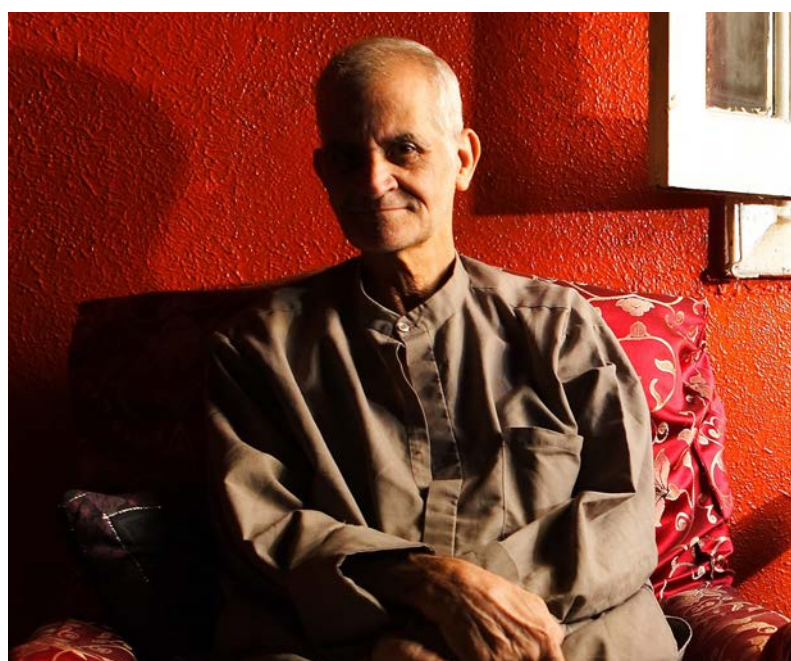


PROGRESS ON THE HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS AND TARGETS IN THE EASTERN MEDITERRANEAN REGION, 2020



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CONTENTS

Foreword	viii
Acknowledgements	ix
Acronyms and abbreviations	x
Executive summary	xi
Introduction	1
Data and methodology	2
» GOAL 1: END POVERTY IN ALL ITS FORMS EVERYWHERE	4
Target 1.1: By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US\$ 1.25 a day	4
» Indicator 1.1.1: Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	4
» GOAL 2: END HUNGER, ACHIEVE FOOD SECURITY AND IMPROVED NUTRITION AND PROMOTE SUSTAINABLE AGRICULTURE	6
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	6
» Indicator 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.	6
» Indicator 2.2.2: Prevalence of wasting (weight for height >-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	7
» Indicator 2.2.2: Prevalence of overweight (weight for height >+2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	8
» GOAL 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES	10
Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births	10
» Indicator 3.1.1: Maternal mortality ratio	10
» Indicator 3.1.2: Proportion of births attended by skilled health personnel	12
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	14
» Indicator 3.2.1: Under-5 mortality rate	14
» Indicator 3.2.2: Neonatal mortality rate	16

CONTENTS

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	18
» Indicator 3.3.1: Number of new HIV infections per 1000 uninfected population, by sex, age and key populations	18
» Indicator 3.3.2: Tuberculosis incidence per 100 000 population	20
» Indicator 3.3.3: Malaria incidence per 1000 population at risk	22
» Indicator 3.3.4: Hepatitis B incidence per 100 000 population	24
» Indicator 3.3.5: Number of people requiring interventions against neglected tropical diseases	26
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	28
» Indicator 3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	28
» Indicator 3.4.2: Suicide mortality rate	30
Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	32
» Indicator 3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	32
Target 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents	43
» Indicator 3.6.1: Death rate due to road traffic injuries	43
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	36
» 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	36
» Indicator 3.7.2: Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group	38
Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	40
» Indicator 3.8.1: Coverage of essential health services	40
» Indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income (greater than 10% or 25%)	42
Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	45
» Indicator 3.9.1: Mortality rate attributed to household and ambient air pollution	45
» Indicator 3.9.2: Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe water, sanitation and hygiene (WASH) services)	47
» Indicator 3.9.3: Mortality rate attributed to unintentional poisoning	49

CONTENTS

Target 3.a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	51
» Indicator 3.a.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older	51
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	53
» Indicator 3.b.1: Proportion of the target population covered by all vaccines included in their national programme	53
» Indicator 3.b.2: Total net official development assistance to medical research and basic health sectors per capita, by recipient countries (US\$)	57
» Indicator 3.b.3: Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	59
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	61
» Indicator 3.c.1: Health worker density and distribution	61
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	66
» Indicator 3.d.1: International Health Regulations (IHR) capacity and health emergency preparedness	66
» Indicator 3.d.2: Percentage of bloodstream infections due to selected antimicrobial-resistant organisms	68
» GOAL 4: ENSURE INCLUSIVE AND EQUITABLE QUALITY EDUCATION AND PROMOTE LIFELONG LEARNING OPPORTUNITIES FOR ALL	71
Target 4.1: By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	71
» Indicator 4.1.1: Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex	71
Target 4.6: By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy	73
» Indicator 4.6.1: Proportion of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex	73

CONTENTS

» GOAL 5: ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS	75
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	75
» Indicator 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	75
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	77
» Indicator 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	77
» GOAL 6: ENSURE AVAILABILITY AND SUSTAINABLE MANAGEMENT OF WATER AND SANITATION FOR ALL	79
Target 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking-water for all	79
» Indicator 6.1.1: Proportion of population using safely managed drinking-water services	79
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	81
» Indicator 6.2.1: Proportion of population using: (a) safely managed sanitation services; and (b) a hand-washing facility with soap and water	81
» GOAL 8: PROMOTE SUSTAINED, INCLUSIVE AND SUSTAINABLE ECONOMIC GROWTH, FULL AND PRODUCTIVE EMPLOYMENT AND DECENT WORK FOR ALL	83
Target 8.5: By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value	83
» Indicator 8.5.2: Unemployment rate, by sex, age and persons with disabilities	83

CONTENTS

» GOAL 11: MAKE CITIES AND HUMAN SETTLEMENTS INCLUSIVE, SAFE, RESILIENT AND SUSTAINABLE	87
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	87
» Indicator 11.6.2: Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)	87
» GOAL 16: PROMOTE PEACEFUL AND INCLUSIVE SOCIETIES FOR SUSTAINABLE DEVELOPMENT, PROVIDE ACCESS TO JUSTICE FOR ALL AND BUILD EFFECTIVE, ACCOUNTABLE AND INCLUSIVE INSTITUTIONS AT ALL LEVELS	89
Target 16.1: Significantly reduce all forms of violence and related death rates everywhere	89
» Indicator 16.1.1: Estimates of rates of homicides per 100 000 population, 2010-2019	89
Target 16.2: End abuse, exploitation, trafficking and all forms of violence against and torture of children	91
» Indicator 16.2.1: Proportion of children aged 1-17 years who experienced any physical punishment and or psychological aggression by caregivers in the past month	91
Summary of findings	93
Five key challenges	96
Way forward	97
References	99
Annex 1 Data sources for the health-related SDG indicators	102
Annex 2 SDG indicators and definitions	111
Annex 3 Data availability by health-related SDG indicator and country	112

FOREWORD



The 2030 Agenda for Sustainable Development includes a vision of healthy lives and well-being for all at all ages. Addressing the health-related targets covered by Sustainable Development Goal (SDG) 3 cannot be achieved without also addressing many of the other 16 SDGs. Realizing this vision requires that we know where we are so that we can see what we need to do. The 2030 Agenda for Sustainable Development includes a vision of healthy lives and well-being for all at all ages. Addressing the health-related targets covered by Sustainable Development Goal (SDG) 3 cannot be achieved without also addressing many of the other 16 SDGs. Realizing this vision requires that we know where we are so that we can see what we need to do.

Timely and high-quality data are critical for assessing the progress made towards meeting the health-related SDGs in the Eastern Mediterranean Region and in WHO's vision for the Region, Vision 2023: health for all by all – a call for solidarity and action.

In order to guide the implementation of interventions at country level, this regional profile presents for the first time a snapshot of the progress made in addressing the health-related SDG targets and indicators in the Region, the existing challenges and the steps required for accelerated action.

The report reveals that some countries still struggle to control infectious diseases, while others face a greater threat from chronic lifestyle-related diseases such as cardiovascular disease, diabetes, respiratory disease and cancer. Progress is being

made in other areas, such as improvements to health services, vaccination and skilled birth attendance coverage, and in increasing access to improved drinking-water and sanitation. However, the impact of the coronavirus disease (COVID-19) pandemic threatens such achievements and has exposed significant health inequities in the Region.

In addition, large data gaps continue to hamper the monitoring of progress and finding of solutions to accelerate progress towards achieving the health-related SDG targets. Good reliable data on health, health risks, access to services and health outcomes are crucial for informing decision-making and knowledge translation. Building on existing partnerships at the national, regional and global level, WHO will continue to invest in strengthening health information systems, identify trends and promote evidence-based policy dialogue to support the acceleration of progress.

I look forward to the periodic updating of this regional profile to highlight the progress being made on our journey together – towards achieving the ambitious goals of the 2030 Agenda for Sustainable Development.

Dr Ahmed Al-Mandhari

WHO Regional Director for the Eastern Mediterranean

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ACRONYMS AND ABBREVIATIONS

AMR	antimicrobial resistance
COVID-19	coronavirus disease
DAC	Development Assistance Committee
DALY	disability-adjusted life year
DTP3	diphtheria-tetanus-pertussis third dose
<i>E. coli</i>	<i>Escherichia coli</i>
HBsAg	hepatitis B surface antigen
IHR	International Health Regulations
MCV2	measles-containing-vaccine second dose
MMR	maternal mortality ratio
MRSA	methicillin-resistant <i>Staphylococcus aureus</i>
NCD	noncommunicable disease
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
PCV3	pneumococcal conjugate third dose
PLHIV	people living with HIV/AIDS
RMH	reproductive and maternal health
<i>S. aureus</i>	<i>Staphylococcus aureus</i>
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WHO FCTC	World Health Organization Framework Convention on Tobacco Control

EXECUTIVE SUMMARY

This document reports on the progress made in achieving the health-related SDGs and targets in the Eastern Mediterranean Region of the World Health Organization (WHO). It presents regional trends for these SDGs and targets using data available from WHO and estimates developed by other United Nations agencies from January 2010 to September 2020.

Data on health-related SDG indicators were compiled from several sources including the WHO regional core health indicators annual reports, WHO Global Health Observatory and estimates developed by a number of United Nations interagency groups. Data from the WHO regional core health indicators programme (the annual reports and the Regional Health Observatory) were used since these are reported by Member States each year to WHO. All data were used to compute median and weighted mean values for the Region for 2015 and 2019 for most indicators depending on data availability. Data availability for SDG 3 target indicators varied considerably, with substantial gaps across indicators of cause-specific mortality. A total of 50 indicators with sufficient data have been analysed and presented in the main report.

Progress was observed for over half of the indicators (28 out of 50) at regional level. However, for seven of these indicators the rate of progress is too slow to meet global targets. In addition, progress has stalled for eight indicators. Large inter-country differences exist both in current status and in the progress being made towards the SDGs across most indicators. The unavailability of data for around one in four indicators (12 out of 50) hinders the ability to report on the progress made.

Although there has been improvement in the coverage of health services, the lack of data on financial protection hampers understanding of the progress made towards universal health coverage (UHC) in the Region. In addition, despite

some progress being made on the unfinished and expanded Millennium Development Goals agenda, reductions in maternal, child and neonatal mortality remain slower than expected. Similarly, the expansion of vaccination coverage remains suboptimal. In addition, progress in reducing the overall rates of HIV and malaria cases have stalled, while mortality rates due to noncommunicable diseases (NCDs), pollution and unintentional poisoning are not being reduced, and much greater efforts are needed. Similarly, progress in reducing road traffic injuries remains slow and is a major regional concern as such injuries, alongside NCDs and mental health issues, continue to represent a major health burden in the Region.

The progress being made in addressing risks to health and health determinants is also mixed. Although fewer children are malnourished, progress has stalled in reducing the percentage of children under 5 years of age who are overweight. In addition, despite progress in increasing access to improved drinking-water and sanitation, millions of people in the Region still lack these basic services. The Region is seeing an increased proportion of children in primary school, young people who are literate, and men and women who are employed. However, a lack of data on poverty, violence-related deaths and gender inequality is resulting in an incomplete picture with respect to key health determinants. In addition, the negative impact of the COVID-19 pandemic on economies and food security is threatening the progress made in all these areas.

This report also highlights five key challenges faced by the Region as it moves forward on the health-related SDGs. Among these challenges, fragmented health care services and suboptimal health workforce production and an imbalanced skills mix is limiting the provision of comprehensive health services, especially for NCDs, injury prevention and post-injury emergency services.

While this challenge affects almost all countries of the Region, several countries are also experiencing stagnation in achieving key global and national goals in improving maternal and child health outcomes, as well as reducing the burden of communicable diseases. Limited national financial investment in health and weak regulatory measures threaten the ability of countries to mitigate the impact of climate change, address several SDG targets and ensure a whole-of-society approach to addressing risk factors and health determinants. Large data gaps due to fragmentation of data sources, limited data disaggregation and limited epidemiological and operational research is also hampering the ability of countries to take evidence-based public health actions.

Resolving data gaps will require strategic investment in the timely conducting of key household surveys, as well as the enhancing of well-connected and standardized routine information systems. In addition, many countries of the Region are also directly or indirectly affected by conflict, civil unrest and environmental threats. Furthermore, structural and sociocultural barriers continue to limit access by women to vital health services and to drive large health disparities both between and within countries.

The way forward demands continuing the promotion of UHC and comprehensive essential health services, strengthening health systems capacity to mitigate the health impact of emergencies, and investing in building a diverse and professional health workforce.

In addition, the strengthening of government leadership and regulatory functions will help to ensure sustainable health investment for basic health services and the adoption of regulations, standards and policies to address risk factors. Multisectoral action through the health-in-all-policies approach will not only promote health security but will also help to address health risk factors and health determinants, including by mitigating the health impacts of the COVID-19 pandemic and climate change. Strengthening health information systems will also inevitably be a critical factor in allowing countries to measure progress and to utilize quality data to inform public health actions. Finally, ensuring data disaggregation and focusing health systems on addressing the differential exposures to health risks and barriers will help to ensure gender- and equity-sensitive responses, and to make sure we leave no one behind.

INTRODUCTION

This document reports on the progress made in achieving the health-related SDGs and targets in the WHO Eastern Mediterranean Region. It presents regional trends for these SDGs and targets using data available from WHO and estimates developed by other United Nations agencies from January 2010 to September 2020. The report thus serves as a baseline and early progress measure for the SDG targets and indicators covered.

For ease of reading, a series of fact sheets present the regional and country trends for each of the health-related targets and indicators. Each fact sheet also outlines the regional challenges to be overcome and the steps required to accelerate progress if these goals are to be met by 2030. To support countries in achieving each of the targets, a range of WHO tools and guidance are identified as well as key references related to the target.

Meeting the overall SDG 3 to “Ensure healthy lives and promote well-being for all at all ages” will depend upon achieving all of the associated targets. In particular, the achievement of UHC (target 3.8) will be key to achieving all the other SDG 3 targets; whether these are related to mortality (targets 3.1, 3.2, 3.4, 3.6 and 3.9) morbidity (targets 3.3, 3.5 and 3.7) or means of implementation (targets 3.a–d).

Achieving SDG 3 will also depend on achieving the other SDGs (Fig. 1) as some of these are: (a) risk factors that have direct effects on health (SDGs 2, 6, 7, 11, 13 and 16); (b) determinants of health (SDGs 1, 4, 5, 8, 9, 12, 14 and 15); or (c) cross-cutting (SDGs 10 and 17). For example, achieving SDG target 3.4 on reducing mortality from NCDs will depend not only on achieving other SDG 3 health targets such as UHC and tobacco control but also other SDG health-related targets, such as reducing indoor and outdoor air pollution (SDG targets 7.1.2 and 11.6.2) while also addressing their interactions with poverty (SDG 1), nutrition (SDG 2) and gender (SDG 5).

Fig. 1. Health in the SDG era



Source: https://www.who.int/health-topics/sustainable-development-goals#tab=tab_1

DATA AND METHODOLOGY

Monitoring progress towards the health-related SDGs and targets requires high-quality data from each country to track changes against specific indicators.

There is no single source of data for monitoring progress towards the health-related SDGs for countries of the Region covering the period of interest, that is from 2015 (SDG baseline) to 2019. Data on health-related SDGs were therefore compiled from several sources, including the annual WHO regional core health indicators reports (1–3); the United Nations Global SDG database (4); the Global Database on Child Growth and Malnutrition (5); Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation (6, 7); the WHO Global Health Observatory on tuberculosis, malaria, hepatitis B and alcohol (8–11); WHO Global Health Estimates (12); Estimates and Projections of Family Planning Indicators by the United Nations Population Division (13); WHO Global Health Observatory on UHC (14); WHO-UNICEF estimates of immunization coverage (15–17); WHO Global Observatory on Health R&D (18); WHO Regional Health Observatory (19); and the WHO Global Health Observatory on intimate partner violence, ambient air pollution, and homicides (20–22). To a large extent, data from the WHO regional core health indicators programme (the annual reports and the Regional Health Observatory) were used since they are reported by Member States to WHO each year. Efforts were made to ensure that the reference years shown for data obtained from published reports and electronic databases corresponded to the years when the data were collected and not the year in which the data were published.

All data were used to compute median and mean values for the Region for 2015 and 2019 for most indicators depending on data availability.

A number of indicators had data available only for 2019. In cases where data were not available, the most recent value or year closest to 2015 (2014 or 2013) or 2018 (2016 or 2015) was used to compute the median and mean values for the Region. In cases where no value was available from that time period for all countries, a regional median was computed using those countries with data. The compiled data were also used to compute population-weighted means for the Region with population numbers obtained from the World Population Prospects 2019 (23). For selected indicators such as child mortality, data were available for as recently as 2019. For all indicators, charts were prepared from the available data, and computed means and median values were plotted to show data availability and trends since 2015. For selected indicators, data were available from 2010 and provided an opportunity to assess trends prior to the SDG baseline year of 2015. All sources of data were validated by technical departments within the WHO Regional Office for the Eastern Mediterranean.

More details on the sources of data are provided in Annex 1, while Annex 2 indicates where further information can be found on the development of the global indicator framework and on the metadata used for each indicator. Annex 3 summarizes data availability across all indicators, by country and year. As shown in Fig. 2, the availability of data on SDG 3 target indicators varies considerably over the period 2014–2019, with substantial gaps existing across indicators on cause-specific mortality. A total of 50 indicators with sufficient data are analysed and presented in this report.



» GOAL 1: END POVERTY IN ALL ITS FORMS EVERYWHERE

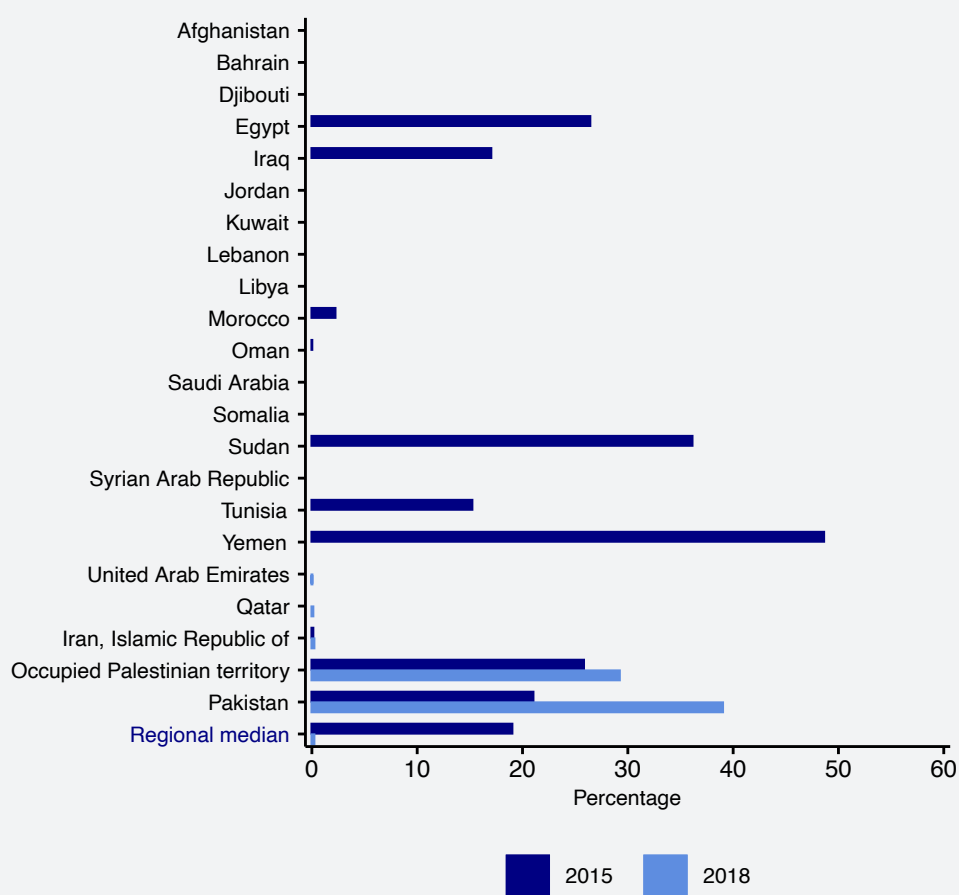
Target 1.1: By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US\$ 1.25 a day

Indicator 1.1.1: Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)

Current situation

- Decreases in the proportion of population living in poverty between 2015 and 2018 (median = 19% and 0.2% respectively) are likely to be underestimates since trend data are only available from three countries.
- In 2015, the proportion of the population living below the international poverty line was highest in Yemen (~50%) and lowest in Oman (0%).
- During the period 2016–2018, the proportion was highest in Pakistan (39% in 2016) and lowest in the United Arab Emirates (0.01% in 2018).
- For countries in the Region with reported data, the proportion of the population living below the international poverty line was higher than the global proportion of 8.2% in 2019 (24). This situation has been exacerbated by the COVID-19 pandemic, with more than 71 million people pushed into extreme poverty in 2020 (24).

1.1.1 Proportion of population living below the international poverty line (%), 2015–2018



Key message

- Limited data on poverty estimates in most countries of the Region hamper the ability to reliably track progress in achieving SDG 1.

Challenges

- According to the World Bank 2020 report (25), one in five people in the Middle East and North Africa live near violent conflict, with chronic violence contributing to the increase in regional poverty. Nearly half of the economies in the Middle East and North Africa region are classified as fragile and conflict-affected states.
- The COVID-19 pandemic has severely affected already vulnerable economies in the Region by exacerbating structural economic issues, including but not limited to higher youth and female unemployment, large and inefficient public sectors, non-competitive business environment and governance challenges.

Steps for accelerated action

In the wake of the COVID-19 devastation, the 2020 United Nations High-Level Meeting on “Trends, options and strategies in poverty eradication across the world” recommended the following actions (26):

- people-centred public policies should be instituted to allow for scaled up investment in universal health care, education, social protection, equitable access to digital technology, and support to small- and medium-sized enterprises;
- the oversight, regulatory and coordination functions of the public sector should be strengthened, taking into account the effective engagement of civil society and the private sector;
- small- and medium-sized enterprises, including women-led businesses, should be helped to grow and to contribute their fair share to the eradication of poverty; and
- urgent international cooperation should be mobilized to support developing countries through the allocation of an extra recovery package, provision of liquidity and financial assistance through postponement of debt repayment.

Available guidance/tools

- Corral P, Irwin A, Krishnan N, Mahler DG Vishwanath T. Fragility and conflict. On the front lines of the fight against poverty. Washington, DC: World Bank. 2020: <https://openknowledge.worldbank.org/bitstream/handle/10986/33324/9781464815409.pdf?sequence=14&isAllowed=y>
- Report of the High-Level Meeting on “Trends, options and strategies in poverty eradication across the world” and the inauguration of the Alliance for Poverty Eradication. 30 June 2020: <https://www.un.org/pga/74/event/trends-options-and-strategies-in-poverty-eradication-across-the-world/>

» GOAL 2: END HUNGER, ACHIEVE FOOD SECURITY AND IMPROVED NUTRITION AND PROMOTE SUSTAINABLE AGRICULTURE

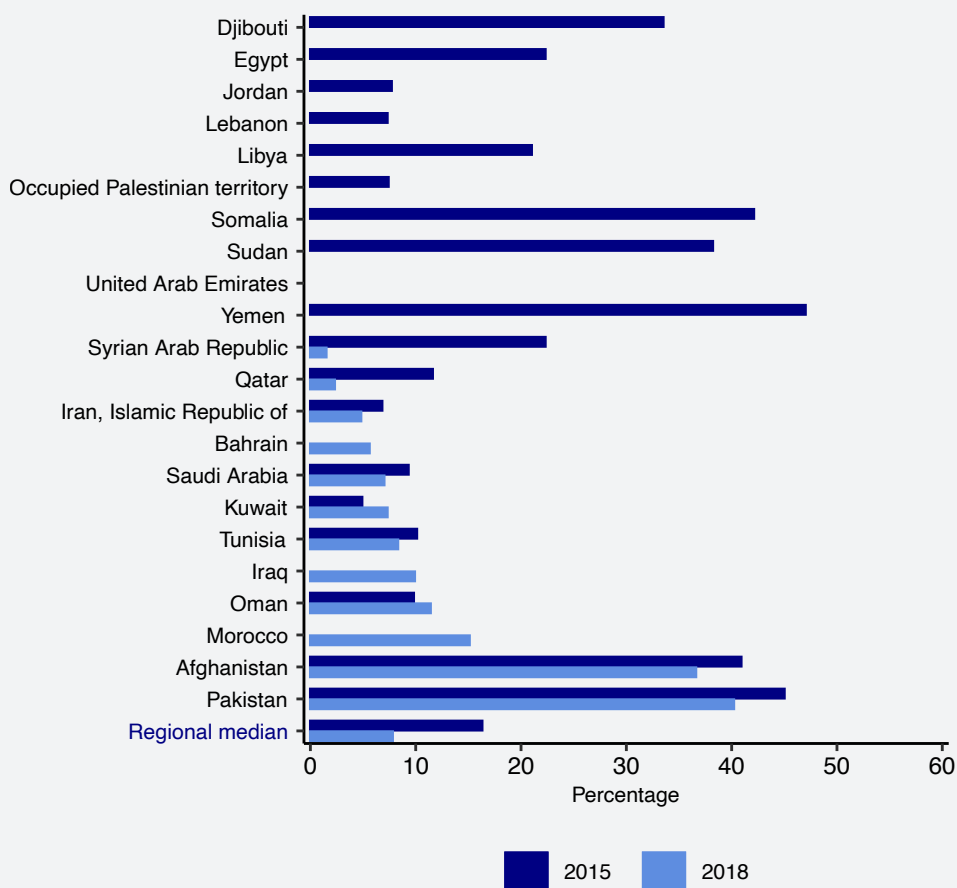
Target 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

Indicator 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

Current situation

- Seven of the nine countries with data available to measure trends showed reductions in stunting prevalence, which is reflected in the regional median values.
- Globally, the proportion of stunting among children under 5 years of age was 23% in 2015 and declined to 21% in 2019. These proportions are higher than the median values for the Region (24).
- For countries with data available for the period 2016–2018 the prevalence of stunting among children under 5 years of age was lowest in the Syrian Arab Republic (7%) and highest in Pakistan (40%).

2.2.1 Stunting among children under 5, 2015–2018

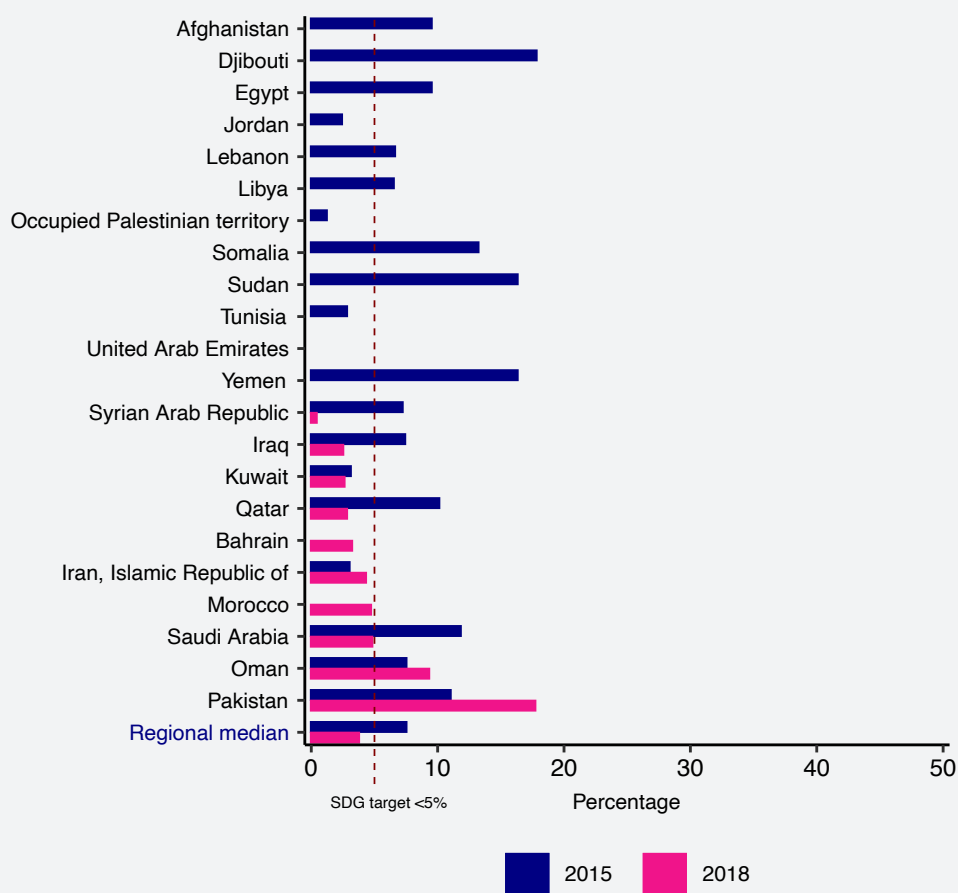


Indicator 2.2.2: Prevalence of wasting (weight for height >-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

Current situation

- In the period 2013–2015, four out of 19 countries with available data had already achieved the SDG target of $<5\%$ wasting among children under 5 years of age. This had increased to seven countries by 2018.
- For countries with data available for the period 2016–2018, the prevalence of wasting among children under 5 years of age was lowest in the Syrian Arab Republic (0.4%) and highest in Pakistan (17.7%).
- Between 2015 and 2018 the prevalence of wasting among children under 5 years of age increased in the Islamic Republic of Iran, Oman and Pakistan; in 2019, 6.9% of children under 5 years of age were affected by wasting worldwide.

