.7	55	133.0	24.6	2.2	16.2	89	78	89

[a] Comparable estimates refer to country values which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators.

[b] (per 100 000 live births)
[c] (per 1000 live births)
[d] (per 1000 uninfected population)
[e] (per 100 000 population)
[f] (per 1000 population at risk)
[g] (%)
[h] (crude, per 100 000 population)
[i] (litres of pure alcohol per capita ≥15 years)
[j] (age-standardized, per 100 000 population)

Region of the Americas

Key statistics (2016)

Age distribution of population and deaths by sex

Population: 70+, 60–69, 50–59, 30–49, 15–29, 5–14, <5
Deaths: 70+, 60–69, 50–59, 30–49, 15–29, 5–14, <5

Males | Females
80 60 40 20 0 0 20 40 60 80

(%)

Life expectancy at birth

Males
Females

0 10 20 30 40 50 60 70 80

Years

■ Lost HALE
■ HALE

Lost healthy life expectancy (HALE) represents equivalent year(s) of full health lost through years lived with morbidity and disability. This ranged within the region from 10 to 13.7 years by country (8.6–11% of life expectancy). Although females live longer, lost HALE is longer as well; on average 1.8 years or 1.4% more than males.

Current health expenditure per capita

1126 US$
Regional average

Range of gauge is the maximum value among WHO regions; orange portion is the global average.

Underlying data availability

Primary data

3.1.2 Skilled birth attendance
3.3.5 Need for NTD interventions
3.b.2 ODA for research & health
3.d.1 IHR core capacity score
6.a.1 ODA for WASH
3.c.1 Health workforce
17.19.2 Cause-of-death data completeness
3.7.2 Adolescent birth rate
2.2.1 Stunting
2.2.2 Wasting & overweight
3.7.1 Family planning
5.2.1 Intimate partner violence
3.8.2 Financial protection

Percentage of countries (%)

Year range ■ 2009–2013 ■ 2014–2018   See Fig. 9.1 for further details.

Comparable estimates with sex disaggregation

3.2.1 Under-five mortality rate
3.3.1 New HIV infections
3.3.2 Tuberculosis incidence
3.4.1–2 Probability of dying from the 4 major NCDs and suicide mortality rate
3.5.2 Alcohol consumption
3.9.1–3 Air pollution, unsafe WASH, unintentional poisoning mortality rate
3.a.1 Tobacco smoking prevalence
16.1.1 Mortality rate due to homicide

By sex / Both sexes

Percentage of countries (%)
Average lag (years)

Time lag between estimate and underlying data
■ No underlying data since 2000   ■ ≤4 years
■ >4 years   ● Average lag

Incorporating an equity focus in data analysis to drive change: accelerating the reduction of adolescent pregnancy in Latin America and the Caribbean

Although total fertility in Latin America and the Caribbean (LAC) has declined over the past 30 years, adolescent fertility rates have dropped only slightly during that period. The rates continue to be the second highest in the world (surpassed only by those in sub-Saharan Africa), and are estimated at 66.5 births per 1000 girls aged 15–19 years for 2010–2015, compared with 46 births per 1000 girls in the same age group worldwide.[1]

Not all adolescent girls in LAC are equally affected by early pregnancy (Fig. A2). Girls with no education or only primary education, girls in the lower wealth quintiles and Indigenous girls are up to four times more likely to initiate childbearing compared with girls with secondary or higher education, those from the highest wealth quintiles and non-indigenous girls.

Accelerating progress in the reduction of adolescent pregnancy in this region will require countries to adequately identify which groups are most affected, and to understand which barriers these groups face in accessing prevention services and know how to redesign approaches to effectively reach these vulnerable subgroups.

The Pan American Health Organization (PAHO), in collaboration with other UN partners, is supporting the roll-out of tools to facilitate equity-based analysis and redesign of programmes to reach the most vulnerable groups. Within this context, support was provided to the Dominican Republic, the country with the highest adolescent pregnancy rate in the WHO

Region of the Americas, to evaluate their adolescent pregnancy prevention plan by applying an equity-based approach towards analysis of the burden of adolescent pregnancy and the barriers the most affected groups face to access health services, using

the methodology proposed in the WHO Innov8 tool.[2] As a result, the recently launched 2019–2023 plan has a stronger focus on vulnerable groups, and on equity-based interventions to reach these groups.

Fig. A2. Percentage of adolescents aged 15–19 years who had begun childbearing in selected LAC countries, by wealth index quintile, 2008–2016

Barbados (MICS 2012), Belize (MICS 2015–2016), Bolivia (DHS 2008), Colombia (DHS 2015), Costa Rica (MICS 2011), Dominican Republic (DHS 2013), El Salvador (MICS 2014), Guyana (DHS 2009), Haiti (DHS 2012), Honduras (DHS 2011–2012), Mexico (MICS 2015), Peru (DHS 2012)

Poorest / Middle / Richest
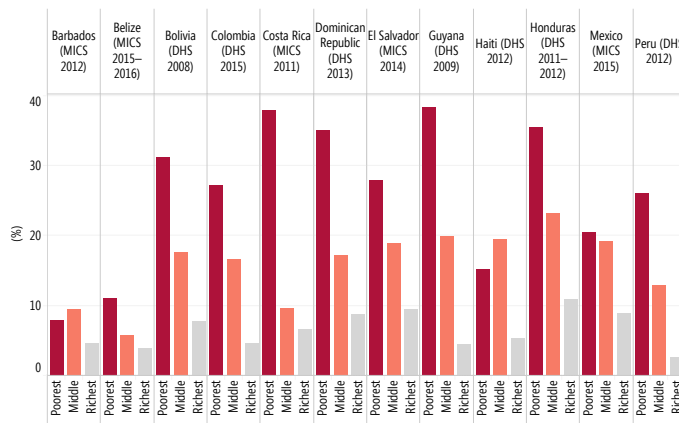
Sources: The DHS Program[a] and the United Nations Children's Fund[b].
[a] The DHS Program. Statcompiler [Internet] (available at https://www.statcompiler.com/en/, accessed 28 March 2019).
[b] United Nations Children's Fund. Multiple Indicators Cluster Surveys [Internet]. UNICEF MICS [cited 4 August 2017] (available at https://mics.unicef.org/, accessed 28 March 2019).

[1] Caffe S, Plesons M, Camacho AV, Brumana L, Abdool S, Huaynoc S, et al. Looking back and moving forward: can we accelerate progress on adolescent pregnancy in the Americas? Reprod Health. 2017;14(1):83. doi:10.1186/s12978-017-0345-y.

[2] Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook [Internet]. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250442/9789241511391-eng.pdf?ua=1, accessed 28 March 2019).

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Member State	3.1.1 Maternal mortality ratio[b] (2015)	3.2.1 Under-five mortality rate[c] (2017)	3.2.2 Neonatal mortality rate[c] (2017)	3.3.1 New HIV infections[d] (2017)	3.3.2 Tuberculosis incidence[e] (2017)	3.3.3 Malaria incidence[f] (2017)	3.3.4 Hepatitis B prevalence[g] (2015)	3.4.1 Probability of dying from the 4 major NCDs[g] (2016)	3.4.2 Suicide mortality rate[h] (2016)	3.5.2 Alcohol consumption[i] (2016)	3.6.1 Road traffic mortality rate[h] (2016)	3.8.1 UHC service coverage index (2015)	3.9.1 Air pollution mortality rate[j] (2016)	3.9.2 WASH mortality rate[h] (2016)	3.9.3 Poisoning mortality rate[h] (2016)	3.a.1 Tobacco smoking prevalence[g] (2016)	3.b.1 DTP3 immunization[g] (2017)	3.b.1 MCV2 immunization[g] (2017)	3.b.1 PCV3 immunization[g] (2017)
Antigua and Barbuda		7	4		1.1		0.38	22.6	0.5	7	7.9	75	29.9	0.1	0.4		95	68	
Argentina	52	10	6	0.15	26	0	0.01	15.8	9.2	9.8	14	76	26.6	0.4	0.6	22	86	89	76
Bahamas	80	7	4	0.38	15		0.31	15.5	1.7	4.4		72	19.9	0.1	0.1	11.8	94	76	93
Barbados	27	12	8	0.57	0		0.34	16.2	0.8	9.6	5.6	79	31.1	0.2	0.2	8.2	90	77	89
Belize	28	14	9	0.93	36	0	1.49	22.1	4.7	6.8	28.3	61	68.6	1	0.5		88	88	
Bolivia (Plurinational State of)	206	35	19	0.14	111	1.3	0.2	17.2	12.2	4.8	15.5	60	63.7	5.6	2		84		83
Brazil	44	15	9	0.24	44	5.1	0.07	16.6	6.5	7.8	19.7	77	29.9	1	0.2	14	89	41	84
Canada	7	5	4		5.5		1.03	9.8	12.5	8.9	5.8		7	0.4	0.3	14.3	91	86	80
Chile	22	7	5	0.33	17		0.28	12.4	10.6	9.3	12.5	70	25.3	0.2	0.3	37.9	93	90	93
Colombia	64	15	8		33	7.4	0.21	15.8	7.2	5.8	18.5	76	37	0.8	0.4	9.1	92	89	91
Costa Rica	25	9	6	0.22	9.7	0	0.17	11.5	7.9	4.8	16.7	75	23.3	0.9	0.3	11.9	96	93	96
Cuba	39	5	2	0.17	7.1		0.12	16.4	13.9	6.1	8.5	78	49.5	1	0.3	35.2	99	99	
Dominica		34	27		1.6		0.39			8.2	10.9						91	81	
Dominican Republic	92	30	20	0.22	45	0.1	0.34	19	9.9	6.9	34.6	74	43	2.2	0.4	13.8	84		64
Ecuador	64	15	8	0.12	43	2.6	0.32	13	7.1	4.4	21.3	75	24.5	0.6	0.6	7.2	85	73	84
El Salvador	54	15	7	0.19	72	0	0.57	14	13.7	3.8	22.2	77	41.9	2	0.2	10.7	85	86	87
Grenada	27	17	11		3.2		0.47	21.4	1.7	9.3	9.3	72	45.3	0.3	0.4		96	79	
Guatemala	88	28	13	0.14	25	0.4	0.05	14.9	2.7	2.5	16.6	57	73.8	6.3	1.1		82	81	84
Guyana	229	31	19	0.62	86	32	0.95	30.5	29.2	6.3	24.6	68	107.8	3.6	0.7		97	93	97
Haiti	359	72	28	0.73	181	3.3	2.04	26.5	11.7	5.8		47	184.3	23.8	2.6	13	60	25	
Honduras	129	18	10	0.1	38	0.2	0.25	14	2.9	4	16.7	64	60.7	3.6	0.4		97		97
Jamaica	89	15	11	0.66	5.1		0.16	14.7	2.2	4.2	13.6	60	25.4	0.6	0.2	17	93	95	
Mexico	38	13	8	0.12	22	0.3	0.04	15.7	5.1	6.5	13.1	76	36.7	1.1	0.2	14.2	97	98	91
Nicaragua	150	17	7	0.07	45	5.1	0.14	14.2	12.2	5.2		70	55.7	2.2	0.6		98	84	98
Panama	94	16	9	0.4	54	0.2	0.22	13	4.3	7.9	14.3	75	25.8	1.9	0.4	6.2	81	93	90
Paraguay	132	21	11	0.2	44	0	0.65	17.5	9.5	7.2	22.7	69	57.5	1.5	0.3	13.3	92	82	93
Peru	68	15	7	0.09	116	5.6	0.24	12.6	4.9	6.3	13.5	78	63.9	1.3	0.9		83	66	80
Saint Kitts and Nevis		14	9		2.1		0.38			9.4							97	95	
Saint Lucia	48	17	12		7.7		0.39	18.8	7.8	9.9	35.4	69	30	0.6	0.2		80	73	
Saint Vincent and the Grenadines	45	16	10		2.1		0.42	23.2	2.4	8.2		65	47.6	1.3	0.2		99	99	
Suriname	155	20	10	0.56	29	0.5	0.36	21.7	22.8	5.1	14.5	68	56.7	2	0.4	25.2	81	44	
Trinidad and Tobago	63	26	17	0.24	17		0.43	21.3	13.6	8.4	12.1	75	38.6	0.1	0.2		89	65	93
United States of America	14	7	4		3.1		0.04	14.6	15.3	9.8	12.4		13.3	0.2	0.9	21.9	94	94	93
Uruguay	15	8	5	0.19	31		0.35	16.7	18.4	10.8	13.4	79	17.5	0.4	0.4	17	95	92	94
Venezuela (Bolivarian Republic of)	95	31	20		42	47.6	0.62	18.1	3.7	5.6	33.7	73	34.6	1.4	0.3		84	59	

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Deaths: 70+, 60-69, 50-59, 30-49, 15-29, 5-14, <5

80 60 40 20 0 0 20 40 60 80

Males | Females

(%)

Life expectancy at birth

Males

Females

0 10 20 30 40 50 60 70 80

Years

Lost HALE
HALE

Lost healthy life expectancy (HALE) represents equivalent year(s) of full health lost through years lived with morbidity and disability. This ranged within the region from 9 to 14.9 years by country (8.4-10.5% of life expectancy). Although females live longer, lost HALE is longer as well; on average 1.7 years or 1.7% more than males.

Current health expenditure per capita

96 US$
Regional average

Range of gauge is the maximum value among WHO regions; orange portion is the global average.

Underlying data availability

Primary data

Indicator	
3.3.5	Need for NTD interventions
3.b.2	ODA for research & health
3.c.1	Health workforce
3.d.1	IHR core capacity score
6.a.1	ODA for WASH
3.7.1	Family planning
2.2.1	Stunting
2.2.2	Wasting & overweight
3.1.2	Skilled birth attendance
3.7.2	Adolescent birth rate
3.8.2	Financial protection
5.2.1	Intimate partner violence
17.19.2	Cause-of-death data completeness

Percentage of countries (%)

Year range: 2009–2013, 2014–2018

See Fig. 9.1 for further details.

Comparable estimates with sex disaggregation

Indicator	
3.2.1	Under-five mortality rate
3.3.1	New HIV infections
3.3.2	Tuberculosis incidence
3.4.1–2	Probability of dying from the 4 major NCDs and suicide mortality rate
3.5.2	Alcohol consumption
3.9.1–3	Air pollution, unsafe WASH, unintentional poisoning mortality rate
3.a.1	Tobacco smoking prevalence
16.1.1	Mortality rate due to homicide

By sex / Both sexes

Percentage of countries (%)

Average lag (years)

Time lag between estimate and underlying data
No underlying data since 2000 | ≤4 years
>4 years | Average lag

Trends in universal health coverage index and noncommunicable diseases

The universal health coverage (UHC) service coverage index (SCI) comprises 16 indicators across four programme areas: reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases (NCDs); and health service capacity, access and health security. Overall, the regional average for the UHC SCI was 56% in 2015 compared with 44% in 2010, implying significant improvement in coverage of essential health services in the region since 2010. Improvements were seen in all 11 countries of the WHO South-East Asia Region except in the Maldives (Fig. A3), where it declined slightly due to missing data for some key indicators. Despite improvements, there is still much to do to advance essential service coverage. It is estimated that more than 800 million people in the region still do not have sufficient access to essential health services.

Fig. A3. Change in UHC service coverage index, WHO South-East Asia Region, 2010–2015

2010 | 2015

UHC index

Global average 2015

Country	2010	2015
Thailand		75
Democratic People's Republic of Korea		68
Sri Lanka		62
Myanmar		60
Bhutan		59
India		56
Maldives		55
Indonesia		49
Timor-Leste		47
Bangladesh		46
Nepal		46
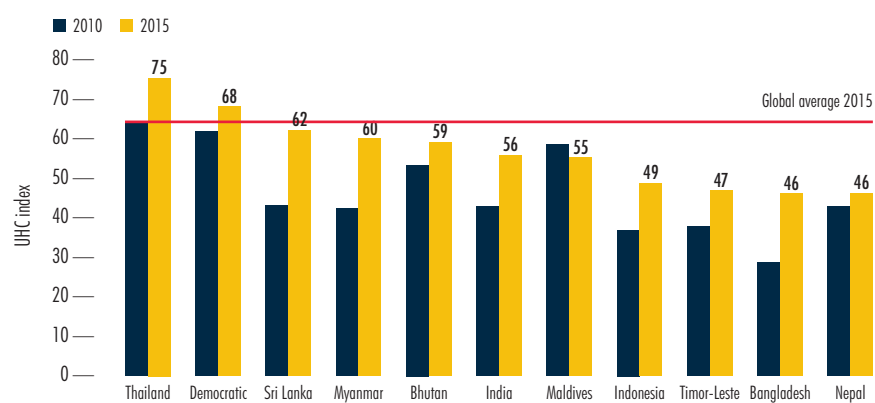
Source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region: 2018 update (https://apps.who.int/iris/handle/10665/274313, accessed 28 March 2019).

In the WHO South-East Asia Region, NCDs are the leading cause of death, accounting for 66% of total deaths. More than 48% of NCD deaths occur before the age of 70 years, the highest proportion of premature deaths in the world. Cardiovascular disease, cancers, diabetes and chronic respiratory disease contribute to more than 80% of NCD deaths in the region, with variation in the probability of dying from these diseases between Member States (Fig. A4).

The risk of premature mortality due to the four above-mentioned NCDs has declined in most countries in the region since 2000, except in Indonesia, where it is almost at the same level, and in the Democratic People's Republic of Korea and Myanmar, where there is a slight upward trend. Males have a higher probability than females of premature death due to NCDs in all countries except Bangladesh, where the probabilities for females and males are similar.

Fig. A4. Probability of dying aged 30–70 years due to the four major NCDs

Source: Global health estimates 2016: Life expectancy, 2000–2016. Geneva: World Health Organization; 2018 (https://www.who.int/gho/mortality_burden_disease/life_tables/en/, accessed 21 March 2019).

Summary of SDG 3 indicators that are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2015	3.2.1 Under-five mortality rate[c] 2017	3.2.2 Neonatal mortality rate[c] 2017	3.3.1 New HIV infections[d] 2017	3.3.2 Tuberculosis incidence[e] 2017	3.3.3 Malaria incidence[f] 2017	3.3.4 Hepatitis B prevalence[g] 2015	3.4.1 Probability of dying from the 4 major NCDs[g] 2016	3.4.2 Suicide mortality rate[h] 2016	3.5.2 Alcohol consumption[i] 2016	3.6.1 Road traffic mortality rate[h] 2016	3.8.1 UHC service coverage index 2015	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[h] 2016	3.9.3 Poisoning mortality rate[h] 2016	3.a.1 Tobacco smoking prevalence[g] 2016	3.b.1 DTP3 immunization[g] 2017	3.b.1 MCV2 immunization[g] 2017	3.b.1 PCV3 immunization[g] 2017
Bangladesh	176	32	18	0.01	221	1.9	1.38	21.6	5.9	0.0	15.3	46	149.0	11.9	0.3	22.9	97	96	97
Bhutan	148	31	17		134	0.0	0.81	23.3	11.4	0.6	17.4	59	124.5	3.9	0.6		98	99	
Democratic People's Republic of Korea	82	19	10		513	0.2	0.53	25.6	11.2	3.9		68	207.2	1.4	1.9		97	98	
India	174	39	24	0.10	204	7.7	0.51	23.3	16.3	5.7	22.6	56	184.3	18.6	2.4	11.3	88	77	
Indonesia	126	25	12	0.19	319	5.8	1.07	26.4	3.4	0.8	12.2	49	112.4	7.1	0.4	39.5	79	63	
Maldives	68	8	5		39		0.19	13.4	2.3	2.7	0.9	55	25.6	0.3	0.0	28.6	99	99	
Myanmar	178	49	24	0.21	358	3.7	2.03	24.2	7.8	4.8	19.9	60	156.4	12.6	1.4	20.8	89	80	89
Nepal	258	34	21	0.03	152	0.5	0.31	21.8	8.8	2.0	15.9	46	193.8	19.8	0.4	23.7	90	59	80
Sri Lanka	30	9	6	<0.01	64	0.0	0.64	17.4	14.6	4.3	14.9	62	79.8	1.2	0.4	13.7	99	99	
Thailand	20	10	5		156	0.8	0.17	14.5	14.4	8.3	32.7	75	61.5	3.5	0.4	20.4	99	95	
Timor-Leste	215	48	21		498	0.1	0.87	19.9	4.6	2.1	12.7	47	139.8	9.9	0.4	42.2	76	50	

[a] Comparable estimates refer to country values which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators.

[b] (per 100 000 live births)
[c] (per 1000 live births)
[d] (per 1000 uninfected population)
[e] (per 100 000 population)
[f] (per 1000 population at risk)
[g] (%)
[h] (crude, per 100 000 population)
[i] (litres of pure alcohol per capita ≥15 years)
[j] (age-standardized, per 100 000 population)

Key statistics (2016)

Age distribution of population and deaths by sex

Population
70+
60-69
50-59
30-49
15-29
5-14
<5

Deaths
70+
60-69
50-59
30-49
15-29
5-14
<5

80 60 40 20 0 0 20 40 60 80

Males | Females

(%)

### Life expectancy at birth

Males

Females

0 10 20 30 40 50 60 70 80

Lost HALE
HALE

Years

Lost healthy life expectancy (HALE) represents equivalent year(s) of full health lost through years lived with morbidity and disability. This ranged within the region from 8.2 to 14.9 years by country (7.6-11.8% of life expectancy). Although females live longer, lost HALE is longer as well; on average 2 years or 1.6% more than males.

Current health expenditure per capita

1990 US$
Regional average

Range of gauge is the maximum value among WHO regions, orange portion is the global average.

Underlying data availability

Primary data

| 3.3.5 | 3.b.2 | 3.c.1 | 3.d.1 | 6.a.1 | 3.7.2 | 17.19.2 | 3.1.2 | 3.8.2 | 3.7.1 | 2.2.1 | 2.2.2 | 5.2.1 |

Need for NTD interventions | ODA for research & health | Health workforce | IHR core capacity score | ODA for WASH | Adolescent birth rate | Cause-of-death data completeness | Skilled birth attendance | Financial protection | Family planning | Stunting | Wasting & overweight | Intimate partner violence

Percentage of countries (%)

100
80
60
40
20
0

Year range 2009–2013 2014–2018 See Fig. 9.1 for further details.

Comparable estimates with sex disaggregation

| 3.2.1 | 3.3.1 | 3.3.2 | 3.4.1–2 | 3.5.2 | 3.9.1–3 | 3.a.1 | 16.1.1 |

Under-five mortality rate | New HIV infections | Tuberculosis incidence | Probability of dying from the 4 major NCDs and suicide mortality rate | Alcohol consumption | Air pollution, unsafe WASH, unintentional poisoning mortality rate | Tobacco smoking prevalence | Mortality rate due to homicide

By sex | Both sexes (repeated for each indicator)

Percentage of countries (%)

Average lag (years)

Time lag between estimate and underlying data
No underlying data since 2000 ≤4 years
>4 years Average lag

The WHO European Childhood Obesity Surveillance Initiative

Nutrition is central to achieving multiple SDGs. With economic growth, childhood obesity is increasing throughout the world, and especially in Europe. In the context of a life-course approach, obesity is of particular importance, because children are particularly vulnerable and the condition has negative impacts on health and well-being throughout life.

Comprehensive, timely and accurate assessment of the magnitude of childhood obesity is needed to raise awareness and stimulate appropriate policy responses by countries. The WHO Regional Office for Europe and its Office for the Prevention and Control of Noncommunicable Diseases (NCD Office) in Moscow have supported the implementation of the WHO European Childhood Obesity Surveillance Initiative (COSI), which measures trends in child nutrition, along with data on lifestyle behaviours and environment. The initiative started in 2007 in 12 countries, and by 2017 had expanded to over 300 000 children from 40 Member States. The survey is repeated every 2–3 years in primary schools (children aged 6–9 years), thus allowing for the efficient assessment of trends.

For many countries, COSI provided, for the first time, high-quality nationally representative data on child growth, which allows Member States to take actions to tackle childhood overweight and obesity across Europe. For example, Portugal was one of the 12 countries involved in the first round of COSI. Between 2008 and 2016, childhood overweight decreased by 19% and obesity by 24%, while physical activity levels increased. Although these findings are encouraging, the prevalence of overweight and obesity remain high, and sedentary behaviours have increased, mainly due to increased time spent playing computer games. Kazakhstan joined COSI for the fourth round of data collection in 2015–2016. Stakeholders report

that COSI results have made it possible to identify risk factors and have empowered health advocates. The results will enable policy-makers and public health professionals to design more targeted and cost-effective strategies and interventions to address childhood overweight and obesity.

In the WHO European Region, the prevalence of childhood overweight and obesity is highest in

Mediterranean countries, where nearly every second boy is overweight and every fifth boy is obese. In 29 of 35 countries for which data are available, a higher proportion of boys are overweight compared with girls (in six countries a higher proportion of girls are overweight). In 33 of 35 countries, a higher proportion of boys are obese compared with girls (in two countries, a higher proportion of girls are obese) (Fig. A5).

Fig. A5. Proportion of children aged 6–8 years who are overweight and obese, WHO European Region, 2015–2017

Boys (%)
40
20
0

Girls (%)
40
20
0

Albania | Austria | Bulgaria | Croatia | Cyprus | Czechia | Denmark | Estonia | Finland | France | Georgia | Greece | Hungary | Ireland | Italy | Kazakhstan | Latvia | Lithuania | Malta | Montenegro | North Macedonia | Norway | Poland | Portugal | Romania | Russian Federation* | San Marino | Serbia | Slovakia | Slovenia | Spain | Sweden | Tajikistan | Turkey | Turkmenistan

Overweight Obese

Source: WHO European Childhood Obesity Surveillance Initiative (COSI).

Summary of SDG 3 indicators that are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] (2015)	3.2.1 Under-five mortality rate[c] (2017)	3.2.2 Neonatal mortality rate[c] (2017)	3.3.1 New HIV infections[d] (2017)	3.3.2 Tuberculosis incidence[e] (2017)	3.3.3 Malaria incidence[f] (2017)	3.3.4 Hepatitis B prevalence[g] (2015)	3.4.1 Probability of dying from the 4 major NCDs[g] (2016)	3.4.2 Suicide mortality rate[h] (2016)	3.5.2 Alcohol consumption[i] (2016)	3.6.1 Road traffic mortality rate[h] (2016)	3.8.1 UHC service coverage index (2015)	3.9.1 Air pollution mortality rate[j] (2016)	3.9.2 WASH mortality rate[h] (2016)	3.9.3 Poisoning mortality rate[h] (2016)	3.a.1 Tobacco smoking prevalence[g] (2016)	3.b.1 DTP3 immunization[g] (2017)	3.b.1 MCV2 immunization[g] (2017)	3.b.1 PCV3 immunization[g] (2017)
Albania	29	9	6	0.03	20		1.29	17.0	6.3	7.5	13.6	62	68.0	0.2	0.4	29.2	99	98	99
Andorra		3	1		1.5		0.08			11.3						33.4	99	94	98
Armenia	25	13	7	0.06	36	0.0	0.25	22.3	6.6	5.5	17.1	67	54.8	0.2	0.6	26.8	94	97	94
Austria	4	4	2	0.02	7.4		0.32	11.4	15.6	11.6	5.2	≥80	15.3	0.1	0.2	29.7	90	84	
Azerbaijan	25	23	12	0.08	67	0.0	0.27	22.2	2.6	0.8	8.7	64	63.9	1.1	0.6	21.4	95	97	96
Belarus	4	4	2	0.27	37		0.20	23.7	26.2	11.2	8.9	74	60.7	0.1	2.6	28.3	97	98	
Belgium	7	4	2		9.2		0.18	11.4	20.7	12.1	5.8	≥80	15.7	0.3	0.2	28.3	98	85	94
Bosnia and Herzegovina	11	6	4		27		0.30	17.8	8.8	6.4	15.7	57	79.8	0.1	0.5	39.0	75	80	
Bulgaria	11	8	4	0.03	25		0.31	23.6	11.5	12.7	10.2	64	61.8	0.1	0.6	37.3	92	92	91
Croatia	8	5	3		10.0		0.11	16.7	16.5	8.9	8.1	69	35.5	0.1	0.2	37.1	92	95	
Cyprus	7	3	2	0.06	5.1		0.60	11.3	5.3	10.8	5.1	73	20.1	0.3	0.1	36.2	97	88	81
Czechia	4	3	2	0.03	5.4		0.39	15.0	13.1	14.4	5.9	73	29.6	0.2	0.3	34.4	96	90	
Denmark	6	4	3	0.02	5.1		0.79	11.3	12.8	10.4	4.0	≥80	13.2	0.3	0.1	19.1	98	88	97
Estonia	9	3	1	0.19	15		0.36	17.0	17.8	11.6	6.1	76	25.0	0.0	0.5	31.9	93	91	
Finland	3	2	2		4.9		1.05	10.2	15.9	10.7	4.7	79	7.2	0.0	0.2	20.5	89	92	85
France	8	4	2	0.08	9.0		0.01	10.6	17.7	12.6	5.5	≥80	9.7	0.3	0.5	32.9	96	80	92
Georgia	36	11	7	0.22	86	0.0	0.26	24.9	8.2	9.8	15.3	66	101.8	0.2	0.8	30.4	91	90	80
Germany	6	4	2	0.03	7.5		0.24	12.1	13.6	13.4	4.1	79	16.0	0.6	0.2	30.7	95	93	84
Greece	3	5	3	0.09	4.5		0.37	12.4	5.0	10.4	9.2	70	27.6	0.0	0.2	43.7	99	83	96
Hungary	17	5	2	0.03	7.7		0.44	23.0	19.1	11.4	7.8	70	38.8	0.2	0.3	30.8	99	99	99
Iceland	3	2	1		4.5		0.88	9.1	14.0	9.1	6.6	≥80	8.7	0.1	0.2	14.8	89	95	88
Ireland	8	4	2		7.3		0.01	10.3	11.5	13.0	4.1	78	11.9	0.1	0.2	24.4	95		91
Israel	5	4	2		3.2		0.48	9.6	5.4	3.8	4.2	≥80	15.4	0.1	0.1	25.4	98	96	94
Italy	4	3	2	0.05	7.4		0.61	9.5	8.2	7.5	5.6	≥80	15.0	0.1	0.3	23.8	94	86	91
Kazakhstan	12	10	5	0.19	66	0.0	0.21	26.8	22.5	7.7	17.6	71	62.7	0.4	2.3	25.1	99	99	98
Kyrgyzstan	76	20	11	0.10	144	0.0	0.50	24.9	8.3	6.2	15.4	66	110.7	0.8	0.6	27.1	92	96	88
Latvia	18	4	2		32		0.51	21.9	21.2	12.9	9.3	64	41.3	0.0	0.8	38.3	98	89	87
Lithuania	10	4	2	0.12	50		0.19	20.7	31.9	15.0	8.0	67	34.0	0.1	0.7	29.7	94	92	82
Luxembourg	10	3	2	0.10	6.3		0.24	10.0	13.5	13.0	6.3	≥80	11.6	0.0	0.1	23.5	99	86	95
Malta	9	6	4		11		0.39	10.8	7.5	8.1	6.1	79	20.2	0.0	0.1	25.6	98	83	
Monaco		3	2		0.0		0.20										99	79	
Montenegro	7	3	2	0.04	14		0.65	20.6	10.3	8.0	10.7	54	78.6	0.0	0.5	46.0	87	83	
Netherlands	7	4	2	0.03	5.2		0.04	11.2	12.6	8.7	3.8	≥80	13.7	0.2	0.1	25.9	94	90	93
North Macedonia	8	14	11	0.02	13		0.20	20.3	7.9	8.1	6.4	70	82.2	0.1	0.4		91	97	
Norway	5	3	2	0.03	5.1		0.01	9.2	12.2	7.5	2.7	≥80	8.6	0.2	0.2	20.2	96	91	94
Poland	3	5	3		17		0.04	18.7	16.2	11.6	9.7	75	37.9	0.1	0.2	28.2	98	93	
Portugal	10	4	2	0.07	20		0.10	11.1	14.0	12.3	7.4	≥80	9.8	0.2	0.3	23.2	98	95	96
Republic of Moldova	23	16	12	0.32	95		0.65	24.9	15.9	15.2	9.7	65	78.3	0.1	1.2	25.3	88	92	78
Romania	31	8	4	0.03	72		0.65	21.4	10.4	12.7	10.3	72	59.3	0.4	0.4	30.0	82	75	
Russian Federation	25	8	3	0.70	60		0.88	25.4	31.0	11.7	18.0	63	49.4	0.1	1.7	40.9	97	97	70
San Marino		2	1		0.0		0.32					0.0					86	78	53
Serbia	17	6	3	0.02	19		0.11	19.1	15.6	11.1	7.4	65	62.5	0.7	0.3	39.0	95	91	
Slovakia	6	6	3	0.02	4.8		0.56	17.2	12.8	11.5	6.4	76	33.5	0.0	0.4	30.4	96	97	96
Slovenia	9	2	1	0.03	6.2		1.04	12.7	18.6	12.6	6.4	78	22.6	0.0	0.3	22.6	94	94	55
Spain	5	3	2	0.09	11		0.19	9.9	8.7	10.0	4.1	77	9.9	0.2	0.2	29.4	98	93	
Sweden	4	3	2		5.7		0.32	9.1	14.8	9.2	2.8	≥80	7.2	0.2	0.4	18.9	97	95	96
Switzerland	5	4	3		7.2		0.17	8.6	17.2	11.5	2.7	≥80	10.1	0.1	0.1	25.8	97	89	83
Tajikistan	32	34	15	0.15	85	0.0	0.71	25.3	2.5	3.3	18.1	65	129.3	2.7	1.2		96	98	
Turkey	16	12	6		17		0.32	16.1	7.3	2.0	12.3	71	46.6	0.3	0.3	27.6	96	86	96
Turkmenistan	42	47	21		43	0.0	0.23	29.5	6.7	5.4	14.5	67	79.3	4.0	0.7		99	99	
Ukraine	24	9	5	0.29	84		0.46	24.7	22.4	8.6	13.7	63	70.7	0.3	2.5	30.5	50	84	
United Kingdom	9	4	3		8.9		0.22	10.9	8.9	11.5	3.1	≥80	13.8	0.1	0.2	22.4	94	88	92
Uzbekistan	36	23	12	0.21	73	0.0	0.60	24.5	7.4	2.7	11.5	72	81.1	0.4	1.0	13.0	99	99	99

[a] Comparable estimates refer to country values which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators.