2.2.2 Wasting among children under 5, 2015–2018

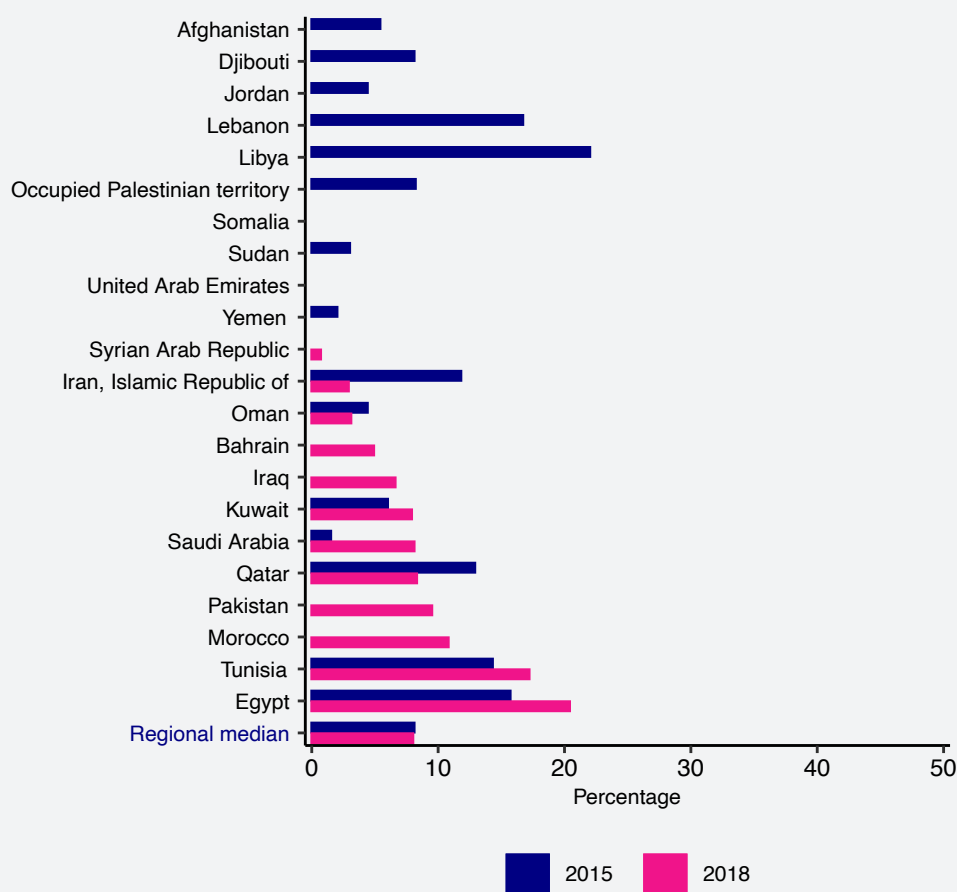


Indicator 2.2.2: Prevalence of overweight (weight for height $>+2$ standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

Current situation

- Although the prevalence of overweight among children under 5 years of age decreased in the Islamic Republic of Iran, Oman and Qatar, it increased in Egypt, Kuwait and Tunisia between 2015 and 2018. The median regional value remained stagnant – a warning sign for future health problems.
- For countries with data available for the period 2016–2018, prevalence of overweight among children under 5 years of age was lowest in the Syrian Arab Republic (0.7%) and highest in Egypt (20.4%).
- Globally in 2019, 5.6% of children under 5 years of age (38 million) were overweight. This global prevalence represents a medium level of severity, signalling that preventive actions are urgently needed for the youngest population (24).

2.2.2 Overweight among children under 5, 2015–2018



Key message

- Urgent actions are required to protect the nutritional status of children – more so during the COVID-19 pandemic.

Challenges

- Lack of government commitment and limited allocation of financial resources to address the double burden of malnutrition especially in low- and middle-income countries.
- Many populations in the Region are directly or indirectly affected by conflict, environmental threats and natural disasters; the challenges of ensuring food security and nutrition are likely to be amplified by the COVID-19 pandemic.
- Many countries continue to face problems with acute malnutrition, and more than half of countries in the Region have programmes to treat severe or moderate acute malnutrition.
- Lack of regulatory measures and fiscal policies to support healthy diets and physical activity among young children, and to address the shift in food consumption towards diets high in salt, fat and sugar in most countries of the Region.
- Marketing of unhealthy food targeting children and adolescents, especially via social media.

Steps for accelerated action

- Strong government leadership, increased political and financing support, and multisectoral participation are crucial for effective action on nutrition.
- Comprehensive multisectoral coordination mechanisms are needed at various levels to harness all of the many different sectors that can play a role in tackling malnutrition, including obesity and other noncommunicable diet-related risk factors.
- To be able to address malnutrition in all its forms, it is important that countries build human resources capacity through the training of nutrition professionals (nutritionists and dietitians) and the provision of nutrition-related training to health professionals and other front-line workers.
- Promote healthy diets high in fruits and vegetables and low in salt, fat (total fat, saturated fatty acids and trans fatty acids) and sugar, especially among schoolchildren and adolescents.

- Breastfeeding (exclusive for the first 6 months and continuation for 2 years) and nutritionally balanced complementary feeding for children under five years of age are key preventive and cost-effective interventions for addressing obesity and NCDs.

Available guidance/tools

- Strategy on nutrition for the Eastern Mediterranean Region 2020–2030: <http://applications.emro.who.int/docs/9789290222996-eng.pdf?ua=1>, last accessed 13 October 2020
- Wheat flour fortification in the Eastern Mediterranean Region: http://applications.emro.who.int/docs/EMROPUB_2019_EN_22339.pdf?ua=1, last accessed 13 October 2020
- International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions. Relevant WHA resolutions can be found at: https://www.who.int/nutrition/topics/wha_nutrition_itycn/en/
- Regional framework for action on obesity prevention 2019–2023: http://applications.emro.who.int/docs/EMROPUB_2019_en_22319.pdf?ua=1
- Healthy diet: https://applications.emro.who.int/docs/EMROPUB_2019_en_23536.pdf?ua=1

Key references

- UNICEF/WHO/World Bank Group. Joint Malnutrition Estimates. Geneva; 2019.
- WHO/UNICEF/World Bank Group. Joint Malnutrition Estimates 2020 edition [online database; cited 29 April 2020]: <https://apps.who.int/gho/tableau-public/tpc-frame.jsp?id=402>
- Global nutrition policy review 2016–2017. Geneva: World Health Organization; 2018.
- National implementation of the baby-friendly hospital initiative. Geneva: World Health Organization; 2017.
- 2017 Regional overview of food security and nutrition. Building resilience for food security and nutrition in times of conflict and crisis: a perspective from the Near East and North Africa Region. Cairo: Food and Agriculture Organization of the United Nations; 2017: <http://www.fao.org/3/I8336EN/i8336en.pdf>

» GOAL 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

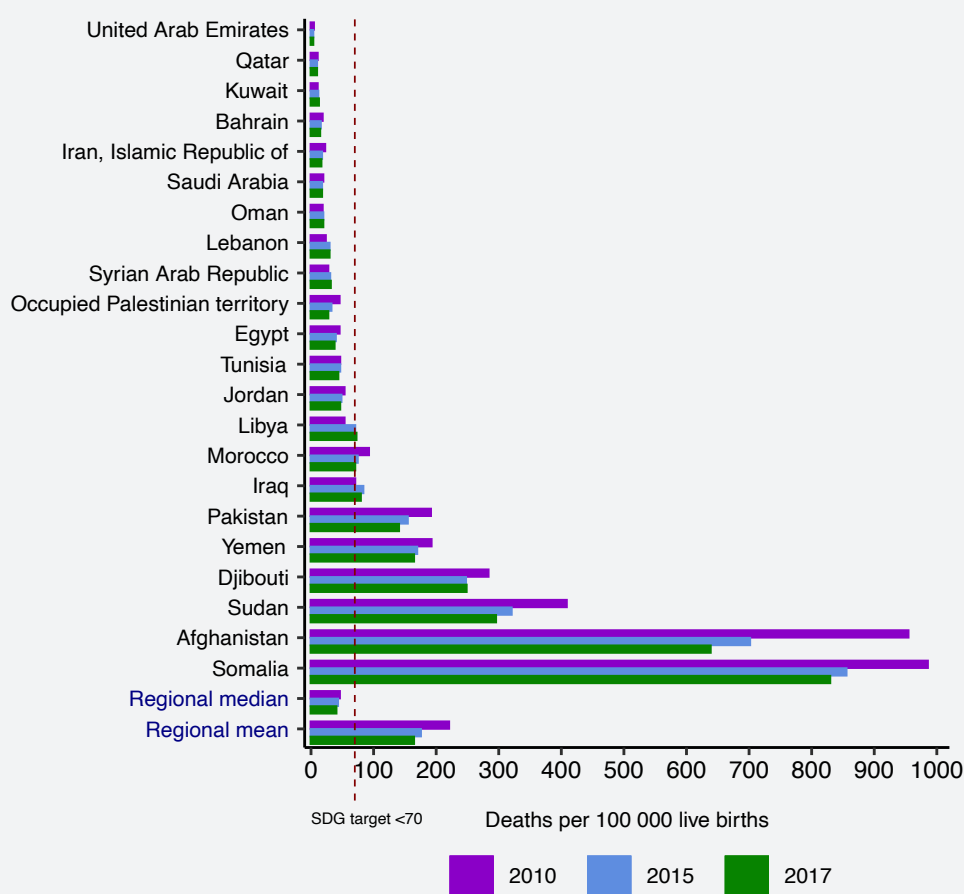
Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births

Indicator 3.1.1: Maternal mortality ratio

Current situation

- The Region has made remarkable progress in reducing maternal mortality from 362 to 175 deaths per 100 000 live births between 1990 and 2015, and to 164 deaths per 100 000 live births by 2017. However, maternal mortality remains one of the main public health concerns of the Region.
- By 2030, all countries should reduce maternal mortality by at least two thirds of their 2010 baseline level. The average global target is a maternal mortality ratio (MMR) of less than 70 deaths per 100 000 live births by 2030. The supplementary national target is that no country should have an MMR of more than 140 deaths per 100 000 live births (twice the global target) by 2030.
- Thirteen countries (60%) of the Region have now met the SDG target of an MMR of less than 70 deaths per 100 000 live births.
- There are notable geographical inequalities across the Region. In 2017, the United Arab Emirates had the lowest MMR (3 deaths per 100 000 live births) while Somalia had the highest (829 deaths per 100 000 live births).
- Five countries (Afghanistan, Djibouti, Somalia, Sudan and Yemen) reported an MMR of more than 140 deaths per 100 000 live births in 2017, which is above the supplementary national target needed to achieve SDG 3.1 by 2030.

3.1.1 Maternal mortality ratios, 2010–2017



Key message

- Maternal mortality remains one of the main public health concerns of the Region.

Challenges

- Fragmented service-delivery mechanisms lacking integration and linkages.
- Deficiencies in trained human resources for sexual and reproductive health (SRH) services.
- Inequitable access to, and poor quality of, SRH services.
- Sociocultural barriers and lack of policies preventing women and girls from achieving their right to positive reproductive health outcomes.
- Lack of sufficient granularity in the available data to guide programme planning and improvements.

Steps for accelerated action

- Ensure SRH integration at policy, programme and service levels, and address the causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.
- Strengthen the skills of health providers in delivering SRH services.
- Ensure equitable reproductive and maternal health (RMH) coverage and better quality of care services.
- Strengthen information, education and communication for SRH services to promote positive RMH outcomes.
- Promote and encourage the use of SRH indicators and surveillance systems (for example, for maternal and perinatal death surveillance and response activities) to improve quality of care and accountability.

Available guidance/tools

- The global strategy for women's, children's and adolescents' health (2016–2030): <https://www.who.int/life-course/partners/global-strategy/en/>
- WHO recommendations on antenatal care for a positive pregnancy experience <https://www.who.int/publications/i/item/9789241549912>
- Robson Classification: implementation manual: https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/robson-classification/en/

[publications/maternal_perinatal_health/robson-classification/en/](https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/robson-classification/en/)

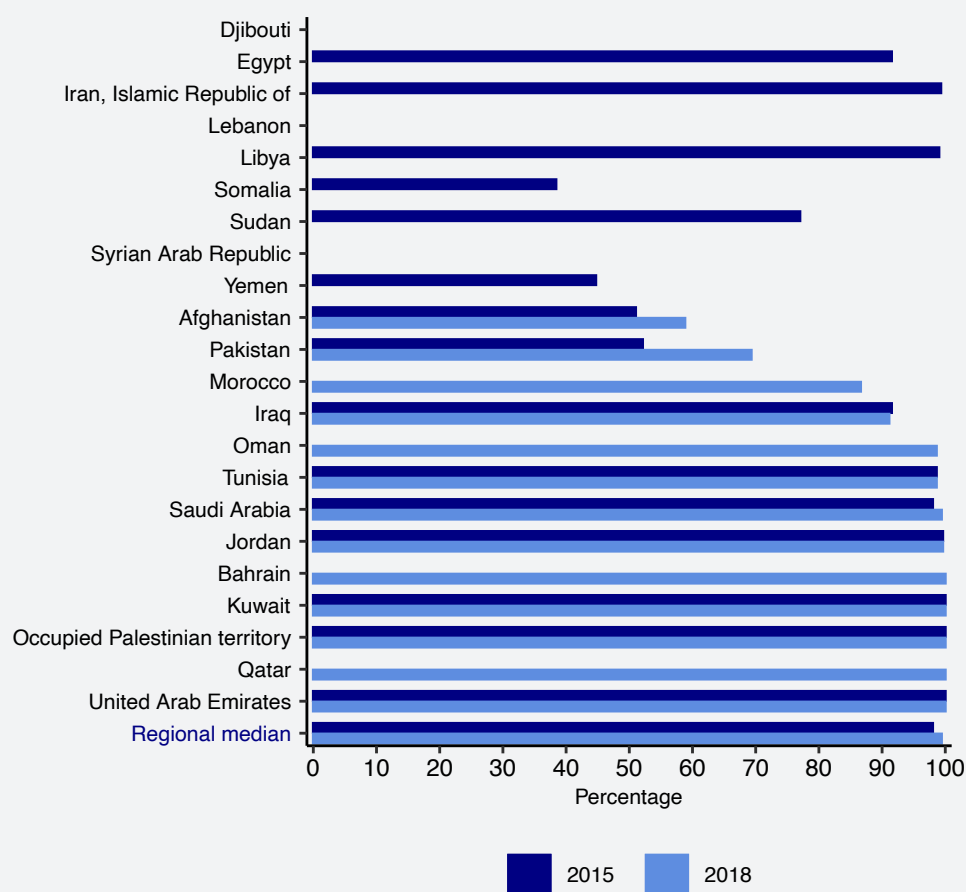
- Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death: https://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/
- Medical eligibility criteria for contraceptive use. Fifth edition, 2015. A WHO family planning cornerstone: https://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/

Key references

- Strategies toward ending preventable maternal mortality (EPMM). Geneva: World Health Organization; 2015: https://www.who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/
- Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: executive summary. Geneva: World Health Organization; 2019: <https://apps.who.int/iris/handle/10665/327596>
- Souza JP, Tunçalp Ö, Vogel JP, Bohren M, Widmer M, Oladapo OT et al. Obstetric transition: the pathway towards ending preventable maternal deaths. *BJOG*. 2014;121(Issue s1):1–4: <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.12735>
- 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/>

Indicator 3.1.2: Proportion of births attended by skilled health personnel**Current situation**

- During the period 2015–2018 the proportion of births attended by skilled health personnel in half of the countries of the Region was almost universal (> 98%).
- In Somalia, Yemen and Afghanistan the proportion of births attended by skilled health personnel were 38.4% (2014), 44.7% (2015) and 58.8% (2018) respectively.
- Eight of the nine countries with data on trends showed an increase in the proportion of births attended by skilled health personnel, with the largest increase seen in Pakistan (from 52.1% in 2015 to 69.3% in 2018).

3.1.2 Births attended by skilled health personnel, 2015–2018

Key message

- Skilled care at the time of delivery is a triple investment (reducing maternal and newborn deaths and stillbirths). The implementation of strategies to improve institutional deliveries should be accelerated.

Challenges

- Deficiencies in supportive regulations, policies and quality-assurance processes.
- Inadequate numbers of trained health personnel and suboptimal distribution of the available trained health personnel.
- Poor infrastructure and facilities at health facilities.
- Non-availability of defined referral and communication pathways and facilities for emergency transport of pregnant women.
- Shortages of essential logistics and supplies.

Steps for accelerated action

- Improve 24/7 access to skilled maternal health care in primary-level facilities to narrow equity gaps and improve institutional deliveries.
- In locations where geographical access is difficult, consider developing “maternity waiting homes” (as per standards or similar structures) to enable mothers to be closer to facilities and/or facilitate access to transportation.
- Increase the availability of skilled health personnel for maternal and newborn care and ensure their equitable deployment.
- Optimize the role of the health workforce through task shifting for SRH services.
- Put in place birth preparedness and complication or emergency readiness plans for every pregnant woman, emphasizing institutional delivery.
- Implement innovative ways of encouraging institutional deliveries of high quality through demand-side financing schemes, building on national and regional best practices.

Available guidance/tools

- WHO recommendations: intrapartum care for a positive childbirth experience: <https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/>

- Standards for improving quality of maternal and newborn care in health facilities: https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/
- Essential competencies for midwifery practice. International Confederation of Midwives: <https://www.internationalmidwives.org/our-work/policy-and-practice/essential-competencies-for-midwifery-practice.html>
- Definition of skilled health personnel providing care during childbirth. The 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO, IPA: <https://www.who.int/reproductivehealth/publications/statement-competent-mnh-professionals/en/>

Key references

- Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: <https://data.unicef.org/resources/trends-maternal-mortality-2000-2017/>

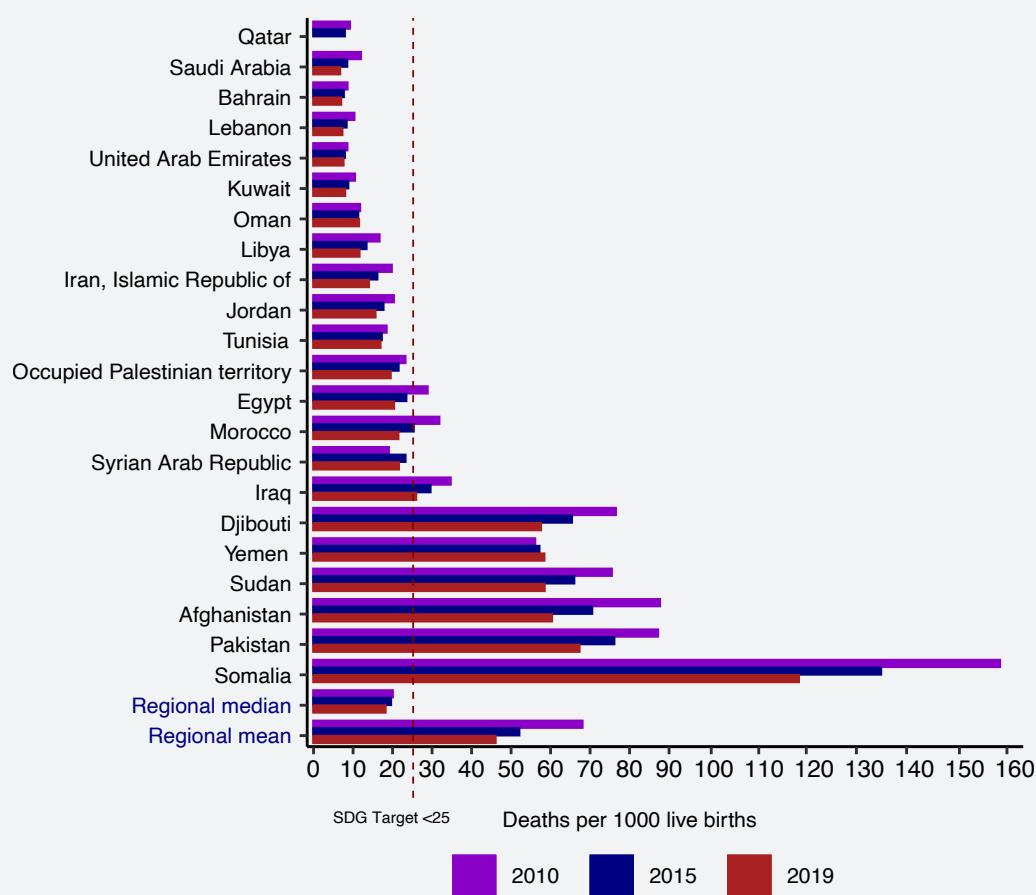
Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births

Indicator 3.2.1: Under-5 mortality rate

Current situation

- Between 2010 and 2019 the median under-5 mortality rate in the Region decreased from 20.0 deaths per 1000 live births to 18.2 deaths per 1000 live births (i.e. the under-5 mortality rate in at least half of the countries in 2019 was below 18.2 deaths per 1000 live births).
- In 2019, under-5 mortality was lowest in Qatar (6.5 deaths per 1000 live births) and highest in Somalia (117.0 deaths per 1000 live births).
- In 2019, under-5 mortality in 15 countries of the Region was lower than the SDG target of less than 25 deaths per 1000 live births.
- In 2019, under-5 mortality in six countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) exceeded 50 deaths per 1000 live births (i.e. more than double the SDG target of less than 25 deaths per 1000 live births).

3.2.1 Under-5 mortality rate, 2010–2019



Key message

- The equity gap in child mortality is huge both within and between countries of the Region. Evidence-based, high-impact interventions to avert child deaths are available for scale-up based on country context, including in humanitarian settings.

Challenges

- Security and instability issues are key challenges, particularly in conflict-affected and humanitarian settings.
- The indirect impact of the COVID-19 pandemic on essential maternal, neonatal, child and adolescent health services.
- Shortage of updated reliable national data to inform evidence-based policy.
- Fragmentation and verticality of child health programmes at country level.
- Scarcity of financial resources for child health interventions, particularly from domestic funds.
- National capacities in planning, implementation, and monitoring and evaluation of child health programmes need to be strengthened.

Steps for accelerated action

- Apply multisectoral child-centred interventions along the life-course.
- Strengthen/scale up the quality of child health care services at each level of the health system (community, primary health care and referral) through the provision of child-friendly health facilities and services, and the availability of child-specific appropriate equipment and appropriately trained and competent staff.
- Build up the capacity of health care providers to deliver quality child health and development services.
- Build national capacities in managing reproductive, maternal, neonatal, child and adolescent health programmes at national and subnational levels, both in stable and humanitarian settings.
- Strengthen community engagement and empower families to care for and protect their children.

Available guidance/tools

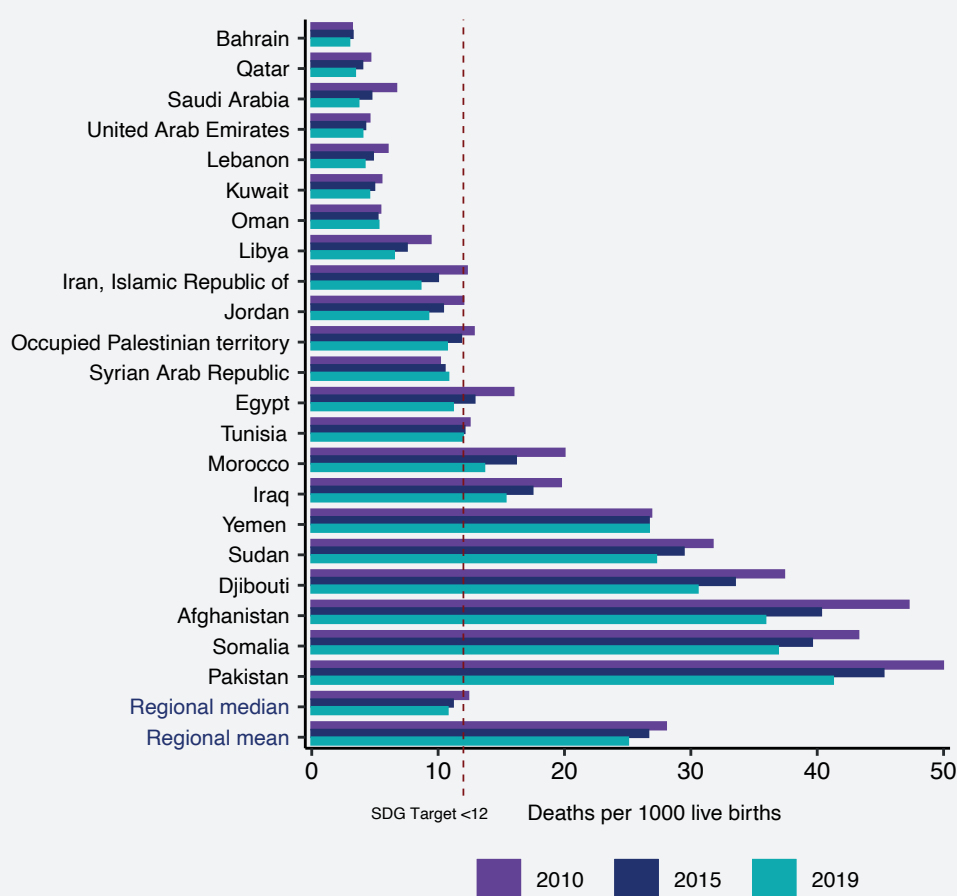
- Regional implementation framework on ending preventable newborn, child and adolescent deaths and improving health and development: https://applications.emro.who.int/docs/RC_Technical_Papers_2019_3_en.pdf?ua=1
- Child and adolescent health in humanitarian settings operational guide: a holistic approach for programme managers [in press]; following publication will be posted at: <http://www.emro.who.int/child-adolescent-health/information-resources/index.html>
- Child and adolescent health: <http://www.emro.who.int/entity/child-adolescent-health/home.html>
- Nurturing care for early childhood development. A framework for helping children survive and thrive to transform health and human potential: <https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf?ua=1#:~:text=The%20Nurturing%20Care%20Framework%20is,to%20make%20use%20of%20it>
- The global strategy for women's, children's and adolescents' health (2016-2030): <https://www.who.int/life-course/partners/global-strategy/en/>
- Standards for improving the quality of care for children and young adolescents in health facilities: https://www.who.int/maternal_child_adolescent/documents/quality-standards-child-adolescent/en/

Key references

- Levels and trends in child mortality. Report 2020: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2020: <https://childmortality.org/wp-content/uploads/2020/09/UNICEF-2020-Child-Mortality-Report.pdf>
- Stillbirth and Child Mortality Estimates [online database]. New York: IGME: UN Inter-agency Group for Child Mortality Estimation: <https://childmortality.org/>

Indicator 3.2.2: Neonatal mortality rate**Current situation**

- The regional median neonatal mortality rate decreased from 12.4 deaths per 1000 live births in 2010 to 10.9 deaths per 1000 live births in 2015 and to 10.7 deaths per 1000 live births in 2019; declines were observed in 20 countries of the Region.
- The proportion of neonatal deaths as part of all under-5 deaths is increasing in all countries, with most neonatal deaths in high-burden countries attributed to preventable causes of death.
- Neonatal mortality has persistently been lowest in Bahrain (3.2 deaths per 1000 live births in 2010 and 2015, and 2.9 deaths per 1000 live births in 2019) and highest in Pakistan (49.9 deaths per 1000 live births in 2010, 45.2 deaths per 1000 live births in 2015 and 41.2 deaths per 1000 live births in 2019).
- In 2019, neonatal mortality in 13 countries of the Region was lower than the SDG target of less than 12 deaths per 1000 live births; however, in six countries (Afghanistan, Djibouti, Somalia, Sudan, Pakistan and Yemen) it exceeded 24 deaths per 1000 live births (i.e. more than double the SDG target of less than 12 deaths per 1000 live births).

3.2.2 Neonatal mortality rate, 2010–2019

Challenges

- Newborn health programmes are fragmented between maternal and child health structures at country level, with weak collaboration between different related programmes.
- Security and instability issues are key challenges, particularly in conflict-affected settings.
- Quality of care is inadequate, with adherence to WHO recommendations and guidelines not up to the desired level.
- Scarcity of financial resources for child health interventions, particularly from domestic funds.
- National capacities in planning, implementation, and monitoring and evaluation of child health programmes need to be strengthened.
- Information systems do not routinely collect the detailed data required to understand and address newborn health issues.
- The global strategy for women's, children's and adolescents' health (2016–2030): <https://www.who.int/life-course/partners/global-strategy/en/>
- Early essential newborn care: clinical practice pocket guide: <https://apps.who.int/iris/handle/10665/208158>
- Standards for improving quality of maternal and newborn care in health facilities: https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/
- Newborn health in humanitarian settings. Field guide: <https://www.healthynewbornnetwork.org/resource/newborn-health-humanitarian-settings-field-guide/>
- Standards for improving the quality of care for small and sick newborns in health facilities: <https://www.who.int/publications/i/item/9789240010765>

Steps for accelerated action

- Prioritize newborn health interventions in national strategies and plans in line with the global “Every newborn” action plan (see below) for ending preventable newborn mortality and stillbirth.
- Invest in improving the quality of maternal and newborn care around the time of birth at facility and community levels.
- Strengthen monitoring and measurement capacities for newborn health indicators such as the number of newborn and maternal deaths and stillbirths.
- Support newborn health care during emergencies.
- Strengthen family knowledge and skills to promote and improve home care for newborns.

Available guidance/tools

- Regional implementation framework on ending preventable newborn, child and adolescent deaths and improving health and development: https://applications.emro.who.int/docs/RC_Technical_Papers_2019_3_en.pdf?ua=1
- Every newborn. An action plan to end preventable deaths: http://www.healthynewbornnetwork.org/hnn-content/uploads/Every_Newborn_Action_Plan-

ENGLISH_updated_July2014.pdf

Key references

- Levels and trends in child mortality. Report 2020: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2020: <https://childmortality.org/wp-content/uploads/2020/09/UNICEF-2020-Child-Mortality-Report.pdf>
- Stillbirth and Child Mortality Estimates [online database]. New York: IGME: UN Inter-agency Group for Child Mortality Estimation: <https://childmortality.org/>

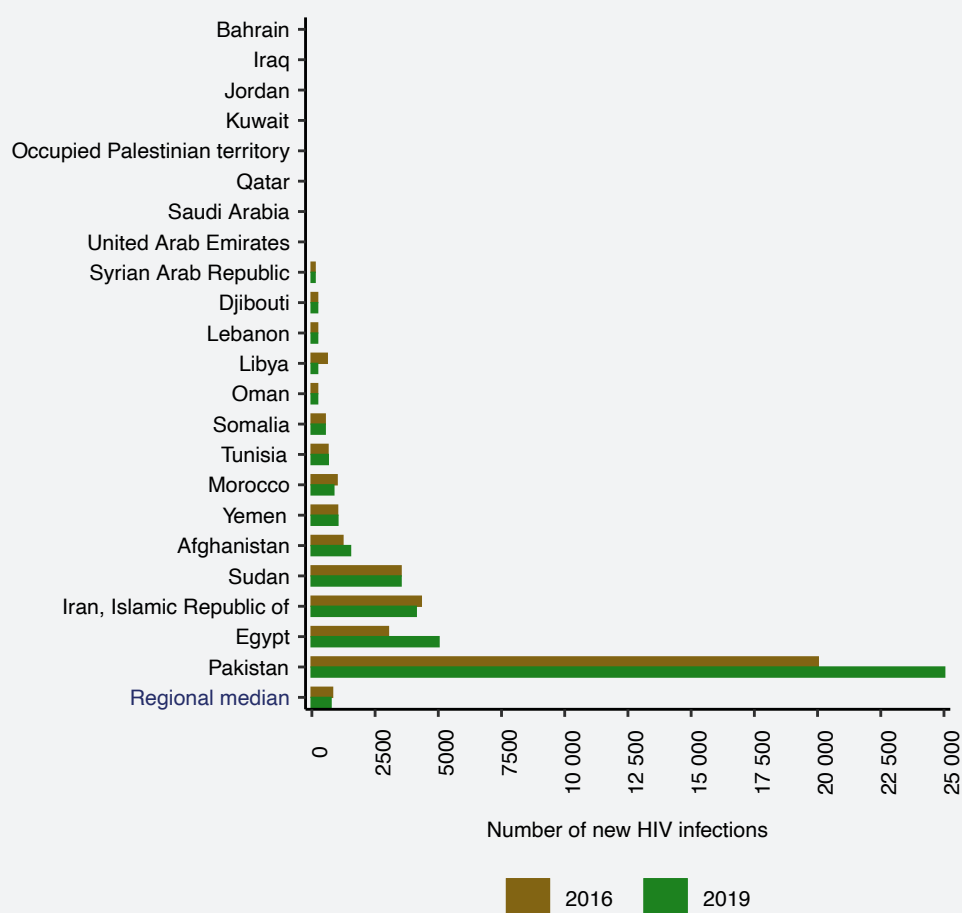
Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases

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

Current situation

- The total number of people living with HIV/AIDS (PLHIV) in the Region had reached 420 000 by 2020.
- Although the global 2020 target was to reduce new infections by 75% compared to 2010 as set out in the Global health sector strategy on HIV, 2016–2021 (see below), the Region is facing an alarming situation with a more than 45% increase in new infections.
- In 2019, it was estimated that there were 44 000 (range: 33 000–67 000) new HIV infections in the Region.
- Since 2015, three countries (the Islamic Republic of Iran, Libya and Morocco) have experienced declines in the annual number of new HIV infections.
- In terms of absolute numbers, Pakistan, Egypt and the Islamic Republic of Iran reported the highest numbers of new HIV infections in the Region in 2019 at 25 000, 5000 and 4100 respectively.

3.3.1 New HIV infections, 2016–2019



Challenges

- The HIV epidemic is concentrated in key populations at increased risk of HIV who are highly stigmatized and face discrimination that affects their access to services.
- Two out of every three PLHIV (67%) are undiagnosed and could transmit the virus unknowingly.
- Low coverage of HIV treatment with antiretrovirals (24%) due to low HIV testing coverage and case identification is hampering efforts to prevent the onward transmission of HIV in the Region.
- In most countries of the Region, the HIV response is largely dependent on external donor funding, which may be a reflection of the limited political commitment and low priority given to HIV.
- Civil unrest and emergencies in some countries of the Region.

Steps for accelerated action

- More focus on data generation, for example through strengthening of HIV/AIDS surveillance activities, including the more frequent conducting of integrated biological and behavioural surveillance surveys.
- Greater involvement of civil society organizations in providing health services for key populations and PLHIV on an appropriate scale.
- Countries should diversify their testing approaches and introduce innovative techniques such as HIV self-testing. This will help more people to become aware of their status, close the diagnosis gap and accordingly link more people to care and treatment.
- Countries should adopt differentiated service delivery models to maximize access to services for key populations, with good quality of care and treatment provided. This will include integration of the services provided for HIV, hepatitis and sexually transmitted infections since these services are provided to the same target groups.
- Strengthen political commitment and ensure supportive health care environments (free of stigma and discrimination) particularly for the most at-risk populations.

Available guidance/tools

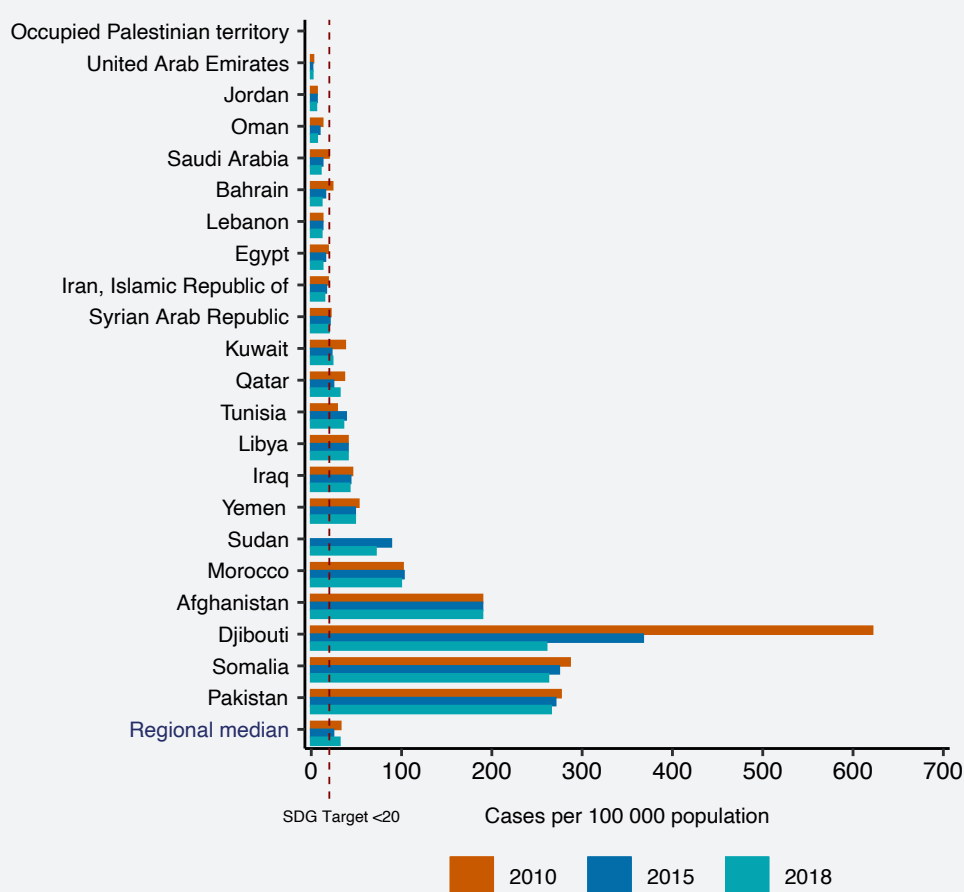
- Global health sector strategy on HIV 2016–2021: <https://www.who.int/hiv/strategy2016-2021/ghss-hiv/en/>
- WHO guidelines on HIV/AIDS: https://www.who.int/publications/guidelines/hiv_aids/en/

Key references

- 2020 Global AIDS update – Seizing the moment – Tackling entrenched inequalities to end epidemics: <https://aids2020.unaids.org/report/>
- Progress report on HIV, viral hepatitis and sexually transmitted infections 2019. Accountability for the global health sector strategies, 2016–2021: <https://www.who.int/hiv/strategy2016-2021/progress-report-2019/en/>
- Latest HIV estimates and updates on HIV policies uptake, November 2020: https://www.who.int/docs/default-source/hiv-hq/latest-hiv-estimates-and-updates-on-hiv-policies-uptake-november2020.pdf?sfvrsn=10a0043d_12

Indicator 3.3.2: Tuberculosis incidence per 100 000 population**Current situation**

- In 2018, the incidence of tuberculosis (TB) was 115 per 100 000 population in the Region; the third highest among the six WHO regions and lower than the estimated global incidence of 132 per 100 000 population.
- A very slow annual decline in incidence (0.9%) occurred in the Region during the period 2000–2018, with a cumulative reduction of 2.8% for the period 2015–2018.
- The incidence varies widely from < 1 per 100 000 population in the United Arab Emirates and the occupied Palestinian territory to more than 180 per 100 000 population in Afghanistan, Djibouti, Pakistan and Somalia.
- In 2018, TB incidence was estimated to be below the SDG target of 20 per 100 000 population in 10 countries of the Region.

3.3.2 Tuberculosis incidence, 2010–2018

Challenges

- 35% of drug-sensitive TB cases remain undiagnosed or not notified to the national TB programmes. Of the estimated drug-resistant TB cases in the Region, 88% were not treated.
- Only around 84 000 (4%) of the 2.2 million individuals targeted by the United Nations General Assembly political declaration to receive preventive treatment between 2018 and 2022 have been reached.
- There is a lack of sustainable domestic funding for TB, especially in high-burden countries. Of the regional budget required in 2020, 32% came from international sources and 19% from domestic sources, leaving a 49% gap.
- WHO consolidated guidelines on tuberculosis. Module 1: Prevention. Tuberculosis preventive treatment. Geneva: World Health Organization; 2020: <https://www.who.int/publications/i/item/who-consolidated-guidelines-on-tuberculosis-module-1-prevention-tuberculosis-preventive-treatment>
- Tackling the drug-resistant TB crisis [website]: <https://www.who.int/activities/tackling-the-drug-resistant-tb-crisis>
- People-centred framework for tuberculosis programme planning and prioritization. User guide. Geneva: World Health Organization; 2019: <https://www.who.int/tb/publications/2019/WHO-CDS-GTB-19.22/en/>

Steps for accelerated action

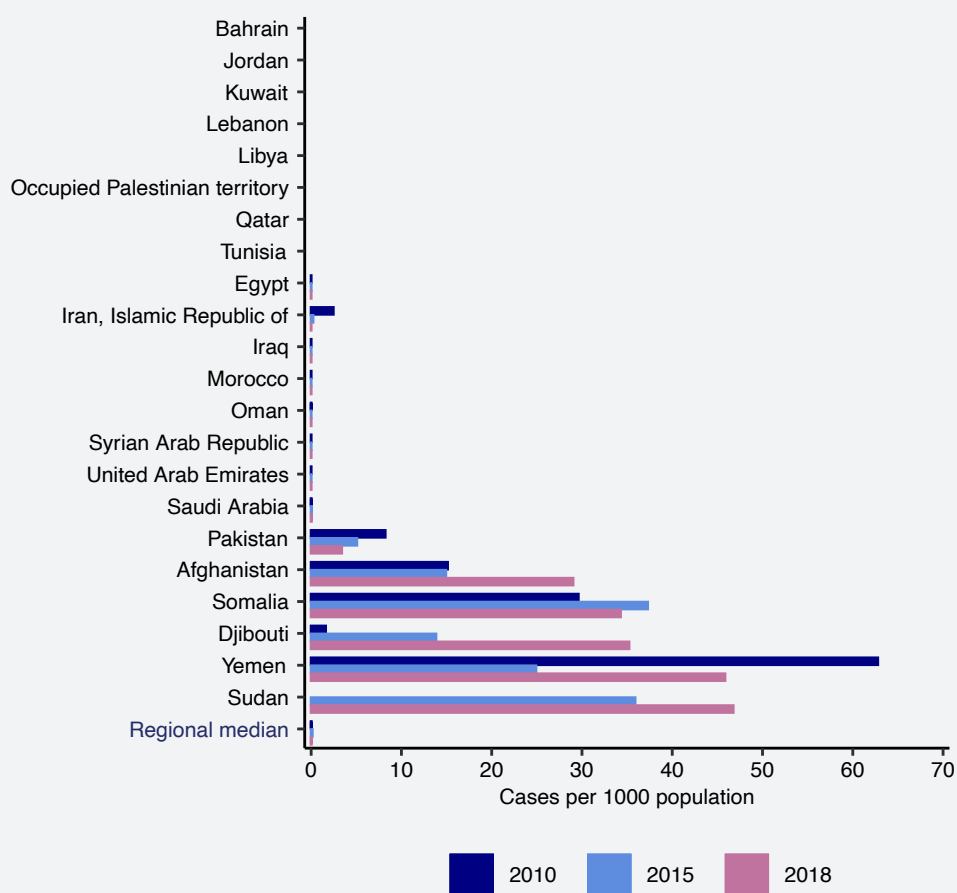
- Integrate and strengthen TB services within primary health care to ensure early diagnosis, systematic screening of contact and at-risk groups, and standardized quality care for all, including for drug-resistant TB.
- Introduce and expand new TB diagnostic technologies and tools (molecular diagnostic test, chest X-ray).
- Ensure UHC of TB prevention and control services by involving all health care providers, especially the private sector in Afghanistan and Pakistan.
- Strengthen TB services focusing on at-risk groups and settings, including TB contacts, PLHIV, TB in urban areas, TB and co-morbidities.
- Scale up the programmatic management of drug-resistant TB and decentralization of services.
- Enhance the programmatic and managerial capacities of the national TB programme.
- Increase domestic funding oriented towards TB services and mobilize other funding resources.

Available guidance/tools

- Implementing the End TB Strategy: the essentials. Geneva: World Health Organization; 2015: <https://www.who.int/tb/strategy/en/>
- Global tuberculosis report 2020. Geneva: World Health Organization; 2020: https://www.who.int/tb/publications/global_report/en/

Indicator 3.3.3: Malaria incidence per 1000 population at risk**Current situation**

- Since 2015, three countries (Egypt, the Islamic Republic of Iran and Oman) have reported zero indigenous cases of malaria for more than three years and have expressed an interest in certification of malaria-free status. This would bring the total number of malaria-free countries in the Region to 15 (up from 12 in 2015).
- Six countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) account for more than 99% of confirmed malaria cases in the Region.
- The estimated incidence in Afghanistan, Djibouti, Sudan and Yemen increased over the period 2010–2018. In Djibouti, the increase in recent years has been alarming, particularly during the period 2018–2020 due to population movement from neighbouring countries, the presence of invasive *Anopheles stephensi* and an inefficient control programme.
- In 2019, Sudan and Yemen had the highest estimated incidence of malaria in the Region at 55.4 and 46.4 cases per 1000 population, respectively.

3.3.3 Malaria incidence, 2010–2018

Challenges

- Political unrest and instability in the Region have led to the displacement of populations and have interrupted health service provision in the context of already weak health systems.
- Emergence of other vector-borne diseases, such as dengue and chikungunya, in malaria-endemic countries.
- Lack of sustained domestic financing and high level of dependency on external funding for malaria control.
- Weak surveillance and health information systems and resulting lack of timely and quality data, which compromises the ability to adjust malaria interventions according to changes in disease burden.
- Environmental changes, global warming and unplanned urbanization.
- Invasive vectors and emergence of histidine-rich protein 2 and 3 gene deletions.
- A framework for malaria elimination: <https://www.who.int/publications/i/item/9789241511988>
- Tailoring malaria interventions in the COVID-19 response: <https://www.who.int/publications/m/item/tailoring-malaria-interventions-in-the-covid-19-response>

Key references

- World malaria report 2020. Geneva: World Health Organization; 2020: <https://www.who.int/publications/i/item/9789240015791>

Steps for accelerated action

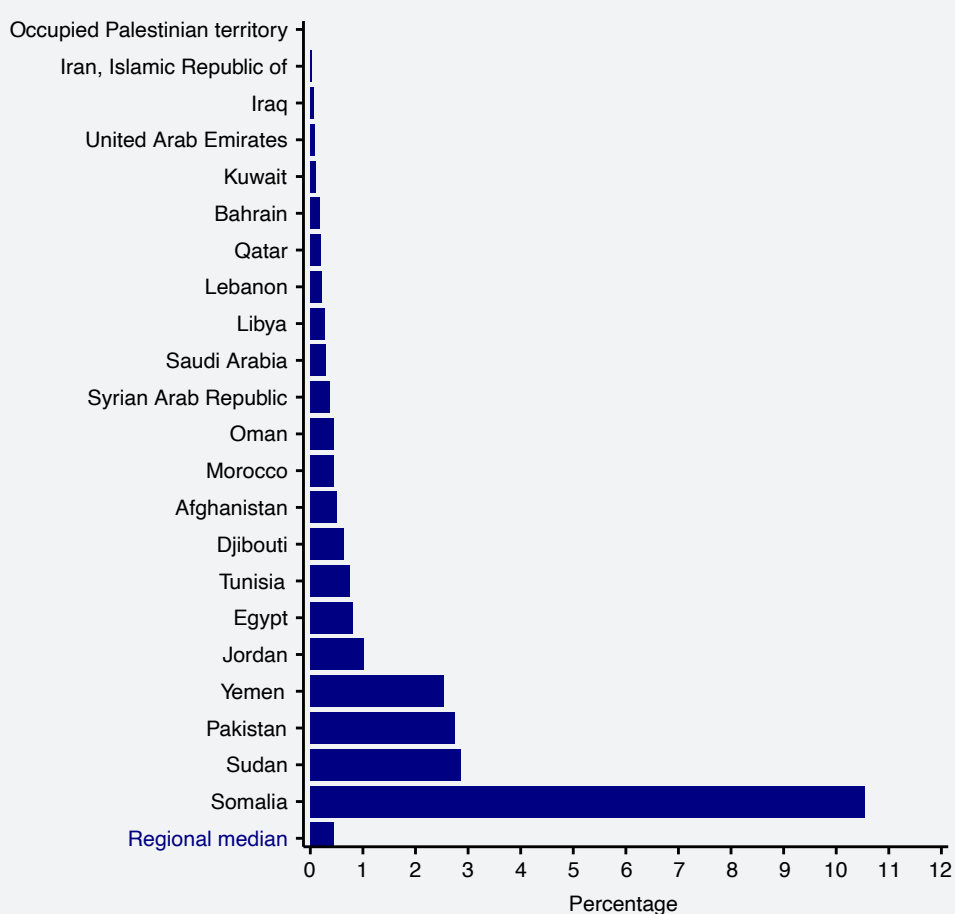
- For endemic countries, intensify collaboration with partners for the optimal use of resources.
- Increase domestic funding oriented towards malaria elimination and control, and mobilize other funding resources. Develop the capacity of local health staff for the integrated control of vector-borne diseases.
- In countries experiencing humanitarian emergencies, ensure that programme capacity is sustained for the continuation of interventions with the involvement of all stakeholders.
- Promote strong community participation and establish partnerships between the public and private sectors as part of a multisectoral approach to ensure a sustainable path towards burden reduction and malaria elimination.

Available guidance/tools

- Global technical strategy for malaria 2016–2030: <https://www.who.int/publications/i/item/9789241564991>
- Malaria surveillance, monitoring & evaluation: a reference manual: <https://www.who.int/publications/i/item/9789241565578>

Indicator 3.3.4: Hepatitis B incidence per 100 000 population**Current situation**

- In 2015, the regional prevalence of hepatitis B surface antigen (HBsAg) among children under 5 years of age was 1.6% and ranged from 0.02% in the Islamic Republic of Iran to 10.54% in Somalia.
- The prevalence of HBsAg among children under 5 years of age in half of the countries of the Region in 2015 was less than 0.44%.

3.3.4 Hepatitis B virus prevalence among children under 5 years, 2015

Challenges

- Hepatitis is not high on the public health agenda in some countries and this is reflected in the non-availability of resources for a national response.
- Lack of data accurately describing the trends and epidemic burden in some countries, especially among key groups such as injecting drug users.
- In some countries of the Region, a proportion of births still occur outside a health care facility, making it challenging to ensure hepatitis vaccination of all newborns.
- Coverage of hepatitis B vaccine birth dose is very low (33%) compared to the global elimination target (90%).
- Very limited testing and treatment interventions, with only 2% of chronic infections diagnosed and less than 1% receiving treatment.
- Expense of diagnostic tools needed for hepatitis diagnosis.
- Weak involvement of civil society.

Steps for accelerated action

- Advocate with decision-makers to introduce hepatitis B birth dose and third dose nationwide in countries with low coverage.
- Implement a comprehensive hepatitis B virus immunization programme, including catch-up hepatitis B virus vaccination for children or adolescents with low coverage, and offer hepatitis B virus vaccination to people at increased risk of acquiring and transmitting the virus.
- Improve hepatitis testing among pregnant women and expand birth dose vaccination.
- Expand access to hepatitis services along the cascade (diagnosis, treatment and cure).

Available guidance/tools

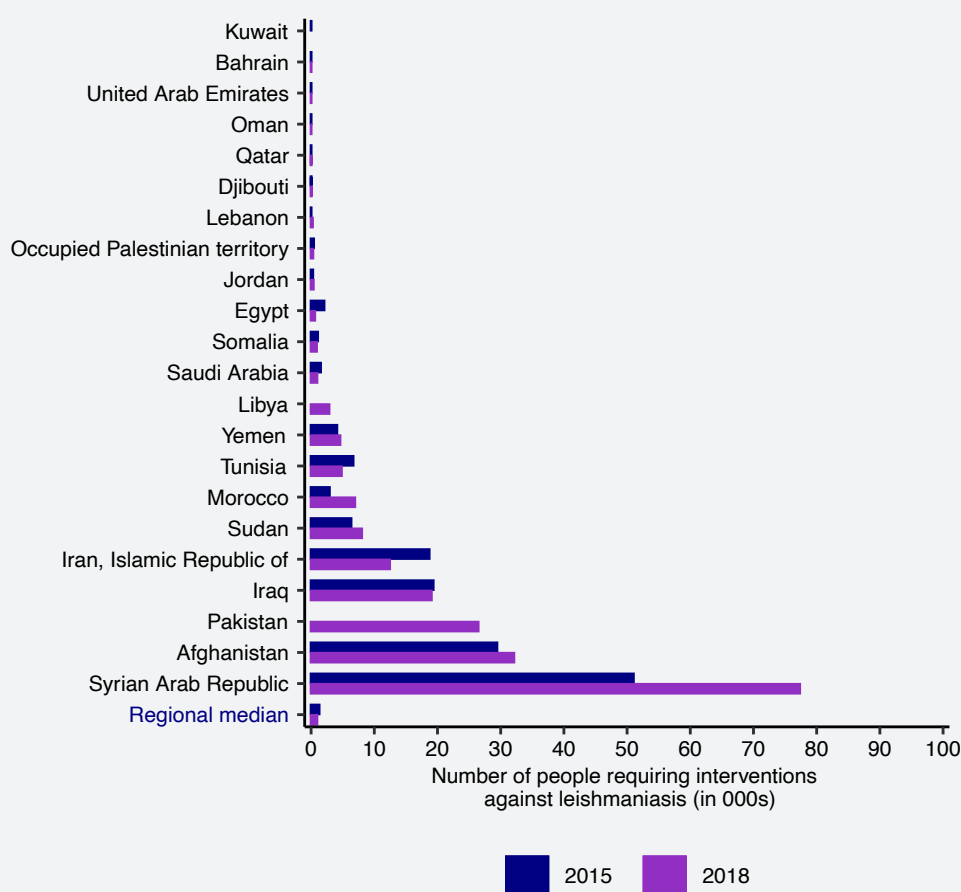
- Global health sector strategy on viral hepatitis 2016–2021: <https://www.who.int/hepatitis/strategy2016-2021/ghss-hep/en/>
- Regional action plan for the implementation of the global health sector strategy on viral hepatitis 2017–2021: <https://apps.who.int/iris/handle/10665/258729>

Key references

- WHO Hepatitis B Vaccine country profiles <https://whohbsagdashboard.surge.sh/>
- Global health sector strategy on viral hepatitis 2016–2021. Geneva: World Health Organization; 2020: <https://www.who.int/hepatitis/strategy2016-2021/ghss-hep/en/>
- Progress report on HIV, viral hepatitis and sexually transmitted infections, 2019. Accountability for the global health sector strategies, 2016–2021. Geneva: World Health Organization; 2019: <https://www.who.int/hiv/strategy2016-2021/progress-report-2019/en/>

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

- Neglected tropical diseases are a major public health problem in the Region, with at least one such disease prevalent in all countries. The main neglected tropical diseases are dengue, leishmaniasis, leprosy, onchocerciasis, rabies, schistosomiasis, soil-transmitted helminthiasis and trachoma.
- Globally, the Region has the highest cutaneous leishmaniasis burden with 181 696 cases reported in 2018 (74% of the global burden); 85% of these cases were in Afghanistan, the Islamic Republic of Iran, Pakistan and the Syrian Arab Republic.
- In 2018, 3501 cases of visceral leishmaniasis were reported, with 74% of these cases occurring in Sudan.
- With some exceptions, most countries reported an increase in leishmaniasis cases in 2018 compared to 2015.

3.3.5 Number of people requiring interventions against leishmaniasis, 2015–2018

Key message

- By 2030 the target is to end the burden of Guinea worm disease, leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma in the Region. Other neglected tropical diseases, mainly dengue, foodborne diseases and leishmaniasis, will be controlled by early case detection and prompt treatment.

Challenges

- Poor access to early diagnosis and effective prompt treatment for cutaneous leishmaniasis and dengue.
- Shortage of suppliers in the global market to make available adequate stocks of effective medicines, mainly for cutaneous leishmaniasis.
- Insufficient implementation of vector and animal reservoir host control interventions (for example, for cutaneous leishmaniasis and dengue).
- Lack of donor support.
- Frequent population migration due to emergencies and conflict.
- Stigma associated with these diseases (for example, cutaneous leishmaniasis and leprosy).

Steps for accelerated action

- Increase access to early diagnosis and treatment by decentralizing case management to the primary health care level.
- Enhance community awareness of the need for early treatment-seeking behaviour.
- Address stigma through community engagement.
- Mobilize resources, partner support and communities to strengthen vector and reservoir host control.
- Strengthen integrated surveillance to prevent outbreaks, monitor disease burden and assess the impact of control measures.

Available guidance/tools

- Leishmaniasis: https://www.who.int/health-topics/leishmaniasis#tab=tab_1
- Control of leishmaniasis. World Health Assembly Resolution WHA60.13: https://apps.who.int/iris/bitstream/handle/10665/22586/A60_R13-en.pdf?sequence=1&isAllowed=y

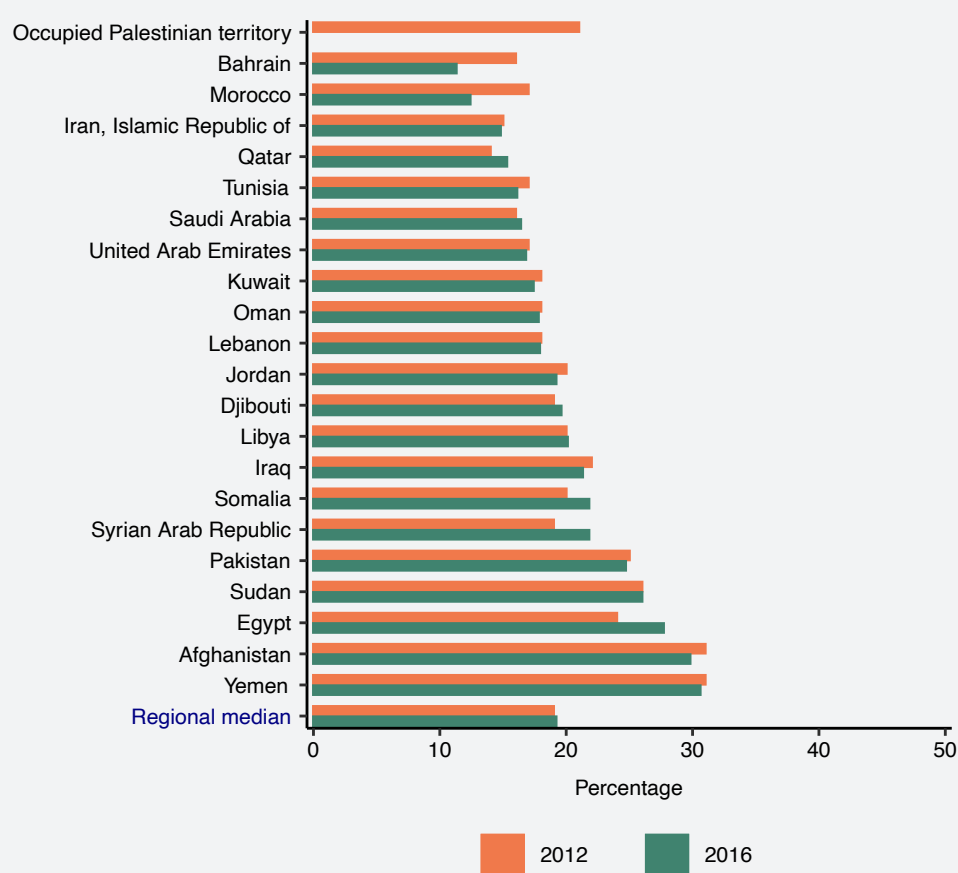
Target 3.4: By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being

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

Current situation

- There were negligible changes in the probability of dying between exact ages 30 and 70 from any of the four main NCDs (cardiovascular disease, cancer, diabetes or chronic respiratory disease) in most countries in the Region over the period 2012–2016; only three countries (Bahrain, Morocco and the United Arab Emirates) experienced significant reductions.
- Projections for the period 2000–2025 indicate that additional countries (the Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia and Tunisia) will show reductions.
- Due to the nature of chronic diseases a longer reporting period is required for this indicator to show any significant changes. When new data become available a clearer trend will be presented.

3.4.1 Probability of dying from any cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70, 2012–2016



Challenges

- Fragmentation of data systems and limited capacity of national health information systems to report on NCD burdens and their risk factors, and to monitor progress.
- Political instability, conflicts and other emergencies, including the impact of the COVID-19 pandemic.
- Lack of investment for addressing NCDs and UHC as part of SDG efforts at national and health sector levels.
- Challenge of developing comprehensive multisectoral multi-stakeholder national NCD responses and coordination mechanisms to ensure policy coherence and a Health-in-All-Policies approach.
- Insufficient focus on health promotion/prevention versus health care.

Steps for accelerated action

- Invest in data systems for health that allow for the collection and reporting of disaggregated data, including the strengthening of mortality registration by cause of death and linkage of mortality records to disease registries (especially cancer registries as a core element).
- Implement the WHO Global Hearts Initiative technical package to address hypertension risk factors.
- Implement the WHO MPOWER and SHAKE technical packages of interventions to mitigate the negative effects of tobacco use and excess sodium consumption respectively.
- Promote hepatitis and human papillomavirus vaccination, and implement strategies to enhance the early detection, screening and treatment of cervical and other preventable or treatable cancers.
- Integrate NCDs into UHC Benefit Packages and into primary health care.
- Scaling up access to essential services for people living with NCDs during humanitarian emergencies.