[b] (per 100 000 live births)
[c] (per 1000 live births)
[d] (per 1000 uninfected population)
[e] (per 100 000 population)
[f] (per 1000 population at risk)
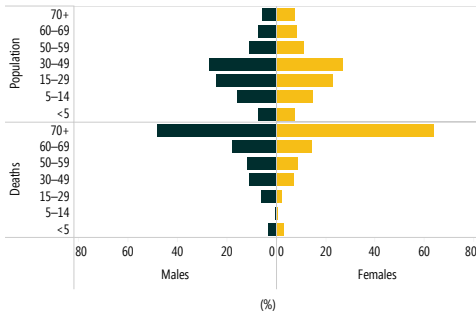[g] (%)
[h] (crude, per 100 000 population)
[i] (litres of pure alcohol per capita ≥15 years)
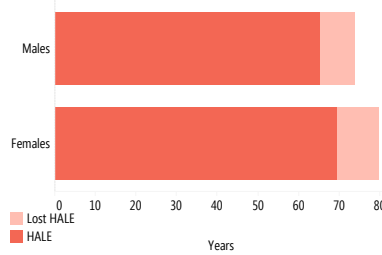[j] (age-standardized, per 100 000 population)

Key statistics (2016)

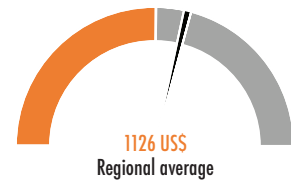### Age distribution of population and deaths by sex

Life expectancy at birth

Lost HALE
HALE

Years

Lost healthy life expectancy (HALE) represents equivalent year(s) of full health lost through years lived with morbidity and disability. This ranged within the region from 9.1 to 16.9 years by country (6–12% of life expectancy). Although females live longer, lost HALE is longer as well; on average 1.7 years or 1.8% more than males.
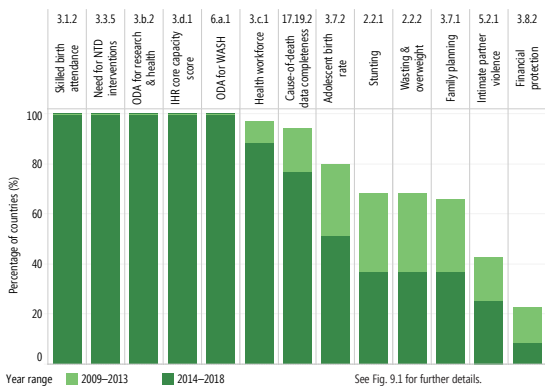
Current health expenditure per capita
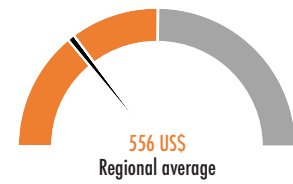
556 US$
Regional average

Range of gauge is the maximum value among WHO regions; orange portion is the global average.

Underlying data availability

Primary data

Year range 2009–2013 2014–2018   See Fig. 9.1 for further details.

Comparable estimates with sex disaggregation

Time lag between estimate and underlying data
No underlying data since 2000   ≤4 years
>4 years   Average lag
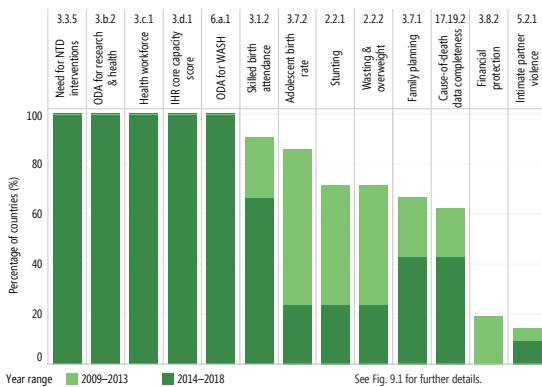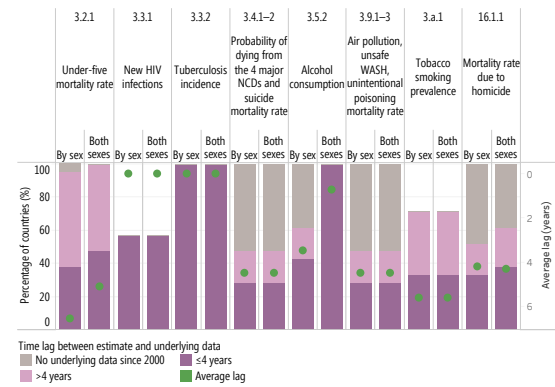
Countries develop long-terms plans for national household survey for better reporting of core health indicators and health-related SDG indicators[1]

The WHO Eastern Mediterranean Region has benefited from a regional plan of action and strategy for strengthening health information systems. Intensive work with Member States since 2012 has resulted in a clear framework for health information systems. The region's 75 core health indicators focus on three main components: health determinants and risks, health status, and health system capacity and response. Reliable reporting and disaggregation of many of these indicators requires nationally representative household surveys. Analysis of survey modules shows the overlaps of indicators from different surveys, with the health examination survey (HES) and demographic and health survey/ multiple indicator cluster survey (DHS/MICS) providing more indicators than the other surveys (Fig. A6).

In many countries, the conduct of household surveys of health significance may not follow carefully planned long-term strategies. It is often the case that a country has conducted several high-profile national household surveys, with significant content overlaps, in a short period of time (e.g. 2–3 years), but then a subsequent survey has not been conducted for up to 10 years. The picture is further compounded for the countries that rely on external support for such surveys, where the timeline of the donor or collaborative institutions or countries might have more influence than the needs of the country on the conduct of surveys. Many countries in the region have been affected by these challenges.

[1] Provided by the WHO Regional Office for the Eastern Mediterranean.

Fig. A6. Survey mapping in the WHO Eastern Mediterranean Region

Mental health survey — 2
HIV Survey in high-risk population — 2
Household expenditure survey — 4
HES 30
16 (overlaps)
DHS/MICS 24
Serology survey for Hepatitis B — 1
STEPS 6
GSHS 4

Numbers denote the number of indicators from the WHO Eastern Mediterranean Region core list covered by each survey.

DHS: Demographic and Health Survey
HES: Health Examination Survey
GSHS: Global school-based student health survey
MICS: Multiple Indicator Cluster Survey
STEPS: Noncommunicable Disease Risk Factors Survey

Source: WHO Regional Office for the Eastern Mediterranean

The WHO Regional Office for the Eastern Mediterranean conducted some desk reviews of key household surveys, followed by an intercountry expert consultation in December 2017 (in Cairo). As a result of these initiatives, a recommended list of survey modules and model national plans for national household surveys were developed.

The model scenario has been discussed through national workshops and consultations with interested countries. Subsequently, several countries (e.g. Bahrain, Islamic Republic of Iran, Qatar and Sudan) have developed their national survey plans to ensure regular availability of data for policy and planning.

Summary of SDG 3 indicators that are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b] 2015	3.2.1 Under-five mortality rate[c] 2017	3.2.2 Neonatal mortality rate[c] 2017	3.3.1 New HIV infections[d] 2017	3.3.2 Tuberculosis incidence[e] 2017	3.3.3 Malaria incidence[f] 2017	3.3.4 Hepatitis B prevalence[g] 2015	3.4.1 Probability of dying from the 4 major NCDs[g] 2016	3.4.2 Suicide mortality rate[h] 2016	3.5.2 Alcohol consumption[i] 2016	3.6.1 Road traffic mortality rate[h] 2016	3.8.1 UHC service coverage index 2015	3.9.1 Air pollution mortality rate[j] 2016	3.9.2 WASH mortality rate[h] 2016	3.9.3 Poisoning mortality rate[h] 2016	3.a.1 Tobacco smoking prevalence[g] 2016	3.b.1 DTP3 immunization[g] 2017	3.b.1 MCV2 immunization[g] 2017	3.b.1 PCV3 immunization[g] 2017
Afghanistan	396	68	39		189	23	0.5	29.8	4.7	0.2	15.1	34	211.1	13.9	1.2		65	39	65
Bahrain	15	7	3	0.04	12		0.18	11.3	5.9	1.9		72	40.1	0	0.2	21.7	97	99	97
Djibouti	229	62	32	0.61	269	31.9	0.64	19.6	6.7	0.5		47	159	31.3	2.4	13.1	68	82	68
Egypt	33	22	12	0.02	13	0	0.8	27.7	4	0.4	9.7	68	108.9	2	0.2	25.2	94	94	
Iran (Islamic Republic of)	25	15	9	0.06	14	0.1	0.02	14.8	4.1	1	20.5	65	50.9	1	1.2	11	99	98	
Iraq	50	30	17		42	0	0.06	21.3	3	0.4	20.7	63	75.1	3	0.5		63	74	33
Jordan	58	17	10		6.8		1.01	19.2	2.9	0.7	24.4	70	51.2	0.6	0.6		99	99	
Kuwait	4	8	4	0.05	27		0.11	17.4	2.3	0	17.6	77	103.8	0	0.2	19.9	99	99	99
Lebanon	15	8	5	0.03	12		0.21	17.9	3.3	1.5	18.1	68	51.4	0.8	0.3	33.8	79	68	68
Libya	9	12	7		40		0.27	20.1	5.2	0	26.1	63	71.9	0.6	0.6		96	94	94
Morocco	121	23	14	0.03	99	0	0.45	12.4	2.9	0.6	19.6	65	49.1	1.9	0.6	24	99	99	99
Oman	17	11	5		6.7	0	0.44	17.8	3.9	0.8	16.1	72	53.9	0	0.4	8.1	99	99	99
Pakistan	178	75	44	0.1	267	4.9	2.75	24.7	2.9	0.3	14.3	40	173.6	19.6	2.3	19.8	75	45	75
Qatar	13	8	4	0.07	26		0.2	15.3	6.6	2	9.3	77	47.4	0	0.4	13.9	97	93	98
Saudi Arabia	12	7	4		10	0.1	0.3	16.4	3.2	0.2	28.8	68	83.7	0.1	0.7	13.6	98	96	98
Somalia	732	127	39	0.03	266	36.7	10.54	21.8	4.7	0	27.1	22	212.8	86.6	4.6		42		
Sudan	311	63	30	0.12	77	37.4	2.86	26	8.1	0.5	25.7	43	184.9	17.3	3.9		95	72	95
Syrian Arab Republic	68	17	9		19	0	0.37	21.8	1.9	0.3	26.5	60	75.2	3.7	0.4		48		
Tunisia	62	13	8	0.03	34		0.76	16.1	3.4	1.9	22.8	65	56.1	1	0.5	33.5	98	97	
United Arab Emirates	6	9	5		0.8	0	0.08	16.8	2.8	3.8	18.1	63	54.7	0	0.3	19.3	97	99	96
Yemen	385	55	27		48	41.9	2.54	30.6	8.5	0.1		39	194.2	10.2	3.8	18.4	68	46	68

a Comparable estimates refer to country values which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators.

b (per 100 000 live births)
c (per 1000 live births)
d (per 1000 uninfected population)
e (per 100 000 population)
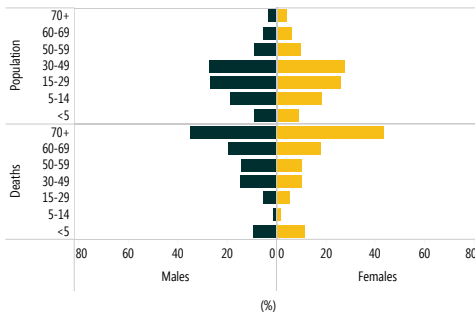f (per 1000 population at risk)
g (%)
h (crude, per 100 000 population)
i (litres of pure alcohol per capita ≥15 years)
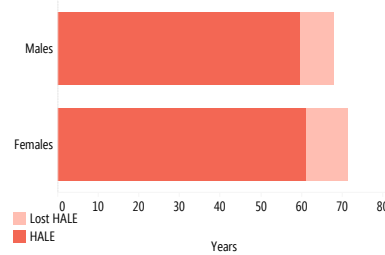j (age-standardized, per 100 000 population)

Western Pacific Region

Key statistics (2016)
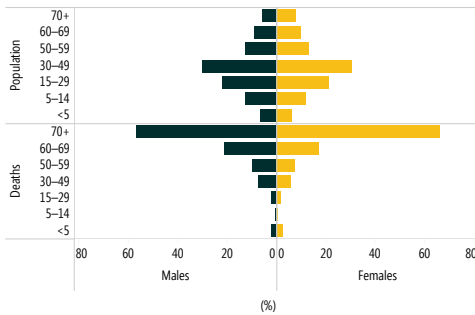
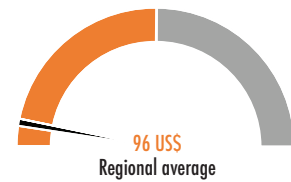### Age distribution of population and deaths by sex

Life expectancy at birth

Lost HALE / HALE
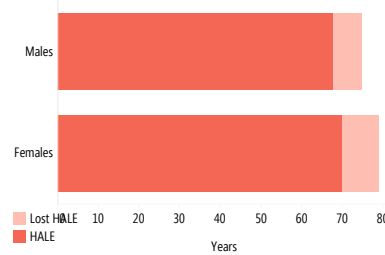
Lost healthy life expectancy (HALE) represents equivalent year(s) of full health lost through years lived with morbidity and disability. This ranged within the region from 7.6 to 14.1 years by country (7.4–10.6% of life expectancy). Although females live longer, lost HALE is longer as well; on average 1.7 years or 1.6% more than males.
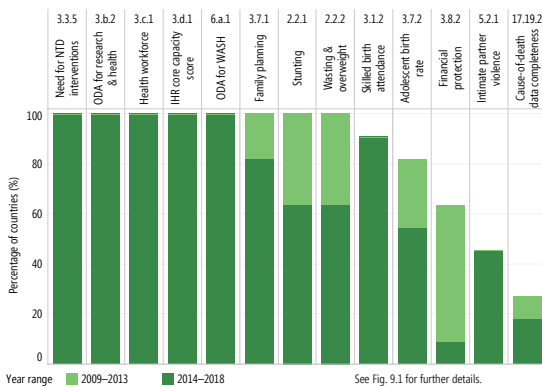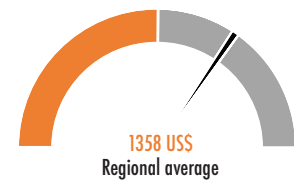
Current health expenditure per capita

1358 US$
Regional average

Range of gauge is the maximum value among WHO regions; orange portion is the global average.

Underlying data availability

Primary data

Year range: 2009–2013 / 2014–2018   See Fig. 9.1 for further details.

Comparable estimates with sex disaggregation

Time lag between estimate and underlying data
No underlying data since 2000 / ≤4 years
>4 years / Average lag
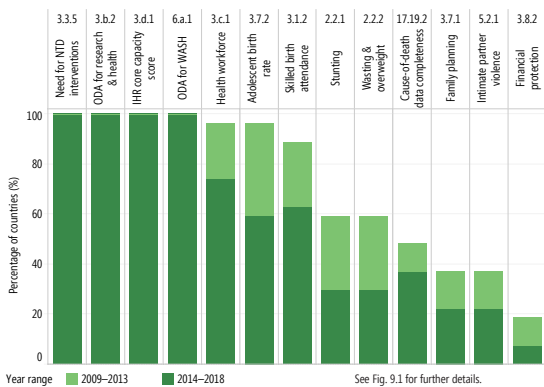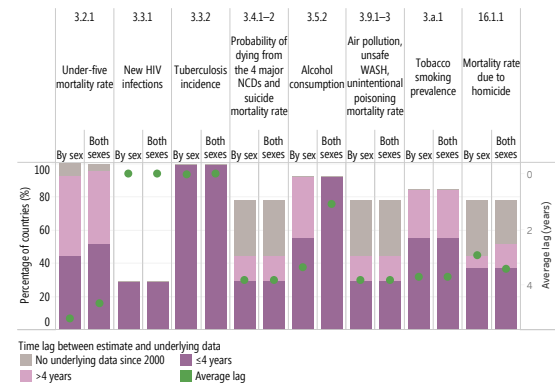
Scope for better vital statistics in the WHO Western Pacific Region

Vital statistics (i.e. birth and death rates) are key to monitoring internationally set goals such as the SDGs. However, in low-resource settings, producing such statistics remains a challenge. Although population censuses and surveys can produce vital statistics, they do not provide the long-term benefits of the CRVS systems that continuously and routinely generate vital statistics, even for the smallest geographical areas and by socioeconomic status. Furthermore, a CRVS system provides a way to establish fundamental human and civil rights, because it provides the individual with a legal identity that would allow that person to exercise their rights, including access to social and health services.

Cause-of-death statistics, another product of CRVS systems, are key to monitoring population health and are essential for policy-makers. Yet globally, few low- and middle-income countries have CRVS systems that produce cause-of-death statistics of sufficient quality to guide public health decision-making. Just about one third of all countries (covering about 20% of the world's population) produce high-quality cause-of-death data collected through a CRVS system, and most of those countries are in Europe and the Americas. A further 72 countries (representing 54% of the world's population) produce lower quality cause-of-death data, while 73 countries lack such data altogether.[1]

Sustained collaborative efforts from various government sectors – health, police, justice, defence or security, foreign affairs, national identity (ID) and civil registration departments – are critical for the effective functioning of CRVS systems. Mechanisms have to be established for sharing, linking and managing information efficiently for these multiple sources. In the Asia-Pacific region, a regional programme for CRVS was endorsed at a high-level meeting of decision-makers in December 2012; this led to the establishment of a regional support mechanism to support countries in assessing, strengthening and capacity-building.[2] Furthermore, in 2014, the Ministerial Conference on CRVS – attended by ministers and senior representatives of the civil registration, health, statistics and civil society – declared 2015–2024 to be the CRVS Decade for Asia and the Pacific.[3]

The Philippines is an example of the government-led engagement across several sectors, such as the Philippines Statistics Authority, local civil registrars, and the Department of Health. This engagement has resulted in streamlining of the process for registration of births and deaths, which has also benefited other health services and sectors.

Since 2000, the government has mandated national implementation of International Classification of Diseases 10th Revision (ICD-10) in all health facilities, to improve morbidity and mortality statistics submitted to the Philippines Statistics Authority.[4] With the assistance of global and regional partners, several actions to improve information on causes of death have been put in place; these actions include standard reporting procedures, and capacity-building activities to ensure that health professionals are trained for certifying the cause of death (and integration of such training in medical school curricula).

The latest estimates suggest an increase in the completeness of death registration data, from 75% in early 1990s to 89% in 2015, whereas birth registration completeness is currently estimated to be greater than 90%.[5] Key elements for establishing a functional CRVS system that can produce vital statistics to support development and health policies are political commitment, public engagement, coordination, enforcement of operational procedures and capacity-building.

1   World health statistics 2017: monitoring health for the SDGs. Geneva: World Health Organization; 2017 (https://www.who.int/gho/publications/world_health_statistics/2017/en/, accessed 27 March 2019).

2   High-level meeting on the improvement of civil registration and vital statistics (CRVS) in Asia and the Pacific. Bangkok: United Nations Economic and Social Commission for Asia and the Pacific;(https://www.unescap.org/events/high-level-meeting-improvement-civil-registration-and-vital-statistics-crvs-asia-and-pacific, accessed 27 March 2019).

3   Ministerial Conference on Civil Registration and Vital Statistics (CRVS) in Asia and the Pacific (https://www.unescap.org/events/ministerial-conference-civil-registration-and-vital-statistics-asia-and-pacific, accessed 28 March 2019).

4   See https://psa.gov.ph/civil-registration-page and https://psa.gov.ph/vital-statistics.

5   WHO estimates, 2019, and Demographic and Social Statistics Branch, United Nations Statistics Division (UNSD), Department of Economic and Social Affairs, United Nations.

Summary of SDG 3 indicators that are reported as comparable estimates[a]

Member State	3.1.1 Maternal mortality ratio[b]	3.2.1 Under-five mortality rate[c]	3.2.2 Neonatal mortality rate[c]	3.3.1 New HIV infections[d]	3.3.2 Tuberculosis incidence[e]	3.3.3 Malaria incidence[f]	3.3.4 Hepatitis B prevalence[g]	3.4.1 Probability of dying from the 4 major NCDs[g]	3.4.2 Suicide mortality rate[h]	3.5.2 Alcohol consumption[i]	3.6.1 Road traffic mortality rate[h]	3.8.1 UHC service coverage index	3.9.1 Air pollution mortality rate[j]	3.9.2 WASH mortality rate[h]	3.9.3 Poisoning mortality rate[h]	3.a.1 Tobacco smoking prevalence[g]	3.b.1 DTP3 immunization[g]	3.b.1 MCV2 immunization[g]	3.b.1 PCV3 immunization[g]
	2015	2017	2017	2017	2017	2017	2015	2016	2016	2016	2016	2015	2016	2016	2016	2016	2017	2017	2017
Australia	6	4	2	0.04	6.8		0.15	9.1	13.2	10.6	5.6	≥80	8.4	0.1	0.2	14.8	95	93	94
Brunei Darussalam	23	11	5		64		0.34	16.6	4.6	0.4		≥80	13.3	0.0	0.3	16.5	99	98	
Cambodia	161	29	15	0.04	326	18.4	0.56	21.1	5.3	6.7	17.8	55	149.8	6.5	0.6	17.9	93	61	82
China	27	9	5		63	0.0	0.83	17.0	9.7	7.2	18.2	76	112.7	0.6	1.4	25.2	99	99	
Cook Islands		8	4		0.0		0.22			10.6	17.3					25.5	99	95	
Fiji	30	25	11		49		0.34	30.6	5.0	3.0	9.6	66	99.0	2.9	0.4	22.5	99	94	99
Japan	5	3	1	0.01	15		1.95	8.4	18.5	8.0	4.1	≥80	11.9	0.2	0.4	22.5	99	95	99
Kiribati	90	55	23		413		3.65	28.4	14.4	0.4	4.4	40	140.2	16.7	2.6	47.4	90	79	91
Lao People's Democratic Republic	197	63	28		168	5.8	1.94	27.0	8.6	10.4	16.6	48	188.5	11.3	0.9	29.3	85		83
Malaysia	40	8	4	0.25	93	0.1	0.17	17.2	5.5	0.9	23.6	70	47.4	0.4	0.5	21.7	99	99	
Marshall Islands		34	16		480		1.56										80	62	72
Micronesia (Federated States of)	100	32	17		165		0.89	26.1	11.1	2.5	1.9	60	151.8	3.6	1.0		73	52	65
Mongolia	44	17	9	0.01	428		1.72	30.2	13.0	7.4	16.5	63	155.9	1.3	1.6	26.0	99	98	13
Nauru		33	21		91		2.11			6.0						40.0	87		
New Zealand	11	5	3		7.5		1.20	10.1	12.1	10.7	7.8	≥80	7.2	0.1	0.2	16.0	94	90	94
Niue		22	11		71		0.24		7.0							14.9	99	99	99
Palau		15	8		106		0.21									15.2	97	95	89
Papua New Guinea	215	53	24	0.37	432	181.9	2.24	30.0	6.0	1.2	14.2	41	152.0	16.3	1.7	36.2	62		44
Philippines	114	28	14	0.12	554	0.3	1.07	26.8	3.2	6.6	12.3	58	185.2	4.2	0.2	24.3	88	80	61
Republic of Korea	11	3	2		70	0.1	0.69	7.8	26.9	10.2	9.8	≥80	20.5	1.8	0.5	23.6	98	97	98
Samoa	51	17	9		18		1.05	20.6	4.4	2.5	11.3	56	85.0	1.5	0.5	27.4	74		
Singapore	10	3	1	0.08	47		0.47	9.3	9.9	2.0	2.8	≥80	25.9	0.1	0.1	16.8	96	90	83
Solomon Islands	114	21	9		76	171.0	2.93	23.8	4.7	1.4	17.4	50	137.0	6.2	0.9		94		81
Tonga	124	16	7		12		2.35	23.3	3.5	1.5	16.8	62	73.3	1.4	1.3	28.1	81		
Tuvalu		25	16		236		0.70			1.7							96	94	
Vanuatu	78	27	12		51	8.2	8.48	23.3	4.5	1.0	15.9	56	135.6	10.4	0.9	18.7	85		
Viet Nam	54	21	11		129	0.1	1.20	17.1	7.3	8.4	26.4	73	64.5	1.6	0.9	23.5	94	93	

a Comparable estimates refer to country values which may be adjusted or modelled to allow comparisons between countries and are produced for countries with underlying primary data and, in some cases, for those without. Shading from blue to orange represents low to high for mortality, incidence and prevalence indicators; and from high to low for immunization coverage and service index indicators.

b (per 100 000 live births)
c (per 1000 live births)
d (per 1000 uninfected population)
e (per 100 000 population)
f (per 1000 population at risk)
g (%)
h (crude, per 100 000 population)
i (litres of pure alcohol per capita ≥15 years)
j (age-standardized, per 100 000 population)

ANNEX 2

Tables of health statistics by country, WHO region and globally

Explanatory notes

The statistics shown below represent official World Health Organization (WHO) statistics for selected health-related Sustainable Development Goal (SDG) indicators, based on evidence available in early 2019. In addition, summary measures of health, such as (healthy) life expectancy, and basic demographic and health-economic statistics are included to provide a general indication of the situation.

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

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

For the first time in the World Health Statistics series, the availability of the underlying data is indicated in the annex table for SDGs[2] for country values. Indicators that are of primary or other data type are formatted in bold font if the reference year is 2014 onwards, and in normal font if the reference year is between 2009 and 2013. For comparable estimates, data are formatted in bold if primary data were available 4 years preceding the estimate year, normal font if they were available outside of the 4 preceding years and faded font if country estimates were imputed without primary data.

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

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

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

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[1] The Global Health Observatory (GHO) is WHO's portal providing access to data and analyses for monitoring the global health situation (available at https://www.who.int/gho/en/, accessed 28 March 2019).

[2] Excludes total population, life expectancy, healthy life expectancy and current health expenditure (CHE) indicators, which are not official SDG indicators.