Available guidance/tools

- Global action plan for the prevention and control of NCDs 2013–2020 (extended to 2030 by Decision WHA72(11) 2019; and Tackling NCDs – Best buys; and other recommended

WHO interventions: <https://www.who.int/ncds/publications/en/>

WHO NCD packages:

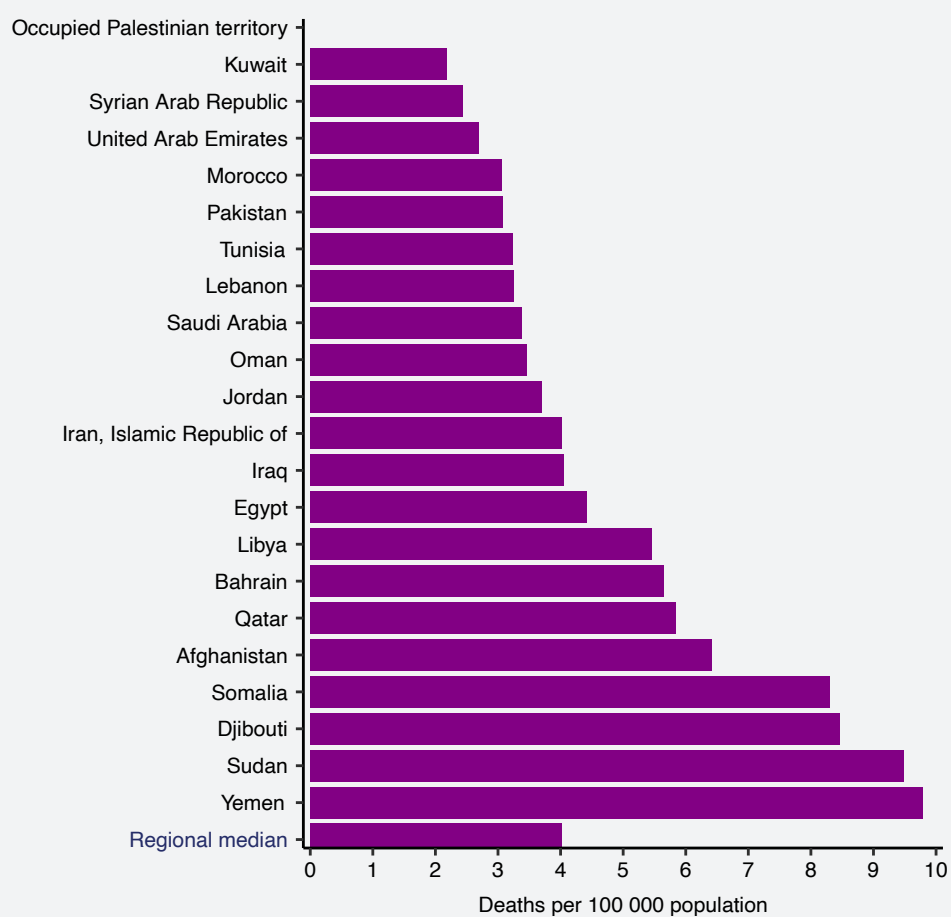
- Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings: https://www.who.int/cardiovascular_diseases/publications/pen2010/en/
- Global Hearts Initiative. Working together to beat cardiovascular diseases (including: HEARTS-SHAKE-REPLACE-SAFER-MPOWER-ACTIVE): https://www.who.int/cardiovascular_diseases/global-hearts/en/
- Regional publications on NCDs: <http://www.emro.who.int/noncommunicable-diseases/publications/>
- WHO Global Diabetes Compact: <https://www.who.int/initiatives/the-who-global-diabetes-compact/>
- WHO Global Initiative for Childhood Cancer – which aims to achieve at least a 60% survival rate for children with cancer by 2030: <https://www.who.int/cancer/childhood-cancer/en/>
- Global strategy to accelerate the elimination of cervical cancer as a public health problem: <https://www.who.int/publications/i/item/9789240014107>

Key references

- Noncommunicable diseases progress monitor 2020. Geneva: World Health Organization; 2020: <https://www.who.int/publications/i/item/ncd-progress-monitor-2020>
- Noncommunicable diseases country profiles 2018. Geneva: World Health Organization; 2018: <https://www.who.int/publications/i/item/ncd-country-profiles-2018>

Indicator 3.4.2: Suicide mortality rate**Current situation**

- The suicide mortality rate in the Region in 2016 ranged from 2.2 deaths per 100 000 population in Kuwait to 9.8 deaths per 100 000 population in Yemen.
- The suicide mortality rate in half of the countries of the Region in 2016 was less than 4.1 deaths per 100 000 population.
- When standardized by age, the suicide mortality rate in the Region in 2016 was 4.9 deaths per 100 000 population.

3.4.2 Suicide mortality rate, 2016

Challenges

- Lack of evidence-based intersectoral policy support as only one third of countries globally (32.5%) have adopted a comprehensive national strategy or action plan, and regionally this proportion is even lower.
- Only one country in the Region has good vital registration of suicide mortality compared to 60 countries globally; in other countries, estimated suicide rates are based on modelling.
- In most countries of the Region, suicide is not perceived to be a significant public health concern due to sociocultural and religious taboos leading to stigma associated with suicide; in some countries, suicidal behaviour is still criminalized.
- Suicide prevention and management of suicidal behaviours are not part of the UHC package in the majority of countries and are not part of the teaching/training curricula for health care staff and first responders.
- Public health action for the prevention of suicide. A framework: https://apps.who.int/iris/bitstream/handle/10665/75166/9789241503570_eng.pdf;jsessionid=EC2DEF32254B2B1B954085DA8379B-B13?sequence=1
- Suicide prevention: toolkit for engaging communities: <https://www.who.int/publications/i/item/suicide-prevention-toolkit-for-engaging-communities>
- Preventing suicide: a manual for case registration of suicide and attempted suicide: https://apps.who.int/iris/bitstream/handle/10665/250536/EMRPUB_2014_EN_1688.pdf?sequence=1&isAllowed=y
- WHO Mental Health Gap Action Programme (mhGAP) [website]: https://www.who.int/mental_health/mhgap/en/
- LIVE LIFE: Preventing suicide: <https://www.who.int/publications/i/item/live-life-preventing-suicide>

Steps for accelerated action

- Develop comprehensive multisectoral national suicide prevention strategies for an effective national response.
- Establish/strengthen surveillance and quality data collection for suicide and suicide attempts, including in civil registration and vital statistics systems.
- Include evidence-based interventions for preventing suicides and suicide attempts as part of the UHC service package, such as reducing access to means, responsible media reporting, school-based life skills interventions, early identification and treatment of mental and substance use disorders, follow-up care, and community support and crisis help lines.
- Conduct targeted campaigns to fight stigma and support those bereaved by suicide.

Available guidance/tools

- Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm: <https://www.who.int/publications/i/item/practice-manual-for-establishing-and-maintaining-surveillance-systems-for-suicide-attempts-and-self-harm>
- Preventing suicide: a resource series: <https://www.who.int/publications/i/item/preventing-suicide-a-resource-series>

Key references

- Suicide in the world: global health estimates. Geneva: World Health Organization; 2019: <https://apps.who.int/iris/handle/10665/326948>
- National suicide prevention strategies: progress, examples and indicators. Geneva: World Health Organization; 2018: https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/
- Preventing suicide: a global imperative. Geneva: World Health Organization; 2014: https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

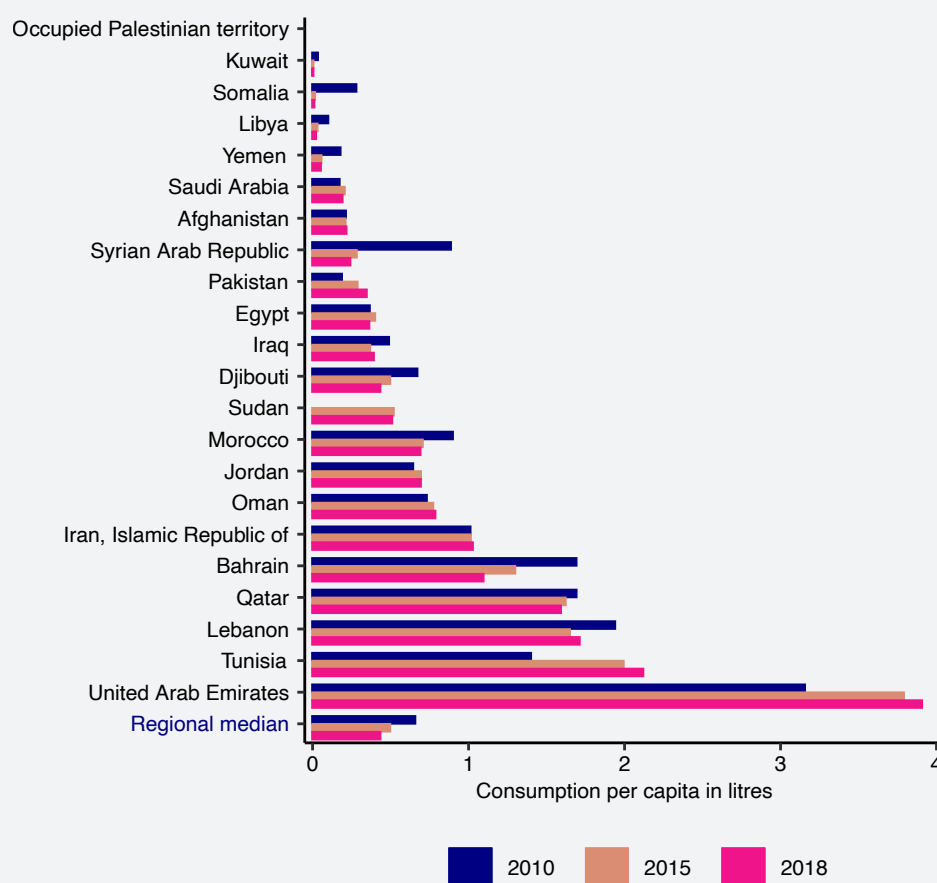
Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

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

Current situation

- Total alcohol per capita consumption among individuals aged 15 years and older was less than 0.6 litres in the Region and remained stable throughout the period 2000–2016.
- In all countries of the Region, alcohol per capita consumption remained below 4 litres of pure alcohol over the period 2010–2018.
- Consistent with global trends, there was a decline in the proportion of current drinkers in the Region over the period 2010–2016 (from 3.7% to 2.9%).
- One quarter (25.5%) of all alcohol consumed worldwide is in the form of unrecorded alcohol. However, in the Region, unrecorded alcohol consumption makes up 70.5% of total alcohol consumption.
- The prevalence of alcohol use disorders in the Region (3.4 million people, representing 0.8% of the population aged 15 years and older) is the lowest among all six WHO regions.
- In 2016, the proportions of all deaths and disability-adjusted life years (DALYs) attributable to alcohol consumption in the Region (0.7% of all deaths and 0.7% of all DALYs) were the lowest among all six WHO regions.

3.5.2 Harmful use of alcohol, 2010–2018



Challenges

- In the Region, unrecorded alcohol consumption accounts for a high proportion (70.5%) of total alcohol consumption.
- High levels of alcohol consumption among drinkers in the Region are leading to harmful health consequences. For example, alcohol consumption has had a net detrimental age-standardized effect on diabetes in the Region, causing 0.1 deaths and 4.0 DALYs per 100 000 people.
- Most countries of the Region (82%) do not have a national alcohol policy/strategy to reduce the harmful use of alcohol.
- Very limited data are available on alcohol consumption, its harmful consequences, treatment services for alcohol use disorders and the treatment coverage for alcohol use disorders in the Region.

Steps for accelerated action

- Develop and strengthen evidence-based national alcohol policies that consider the social, cultural and religious context of the countries in the Region. Even in countries with a total ban on alcohol, a national policy on alcohol use allows the country to monitor and address the public health consequences of alcohol use.
- Establish an effective monitoring and surveillance system to collect information on alcohol consumption and its harmful consequences using definitions and data-collection procedures compatible with WHO's global and regional information systems.
- Build and enhance the capacity of the health care system to provide prevention, treatment and care services for alcohol use disorders and co-morbid conditions.

Available guidance/tools

- The SAFER technical package: five areas of intervention at national and subnational levels. Geneva: World Health Organization; 2019: <https://www.who.int/publications/i/item/the-safer-technical-package>
- Global Information System on Alcohol and Health (GISAH) [online database]: https://www.who.int/substance_abuse/activities/gisah/en/
- Resource tool on alcohol taxation and pricing policies. Geneva: World Health Organization; 2017: <https://www.who.int/publications/i/item/resource-tool-on-alcohol-taxation-and-pricing-policies>

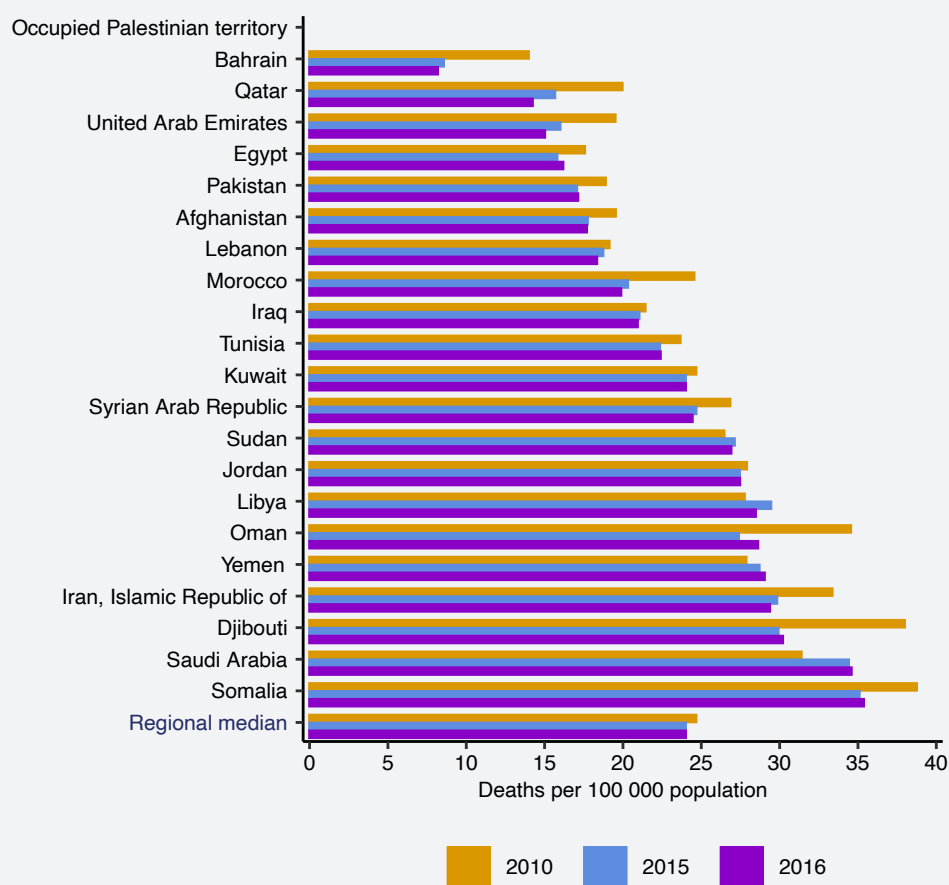
Key references

- Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010: <https://www.who.int/publications/i/item/9789241599931>
- Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018: https://www.who.int/substance_abuse/publications/global_alcohol_report/gsr_2018/en/

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**Current situation**

- There were negligible changes in the death rate from road traffic injuries in most countries of the Region over the period 2010–2016.
- In 2016, the death rate from road traffic injuries was lowest in Bahrain (8.2 deaths per 100 000 population) and highest in Somalia (35.4 deaths per 100 000 population).
- The median death rate from road traffic injuries in the Region declined slightly from 24.7 deaths per 100 000 population in 2010 to 24.0 deaths per 100 000 population in 2016.

3.6.1 Mortality rate from road traffic injuries, 2010–2016

Challenges

- Insufficient adoption of a whole system approach including for post-crash emergency care.
- Multiplicity and fragmentation of data sources with under-reporting and lack of standard definition of deaths and injuries.
- Weak regulatory environment, including: (a) national laws that do not meet best practice on all of the five key road safety behavioural risk factors; (b) failure to meet international standards for vehicles and road infrastructure; and (c) inadequate enforcement, implementation and evaluation of policy and legislative frameworks.
- Insufficient consideration of the needs of all road users, including vulnerable road users (such as pedestrians, motorcyclists and cyclists).
- Contextual challenges including crisis and post-crisis situations.

Steps for accelerated action

- Review/update national plans for road safety based on the new global plan for the second Decade of Action for Road Safety 2021–2030 (see below) in line with the specific national context.
- Evaluate country-level implementation of road safety interventions, and their cost-effectiveness and impact in reducing road traffic deaths and injuries.
- Improve both the consistency and quality of road traffic data by adopting a standard definition of road traffic death and injuries and improving data linkages between multiple sectors and data sources.
- Update/enact laws and regulations that meet best practice criteria on behavioural risk factors and strictly enforce them, including implementing the United Nations vehicle safety regulations or equivalent national standards and best practice road standards to ensure the safety of all road users.
- Develop/improve organized and integrated pre-hospital and facility-based emergency care systems.

Available guidance/tools

- Global status report on road safety 2018: https://www.who.int/violence_injury_prevention/road_safety_status/2018/en/
- Save lives: a road safety technical package: http://www.who.int/violence_injury_prevention/publications/road_traffic/save-lives-package/en/
- “How to” road safety manuals: <https://www.who.int/roadsafety/projects/manuals/en/>
- Data systems: a road safety manual for decision-makers and practitioners: <https://www.who.int/publications/i/item/data-systems>
- Strengthening road safety legislation: a practice and resource manual for countries: http://apps.who.int/iris/bitstream/handle/10665/85396/9789241505109_eng.pdf;jsessionid=3F3767A056686343CB3C9539F-55030CB?sequence=1
- Decade of Action for Road Safety 2021–2030 [website]: <https://www.who.int/teams/social-determinants-of-health/safety-and-mobility/decade-of-action-for-road-safety-2021-2030#:~:text=This%20new%20Decade%20of%20Action%20for%20Road%20Safety,Week%20to%20be%20held%20from%2017-23%20May%202021>

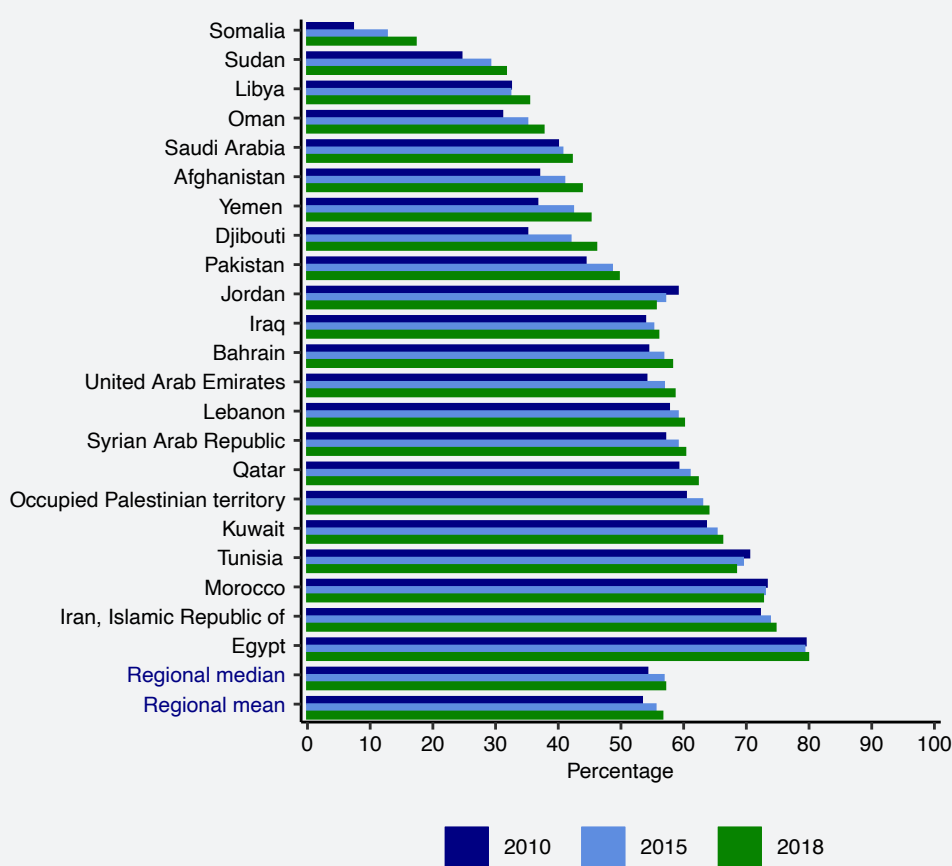
Target 3.7: By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

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

Current situation

- There were negligible changes in the proportion of women of reproductive age who had their need for family planning satisfied with modern methods in almost all countries of the Region over the period 2010–2018.
- The proportion of women of reproductive age having their need for family planning satisfied with modern methods remained lowest in Somalia (from 7.2% in 2010 to 17.2% in 2018) and highest in Egypt (from 79.4% in 2010 to 79.8% in 2018).
- In 2018, less than half of women of reproductive age had their need for family planning satisfied with modern methods in Afghanistan, Djibouti, Libya, Oman, Pakistan, Saudi Arabia, Somalia, Sudan and Yemen.

3.7.1 Women of reproductive age (15–49) who had their need for family planning satisfied with modern methods, 2010–2018



Challenges

- Deficiencies in policies and strategies for promoting family planning based on the needs of women and couples.
- Shortage of supplies of modern family planning methods and associated commodities (for example, syringes), and inequitable access to family planning services.
- Limited quality of care, with poor family planning counselling for women and couples.
- Sociocultural and gender-based barriers due to misconceptions and misguided attitudes towards the adoption of modern family planning methods.

Steps for accelerated action

- Develop and strengthen evidence-based family planning policies, national plans and guidelines in response to the needs of women and couples.
- Secure family planning funding and a modern method mix, including new methods at health facility level.
- Improve the quality of care of services for contraception through good counselling and communication.
- Inform and raise the awareness of women and couples of the benefits of family planning and the prevention and management of side-effects.

Available guidance/tools

- Family planning – a global handbook for providers. 2018 edition: <https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/>
- Medical eligibility criteria for contraceptive use. Fifth edition: <https://www.who.int/publications/i/item/9789241549158>
- Selected practice recommendations for contraceptive use. Third edition 2016: https://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/
- Quality of care in contraceptive information and services, based on human rights standards. A checklist for health care providers: <https://www.who.int/reproductivehealth/publications/qoc-contraceptive-services/en/>
- A guide to identifying and documenting best practices in family planning programmes:

https://www.who.int/reproductivehealth/publications/family_planning/best-practices-fp-programs/en/

- WHO concise guide to implementing and scaling up family planning service improvements: <http://fps-scale-up-guide.srhr.org/src/docs/implementing-and-scaling-up-family-planning-service-improvements-2018-eng.pdf>
- Implementation guide for the medical eligibility criteria and selected practice recommendations for contraceptive use guidelines: https://www.who.int/reproductivehealth/publications/family_planning/mec-spr-implementation-guide/en/
- Monitoring human rights in contraceptive services and programmes: <https://www.who.int/publications/i/item/9789241513036>
- Contraceptive eligibility for women at high risk of HIV: <https://www.who.int/publications/i/item/9789241550574>

Key references

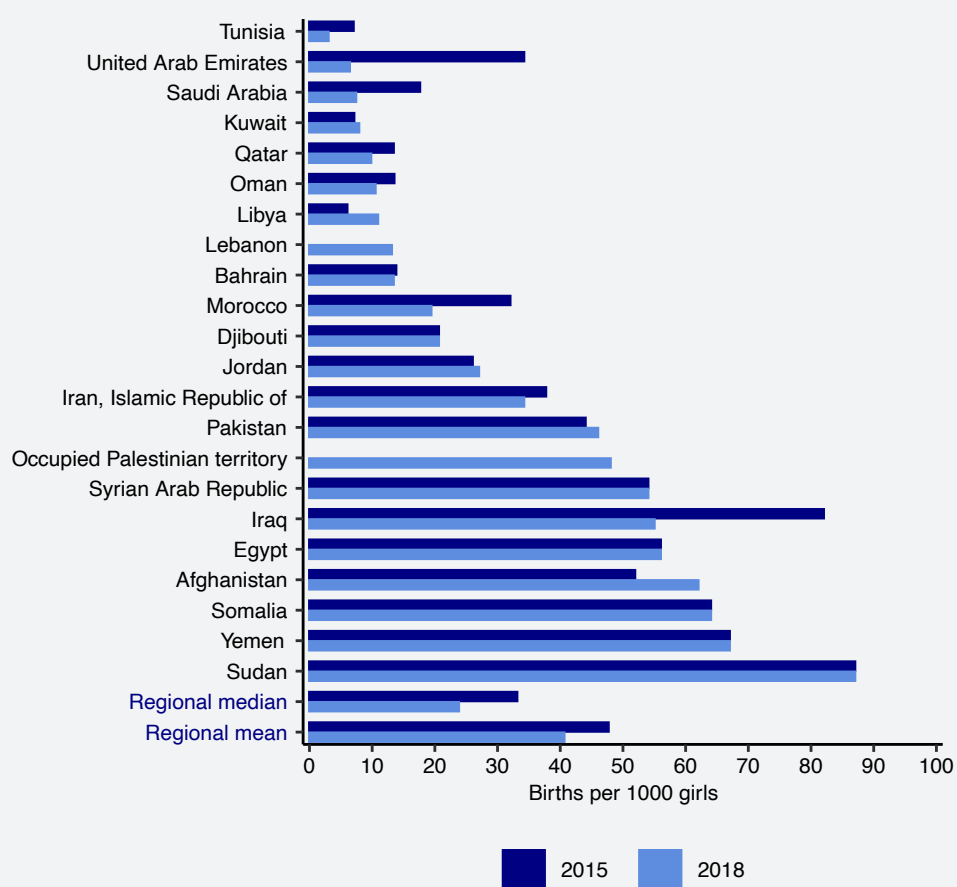
- Contraception [website]: https://www.who.int/health-topics/contraception#tab=tab_1
- The Global Health Observatory. Family planning needs satisfied [online database]: <https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/family-planning-needs-satisfied>
- Task sharing to improve access to family planning/contraception. Summary brief. Geneva: World Health Organization; 2017: <https://www.who.int/publications/i/item/WHO-RHR-17.20>
- Training resource package for family planning [website]: <https://www.fptraining.org/>
- Emergency contraception [website]: <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>
- Coronavirus disease (COVID-19): Contraception and family planning [website]: <https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-contraception-and-family-planning>

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

Current situation

- There were negligible changes in adolescent fertility in most countries of the Region between 2015 and 2018.
- However, there were large variations in adolescent birth rates in the Region during the same period.
- In 2018, the adolescent birth rate in the Region ranged from 3 births per 1000 women aged 15–19 years in Tunisia to 87 births per 1000 women aged 15–19 years in Sudan.
- The median adolescent birth rate in the Region decreased slightly from 33.1 births per 1000 women aged 15–19 years in 2015 to 23.8 births per 1000 women aged 15–19 years in 2018.

3.7.2 Adolescent birth rate (per 1000 girls aged 15–19 years), 2015–2018



Challenges

- Addressing adolescent fertility issues has strong sociocultural aspects, including low mean age of marriage as well as childhood marriage in most communities of the Region.
- Lack of prioritization of adolescent health on the national health agenda.
- Political instability and emergencies, particularly in conflict-affected settings.
- Insufficient information on adolescent fertility, including disaggregated data by age, sex and other stratifiers.
- The COVID-19 pandemic has had, and will continue to have, a negative effect on access by adolescents to essential services to control fertility.
- Poor access to, and integration of, adolescent health services, including reproductive health services in primary health care settings.

Steps for accelerated action

- Implement resolution EM/RC64/R.4 on “Operationalization of the adolescent health component of the Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016–2030” by adopting the Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation.
- Advocate for, and sensitize policy-makers on, adolescent SRH issues with strong community engagement.
- Engage adolescents in different stages of planning, implementation, and monitoring and evaluation of SRH programmes.
- Adopt a multisectoral approach to improve the reproductive health of adolescents through a life-course approach.
- Integrate adolescent health services into primary health care to improve access to quality, friendly and comprehensive health care services.
- Build national capacities for the provision of quality adolescent health care services.
- Prioritize adolescent health issues in humanitarian settings.

Available guidance/tools

- Operationalization of the adolescent health component of the Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016–2030. Regional Committee for the Eastern Mediterranean. Sixty-fourth session. Agenda item 3(C). EM/RC64/R.4. October 2017: https://applications.emro.who.int/docs/RC64_Resolutions_2017_R4_20133_EN.pdf?ua=1
- Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation [website]: https://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/
- Regional implementation framework on ending preventable newborn, child and adolescent deaths and improving health and development 2019–2023. Regional Committee for the Eastern Mediterranean. Sixty-sixth session. Provisional agenda item 3(a). EM/RC66/3. September 2019: https://applications.emro.who.int/docs/RC_Technical_Papers_2019_3_en.pdf?ua=1
- Child and adolescent health in humanitarian settings operational guide: a holistic approach for programme managers [in preparation]; following publication will be posted at: <http://www.emro.who.int/child-adolescent-health/information-resources/index.html>
- Global strategy for women’s, children’s and adolescents’ health (2016–2030). Survive–Thrive–Transform. New York: Every Woman Every Child; 2015: <https://www.who.int/life-course/partners/global-strategy/en/>
- WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018: <https://www.who.int/reproductivehealth/publications/adolescent-srhr-who-recommendations/en/>

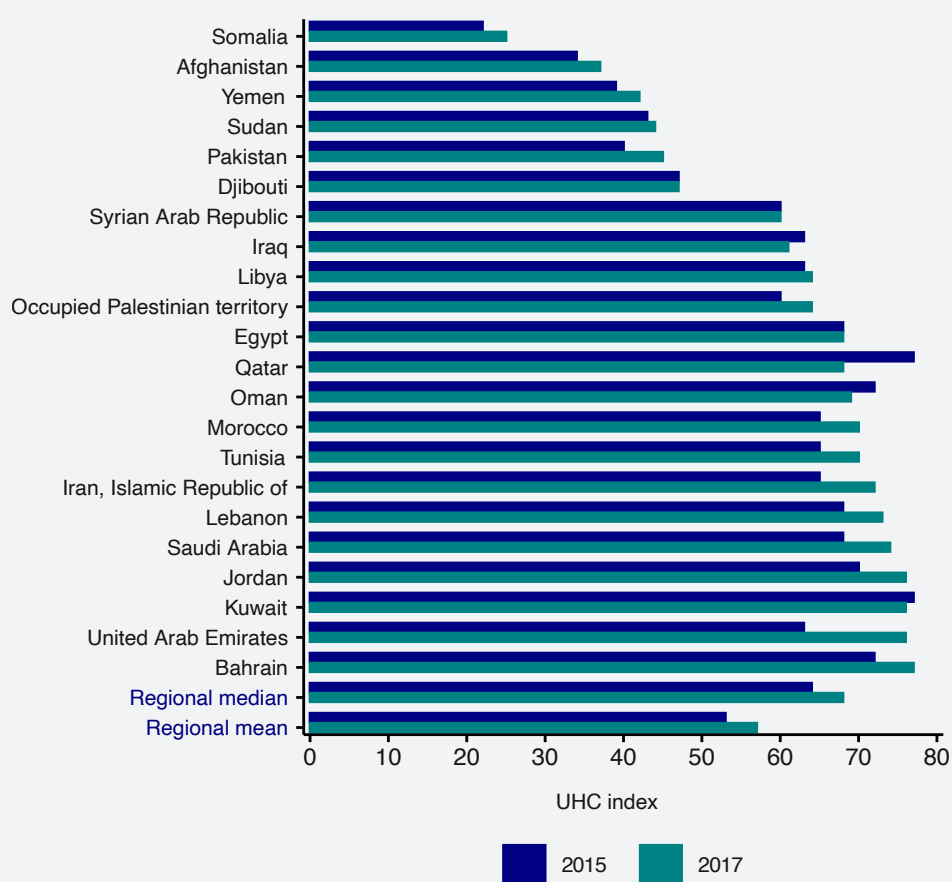
Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Indicator 3.8.1: Coverage of essential health services

Current situation

- There were modest improvements in the UHC service coverage index in most countries of the Region between 2015 and 2017.
- On a unit scale of 0 to 100, the UHC service coverage index in the Region in 2017 ranged from 25 in Somalia to 77 in Bahrain.
- In 2017, the UHC service coverage index was greater than 50 in all countries of the Region except Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.
- There was a modest increase in the median UHC service coverage index in the Region, from 53 in 2015 to 57 in 2017.