Member State	Total population [a] (000s) Comparable estimates			Life expectancy at birth [b,c] (years) Comparable estimates			Healthy life expectancy at birth [b,c] (years) Comparable estimates			Current health expenditure (CHE) per capita [d] (US$) Comparable estimates
Data Type	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
	2017			2016			2016			2016
Afghanistan	18 310	17 220	35 530	61.0	64.5	62.6	52.1	54.1	53.0	57
Albania	1 479	1 451	2 930	74.3	78.6	76.4	66.7	69.6	68.1	272
Algeria	20 866	20 452	41 318	75.4	77.4	76.4	65.4	65.6	65.5	260
Andorra	38	39	77	-	-	-	-	-	-	3 835
Angola	14 605	15 179	29 784	60.3	64.9	62.6	53.8	57.7	55.8	95
Antigua and Barbuda	49	53	102	72.5	77.5	75.0	65.2	68.8	67.0	623
Argentina	21 668	22 603	44 271	73.5	80.3	76.9	65.9	70.7	68.4	955
Armenia	1 378	1 552	2 930	71.2	78.1	74.8	63.6	68.7	66.3	359
Australia	12 181	12 270	24 451	81.0	84.8	82.9	71.8	74.1	73.0	5 002
Austria	4 283	4 452	8 735	79.4	84.2	81.8	70.9	73.9	72.4	4 688
Azerbaijan	4 895	4 932	9 828	70.3	75.7	73.1	62.8	66.9	64.9	268
Bahamas	194	202	395	72.6	78.6	75.7	64.7	68.8	66.8	1 835
Bahrain	936	556	1 493	78.6	79.6	79.1	68.3	67.6	68.1	1 099
Bangladesh	83 036	81 634	164 670	71.1	74.4	72.7	62.6	64.1	63.3	34
Barbados	137	149	286	73.1	78.0	75.6	65.4	68.5	67.0	1 164
Belarus	4 406	5 062	9 468	68.8	79.2	74.2	61.4	69.3	65.5	318
Belgium	5 636	5 793	11 429	78.8	83.5	81.1	70.2	73.0	71.6	4 149
Belize	187	188	375	67.9	73.4	70.5	60.7	64.5	62.5	304
Benin	5 575	5 601	11 176	59.7	62.4	61.1	52.5	54.4	53.5	30
Bhutan	429	379	808	70.4	70.8	70.6	60.8	60.5	60.7	91
Bolivia (Plurinational State of)	5 533	5 519	11 052	69.1	74.0	71.5	61.3	64.8	63.0	213
Bosnia and Herzegovina	1 722	1 785	3 507	74.8	79.8	77.3	64.9	69.4	67.2	444
Botswana	1 133	1 159	2 292	63.6	68.4	66.1	55.2	59.5	57.5	380
Brazil	102 855	106 433	209 288	71.4	78.9	75.1	63.4	68.7	66.0	1 016
Brunei Darussalam	221	208	429	75.3	77.6	76.4	67.0	68.8	67.9	631
Bulgaria	3 444	3 641	7 085	71.4	78.4	74.9	63.5	69.2	66.4	612
Burkina Faso	9 572	9 621	19 193	59.6	60.9	60.3	52.7	53.1	52.9	41
Burundi	5 347	5 518	10 864	58.5	61.8	60.1	51.2	54.0	52.6	23
Cabo Verde	272	274	546	71.1	75.0	73.2	63.1	65.8	64.5	160
Cambodia	7 810	8 196	16 005	67.3	71.2	69.4	59.4	62.1	60.8	78
Cameroon	12 038	12 015	24 054	56.7	59.4	58.1	50.1	52.0	51.1	64
Canada	18 172	18 452	36 624	80.9	84.7	82.8	72.0	74.3	73.2	4 458
Central African Republic	2 298	2 361	4 659	51.7	54.4	53.0	43.9	45.9	44.9	16
Chad	7 458	7 442	14 900	53.1	55.4	54.3	46.5	48.0	47.2	32
Chile	8 944	9 111	18 055	76.5	82.4	79.5	67.9	71.5	69.7	1 191
China	730 006	687 499	1417 505	75.0	77.9	76.4	68.0	69.3	68.7	398
Colombia	24 140	24 925	49 066	71.5	78.8	75.1	64.4	69.8	67.1	340
Comoros	411	403	814	62.3	65.5	63.9	55.4	57.8	56.6	59
Congo	2 632	2 629	5 261	63.0	65.6	64.3	55.9	57.6	56.7	70
Cook Islands	9	9	17	-	-	-	-	-	-	576
Costa Rica	2 454	2 452	4 906	77.0	82.2	79.6	69.1	72.7	70.9	889
Côte d'Ivoire	12 307	11 988	24 295	-	-	-	-	-	-	68
Croatia	2 019	2 170	4 189	75.0	81.5	78.2	66.4	71.7	69.0	884
Cuba	5 745	5 740	11 485	76.8	81.3	79.0	68.4	71.4	69.9	971
Cyprus	590	589	1 180	78.4	83.1	80.7	71.9	74.8	73.3	1 634
Czechia	5 219	5 399	10 618	76.2	82.1	79.1	67.0	71.6	69.3	1 322
Democratic People's Republic of Korea	12 468	13 023	25 491	68.2	75.5	71.9	62.1	66.9	64.6	-
Democratic Republic of the Congo	40 581	40 759	81 340	58.9	62.0	60.5	51.3	53.8	52.5	21
Denmark	2 852	2 882	5 734	79.3	83.2	81.2	70.7	73.0	71.8	5 566
Djibouti	480	477	957	62.2	65.5	63.8	55.3	57.9	56.6	70
Dominica	37	37	74	-	-	-	-	-	-	419
Dominican Republic	5 361	5 406	10 767	70.6	76.7	73.5	63.1	67.5	65.2	414
Ecuador	8 309	8 316	16 625	74.1	78.9	76.5	66.1	69.7	67.9	505
Egypt	49 325	48 228	97 553	68.2	73.0	70.5	59.9	62.4	61.1	131
El Salvador	2 995	3 383	6 378	69.0	78.1	73.7	61.7	69.0	65.5	294
Equatorial Guinea	702	566	1 268	57.9	61.7	59.5	52.5	55.3	53.8	281
Eritrea	2 540	2 529	5 069	62.9	67.1	65.0	56.0	59.0	57.4	30

Current health expenditure (CHE) as percentage of gross domestic product (GDP) [d] (%)	Maternal mortality ratio [e] (per 100 000 live births)	Proportion of births attended by skilled health personnel [f] (%)	Under-five mortality rate [g] (per 1000 live births)			Neonatal mortality rate [g] (per 1000 live births)	New HIV infections [h] (per 1000 uninfected population)			Member State
Comparable estimates	Comparable estimates	Primary data	Comparable estimates			Comparable estimates	Comparable estimates			
			Male	Female	Both sexes		Male	Female	Both sexes	
2016	2015	2009–2018	2017			2017	2017			
10.2	396	59	72	64	68	39	-	-	-	Afghanistan
6.7	29	100	10	8	9	6	0.05	0.02	0.03	Albania
6.6	140	97	26	23	24	15	0.03	0.03	0.03	Algeria
10.4	-	100 ah	4	3	3	1	-	-	-	Andorra
2.9	477	47	87	75	81	29	0.73	1.23	0.99	Angola
4.3	-	100 ai	8	7	7	4	-	-	-	Antigua and Barbuda
7.5	52	94	11	9	10	6	0.21	0.09	0.15	Argentina
9.9	25	100 ah	14	11	13	7	0.09	0.03	0.06	Armenia
9.3	6	97 ai	4	3	4	2	0.07	0.01	0.04	Australia
10.4	4	98 ai	4	3	4	2	0.04	0.01	0.02	Austria
6.9	25	100 ah	25	21	23	12	0.11	0.04	0.08	Azerbaijan
6.4	80	99 ai	8	7	7	4	0.54	0.23	0.38	Bahamas
4.9	15	100 ai	8	7	7	3	0.04	0.03	0.04	Bahrain
2.4	176	68	35	30	32	18	0.01	0.01	0.01	Bangladesh
7.0	27	99 ai	14	11	12	8	0.83	0.33	0.57	Barbados
6.3	4	100 ah	4	3	4	2	0.34	0.20	0.27	Belarus
10.0	7	-	4	3	4	2	-	-	-	Belgium
6.1	28	92 ai	16	13	14	9	1.03	0.83	0.93	Belize
3.9	405	78	104	93	98	33	0.30	0.44	0.37	Benin
3.5	148	96 ah	34	28	31	17	-	-	-	Bhutan
6.9	206	71 ai	38	31	35	19	0.19	0.08	0.14	Bolivia (Plurinational State of)
9.2	11	100	6	5	6	4	-	-	-	Bosnia and Herzegovina
5.5	129	100 ai	41	34	38	25	6.61	8.38	7.47	Botswana
11.8	44	99 ai	17	13	15	9	0.33	0.14	0.24	Brazil
2.3	23	100 ah	11	10	11	5	-	-	-	Brunei Darussalam
8.2	11	100	8	7	8	4	0.05	0.01	0.03	Bulgaria
6.8	371	80	85	77	81	25	0.22	0.24	0.23	Burkina Faso
7.7	712	85	66	56	61	22	0.25	0.34	0.29	Burundi
5.3	42	93	19	16	17	10	0.20	0.27	0.24	Cabo Verde
6.1	161	89 ah	33	26	29	15	0.04	0.04	0.04	Cambodia
4.7	596	65	90	78	84	26	0.94	1.54	1.24	Cameroon
10.5	7	98 ai	6	5	5	4	-	-	-	Canada
4.3	882	40	128	115	122	42	1.51	1.92	1.71	Central African Republic
4.5	856	20	130	116	123	35	0.35	0.47	0.41	Chad
8.5	22	100	8	7	7	5	0.48	0.19	0.33	Chile
5.0	27	100 ah	10	9	9	5	-	-	-	China
5.9	64	99	16	13	15	8	-	-	-	Colombia
7.6	335	82	74	63	69	32	0.02	0.01	0.01	Comoros
4.6	442	91	52	43	48	19	1.17	2.02	1.59	Congo
3.4	-	100 ah	8	7	8	4	-	-	-	Cook Islands
7.6	25	99	10	8	9	6	0.31	0.13	0.22	Costa Rica
4.4	645	74	97	80	89	34	1.24	1.33	1.29	Côte d'Ivoire
7.2	8	100	5	4	5	3	-	-	-	Croatia
12.2	39	100 ai	6	5	5	2	0.24	0.09	0.17	Cuba
6.9	7	96 ai	3	3	3	2	0.09	0.02	0.06	Cyprus
7.1	4	100 ai	4	3	3	2	0.05	<0.01	0.03	Czechia
-	82	100	21	17	19	10	-	-	-	Democratic People's Republic of Korea
3.9	693	80	98	84	91	29	0.12	0.23	0.17	Democratic Republic of the Congo
10.4	6	95 ai	5	4	4	3	0.04	0.01	0.02	Denmark
3.5	229	87 ah	67	56	62	32	0.53	0.69	0.61	Djibouti
5.3	-	97 ai	37	31	34	27	-	-	-	Dominica
6.2	92	100 ai	33	27	30	20	0.24	0.21	0.22	Dominican Republic
8.4	64	96	16	13	15	8	0.18	0.08	0.12	Ecuador
4.6	33	92	23	21	22	12	0.03	0.01	0.02	Egypt
7.0	54	100	16	13	15	7	0.27	0.12	0.19	El Salvador
3.4	342	68 ah	96	83	90	31	3.19	3.76	3.45	Equatorial Guinea
3.0	501	34	48	38	43	18	0.12	0.20	0.16	Eritrea

Member State	Total population [a] (000s) Comparable estimates			Life expectancy at birth [b,c] (years) Comparable estimates			Healthy life expectancy at birth [b,c] (years) Comparable estimates			Current health expenditure (CHE) per capita [d] (US$) Comparable estimates
Data Type	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
	2017			2016			2016			2016
Estonia	614	696	1 310	73.0	82.1	77.8	64.6	71.4	68.2	1 185
Eswatini	662	705	1 367	-	-	-	-	-	-	221
Ethiopia	52 406	52 551	104 957	63.7	67.3	65.5	56.1	58.9	57.5	28
Fiji	460	446	906	67.1	73.1	69.9	59.6	63.3	61.3	180
Finland	2 722	2 801	5 523	78.7	84.2	81.4	69.8	73.5	71.7	4 117
France	31 949	33 031	64 980	80.1	85.7	82.9	71.8	74.9	73.4	4 263
Gabon	1 040	985	2 025	64.8	68.2	66.4	57.8	59.7	58.7	220
Gambia	1 040	1 061	2 101	60.6	63.3	61.9	53.7	55.2	54.4	21
Georgia	1 868	2 044	3 912	68.3	76.8	72.6	61.5	68.4	64.9	308
Germany	40 435	41 679	82 114	78.7	83.3	80.9	70.2	73.0	71.6	4 714
Ghana	14 368	14 466	28 834	62.5	64.4	63.4	55.8	57.0	56.4	68
Greece	5 493	5 667	11 160	78.7	83.7	81.1	70.5	73.6	72.0	1 511
Grenada	54	54	108	71.0	75.9	73.4	63.0	66.5	64.7	516
Guatemala	8 324	8 589	16 914	70.4	76.0	73.2	62.2	66.2	64.2	241
Guinea	6 376	6 341	12 717	59.4	60.2	59.8	52.1	52.2	52.2	37
Guinea-Bissau	916	945	1 861	58.4	61.2	59.8	50.6	52.9	51.7	39
Guyana	393	385	778	63.6	69.0	66.2	56.4	60.4	58.3	192
Haiti	5 430	5 551	10 981	61.3	65.7	63.5	53.9	56.8	55.3	38
Honduras	4 620	4 645	9 265	72.9	77.5	75.2	65.1	68.5	66.8	200
Hungary	4 625	5 097	9 722	72.3	79.4	76.0	64.1	69.5	66.8	943
Iceland	168	167	335	80.9	83.9	82.4	72.3	73.8	73.0	5 064
India	693 959	645 221	1339 180	67.4	70.3	68.8	58.7	59.9	59.3	62
Indonesia	132 898	131 093	263 991	67.3	71.4	69.3	60.4	63.0	61.7	112
Iran (Islamic Republic of)	40 816	40 347	81 163	74.6	76.9	75.7	64.9	65.9	65.4	415
Iraq	19 376	18 899	38 275	67.5	72.2	69.9	57.4	60.6	59.0	153
Ireland	2 362	2 400	4 762	79.7	83.4	81.5	71.1	73.2	72.1	4 759
Israel	4 133	4 188	8 322	80.3	84.2	82.3	71.7	74.1	72.9	2 837
Italy	28 929	30 431	59 360	80.5	84.9	82.7	72.0	74.3	73.2	2 739
Jamaica	1 438	1 452	2 890	73.6	78.5	76.0	65.3	68.5	66.9	296
Japan	62 256	65 228	127 484	81.1	87.1	84.2	72.6	76.9	74.8	4 233
Jordan	4 913	4 789	9 702	72.7	76.0	74.3	65.4	67.5	66.4	224
Kazakhstan	8 817	9 388	18 205	66.8	75.3	71.1	59.9	66.7	63.4	262
Kenya	24 701	24 999	49 700	64.4	68.9	66.7	57.0	60.8	58.9	66
Kiribati	57	59	116	63.6	68.6	66.1	56.0	59.4	57.8	188
Kuwait	2 375	1 761	4 137	73.9	76.0	74.8	66.3	66.2	66.3	1 068
Kyrgyzstan	2 998	3 048	6 045	67.7	75.2	71.4	60.7	66.4	63.5	73
Lao People's Democratic Republic	3 421	3 437	6 858	64.2	67.4	65.8	56.9	58.8	57.9	55
Latvia	895	1 054	1 950	70.0	79.6	75.1	62.4	69.5	66.2	874
Lebanon	3 051	3 031	6 082	75.1	77.7	76.3	65.5	66.8	66.1	662
Lesotho	1 084	1 149	2 233	51.0	54.6	52.9	45.0	47.9	46.6	86
Liberia	2 387	2 345	4 732	62.0	63.9	62.9	53.9	55.1	54.5	68
Libya	3 213	3 161	6 375	69.0	75.0	71.9	60.5	64.2	62.3	-
Lithuania	1 332	1 559	2 890	69.7	80.2	75.0	61.9	70.0	66.1	988
Luxembourg	293	290	583	80.1	84.6	82.5	71.1	73.7	72.6	6 271
Madagascar	12 752	12 819	25 571	64.6	67.6	66.1	57.1	59.5	58.3	24
Malawi	9 225	9 397	18 622	61.4	66.8	64.2	53.9	58.4	56.2	30
Malaysia	16 325	15 299	31 624	73.2	77.6	75.3	65.3	68.1	66.6	362
Maldives	248	188	436	77.2	79.9	78.4	69.7	69.7	69.8	1 048
Mali	9 279	9 263	18 542	57.5	58.4	58.0	50.4	51.0	50.7	30
Malta	216	214	431	79.6	83.3	81.4	71.3	73.3	72.2	2 328
Marshall Islands	27	26	53	-	-	-	-	-	-	851
Mauritania	2 228	2 192	4 420	62.6	65.2	63.9	55.6	57.2	56.4	47
Mauritius	626	639	1 265	71.6	78.1	74.8	63.6	68.2	65.8	553
Mexico	64 312	64 851	129 163	74.0	79.2	76.6	65.8	69.6	67.7	462
Micronesia (Federated States of)	54	51	106	68.4	70.8	69.6	60.4	61.7	61.1	387
Monaco	19	20	39	-	-	-	-	-	-	2 940
Mongolia	1 521	1 554	3 076	65.7	74.2	69.8	58.6	65.5	61.9	141

	3.1		3.2				3.3			
Current health expenditure (CHE) as percentage of gross domestic product (GDP) [d] (%)	Maternal mortality ratio [e] (per 100 000 live births)	Proportion of births attended by skilled health personnel [f] (%)	Under-five mortality rate [g] (per 1000 live births)			Neonatal mortality rate [g] (per 1000 live births)	New HIV infections [h] (per 1000 uninfected population)			
Comparable estimates	Comparable estimates	Primary data	Comparable estimates			Comparable estimates	Comparable estimates			
			Male	Female	Both sexes		Male	Female	Both sexes	
2016	2015	2009–2018	2017			2017	2017			Member State
6.7	9	99 ai	3	3	3	1	0.30	0.10	0.19	Estonia
7.7	389	88	58	49	54	17	6.77	9.32	8.02	Eswatini
4.0	353	28 ah	65	52	59	29	0.14	0.21	0.17	Ethiopia
3.5	30	100 ah	28	23	25	11	-	-	-	Fiji
9.5	3	100 ai	3	2	2	2	-	-	-	Finland
11.5	8	98 ai	5	4	4	2	0.11	0.05	0.08	France
3.1	291	89 ah	53	44	48	22	1.02	2.23	1.60	Gabon
4.4	706	57	68	59	64	28	0.63	0.73	0.68	Gambia
8.4	36	100	12	10	11	7	0.38	0.08	0.22	Georgia
11.1	6	99 ai	4	3	4	2	-	-	0.03	Germany
4.4	319	78	54	44	49	24	0.51	0.86	0.68	Ghana
8.5	3	100 ah	6	5	5	3	0.14	0.03	0.09	Greece
5.2	27	99 ai	18	15	17	11	-	-	-	Grenada
5.8	88	69 ai	30	25	28	13	0.18	0.11	0.14	Guatemala
5.5	679	63 ah	91	81	86	24	0.58	0.74	0.66	Guinea
6.1	549	45 ah	90	78	84	37	1.16	1.46	1.31	Guinea-Bissau
4.2	229	86	35	27	31	19	0.67	0.56	0.62	Guyana
5.4	359	42	77	66	72	28	0.69	0.71	0.73	Haiti
8.4	129	74 ai	20	16	18	10	0.14	0.06	0.10	Honduras
7.4	17	100 ah	5	4	5	2	0.05	0.01	0.03	Hungary
8.3	3	98 ai	2	2	2	1	-	-	-	Iceland
3.6	174	81 ah	39	40	39	24	-	-	0.10	India
3.1	126	94	28	22	25	12	0.24	0.14	0.19	Indonesia
8.1	25	99 ah	16	14	15	9	0.09	0.03	0.06	Iran (Islamic Republic of)
3.3	50	96	33	27	30	17	-	-	-	Iraq
7.4	8	100 ai	4	3	4	2	-	-	-	Ireland
7.3	5	-	4	3	4	2	-	-	-	Israel
8.9	4	100 ai	4	3	3	2	0.07	0.02	0.05	Italy
6.1	89	98 ai	17	13	15	11	-	-	0.66	Jamaica
10.9	5	100 ai	3	2	3	1	0.02	<0.01	0.01	Japan
5.5	58	100	18	16	17	10	-	-	-	Jordan
3.5	12	99	11	9	10	5	0.28	0.12	0.19	Kazakhstan
4.5	510	62	50	42	46	21	0.99	1.44	1.21	Kenya
11.9	90	98 ah	59	50	55	23	-	-	-	Kiribati
3.9	4	100 ai	9	8	8	4	0.07	0.03	0.05	Kuwait
6.6	76	98	22	18	20	11	0.14	0.06	0.10	Kyrgyzstan
2.4	197	64	69	58	63	28	-	-	-	Lao People's Democratic Republic
6.2	18	100 ai	5	4	4	2	-	-	-	Latvia
8.0	15	-	8	7	8	5	0.04	0.01	0.03	Lebanon
8.1	487	78	93	79	86	38	8.03	10.13	9.07	Lesotho
9.6	725	61	80	69	75	25	0.43	0.60	0.51	Liberia
-	9	100 ah	14	11	12	7	-	-	-	Libya
6.7	10	100 ah	5	4	4	2	0.18	0.06	0.12	Lithuania
6.2	10	100 ai	3	2	3	2	0.17	0.04	0.10	Luxembourg
6.0	353	44	48	40	44	18	0.30	0.13	0.22	Madagascar
9.8	634	90 ah	60	50	55	23	2.10	2.69	2.39	Malawi
3.8	40	100 ah	9	7	8	4	0.43	0.07	0.25	Malaysia
10.6	68	96	9	7	8	5	-	-	-	Maldives
3.8	587	44	111	101	106	35	0.48	0.62	0.55	Mali
9.3	9	100 ai	7	6	6	4	-	-	-	Malta
23.3	-	92	40	32	34	16	-	-	-	Marshall Islands
4.2	602	69	85	73	79	34	0.08	0.05	0.06	Mauritania
5.7	53	100 ah	14	12	13	8	-	-	-	Mauritius
5.5	38	98	15	12	13	8	0.18	0.05	0.12	Mexico
12.6	100	100 ah	35	29	32	17	-	-	-	Micronesia (Federated States of)
1.7	-	-	4	3	3	2	-	-	-	Monaco
3.8	44	99	20	14	17	9	0.02	<0.01	0.01	Mongolia

Member State	Total population [a] (000s) Comparable estimates			Life expectancy at birth [b,c] (years) Comparable estimates			Healthy life expectancy at birth [b,c] (years) Comparable estimates			Current health expenditure (CHE) per capita [d] (US$) Comparable estimates
Data Type	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
	2017			2016			2016			2016
Montenegro	310	319	629	74.4	79.2	76.8	66.1	70.1	68.1	532
Morocco	17 701	18 039	35 740	74.8	77.0	76.0	65.0	65.5	65.3	171
Mozambique	14 490	15 179	29 669	57.7	62.3	60.1	50.3	53.9	52.2	19
Myanmar	26 068	27 303	53 371	64.6	68.9	66.8	56.9	59.9	58.4	62
Namibia	1 233	1 301	2 534	61.1	66.1	63.7	53.8	57.9	55.9	403
Nauru	6	6	11	-	-	-	-	-	-	1 012
Nepal	14 226	15 079	29 305	68.8	71.6	70.2	60.5	62.1	61.3	45
Netherlands	8 476	8 560	17 036	80.0	83.2	81.6	71.3	72.8	72.1	4 742
New Zealand	2 314	2 392	4 706	80.5	84.0	82.2	71.8	73.9	72.8	3 745
Nicaragua	3 065	3 152	6 218	72.5	78.4	75.5	64.8	69.0	66.9	188
Niger	10 770	10 708	21 477	59.0	60.8	59.8	52.0	53.1	52.5	23
Nigeria	96 729	94 157	190 886	54.7	55.7	55.2	48.7	49.2	48.9	79
Niue	1	1	2	-	-	-	-	-	-	1 010
North Macedonia	1 041	1 042	2 083	-	-	-	-	-	-	328
Norway	2 677	2 629	5 305	80.6	84.3	82.5	71.8	74.3	73.0	7 478
Oman	3 053	1 584	4 636	75.3	79.5	77.0	64.0	67.7	65.6	648
Pakistan	101 199	95 817	197 016	65.7	67.4	66.5	57.6	57.9	57.7	40
Palau	11	11	22	-	-	-	-	-	-	1 674
Panama	2 054	2 045	4 099	75.0	81.2	78.0	67.2	71.8	69.4	1 041
Papua New Guinea	4 197	4 054	8 251	63.6	68.3	65.9	56.7	59.5	58.0	55
Paraguay	3 455	3 356	6 811	72.4	76.1	74.2	64.2	66.4	65.3	327
Peru	16 065	16 100	32 165	73.4	78.3	75.9	65.8	69.2	67.5	316
Philippines	52 801	52 117	104 918	66.2	72.6	69.3	59.4	64.2	61.7	129
Poland	18 434	19 737	38 171	73.8	81.6	77.7	65.4	71.7	68.5	809
Portugal	4 888	5 441	10 330	78.3	84.5	81.4	70.0	74.0	72.0	1 801
Qatar	1 981	658	2 639	77.3	79.9	78.1	68.4	68.4	68.6	1 827
Republic of Korea	25 510	25 472	50 982	79.5	85.6	82.7	70.7	75.1	73.0	2 044
Republic of Moldova	1 944	2 107	4 051	67.6	75.3	71.5	60.7	66.4	63.6	171
Romania	9 534	10 145	19 679	71.6	79.0	75.2	63.7	69.7	66.6	476
Russian Federation	66 917	77 072	143 990	66.4	77.2	72.0	59.1	67.5	63.5	469
Rwanda	5 987	6 222	12 208	66.1	69.9	68.0	58.8	61.0	59.9	48
Saint Kitts and Nevis	27	28	55	-	-	-	-	-	-	931
Saint Lucia	88	91	179	73.0	78.3	75.6	64.6	68.3	66.4	490
Saint Vincent and the Grenadines	55	54	110	69.4	74.9	72.0	61.5	65.6	63.4	250
Samoa	101	95	196	72.0	78.4	75.1	64.1	68.0	66.0	227
San Marino	16	17	33	-	-	-	-	-	-	3 013
Sao Tome and Principe	102	103	204	66.7	70.7	68.7	59.0	62.3	60.7	105
Saudi Arabia	18 798	14 140	32 938	73.5	76.5	74.8	65.5	65.8	65.7	1 147
Senegal	7 787	8 063	15 851	64.7	68.7	66.8	57.3	60.1	58.8	53
Serbia	4 295	4 495	8 791	73.8	78.9	76.3	65.4	69.4	67.4	494
Seychelles	47	48	95	69.0	78.0	73.3	62.2	69.5	65.7	597
Sierra Leone	3 743	3 815	7 557	52.5	53.8	53.1	47.2	48.1	47.6	86
Singapore	2 821	2 888	5 709	80.8	85.0	82.9	74.7	77.6	76.2	2 462
Slovakia	2 648	2 799	5 448	73.8	80.9	77.4	65.3	71.2	68.3	1 179
Slovenia	1 033	1 047	2 080	78.0	83.7	80.9	68.3	72.6	70.5	1 834
Solomon Islands	311	301	611	69.7	72.7	71.1	61.4	62.5	61.9	106
Somalia	7 344	7 399	14 743	53.7	57.3	55.4	48.8	51.3	50.0	-
South Africa	27 836	28 881	56 717	60.2	67.0	63.6	53.2	58.2	55.7	428
South Sudan	6 301	6 275	12 576	57.7	59.6	58.6	50.0	51.3	50.6	8
Spain	22 730	23 625	46 354	80.3	85.7	83.0	72.2	75.4	73.8	2 390
Sri Lanka	10 034	10 843	20 877	72.1	78.5	75.3	64.4	69.3	66.8	153
Sudan	20 257	20 276	40 533	63.4	66.9	65.1	54.7	56.8	55.7	152
Suriname	283	281	563	68.7	75.1	71.8	61.0	65.4	63.2	356
Sweden	4 960	4 951	9 911	80.6	84.1	82.3	71.5	73.4	72.4	5 711
Switzerland	4 199	4 277	8 476	81.2	85.2	83.3	72.4	74.5	73.5	9 836
Syrian Arab Republic	9 231	9 039	18 270	59.4	68.9	63.8	52.5	59.5	55.8	-
Tajikistan	4 481	4 441	8 921	68.7	73.0	70.8	61.7	65.3	63.5	56

Current health expenditure (CHE) as percentage of gross domestic product (GDP) [d] (%)	3.1 Maternal mortality ratio [e] (per 100 000 live births)	3.1 Proportion of births attended by skilled health personnel [f] (%)	3.2 Under-five mortality rate [g] (per 1000 live births)			Neonatal mortality rate [g] (per 1000 live births)	3.3 New HIV infections [h] (per 1000 uninfected population)			Member State
Comparable estimates	Comparable estimates	Primary data	Comparable estimates			Comparable estimates	Comparable estimates			
			Male	Female	Both sexes		Male	Female	Both sexes	
2016	2015	2009–2018	2017			2017	2017			
7.6	7	99	4	3	4	2	0.06	0.02	0.04	Montenegro
5.8	121	87 ai	26	21	23	14	0.04	0.02	0.03	Morocco
5.1	489	73	77	68	72	27	4.12	5.36	4.75	Mozambique
5.1	178	60 ah	53	44	49	24	0.29	0.13	0.21	Myanmar
9.1	265	88	48	40	44	18	3.07	3.90	3.49	Namibia
11.1	-	-	36	30	33	21	-	-	-	Nauru
6.3	258	58 ah	36	31	34	21	0.04	0.02	0.03	Nepal
10.4	7	-	4	4	4	2	0.05	0.01	0.03	Netherlands
9.2	11	96 ai	6	5	5	3	-	-	-	New Zealand
8.7	150	90 ai	19	15	17	7	0.09	0.04	0.07	Nicaragua
6.2	553	40	88	81	85	26	0.08	0.09	0.08	Niger
3.6	814	43	106	94	100	33	-	-	-	Nigeria
7.3	-	100 ah	24	19	22	11	-	-	-	Niue
6.3	8	100 ah	15	13	14	11	0.04	0.01	0.02	North Macedonia
10.5	5	99 ai	3	2	3	2	-	-	0.03	Norway
4.3	17	100 ah	12	10	11	5	-	-	-	Oman
2.8	178	69	78	71	75	44	0.14	0.06	0.10	Pakistan
11.7	-	100	17	14	15	8	-	-	-	Palau
7.3	94	94	18	14	16	9	0.57	0.24	0.40	Panama
2.0	215	-	58	49	53	24	0.33	0.42	0.37	Papua New Guinea
8.0	132	97 ai	23	19	21	11	0.28	0.12	0.20	Paraguay
5.1	68	93 ai	16	13	15	7	0.14	0.04	0.09	Peru
4.4	114	84	31	25	28	14	0.21	0.02	0.12	Philippines
6.5	3	100 ai	5	4	5	3	-	-	-	Poland
9.1	10	99 ai	4	3	4	2	0.12	0.03	0.07	Portugal
3.1	13	100	8	7	8	4	0.09	0.04	0.07	Qatar
7.3	11	100 ai	4	3	3	2	-	-	-	Republic of Korea
9.0	23	100 ah	17	14	16	12	0.45	0.19	0.32	Republic of Moldova
5.0	31	95 ah	9	7	8	4	0.05	0.02	0.03	Romania
5.3	25	100 ah	8	7	8	3	0.98	0.46	0.70	Russian Federation
6.8	290	91 ah	41	34	38	16	0.51	0.72	0.61	Rwanda
5.7	-	100 ai	15	13	14	9	-	-	-	Saint Kitts and Nevis
5.3	48	99 ai	18	15	17	12	-	-	-	Saint Lucia
3.6	45	99 ai	18	15	16	10	-	-	-	Saint Vincent and the Grenadines
5.5	51	83 ah	18	15	17	9	-	-	-	Samoa
6.4	-	-	2	2	2	1	-	-	-	San Marino
6.0	156	93 ah	36	29	32	14	-	-	-	Sao Tome and Principe
5.7	12	100 ah	8	7	7	4	-	-	-	Saudi Arabia
5.6	315	68	49	41	45	21	0.09	0.12	0.10	Senegal
9.1	17	100 ah	6	5	6	4	0.03	0.01	0.02	Serbia
3.9	-	99 ah	15	13	14	9	-	-	-	Seychelles
16.5	1 360	69	116	104	111	34	0.40	0.47	0.44	Sierra Leone
4.5	10	100 ai	3	3	3	1	0.14	0.02	0.08	Singapore
7.1	6	99 ah	6	5	6	3	0.03	0.01	0.02	Slovakia
8.5	9	100 ai	2	2	2	1	0.06	0.01	0.03	Slovenia
5.2	114	86 ah	23	19	21	9	-	-	-	Solomon Islands
-	732	-	133	121	127	39	0.03	0.04	0.03	Somalia
8.1	138	97	41	33	37	11	4.63	6.29	5.46	South Africa
3.2	789	19 ah	101	92	96	40	1.02	1.32	1.17	South Sudan
9.0	5	-	3	3	3	2	0.15	0.03	0.09	Spain
3.9	30	-	10	8	9	6	<0.01	<0.01	<0.01	Sri Lanka
5.7	311	78 ah	68	58	63	30	0.13	0.11	0.12	Sudan
6.1	155	80 ai	22	17	20	10	0.53	0.58	0.56	Suriname
10.9	4	-	3	3	3	2	-	-	-	Sweden
12.2	5	-	5	4	4	3	-	-	-	Switzerland
-	68	96 ah	19	16	17	9	-	-	-	Syrian Arab Republic
7.0	32	95	37	30	34	15	0.22	0.07	0.15	Tajikistan

Data Type	Total population [a] (000s) Comparable estimates			Life expectancy at birth [b,c] (years) Comparable estimates			Healthy life expectancy at birth [b,c] (years) Comparable estimates			Current health expenditure (CHE) per capita [d] (US$) Comparable estimates
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
Member State	**2017**			**2016**			**2016**			**2016**
Thailand	33 665	35 373	69 038	71.8	79.3	75.5	64.0	69.8	66.8	222
Timor-Leste	658	638	1 296	66.8	70.4	68.6	57.7	60.7	59.2	80
Togo	3 887	3 911	7 798	59.7	61.5	60.6	53.6	54.2	53.9	39
Tonga	54	54	108	70.5	76.4	73.4	62.6	66.0	64.3	203
Trinidad and Tobago	674	695	1 369	68.2	75.6	71.8	60.4	66.2	63.3	1 064
Tunisia	5 697	5 835	11 532	74.1	78.1	76.0	65.3	67.3	66.3	257
Turkey	39 767	40 978	80 745	73.3	79.4	76.4	64.4	67.6	66.0	469
Turkmenistan	2 835	2 923	5 758	64.7	71.7	68.2	58.7	64.1	61.4	423
Tuvalu	6	6	11	-	-	-	-	-	-	507
Uganda	21 321	21 542	42 863	60.2	64.8	62.5	52.9	56.9	54.9	38
Ukraine	20 446	23 777	44 223	67.6	77.1	72.5	60.3	67.6	64.0	141
United Arab Emirates	6 806	2 594	9 400	76.5	78.7	77.2	66.0	68.3	66.7	1 323
United Kingdom	32 655	33 527	66 182	79.7	83.2	81.4	70.9	72.9	71.9	3 958
United Republic of Tanzania	28 342	28 968	57 310	62.0	65.8	63.9	54.9	58.0	56.5	35
United States of America	160 593	163 866	324 459	76.1	81.1	78.6	66.9	70.1	68.5	9 870
Uruguay	1 670	1 787	3 457	73.2	80.8	77.4	65.8	71.2	68.8	1 379
Uzbekistan	15 907	16 003	31 911	69.7	75.0	72.3	62.9	66.2	64.5	135
Vanuatu	140	136	276	70.1	74.1	72.0	61.9	63.7	62.7	110
Venezuela (Bolivarian Republic of)	15 905	16 072	31 977	69.5	79.0	74.1	62.5	70.0	66.1	-
Viet Nam	47 278	48 262	95 541	71.7	80.9	76.3	64.2	70.7	67.5	123
Yemen	14 271	13 979	28 250	63.9	66.8	65.3	54.6	55.5	55.1	-
Zambia	8 482	8 612	17 094	60.2	64.4	62.3	52.6	56.0	54.3	57
Zimbabwe	8 051	8 479	16 530	59.6	63.1	61.4	52.7	55.9	54.4	94
WHO region										
African Region	522 534	524 616	1 047 149	59.6	62.7	61.2	52.6	54.9	53.8	103
Region of the Americas	495 283	506 026	1 001 309	73.8	79.8	76.8	65.5	69.6	67.5	1126
South-East Asia Region	1 007 688	960 775	1 968 462	67.9	71.3	69.5	59.5	61.3	60.4	96
European Region	446 024	473 434	919 458	74.2	80.8	77.5	66.1	70.7	68.4	1990
Eastern Mediterranean Region	349 135	327 829	676 964	67.7	70.7	69.1	59.1	60.4	59.7	556
Western Pacific Region	969 899	930 076	1 899 975	75.0	78.9	76.9	67.7	70	68.9	1358
Global	**3 790 563**	**3 722 756**	**7 513 317**	**69.8**	**74.2**	**72.0**	**62.0**	**64.8**	**63.3**	**1001**

	3.1		3.2				3.3		
Current health expenditure (CHE) as percentage of gross domestic product (GDP) [d] (%)	Maternal mortality ratio [e] (per 100 000 live births)	Proportion of births attended by skilled health personnel [f] (%)	Under-five mortality rate [g] (per 1000 live births)			Neonatal mortality rate [g] (per 1000 live births)	New HIV infections [h] (per 1000 uninfected population)		
Comparable estimates	Comparable estimates	Primary data	Comparable estimates			Comparable estimates	Comparable estimates		
			Male	Female	Both sexes		Male	Female	Both sexes
2016	2015	2009–2018	2017			2017	2017			Member State

2016	2015	2009–2018	Male	Female	Both sexes	2017	Male	Female	Both sexes	Member State
3.7	20	99 [ah]	11	9	**10**	5	-	-	-	Thailand
4.0	215	57 [ah]	52	44	48	21	-	-	-	Timor-Leste
6.6	**368**	**45**	79	67	73	25	**0.55**	**0.74**	**0.65**	Togo
5.3	124	96	14	18	16	7	-	-	-	Tonga
6.5	63	**100** [ai]	29	24	26	17	**0.34**	**0.14**	**0.24**	Trinidad and Tobago
7.0	62	74	14	12	13	8	**0.04**	**0.02**	**0.03**	Tunisia
4.3	**16**	**98** [ah]	**12**	**11**	**12**	6	-	-	-	Turkey
6.6	42	**100**	53	41	47	21	-	-	-	Turkmenistan
15.5	-	-	27	22	25	16	-	-	-	Tuvalu
6.2	**343**	**74**	**54**	**44**	**49**	**20**	**1.20**	**1.53**	**1.37**	Uganda
6.7	**24**	**100** [ah]	10	8	9	5	**0.36**	**0.22**	**0.29**	Ukraine
3.5	**6**	**100** [ah]	**10**	**8**	**9**	5	-	-	-	United Arab Emirates
9.8	**9**	-	**5**	**4**	**4**	3	-	-	-	United Kingdom
4.1	398	64 [ah]	**58**	**50**	**54**	21	**1.22**	**1.50**	**1.36**	United Republic of Tanzania
17.1	**14**	99	**7**	**6**	**7**	4	-	-	-	United States of America
9.1	**15**	**100** [ai]	**9**	**7**	**8**	5	**0.32**	**0.07**	**0.19**	Uruguay
6.3	36	**100** [ah]	26	19	**23**	12	**0.30**	**0.13**	**0.21**	Uzbekistan
3.7	78	89 [ah]	29	25	**27**	**12**	-	-	-	Vanuatu
3.2	95	95 [ai]	**34**	**27**	**31**	20	-	-	-	Venezuela (Bolivarian Republic of)
5.7	54	**94**	**24**	**17**	**21**	11	-	-	-	Viet Nam
-	385	45 [ah]	59	51	55	27	-	-	-	Yemen
4.5	**224**	**63**	65	55	60	22	**2.92**	**3.80**	**3.60**	Zambia
9.4	**443**	**78**	**55**	**45**	**50**	22	**2.82**	**3.33**	**3.08**	Zimbabwe

2016	2015	2009–2018	Male	Female	Both sexes	2017	Male	Female	Both sexes	WHO region
5.9	542	59	79	68	74	27	1.07	1.37	1.22	African Region
7.5	52	95	16	13	14	8	0.23	0.09	0.16	Region of the Americas
4.0	164	81	36	36	36	21	0.10	0.06	0.08	South-East Asia Region
8.0	16	99	10	8	9	5	0.24	0.11	0.18	European Region
5.3	166	79	53	47	50	27	0.09	0.04	0.06	Eastern Mediterranean Region
5.6	41	97	14	12	13	6	0.08	0.03	0.06	Western Pacific Region

2016	2015	2009–2018	Male	Female	Both sexes	2017	Male	Female	Both sexes	
6.6	216	81	41	37	39	18	0.26	0.24	0.25	**Global**

Member State	Tuberculosis incidence [i] (per 100 000 population)			Malaria incidence [j] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years [k] (%)	Reported number of people requiring interventions against NTDs [l]	Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70 [c,m] (%)		
	3.3 contd.						3.4		
Data Type	Comparable estimates			Comparable estimates	Comparable estimates	Primary data	Comparable estimates		
	Male	Female	Both sexes				Male	Female	Both sexes
	2017			2017	2015	2017	2016		
Afghanistan	179	199	189	23.0	0.50	13 547 677	31.8	27.7	29.8
Albania	25	14	20	-	1.29	6	20.7	13.1	17.0
Algeria	81	58	70	0.0	0.22	13 140	15.2	13.2	14.2
Andorra	2.0	1.0	1.5	-	0.08	0	-	-	-
Angola	455	265	359	155.0	4.85	14 739 913	17.2	16.0	16.5
Antigua and Barbuda	1.5	0.8	1.1	-	0.38	161	25.2	20.0	22.6
Argentina	31	22	26	0.0	0.01	1 122	19.7	12.2	15.8
Armenia	49	24	36	0.0	0.25	39 149	30.9	15.0	22.3
Australia	7.2	6.4	6.8	-	0.15	20 123	11.0	7.2	9.1
Austria	9.8	5.1	7.4	-	0.32	135	14.4	8.5	11.4
Azerbaijan	86	47	67	0.0	0.27	1 655 112	28.7	16.1	22.2
Bahamas	19	11	15	-	0.31	3 940	18.6	12.7	15.5
Bahrain	10	14	12	-	0.18	2	10.9	11.9	11.3
Bangladesh	285	156	221	1.9	1.38	56 339 392	22.6	20.4	21.6
Barbados	0.0	0.0	0.0	-	0.34	398	19.7	12.9	16.2
Belarus	55	20	37	-	0.20	0	35.2	13.8	23.7
Belgium	12	6.4	9.2	-	0.18	12	14.1	8.6	11.4
Belize	46	26	36	<0.1	1.49	6 903	25.5	18.5	22.1
Benin	72	44	58	367.9	5.55	5 909 521	19.9	19.3	19.6
Bhutan	160	104	134	<0.1	0.81	234 506	21.9	24.9	23.3
Bolivia (Plurinational State of)	134	88	111	1.3	0.20	1 773 280	17.7	16.8	17.2
Bosnia and Herzegovina	36	19	27	-	0.30	0	23.1	12.9	17.8
Botswana	375	226	300	2.0	0.19	241 157	23.4	17.9	20.3
Brazil	60	27	44	5.1	0.07	9 411 158	20.0	13.5	16.6
Brunei Darussalam	84	42	64	-	0.34	2	18.5	14.8	16.6
Bulgaria	34	16	25	-	0.31	218	32.0	15.5	23.6
Burkina Faso	61	37	49	412.0	4.29	6 531 262	22.5	21.2	21.7
Burundi	144	86	114	194.5	2.59	5 340 398	23.1	22.7	22.9
Cabo Verde	167	102	134	3.0	0.71	145 562	19.0	15.9	17.2
Cambodia	389	266	326	18.4	0.56	5 298 995	23.9	19.1	21.1
Cameroon	240	148	194	303.8	1.90	16 222 133	22.3	20.9	21.6
Canada	6.0	5.0	5.5	-	1.03	5	11.5	8.1	9.8
Central African Republic	530	320	423	387.3	6.62	3 765 243	23.9	22.4	23.1
Chad	191	117	154	188.6	3.08	6 222 557	24.2	23.7	23.9
Chile	22	13	17	-	0.28	15	14.8	10.1	12.4
China	83	42	63	0.0	0.83	26 376 326	19.8	14.1	17.0
Colombia	42	24	33	7.4	0.21	3 391 009	18.3	13.5	15.8
Comoros	43	27	35	4.0	1.96	828 148	24.8	21.2	22.9
Congo	465	288	376	197.6	4.11	1 784 187	15.9	17.4	16.7
Cook Islands	0.0	0.0	0.0	-	0.22	0	-	-	-
Costa Rica	12	7.0	9.7	<0.1	0.17	7 794	13.7	9.4	11.5
Côte d'Ivoire	181	114	148	138.9	3.04	20 479 536	28.2	30.1	29.1
Croatia	13	6.8	10	-	0.11	15	22.8	10.7	16.7
Cuba	9.1	5.2	7.1	-	0.12	40 866	19.0	13.8	16.4
Cyprus	6.6	3.6	5.1	-	0.60	4	15.2	7.5	11.3
Czechia	7.1	3.7	5.4	-	0.39	1	20.0	10.2	15.0
Democratic People's Republic of Korea	651	380	513	0.2	0.53	5 554 958	34.4	17.6	25.6
Democratic Republic of the Congo	400	244	322	307.6	1.43	55 563 632	19.7	19.2	19.4
Denmark	6.6	3.5	5.1	-	0.79	0	13.1	9.5	11.3
Djibouti	295	242	269	31.9	0.64	110 561	21.2	18.2	19.6
Dominica	2.0	1.1	1.6	-	0.39	6 920	-	-	-
Dominican Republic	57	33	45	0.1	0.34	2 805 557	21.7	16.5	19.0
Ecuador	59	27	43	2.6	0.32	1 848 654	13.9	12.2	13.0
Egypt	15	11	13	0.0	0.80	5 021 586	31.5	23.8	27.7
El Salvador	118	31	72	0.0	0.57	1 411 062	15.1	13.1	14.0
Equatorial Guinea	200	179	191	343.3	8.66	429 326	22.6	21.3	22.0

Suicide mortality rate [c,m] (per 100 000 population)			Total alcohol per capita (≥age 15 years) consumption [n] (litres of pure alcohol)			Road traffic mortality rate [o] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods [p] (%)	Adolescent birth rate [q] (per 1000 women aged 15–19 years)	
Comparable estimates			Comparable estimates			Comparable estimates	Primary data	Primary data	
Male	Female	Both sexes	Male	Female	Both sexes	2016	2009–2018	2009–2017	Member State
2016			2016						
7.6	1.5	4.7	0.4	0.0	0.2	15.1	42.2 [aj]	87.0	Afghanistan
7.9	4.7	6.3	12.5	2.6	7.5	13.6	4.9	18.9	Albania
4.7	1.7	3.2	1.7	0.2	0.9	-	77.2 [aj]	12.4	Algeria
-	-	-	18.0	4.7	11.3	-	-	3.1	Andorra
7.0	2.5	4.7	10.7	2.3	6.4	23.6	29.8	163.0	Angola
0.0	0.9	0.5	12.2	2.5	7.0	7.9	-	-	Antigua and Barbuda
15.1	3.5	9.2	16.1	4.0	9.8	14.0	-	65.5	Argentina
10.8	2.8	6.6	10.4	1.6	5.5	17.1	36.9 [aj]	24.1	Armenia
19.5	7.0	13.2	16.7	4.7	10.6	5.6	-	11.9	Australia
23.9	7.7	15.6	18.5	5.1	11.6	5.2	-	7.6	Austria
4.2	1.1	2.6	1.5	0.2	0.8	8.7	-	52.8	Azerbaijan
3.0	0.5	1.7	7.6	1.4	4.4	-	-	32.0	Bahamas
8.4	1.9	5.9	2.8	0.3	1.9	-	-	14.3	Bahrain
4.7	7.0	5.9	0.0	0.0	0.0	15.3	72.6 [aj]	78.0	Bangladesh
1.0	0.5	0.8	16.6	3.4	9.6	5.6	70.0 [aj]	-	Barbados
46.9	8.2	26.2	18.0	5.5	11.2	8.9	74.2 [aj]	16.1	Belarus
27.8	13.8	20.7	19.4	5.2	12.1	5.8	-	6.6	Belgium
7.9	1.6	4.7	11.4	2.2	6.8	28.3	65.9 [aj]	69.0	Belize
13.9	5.9	9.9	5.3	0.8	3.0	27.5	25.9 [aj]	94.0	Benin
14.0	8.5	11.4	0.9	0.1	0.6	17.4	84.6 [aj]	28.4	Bhutan
15.8	8.6	12.2	8.0	1.6	4.8	15.5	50.3 [aj]	71.0	Bolivia (Plurinational State of)
14.1	3.6	8.8	10.9	2.1	6.4	15.7	21.9 [aj]	10.7	Bosnia and Herzegovina
14.2	4.5	9.3	14.4	2.4	8.4	23.8	-	37.5	Botswana
10.0	3.1	6.5	13.4	2.4	7.8	19.7	-	60.8	Brazil
6.4	2.7	4.6	0.6	0.2	0.4	-	-	11.4	Brunei Darussalam
18.2	5.1	11.5	21.0	4.9	12.7	10.2	-	39.4	Bulgaria
10.2	5.3	7.7	14.2	2.4	8.2	30.5	56.4	122.0	Burkina Faso
13.4	4.9	9.1	13.0	2.2	7.5	34.7	38.0	58.0	Burundi
16.5	6.1	11.3	10.0	1.7	5.7	25.0	-	80.0	Cabo Verde
7.8	2.9	5.3	11.9	2.0	6.7	17.8	56.5	57.0	Cambodia
17.1	7.4	12.2	15.2	2.7	8.9	30.1	47.0	119.0	Cameroon
18.1	7.0	12.5	14.6	3.4	8.9	5.8	-	11.1	Canada
11.5	4.0	7.7	5.7	1.0	3.3	33.6	28.7 [aj]	229.0	Central African Republic
10.3	7.4	8.8	2.7	0.4	1.6	27.6	20.2	179.0	Chad
17.2	4.0	10.6	15.0	3.7	9.3	12.5	-	40.6	Chile
9.1	10.3	9.7	11.7	2.5	7.2	18.2	-	9.2	China
11.6	2.8	7.2	10.1	1.8	5.8	18.5	86.6	71.6	Colombia
9.9	3.6	6.8	1.6	0.2	0.9	26.5	28.8	70.0	Comoros
8.4	3.3	5.9	12.9	2.8	7.8	27.4	43.2	147.0	Congo
-	-	-	17.5	3.7	10.6	17.3	-	67.0	Cook Islands
13.5	2.4	7.9	8.2	1.4	4.8	16.7	89.1 [aj]	53.2	Costa Rica
20.6	8.3	14.5	14.0	2.4	8.4	23.6	39.4 [aj]	129.0	Côte d'Ivoire
25.6	7.9	16.5	15.1	3.3	8.9	8.1	-	9.6	Croatia
22.1	5.8	13.9	10.2	1.9	6.1	8.5	88.8	50.4	Cuba
8.2	2.3	5.3	17.1	4.2	10.8	5.1	-	4.9	Cyprus
21.4	5.1	13.1	23.2	6.2	14.4	5.9	-	11.6	Czechia
14.1	8.5	11.2	6.7	1.2	3.9	-	89.8 [aj]	-	Democratic People's Republic of Korea
8.4	2.9	5.7	4.4	0.8	2.6	33.7	18.9	138.0	Democratic Republic of the Congo
17.3	8.2	12.8	16.5	4.5	10.4	4.0	-	2.5	Denmark
9.0	4.3	6.7	0.9	0.1	0.5	-	-	20.6	Djibouti
-	-	-	13.8	2.7	8.2	10.9	-	-	Dominica
16.8	3.1	9.9	11.6	2.2	6.9	34.6	81.7	45.3	Dominican Republic
10.3	3.9	7.1	7.4	1.5	4.4	21.3	79.4	56.5	Ecuador
6.4	1.5	4.0	0.7	0.1	0.4	9.7	80.0 [aj]	56.0	Egypt
24.2	4.5	13.7	6.9	1.1	3.8	22.2	80.0	69.2	El Salvador
23.5	7.7	16.4	17.4	4.7	11.3	24.6	20.7 [aj]	176.0	Equatorial Guinea

PART 2

	3.3 contd.					3.4		
	Tuberculosis incidence [i] (per 100 000 population)			Malaria incidence [j] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years [k] (%)	Reported number of people requiring interventions against NTDs [l]	Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70 [c,m] (%)		
Data Type	Comparable estimates			Comparable estimates	Comparable estimates	Primary data	Comparable estimates		
	Male	Female	Both sexes				Male	Female	Both sexes
Member State	2017			2017	2015	2017	2016		
Eritrea	73	60	67	22.9	0.74	1 076 700	25.3	22.7	23.9
Estonia	21	9.9	15	-	0.36	9	25.0	10.3	17.0
Eswatini	360	259	308	1.9	0.85	261 261	29.8	24.4	26.7
Ethiopia	179	149	164	37.4	2.61	69 802 696	18.7	18.0	18.3
Fiji	66	32	49	-	0.34	911 449	36.8	24.0	30.6
Finland	6.4	3.4	4.9	-	1.05	5	13.3	7.2	10.2
France	12	6.4	9.0	-	0.01	321	14.1	7.2	10.6
Gabon	637	414	529	168.9	4.16	694 119	14.9	13.9	14.4
Gambia	253	97	174	56.7	1.17	160 763	21.9	18.9	20.4
Georgia	116	58	86	0.0	0.26	412 310	34.9	15.9	24.9
Germany	10	4.9	7.5	-	0.24	752	15.2	8.9	12.1
Ghana	179	125	152	270.7	3.61	16 388 663	18.2	23.2	20.8
Greece	5.9	3.1	4.5	-	0.37	41	17.3	7.7	12.4
Grenada	4.1	2.3	3.2	-	0.47	239	25.5	17.3	21.4
Guatemala	29	22	25	0.4	0.05	4 836 947	14.9	15.0	14.9
Guinea	209	143	176	336.7	7.47	7 620 187	21.8	22.9	22.4
Guinea-Bissau	470	281	374	58.0	2.12	1 348 965	20.2	19.9	20.0
Guyana	109	63	86	32.0	0.95	730 205	32.4	28.8	30.5
Haiti	205	159	181	3.3	2.04	6 052 962	28.2	25.0	26.5
Honduras	46	29	38	0.2	0.25	2 726 402	16.1	12.1	14.0
Hungary	10	5.2	7.7	-	0.44	31	31.1	15.6	23.0
Iceland	5.8	3.1	4.5	-	0.88	1	9.9	8.2	9.1
India	255	150	204	7.7	0.51	515 659 936	26.7	19.8	23.3
Indonesia	370	267	319	5.8	1.07	100 463 256	30.3	22.6	26.4
Iran (Islamic Republic of)	15	13	14	0.1	0.02	31	16.0	13.7	14.8
Iraq	40	44	42	0.0	0.06	2 170 486	24.6	18.3	21.3
Ireland	9.5	5.1	7.3	-	0.01	10	11.9	8.7	10.3
Israel	4.2	2.3	3.2	-	0.48	0	11.8	7.5	9.6
Italy	10	4.7	7.4	-	0.61	103	12.0	7.2	9.5
Jamaica	6.5	3.7	5.1	-	0.16	305 891	16.0	13.4	14.7
Japan	19	12	15	-	1.95	8	11.2	5.7	8.4
Jordan	7.4	6.2	6.8	-	1.01	155	22.8	15.6	19.2
Kazakhstan	82	51	66	0.0	0.21	1	36.8	18.5	26.8
Kenya	428	211	319	70.8	0.86	11 626 062	13.9	13.0	13.4
Kiribati	569	263	413	-	3.65	120 007	34.4	22.9	28.4
Kuwait	26	29	27	-	0.11	6	19.1	14.7	17.4
Kyrgyzstan	165	123	144	0.0	0.50	113 625	33.4	17.3	24.9
Lao People's Democratic Republic	227	109	168	5.8	1.94	1 953 002	29.3	24.9	27.0
Latvia	45	21	32	-	0.51	19	32.0	13.4	21.9
Lebanon	13	11	12	-	0.21	1	20.3	15.2	17.9
Lesotho	846	494	665	-	1.64	387 573	28.7	25.2	26.6
Liberia	379	236	308	192.6	7.75	2 590 621	17.5	17.7	17.6
Libya	46	34	40	-	0.27	2 834	24.4	15.9	20.1
Lithuania	76	29	50	-	0.19	57	30.6	12.4	20.7
Luxembourg	8.1	4.5	6.3	-	0.24	2	12.2	7.7	10.0
Madagascar	295	181	238	90.9	4.36	20 215 764	24.5	21.5	22.9
Malawi	152	110	131	231.1	3.03	11 771 796	18.8	14.5	16.4
Malaysia	111	73	93	0.1	0.17	83 042	20.1	14.0	17.2
Maldives	43	33	39	-	0.19	1 004	16.2	10.3	13.4
Mali	68	41	55	386.2	4.88	6 841 620	22.6	26.2	24.6
Malta	14	7.9	11	-	0.39	9	13.6	8.0	10.8
Marshall Islands	646	311	480	-	1.56	19 594	-	-	-
Mauritania	120	75	97	53.9	4.29	855 084	18.3	18.0	18.1
Mauritius	15	8.8	12	-	0.61	0	27.8	17.5	22.6
Mexico	27	17	22	0.3	0.04	28 886 412	17.4	14.1	15.7
Micronesia (Federated States of)	218	109	165	-	0.89	70 736	29.0	23.1	26.1

3.4			3.4			3.6	3.7	3.7	
Suicide mortality rate [c,m] (per 100 000 population)			Total alcohol per capita (≥age 15 years) consumption [n] (litres of pure alcohol)			Road traffic mortality rate [o] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods [p] (%)	Adolescent birth rate [q] (per 1000 women aged 15–19 years)	
Comparable estimates			Comparable estimates			Comparable estimates	Primary data	Primary data	
Male	Female	Both sexes	Male	Female	Both sexes	2016	2009–2018	2009–2017	Member State
2016			2016						
12.3	3.6	7.9	2.2	0.3	1.3	25.3	21.0	-	Eritrea
30.6	6.6	17.8	19.4	4.9	11.6	6.1	-	12.5	Estonia
19.5	7.5	13.3	17.3	2.9	9.9	26.9	82.9	87.0	Eswatini
11.2	3.1	7.2	5.0	0.8	2.9	26.7	62.3 [aj]	80.0	Ethiopia
7.5	2.4	5.0	5.2	0.7	3.0	9.6	-	40.0	Fiji
23.9	8.1	15.9	17.2	4.4	10.7	4.7	-	6.2	Finland
23.9	11.7	17.7	20.3	5.4	12.6	5.5	-	5.0	France
10.7	3.2	7.1	18.1	4.6	11.5	23.2	44.0	91.0	Gabon
6.6	3.7	5.1	6.6	1.1	3.8	29.7	26.7	88.0	Gambia
14.2	2.7	8.2	17.7	2.9	9.8	15.3	52.8 [aj]	43.6	Georgia
19.7	7.7	13.6	21.3	5.9	13.4	4.1	-	7.8	Germany
8.7	2.1	5.4	4.7	0.7	2.7	24.9	46.2 [aj]	59.0	Ghana
8.1	2.0	5.0	17.2	4.1	10.4	9.2	-	8.0	Greece
1.5	1.9	1.7	15.4	3.1	9.3	9.3	-	-	Grenada
3.7	1.8	2.7	4.3	0.7	2.5	16.6	66.1	92.0	Guatemala
7.5	5.0	6.3	2.2	0.3	1.3	28.2	21.5 [aj]	146.0	Guinea
4.7	3.3	4.0	8.3	1.3	4.8	31.1	55.7	106.0	Guinea-Bissau
43.7	14.4	29.2	10.6	1.9	6.3	24.6	51.5	74.0	Guyana
17.0	6.5	11.7	10.0	1.8	5.8	-	43.1	55.0	Haiti
4.4	1.5	2.9	6.9	1.2	4.0	16.7	76.0	103.0	Honduras
29.7	9.6	19.1	19.1	4.5	11.4	7.8	-	22.8	Hungary
22.3	5.6	14.0	14.5	3.8	9.1	6.6	-	8.0	Iceland
17.8	14.7	16.3	9.4	1.7	5.7	22.6	67.2	28.1	India
4.8	2.0	3.4	1.4	0.2	0.8	12.2	77.6	40.1	Indonesia
5.0	3.1	4.1	1.9	0.1	1.0	20.5	68.6 [aj]	37.9	Iran (Islamic Republic of)
3.4	2.6	3.0	0.7	0.1	0.4	20.7	54.6 [aj]	82.0	Iraq
18.5	4.6	11.5	20.4	5.8	13.0	4.1	-	8.7	Ireland
8.1	2.7	5.4	6.4	1.4	3.8	4.2	-	9.7	Israel
12.1	4.5	8.2	12.5	2.8	7.5	5.6	-	5.1	Italy
3.3	1.0	2.2	7.1	1.2	4.2	13.6	79.2 [aj]	45.7	Jamaica
26.0	11.4	18.5	13.5	2.9	8.0	4.1	-	4.1	Japan
3.6	2.2	2.9	1.3	0.2	0.7	24.4	56.7 [aj]	26.0	Jordan
38.3	7.6	22.5	13.6	2.4	7.7	17.6	79.4 [aj]	36.0	Kazakhstan
5.1	1.2	3.2	5.8	0.9	3.4	27.8	76.0	96.0	Kenya
24.1	5.0	14.4	0.8	0.1	0.4	4.4	35.8 [aj]	49.9	Kiribati
2.8	1.7	2.3	0.0	0.0	0.0	17.6	-	6.1	Kuwait
13.2	3.5	8.3	11.0	1.7	6.2	15.4	66.2	38.1	Kyrgyzstan
11.4	5.7	8.6	17.6	3.3	10.4	16.6	71.6 [aj]	75.6	Lao People's Democratic Republic
37.6	7.3	21.2	21.7	5.7	12.9	9.3	-	18.0	Latvia
4.2	2.4	3.3	2.7	0.3	1.5	18.1	-	-	Lebanon
17.8	24.4	21.2	8.9	1.3	5.0	28.9	78.9	94.0	Lesotho
7.1	6.6	6.8	9.9	1.6	5.8	35.9	41.4	104.8	Liberia
8.1	2.2	5.2	0.1	0.0	0.0	26.1	24.0 [aj]	10.9	Libya
58.1	9.5	31.9	24.9	6.9	15.0	8.0	-	14.1	Lithuania
18.6	8.3	13.5	19.7	6.3	13.0	6.3	-	5.6	Luxembourg
5.6	2.2	3.9	3.4	0.5	1.9	28.6	60.5 [aj]	152.0	Madagascar
5.8	1.6	3.7	6.4	1.0	3.7	31.0	73.9	136.0	Malawi
7.8	3.2	5.5	1.6	0.3	0.9	23.6	-	11.5	Malaysia
3.0	1.3	2.3	4.8	0.6	2.7	0.9	42.5 [aj]	12.9	Maldives
6.9	2.7	4.8	2.2	0.3	1.3	23.1	35.0	174.0	Mali
12.1	2.8	7.5	13.2	2.9	8.1	6.1	-	11.4	Malta
-	-	-	-	-	-	-	-	84.5	Marshall Islands
6.6	2.2	4.4	0.1	0.0	0.0	24.7	30.4 [aj]	77.0	Mauritania
13.3	2.4	7.8	6.3	1.0	3.6	13.7	40.8 [aj]	24.1	Mauritius
8.0	2.3	5.1	11.1	2.1	6.5	13.1	79.8	66.2	Mexico
15.8	6.3	11.1	4.2	0.6	2.5	1.9	-	44.0	Micronesia (Federated States of)