3.8.1 UHC service coverage index, 2015–2017



Challenges

- Data gaps on service coverage limit the ability of countries to monitor progress on the ground, including the limited availability of disaggregated data (for example, by geography, sex, age, race/ethnicity and migratory status) and subnational data.
- Low levels of funding and imbalanced allocations to urban curative services rather than to preventive services and primary care.
- Fragmentation of health services across public sector entities, and between levels of care and multiple types of providers (including between public and private sectors), hampers the integration and delivery of standardized service delivery packages.

Steps for accelerated action

- Despite modest improvements in the coverage of essential health services in most of the countries, population growth rates will offset the gains being made; hence, to reach the target of UHC by 2030, coverage would need to be significantly increased.
- Expand health services using comprehensive and integrated packages, including preventive, promotive, curative, rehabilitative and palliative services, across all levels of care using a range of public and private sector providers and a functioning referral system.
- Enhance quality of care through institutionalized systems of patient safety, audit and surveillance.
- Health systems strengthening with a focus on equity is needed so that more people are provided with needed services over the life-course.
- Strengthen health information systems to enable the collection, analysis and use of disaggregated data to monitor key components of UHC (health systems, infectious disease, NCDs, and reproductive, maternal, newborn and child health).
- In emergency settings, broaden the use of the Humanitarian–Development–Peace Nexus approach for building resilient health systems rather than focusing only on developing essential service packages and maintaining essential services.

Available guidance/tools

- Universal health coverage (UHC) – priority benefits package [website]: <http://www.emro.who.int/uhc-pbp/index.html>

Key references

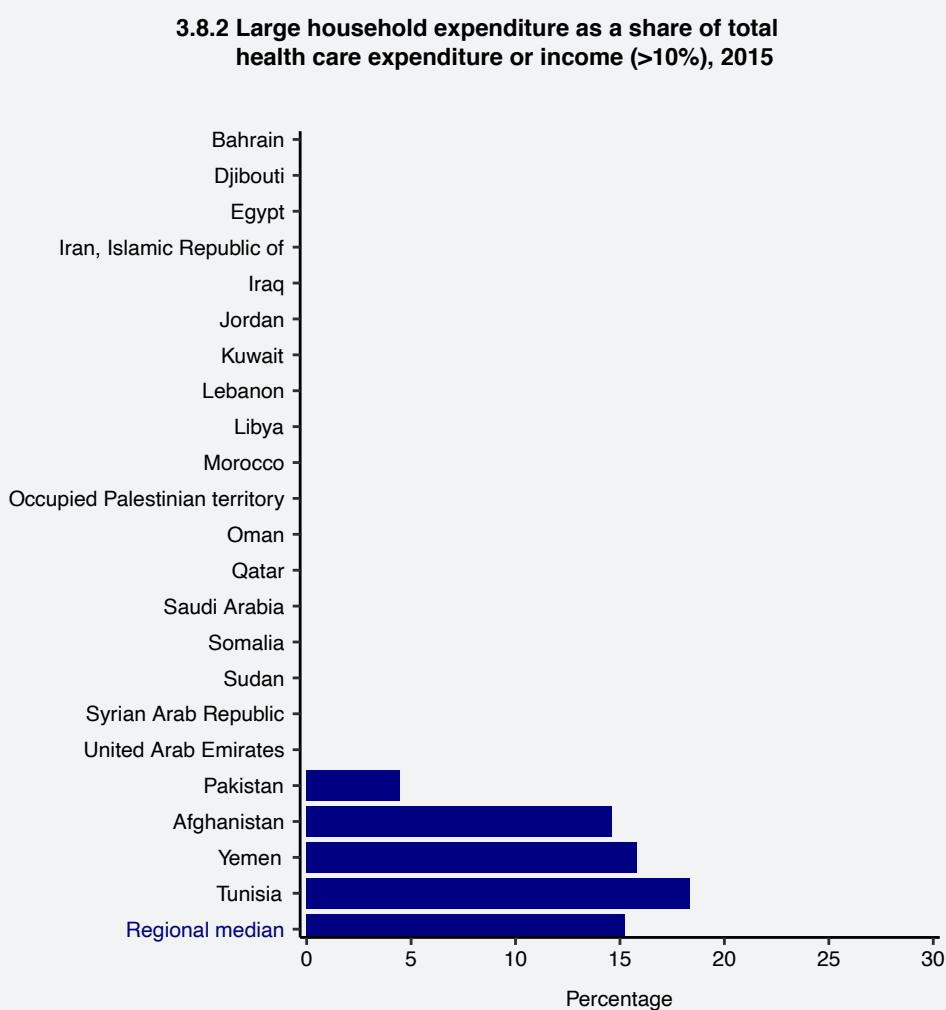
- Primary health care on the road to universal health coverage. 2019 Global monitoring report. Conference edition. Geneva: World Health Organization: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1
- Tracking universal health coverage: 2017 Global monitoring report. World Health Organization and the International Bank for Reconstruction and Development/The World Bank; 2017: https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/
- Hogan DR, Stevens GA, Hosseinpoor AR, Boerma T. Monitoring universal health coverage within the Sustainable Development Goals: development and baseline data for an index of essential health services. *Lancet Glob Health*. 2018;6(2):e152–e168: [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30472-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30472-2/fulltext)

Indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income (greater than 10% or 25%)

Current situation

Expenditure exceeding 10%

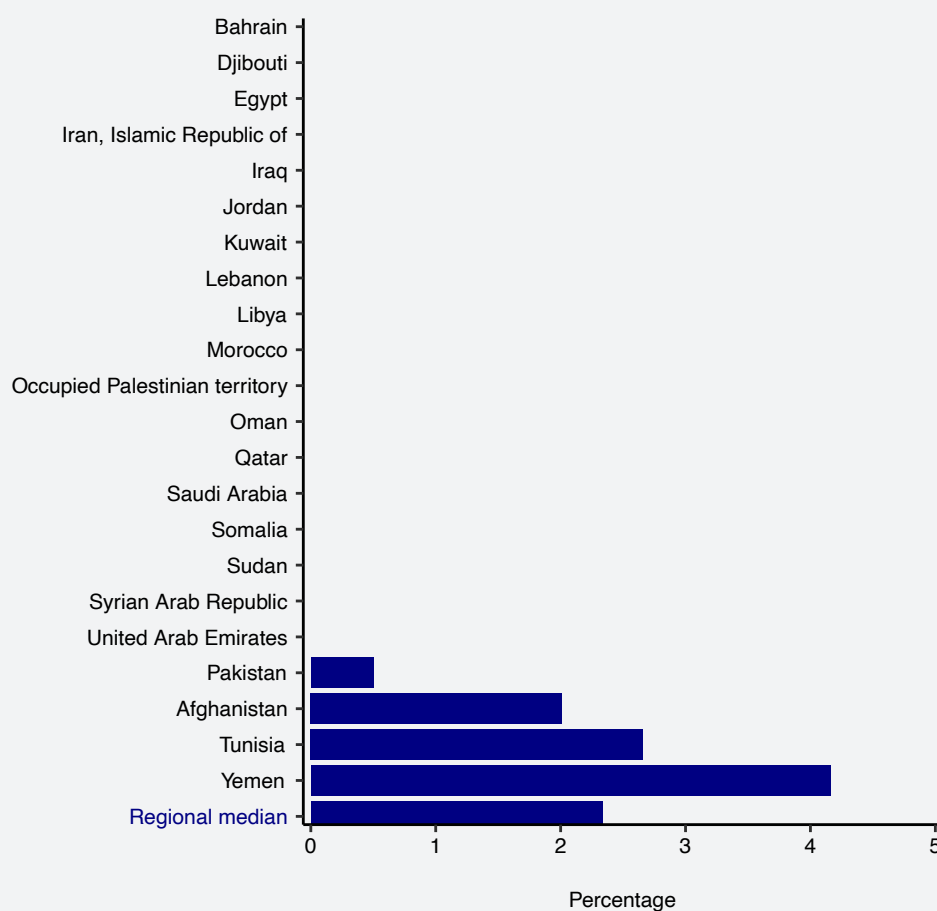
- The proportion of the population with household expenditures on health greater than 10% of total household expenditure or income was lowest in Pakistan (4.5%) and highest in Tunisia (18.6%).
- The proportion of population with household expenditures on health greater than 10% of total household expenditure or income was less than 20% in all countries with available data.



Expenditure exceeding 25%

- The proportion of the population with household expenditures on health greater than 25% of total household expenditure or income was lowest in Pakistan (0.5%) and highest in Yemen (4.1%).
- The proportion of the population with household expenditures on health greater than 25% of total household expenditure or income was less than 5% in all countries with available data.

3.8.2 Large household expenditure as a share of total health care expenditure or income (>25%), 2015



Challenges

- Low public spending on health.
- High out-of-pocket costs are a major barrier to access and continuity of care and can push the poorest below or further below the poverty line.
- Fragmented health care coverage with a growing unregulated private sector renders a large proportion of the population uninsured.
- Two thirds of countries are directly or indirectly affected by complex political conflicts and emergencies.

Steps for accelerated action

- Advocate for health financing and social protection reform with key stakeholders using available country-level evidence such as level of coverage by prepayment schemes, public spending on health and out-of-pocket spending on health.
- Ensure that additional resources are channelled through the compulsory pre-paid pooled arrangements and not through out-of-pocket expenditures that make the household prone to financial risk.
- Improve cost efficiency within the health sector through good governance for greater transparency and accountability, institutionalizing analytical tools (such as national health accounts, burden of disease measurement, cost-effectiveness analysis and health technology assessment) and bulk purchasing of medicines, vaccines and health technologies.

Available guidance/tools

- Developing a national health financing strategy: a reference guide. Health Financing Guidance No 3: https://www.who.int/health_financing/tools/developing-health-financing-strategy/en/
- Towards universal health coverage: thinking public. Overview of trends in public expenditure on health (2000–2014). Health Financing Guidance No 7: https://www.who.int/health_financing/documents/towards-uhc/en/
- Governance for strategic purchasing: an analytical framework to guide a country assessment. Health Financing Guidance No 6: <https://www.who.int/publications-detail-redirect/governance-for-strategic-purchasing-an-analytical-framework-to-guide-a-country-assessment>

Key references

- Primary health care on the road to universal health coverage. 2019 Global monitoring report. Conference edition. Geneva: World Health Organization: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1
- Towards universal health coverage: thinking public. Overview of trends in public expenditure on health (2000–2014). Health Financing Guidance No 7. Geneva: World Health Organization; 2017: https://www.who.int/health_financing/documents/towards-uhc/en/
- Tracking universal health coverage: 2017 Global monitoring report. World Health Organization and the International Bank for Reconstruction and Development/The World Bank; 2017: https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/
- Wagstaff A, Flores G, Hsu J, Smits M-F, Chepnog K, Buisman LR et al. Progress on catastrophic health spending in 133 countries: a retrospective observational study. *Lancet Glob Health*. 2018;6(2):e169–e179: [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30429-1/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30429-1/fulltext)

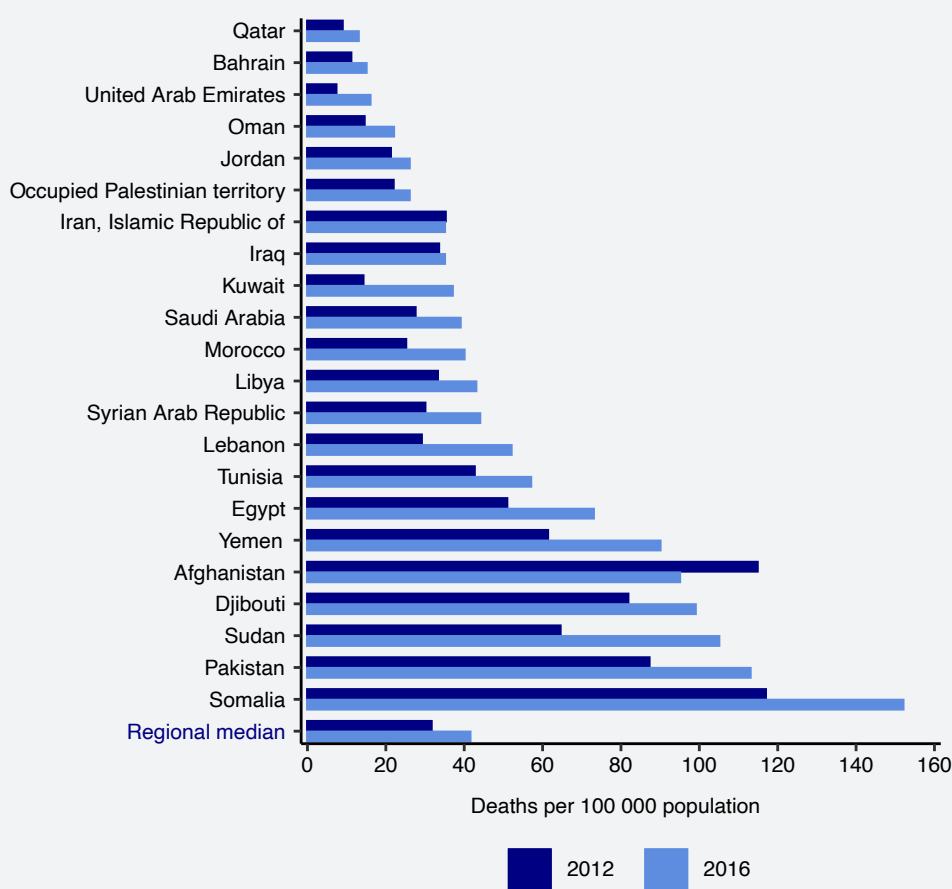
Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

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

Current situation

- The mortality rate attributed to household and ambient air pollution increased in most countries of the Region between 2012 and 2016. Only Afghanistan experienced a significant reduction in the mortality rate attributed to household and ambient air pollution between 2012 and 2016.
- Afghanistan, Djibouti, Egypt, Pakistan, Somalia, Sudan and Yemen reported most of the mortality burden attributed to household and ambient air pollution in the Region between 2012 and 2016.
- In 2016, the mortality rate attributed to household and ambient air pollution in the Region ranged from 13 deaths per 100 000 population in Qatar to 152 deaths per 100 000 population in Somalia.
- The median mortality rate attributed to household and ambient air pollution in the Region increased from 31.6 deaths per 100 000 population in 2012 to 41.5 deaths per 100 000 population in 2016.

3.9.1 Mortality rate attributed to household and ambient air pollution, 2012–2016



Challenges

- Natural and anthropogenic sources of air pollution in the Region make the levels of air pollution with particulates the highest in the world. The existence of a toxic mixture of natural and man-made particulate matter is thus a major challenge, along with a public perception that natural pollutants are harmless.
- Weak environmental monitoring and health surveillance systems, including standards that do not align with international standards and limited regional-specific evidence of the health impact of air pollution, along with a lack of related economic evaluation studies.
- Poor coordination between all relevant stakeholders to mitigate these challenges.
- Health and the environment. Draft road map for an enhanced global response to the adverse health effects of air pollution: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_18-en.pdf?ua=1&ua=1
- The WHO Data Integration Model for Air Quality (DIMAQ) [online database]: <https://www.who.int/airpollution/data/modelled-estimates/en/>
- AirQ+: software tool for health risk assessment of air pollution: <https://www.euro.who.int/en/health-topics/environment-and-health/air-quality/activities/airq-software-tool-for-health-risk-assessment-of-air-pollution>

Key references

Steps for accelerated action

- Develop comprehensive strategies to tackle the health impacts of air pollution at the regional, country and local levels.
- Develop/strengthen communication strategies to raise awareness and stimulate demand for policies to tackle air pollution, prevent associated diseases and thus improve well-being at regional, country and local levels.
- Develop interventions to address air pollution and health in other relevant regional processes related to health, environment and sustainable development.
- Include air pollution reduction in regional and national public health programmes and strategies, for example to prevent NCDs.
- Develop national tools to support implementation of WHO air quality guidelines as relevant, and the implementation of national and subnational action plans on air pollution and health.
- WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide. Global update 2005. Summary of risk assessment. Geneva: World Health Organization; 2006: https://www.who.int/phe/health_topics/outdoorair/outdoorair_aqg/en/
- Accelerating regional implementation of the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, 2018. Regional Committee for the Eastern Mediterranean. Sixty-sixth session. Provisional agenda item 3(e). EM/RC66/7. September 2019: https://applications.emro.who.int/docs/RC_Technical_Papers_2019_7_en.pdf?ua=1
- Arab Strategy and Framework of Action on Health and Environment 2017–2030. A regional strategy on health and environment for Arab states and an action guideline. League of Arab States in collaboration with WHO and the United Nations Environment Programme. Amman, Jordan 2017: <http://www.shorturl.at/egkA5>

Available guidance/tools

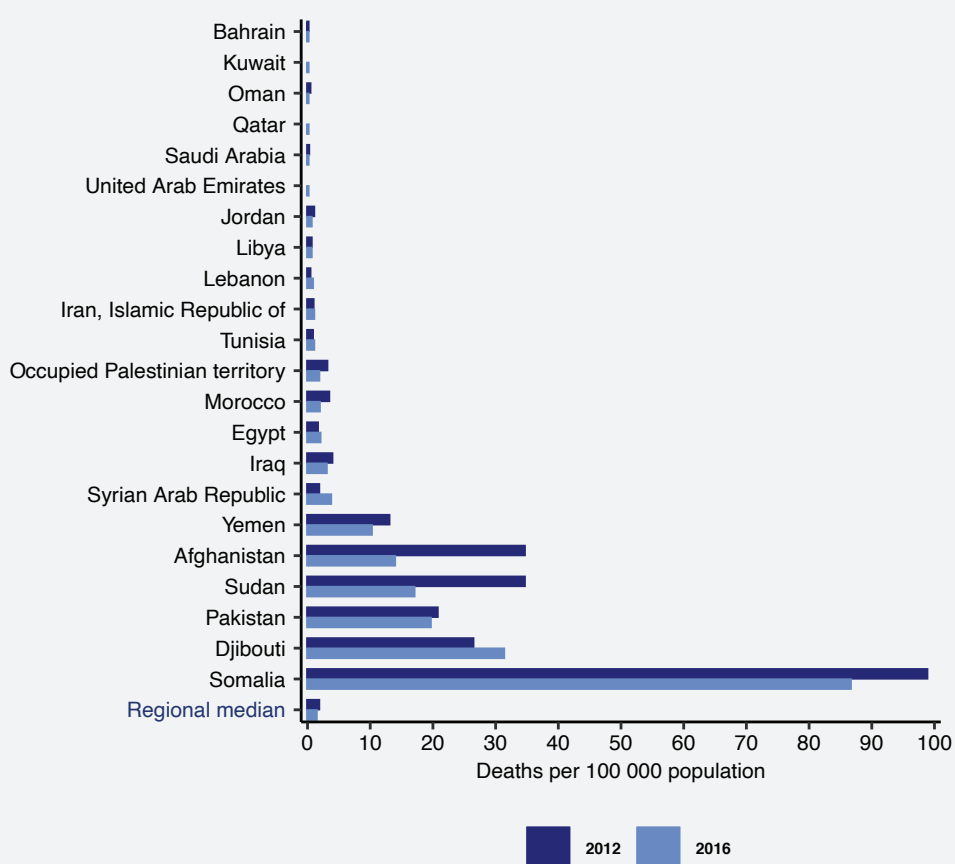
- Progress report on the regional plan of action for implementation of the roadmap for an enhanced global response to the adverse health effects of air pollution. EM/RC64/INF. DOC.3: https://applications.emro.who.int/docs/RC_technical_papers_2017_inf_doc_3_20013_en.pdf
- WHO guidelines on indoor and ambient air quality: <https://www.who.int/airpollution/guidelines/en/>

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

Current situation

- The mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene remained below 4 deaths per 100 000 population in most countries of the Region during the period 2012–2016.
- Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen reported most of the mortality burden attributed to unsafe water, unsafe sanitation and lack of hygiene in the Region during the period 2012–2016.
- In 2016, the mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene was lowest in the United Arab Emirates (0.1 deaths per 100 000 population) and highest in Somalia (86.6 deaths per 100 000 population).
- There were negligible changes in the median mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene in the Region during the period 2012–2016 (from 1.8 deaths per 100 000 population in 2012 to 1.4 deaths per 100 000 population in 2016).

3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene, 2012–2016



Challenges

- The high mortality rates in Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen correspond squarely to poor sanitation, drinking-water and hygiene coverage in these countries. As of 2020:
 - » the total number of people in the Region practising open defecation was around 46.7 million (6.4% of the regional population); and
 - » the total number of people in the Region lacking basic sanitation was around 245.7 million (33.6% of the regional population).
- Climate change, increasing water scarcity, population growth, demographic changes, urbanization, and conflict and civil unrest, particularly in low-income countries of the Region.
- Inadequate or inappropriately managed water and sanitation services expose individuals to preventable health risks, and there is a lack of basic infrastructure for safe water in conflict-affected and crisis areas of the Region.
- Insufficient data on water and sanitation services (including in health care facilities) to inform advocacy and support implementation efforts.

Steps for accelerated action

- Invest in improving water, sanitation and hygiene services in Afghanistan, Pakistan, Somalia, Sudan and Yemen.
- Conduct national assessments of the availability and quality of water and sanitation services in health care facilities as a basis for establishing standards and developing a road map for improvement, including in emergency settings.

Available guidance/tools

- Water sanitation and health. Water safety and quality [website]: <https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health/water-safety-and-quality> including WHO guidelines on drinking-water quality and other related guidance.
- Water sanitation hygiene. Sanitation and wastewater [website]: https://www.who.int/water_sanitation_health/sanitation-waste/en/ including the WHO Guidelines on sanitation and health: https://www.who.int/water_sanitation_health/sanitation-waste/sanitation/sanitation-guidelines/en/ and other related guidance.

Key references

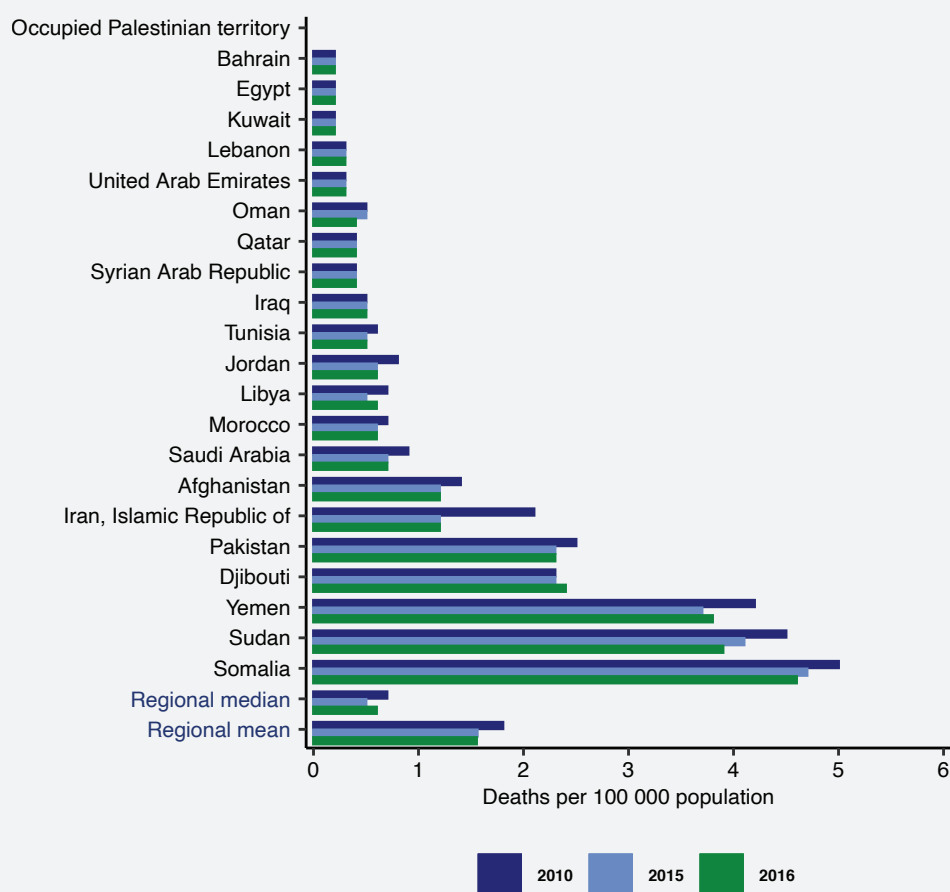
- Progress on household drinking water, sanitation and hygiene 2000–2017. Special focus on inequalities. New York: United Nations Children's Fund and World Health Organization; 2019: https://www.who.int/water_sanitation_health/publications/jmp-report-2019/en/
- Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization and United Nations Children's Fund; 2017: https://www.who.int/water_sanitation_health/publications/jmp-2017/en/
- WHO/UNICEF Joint Monitoring Programme [online database]: www.washdata.org

Indicator 3.9.3: Mortality rate attributed to unintentional poisoning

Current situation

- In 2016, the mortality rate attributed to unintentional poisoning in the Region ranged from 0.2 deaths per 100 000 population in Bahrain, Egypt and Kuwait to 4.6 deaths per 100 000 population in Somalia.
- There were negligible changes in the median mortality rate attributed to unintentional poisoning in the Region over the period 2010–2016 (from 0.7 deaths per 100 000 population in 2010 to 0.6 deaths per 100 000 population in 2016).
- The average mortality rate attributed to unintentional poisoning in the Region was 1.8 deaths per 100 000 population in 2010, declining to 1.6 and then 1.5 deaths per 100 000 population in 2015 and 2016 respectively.

3.9.3 Mortality rate attributed to unintentional poisoning, 2010–2016



Challenges

- There are few functional national poison control centres in the Region.
- Many event and syndromic surveillance systems do not capture information on poisoning.
- Limited public health laboratory capacity to detect chemical poisoning.
- Limited awareness of chemical poisoning among agricultural and industrial workers, and among households and families.

Steps for accelerated action

- Increase awareness of the sources of poisonings at household, agricultural and industrial levels.
- Strengthen the regulatory framework to limit the availability of, and access to, highly toxic pesticides and other hazardous chemicals.
- Establish/strengthen event and syndromic surveillance systems to collect and report data on poisonings at national and subnational levels.
- Strengthen public health laboratory capacity to detect chemical poisoning.
- Establish functioning poison centre(s) that serve the whole country 24/7.

Available guidance/tools

- The International Programme on Chemical Safety (IPCS) INTOX Programme [website]: <https://www.who.int/ipcs/poisons/intox/en/>
- The Eastern Mediterranean Poison Centers Network [website]: <https://www.empoisoncentres.org/>
- The WHO Global Chemicals and Health Network [website]: <https://www.who.int/ipcs/saicm/network/en/>
- Chemicals road map. Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond: https://www.who.int/ipcs/saicm/ChemicalsRoadMapbrochure_en.pdf?ua=1
- Concise International Chemical Assessment Documents (CICADs) [website]: <https://www.who.int/ipcs/publications/cicad/en/>
- WHO Health and Safety Guides (HSGs) [website]: <https://www.who.int/ipcs/publications/hsg/en/>

Key references

- Guidelines for poison control. Geneva: World Health Organization; 1997 (new version planned for 2021): https://www.who.int/ipcs/publications/training_poisons/guidelines_poison_control/en/
- Guidelines on the prevention of toxic exposures. Education and public awareness activities. Geneva: World Health Organization; 2004. Published by WHO in collaboration with the United Nations Environment Programme and the International Labour Organization: https://www.who.int/ipcs/features/prevention_guidelines.pdf
- Safer access to pesticides for suicide prevention. Experiences from community interventions. Geneva: World Health Organization; 2016: https://www.who.int/mental_health/suicide-prevention/pesticides_community_interventions/en/

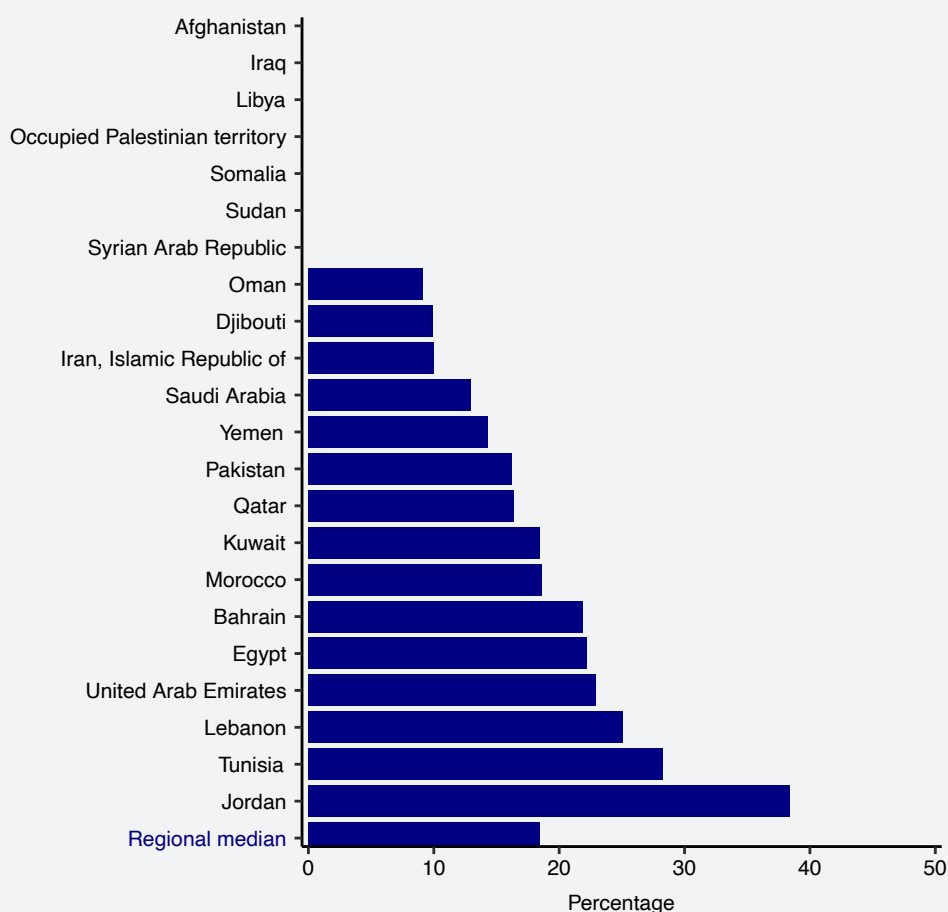
Target 3.a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

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

Current situation

- In 2015, the age-standardized prevalence of current tobacco use among persons aged 15 years and older in the Region ranged from 9.1% in Oman to 38.4% in Jordan.
- The median age-standardized prevalence of current tobacco use among persons aged 15 years and older in the Region in 2015 was 18.5%, with seven countries (Bahrain, Egypt, Jordan, Lebanon, Morocco, Tunisia and the United Arab Emirates) having rates above the median.