Member State	Tuberculosis incidence [i] (per 100 000 population) Comparable estimates			Malaria incidence [j] (per 1000 population at risk) Comparable estimates	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years [k] (%) Comparable estimates	Reported number of people requiring interventions against NTDs [l] Primary data	Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70 [c,m] (%) Comparable estimates		
Data Type	Male	Female	Both sexes				Male	Female	Both sexes
	2017			2017	2015	2017	2016		
Monaco	0.0	0.0	0.0	-	0.20	0	-	-	-
Mongolia	483	374	428	-	1.72	17	38.8	21.9	30.2
Montenegro	18	9.5	14	-	0.65	4	26.4	14.9	20.6
Morocco	120	79	99	0.0	0.45	6 926	13.3	11.3	12.4
Mozambique	700	409	551	337.9	3.67	23 455 304	19.6	17.4	18.4
Myanmar	471	250	358	3.7	2.03	37 482 212	27.3	21.5	24.2
Namibia	509	342	423	44.6	0.66	1 103 903	24.7	18.7	21.3
Nauru	123	59	91	-	2.11	2 844	-	-	-
Nepal	207	101	152	0.5	0.31	16 062 081	24.8	19.2	21.8
Netherlands	6.8	3.7	5.2	-	0.04	41	12.7	9.7	11.2
New Zealand	10	4.7	7.5	-	1.20	3	11.6	8.6	10.1
Nicaragua	55	36	45	5.1	0.14	1 614 121	14.8	13.7	14.2
Niger	111	68	90	358.6	6.01	14 068 652	20.1	19.8	20.0
Nigeria	277	159	219	281.1	2.61	133 972 720	20.9	23.9	22.5
Niue	95	47	71	-	0.24	0	-	-	-
North Macedonia	17	9.1	13	-	0.20	9	25.3	15.4	20.3
Norway	6.6	3.6	5.1	-	0.01	40	10.7	7.7	9.2
Oman	5.6	8.8	6.7	0.0	0.44	1	19.4	15.5	17.8
Pakistan	288	244	267	4.9	2.75	31 683 212	26.6	22.6	24.7
Palau	142	69	106	-	0.21	0	-	-	-
Panama	73	36	54	0.2	0.22	436 029	15.4	10.8	13.0
Papua New Guinea	548	312	432	181.9	2.24	6 546 649	33.6	26.6	30.0
Paraguay	59	27	44	0.0	0.65	1 974 853	18.7	16.3	17.5
Peru	141	91	116	5.6	0.24	2 679 217	14.1	11.2	12.6
Philippines	773	332	554	0.3	1.07	49 143 288	32.8	21.0	26.8
Poland	24	10	17	-	0.04	104	25.3	12.4	18.7
Portugal	26	14	20	-	0.10	13	15.5	7.0	11.1
Qatar	19	47	26	-	0.20	21	16.0	13.7	15.3
Republic of Korea	83	58	70	0.1	0.69	3	10.9	4.7	7.8
Republic of Moldova	142	52	95	-	0.65	0	33.7	17.3	24.9
Romania	100	45	72	-	0.65	22	29.3	13.9	21.4
Russian Federation	90	34	60	-	0.88	3	36.5	16.1	25.4
Rwanda	76	40	57	505.6	1.74	5 328 513	19.6	17.0	18.2
Saint Kitts and Nevis	2.7	1.5	2.1	-	0.38	10	-	-	-
Saint Lucia	10	5.5	7.7	-	0.39	23 465	20.7	16.9	18.8
Saint Vincent and the Grenadines	2.6	1.5	2.1	-	0.42	5	27.1	19.1	23.2
Samoa	23	12	18	-	1.05	61 325	26.1	14.7	20.6
San Marino	0.0	0.0	0.0	-	0.32	0	-	-	-
Sao Tome and Principe	147	89	118	11.0	1.36	192 800	18.7	18.6	18.5
Saudi Arabia	12	7.2	10	0.1	0.30	1 021	17.8	14.2	16.4
Senegal	154	91	122	64.6	3.48	12 005 592	19.2	17.2	18.1
Serbia	22	16	19	-	0.11	0	24.6	13.7	19.1
Seychelles	24	15	19	-	0.15	0	28.7	13.2	21.2
Sierra Leone	359	244	301	379.7	8.18	7 000 858	28.2	32.6	30.5
Singapore	57	37	47	-	0.47	2 695	11.8	6.9	9.3
Slovakia	6.4	3.3	4.8	-	0.56	9	23.6	11.2	17.2
Slovenia	8.1	4.3	6.2	-	1.04	12	16.4	8.9	12.7
Solomon Islands	102	50	76	171.0	2.93	530 022	26.1	21.4	23.8
Somalia	313	219	266	36.7	10.54	2 532 411	21.7	22.0	21.8
South Africa	671	466	567	4.0	1.74	19 334 622	32.3	21.2	26.2
South Sudan	181	111	146	141.7	21.13	9 500 223	20.0	19.5	19.8
Spain	14	7.9	11	-	0.19	316	13.6	6.4	9.9
Sri Lanka	86	44	64	0.0	0.64	187 588	22.1	13.2	17.4
Sudan	90	63	77	37.4	2.86	11 031 353	27.8	24.3	26.0
Suriname	36	21	29	0.5	0.36	54 467	26.4	17.2	21.7
Sweden	7.3	4.0	5.7	-	0.32	140	10.7	7.6	9.1

PART 2

3.4			3.4			3.6	3.7	3.7	
Suicide mortality rate [c,m] (per 100 000 population)			Total alcohol per capita (≥age 15 years) consumption [n] (litres of pure alcohol)			Road traffic mortality rate [o] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods [p] (%)	Adolescent birth rate [q] (per 1000 women aged 15–19 years)	
Comparable estimates			Comparable estimates			Comparable estimates	Primary data	Primary data	
Male	Female	Both sexes	Male	Female	Both sexes	2016	2009–2018	2009–2017	Member State
-	-	-	-	-	-	-	-	-	Monaco
22.6	3.5	13.0	12.8	2.1	7.4	16.5	65.2	26.7	Mongolia
15.4	5.3	10.3	13.5	2.8	8.0	10.7	42.8	11.1	Montenegro
2.3	3.4	2.9	1.1	0.1	0.6	19.6	68.6 [aj]	-	Morocco
7.4	2.5	4.9	4.3	0.7	2.4	30.1	55.5	167.0	Mozambique
5.9	9.5	7.8	8.5	1.3	4.8	19.9	74.9	36.0	Myanmar
14.1	3.6	8.7	17.3	2.9	9.8	30.4	80.4	82.0	Namibia
-	-	-	10.5	1.6	6.0	-	-	94.0	Nauru
9.7	7.9	8.8	3.6	0.6	2.0	15.9	56.0 [aj]	88.0	Nepal
16.2	9.0	12.6	13.9	3.6	8.7	3.8	-	3.2	Netherlands
17.9	6.6	12.1	17.2	4.6	10.7	7.8	-	16.0	New Zealand
19.3	5.3	12.2	9.1	1.5	5.2	-	92.6 [aj]	92.0	Nicaragua
5.9	3.3	4.6	0.9	0.1	0.5	26.2	45.5 [aj]	146.0	Niger
9.9	9.2	9.5	21.9	4.6	13.4	21.4	42.8	145.0	Nigeria
-	-	-	12.0	2.1	7.0	-	-	20.0	Niue
11.9	3.9	7.9	13.5	2.8	8.1	6.4	22.3 [aj]	16.2	North Macedonia
15.9	8.4	12.2	11.6	3.2	7.5	2.7	-	4.6	Norway
5.6	0.8	3.9	1.0	0.1	0.8	16.1	39.6 [aj]	13.5	Oman
2.7	3.0	2.9	0.6	0.1	0.3	14.3	48.5 [aj, ak]	44.0	Pakistan
-	-	-	-	-	-	-	-	27.0	Palau
7.4	1.2	4.3	13.2	2.6	7.9	14.3	73.3	78.8	Panama
8.6	3.3	6.0	2.1	0.3	1.2	14.2	-	-	Papua New Guinea
12.4	6.5	9.5	12.2	2.1	7.2	22.7	78.9	-	Paraguay
7.2	2.7	4.9	10.5	2.2	6.3	13.5	66.6 [aj]	49.4	Peru
4.3	2.0	3.2	11.3	1.9	6.6	12.3	52.5	47.0	Philippines
28.9	4.3	16.2	19.2	4.7	11.6	9.7	-	12.3	Poland
22.2	6.5	14.0	20.5	5.1	12.3	7.4	-	8.2	Portugal
8.5	0.9	6.6	2.5	0.4	2.0	9.3	68.9 [aj]	10.5	Qatar
38.4	15.4	26.9	16.7	3.9	10.2	9.8	-	1.3	Republic of Korea
27.9	4.7	15.9	25.2	6.1	15.2	9.7	60.4 [aj]	26.7	Republic of Moldova
17.9	3.3	10.4	21.0	5.0	12.7	10.3	-	35.3	Romania
55.9	9.4	31.0	18.7	5.8	11.7	18.0	72.4 [aj]	24.0	Russian Federation
9.7	3.8	6.7	16.0	2.9	9.0	29.7	62.9	45.0	Rwanda
-	-	-	15.5	3.4	9.4	-	-	-	Saint Kitts and Nevis
13.5	2.2	7.8	16.7	3.4	9.9	35.4	72.4 [aj]	-	Saint Lucia
3.9	0.9	2.4	13.7	2.7	8.2	-	-	63.7	Saint Vincent and the Grenadines
6.7	1.9	4.4	4.3	0.6	2.5	11.3	39.4 [aj]	39.2	Samoa
-	-	-	-	-	-	0.0	-	0.0	San Marino
3.0	1.6	2.3	11.8	2.0	6.8	27.5	52.2	92.0	Sao Tome and Principe
4.5	1.5	3.2	0.3	0.1	0.2	28.8	-	-	Saudi Arabia
9.3	2.9	6.0	1.3	0.2	0.7	23.4	50.9	80.0	Senegal
23.5	8.1	15.6	18.5	4.1	11.1	7.4	38.7	16.4	Serbia
16.4	2.4	9.3	19.7	4.1	12.0	15.9	-	65.8	Seychelles
11.3	8.1	9.7	9.8	1.6	5.7	-	44.7 [aj]	125.0	Sierra Leone
13.8	6.1	9.9	3.3	0.8	2.0	2.8	-	2.7	Singapore
22.7	3.5	12.8	18.9	4.6	11.5	6.1	-	24.3	Slovakia
30.4	6.9	18.6	20.4	5.1	12.6	6.4	-	4.5	Slovenia
6.8	2.6	4.7	2.5	0.3	1.4	17.4	38.0 [aj]	78.0	Solomon Islands
6.3	3.1	4.7	0.0	0.0	0.0	27.1	-	64.0	Somalia
18.7	4.7	11.6	16.2	2.7	9.3	25.9	77.9 [aj]	71.0	South Africa
4.9	2.6	3.7	-	-	-	29.9	5.6 [aj]	-	South Sudan
13.1	4.5	8.7	16.4	4.0	10.0	4.1	-	7.7	Spain
23.5	6.4	14.6	7.7	1.2	4.3	14.9	74.3 [aj]	-	Sri Lanka
12.2	4.0	8.1	0.9	0.1	0.5	25.7	30.1 [aj]	87.0	Sudan
34.7	10.9	22.8	8.7	1.6	5.1	14.5	73.2 [aj]	57.7	Suriname
19.1	10.5	14.8	14.6	3.8	9.2	2.8	-	4.5	Sweden

ANNEX 2
Part 2

	3.3 contd.						3.4		
	Tuberculosis incidence [i] (per 100 000 population)			Malaria incidence [j] (per 1000 population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years [k] (%)	Reported number of people requiring interventions against NTDs [l]	Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70 [c,m] (%)		
Data Type	Comparable estimates			Comparable estimates	Comparable estimates	Primary data	Comparable estimates		
	Male	Female	Both sexes				Male	Female	Both sexes
Member State	2017			2017	2015	2017	2016		
Switzerland	9.4	5.0	7.2	-	0.17	0	10.6	6.6	8.6
Syrian Arab Republic	22	16	19	0.0	0.37	1 925 000	24.9	18.7	21.8
Tajikistan	92	77	85	0.0	0.71	2 844 918	28.6	22.0	25.3
Thailand	211	105	156	0.8	0.17	53 368	18.3	11.0	14.5
Timor-Leste	597	396	498	0.1	0.87	1 279 948	21.7	18.0	19.9
Togo	51	31	41	370.9	3.36	5 376 102	24.1	23.1	23.6
Tonga	16	7.6	12	-	2.35	37 131	29.7	17.5	23.3
Trinidad and Tobago	22	12	17	-	0.43	18 226	24.6	18.0	21.3
Tunisia	33	34	34	-	0.76	4 800	20.2	12.2	16.1
Turkey	19	14	17	0.0	0.32	0	21.5	11.3	16.1
Turkmenistan	50	35	43	0.0	0.23	182	36.7	22.9	29.5
Tuvalu	315	155	236	-	0.70	10 782	-	-	-
Uganda	288	114	201	200.7	3.16	22 879 140	23.8	20.3	21.9
Ukraine	121	51	84	-	0.46	0	35.1	16.2	24.7
United Arab Emirates	0.6	1.3	0.8	0.0	0.08	0	17.3	15.5	16.8
United Kingdom	10	7.5	8.9	-	0.22	473	12.9	9.0	10.9
United Republic of Tanzania	368	173	269	113.0	1.69	26 709 404	18.5	17.4	17.9
United States of America	3.8	2.4	3.1	-	0.04	539	17.5	11.8	14.6
Uruguay	41	22	31	-	0.35	5	21.4	12.5	16.7
Uzbekistan	81	65	73	0.0	0.60	405 951	29.7	19.6	24.5
Vanuatu	68	33	51	8.2	8.48	277 708	27.2	19.2	23.3
Venezuela (Bolivarian Republic of)	55	29	42	47.6	0.62	4 454 888	21.8	14.5	18.1
Viet Nam	184	76	129	0.1	1.20	6 953 978	23.4	11.5	17.1
Yemen	47	49	48	41.9	2.54	7 342 169	33.2	28.2	30.6
Zambia	446	276	361	203.3	1.84	12 635 340	18.5	17.4	17.9
Zimbabwe	264	181	221	95.2	4.38	10 660 813	18.7	19.8	19.3

WHO region

African Region	294	179	237	219.4	2.34	594	21.1	20.1	20.6
Region of the Americas	36	20	28	7.3	0.07	76	17.8	12.6	15.1
South-East Asia Region	279	169	226	7.1	0.26	733	26.5	19.6	23.1
European Region	40	20	30	0.0	0.21	5	22.2	11.6	16.7
Eastern Mediterranean Region	121	105	113	14.8	0.69	75	24.1	19.8	22.0
Western Pacific Region	126	62	95	2.5	0.38	98	19.3	13.1	16.2

Global	168	99	134	59.1	0.80	1 583	21.6	15.0	18.3

3.4			3.4			3.6	3.7	3.7	
Suicide mortality rate [c,m] (per 100 000 population)			Total alcohol per capita (≥age 15 years) consumption [n] (litres of pure alcohol)			Road traffic mortality rate [o] (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods [p] (%)	Adolescent birth rate [q] (per 1000 women aged 15–19 years)	
Comparable estimates			Comparable estimates			Comparable estimates	Primary data	Primary data	
Male	Female	Both sexes	Male	Female	Both sexes				
2016			2016			2016	2009–2018	2009–2017	Member State
22.0	12.4	17.2	18.1	5.1	11.5	2.7	-	5.5	Switzerland
2.9	0.9	1.9	0.6	0.1	0.3	26.5	53.3 [aj]	54.0	Syrian Arab Republic
3.7	1.3	2.5	5.7	0.8	3.3	18.1	44.8 [aj]	54.0	Tajikistan
23.4	5.9	14.4	14.3	2.5	8.3	32.7	89.2 [aj]	42.5	Thailand
6.2	2.9	4.6	3.5	0.5	2.1	12.7	37.4	50.0	Timor-Leste
12.8	6.4	9.6	5.4	0.9	3.1	29.2	37.4	85.0	Togo
4.3	2.7	3.5	2.7	0.4	1.5	16.8	47.9 [aj]	30.0	Tonga
23.0	4.5	13.6	13.9	3.1	8.4	12.1	58.2 [aj]	38.0	Trinidad and Tobago
4.4	2.3	3.4	3.6	0.2	1.9	22.8	73.2 [aj]	6.9	Tunisia
11.4	3.3	7.3	3.7	0.4	2.0	12.3	59.7 [aj]	26.9	Turkey
10.1	3.5	6.7	9.5	1.5	5.4	14.5	75.6 [aj]	28.0	Turkmenistan
-	-	-	3.1	0.4	1.7	-	-	28.0	Tuvalu
10.7	9.1	9.9	16.1	3.0	9.5	29.0	53.5 [aj]	141.0	Uganda
41.1	6.3	22.4	14.1	4.0	8.6	13.7	68.0 [aj]	26.1	Ukraine
3.6	0.7	2.8	4.8	0.6	3.8	18.1	-	34.2	United Arab Emirates
13.5	4.4	8.9	18.4	4.8	11.5	3.1	-	13.7	United Kingdom
7.7	3.2	5.4	16.0	2.9	9.4	29.2	54.0	132.0	United Republic of Tanzania
23.6	7.2	15.3	15.8	4.1	9.8	12.4	77.2 [aj]	20.3	United States of America
29.2	8.3	18.4	17.8	4.5	10.8	13.4	-	51.3	Uruguay
9.9	4.8	7.4	4.8	0.7	2.7	11.5	-	29.5	Uzbekistan
6.6	2.2	4.5	1.8	0.2	1.0	15.9	50.7 [aj]	78.0	Vanuatu
6.3	1.1	3.7	9.7	1.7	5.6	33.7	-	94.5	Venezuela (Bolivarian Republic of)
10.9	3.7	7.3	14.5	2.5	8.4	26.4	69.6	30.1	Viet Nam
11.3	5.6	8.5	0.1	0.0	0.1	-	37.7 [aj]	67.0	Yemen
8.8	3.5	6.1	8.4	1.4	4.8	-	62.4	141.0	Zambia
15.7	6.0	10.7	8.5	1.3	4.8	34.7	84.8	110.0	Zimbabwe
									WHO region
9.9	4.9	7.4	10.3	2.4	6.3	26.6	55.7	99.1	African Region
15.1	4.6	9.8	12.4	3.6	8.0	15.6	82.8	48.6	Region of the Americas
14.8	11.6	13.2	7.5	1.6	4.5	20.7	71.4	33.0	South-East Asia Region
24.8	6.6	15.4	15.8	4.5	9.8	9.3	76.7	16.6	European Region
5.1	2.7	3.9	0.9	0.1	0.6	18.0	60.8	44.5	Eastern Mediterranean Region
10.9	9.4	10.2	11.3	3.2	7.3	16.9	87.2	14.2	Western Pacific Region
13.5	7.7	10.6	10.1	2.7	6.4	18.2	75.7	43.9	**Global**

	3.8			3.9					
	UHC service coverage index [r]	Population with household expenditures on health >10% of total household expenditure or income [s] (%)	Population with household expenditures on health >25% of total household expenditure or income [s] (%)	Age-standardized mortality rate attributed to household and ambient air pollution [c,t] (per 100 000 population)			Mortality rate attributed to exposure to unsafe Water, Sanitation and Hygiene (WASH) services [c,t] (per 100 000 population)		
Data Type	Comparable estimates	Primary data	Primary data	Comparable estimates			Comparable estimates		
				Male	Female	Both sexes	Male	Female	Both sexes
Member State	2015	2009–2015	2009–2015	2016			2016		
Afghanistan	34	-	-	228.7	194.7	211.1	12.6	15.3	13.9
Albania	62	16.7	5.0	82.4	54.7	68.0	0.2	0.1	0.2
Algeria	76	-	-	55.2	44.3	49.7	1.7	2.0	1.9
Andorra	-	-	-	-	-	-	-	-	-
Angola	36	-	-	120.2	116.9	118.5	52.6	45.2	48.8
Antigua and Barbuda	75	-	-	37.2	24.1	29.9	0.1	0.1	0.1
Argentina	76	-	-	35.8	19.9	26.6	0.3	0.4	0.4
Armenia	67	16.1	4.9	77.5	38.1	54.8	0.2	0.2	0.2
Australia	≥80	3.7	0.5	10.2	6.7	8.4	0.1	0.1	0.1
Austria	≥80	-	-	19.4	11.8	15.3	0.1	0.2	0.1
Azerbaijan	64	-	-	80.0	51.1	63.9	1.3	1.0	1.1
Bahamas	72	-	-	25.7	15.2	19.9	0.1	0.1	0.1
Bahrain	72	-	-	44.6	34.9	40.1	<0.1	<0.1	<0.1
Bangladesh	46	13.6	4.8	161.3	136.8	149.0	10.1	13.8	11.9
Barbados	79	-	-	38.9	24.9	31.1	0.1	0.2	0.2
Belarus	74	4.4	0.2	93.6	39.6	60.7	0.1	0.1	0.1
Belgium	≥80	11.5	1.4	20.6	11.6	15.7	0.2	0.4	0.3
Belize	61	-	-	82.5	54.7	68.6	1.0	0.9	1.0
Benin	41	-	-	219.5	193.2	205.0	65.1	54.4	59.7
Bhutan	59	-	-	119.9	130.3	124.7	3.4	4.6	3.9
Bolivia (Plurinational State of)	60	-	-	72.4	55.9	63.7	6.2	4.9	5.6
Bosnia and Herzegovina	57	8.6	1.3	100.8	62.1	79.8	0.1	0.1	0.1
Botswana	60	-	-	120.4	88.0	101.3	11.2	12.3	11.8
Brazil	77	-	-	37.2	24.1	29.9	1.0	1.1	1.0
Brunei Darussalam	≥80	-	-	15.3	11.4	13.3	<0.1	<0.1	<0.1
Bulgaria	64	12.8	0.8	82.0	45.1	61.8	0.1	0.1	0.1
Burkina Faso	39	3.5	0.6	222.8	194.0	206.2	45.5	53.7	49.6
Burundi	43	-	-	186.8	173.1	179.9	64.0	66.8	65.4
Cabo Verde	62	-	-	120.4	85.2	99.5	4.3	4.0	4.1
Cambodia	55	20.0	5.6	163.9	139.5	149.8	6.6	6.3	6.5
Cameroon	44	10.8	3.0	228.3	189.7	208.1	46.2	44.1	45.2
Canada	≥80	2.6	0.5	8.7	5.4	7.0	0.3	0.4	0.4
Central African Republic	33	-	-	220.6	203.5	211.9	89.7	74.7	82.1
Chad	29	-	-	300.5	261.5	280.1	107.0	95.0	101.0
Chile	70	-	-	32.8	19.3	25.3	0.2	0.2	0.2
China	76	-	-	126.1	100.3	112.7	0.5	0.7	0.6
Colombia	76	16.9	2.8	45.4	30.0	37.0	0.7	0.8	0.8
Comoros	47	-	-	192.5	154.4	172.4	51.1	50.3	50.7
Congo	38	2.0	0.4	121.8	138.0	130.7	43.5	33.9	38.7
Cook Islands	-	-	-	-	-	-	-	-	-
Costa Rica	75	10.1	1.8	28.6	18.4	23.3	0.7	1.0	0.9
Côte d'Ivoire	44	-	-	278.9	258.5	269.1	49.5	44.7	47.2
Croatia	69	2.8	0.3	48.4	25.2	35.5	0.1	0.1	0.1
Cuba	78	-	-	57.7	42.1	49.5	1.0	1.0	1.0
Cyprus	73	16.1	1.5	28.0	13.2	20.1	0.3	0.3	0.3
Czechia	73	2.2	0.1	39.6	21.5	29.6	0.1	0.2	0.2
Democratic People's Republic of Korea	68	-	-	287.5	158.5	207.2	1.6	1.1	1.4
Democratic Republic of the Congo	40	-	-	159.7	166.0	163.9	69.8	49.8	59.8
Denmark	≥80	2.9	0.5	15.8	10.9	13.2	0.2	0.4	0.3
Djibouti	47	-	-	176.8	142.8	159.0	29.4	33.2	31.3
Dominica	-	-	-	-	-	-	-	-	-
Dominican Republic	74	-	-	50.0	36.3	43.0	2.2	2.2	2.2
Ecuador	75	-	-	28.8	20.7	24.5	0.6	0.7	0.6
Egypt	68	26.2	3.9	130.4	90.4	108.9	1.8	2.2	2.0
El Salvador	77	-	-	50.8	34.9	41.9	2.4	1.6	2.0
Equatorial Guinea	45	-	-	180.9	174.2	177.7	21.0	23.9	22.3

Mortality rate from unintentional poisoning ^{c,m} (per 100 000 population)			Age-standardized prevalence of tobacco smoking among persons aged 15 years and older ^u (%)			Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds ^v (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age ^v (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year olds ^v (%)	Total net official development assistance to medical research and basic health sectors per capita ^w (US$), by recipient country	Member State
Comparable estimates			Comparable estimates			Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
Male	Female	Both sexes	Males	Females	Both sexes					
2016			2016			2017	2017	2017	2017	
0.5	1.9	1.2	-	-	-	65	39	65	5.70	Afghanistan
0.5	0.4	0.4	51.2	7.1	29.2	99	98	99	0.78	Albania
0.9	0.6	0.8	30.4	0.7	15.6	91	92	89	0.01	Algeria
-	-	-	37.8	29.0	33.4	99	94	98	-	Andorra
3.4	2.0	2.7	-	-	-	52	30	59	2.09	Angola
0.3	0.4	0.4	-	-	-	95	68	-	0.41	Antigua and Barbuda
0.8	0.5	0.6	27.7	16.2	22.0	86	89	76	0.03	Argentina
0.9	0.4	0.6	52.1	1.5	26.8	94	97	94	2.12	Armenia
0.2	0.2	0.2	16.5	13.0	14.8	95	93	94	-	Australia
0.3	0.2	0.2	30.9	28.4	29.7	90	84	-	-	Austria
0.8	0.3	0.6	42.5	0.3	21.4	95	97	96	0.85	Azerbaijan
0.2	0.1	0.1	20.4	3.1	11.8	94	76	93	-	Bahamas
0.3	0.1	0.2	37.6	5.8	21.7	97	99	97	-	Bahrain
0.3	0.2	0.3	44.7	1.0	22.9	97	96	97	1.37	Bangladesh
0.2	0.2	0.2	14.5	1.9	8.2	90	77	89	-	Barbados
4.3	1.1	2.6	46.1	10.5	28.3	97	98	-	0.32	Belarus
0.3	0.2	0.2	31.4	25.1	28.3	98	85	94	-	Belgium
0.7	0.3	0.5	-	-	-	88	88	-	5.47	Belize
4.3	2.7	3.5	12.3	0.6	6.5	82	-	75	7.87	Benin
0.7	0.5	0.6	-	-	-	98	99	-	3.19	Bhutan
2.6	1.4	2.0	-	-	-	84	-	83	1.93	Bolivia (Plurinational State of)
0.6	0.4	0.5	47.7	30.2	39.0	75	80	-	9.76	Bosnia and Herzegovina
1.2	1.1	1.1	34.4	5.7	20.1	95	74	89	7.64	Botswana
0.2	0.2	0.2	17.9	10.1	14.0	89	41	84	0.03	Brazil
0.4	0.2	0.3	30.9	2.0	16.5	99	98	-	-	Brunei Darussalam
0.8	0.4	0.6	44.4	30.1	37.3	92	92	91	-	Bulgaria
3.4	2.6	3.0	23.9	1.6	12.8	91	50	91	4.37	Burkina Faso
6.8	3.7	5.2	-	-	-	91	75	91	8.75	Burundi
0.6	0.5	0.5	16.5	2.1	9.3	96	85	-	2.99	Cabo Verde
0.7	0.5	0.6	33.7	2.0	17.9	93	61	82	4.83	Cambodia
4.0	2.2	3.1	-	-	-	86	-	84	2.46	Cameroon
0.3	0.3	0.3	16.6	12.0	14.3	91	86	80	-	Canada
4.2	2.3	3.2	-	-	-	47	-	47	10.49	Central African Republic
4.8	2.4	3.6	-	-	-	41	-	-	2.44	Chad
0.3	0.1	0.2	41.5	34.2	37.9	93	90	93	0.03	Chile
1.1	1.6	1.4	48.4	1.9	25.2	99	99	-	0.10	China
0.5	0.2	0.4	13.5	4.7	9.1	92	89	91	0.22	Colombia
2.8	1.9	2.4	23.6	4.4	14.0	91	-	-	2.92	Comoros
1.4	1.0	1.2	52.3	1.7	27.0	69	-	66	1.43	Congo
-	-	-	29.8	21.2	25.5	99	95	-	4.78	Cook Islands
0.5	0.1	0.3	17.4	6.4	11.9	96	93	96	0.06	Costa Rica
5.1	2.8	3.9	-	-	-	84	-	99	3.98	Côte d'Ivoire
0.2	0.1	0.2	39.9	34.3	37.1	92	95	-	-	Croatia
0.1	0.5	0.3	53.3	17.1	35.2	99	99	-	0.06	Cuba
0.1	0.1	0.1	52.7	19.6	36.2	97	88	81	-	Cyprus
0.4	0.2	0.3	38.3	30.5	34.4	96	90	-	-	Czechia
2.0	1.8	1.9	-	-	-	97	98	-	0.98	Democratic People's Republic of Korea
3.9	2.5	3.2	-	-	-	81	-	79	5.32	Democratic Republic of the Congo
0.2	0.1	0.1	18.8	19.3	19.1	98	88	97	-	Denmark
2.9	1.8	2.4	24.5	1.7	13.1	68	82	68	8.85	Djibouti
-	-	-	-	-	-	91	81	-	0.49	Dominica
0.4	0.4	0.4	19.1	8.5	13.8	84	-	64	0.39	Dominican Republic
0.8	0.4	0.6	12.3	2.0	7.2	85	73	84	0.47	Ecuador
0.3	0.2	0.2	50.1	0.2	25.2	94	94	-	0.05	Egypt
0.3	0.1	0.2	18.8	2.5	10.7	85	86	87	1.01	El Salvador
2.2	1.5	1.9	-	-	-	25	-	-	2.00	Equatorial Guinea