3.a.1 Prevalence of tobacco use among persons aged 15 years and older, 2015



Challenges

- Lack of high-level political understanding and comprehension of the problem and challenges.
- Lack of regular data collection at national level and significant gaps between each surveillance round for adults and young people.
- Weak multisectoral approach to enacting and enforcing most of the recommended tobacco-control policies in the WHO Framework Convention on Tobacco Control (WHO FCTC), MPOWER and NCD best buys in all countries of the Region, especially in addressing affordability as the Region has the lowest average price of tobacco products globally.
- Competing health priorities that push back the tobacco-control agenda, either due to unrest in the Region or health emergencies such as the COVID-19 pandemic.
- Growing popularity of both novel tobacco and novel nicotine products.
- Tobacco industry activities that undermine tobacco control at national level.
- Regional framework for action on tobacco control: <http://www.emro.who.int/tfi/publications/regional-framework-for-action-on-tobacco-control.html>
- WHO Tobacco Free Initiative [website]: <https://www.who.int/health-topics/tobacco> and regional Tobacco Free Initiative resources [website]: <http://www.emro.who.int/entity/tobacco-free-initiative/index.html>

Key references

Steps for accelerated action

- Adopt a multisectoral national plan of action that clarifies the priorities very clearly.
- Identify and address legislative gaps to achieve the highest level of implementation of every tobacco-control policy under the WHO FCTC, MPOWER and NCD best buys.
- Continue to monitor the tobacco epidemic to make sure that trends in tobacco use are well documented.
- Regulate all novel tobacco and nicotine products.
- Strengthen the enforcement and implementation at country level of existing legislation.
- The WHO Framework Convention on Tobacco Control (FCTC). Guidelines and policy options and recommendations for implementation of the WHO FCTC: https://www.who.int/fctc/treaty_instruments/en/
- The WHO Framework Convention on Tobacco Control (FCTC). Guidelines and policy options and recommendations for implementation of the WHO FCTC [website]: https://www.who.int/fctc/treaty_instruments/en/
- WHO report on the global tobacco epidemic, 2019. Offer help to quit tobacco use. Geneva: World Health Organization; 2019: <https://www.who.int/teams/health-promotion/tobacco-control/who-report-on-the-global-tobacco-epidemic-2019>
- Global Youth Tobacco Survey and Global Adult Tobacco Survey [online databases]: <http://www.emro.who.int/tfi/statistics/index.html>
- WHO global report on trends in prevalence of tobacco use 2000–2025. Third Edition. Geneva: World Health Organization; 2019: <https://www.who.int/publications/i/item/who-global-report-on-trends-in-prevalence-of-tobacco-use-2000-2025-third-edition>
- Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: World Health Organization; 2013: <https://www.who.int/publications-detail-redirect/global-action-plan-for-the-prevention-and-control-of-noncommunicable-diseases-2013-2020>
- The economics of tobacco and tobacco control. NCI Tobacco Control Monograph Series 21. US National Cancer Institute and World Health Organization. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; and Geneva: World Health Organization; 2016: <https://cancercontrol.cancer.gov/brp/tcrb/monographs/monograph-21>

Available guidance/tools

- The WHO Framework Convention on Tobacco Control (FCTC). Guidelines and policy options and recommendations for implementation of the WHO FCTC: https://www.who.int/fctc/treaty_instruments/en/
- Regional strategy and action plan for tobacco control 2019–2023: <https://applications.emro.who.int/docs/EMTFI195E.pdf?ua=1>

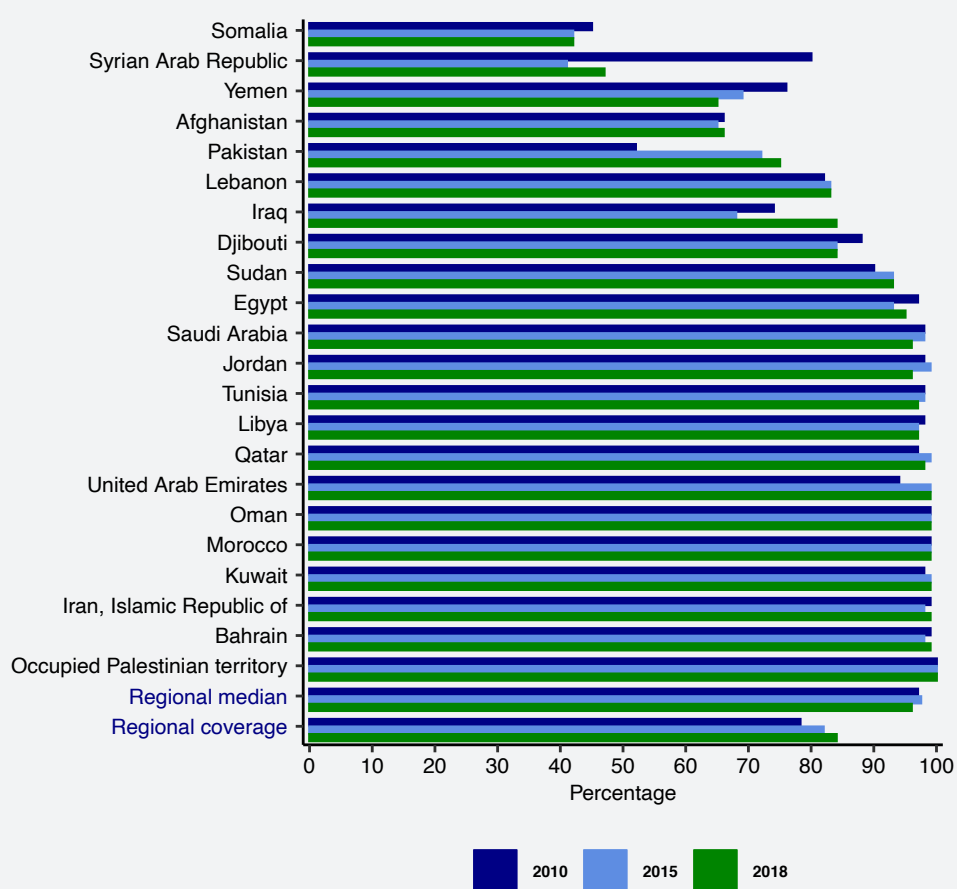
Target 3.b: Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public 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

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

Current situation

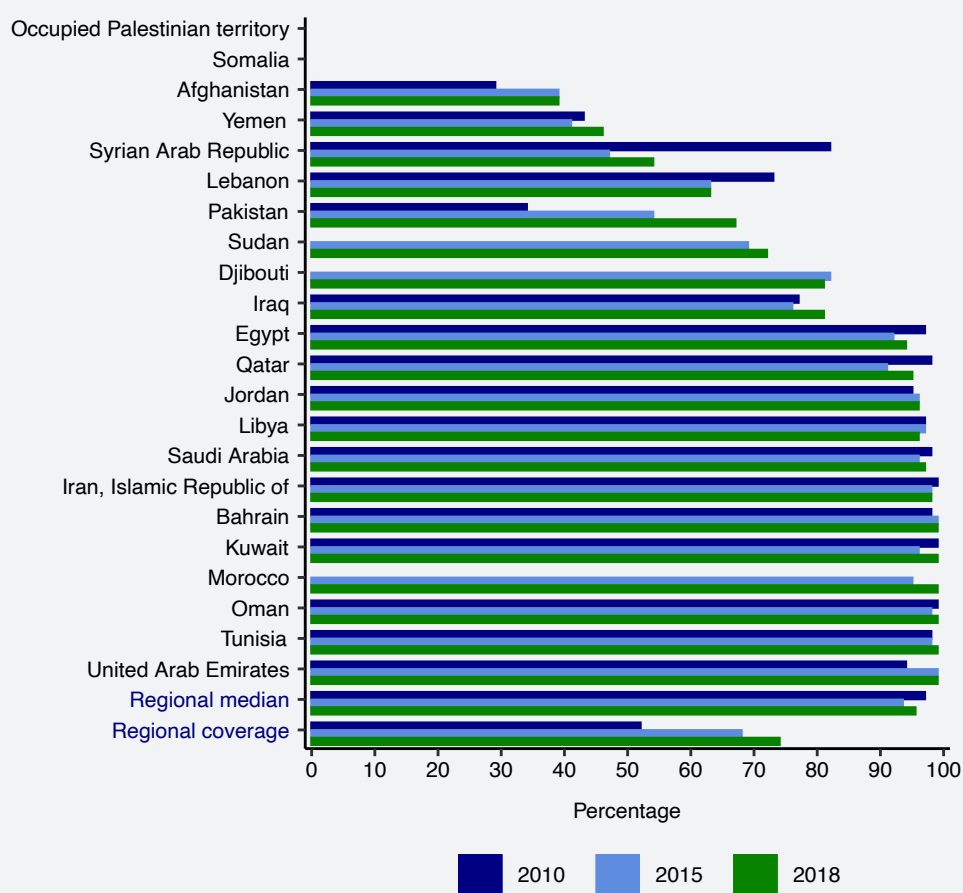
- The percentage of surviving infants who received the diphtheria-tetanus-pertussis third dose (DTP3) vaccine in a given year was at least 90% in half of the countries of the Region in the period 2010–2018.
- The percentage of surviving infants who received DTP3 vaccine in a given year remained lowest in Somalia during this period (45% in 2010 and 42% in 2018).
- In 2018, the median percentage of surviving infants who received DTP3 vaccine in the Region was 96%.

3.b.1 Coverage of DTP3 vaccination, 2010–2018

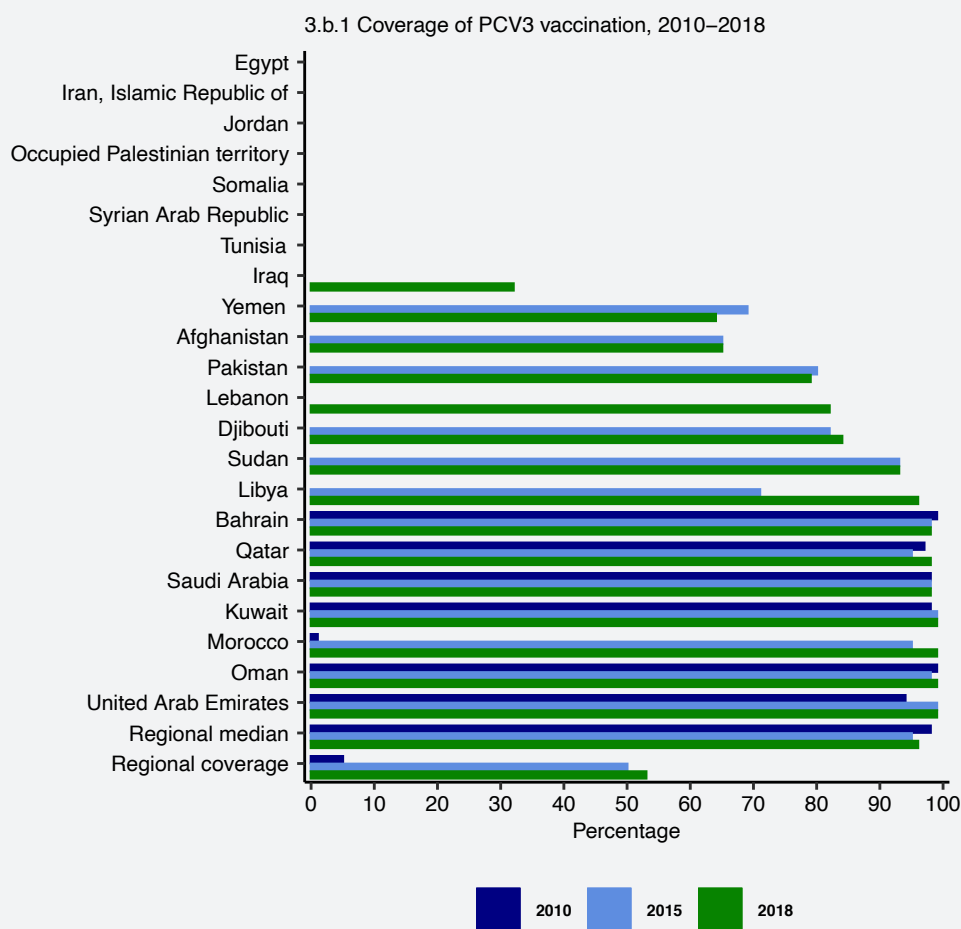


- The percentage of children who received measles-containing-vaccine second dose (MCV2) remained above 90% in 10 countries of the Region during the period 2010–2018 and was lowest in Afghanistan (39%). Somalia is yet to introduce MCV2 into their national schedule.
- In 2018, the median percentage of children who received MCV2 in the Region was 96%. The regional coverage for MCV2 in the Region was 74% in 2018; an increase from 52% in 2010 and 68% in 2015.

3.b.1 Coverage of MCV2 vaccination, 2010–2018



- In 2010, pneumococcal conjugate third dose (PCV3) coverage was 5% in the Region. This increased to 50% in 2015 and to 52% in 2018. There were modest changes in the percentage of one-year-olds who received PCV3 in most countries of the Region with data available between 2015 and 2018.
- The percentage of one-year-olds who received PCV3 in nine countries of the Region with data available in 2018 was above 90%, with a median value in all countries of the Region with data available in 2018 of 92%.



Challenges

- Lack of coordination between immunization and other preventive and curative services needed for a comprehensive approach to disease control.
- Weak health systems in most low-and low-middle-income countries, particularly in areas of governance relating to accountability and management capacity.
- Absence of adequate and sustainable public investment, with high donor dependence and non-judicious use of resources, especially in relation to supplementary immunization activities and the introduction of new vaccines.
- Absence of a strong and transparent policy and process for vaccine selection and procurement for the national programmes.
- Poor disease surveillance and inadequate quality of immunization programme input, process and output data, especially at the subnational level, often linked with unreliable and inconsistent denominators.
- Conflict and insecurity are hampering the implementation of planned activities, especially outreach and mobile activities for vaccine delivery and supplementary immunization campaigns.

Steps for accelerated action

- Strengthen all components of the health system, including governance and accountability.
- Secure adequate and sustainable public investment for the national immunization programme.
- Develop and implement a strong national immunization policy.
- Improve capacity for evidence-based decision-making on the introduction of essential vaccines in the national context taking into account global recommendations.
- Put in place a transparent and efficient vaccine procurement system and supply chain.
- Strengthen the health information system to better monitor and evaluate immunization programmes, including by broadening approaches to monitor the epidemiology of diseases targeted by vaccination, as well as inequities.

Available guidance/tools

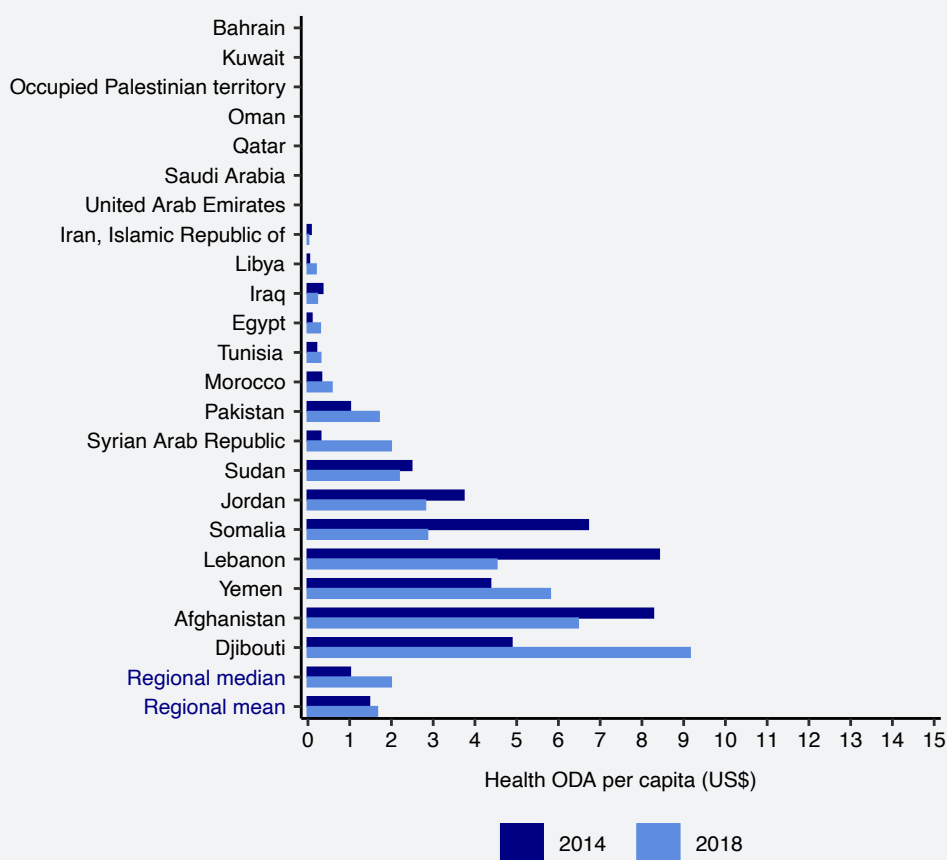
- WHO vaccine position papers [website]: <https://www.who.int/immunization/documents/positionpapers/en/>
- Duclos P. National immunization technical advisory groups (NITAGs): guidance for their establishment and strengthening. Vaccine. 2010;28(Suppl. 1):A18-A25: https://www.who.int/immunization/sage/meetings/2017/april/3_National_Immunization_Technical_Advisory_Groups_Guidance.pdf
- A guide for conducting an expanded programme on immunization (EPI) review: https://www.who.int/immunization/documents/WHO_IVB_17.17/en/
- Immunization agenda 2030: a global strategy to leave no one behind: <https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030>

Indicator 3.b.2: Total net official development assistance to medical research and basic health sectors per capita, by recipient countries (US\$)

Current situation

- In 2018, official development assistance (ODA) to medical research and basic health sectors per capita ranged from US\$ 0 to US\$ 9.14 in the Region. In fact, total ODA to medical research and basic health sectors in half of the countries of the Region was below US\$ 1.98.
- It should be noted that such estimates do not cover the intramural (domestic) funding of health research, which is a characteristic of the most populous countries of the Region such as Egypt, the Islamic Republic of Iran, Pakistan and Saudi Arabia.

3.b.2 ODA for medical research and basic health sectors per capita, by recipient country, 2014–2018



Challenges

- The data source is the Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC), also quoted at the WHO Global Observatory on Health Research and Development, which provides a DAC list of ODA recipients in the Region (27). This source may not accurately reflect the true progress made for indicator 3.b.2 in the Region. In voluntary national reviews (for example in Saudi Arabia in 2018) the indicator 3.b.2 was not included in the statistical annex of the full English report or in the narrative (28). This is similar to voluntary national reviews conducted in 2019 in Iraq (29) and Kuwait (30).

Key references

- WHO Global Observatory on Health R&D [online database]: <https://www.who.int/research-observatory/en/>

Steps for accelerated action

- As an example, the United Kingdom is highlighting “total net official development assistance to medical research and basic health sectors” for this indicator (31) – which could also be adopted by some of the countries in the Region that are actively providing ODA to recipient countries in the Region or possibly in other WHO regions.
- It is recommended that countries in the Region undertaking voluntary national SDG reviews include indicator 3.b.2 to reflect the efforts being made in this area.

Available guidance/tools

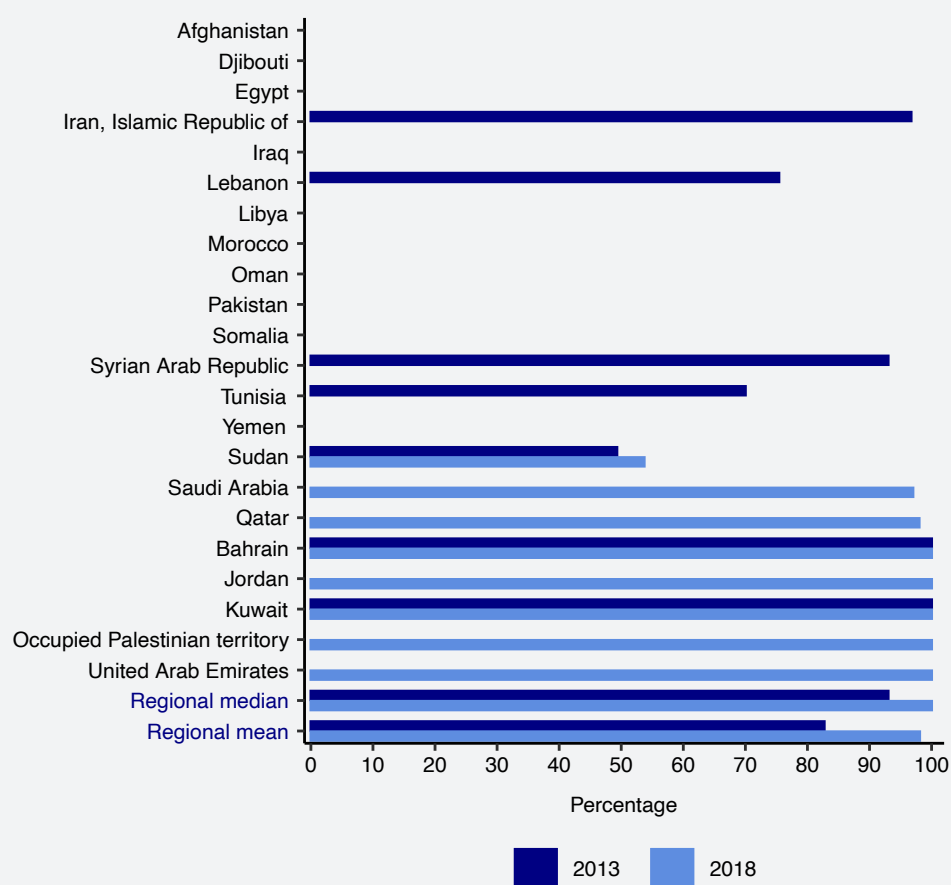
- A systematic approach for undertaking a research priority-setting exercise: guidance for WHO staff: <https://apps.who.int/iris/handle/10665/334408>
- The WHO strategy on research for health: https://apps.who.int/iris/bitstream/handle/10665/77935/9789241503259_eng.pdf;jsessionid=D92838E04CE129646D43DE0F-267168C5?sequence=1
- The World Health Report 2013. Research for universal health coverage: <https://www.who.int/publications/i/item/9789240690837>
- Technical paper. Strategic directions for scaling up research for health in the Eastern Mediterranean Region (EM/RC58/6): https://applications.emro.who.int/docs/RC_technical_papers_2011_6_14226.pdf?ua=1

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

Current situation

- In 2018, the availability of essential medicines in public health facilities was 100% in Bahrain, Jordan, Kuwait, the occupied Palestinian territory and the United Arab Emirates; 98% in Qatar; 97% in Saudi Arabia; and 53.7% in Sudan.

3.b.3 Availability of essential medicines in public health facilities, 2013–2018



Challenges

- Unavailability of quality data on access to medicines in the Region.
- Data-collection mechanisms (for example, health facility surveys and assessments, household surveys, disease-specific registries or databases, and pharmaceutical sector country profiles) require human and financial resources that are not available in many countries of the Region.
- The measurement and monitoring of access to medicines is not a priority for countries despite the progress made in improving the availability and affordability of medicines.
- Lack of automated systems to track the availability of medicines at health facilities in the Region.
- MedMon – WHO Essential Medicines and Health Products Price and Availability Monitoring Mobile Application [online tool]: <https://www.who.int/medicines/areas/policy/monitoring/empmedmon/en/>
- Monitoring the components and predictors of access to medicines. Geneva: World Health Organization; 2019: <https://www.who.int/medicines/areas/policy/monitoring/monitoring-the-components-of-access-to-medicines.pdf>

Steps for accelerated action

- Identify and secure needed technical and financial resources to support countries in strengthening their national health and pharmaceutical information systems, with a focus on improving the collection, analysis and use of data on access to medicines.
- Identify key strategic areas for the development of a technical package on measurement of access to medicines in the Region.
- Build country capacity to collect, analyse and use data on access to medicines.

Available guidance/tools

- Regional strategy to improve access to medicines and vaccines in the Eastern Mediterranean, 2020–2030, including lessons from the COVID-19 pandemic. Regional Committee for the Eastern Mediterranean. Sixty-seventh session. Provisional agenda item 4(a). EM/RC67/6. October 2020: <https://apps.who.int/iris/handle/10665/335952>
- Measuring medicine prices, availability, affordability and price components. Second edition. Geneva: World Health Organization and Health Action International; 2008: http://www.who.int/medicines/areas/access/medicines_prices08/en/
- Service availability and readiness assessment (SARA). An annual monitoring system for service delivery. Reference manual. Geneva: World Health Organization; 2013: http://www.who.int/healthinfo/systems/SARA_Reference_Manual_Full.pdf

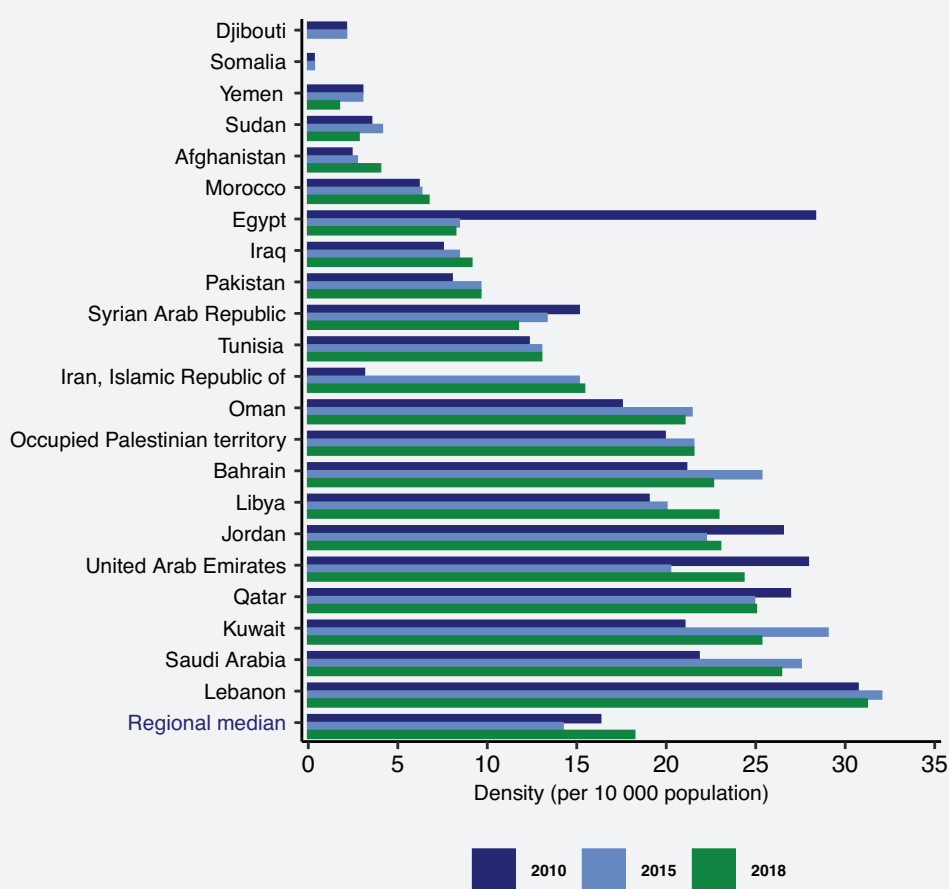
Target 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

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

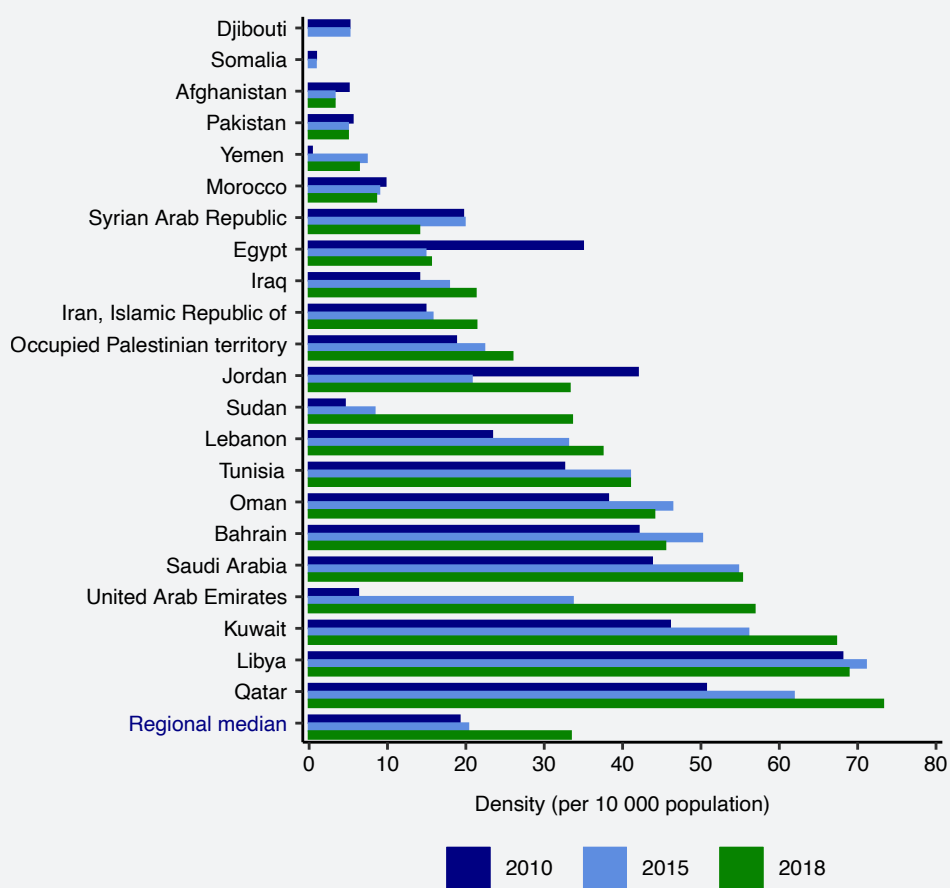
Current situation

- There were only modest changes in the density of physicians, nurses and midwives, pharmacists and dentists per 10 000 population in most countries of the Region between 2010 and 2018.
- Seven of the 22 countries of the Region are experiencing a critical shortage of healthworkers, with the density of physicians, nurses and midwives below 23 per 10 000, while about 40% of countries are below the threshold level of 44.5 physicians, nurses and midwives per 10 000 population needed to advance UHC.