PART 3

	3.8			3.9					
	UHC service coverage index [r]	Population with household expenditures on health >10% of total household expenditure or income [s] (%)	Population with household expenditures on health >25% of total household expenditure or income [s] (%)	Age-standardized mortality rate attributed to household and ambient air pollution [c,t] (per 100 000 population)			Mortality rate attributed to exposure to unsafe Water, Sanitation and Hygiene (WASH) services [c,t] (per 100 000 population)		
Data Type	Comparable estimates	Primary data	Primary data	Comparable estimates			Comparable estimates		
				Male	Female	Both sexes	Male	Female	Both sexes
Member State	2015	2009–2015	2009–2015	2016			2016		
Eritrea	38	-	-	200.9	149.9	173.7	47.6	43.5	45.6
Estonia	76	8.8	1.2	36.2	17.3	25.0	<0.1	<0.1	<0.1
Eswatini	58	13.4	2.0	156.9	123.7	137.0	25.9	29.8	27.9
Ethiopia	39	-	-	158.2	131.9	144.4	46.5	40.8	43.7
Fiji	66	-	-	130.7	69.8	99.0	3.5	2.2	2.9
Finland	79	6.4	1.0	10.0	4.9	7.2	<0.1	<0.1	<0.1
France	≥80	-	-	13.3	6.7	9.7	0.2	0.3	0.3
Gabon	52	-	-	79.1	73.0	76.0	22.5	18.6	20.6
Gambia	46	-	-	254.1	220.1	237.0	30.9	28.4	29.7
Georgia	66	29.2	9.0	139.9	73.0	101.8	0.2	0.2	0.2
Germany	79	-	-	20.5	12.0	16.0	0.5	0.7	0.6
Ghana	45	-	-	203.0	204.1	203.8	18.2	19.4	18.8
Greece	70	14.6	1.8	36.1	19.9	27.6	<0.1	0.1	<0.1
Grenada	72	-	-	51.5	38.9	45.3	0.7	<0.1	0.3
Guatemala	57	1.4	0.0	81.2	67.8	73.8	6.6	6.0	6.3
Guinea	35	7.0	1.3	249.4	237.1	243.3	48.3	41.0	44.6
Guinea-Bissau	39	-	-	224.5	205.9	214.7	37.7	33.0	35.3
Guyana	68	-	-	117.3	98.4	107.8	4.1	3.2	3.6
Haiti	47	-	-	197.5	172.4	184.3	27.5	20.1	23.8
Honduras	64	-	-	75.6	47.8	60.7	3.4	3.8	3.6
Hungary	70	7.4	0.3	53.3	28.4	38.8	0.2	0.3	0.2
Iceland	≥80	-	-	10.6	7.0	8.7	0.1	0.1	0.1
India	56	17.3	3.9	202.3	166.0	184.3	15.9	21.5	18.6
Indonesia	49	3.6	0.4	134.0	93.6	112.4	6.3	7.8	7.1
Iran (Islamic Republic of)	65	15.8	3.8	55.6	45.9	50.9	1.0	1.0	1.0
Iraq	63	-	-	88.0	64.0	75.1	3.8	2.3	3.0
Ireland	78	6.4	0.7	14.7	9.4	11.9	<0.1	0.1	0.1
Israel	≥80	6.7	1.0	20.6	11.1	15.4	0.2	0.3	0.2
Italy	≥80	9.3	1.1	19.6	11.1	15.0	0.1	0.2	0.1
Jamaica	60	-	-	30.0	21.3	25.4	0.7	0.6	0.6
Japan	≥80	-	-	16.7	8.1	11.9	0.1	0.2	0.2
Jordan	70	-	-	64.7	38.6	51.2	0.5	0.8	0.6
Kazakhstan	71	1.8	0.1	85.6	46.6	62.7	0.4	0.4	0.4
Kenya	57	-	-	81.4	74.9	78.1	52.6	49.7	51.2
Kiribati	40	-	-	186.8	106.9	140.2	13.5	19.7	16.7
Kuwait	77	-	-	113.6	88.8	103.8	<0.1	<0.1	<0.1
Kyrgyzstan	66	3.5	0.8	142.3	86.9	110.7	0.8	0.7	0.8
Lao People's Democratic Republic	48	-	-	196.2	181.9	188.5	11.2	11.4	11.3
Latvia	64	-	-	60.4	28.5	41.3	<0.1	<0.1	<0.1
Lebanon	68	-	-	61.2	41.0	51.4	0.7	0.9	0.8
Lesotho	45	-	-	196.4	165.8	177.6	38.6	49.8	44.4
Liberia	34	-	-	167.6	171.7	170.2	43.5	39.5	41.5
Libya	63	-	-	92.0	54.3	71.9	0.5	0.7	0.6
Lithuania	67	9.8	1.6	50.8	22.8	34.0	0.1	0.1	0.1
Luxembourg	≥80	3.4	0.2	15.0	8.5	11.6	<0.1	0.1	<0.1
Madagascar	30	-	-	166.9	152.8	159.6	30.8	29.7	30.2
Malawi	44	1.6	0.1	129.7	103.5	115.0	29.1	27.5	28.3
Malaysia	70	-	-	55.9	39.1	47.4	0.4	0.5	0.4
Maldives	55	20.1	1.6	29.7	21.2	25.6	0.4	0.2	0.3
Mali	32	-	-	201.0	215.7	209.1	70.4	71.1	70.7
Malta	79	15.9	2.8	26.1	15.1	20.2	<0.1	0.1	<0.1
Marshall Islands	-	-	-	-	-	-	-	-	-
Mauritania	33	-	-	183.7	157.0	169.5	40.7	36.5	38.6
Mauritius	64	-	-	49.9	28.4	38.3	0.7	0.4	0.6
Mexico	76	7.1	1.9	44.0	30.3	36.7	1.0	1.1	1.1
Micronesia (Federated States of)	60	-	-	170.7	134.9	151.8	3.4	3.7	3.6

3.9			3.a			3.b				
Mortality rate from unintentional poisoning c,m (per 100 000 population)			Age-standardized prevalence of tobacco smoking among persons aged 15 years and older u (%)			Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds v (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age v (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year olds v (%)	Total net official development assistance to medical research and basic health sectors per capita w (US$), by recipient country	
Comparable estimates			Comparable estimates			Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Member State
Male	Female	Both sexes	Males	Females	Both sexes					
2016			2016			2017	2017	2017	2017	
5.6	2.7	4.2	11.4	0.2	5.8	95	88	95	5.39	Eritrea
0.8	0.2	0.5	39.3	24.5	31.9	93	91	-	-	Estonia
3.2	3.4	3.3	16.5	1.7	9.1	90	89	87	10.02	Eswatini
3.6	2.2	2.9	8.5	0.4	4.5	73	-	68	3.64	Ethiopia
0.7	0.2	0.4	34.8	10.2	22.5	99	94	99	5.90	Fiji
0.3	0.2	0.2	22.6	18.3	20.5	89	92	85	-	Finland
0.3	0.6	0.5	35.6	30.1	32.9	96	80	92	-	France
1.1	0.8	0.9	-	-	-	75	-	-	1.27	Gabon
2.3	1.5	1.9	31.2	0.7	16.0	92	68	90	23.75	Gambia
1.2	0.5	0.8	55.5	5.3	30.4	91	90	80	2.05	Georgia
0.1	0.2	0.2	33.1	28.2	30.7	95	93	84	-	Germany
2.0	1.3	1.7	7.7	0.3	4.0	99	83	99	4.56	Ghana
0.3	0.1	0.2	52.0	35.3	43.7	99	83	96	-	Greece
0.4	0.3	0.4	-	-	-	96	79	-	0.19	Grenada
1.4	0.8	1.1	-	-	-	82	81	84	1.50	Guatemala
3.8	2.1	3.0	-	-	-	45	-	-	6.27	Guinea
2.9	1.5	2.2	-	-	-	87	-	87	11.97	Guinea-Bissau
0.7	0.7	0.7	-	-	-	97	93	97	4.60	Guyana
3.0	2.2	2.6	23.1	2.9	13.0	60	25	-	8.85	Haiti
0.6	0.2	0.4	-	-	-	97	-	97	1.16	Honduras
0.4	0.1	0.3	34.8	26.8	30.8	99	99	99	-	Hungary
0.3	0.1	0.2	15.2	14.3	14.8	89	95	88	-	Iceland
2.8	1.9	2.4	20.6	1.9	11.3	88	77	-	0.21	India
0.6	0.2	0.4	76.1	2.8	39.5	79	63	-	1.38	Indonesia
1.6	0.8	1.2	21.1	0.8	11.0	99	98	-	0.02	Iran (Islamic Republic of)
0.6	0.4	0.5	-	-	-	63	74	33	0.17	Iraq
0.3	0.1	0.2	25.7	23.0	24.4	95	-	91	-	Ireland
0.2	0.1	0.1	35.4	15.4	25.4	98	96	94	-	Israel
0.2	0.3	0.3	27.8	19.8	23.8	94	86	91	-	Italy
0.2	0.2	0.2	28.6	5.3	17.0	93	95	-	0.92	Jamaica
0.6	0.3	0.4	33.7	11.2	22.5	99	95	99	-	Japan
0.5	0.8	0.6	-	-	-	99	99	-	4.05	Jordan
3.3	1.3	2.3	43.1	7.0	25.1	99	99	98	0.64	Kazakhstan
2.5	1.1	1.8	20.4	1.2	10.8	82	35	71	4.98	Kenya
3.1	2.0	2.6	58.9	35.9	47.4	90	79	91	22.30	Kiribati
0.2	0.1	0.2	37.0	2.7	19.9	99	99	99	-	Kuwait
0.8	0.4	0.6	50.5	3.6	27.1	92	96	88	4.08	Kyrgyzstan
1.0	0.8	0.9	51.2	7.3	29.3	85	-	83	4.68	Lao People's Democratic Republic
1.5	0.3	0.8	51.0	25.6	38.3	98	89	87	-	Latvia
0.3	0.3	0.3	40.7	26.9	33.8	79	68	68	6.44	Lebanon
3.0	3.3	3.1	53.9	0.4	27.2	93	82	93	14.01	Lesotho
2.5	1.1	1.8	18.1	1.5	9.8	86	-	86	13.78	Liberia
0.8	0.4	0.6	-	-	-	96	94	94	0.89	Libya
1.2	0.3	0.7	38.0	21.3	29.7	94	92	82	-	Lithuania
0.1	0.1	0.1	26.0	20.9	23.5	99	86	95	-	Luxembourg
4.0	2.6	3.3	-	-	-	74	-	74	3.22	Madagascar
2.5	1.5	2.0	24.7	4.4	14.6	88	67	88	15.55	Malawi
0.6	0.3	0.5	42.4	1.0	21.7	99	99	-	0.08	Malaysia
0.0	0.0	0.0	55.0	2.1	28.6	99	99	-	1.42	Maldives
4.2	2.4	3.3	23.0	1.6	12.3	66	-	57	7.08	Mali
0.2	0.1	0.1	30.2	20.9	25.6	98	83	-	-	Malta
-	-	-	-	-	-	80	62	72	3.77	Marshall Islands
2.5	1.2	1.9	-	-	-	81	-	77	3.66	Mauritania
0.1	0.1	0.1	40.7	3.2	22.0	94	95	84	0.87	Mauritius
0.6	0.3	0.4	21.4	6.9	14.2	97	98	91	0.03	Mexico
1.4	0.6	1.0	-	-	-	73	52	65	1.03	Micronesia (Federated States of)

PART 3

	3.8			3.9					
Data Type	UHC service coverage index [r]	Population with household expenditures on health >10% of total household expenditure or income [s] (%)	Population with household expenditures on health >25% of total household expenditure or income [s] (%)	Age-standardized mortality rate attributed to household and ambient air pollution [c,t] (per 100 000 population)			Mortality rate attributed to exposure to unsafe Water, Sanitation and Hygiene (WASH) services [c,t] (per 100 000 population)		
	Comparable estimates	Primary data	Primary data	Comparable estimates			Comparable estimates		
				Male	Female	Both sexes	Male	Female	Both sexes
Member State	2015	2009–2015	2009–2015	2016			2016		
Monaco	-	-	-	-	-	-	-	-	-
Mongolia	63	2.4	0.5	203.4	118.5	155.9	1.8	0.8	1.3
Montenegro	54	8.9	1.0	98.2	61.9	78.6	<0.1	<0.1	<0.1
Morocco	65	-	-	58.4	41.6	49.1	1.8	2.0	1.9
Mozambique	42	-	-	113.8	106.4	110.0	28.2	27.1	27.6
Myanmar	60	-	-	187.5	133.0	156.4	13.1	12.2	12.6
Namibia	59	-	-	168.1	128.9	145.0	18.4	18.3	18.3
Nauru	-	-	-	-	-	-	-	-	-
Nepal	46	27.4	3.3	216.5	173.4	193.8	14.9	24.4	19.8
Netherlands	≥80	-	-	16.6	11.2	13.7	0.2	0.3	0.2
New Zealand	≥80	-	-	8.6	5.9	7.2	0.1	0.2	0.1
Nicaragua	70	27.7	8.9	62.5	50.0	55.7	2.4	2.0	2.2
Niger	33	4.1	0.4	266.9	237.5	251.8	74.7	66.9	70.8
Nigeria	39	24.8	8.9	300.9	312.6	307.4	71.6	65.6	68.6
Niue	-	-	-	-	-	-	-	-	-
North Macedonia	70	-	-	102.9	63.8	82.2	0.1	0.1	0.1
Norway	≥80	-	-	10.4	6.9	8.6	0.2	0.3	0.2
Oman	72	-	-	61.9	43.1	53.9	<0.1	<0.1	<0.1
Pakistan	40	1.0	0.0	197.2	149.0	173.6	16.0	23.4	19.6
Palau	-	-	-	-	-	-	-	-	-
Panama	75	-	-	31.2	20.9	25.8	2.1	1.7	1.9
Papua New Guinea	41	-	-	183.8	125.3	152.0	14.6	18.1	16.3
Paraguay	69	-	-	66.3	49.2	57.5	1.4	1.5	1.5
Peru	78	8.3	1.2	74.2	54.8	63.9	1.3	1.2	1.3
Philippines	58	6.3	1.4	225.4	150.7	185.2	4.8	3.6	4.2
Poland	75	13.9	1.6	53.3	26.2	37.9	0.1	0.1	0.1
Portugal	≥80	18.4	3.3	13.2	7.1	9.8	0.1	0.2	0.2
Qatar	77	-	-	51.7	37.0	47.4	<0.1	<0.1	<0.1
Republic of Korea	≥80	-	-	29.4	14.0	20.5	1.4	2.2	1.8
Republic of Moldova	65	16.1	3.6	101.7	60.9	78.3	0.1	0.1	0.1
Romania	72	12.0	2.3	78.5	43.7	59.3	0.3	0.4	0.4
Russian Federation	63	4.9	0.6	73.3	33.5	49.4	0.1	0.1	0.1
Rwanda	53	4.6	0.7	124.8	117.8	121.4	19.2	19.5	19.3
Saint Kitts and Nevis	-	-	-	-	-	-	-	-	-
Saint Lucia	69	-	-	36.0	24.6	30.0	1.0	0.3	0.6
Saint Vincent and the Grenadines	65	-	-	56.2	39.6	47.6	1.4	1.3	1.3
Samoa	56	-	-	116.4	58.4	85.0	1.5	1.5	1.5
San Marino	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	54	-	-	168.2	158.1	162.4	11.0	11.7	11.4
Saudi Arabia	68	-	-	92.8	72.0	83.7	0.1	0.1	0.1
Senegal	41	3.3	0.2	171.6	151.6	160.7	25.9	21.9	23.9
Serbia	65	9.0	0.7	81.8	46.7	62.5	0.6	0.9	0.7
Seychelles	68	-	-	70.2	31.1	49.3	0.2	0.1	0.2
Sierra Leone	36	-	-	314.1	333.3	324.1	86.8	75.8	81.3
Singapore	≥80	-	-	33.4	19.4	25.9	<0.1	0.1	0.1
Slovakia	76	3.8	0.4	47.1	23.6	33.5	<0.1	0.1	<0.1
Slovenia	78	2.9	0.3	28.9	17.1	22.6	<0.1	<0.1	<0.1
Solomon Islands	50	-	-	157.8	116.0	137.0	6.8	5.5	6.2
Somalia	22	-	-	222.0	203.7	212.8	83.4	89.7	86.6
South Africa	67	1.4	0.1	117.9	65.9	86.7	13.9	13.4	13.7
South Sudan	30	-	-	168.5	161.3	165.1	65.9	60.7	63.3
Spain	77	5.7	1.2	14.2	6.4	9.9	0.1	0.2	0.2
Sri Lanka	62	2.9	0.1	99.9	62.6	79.8	1.2	1.2	1.2
Sudan	43	-	-	195.7	175.0	184.9	16.3	18.3	17.3
Suriname	68	-	-	74.1	42.3	56.7	2.1	2.0	2.0
Sweden	≥80	-	-	8.7	5.8	7.2	0.2	0.3	0.2

3.9 Mortality rate from unintentional poisoning [c,m] (per 100 000 population)			3.a Age-standardized prevalence of tobacco smoking among persons aged 15 years and older [u] (%)			3.b Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds [v] (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age [v] (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year olds [v] (%)	Total net official development assistance to medical research and basic health sectors per capita [w] (US$), by recipient country	Member State
Comparable estimates			Comparable estimates			Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
Male	Female	Both sexes	Males	Females	Both sexes					
2016			2016			2017	2017	2017	2017	
-	-	-	-	-	-	99	79	-	-	Monaco
2.2	1.0	1.6	46.5	5.5	26.0	99	98	13	3.79	Mongolia
0.6	0.4	0.5	47.9	44.0	46.0	87	83	-	0.07	Montenegro
0.7	0.5	0.6	47.1	0.8	24.0	99	99	99	0.62	Morocco
3.5	2.4	2.9	29.1	5.1	17.1	80	45	80	7.76	Mozambique
0.9	1.9	1.4	35.2	6.3	20.8	89	80	89	2.22	Myanmar
1.6	1.5	1.5	34.2	9.7	22.0	88	32	67	5.37	Namibia
-	-	-	36.9	43.0	40.0	87	-	-	39.58	Nauru
0.6	0.3	0.4	37.8	9.5	23.7	90	59	80	2.09	Nepal
0.1	0.1	0.1	27.3	24.4	25.9	94	90	93	-	Netherlands
0.3	0.1	0.2	17.2	14.8	16.0	94	90	94	-	New Zealand
0.8	0.4	0.6	-	-	-	98	84	98	4.92	Nicaragua
5.3	3.0	4.2	15.4	0.1	7.8	81	38	80	4.04	Niger
3.7	2.2	3.0	10.8	0.6	5.7	42	-	36	3.51	Nigeria
-	-	-	19.3	10.5	14.9	99	99	99	30.10	Niue
0.5	0.3	0.4	-	-	-	91	97	-	0.49	North Macedonia
0.2	0.1	0.2	20.7	19.6	20.2	96	91	94	-	Norway
0.6	0.1	0.4	15.6	0.5	8.1	99	99	99	-	Oman
0.8	3.9	2.3	36.7	2.8	19.8	75	45	75	1.96	Pakistan
-	-	-	22.7	7.7	15.2	97	95	89	3.81	Palau
0.5	0.2	0.4	9.9	2.4	6.2	81	93	90	1.16	Panama
2.6	0.7	1.7	48.8	23.5	36.2	62	-	44	5.45	Papua New Guinea
0.4	0.3	0.3	21.6	5.0	13.3	92	82	93	1.13	Paraguay
1.2	0.6	0.9	-	-	-	83	66	80	0.38	Peru
0.3	0.2	0.2	40.8	7.8	24.3	88	80	61	0.72	Philippines
0.3	0.2	0.2	33.1	23.3	28.2	98	93	-	-	Poland
0.3	0.2	0.3	30.0	16.3	23.2	98	95	96	-	Portugal
0.5	0.1	0.4	26.9	0.8	13.9	97	93	98	-	Qatar
0.7	0.3	0.5	40.9	6.2	23.6	98	97	98	-	Republic of Korea
1.7	0.7	1.2	44.6	5.9	25.3	88	92	78	3.16	Republic of Moldova
0.5	0.3	0.4	37.1	22.9	30.0	82	75	-	-	Romania
2.7	0.8	1.7	58.3	23.4	40.9	97	97	70	-	Russian Federation
3.2	1.5	2.4	21.0	4.7	12.9	98	95	98	7.16	Rwanda
-	-	-	-	-	-	97	95	-	-	Saint Kitts and Nevis
0.2	0.2	0.2	-	-	-	80	73	-	3.07	Saint Lucia
0.2	0.2	0.2	-	-	-	99	99	-	-	Saint Vincent and the Grenadines
0.7	0.3	0.5	38.1	16.7	27.4	74	-	-	20.90	Samoa
-	-	-	-	-	-	86	78	53	-	San Marino
1.6	0.1	0.9	-	-	-	95	76	95	30.44	Sao Tome and Principe
0.8	0.5	0.7	25.4	1.8	13.6	98	96	98	-	Saudi Arabia
3.0	1.6	2.3	16.6	0.4	8.5	93	70	92	4.53	Senegal
0.4	0.2	0.3	40.2	37.7	39.0	95	91	-	2.86	Serbia
0.7	0.5	0.6	35.7	7.1	21.4	97	99	-	0.19	Seychelles
5.2	3.1	4.1	41.3	8.8	25.1	90	55	90	8.72	Sierra Leone
0.1	0.1	0.1	28.3	5.2	16.8	96	90	83	-	Singapore
0.5	0.3	0.4	37.7	23.1	30.4	96	97	96	-	Slovakia
0.4	0.2	0.3	25.0	20.1	22.6	94	94	55	-	Slovenia
1.4	0.4	0.9	-	-	-	94	-	81	7.15	Solomon Islands
5.9	3.2	4.6	-	-	-	42	-	-	3.74	Somalia
1.3	1.1	1.2	33.2	8.1	20.7	66	60	60	2.15	South Africa
5.3	2.7	4.0	-	-	-	26	-	-	13.79	South Sudan
0.2	0.2	0.2	31.4	27.4	29.4	98	93	-	-	Spain
0.6	0.3	0.4	27.0	0.3	13.7	99	99	-	2.35	Sri Lanka
5.0	2.9	3.9	-	-	-	95	72	95	2.10	Sudan
0.4	0.3	0.4	42.9	7.4	25.2	81	44	-	4.94	Suriname
0.5	0.3	0.4	18.9	18.8	18.9	97	95	96	-	Sweden

	3.8			3.9					
	UHC service coverage index [r]	Population with household expenditures on health >10% of total household expenditure or income [s] (%)	Population with household expenditures on health >25% of total household expenditure or income [s] (%)	Age-standardized mortality rate attributed to household and ambient air pollution [c,t] (per 100 000 population)			Mortality rate attributed to exposure to unsafe Water, Sanitation and Hygiene (WASH) services [c,t] (per 100 000 population)		
Data Type	Comparable estimates	Primary data	Primary data	Comparable estimates			Comparable estimates		
				Male	Female	Both sexes	Male	Female	Both sexes
Member State	2015	2009–2015	2009–2015	2016			2016		
Switzerland	≥80	-	-	12.7	7.7	10.1	0.1	0.2	0.1
Syrian Arab Republic	60	-	-	90.2	62.1	75.2	3.2	4.1	3.7
Tajikistan	65	-	-	145.5	115.3	129.3	3.0	2.4	2.7
Thailand	75	3.4	0.7	79.3	46.5	61.5	3.7	3.4	3.5
Timor-Leste	47	-	-	150.1	129.6	139.8	10.0	9.8	9.9
Togo	42	-	-	267.1	233.7	249.6	42.1	41.1	41.6
Tonga	62	-	-	107.1	47.8	73.3	0.8	2.0	1.4
Trinidad and Tobago	75	-	-	48.7	30.1	38.6	0.2	0.1	0.1
Tunisia	65	16.7	2.4	72.0	42.5	56.1	0.8	1.2	1.0
Turkey	71	3.1	0.3	68.8	29.4	46.6	0.3	0.3	0.3
Turkmenistan	67	-	-	100.0	63.1	79.3	4.5	3.5	4.0
Tuvalu	-	-	-	-	-	-	-	-	-
Uganda	44	-	-	155.9	154.8	155.7	32.7	30.4	31.6
Ukraine	63	7.2	1.1	99.8	51.1	70.7	0.3	0.2	0.3
United Arab Emirates	63	-	-	58.6	44.7	54.7	<0.1	<0.1	<0.1
United Kingdom	≥80	1.6	0.5	17.0	10.9	13.8	0.1	0.2	0.2
United Republic of Tanzania	39	9.9	2.5	143.3	135.3	139.0	36.2	40.6	38.4
United States of America	≥80	4.8	0.8	16.6	10.4	13.3	0.2	0.3	0.2
Uruguay	79	-	-	25.0	12.2	17.5	0.3	0.4	0.4
Uzbekistan	72	-	-	100.4	65.5	81.1	0.5	0.4	0.4
Vanuatu	56	-	-	161.6	110.7	135.6	12.2	8.6	10.4
Venezuela (Bolivarian Republic of)	73	-	-	45.1	25.9	34.6	1.4	1.4	1.4
Viet Nam	73	9.8	2.1	95.1	42.7	64.5	2.1	1.1	1.6
Yemen	39	-	-	211.0	179.3	194.2	8.7	11.8	10.2
Zambia	56	0.3	0.0	134.0	121.5	127.2	36.6	33.2	34.9
Zimbabwe	55	-	-	132.7	133.0	133.0	27.1	22.2	24.6

WHO region									
African Region	44	10.3	2.6	189.9	175.6	180.9	48.2	43.5	45.8
Region of the Americas	78	11.1	1.9	35.9	24.4	29.7	1.2	1.1	1.2
South-East Asia Region	55	12.8	2.8	185.5	147.1	165.8	13.3	17.6	15.4
European Region	73	7.0	1.0	49.4	26.3	36.3	0.3	0.3	0.3
Eastern Mediterranean Region	53	9.5	1.4	140.3	110.0	125.0	9.2	12.2	10.6
Western Pacific Region	75	14.8	3.9	118.1	89.3	102.8	1.0	1.0	1.0

| Global | 64 | 11.7 | 2.6 | 128.5 | 101.1 | 114.1 | 11.4 | 12.1 | 11.7 |

3.9			3.a			3.b			
Mortality rate from unintentional poisoning c,m (per 100 000 population)			Age-standardized prevalence of tobacco smoking among persons aged 15 years and older u (%)			Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds v (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age v (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year olds v (%)	Total net official development assistance to medical research and basic health sectors per capita w (US$), by recipient country
Comparable estimates			Comparable estimates			Comparable estimates	Comparable estimates	Comparable estimates	Primary data
Male	Female	Both sexes	Males	Females	Both sexes				
2016			2016			2017	2017	2017	2017	**Member State**
0.1	0.1	0.1	28.9	22.6	25.8	97	89	83	-	Switzerland
0.4	0.4	0.4	-	-	-	48	-	-	1.59	Syrian Arab Republic
1.4	0.9	1.2	-	-	-	96	98	-	4.19	Tajikistan
0.5	0.3	0.4	38.8	1.9	20.4	99	95	-	0.55	Thailand
0.5	0.4	0.4	78.1	6.3	42.2	76	50	-	9.29	Timor-Leste
3.0	1.8	2.4	14.2	0.9	7.6	90	-	90	5.66	Togo
1.5	1.2	1.3	44.4	11.8	28.1	81	-	-	36.07	Tonga
0.3	0.2	0.2	-	-	-	89	65	93	-	Trinidad and Tobago
0.5	0.4	0.5	65.8	1.1	33.5	98	97	-	0.46	Tunisia
0.4	0.2	0.3	41.1	14.1	27.6	96	86	96	2.06	Turkey
0.9	0.6	0.7	-	-	-	99	99	-	0.47	Turkmenistan
-	-	-	-	-	-	96	94	-	9.02	Tuvalu
4.0	2.4	3.2	16.7	3.4	10.1	85	-	81	5.19	Uganda
4.3	1.1	2.5	47.4	13.5	30.5	50	84	-	0.77	Ukraine
0.2	0.3	0.3	37.4	1.2	19.3	97	99	96	-	United Arab Emirates
0.3	0.2	0.2	24.7	20.0	22.4	94	88	92	-	United Kingdom
3.2	2.2	2.7	26.7	3.3	15.0	97	79	97	5.11	United Republic of Tanzania
1.0	0.8	0.9	24.6	19.1	21.9	95	94	93	-	United States of America
0.6	0.3	0.4	19.9	14.0	17.0	95	92	94	0.06	Uruguay
1.5	0.5	1.0	24.7	1.3	13.0	99	99	99	1.25	Uzbekistan
1.3	0.4	0.9	34.5	2.8	18.7	85	-	-	14.82	Vanuatu
0.4	0.2	0.3	-	-	-	84	59	-	0.03	Venezuela (Bolivarian Republic of)
1.7	0.1	0.9	45.9	1.0	23.5	94	93	-	0.92	Viet Nam
4.8	2.7	3.8	29.2	7.6	18.4	68	46	68	10.09	Yemen
3.8	2.1	2.9	24.7	3.1	13.9	94	64	94	12.79	Zambia
2.2	2.3	2.2	30.7	1.6	16.2	89	78	89	8.98	Zimbabwe
										WHO region
3.4	2.1	2.7	17.5	2.2	9.8	72	25	68	4.83	African Region
0.7	0.5	0.6	21.4	12.4	16.9	91	74	82	0.42	Region of the Americas
2.1	1.4	1.8	31.6	2.2	16.9	88	77	12	0.60	South-East Asia Region
1.0	0.4	0.7	38.1	20.7	29.4	94	90	70	-	European Region
1.2	1.8	1.5	34.0	2.2	18.1	81	67	52	1.89	Eastern Mediterranean Region
1.0	1.3	1.1	46.0	3.0	24.5	97	94	16	0.30	Western Pacific Region
1.6	1.2	1.4	33.7	6.2	19.9	85	67	44	1.39	**Global**

PART 3

	3.c				3.d	1.a	2.2		
	Density of medical doctors ˣ (per 10 000 population)	Density of nursing and midwifery personnel ˣ (per 10 000 population)	Density of dentists ˣ (per 10 000 population)	Density of pharmacists ˣ (per 10 000 population)	Average of 13 International Health Regulations core capacity scores ʸ	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) ᵈ,ᶻ (%)	Prevalence of stunting in children under 5 ᵃᵃ (%)		
Data Type	Primary data	Primary data	Primary data	Primary data	Primary data	Comparable estimates	Primary data		
							Boys	Girls	Both sexes
Member State	2009–2018	2009–2018	2009–2018	2009–2018	2018	2016	2009–2018		
Afghanistan	2.8	3.2	<0.1	0.5	35	2.0	-	-	40.9
Albania	12.0	36.0	-	8.4	-	9.5	11.6	11.0	11.3
Algeria	18.3	22.4	-	-	80	10.7	12.6	10.7	11.7
Andorra	33.3	40.1	8.2	10.1	37	14.0	-	-	-
Angola	2.1	13.1	-	-	59	5.4	41.0	34.1	37.6
Antigua and Barbuda	27.6	31.2	-	-	42	10.8	-	-	-
Argentina	39.6	25.8	-	-	64	13.6	-	-	-
Armenia	29.0	56.1	3.9	0.5	83	6.1	10.9	7.8	9.4
Australia	35.9	126.6	5.9	8.7	90	17.4	-	-	-
Austria	51.4	81.8	5.7	7.1	59	14.9	-	-	-
Azerbaijan	34.5	69.6	2.7	2.0	83	3.9	18.0	17.5	17.8
Bahamas	19.4	31.4	2.6	5.5	50	16.0	-	-	-
Bahrain	9.3	24.9	1.0	1.6	88	8.4	-	-	-
Bangladesh	5.3	3.1	0.5	1.6	58	3.4	36.8	35.5	36.2
Barbados	24.9	60.3	3.1	-	-	9.3	8.9	6.4	7.7
Belarus	40.8	114.4	5.7	3.4	-	8.5	-	-	-
Belgium	33.2	111.0	7.5	12.2	80	15.8	-	-	-
Belize	11.3	16.9	1.5	6.8	33	12.4	18.6	20.0	15.0
Benin	1.6	6.1	<0.1	<0.1	35	3.7	35.8	32.4	32.2
Bhutan	3.7	15.1	0.8	0.5	53	8.3	33.4	33.6	33.5
Bolivia (Plurinational State of)	16.1	7.4	2.2	2.3	-	11.3	16.1	16.1	16.1
Bosnia and Herzegovina	20.0	63.0	2.3	1.2	33	15.4	8.9	8.9	8.9
Botswana	3.7	33.0	0.4	2.1	26	9.2	-	-	-
Brazil	21.5	97.1	12.4	6.8	87	9.9	-	-	-
Brunei Darussalam	17.7	66.0	2.3	1.7	-	5.7	22.8	16.7	19.7
Bulgaria	39.9	53.0	9.8	-	64	11.9	-	-	-
Burkina Faso	0.6	5.7	<0.1	0.1	29	11.0	22.7	19.4	21.1
Burundi	0.5	6.8	<0.1	0.1	23	8.5	59.4	52.4	55.9
Cabo Verde	7.7	12.3	0.1	0.1	46	9.9	-	-	-
Cambodia	1.7	9.5	0.2	0.3	46	6.2	41.4	38.1	32.4
Cameroon	0.9	9.3	<0.1	0.1	38	3.0	33.5	29.8	31.7
Canada	26.1	99.1	6.4	10.0	99	19.0	-	-	-
Central African Republic	0.6	2.0	<0.1	<0.1	13	5.1	41.7	37.5	39.6
Chad	0.5	3.6	-	0.1	29	5.9	40.9	38.6	39.8
Chile	10.8	8.6	1.6	<0.1	74	19.7	2.1	1.6	1.8
China	17.9	23.1	0.9	3.0	94	9.1	9.9	8.9	8.1
Colombia	20.8	12.6	9.6	-	66	13.4	13.7	11.4	12.6
Comoros	1.7	9.2	0.2	0.2	19	3.6	33.1	29.1	31.1
Congo	1.2	17.4	0.3	0.4	47	3.9	25.1	23.8	21.2
Cook Islands	14.2	58.0	12.5	0.6	65	5.7	-	-	-
Costa Rica	11.5	8.0	0.1	1.9	70	29.2	4.8	6.6	5.6
Côte d'Ivoire	2.3	8.5	0.2	1.1	44	4.9	32.7	27.2	21.6
Croatia	30.0	81.1	8.5	6.6	73	12.0	-	-	-
Cuba	81.9	77.9	16.6	-	77	17.3	-	-	-
Cyprus	19.5	52.5	7.3	1.6	74	7.5	-	-	-
Czechia	43.1	84.1	7.5	6.8	67	14.8	-	-	-
Democratic People's Republic of Korea	36.7	44.4	2.2	4.0	63	-	29.9	25.8	19.1
Democratic Republic of the Congo	0.9	4.7	<0.1	<0.1	34	3.7	45.1	40.3	42.7
Denmark	44.6	103.0	7.4	5.1	96	16.3	-	-	-
Djibouti	2.2	5.4	0.2	2.3	37	3.1	33.7	33.3	33.5
Dominica	10.8	59.0	0.7	-	70	8.0	-	-	-
Dominican Republic	15.6	3.1	2.1	-	48	16.0	8.1	6.1	7.1