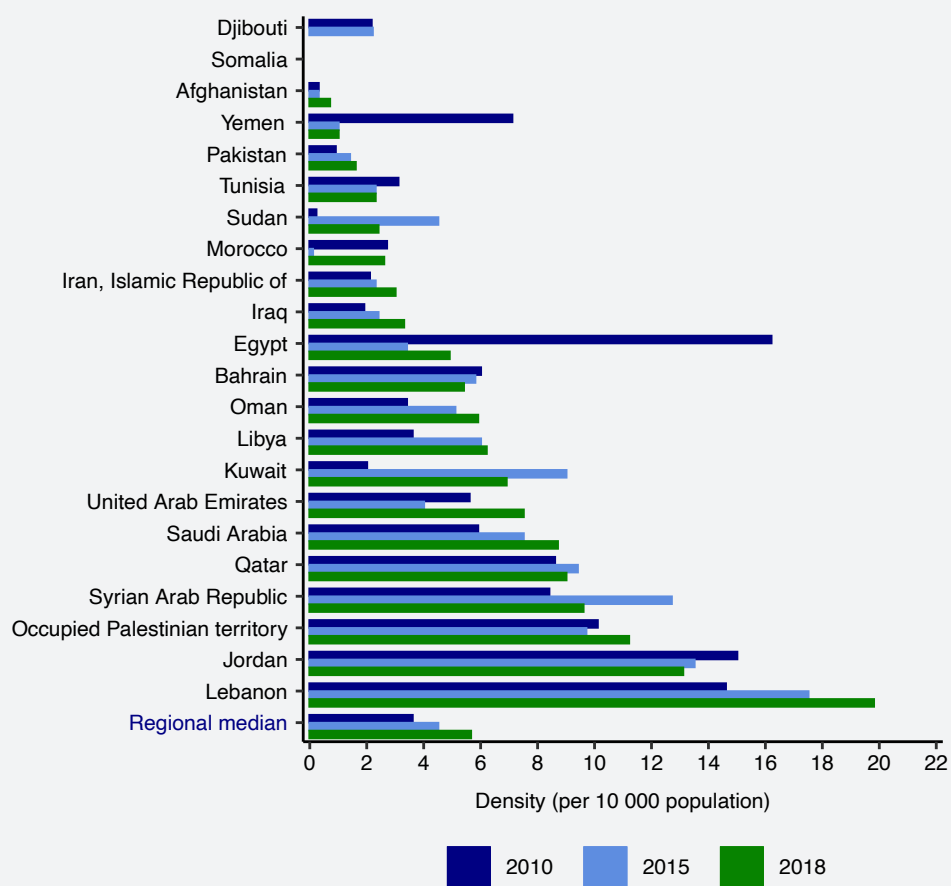
3.c.1 Density of physicians per 10 000 population, 2010–2018



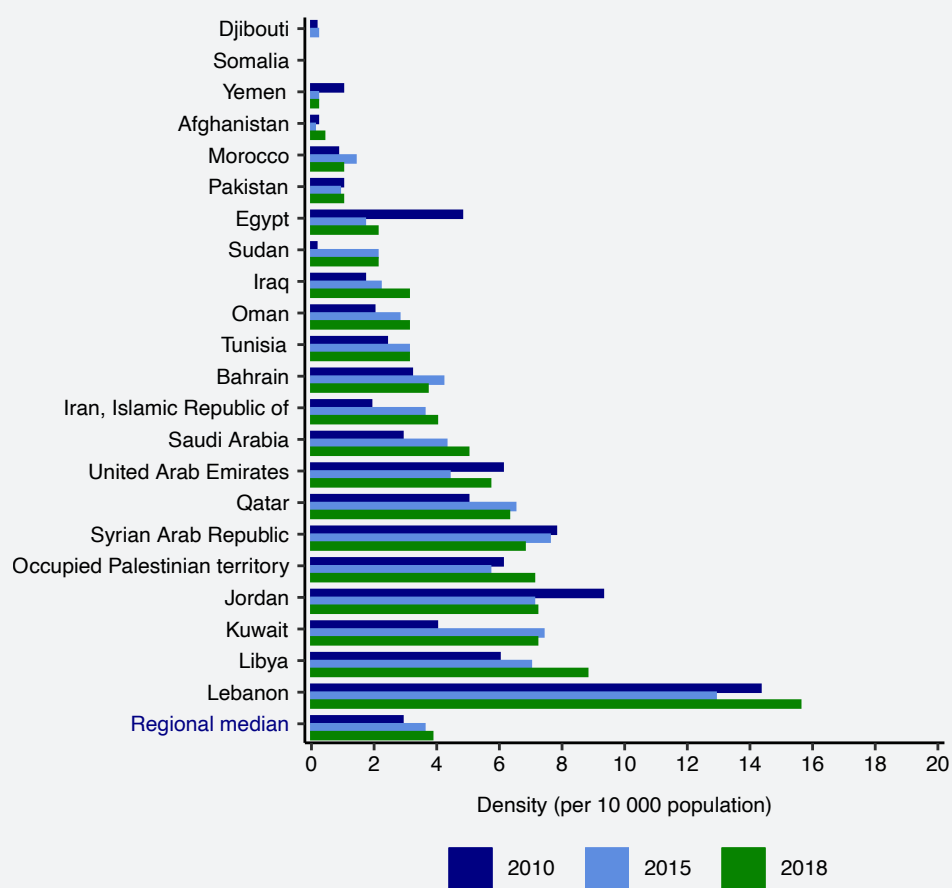
3.c.1 Density of nurses and midwives per 10 000 population, 2010–2018



3.c.1 Density of pharmacists per 10 000 population, 2010–2018



3.c.1 Density of dentists per 10 000 population, 2010–2018



Challenges

- Health workforce information systems are generally weak, fragmented and incomplete in the Region and face data quality and periodicity challenges.
- Available health workforce data tend to be mostly for the public sector, with limited information on the active workforce in other sectors. There are also discrepancies between the active and reported workforce due to fragmented and non-updated databases.
- The suboptimal production and availability of the health workforce, and imbalances in its skill mix and geographical distribution, are challenges faced by a majority of countries in the Region.
- There are also concerns in relation to the quality, relevance and performance of both the existing and future health workforces.

Steps for accelerated action

- Develop and implement comprehensive health workforce policies and strategic plans to optimize health workforce availability, accessibility, acceptability, quality and performance, based on an understanding of labour market dynamics, in order to:
 - » scale up and sustain the production of health workers of appropriate quality and relevance, and in appropriate quantities; and
 - » improve the recruitment, deployment, retention, motivation and performance of health workers.
- Regulate and manage exits from the health labour market.
- Strengthen capacities for health workforce governance and regulation by:
 - » strengthening the capacity of health workforce governance structures at all levels; and
 - » establishing and strengthening the regulation of health workforce practices and education.
- Strengthen the health workforce information base to guide the design, implementation and monitoring of health workforce strategic plans by:
 - » establishing/strengthening health workforce databases, information and evidence; and
 - » ensuring mechanisms to collect, report, analyse and use reliable workforce data, for example by establishing/strengthening a national health workforce observatory.
- Mobilize and align investment in the health workforce to ensure the implementation of strategic plans to meet current and future health workforce needs.

Available guidance/tools

- Framework for action for health workforce development in the Eastern Mediterranean Region 2017–2030: https://applications.emro.who.int/docs/EMROPub_2018_EN_20314.pdf?ua=1&ua=1&ua=1
- Strengthening the nursing workforce to advance universal health coverage in the Eastern Mediterranean Region: https://applications.emro.who.int/docs/RC_Technical_Papers_2019_4_en.pdf?ua=1 and <https://applications.emro.who.int/docs/RC66-R3-eng.pdf?ua=1>
- Review of medical education in the Eastern Mediterranean Region: challenges, priorities and a framework for action: https://applications.emro.who.int/docs/RC_technical_papers_2015_3_16503_EN.pdf and https://applications.emro.who.int/docs/RC62_Resolutions_2015_R4_16579_EN.pdf?ua=1&ua=1
- Health workforce response to the COVID-19 pandemic: <https://applications.emro.who.int/docs/EMCSR280E.pdf?ua=1&ua=1>

Key references

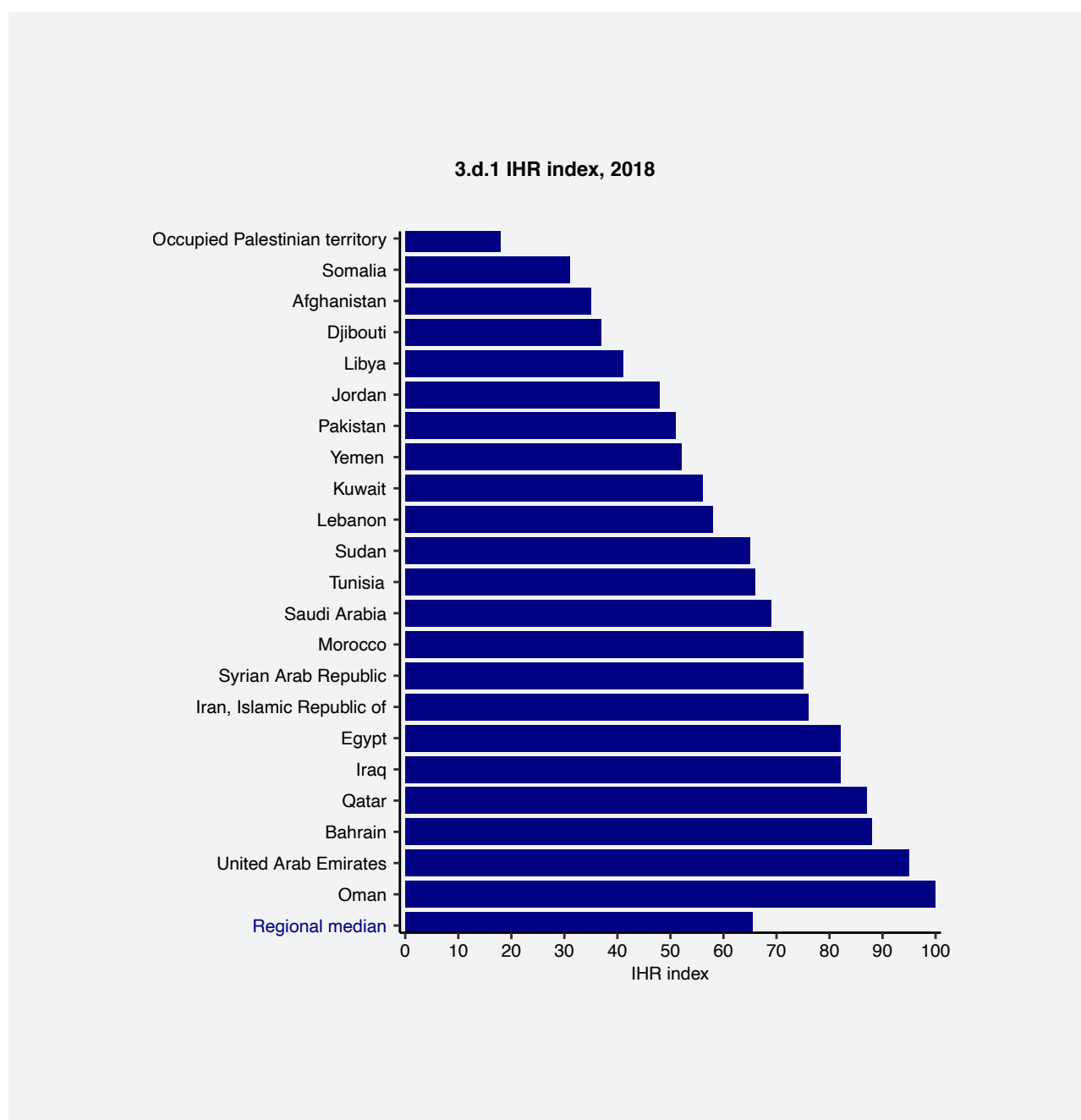
- Health workforce [website]: <http://www.emro.who.int/entity/health-workforce/index.html>
- State of the world's nursing 2020: investing in education, jobs and leadership. Geneva: World Health Organization; 2020: <https://apps.who.int/iris/handle/10665/331677>

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

Current situation

- The International Health Regulations (IHR) capacity and health emergency preparedness index in the Region in 2018 ranged from 18 in the occupied Palestinian territory to 100 in Oman.
- In 2018, the IHR capacity and health emergency preparedness index in half of the countries of the Region was below 65.5.



Challenges

- Limited awareness of IHR obligations across national sectors. The IHR are often seen as a rigid legal process and not operational in nature which severely limits the mandate of the IHR National Focal Point.
- Weak national capacities for surveillance and response functions required to facilitate the timely notification of any event that may constitute a public health emergency of international concern, and to respond to requests for verification of information about these events.
- Difficulties in fostering multisectoral coordination mechanisms and advocacy across all relevant national sectors to ensure that IHR implementation is effected as a national legal obligation, and sustaining political commitment to developing the core capacities of IHR (2005).

Steps for accelerated action

- Adopt an all-hazards approach to health threats. Countries should conduct an all-hazards risk assessment and develop their public health preparedness and response plans.
- Ensure that public health preparedness and response and disaster risk reduction plans for all hazards are in place, developed and disseminated through a multisectoral approach and based on the identified risk profile.
- Ensure that National Action Plans for Health Security are implemented across all sectors and reviewed in the context of the COVID-19 pandemic response and updated to enhance health security and the health system.
- Exercises, drills, assessments and evaluations should be systematically conducted to test capacities and plans to ensure that these are adequate and operational.
- Ensure a resourced workforce strategy for IHR implementation across all relevant sectors, including appropriate training.
- Identify competency gaps in the IHR workforce to recalibrate training for the highest priority needs.
- Establish requirements at points of entry to respond to public health emergencies.

Available guidance/tools

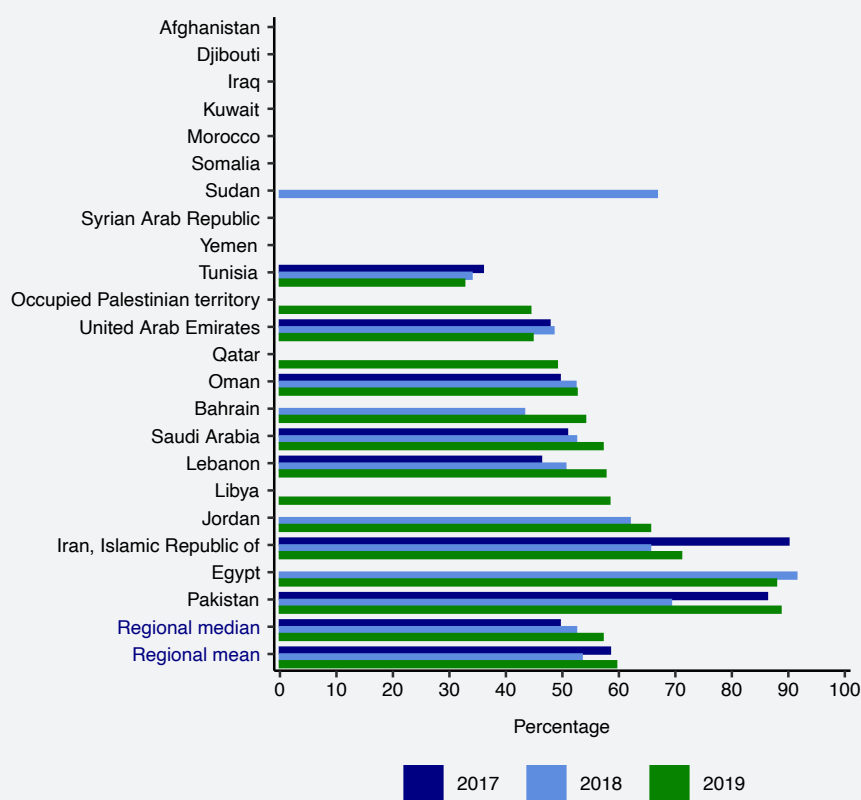
- IHR Monitoring and Evaluation Framework: <https://extranet.who.int/sph/ihr-monitoring-evaluation>
- National Action Plan for Health Security: <https://www.who.int/ihr/procedures/health-security-national-action-plan/en/>
- State Party self-assessment annual reporting tool. International Health Regulations (2005): <https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.16/en/>

Key references

- International Health Regulations (2005). Third edition. Geneva: World Health Organization; 2016: <https://www.who.int/publications/i/item/9789241580496>
- Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005). Seventy-third World Health Assembly. Agenda item 13.2. Resolution WHA73.8. 13 November 2020: https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R8-en.pdf

Indicator 3.d.2: Percentage of bloodstream infections due to selected antimicrobial-resistant organisms¹**Current situation****3.d.2: Percentage of bloodstream infections due to *Escherichia coli* caused by *E. coli* resistant to third-generation cephalosporin (ESBL-*E. coli*)**

- There is wide variation in the percentage of such resistance among countries in the Region.
- In 2017, the average percentage of all bloodstream infections due to *E. coli* caused by ESBL-*E. coli* reported from seven countries was 58.4% (ranging from 35.9% in Tunisia to 90% in the Islamic Republic of Iran).
- In 2018, the average percentage of such infections reported from 11 countries was 53.4% (ranging from 33.9% in Tunisia to 91.4% in Egypt).
- In 2019, data from 13 countries showed that the average percentage of such infections was 59.5% (ranging from 32.6% in Tunisia to 88.6% in Pakistan).

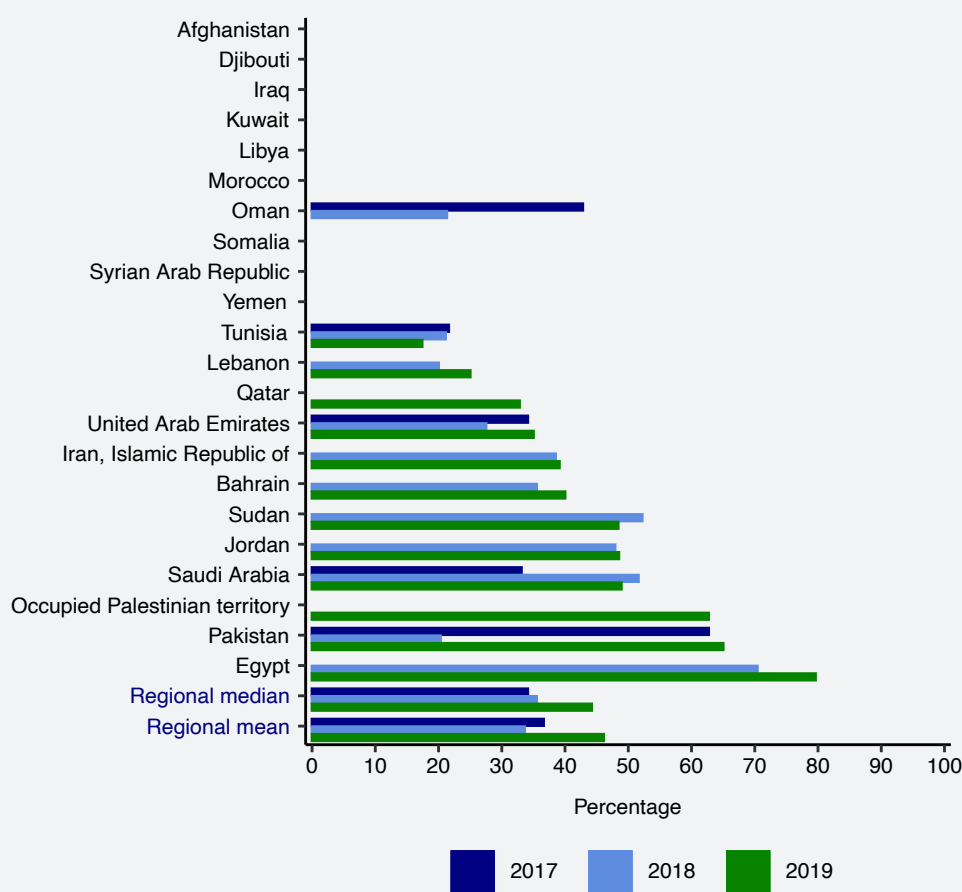
3.d.2 Bloodstream infections due to methicillin-resistant *Staphylococcus aureus*, 2017–2019

¹ *Escherichia coli* (*E. coli*) and *Staphylococcus aureus* (*S. aureus*) are bacteria that cause several acute human infections, both at the community and health care facility levels. *E. coli* is highly prevalent in both humans and animals, and in the environment, and is thus an excellent indicator for monitoring antimicrobial resistance (AMR) across different sectors in line with the AMR One Health approach. *E. coli* resistant to third-generation cephalosporins are largely spread in hospital settings and infections with this type of resistant bacterium leads to the increased use of last-resort antibiotics (carbapenems) against which new types of AMR are emerging. The effective control of *E. coli* resistant to third-generation cephalosporins (ESBL-*E. coli*) and of methicillin-resistant *S. aureus* (MRSA) will ultimately preserve the effectiveness of last-resort antibiotics in treating severe infections.

3.d.2: Percentage of bloodstream infections due to *Staphylococcus aureus* caused by methicillin-resistant *S. aureus* (MRSA)

- There is wide variation in the percentage of such resistance among countries in the Region.
- In 2017, the average percentage of *S. aureus* bloodstream infections caused by MRSA reported from five countries was 36.6% (ranging from 21.6% in Tunisia to 62.7% in Pakistan).
- In 2018, the average percentage of such infections reported from 11 countries was 33.6% (ranging from 20.3% in Pakistan to 70.4% in Egypt).
- In 2019, 12 countries reported data on MRSA, with the average percentage of such infections increasing to 46.1% (ranging from 17.4% in Tunisia to 79.6% in Egypt).

3.d.2 Bloodstream infections due to methicillin-resistant *Staphylococcus aureus*, 2017–2019



Key message

- The Region has a high percentage of resistant organisms (ESBL-*E. coli* and MRSA) causing bloodstream infections among patients. These types of resistant infections require extensive use of antibiotics as well as the use of last-resort drugs (such as carbapenems for ESBL-*E. coli* and vancomycin for MRSA) which contributes to the increasing emergence of resistant organisms.

Challenges

- Lack of political engagement and leadership to support the antimicrobial resistance (AMR) agenda in the Region.
- Disrupted health systems in several countries of the Region due to political unrest and crisis situations.
- Lack of national capacities, particularly in low-resourced countries in the fields of epidemiology, surveillance, data management, microbiology, and infection prevention and control.
- Limited capacities of microbiology laboratories in several low- and middle-income countries are hindering the reporting of good quality AMR data.
- Limited intersectoral collaboration between the human, animal and environmental sectors.
- Limited or lack of national legislation to control the use of antimicrobials in the human and animal sectors.

Steps for accelerated action

- Enhance advocacy on AMR to ensure political leadership and engagement, as well as enforcing national policies and legislation to contain AMR.
- Ensure all countries in the Region establish national AMR surveillance systems, as well as report AMR data to the WHO Global Antimicrobial Resistance Surveillance System (GLASS).
- Ensure countries establish/strengthen national and facility-level infection prevention and control programmes to reduce the spread of resistant organisms in the health care setting.
- Enhance national capacities in the areas of surveillance, microbiology, infection prevention and control, and antimicrobial stewardship.
- Strengthen information, education, and communication activities on AMR.

Available guidance/tools

- Global Antimicrobial Resistance Surveillance System. Manual for early implementation: <https://www.who.int/antimicrobial-resistance/publications/surveillance-system-manual/en/>
- Global Antimicrobial Resistance Surveillance System (GLASS). Guide to preparing aggregated antimicrobial resistance data files: <https://apps.who.int/iris/bitstream/handle/10665/251557/WHO-DGO-AMR-2016.6-eng.pdf;sequence=1>
- Global Antimicrobial Resistance Surveillance System (GLASS). Guide to uploading aggregated antimicrobial resistance data: <https://www.who.int/glass/resources/publications/uploading-data-guide/en/>
- National antimicrobial resistance surveillance systems and participation in the Global Antimicrobial Resistance Surveillance System (GLASS). A guide to planning, implementation, and monitoring and evaluation: <https://apps.who.int/iris/bitstream/handle/10665/251554/WHO-DGO-AMR-2016.4-eng.pdf?sequence=1>
- Interim practical manual supporting national implementation of the WHO Guidelines on core components of infection prevention and control programmes: <https://www.who.int/infection-prevention/tools/core-components/cc-implementation-guideline.pdf?ua=1>

Key references

- Global Antimicrobial Resistance Surveillance System (GLASS) [website]: <https://www.who.int/glass/en/>
- Global Antimicrobial Resistance Surveillance System (GLASS) report. Early implementation 2016–2017. Geneva: World Health Organization; 2017: <http://apps.who.int/iris/bitstream/handle/10665/259744/9789241513449-eng.pdf?sequence=1>
- Global Antimicrobial Resistance Surveillance System (GLASS) report. Early implementation 2017–2018. Geneva: World Health Organization; 2018: <https://apps.who.int/iris/bitstream/handle/10665/279656/9789241515061-eng.pdf?ua=1>
- Global Antimicrobial Resistance and Use Surveillance System (GLASS) report. Early implementation 2020. Geneva: World Health Organization; 2020: <https://apps.who.int/iris/bitstream/handle/10665/332081/9789240005587-eng.pdf>

» GOAL 4: ENSURE INCLUSIVE AND EQUITABLE QUALITY EDUCATION AND PROMOTE LIFELONG LEARNING OPPORTUNITIES FOR ALL

Target 4.1: By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

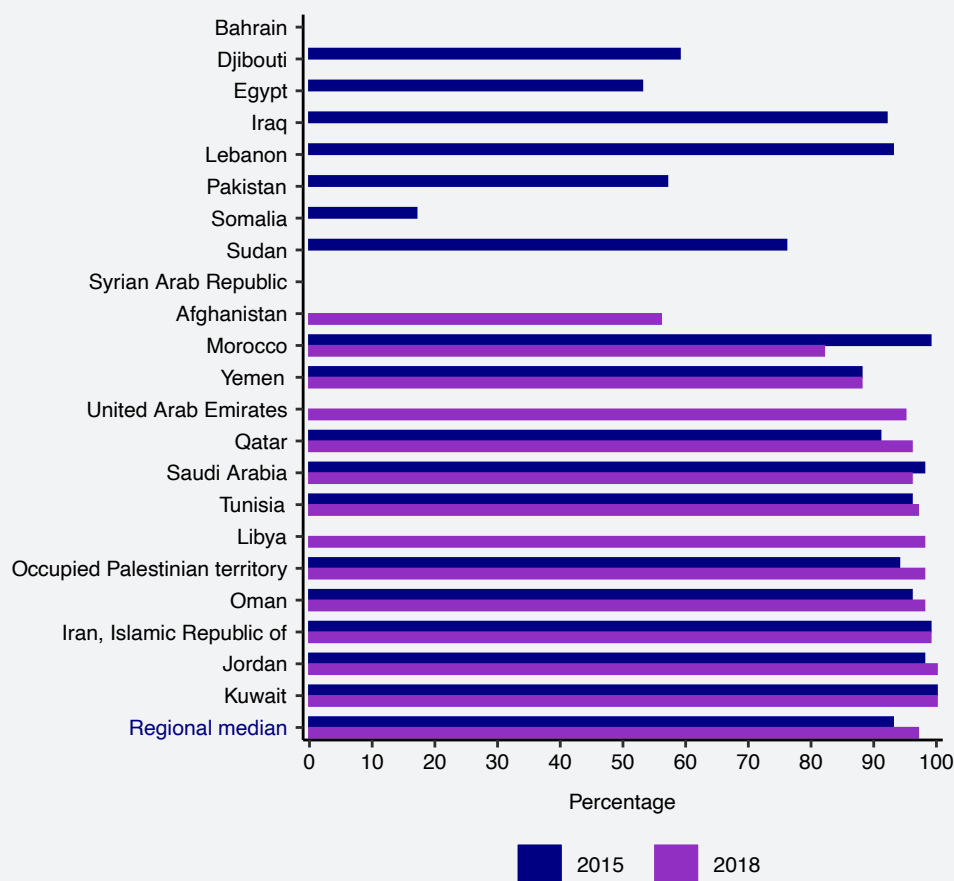
Indicator 4.1.1: Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex

Net primary school enrolment ratio per 100 school-age children

Current situation

- There were negligible changes in the net primary school enrolment ratio between 2015 and 2018 in most countries of the Region.
- In 2018, net primary school enrolment ratio in the Region ranged from 56% in Afghanistan to 100% in Jordan and Kuwait.
- In 2018, net primary school enrolment ratio in half of the countries of the Region with available estimates was above 97%.

4.1.1 Net primary school enrolment ratio per 100 school-age children, 2015–2018



Challenges

- Conflict and crises leave a significant proportion of children not in school, and put others at risk as education facilities are jeopardized by continued conflicts.
- Poor quality educational systems are leaving children ill-equipped for the labour market and thus for meaningful and dignified work.

Steps for accelerated action

- Transform education systems to provide children and young people with flexible learning opportunities and to equip them with skills and knowledge beyond traditional literacy and numeracy.
- Align curricula, assessment and teacher development systems for relevant learning.
- Promote child-friendly, violence-free learning environments in schools and the community.
- Include child-centred teaching methods and life-skills-related content aligned with the requirements of the labour market.
- Implement innovative and technology-enabled interventions to expand access to education and learning throughout the life-cycle.