2.2			2.2			5.2	6.1	6.2	6.a	
Prevalence of wasting in children under 5 [aa] (%)			Prevalence of overweight in children under 5 [aa] (%)			Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months [ab] (%)	Proportion of population using safely managed drinking-water services [ac] (%)	Proportion of population using safely managed sanitation services [ac] (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan [ad] (constant 2016 US$ millions)	
Primary data			Primary data			Primary data	Comparable estimates	Comparable estimates	Primary data	
Boys	Girls	Both sexes	Boys	Girls	Both sexes					
2009–2018			2009–2018			2009–2017	2015	2015	2017	Member State
-	-	9.5	-	-	5.4	46	-	-	91.15	Afghanistan
1.2	2.0	1.6	17.3	15.4	16.4	-	69	65	58.99	Albania
4.4	3.8	4.1	12.9	12.0	12.4	-	-	19	3.66	Algeria
-	-	-	-	-	-	-	-	100	-	Andorra
5.6	4.3	4.9	3.1	3.6	3.4	26	-	-	46.64	Angola
-	-	-	-	-	-	-	-	-	0.37	Antigua and Barbuda
-	-	-	-	-	-	-	-	26	11.39	Argentina
4.0	5.0	4.5	14.6	12.7	13.7	4	61	-	76.78	Armenia
-	-	-	-	-	-	-	-	74	-	Australia
-	-	-	-	-	-	-	99	97	-	Austria
4.0	2.1	3.2	15.1	12.8	14.1	-	72	-	84.61	Azerbaijan
-	-	-	-	-	-	-	-	-	-	Bahamas
-	-	-	-	-	-	-	99	93	-	Bahrain
15.1	13.6	14.4	1.6	1.5	1.6	29 [ah]	56	-	283.77	Bangladesh
8.3	5.0	6.8	11.3	13.3	12.2	-	-	-	-	Barbados
-	-	-	-	-	-	-	94	76	2.79	Belarus
-	-	-	-	-	-	-	98	97	-	Belgium
3.2	3.4	1.8	8.6	7.1	7.3	-	-	-	0.36	Belize
6.3	4.4	5.0	2.2	1.3	1.9	-	-	-	29.08	Benin
6.2	5.5	5.9	7.5	7.6	7.6	-	34	-	11.64	Bhutan
2.5	1.4	2.0	11.1	9.2	10.1	27 [ah]	-	19	193.23	Bolivia (Plurinational State of)
2.3	2.4	2.3	16.7	18.0	17.4	-	89	23	49.03	Bosnia and Herzegovina
-	-	-	-	-	-	-	-	-	0.08	Botswana
-	-	-	-	-	-	-	-	39	94.88	Brazil
2.7	3.0	2.9	8.9	7.8	8.3	-	-	-	-	Brunei Darussalam
-	-	-	-	-	-	-	97	74	-	Bulgaria
9.7	7.5	8.6	2.0	1.3	1.7	9	-	-	110.81	Burkina Faso
5.6	4.6	5.1	1.5	1.2	1.4	28	-	-	22.88	Burundi
-	-	-	-	-	-	-	-	-	32.79	Cabo Verde
11.4	10.6	9.8	1.8	1.9	2.2	11	24	-	159.90	Cambodia
5.6	4.8	5.2	7.1	6.2	6.7	33	-	-	120.14	Cameroon
-	-	-	-	-	-	-	-	77	-	Canada
8.8	6.3	7.6	2.1	1.7	1.9	-	-	-	3.48	Central African Republic
14.7	11.9	13.3	2.8	2.8	2.8	18	-	-	42.99	Chad
0.3	0.2	0.3	10.0	8.7	9.3	-	98	85	4.63	Chile
2.4	2.1	1.9	7.5	5.6	9.1	-	-	60	87.60	China
0.9	0.9	0.9	5.4	4.2	4.8	18	71	20	12.40	Colombia
11.7	10.9	11.3	11.2	10.0	10.6	5	-	-	4.02	Comoros
6.3	5.8	8.2	3.5	3.5	5.9	-	37	-	9.34	Congo
-	-	-	-	-	-	9 [ah]	-	-	3.30	Cook Islands
0.6	1.5	1.0	8.3	7.9	8.1	-	90	-	28.66	Costa Rica
9.3	6.0	6.1	3.5	3.0	1.5	22 [ah]	46	-	7.55	Côte d'Ivoire
-	-	-	-	-	-	-	90	60	-	Croatia
-	-	-	-	-	-	-	-	31	37.30	Cuba
-	-	-	-	-	-	-	100	76	-	Cyprus
-	-	-	-	-	-	-	98	91	-	Czechia
4.1	3.8	2.5	-	-	2.3	-	-	-	1.00	Democratic People's Republic of Korea
9.3	6.9	8.1	4.5	4.4	4.4	37	-	-	132.18	Democratic Republic of the Congo
-	-	-	-	-	-	-	97	93	-	Denmark
22.8	20.4	21.6	7.8	8.5	8.1	-	-	-	20.46	Djibouti
-	-	-	-	-	-	-	-	-	2.71	Dominica
2.8	2.0	2.4	7.9	7.3	7.6	16	-	-	35.99	Dominican Republic

	3.c				3.d	1.a	2.2		
	Density of medical doctors ˣ (per 10 000 population)	Density of nursing and midwifery personnel ˣ (per 10 000 population)	Density of dentists ˣ (per 10 000 population)	Density of pharmacists ˣ (per 10 000 population)	Average of 13 International Health Regulations core capacity scores ʸ	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) ᵈ,ᶻ (%)	Prevalence of stunting in children under 5 ᵃᵃ (%)		
Data Type	Primary data	Primary data	Primary data	Primary data	Primary data	Comparable estimates	Primary data		
							Boys	Girls	Both sexes
Member State	2009–2018	2009–2018	2009–2018	2009–2018	2018	2016	2009–2018		
Ecuador	20.5	12.0	3.2	0.4	73	11.0	25.9	21.8	23.9
Egypt	7.9	14.0	2.0	4.3	82	4.2	23.6	20.8	22.3
El Salvador	15.7	22.8	-	6.6	75	20.9	15.3	12.0	13.6
Equatorial Guinea	4.0	5.0		-	22	2.6	30.3	22.2	26.2
Eritrea	-	-	-	-	35	2.9	51.2	49.6	52.0
Estonia	34.7	64.5	9.6	7.3	74	12.4	-	-	-
Eswatini	0.8	20.0	0.4	0.2	42	15.2	29.2	21.8	25.5
Ethiopia	1.0	8.4	-	0.1	58	6.0	41.4	35.2	38.4
Fiji	8.4	29.4	0.7	1.1	63	7.7	-	-	-
Finland	38.1	147.2	7.2	11.0	94	13.1	-	-	-
France	32.3	96.9	6.6	10.8	82	17.0	-	-	-
Gabon	3.6	25.8	<0.1	0.2	40	9.2	19.2	14.7	17.0
Gambia	1.1	16.3	0.1	<0.1	35	2.8	25.9	23.1	24.6
Georgia	51.0	40.9	6.2	0.8	66	10.3	12.3	10.2	11.3
Germany	42.1	132.0	8.6	6.4	91	21.4	-	-	-
Ghana	1.8	12.0	-	3.6	47	6.5	20.4	17.0	18.8
Greece	45.9	33.7	12.2	10.3	-	10.3	-	-	-
Grenada	14.5	31.4	1.6	7.0	-	9.0	-	-	-
Guatemala	3.6	9.5	0.1	<0.1	62	17.9	47.3	46.1	46.7
Guinea	0.8	3.8	-	0.1	55	4.1	32.2	29.9	32.4
Guinea-Bissau	2.0	14.0	<0.1	0.1	40	12.9	29.1	26.1	27.6
Guyana	8.0	13.4	0.4	0.1	-	7.7	12.5	9.9	11.3
Haiti	2.3	6.8	0.2	0.3	39	4.4	24.0	19.9	21.9
Honduras	3.1	8.8	0.3	-	34	14.0	24.3	20.8	22.6
Hungary	32.3	66.4	6.2	7.5	67	10.4	-	-	-
Iceland	39.7	156.8	8.3	5.1	84	14.9	-	-	-
India	7.8	21.1	1.9	6.8	75	3.1	38.3	37.4	37.9
Indonesia	3.8	20.6	0.5	1.7	63	8.3	37.2	35.5	36.4
Iran (Islamic Republic of)	11.4	18.7	3.3	2.0	85	22.6	-	-	6.8
Iraq	8.2	16.8	2.5	2.9	82	1.7	22.8	21.3	22.1
Ireland	30.9	142.9	6.0	11.0	67	19.7	-	-	-
Israel	32.2	52.0	8.0	7.5	91	11.6	-	-	-
Italy	40.9	58.7	8.3	11.5	85	13.5	-	-	-
Jamaica	13.2	11.4	0.9	0.2	76	12.9	7.0	4.9	6.0
Japan	24.1	115.2	8.0	18.0	-	23.4	7.6	6.5	7.1
Jordan	23.4	33.9	7.3	16.1	48	12.0	9.3	6.2	7.8
Kazakhstan	32.5	84.9	3.7	8.1	71	9.4	7.7	8.3	8.0
Kenya	2.0	15.4	0.2	0.5	35	6.1	29.9	22.4	26.2
Kiribati	2.0	48.3	0.7	0.3	51	5.5	-	-	-
Kuwait	25.8	69.7	6.6	4.8	56	6.2	7.3	4.5	4.9ᵃˡ
Kyrgyzstan	18.8	64.3	1.7	0.4	57	6.6	13.8	12.0	12.9
Lao People's Democratic Republic	5.0	9.8	0.5	1.9	35	3.7	45.7	42.6	44.2
Latvia	31.9	48.2	7.2	8.3	75	9.2	-	-	-
Lebanon	22.7	26.4	11.1	13.8	58	14.3	-	-	-
Lesotho	0.7	6.5	-	-	33	10.9	39.1	28.1	33.4
Liberia	0.4	1.0	0.1	0.1	46	3.9	34.7	29.0	32.1
Libya	21.6	67.4	9.1	6.2	41	-	-	-	-
Lithuania	43.4	79.2	9.6	9.2	82	12.8	-	-	-
Luxembourg	30.3	123.5	10.0	7.1	76	11.9	-	-	-
Madagascar	1.8	1.1	0.1	<0.1	26	17.8	51.5	46.3	48.9
Malawi	0.2	2.5	-	-	42	9.8	39.3	35.6	37.4
Malaysia	15.1	40.7	3.4	3.4	95	8.2	-	-	20.7
Maldives	10.4	39.5	0.2	4.8	44	20.2	19.9	17.3	18.6

PART 4

2.2						5.2	6.1	6.2	6.a	
Prevalence of wasting in children under 5 [aa] (%)			Prevalence of overweight in children under 5 [aa] (%)			Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months [ab] (%)	Proportion of population using safely managed drinking-water services [ac] (%)	Proportion of population using safely managed sanitation services [ac] (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan [ad] (constant 2016 US$ millions)	
Primary data			Primary data			Primary data	Comparable estimates	Comparable estimates	Primary data	
Boys	Girls	Both sexes	Boys	Girls	Both sexes					Member State
2009–2018			2009–2018			2009–2017	2015	2015	2017	
1.8	1.4	1.6	8.4	7.6	8.0	11 [ah]	74	42	46.00	Ecuador
9.4	9.5	9.5	16.3	15.0	15.7	14	-	61	144.62	Egypt
2.6	1.7	2.1	6.2	6.6	6.4	7 [ah]	-	-	12.71	El Salvador
2.7	3.6	3.1	11.6	7.9	9.7	44	-	-	-	Equatorial Guinea
16.6	14.1	15.3	1.6	2.1	2.0	-	-	-	0.65	Eritrea
-	-	-	-	-	-	-	82	93	-	Estonia
2.3	1.7	2.0	9.0	8.9	9.0	-	-	-	5.02	Swaziland
10.2	9.8	10.0	3.1	2.8	2.9	20	11	-	214.62	Ethiopia
-	-	-	-	-	-	-	-	-	2.63	Fiji
-	-	-	-	-	-	-	97	92	-	Finland
-	-	-	-	-	-	-	93	92	-	France
3.7	3.2	3.4	9.2	6.2	7.7	32	-	-	3.85	Gabon
12.1	9.9	11.0	3.0	3.3	3.2	7	-	-	1.67	Gambia
1.8	1.5	1.6	21.3	18.3	19.9	-	73	-	66.69	Georgia
-	-	-	-	-	-	-	99	95	-	Germany
4.3	5.1	4.7	3.6	1.6	2.6		27	-	71.56	Ghana
-	-	-	-	-	-	-	99	75	-	Greece
-	-	-	-	-	-	-	-	-	3.61	Grenada
1.0	0.4	0.8	5.1	4.8	4.9	9	61	-	14.61	Guatemala
10.4	9.5	8.1	4.5	3.0	4.0	-	-	-	19.38	Guinea
6.3	5.6	6.0	2.7	1.9	2.3	-	-	-	4.64	Guinea-Bissau
6.7	6.2	6.4	5.7	4.8	5.3	-	-	-	14.21	Guyana
4.2	3.3	3.7	4.0	2.8	3.4	14	-	-	34.34	Haiti
1.8	0.9	1.4	5.5	4.8	5.2	11	-	-	10.21	Honduras
-	-	-	-	-	-	-	82	76	-	Hungary
-	-	-	-	-	-	-	98	69	-	Iceland
21.7	19.8	20.8	2.4	2.4	2.4	22	-	-	663.51	India
14.2	12.7	13.5	11.8	11.3	11.5	-	-	-	121.90	Indonesia
-	-	4.0	-	-	-	-	91	-	1.17	Iran (Islamic Republic of)
6.6	6.4	6.5	11.8	10.8	11.4	-	-	32	208.66	Iraq
-	-	-	-	-	-	-	99	70	-	Ireland
-	-	-	-	-	-	-	99	93	-	Israel
-	-	-	-	-	-	-	94	95	-	Italy
3.5	3.7	3.6	7.7	9.0	8.3	9 [ah]	-	-	0.55	Jamaica
2.9	1.7	2.3	1.9	1.1	1.5	-	97	100	-	Japan
2.4	2.4	2.4	5.6	3.8	4.7	14	93	77	508.32	Jordan
2.9	3.3	3.1	8.7	10.0	9.3	-	-	-	0.71	Kazakhstan
4.5	3.9	4.2	4.7	3.5	4.1	26	-	-	213.78	Kenya
-	-	-	-	-	-	-	-	-	9.83	Kiribati
2.8	2.0	3.1 [al]	8.9	8.6	6.0 [al]	-	100	100	-	Kuwait
2.8	2.9	2.8	7.8	6.1	7.0	17	66	-	11.65	Kyrgyzstan
6.9	5.8	6.4	1.9	2.1	2.0	6 [ah]	-	-	64.60	Lao People's Democratic Republic
-	-	-	-	-	-	-	82	78	-	Latvia
-	-	-	-	-	-	-	48	20	97.58	Lebanon
2.6	3.1	2.8	8.1	6.9	7.5	-	-	-	10.91	Lesotho
5.9	5.3	5.6	3.1	3.3	3.2	-	-	-	80.19	Liberia
-	-	-	-	-	-	-	-	26	2.21	Libya
-	-	-	-	-	-	-	92	61	-	Lithuania
-	-	-	-	-	-	-	98	94	-	Luxembourg
9.8	6.0	7.9	1.0	1.1	1.1	-	-	-	26.77	Madagascar
3.4	2.2	2.8	5.9	3.3	4.6	24	-	-	107.74	Malawi
-	-	11.5	-	-	6.0	-	92	82	1.77	Malaysia
10.9	10.7	10.8	6.2	6.0	6.1	-	-	-	3.19	Maldives

PART 4

	3.c				3.d	1.a	2.2		
	Density of medical doctors ˣ (per 10 000 population)	Density of nursing and midwifery personnel ˣ (per 10 000 population)	Density of dentists ˣ (per 10 000 population)	Density of pharmacists ˣ (per 10 000 population)	Average of 13 International Health Regulations core capacity scores ʸ	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) ^{d,z} (%)	Prevalence of stunting in children under 5 ^{aa} (%)		
Data Type	Primary data	Primary data	Primary data	Primary data	Primary data	Comparable estimates	Primary data		
							Boys	Girls	Both sexes
Member State	2009–2018	2009–2018	2009–2018	2009–2018	2018	2016	2009–2018		
Mali	1.4	3.8	<0.1	0.1	49	5.3	32.9	27.8	30.4
Malta	38.3	89.5	4.8	13.1	60	15.8	-	-	-
Marshall Islands	4.6	35.5	0.8	0.8	49	20.7	39.3	30.0	34.8
Mauritania	1.8	10.3	0.2	0.2	26	5.5	17.5	16.3	27.9
Mauritius	20.2	33.8	3.0	3.9	62	10.0	-	-	-
Mexico	22.5	29.0	1.0	0.5	86	10.4	10.7	9.3	10.0
Micronesia (Federated States of)	1.9	36.1	-	-	-	5.7	-	-	-
Monaco	65.6	202.6	10.0	25.7	82	6.7	-	-	-
Mongolia	28.9	39.8	2.4	9.1	86	5.3	11.1	10.5	7.3
Montenegro	23.3	57.2	0.4	1.7	47	12.1	10.3	8.4	9.4
Morocco	7.3	11.0	1.4	2.6	75	9.1	15.9	13.9	14.9
Mozambique	0.7	4.4	0.1	0.1	53	8.4	45.1	40.8	42.9
Myanmar	8.6	9.8	0.8	0.4	66	4.8	31.1	27.5	29.4
Namibia	-	-	-	-	47	13.8	25.1	20.4	22.7
Nauru	12.4	61.9	1.8	1.8	34	5.0	-	-	-
Nepal	6.5	26.9	2.1	0.9	23	5.3	36.2	35.8	36.0
Netherlands	35.1	111.0	5.1	2.2	89	19.3	-	-	-
New Zealand	30.3	109.6	6.8	6.8	90	22.5	-	-	-
Nicaragua	10.1	15.8	0.4	1.9	73	20.0	18.2	16.4	17.3
Niger	0.5	3.1	<0.1	<0.1	44	5.7	42.6	38.6	40.6
Nigeria	3.8	14.5	0.5	0.9	52	5.0	45.7	41.4	43.6
Niue	-	-	-	-	71	2.0	-	-	-
North Macedonia	28.7	37.9	8.8	4.9	63	13.1	5.6	4.3	4.9
Norway	46.3	181.2	8.7	8.0	92	17.6	-	-	-
Oman	19.7	43.0	2.9	5.3	100	7.6	11.3	8.5	14.1
Pakistan	9.8	5.0	0.9	1.4	51	3.9	48.2	41.8	37.6
Palau	11.8	52.6	-	1.0	60	18.7	-	-	-
Panama	15.7	14.1	2.8	-	71	21.4	-	-	-
Papua New Guinea	0.5	5.1	0.2	0.5	36	7.2	50.9	47.9	49.5
Paraguay	13.7	11.7	1.6	0.3	62	16.2	6.7	4.4	5.6
Peru	12.7	13.5	1.8	0.5	55	15.7	13.8	12.0	12.9
Philippines	12.8	33.3	-	6.2	-	7.1	31.5	29.1	33.4
Poland	24.0	57.2	3.5	7.7	-	11.0	-	-	2.6
Portugal	33.4	63.7	8.7	8.5	77	13.4	-	-	-
Qatar	<0.1	66.0	8.4	10.7	87	6.3	-	-	-
Republic of Korea	23.7	69.7	5.0	7.3	94	13.5	-	-	2.5 ^{am}
Republic of Moldova	32.0	45.1	4.4	4.7	60	12.1	5.8	7.0	6.4
Romania	22.6	61.0	8.1	9.3	72	11.3	-	-	-
Russian Federation	40.1	86.2	2.9	0.5	100	8.2	-	-	-
Rwanda	1.3	8.3	0.1	0.1	67	8.9	43.0	33.4	36.9
Saint Kitts and Nevis	25.2	39.8	3.7	-	48	8.2	-	-	-
Saint Lucia	1.1	15.9	2.3	-	60	8.5	4.0	1.0	2.5
Saint Vincent and the Grenadines	6.6	25.8	-	-	45	9.6	-	-	-
Samoa	3.4	18.6	1.5	0.7	73	12.5	5.6	4.1	4.9
San Marino	61.5	87.8	6.7	6.7	-	12.2	-	-	-
Sao Tome and Principe	3.2	22.6	-	-	39	7.5	20.5	14.0	17.2
Saudi Arabia	23.9	57.0	4.4	7.9	69	10.1	-	-	-
Senegal	0.7	3.1	0.1	0.1	45	6.0	18.2	15.2	16.5
Serbia	31.3	61.2	5.2	8.1	69	12.3	6.8	5.1	6.0
Seychelles	9.5	32.6	2.1	0.3	48	10.0	-	-	7.9 ^{an}
Sierra Leone	0.3	10.0	<0.1	0.3	38	7.9	38.8	36.9	37.8
Singapore	23.1	72.1	3.9	5.1	91	13.6	-	-	-
Slovakia	24.6	91.7	4.9	7.0	69	13.7	-	-	-

PART 4

2.2 Prevalence of wasting in children under 5 [aa] (%)			2.2 Prevalence of overweight in children under 5 [aa] (%)			5.2 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months [ab] (%)	6.1 Proportion of population using safely managed drinking-water services [ac] (%)	6.2 Proportion of population using safely managed sanitation services [ac] (%)	6.a Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan [ad] (constant 2016 US$ millions)	
Primary data			Primary data			Primary data	Comparable estimates	Comparable estimates	Primary data	
Boys	Girls	Both sexes	Boys	Girls	Both sexes					
2009–2018			2009–2018			2009–2017	2015	2015	2017	Member State
15.0	11.9	13.5	1.9	1.9	1.9	-	-	-	135.66	Mali
-	-	-	-	-	-	-	100	93	-	Malta
4.6	2.4	3.5	4.9	3.2	4.1	20 [ah]	-	-	1.94	Marshall Islands
13.1	10.0	14.8	1.1	1.2	1.3	-	-	-	56.55	Mauritania
-	-	-	-	-	-	-	-	-	0.15	Mauritius
2.6	1.4	2.0	19.0	22.4	5.3	10 [ah]	43	45	12.73	Mexico
-	-	-	-	-	-	26 [ah]	-	-	1.19	Micronesia (Federated States of)
-	-	-	-	-	-	-	100	100	-	Monaco
1.2	0.8	1.3	10.9	10.0	11.7	15 [ah]	-	-	10.60	Mongolia
3.1	2.4	2.8	24.7	19.6	22.3	-	90	-	9.60	Montenegro
2.8	1.8	2.3	12.6	8.9	10.8	-	69	38	156.28	Morocco
6.7	5.6	6.1	8.1	7.6	7.8	-	-	-	113.58	Mozambique
7.0	6.2	6.6	1.9	1.1	1.5	11	-	-	75.91	Myanmar
9.0	5.3	7.1	3.8	4.2	4.0	20	-	-	5.26	Namibia
-	-	-	-	-	-	-	-	-	0.11	Nauru
9.4	9.9	9.6	1.3	1.0	1.2	11	27	-	172.21	Nepal
-	-	-	-	-	-	-	100	97	-	Netherlands
-	-	-	-	-	-	-	100	76	-	New Zealand
2.2	2.1	2.2	8.6	7.9	8.3	8 [ah]	59	-	29.76	Nicaragua
12.3	8.0	10.1	1.2	1.0	1.1	-	-	9	80.66	Niger
11.9	9.6	10.8	1.7	1.3	1.5	11	19	-	152.34	Nigeria
-	-	-	-	-	-	-	97	-	0.03	Niue
2.2	1.4	1.8	13.4	11.4	12.4	-	83	-	16.26	North Macedonia
-	-	-	-	-	-	-	95	78	-	Norway
8.1	6.0	7.5	1.5	2.0	4.4	-	89	-	-	Oman
11.1	9.8	7.1	4.7	4.8	2.5	-	36	-	259.76	Pakistan
-	-	-	-	-	-	10 [ah]	-	20	5.39	Palau
-	-	-	-	-	-	10 [ah]	-	-	4.70	Panama
14.4	13.7	14.1	14.3	13.0	13.7	-	-	-	28.53	Papua New Guinea
1.0	0.9	1.0	13.0	11.9	12.4	-	-	-	8.51	Paraguay
0.7	0.4	0.5	9.0	7.1	8.0	11	50	30	57.59	Peru
8.2	7.5	7.1	5.4	4.6	3.9	6	-	-	71.91	Philippines
-	-	-	-	-	-	-	94	77	-	Poland
-	-	-	-	-	-	-	95	62	-	Portugal
-	-	-	-	-	-	-	-	88	-	Qatar
-	-	1.2 [am]	-	-	7.3 [am]	-	98	98	-	Republic of Korea
2.1	1.8	1.9	6.0	3.7	4.9	-	70	-	18.36	Republic of Moldova
-	-	-	-	-	-	-	82	57	-	Romania
-	-	-	-	-	-	-	76	-	-	Russian Federation
2.5	2.1	2.0	8.5	7.4	5.6	21	-	-	57.13	Rwanda
-	-	-	-	-	-	-	-	-	-	Saint Kitts and Nevis
4.1	3.4	3.7	8.9	3.8	6.3	-	-	-	2.74	Saint Lucia
-	-	-	-	-	-	-	-	-	0.03	Saint Vincent and the Grenadines
3.0	4.9	3.9	6.2	4.3	5.3	-	-	-	14.17	Samoa
-	-	-	-	-	-	-	100	78	-	San Marino
4.7	3.3	4.0	2.6	2.2	2.4	26	-	-	7.83	Sao Tome and Principe
-	-	-	-	-	-	-	-	84	-	Saudi Arabia
9.8	8.2	9.0	0.7	1.1	0.9	12	-	24	71.02	Senegal
4.2	3.6	3.9	15.6	12.0	13.9	-	88	24	42.24	Serbia
-	-	4.3 [an]	-	-	10.2 [an]	-	-	-	0.18	Seychelles
10.8	8.2	9.5	8.6	8.9	8.8	29	-	-	39.87	Sierra Leone
-	-	-	-	-	-	-	100	100	-	Singapore
-	-	-	-	-	-	-	93	82	-	Slovakia

PART 4

Member State	Density of medical doctors [x] (per 10 000 population) Primary data 2009–2018	Density of nursing and midwifery personnel [x] (per 10 000 population) Primary data 2009–2018	Density of dentists [x] (per 10 000 population) Primary data 2009–2018	Density of pharmacists [x] (per 10 000 population) Primary data 2009–2018	Average of 13 International Health Regulations core capacity scores [y] Primary data 2018	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) [d,z] (%) Comparable estimates 2016	Prevalence of stunting in children under 5 [aa] (%) Primary data Boys 2009–2018	Girls	Both sexes
Slovenia	30.0	96.8	6.8	6.5	82	13.5	-	-	-
Solomon Islands	2.0	21.3	0.5	1.2	34	8.0	33.7	29.5	31.6
Somalia	0.2	0.6	-	-	31	-	27.7	22.7	25.3
South Africa	9.1	35.2	1.5	1.5	66	13.3	29.4	24.9	27.4
South Sudan	-	-	-	-	39	-	33.4	29.1	31.3
Spain	40.7	55.3	7.2	12.1	84	15.1	-	-	-
Sri Lanka	9.6	21.2	0.9	0.8	46	8.6	19.8	18.7	17.3
Sudan	4.1	8.3	2.1	4.4	65	10.7	40.3	36.1	38.2
Suriname	12.3	41.0	0.5	0.4	73	16.6	9.9	7.6	8.8
Sweden	54.0	115.4	8.0	7.6	92	18.5	-	-	-
Switzerland	42.4	172.8	5.0	5.4	-	22.4	-	-	-
Syrian Arab Republic	12.2	14.6	6.8	10.1	75	-	28.5	26.7	27.6
Tajikistan	17.0	52.3	1.5	-	58	5.0	17.9	17.2	17.5
Thailand	8.1	29.6	1.7	4.2	79	15.3	16.4	16.3	10.5
Timor-Leste	7.2	16.7	0.7	0.1	44	3.2	54.0	47.6	50.9
Togo	0.5	3.0	<0.1	<0.1	32	4.3	28.2	26.9	27.6
Tonga	5.2	39.3	1.1	0.4	57	8.0	9.1	7.0	8.1
Trinidad and Tobago	26.7	35.1	3.6	5.1	49	9.7	-	-	9.2
Tunisia	12.7	26.4	3.1	2.3	66	13.7	11.3	8.8	10.1
Turkey	17.6	26.3	3.2	3.5	73	9.7	11.0	8.6	9.9
Turkmenistan	22.2	46.3	1.2	1.7	67	8.7	11.5	11.4	11.5
Tuvalu	9.2	37.6	4.6	2.8	54	9.0	-	-	-
Uganda	0.9	6.3	0.1	<0.1	51	5.1	30.9	26.9	28.9
Ukraine	30.1	70.6	6.0	0.3	75	7.0	-	-	-
United Arab Emirates	23.9	55.9	5.6	7.4	95	7.9	-	-	-
United Kingdom	28.1	82.9	5.3	8.8	93	18.9	-	-	-
United Republic of Tanzania	0.4	4.1	<0.1	0.1	47	9.5	36.7	32.2	34.5
United States of America	25.9	85.5	6.1	10.5	91	39.5	3.1	1.3	3.5
Uruguay	50.5	19.3	14.8	-	85	19.5	-	-	10.7 [am]
Uzbekistan	23.7	120.7	1.5	0.4	44	9.2	-	-	-
Vanuatu	1.7	13.9	0.7	1.2	34	5.4	-	-	28.5
Venezuela (Bolivarian Republic of)	-	-	-	-	74	1.9	-	-	13.4 [ao]
Viet Nam	8.2	14.3	-	3.4	61	9.0	23.7	21.6	24.6
Yemen	3.1	7.3	0.2	1.0	52	-	47.5	45.3	46.4
Zambia	0.9	8.9	0.2	0.7	31	7.1	42.3	37.7	40.0
Zimbabwe	0.8	1.2	0.2	0.3	55	14.5	30.0	24.2	27.1

WHO region

African Region	2.8	11.0	-	-	42	7.3	-	-	33.1
Region of the Americas	23.3	61.9	-	-	65	15.6	-	-	6.5
South-East Asia Region	7.4	19.9	-	-	56	6.7	-	-	31.9
European Region	33.8	80.6	-	-	74	12.5	-	-	-
Eastern Mediterranean Region	9.9	15.2	-	-	66	8.5	-	-	24.7
Western Pacific Region	18.0	32.6	-	-	64	11.0	-	-	6.4

| **Global** | 15.1 | 34.8 | - | - | 60 | 10.6 | - | - | 21.9 |

2.2 Prevalence of wasting in children under 5 [aa] (%) Primary data			2.2 Prevalence of overweight in children under 5 [aa] (%) Primary data			5.2 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months [ab] (%) Primary data	6.1 Proportion of population using safely managed drinking-water services [ac] (%) Comparable estimates	6.2 Proportion of population using safely managed sanitation services [ac] (%) Comparable estimates	6.a Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan [ad] (constant 2016 US$ millions) Primary data	
Boys	Girls	Both sexes	Boys	Girls	Both sexes					Member State
2009–2018			2009–2018			2009–2017	2015	2015	2017	
-	-	-	-	-	-	-	98	76	-	Slovenia
8.4	8.5	8.5	4.6	4.4	4.5	-	-	-	9.96	Solomon Islands
16.4	13.4	15.0	2.8	3.1	3.0	-	-	14	19.85	Somalia
5.2	6.0	2.5	18.7	15.6	13.3	-	-	-	1.81	South Africa
27.4	21.1	24.3	5.9	5.7	5.8	-	-	-	47.62	South Sudan
-	-	-	-	-	-	-	98	97	-	Spain
12.1	11.5	15.1	0.7	1.0	2.0	-	-	-	142.80	Sri Lanka
17.3	16.2	16.8	3.2	2.8	3.0	-	-	-	20.70	Sudan
6.3	5.2	5.8	5.0	3.0	4.0	-	-	-	1.60	Suriname
-	-	-	-	-	-	-	98	92	-	Sweden
-	-	-	-	-	-	-	95	99	-	Switzerland
12.5	10.5	11.5	17.8	18.1	17.9	-	-	-	8.19	Syrian Arab Republic
6.1	5.0	5.6	17.3	15.3	3.3	19	47	-	17.92	Tajikistan
7.4	6.1	5.4	10.1	11.6	8.2	-	-	-	2.61	Thailand
12.6	8.4	10.5	1.2	1.5	1.4	35	-	-	5.87	Timor-Leste
7.6	5.6	6.6	1.8	2.2	2.0	13	-	-	16.76	Togo
5.4	5.1	5.2	18.6	16.0	17.3	19 [ah]	-	-	2.30	Tonga
-	-	6.4	-	-	11.4	7 [ah]	-	-	-	Trinidad and Tobago
4.2	2.3	3.3	14.7	13.7	14.2	-	93	73	162.01	Tunisia
1.6	2.2	1.9	11.9	10.2	11.1	11 [ah]	-	44	84.80	Turkey
4.4	3.9	4.2	6.0	5.7	5.9	-	86	-	-	Turkmenistan
-	-	-	-	-	-	-	-	9	0.95	Tuvalu
4.1	2.9	3.5	4.9	2.6	3.7	30	6	-	151.62	Uganda
-	-	-	-	-	-	-	92	-	32.02	Ukraine
-	-	-	-	-	-	-	-	93	-	United Arab Emirates
-	-	-	-	-	-	-	96	98	-	United Kingdom
5.2	3.8	4.5	3.8	3.6	3.7	30	-	-	66.53	United Republic of Tanzania
0.4	0.8	0.4	5.1	6.9	9.4	-	99	89	-	United States of America
-	-	1.3 [am]	-	-	7.2 [am]	3 [ah]	-	64	0.68	Uruguay
-	-	-	-	-	-	-	-	-	63.08	Uzbekistan
-	-	4.4	-	-	4.6	44 [ah]	-	-	2.13	Vanuatu
-	-	4.1 [ao]	-	-	6.4 [ao]	-	-	19	0.17	Venezuela (Bolivarian Republic of)
4.5	4.3	6.4	5.4	3.4	5.3	-	-	-	532.27	Viet Nam
17.9	14.8	16.4	2.4	2.5	2.5	-	-	-	34.53	Yemen
6.5	6.0	6.2	6.6	5.9	6.2	27	-	-	130.05	Zambia
3.3	3.3	3.3	6.2	5.1	5.6	20	-	-	22.85	Zimbabwe
										WHO region
-	-	7.0	-	-	3.5	-	26	-	2483.89	African Region
-	-	0.8	-	-	7.2	-	82	43	676.69	Region of the Americas
-	-	15.1	-	-	3.8	-	-	-	1484.41	South-East Asia Region
-	-	-	-	-	-	-	91	67	-	European Region
-	-	7.8	-	-	5.7	-	56	-	1836.26	Eastern Mediterranean Region
-	-	2.2	-	-	6.0	-	-	57	1011.10	Western Pacific Region
-	-	7.3	-	-	5.9	-	71	39	8698.25	**Global**

Member State	Proportion of population with primary reliance on clean fuels [t] (%)	Annual mean concentrations of fine particulate matter (PM$_{2.5}$) in urban areas [t] (µg/m³)	Mortality rate due to homicide [c,m,af] (per 100 000 population)			Completeness of cause-of-death data [c,m,ag] (%)
Data Type	Comparable estimates	Comparable estimates	Comparable estimates			Primary data
			Male	Female	Both sexes	
	2017	**2016**	**2016**			**2009–2017**
Afghanistan	34	53.2	13.5	0.9	7.4	-
Albania	80	17.9	5.8	2.4	4.2	53
Algeria	>95	35.2	6.4	1.9	4.2	-
Andorra	>95 ap	9.9	-	-	-	100
Angola	49	27.9	16.5	3.4	9.8	-
Antigua and Barbuda	>95	17.9	2.7	0.9	1.8	83
Argentina	>95	11.8	10.7	1.9	6.2	100
Armenia	>95	30.5	4.0	1.0	2.4	100
Australia	>95 ap	7.2	1.5	0.8	1.1	100
Austria	>95	12.4	0.6	0.5	0.5	100
Azerbaijan	>95	18.2	3.7	1.0	2.4	-
Bahamas	>95 ap	17.6	52.5	7.8	29.7	89
Bahrain	>95 ap	69.0	0.9	0.4	0.8	96
Bangladesh	19	58.3	4.2	1.7	2.9	-
Barbados	>95	22.2	15.1	5.4	10.0	79
Belarus	>95	18.1	8.0	2.8	5.2	100
Belgium	>95 ap	12.9	1.1	0.8	1.0	100
Belize	87	21.2	51.2	7.8	29.4	89
Benin	6	33.1	9.8	3.0	6.4	-
Bhutan	79	35.3	2.4	0.9	1.7	-
Bolivia (Plurinational State of)	83	20.2	23.5	4.6	14.1	-
Bosnia and Herzegovina	63	27.3	5.0	1.7	3.3	95
Botswana	59	21.2	19.8	3.1	11.4	-
Brazil	>95	11.5	57.8	5.6	31.3	99
Brunei Darussalam	>95 ap	5.8	2.5	1.6	2.0	100
Bulgaria	91	18.8	2.4	1.0	1.7	100
Burkina Faso	10	36.8	13.9	5.6	9.8	-
Burundi	<5	35.6	10.1	3.1	6.6	-
Cabo Verde	75	32.0	12.7	3.8	8.2	93
Cambodia	20	24.0	3.6	0.8	2.2	-
Cameroon	25	65.3	18.5	4.7	11.6	-
Canada	>95 ap	6.5	2.2	0.8	1.5	100
Central African Republic	<5	49.5	22.4	5.5	13.8	-
Chad	<5	53.0	14.9	4.2	9.6	-
Chile	>95	21.0	7.8	1.1	4.4	95
China	58	49.2	1.0	0.8	0.9	62
Colombia	94	15.2	79.7	7.6	43.1	80
Comoros	10	18.6	11.7	4.1	7.9	-
Congo	25	38.7	16.3	4.1	10.2	-
Cook Islands	84	12.0	-	-	-	100
Costa Rica	>95	15.9	18.2	2.2	10.2	87
Côte d'Ivoire	21	23.7	14.3	9.7	12.1	-
Croatia	93	17.0	1.1	0.8	1.0	100
Cuba	90	18.4	8.5	2.5	5.5	100
Cyprus	>95 ap	16.8	1.9	0.8	1.4	68
Czechia	>95	15.1	1.0	0.6	0.8	100
Democratic People's Republic of Korea	11	30.4	5.6	3.2	4.4	-
Democratic Republic of the Congo	<5	37.6	21.1	5.5	13.3	-
Denmark	>95 ap	10.1	0.9	0.7	0.8	100
Djibouti	10	40.4	10.5	3.2	6.8	-
Dominica	91	18.2	-	-	-	100
Dominican Republic	91	12.9	29.1	4.6	16.8	58
Ecuador	>95	14.9	15.7	2.9	9.3	82
Egypt	>95	79.3	7.6	2.0	4.8	94
El Salvador	89	23.4	85.9	10.6	46.0	93
Equatorial Guinea	37	45.9	5.3	1.1	3.4	-
Eritrea	18	42.4	12.2	3.4	7.8	-
Estonia	>95	6.7	5.8	1.8	3.7	100

	7.1	11.6	16.1			17.19.2
	Proportion of population with primary reliance on clean fuels [t] (%)	Annual mean concentrations of fine particulate matter (PM$_{2.5}$) in urban areas [t] (µg/m³)	Mortality rate due to homicide [c,m,af] (per 100 000 population)			Completeness of cause-of-death data [c,m,ag] (%)
Data Type	Comparable estimates	Comparable estimates	Comparable estimates			Primary data
			Male	Female	Both sexes	
Member State	**2017**	**2016**	**2016**			**2009–2017**
Eswatini	51	16.3	32.7	8.0	**20.0**	-
Ethiopia	<5	34.4	11.6	4.0	7.8	-
Fiji	51	10.2	3.8	1.2	2.5	100
Finland	>95 [ap]	5.9	1.7	0.9	1.3	100
France	>95 [ap]	11.6	1.1	0.7	0.9	100
Gabon	81	38.5	14.2	3.0	8.8	-
Gambia	<5	32.2	16.5	2.2	9.3	-
Georgia	79	21.2	8.0	1.5	4.6	90
Germany	>95 [ap]	11.7	0.6	0.8	0.7	100
Ghana	25	31.9	12.3	7.1	9.7	-
Greece	>95	15.7	1.6	0.7	1.1	100
Grenada	>95	21.6	9.9	2.7	6.3	100
Guatemala	43	23.6	44.4	7.7	25.8	100
Guinea	<5	22.4	13.0	4.7	8.9	-
Guinea-Bissau	<5	27.1	7.8	10.5	9.2	-
Guyana	77	20.5	29.3	8.1	18.8	90
Haiti	<5	14.6	45.3	11.1	28.0	-
Honduras	54	20.1	79.1	32.1	55.5	14
Hungary	>95 [ap]	15.6	1.5	1.0	1.3	100
Iceland	>95 [ap]	5.9	1.5	1.0	1.2	100
India	45	65.2	6.1	2.1	4.1	10
Indonesia	65	15.6	6.3	2.8	4.5	-
Iran (Islamic Republic of)	>95	35.1	7.3	1.7	4.5	90
Iraq	>95	57.7	22.7	8.2	15.5	65
Ireland	>95 [ap]	8.3	1.2	0.5	0.8	100
Israel	>95 [ap]	19.5	2.6	1.0	1.8	100
Italy	>95 [ap]	15.3	1.1	0.5	0.8	100
Jamaica	92	13.3	62.4	16.1	39.1	94
Japan	>95 [ap]	11.4	0.3	0.2	0.3	100
Jordan	>95	32.1	4.1	1.6	2.9	56
Kazakhstan	>95	11.3	13.1	3.3	8.1	87
Kenya	14	25.9	8.7	2.0	5.3	-
Kiribati	6	10.5	14.0	4.3	9.1	-
Kuwait	>95 [ap]	57.2	3.9	1.1	2.7	59
Kyrgyzstan	83	18.1	9.3	2.5	5.8	91
Lao People's Democratic Republic	<5	24.5	10.1	4.0	7.0	-
Latvia	>95	12.7	9.0	3.5	6.0	100
Lebanon	-	30.7	7.1	1.9	4.5	-
Lesotho	33	27.8	56.2	15.0	35.0	-
Liberia	<5	17.2	15.1	4.7	10.0	-
Libya	-	44.2	3.9	1.0	2.5	-
Lithuania	>95 [ap]	11.5	9.3	3.1	5.9	99
Luxembourg	>95 [ap]	10.2	0.2	0.2	0.2	100
Madagascar	<5	21.4	10.3	3.5	6.9	-
Malawi	<5	22.1	2.4	0.7	1.5	-
Malaysia	>95	16.0	6.2	1.8	4.1	52
Maldives	>95	7.6	4.8	1.6	3.4	91
Mali	<5	31.2	17.2	5.4	11.3	-
Malta	>95 [ap]	14.0	1.2	0.7	0.9	100
Marshall Islands	66	9.4	-	-	-	-
Mauritania	46	40.8	16.1	5.7	11.0	-
Mauritius	>95	13.5	2.4	0.8	1.6	100
Mexico	86	20.1	29.9	4.0	16.9	100
Micronesia (Federated States of)	12	10.2	6.5	3.1	4.8	-
Monaco	>95 [ap]	12.2	-	-	-	100
Mongolia	41	40.4	15.4	2.4	8.9	84
Montenegro	66	20.2	3.7	1.5	2.6	94
Morocco	>95	31.0	2.1	0.7	1.4	29

PART 5

ANNEX 2
Part 5

	7.1	11.6	16.1			17.19.2
	Proportion of population with primary reliance on clean fuels [t] (%)	Annual mean concentrations of fine particulate matter (PM$_{2.5}$) in urban areas [t] (µg/m³)	Mortality rate due to homicide [c,m,af] (per 100 000 population)			Completeness of cause-of-death data [c,m,ag] (%)
Data Type	Comparable estimates	Comparable estimates	Comparable estimates			Primary data
			Male	Female	Both sexes	
Member State	2017	2016	2016			2009–2017
Mozambique	<5	19.4	4.1	1.1	2.5	-
Myanmar	20	34.7	5.8	2.4	4.1	-
Namibia	44	22.6	32.0	5.3	18.3	-
Nauru	92	12.5	-	-	-	-
Nepal	29	94.3	5.1	1.7	3.3	-
Netherlands	>95 [ap]	12.1	0.8	0.5	0.7	100
New Zealand	>95 [ap]	5.7	1.4	0.9	1.1	100
Nicaragua	54	16.9	24.6	3.4	13.9	79
Niger	<5	70.8	15.4	5.3	10.4	-
Nigeria	7	48.7	14.0	5.4	9.8	-
Niue	93	11.5	-	-	-	-
North Macedonia	66	28.3	2.2	0.8	1.5	100
Norway	>95 [ap]	7.0	0.7	0.5	0.6	100
Oman	>95	38.2	6.4	2.9	5.2	74
Pakistan	44	55.2	13.7	5.3	9.6	-
Palau	>95 [ap]	12.2	-	-	-	95
Panama	90	11.2	36.9	4.0	20.5	92
Papua New Guinea	12	10.9	15.5	4.8	10.2	-
Paraguay	66	11.2	14.1	3.1	8.6	88
Peru	76	24.3	19.0	4.3	11.6	57
Philippines	44	18.4	26.3	3.1	14.8	89
Poland	>95 [ap]	20.5	1.4	0.5	0.9	100
Portugal	>95 [ap]	7.9	1.6	0.9	1.2	100
Qatar	>95	90.3	8.8	3.0	7.4	50
Republic of Korea	>95 [ap]	24.6	1.6	0.9	1.3	100
Republic of Moldova	94	16.0	7.5	3.3	5.3	80
Romania	89	14.3	2.2	0.9	1.6	100
Russian Federation	>95	13.7	18.1	5.5	11.3	100
Rwanda	<5	40.7	8.8	2.3	5.5	-
Saint Kitts and Nevis	>95 [ap]	12.3	-	-	-	88
Saint Lucia	>95	21.2	26.1	5.5	15.6	97
Saint Vincent and the Grenadines	>95	21.2	21.8	5.8	13.8	100
Samoa	31	10.6	4.9	1.4	3.2	-
San Marino	>95 [ap]	13.4	-	-	-	100
Sao Tome and Principe	<5	25.7	10.7	3.3	7.0	-
Saudi Arabia	>95	78.4	6.3	6.1	6.2	42
Senegal	31	37.5	12.3	3.4	7.8	-
Serbia	74	24.3	2.1	1.0	1.6	94
Seychelles	>95	18.7	15.2	4.7	9.9	91
Sierra Leone	<5	20.6	20.3	6.0	13.1	-
Singapore	>95 [ap]	18.3	0.3	0.2	0.2	66
Slovakia	>95	17.5	1.8	0.8	1.3	100
Slovenia	>95	15.8	0.8	0.6	0.7	100
Solomon Islands	8	10.7	6.3	2.1	4.3	-
Somalia	<5	29.5	8.5	2.7	5.6	-
South Africa	86	23.6	54.9	12.1	33.1	92
South Sudan	<5	41.1	7.9	2.2	5.1	-
Spain	>95	9.5	0.8	0.5	0.7	100
Sri Lanka	28	15.2	5.2	1.0	3.0	-
Sudan	44	47.9	9.2	3.1	6.2	-
Suriname	91	23.6	15.4	4.7	10.0	80
Sweden	>95 [ap]	5.9	1.5	0.6	1.0	100
Switzerland	>95 [ap]	10.2	0.5	0.5	0.5	100
Syrian Arab Republic	>95	39.4	3.6	1.3	2.5	83
Tajikistan	83	40.0	2.0	0.7	1.3	87
Thailand	78	26.2	8.8	1.4	5.0	87
Timor-Leste	11	17.9	8.1	2.0	5.1	-
Togo	8	32.7	13.7	4.9	9.3	-

ANNEX 2
Part 5

Member State	7.1 Proportion of population with primary reliance on clean fuels [t] (%) Comparable estimates 2017	11.6 Annual mean concentrations of fine particulate matter (PM$_{2.5}$) in urban areas [t] (µg/m³) Comparable estimates 2016	16.1 Mortality rate due to homicide [c,m,af] (per 100 000 population) Comparable estimates 2016 Male	Female	Both sexes	17.19.2 Completeness of cause-of-death data [c,m,ag] (%) Primary data 2009–2017
Tonga	55	10.1	6.3	2.9	4.6	-
Trinidad and Tobago	>95	22.0	74.3	11.0	42.2	83
Tunisia	>95	35.7	2.6	0.8	1.7	29
Turkey	>95	42.0	4.4	1.0	2.7	92
Turkmenistan	>95	19.0	6.6	1.9	4.2	85
Tuvalu	52	11.4	-	-	-	-
Uganda	<5	48.4	20.1	5.1	12.6	-
Ukraine	>95	18.3	7.0	2.5	4.6	92
United Arab Emirates	>95	39.4	4.8	1.1	3.8	59
United Kingdom	>95 [ap]	10.5	1.6	1.0	1.3	100
United Republic of Tanzania	<5	25.6	11.9	3.7	7.7	-
United States of America	>95 [ap]	7.4	10.6	2.6	6.5	100
Uruguay	>95	8.6	12.7	2.5	7.4	100
Uzbekistan	92	25.3	2.9	0.9	1.9	93
Vanuatu	11	10.3	3.6	1.3	2.5	-
Venezuela (Bolivarian Republic of)	>95	15.8	92.1	6.7	49.2	89
Viet Nam	70	29.7	6.8	0.9	3.8	-
Yemen	63	45.0	8.8	3.2	6.1	-
Zambia	16	24.7	15.4	5.0	10.1	-
Zimbabwe	29	19.4	23.9	6.7	15.1	-

WHO region

	7.1	11.6	Male	Female	Both sexes	17.19.2
African Region	17	35.5	15.9	4.9	10.4	6
Region of the Americas	92	13.4	31.8	4.3	17.9	94
South-East Asia Region	45	57.3	6.0	2.1	4.1	10
European Region	>95	17.6	4.9	1.7	3.3	97
Eastern Mediterranean Region	72	54.0	9.9	3.4	6.8	32
Western Pacific Region	62	42.9	2.9	1.0	1.9	64

	7.1	11.6	Male	Female	Both sexes	17.19.2
Global	61	39.6	10.1	2.6	6.4	49

a   World population prospects: the 2017 revision. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2017 (https://www.un.org/development/desa/publications/world-population-prospects-the-2017-revision.html, accessed 21 March 2019).

b   Global health estimates 2016: Life expectancy, 2000–2016. Geneva: World Health Organization; 2018 (https://www.who.int/gho/mortality_burden_disease/life_tables/en/, accessed 21 March 2019).

c   WHO Member States with a population of less than 90 000 in 2016 were not included in the analysis.

d   Global Health Expenditure Database [online database]. Geneva: World Health Organization (https://apps.who.int/nha/database/Select/Indicators/en/, accessed 15 March 2019). Global and regional aggregates are unweighted averages.

e   Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015 (https://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/, accessed 29 March 2018). WHO Member States with a population of less than 100 000 in 2015 were not included in the analysis. Data availability was defined by the latest year of input data from death registration, household surveys or other sources.

f   Joint UNICEF/WHO database of skilled health personnel, based on population-based national household survey data and routine health systems data. New York: United Nations Children's Fund; 2019 (https://data.unicef.org/topic/maternal-health/delivery-care/, accessed 14 February 2019). Global and regional averages refer to the year range 2013-2018.

g   Levels and trends in child mortality. Report 2018. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. United Nations Children's Fund, World Health Organization, World Bank Group and United Nations Population Division. New York: United Nations Children's Fund; 2018 (https://www.childmortality.org/files_v22/download/UN%20IGME%20Child%20Mortality%20Report%202018.pdf, accessed 15 March 2019). Data availability for both-sexes estimates was defined by the latest year of input data from death registration, population census, household surveys or other sources (https://childmortality.org , accessed 21 March 2019). Data availability for by-sex estimates was defined by the latest year of input data from death registration, population census, household surveys or other sources, obtained from the UN Inter-agency Group for Child Mortality Estimation.

h   AIDSinfo [online database]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) (http://aidsinfo.unaids.org/, accessed 15 March 2019); and HIV/AIDS [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/gho/hiv/epidemic_status/incidence/en/, accessed 15 March 2019).
     Data availability was defined by the latest year of input prevalence or antiretroviral treatment data from surveillance, household surveys or other sources, as informed by UNAIDS.

i   Global tuberculosis report 2018. Geneva: World Health Organization; 2018 (https://www.who.int/tb/publications/global_report/en/, accessed 15 March 2019). Data availability for both-sexes estimates was defined by the latest year of input case notification data from surveillance (https://www.who.int/tb/country/data/download/en/, accessed 21 March 2019). Data availability for by-sex estimates was defined by the latest year of input case notification data from surveillance (unpublished).

j   World malaria report 2018. Geneva: World Health Organization; 2018 (https://www.who.int/malaria/publications/world-malaria-report-2018/en/, accessed 15 March 2019). Data availability was defined by the country estimation method from the WHO Global Malaria Programme.

k   Global and country estimates of immunization coverage and chronic HBV infection [online database]. Geneva: World Health Organization; 23 March 2017 update (https://whohbsagdashboard.com/#global-strategies, accessed 30 March 2019). Global and regional averages are for the year 2017 from updated analysis. This indicator is used here as a proxy for the SDG indicator. Data availability was defined by the latest year of surface antigen sero surveys that were used as input to the estimation process.

l   Neglected tropical diseases [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/gho/neglected_diseases/en/, accessed 15 March 2019). Data availability was defined by the latest year of reported number of cases from surveillance systems of at least one disease.

m   Global health estimates 2016: deaths by cause, age, sex, by country and by region, 2000–2016. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html, accessed 21 March 2019). Data availability was defined by the latest year of input cause-of-death data from death registration system (https://terrance.who.int/mediacentre/data/ghe/GlobalCOD_method_2000_2016.pdf?ua=1, accessed 21 March 2019).

n   WHO Global Information System on Alcohol and Health (GISAH) [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/gho/alcohol/en/, accessed 15 March 2019). Data availability for both-sexes estimates was defined by the latest year of recorded alcohol consumption data from government statistics, country-specific alcohol industry statistics in the public domain, and the Food and Agriculture Organization of the United Nations' statistical database, as compiled by GISAH (https://apps.who.int/gho/data/node.main.A1039?lang=en, accessed 21 March 2019). Data availability for by-sex estimates was defined by the latest year of input sex-ratio data from surveys (https://www.who.int/gho/alcohol/GISAH_1_data_sources_of_abstainer_and_heavy_episodic_drinking_data.pdf, accessed 21 March 2019).

o   Global status report on road safety 2018. Geneva: World Health Organization; 2018 (https://www.who.int/violence_injury_prevention/road_safety_status/2018/en/, accessed 15 March 2019). Data availability was defined by the latest year of reported number of deaths by survey submitted to the WHO Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention (NVI), as of December 2017.

p   World contraceptive use 2019 [online database]. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2019 (forthcoming). Global and regional aggregates are estimates for the year 2019 from the Estimates and Projections of Family Planning Indicators 2019 [online database]. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2019 (forthcoming).

q   Data by country extracted by WHO from world fertility data 2017 [online database]. New York: United Nations, Department of Economic and Social Affairs, Population Division; November 2017 (https://www.un.org/en/development/desa/population/publications/dataset/fertility/wfd2017.shtml, accessed 21 March 2018). Global and regional aggregates refer to a 5-year period (2015–2020) from World population prospects: the 2017 revision. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2017 (https://esa.un.org/unpd/wpp/Download/Standard/Fertility/, accessed 16 February 2018). Additional data by country extracted by WHO from the United Nations Global SDG database [online database]. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (https://unstats.un.org/sdgs/indicators/database/, accessed 21 March 2018)

r   Tracking universal health coverage: 2017 global monitoring report. Geneva and Washington (DC): World Health Organization and the International Bank for Reconstruction and Development/The World Bank; 2017 (https://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.

pdf?sequence=1, accessed 15 March 2019). WHO Member States with a population of less than 90 000 in 2015 were not included in the analysis. Data availability was defined according to the analysis undertaken for the above-mentioned report. Normal font indicates "low" data availability, and bold font indicates "medium" and "high" data availability.

s   Tracking universal health coverage: 2017 global monitoring report. Geneva and Washington (DC): World Health Organization and the International Bank for Reconstruction and Development/The World Bank; 2017 (https://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng. pdf?sequence=1, accessed 15 March 2019). Global and regional aggregates refer to year 2010 and they include country data not show in the table.

t   Public health and environment [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/ gho/phe/en/, accessed 21 March 2019). Solid fuels: Data availability was defined by the latest year of input data on household fuels for cooking, heating and lighting from household surveys and censuses (https://www.who.int/airpollution/data/household-energy-database/en/, accessed 21 March 2019). Particulate matter: Data availability was defined by the latest year of input data on particulate matter ground measurement (https://www.who.int/ airpollution/data/cities/en/, accessed 21 March 2019) and satellite data.

u   WHO global report on trends in prevalence of tobacco smoking, 2nd edition. Geneva: World Health Organization; 2018 (https://www.who.int/tobacco/ publications/surveillance/trends-tobacco-smoking-second-edition/en/, accessed 15 March 2019). Data availability was defined by the latest year of input prevalence data from surveys.

v   WHO/UNICEF estimates of national immunization coverage [online database]. July 2018 revision (https://www.who.int/immunization/monitoring_ surveillance/routine/coverage/en/index4.html, accessed 15 March 2019). Data availability was defined by the latest year of input coverage data from administrative records, household surveys and other sources (https://www.who.int/immunization/monitoring_surveillance/data/Coverage_survey_data. xls?ua=1, accessed February 2019).

w   OECD.Stat [online database]. Paris: Organisation for Economic Co-operation and Development (https://stats.oecd.org/, accessed 19 January 2019).

x   WHO Global Health Workforce Statistics [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://who.int/hrh/ statistics/hwfstats/en/, accessed 15 March 2019). Country comparisons are affected by differences in the occupations included. Please refer to the source for country-specific definitions and other descriptive metadata. The global and WHO regional averages are for 2017, and were calculated using countries with values between 2013 and 2018. Some country estimates were used that are not shown in the annex table.

y   International Health Regulations (2005) Monitoring Framework [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/gho/ihr/en/, accessed 21 March 2019). Responses received as of 24 April 2019.

z   This indicator is presented here because it could constitute the health-related portion of the SDG Indicator 1.a.2. As a composite indicator including several categories of health expenditure, the data availability status was determined by the largest component: government transfers for health. The indicator was classified as documented if a primary source such as a government budget has been used.

aa   Levels and trends in child malnutrition. UNICEF/WHO/World Bank Group Joint Child Malnutrition Estimates. New York, Geneva and Washington (DC): United Nations Children's Fund, World Health Organization and the World Bank Group; 2018. Global and regional aggregates are for the year 2018.

ab   Global SDG Indicators Database [online database]. New York: United Nations, Statistics Division (https://unstats.un.org/sdgs/indicators/database/, accessed 15 March 2019). Includes surveys for women aged 15–49 only.

ac   Progress on drinking water, sanitation and hygiene – 2017 update and SDG baselines. Geneva and New York: World Health Organization and United Nations Children's Fund; 2017 (https://washdata.org/sites/default/files/documents/reports/2018-01/JMP-2017-report-final.pdf, accessed 31 March 2018); and Water and sanitation [online database], Global Health Observatory (GHO) data. Geneva: World Health Organization (https://www.who.int/gho/mdg/ environmental_sustainability/en/, accessed 21 March 2019).

ad   Comparable estimates are only shown for countries with recent primary data. Data availability was defined by the latest year that had a measurement of water quality and the latest year with a measurement of one or more sanitation-related variables. These unpublished data were provided by the WHO WASH programme.

ae   Official development assistance for the water sector (water supply and sanitation, agricultural water resources, flood prevention/control, and hydro-electric power plants), OECD-CRS, 2018 (https://stats.oecd.org/Index.aspx?DataSetCode=crs1, accessed 21 March 2019). Includes CRS purpose codes for water supply and sanitation (CRS 14000), agricultural water resources (CRS 31140), flood prevention / control (CRS 41050), and hydro-electric power plants (CRS 23220).

af   Data availability was defined by the latest year of input cause-of-death data from the death registration system (http://terrance.who.int/mediacentre/data/ ghe/GlobalCOD_method_2000_2016.pdf?ua=1, accessed 21 March 2019) and from criminal justice data as used for homicide estimates published in the Global status report on violence prevention 2014 (https://www.who.int/violence_injury_prevention/violence/status_report/2014/en/, accessed 21 March 2019).

ag   Completeness was assessed relative to the de facto resident populations, and values refer to the latest available value for the period 2009–2017. Global and regional aggregates are for 2017.

ah   Non-standard definition. See indicator footnote for more details.

ai   Proportion of institutional births (%) used as proxy for the SDG indicator.

aj   Data pertain to a non-standard age or marital status group. For more details, see the World contraceptive use 2019 (footnote p).

ak   Preliminary data.

al   Prevalence of overweight was calculated using BMI-for-age z-scores.

am   Survey data did not cover the 0–59 months age range, and data were adjusted for comparability.

an   Data are from a facility-based surveillance system, and they include 80% of health centres in the country.

ao   Conversion of estimates were based on the old NCHS/WHO references to WHO child growth standards when raw data were not available to allow comparability.

ap   For high-income countries with no information on clean fuel use, usage is assumed to be over 95%.

ANNEX 3

WHO regional groupings

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

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

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

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

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

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

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