Key references

- Education: UNICEF Middle East and North Africa [website]: <https://www.unicef.org/mena/education>

Target 4.6: By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy

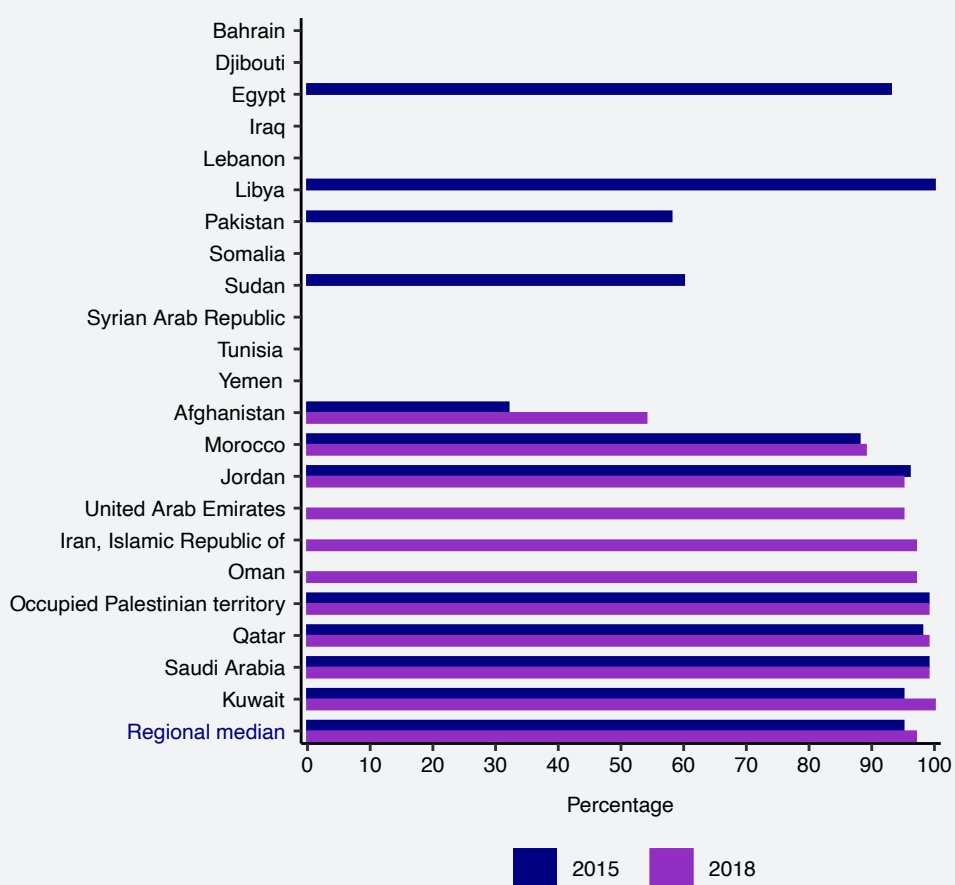
Indicator 4.6.1: Proportion of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex

Literacy rate (15–24 years)

Current situation

- There were negligible changes in literacy rates among individuals aged 15–24 years between 2015 and 2018 in most countries of the Region that have estimates available for both years.
- In 2018, literacy rates among individuals aged 15–24 years in the Region ranged from 54% in Afghanistan to 100% in Kuwait.
- In 2018, the literacy rate among individuals aged 15–24 years in half of the countries of the Region with available estimates was above 97%.

4.6.1 Literacy rate (15–24 years), 2015–2018



Challenges

- Lack of disaggregated data limits the ability to assess different dimensions of inclusiveness.
- Rapid expansion of private education, along with the extra resources for private tutoring and other elements needed to succeed, hamper the ability of children from disadvantaged backgrounds (especially those from rural areas) to access higher education.
- Educational reform and investment have been limited to quantifiable and material infrastructural changes rather than being transformative as envisaged under SDG 4.

Steps for accelerated action

- Rethink the role and value of education in driving transformative change.
- Invest in and continuously reform and upgrade educational systems across the Region.
- Guarantee the right to equitable and quality education.
- Enhance the capacities required to collect disaggregated data by sex, location, disability, income level and other markers, and to measure the quality of education.

Key references

- Education: UNICEF Middle East and North Africa [website]: <https://www.unicef.org/mena/education>

» GOAL 5: ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS

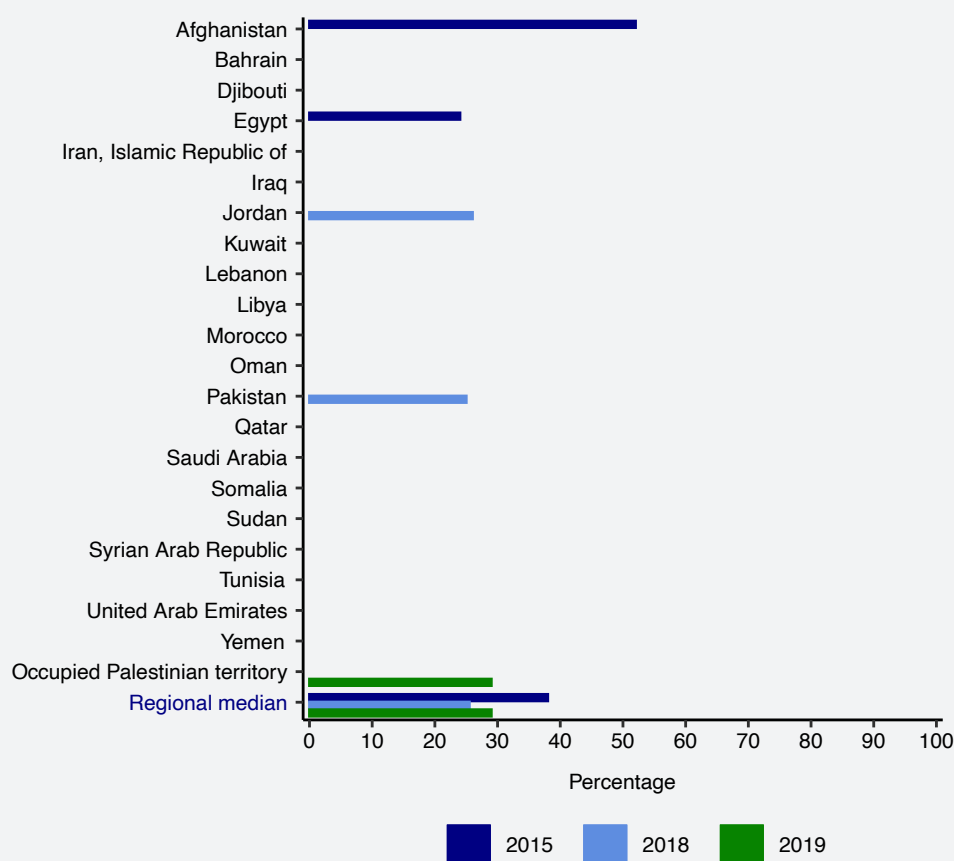
Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

Indicator 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

Current situation

- Based on available data from demographic and health surveys, the 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 in five countries of the Region was 52% in Afghanistan (2015), 24% in Egypt (2015), 26% in Jordan (2017), 29% in the occupied Palestinian territory (2019) and 25% in Pakistan (2018).²
- Overall, 37% of women in the Region experienced physical and/or sexual violence by a partner or sexual violence by a non-partner.

5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to violence, 2015–2019



² One challenge is that although the SDG indicator 5.2.1 standard reference group is 15–49 years, this is not the case across all countries. Some countries calculate the indicator value based on married women aged 18–64 years.

Challenges

- Violence against women is still deeply rooted in structural systems, where gender inequalities and discrimination persist and proliferate.
- Lack of reporting, or under-reporting, which may lead to inaccurate data collection.
- Lack of reliable, comprehensive and comparable data on various forms of violence against women.
- Humanitarian crises and sociopolitical and economic instability in the Region increase the risk of exposure to violence for women and girls and can bring new forms of violence.

Steps for accelerated action

- Strengthen health system leadership and governance by publicly committing to condemning and addressing all forms of violence against women and girls.
- Strengthen health service delivery and health provider capacity to respond to violence against women and girls.
- Strengthen programming to prevent violence against women and girls.
- Enhance national health information systems and surveillance systems to enable the routine collection of data and evidence on violence against women and girls.
- Strengthen the health sector response as part of a multisectoral response by addressing risk factors and determinants of violence, and facilitate equitable access to services.

Available guidance/tools

- Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children: <https://www.who.int/reproductivehealth/publications/violence/global-plan-of-action/en/>
- Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines: <https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>
- Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for

health managers: <https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/>

- Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook: <https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>
- Clinical management of rape and intimate partner violence survivors. Developing protocols for use in humanitarian settings: <https://www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en/>

Key references

- National demographic health surveys. The DHS Program demographic health surveys [online database]: <https://dhsprogram.com/>
- Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013: <https://www.who.int/publications/i/item/9789241564625>

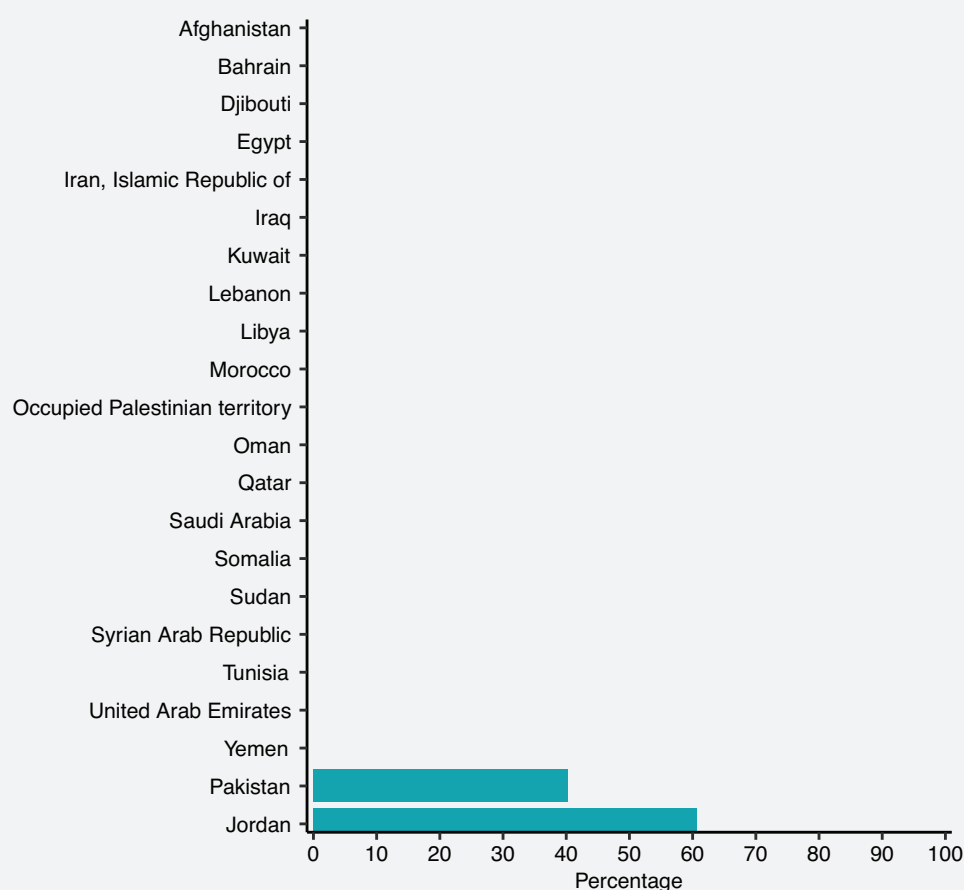
Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

Indicator 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

Current situation

- Data on the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care are lacking in the Region and are only available for two countries of the Region.
- In 2018, the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care was 40.3% in Pakistan and 60.7% in Jordan.

5.6.1 Proportion of women aged 15–49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care, 2018



Challenges

- Gender inequalities and discrimination persist and are proliferating, thus hampering the ability of women to make decisions on their own health.
- Limited access to, affordability and acceptability of SRH services.
- Lack of access to quality information on SRH.
- Traditional beliefs, myths and misconceptions are negatively influencing decision-making on SRH.
- Unavailability of data and poor quality of available data.

Steps for accelerated action

- Empower women to ensure their autonomy in decision-making on their own health through conducive regulatory frameworks, educational and occupational opportunities, and women-centred economic incentives.
- Scale up and improve access to and acceptability of quality SRH services by training service providers on quality of care and provision of contraception and other essential SRH supplies to leave no one behind.
- Improve educational opportunities for the girl child.
- Increase the availability and accessibility of information on reproductive health and challenge misconceptions.
- Include information on reproductive health in the school curriculum.
- Include the appropriate tools for collecting information necessary for monitoring indicator 5.6.1 in population-based surveys such as the Demographic and Health Survey and Multiple Indicator Cluster Survey.

Available guidance/tools

- Quality of care in contraceptive information and services, based on human rights standards: a checklist for health care providers: <https://apps.who.int/iris/bitstream/handle/10665/254826/9789241512091-eng.pdf?sequence=1>
- Women's ability to decide. Issue Brief on Indicator 5.6.1 of the Sustainable Development Goals: https://www.unfpa.org/sites/default/files/resource-pdf/20-033_SDG561-IssueBrief-v4.1.pdf
- Tracking women's decision-making for sexual and reproductive health and reproductive rights: https://www.unfpa.org/sites/default/files/resource-pdf/20-033_SDG561-BrochureA4-v1.21.pdf

» GOAL 6: ENSURE AVAILABILITY AND SUSTAINABLE MANAGEMENT OF WATER AND SANITATION FOR ALL

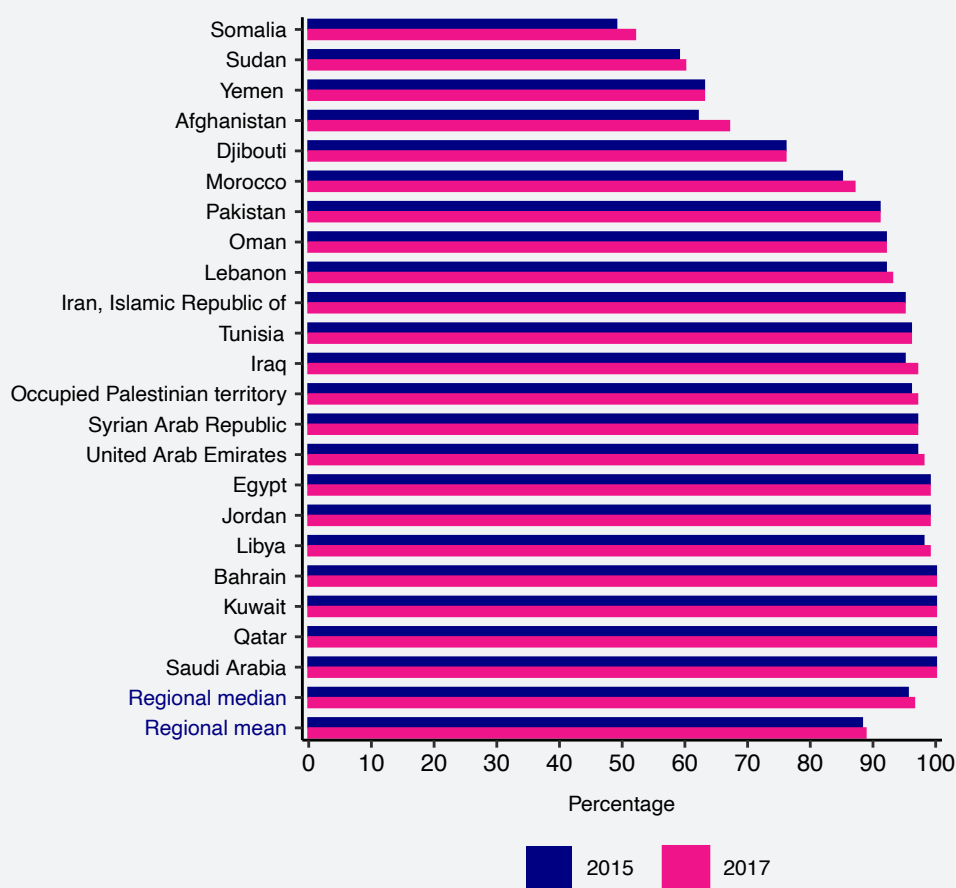
Target 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking-water for all

Indicator 6.1.1: Proportion of population using safely managed drinking-water services

Current situation

- By 2017, 89% of the Region's population had access to at least basic drinking-water services of which only 56% were safely managed.
- There has been only negligible progress (1% increase) in coverage of basic water services since 2015 – the baseline year.
- By 2017, the proportion of the population using safely managed drinking-water services in countries of the Region ranged from 52% in Somalia to 100% in Bahrain, Egypt, Kuwait, Qatar and Saudi Arabia.

6.1.1 Access to improved drinking-water, 2015–2017



Challenges

- Water scarcity, climate change, expanding urbanization, and conflict and crisis are key challenges facing the Region.
- Inadequate coverage of safely managed drinking-water services – by 2017, 11% (75 million people) remained without access to even basic water services, 62 million of whom live in five countries (Pakistan 17 million; Sudan 16 million; Afghanistan 12 million; Yemen 10 million; and Somalia 7 million). While access to basic services is equal to the global average of 89%, access to safely managed services is 56%, well below the global average of 71%.
- Lack of obtainable data on safely managed services due to inaccessibility of data and/or the likely insufficient monitoring of service quality.
- Weak public health sector engagement in their role in regulating and monitoring water and sanitation services.
- Insufficient financial resources to implement WASH plans to meet national targets, and weak regulatory oversight of WASH service delivery.
- The health sector should engage and coordinate with WASH actors to align, prioritize and jointly monitor key indicators at national and subnational levels.
- Ensure health care facilities have and sustain adequate WASH services, and share health surveillance data with WASH actors to inform WASH service delivery.

Available guidance/tools

- Guidelines for drinking-water quality. Fourth edition incorporating the first addendum: https://www.who.int/water_sanitation_health/water-quality/guidelines/en/
- Developing drinking-water quality regulations and standards. General guidance with a special focus on countries with limited resources: https://www.who.int/water_sanitation_health/publications/developing-dwq-regulations/en/
- Water safety planning for small community water supplies. Step-by-step risk management guidance for drinking-water supplies in small communities: https://apps.who.int/iris/bitstream/handle/10665/75145/9789241548427_eng.pdf;%20jsession-id=2F74141084126319713559E5F4E854C2?sequence=1
- Water, sanitation, hygiene and health, A primer for health professionals: https://www.who.int/water_sanitation_health/publications/water_sanitation_hygiene-primer-for-health-professionals/en/

Steps for accelerated action

- Countries with populations lacking basic drinking-water services need to establish and implement investment packages to address those needs – serving the 75 million people who still lack access to even basic services is a priority.
- Implement integrated drinking-water safety management systems encompassing regulation, operational procedures and efficient monitoring surveillance of service quality.
- Strengthen multisectoral approaches to promote universal safely managed water and sanitation services using innovative technologies to address the challenges such as climate change and water scarcity.
- Scale up investment in WASH service delivery, including in areas with a high burden of disease, and/or ensure links between WASH programmes and programmes aiming to reduce adverse health outcomes (for example, AMR, sepsis, and maternal mortality/preventable newborn death).
- Conduct joint sector reviews to guide strategic decisions on resource allocation, extend coverage to those who are unserved and upgrade existing services.

Key references

- Progress on household drinking water, sanitation and hygiene 2000–2017. Special focus on inequalities. New York: United Nations Children's Fund and World Health Organization; 2019: https://www.who.int/water_sanitation_health/publications/jmp-report-2019/en/
- Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization and United Nations Children's Fund; 2017: https://www.who.int/water_sanitation_health/publications/jmp-2017/en/
- WHO/UNICEF Joint Monitoring Programme [online database]: www.washdata.org

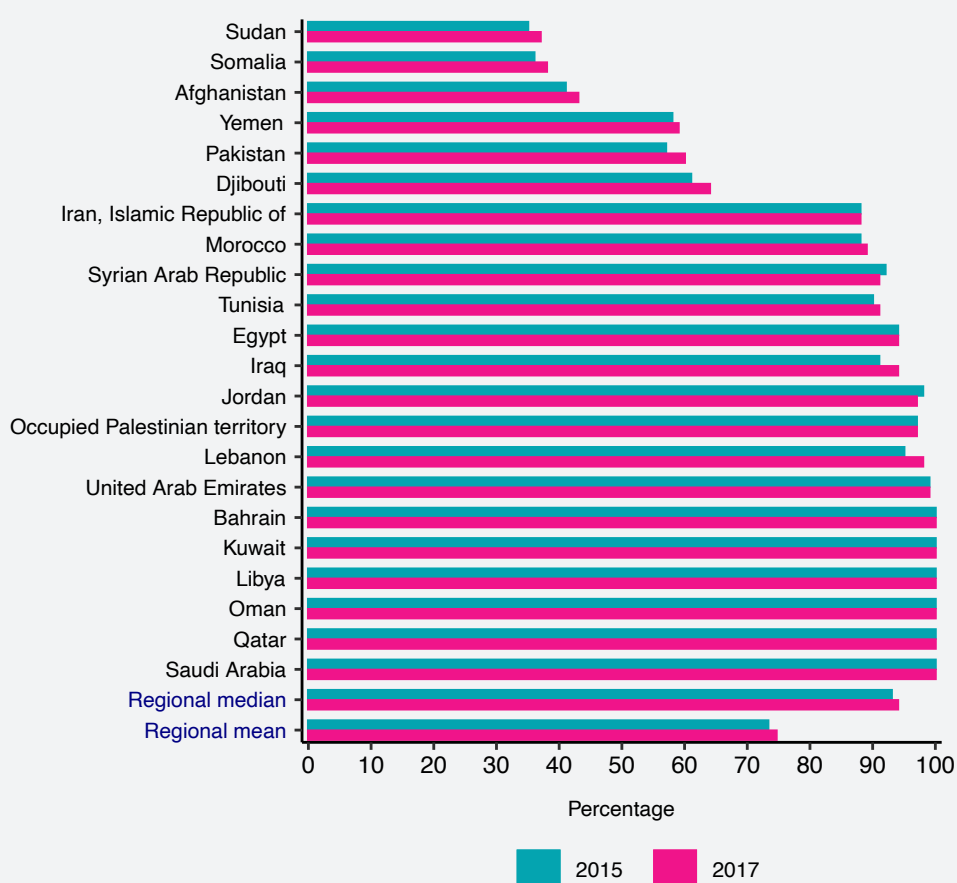
Target 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

Indicator 6.2.1: Proportion of population using: (a) safely managed sanitation services; and (b) a hand-washing facility with soap and water

Current situation

- By 2017, at least basic sanitation services were available to 75% of the population of the Region, representing a modest 2% increase from 2015.
- In 2017, the proportion of the population with access to improved sanitation facilities in countries of the Region ranged from 37% in Sudan to 100% in Bahrain, Libya, Oman, Kuwait, Qatar and Saudi Arabia.
- Rural-urban inequalities remain, with 89% urban basic sanitation coverage compared to 60% rural coverage.
- Open defecation is still practised by around 46.7 million people (6.4% of the Region's population), the majority of whom live in Afghanistan, Pakistan, Somalia, Sudan and Yemen.
- Around 245.7 million people (33.6% of the Region's population) still lack basic sanitation, the majority of whom live in Afghanistan, Pakistan, Somalia, Sudan and Yemen.
- There are not enough data to generate a regional estimate of safely managed sanitation services. However, based on data on 14 countries, while 89% of the urban population had basic sanitation coverage, only 42% had access to safely managed services.

6.2.1 Access to improved sanitation facilities, 2015–2017



Challenges

- Open defecation is still practised by 16% of the regional rural population (54 million people) and basic sanitation services still need to be extended to 25% of the Region's population (171 million people).
- Persistence of rural-urban inequalities, with open defecation practised by 54 million rural population compared to 0.56 million urban population, while 131 million rural residents lack basic sanitation services compared to 40 million urban residents.
- Inadequate coverage of safely managed sanitation services – in the 14 countries for which it was possible to estimate safely managed sanitation services, 89% of the population had access to basic sanitation services but only 42% had access to safely managed sanitation services.
- Lack of obtainable data on safely managed services due to inaccessibility of data and/or the likely insufficient monitoring of service quality.
- Weak public health sector engagement in their role in regulating and monitoring water and sanitation services.
- Insufficient financial resources to implement WASH plans to meet national targets, and weak regulatory oversight for WASH service delivery.
- Conduct joint sector reviews to guide strategic decisions on resource allocation, extend coverage to those who are unserved and upgrade existing services.
- The health sector should engage and coordinate with WASH actors to align, prioritize and jointly monitor key indicators at national and subnational levels.
- Ensure health care facilities have (and sustain) adequate WASH services, and share health surveillance data with WASH actors to inform WASH service delivery.

Available guidance/tools

- Guidelines on sanitation and health [website]: https://www.who.int/water_sanitation_health/sanitation-waste/sanitation/sanitation-guidelines/en/
- Sanitation safety planning. Manual for safe use and disposal of wastewater, greywater and excreta: https://www.who.int/water_sanitation_health/publications/ssp-manual/en/

Key references

- Progress on household drinking water, sanitation and hygiene 2000–2017. Special focus on inequalities. New York: United Nations Children's Fund and World Health Organization; 2019: https://www.who.int/water_sanitation_health/publications/jmp-report-2019/en/
- Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization and United Nations Children's Fund; 2017: https://www.who.int/water_sanitation_health/publications/jmp-2017/en/
- WHO/UNICEF Joint Monitoring Programme [online database]: www.washdata.org

Steps for accelerated action

- Develop and implement national programmes to accelerate the extension of basic sanitation services to the unserved and to end open defecation.
- Establish and implement a national policy and investment package to raise the level of sanitation services from basic to safely managed.
- Strengthen multisectoral approaches to promote universal safely managed water and sanitation services using innovative technologies to address challenges such as climate change and water scarcity.
- Scale up investment in WASH service delivery, including in areas with a high burden of disease, and/or ensure links between WASH programmes and programmes aiming to reduce adverse health outcomes (for example, AMR, sepsis, and maternal mortality/preventable newborn death).

» GOAL 8: PROMOTE SUSTAINED, INCLUSIVE AND SUSTAINABLE ECONOMIC GROWTH, FULL AND PRODUCTIVE EMPLOYMENT AND DECENT WORK FOR ALL

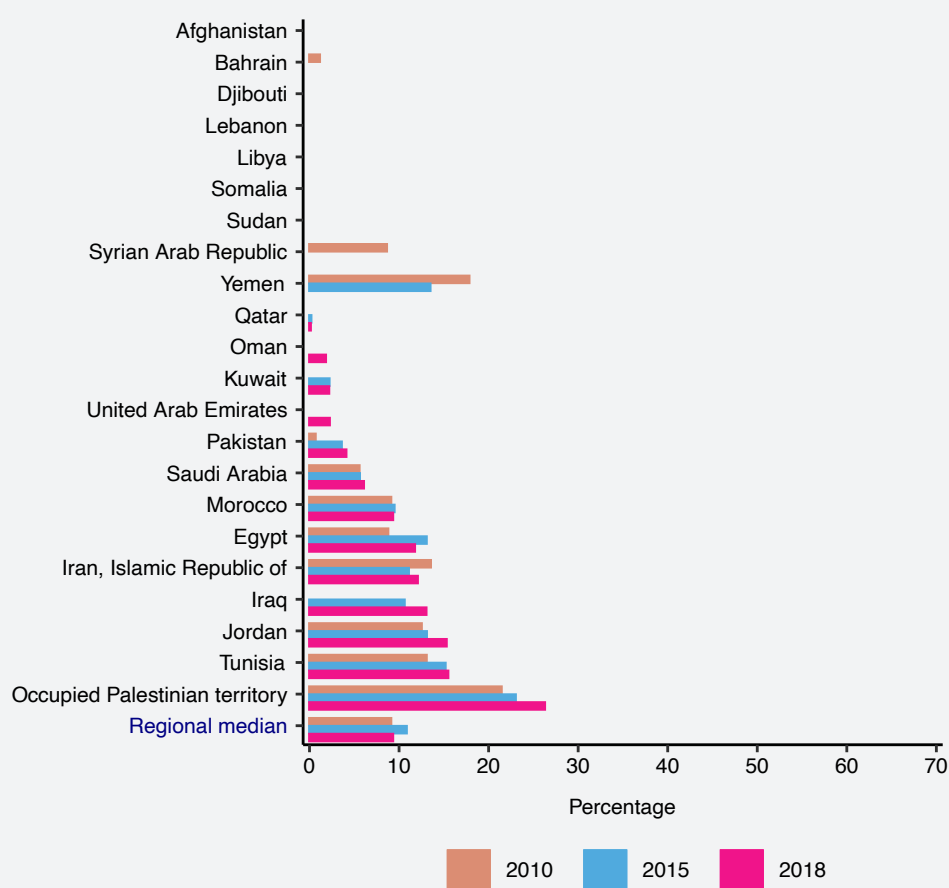
Target 8.5: By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value

Indicator 8.5.2: Unemployment rate, by sex, age and persons with disabilities

Current situation

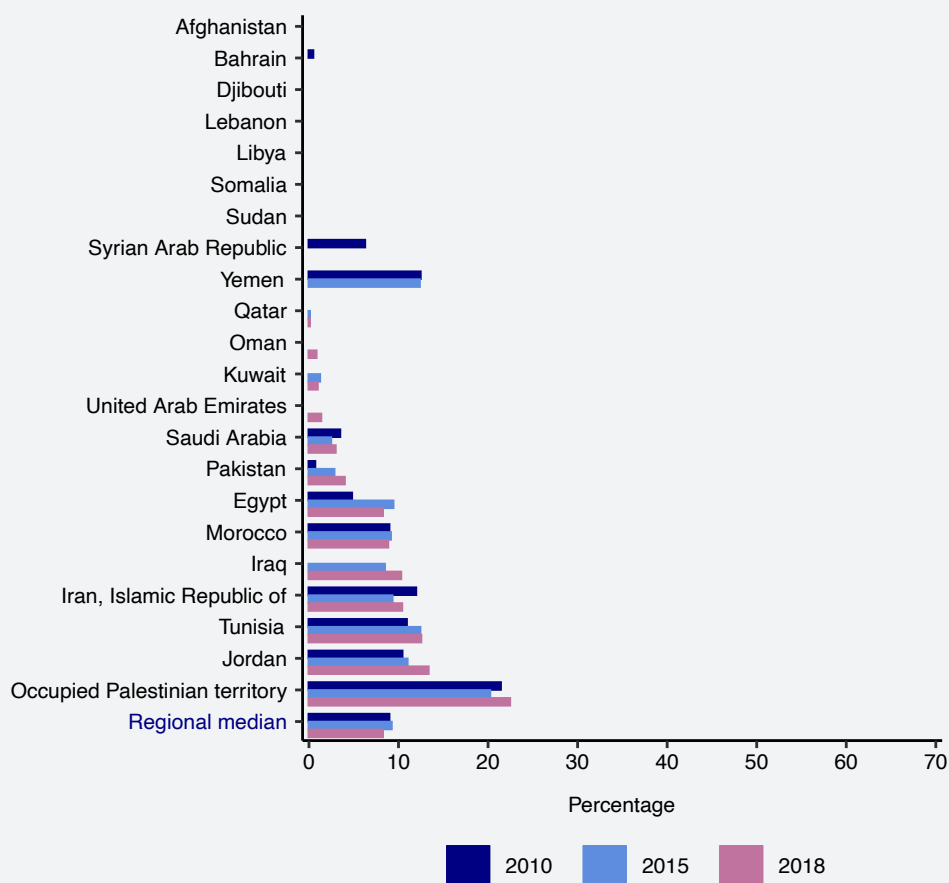
- There were negligible changes in the unemployment rate for both sexes between 2010 and 2018 in most countries of the Region with available estimates.
- In 2018, the unemployment rate for both sexes ranged from 0.11 per 1000 population in Qatar to 26.26 per 1000 population in the occupied Palestinian territory.

8.5.2 Unemployment rate, both sexes, 2010–2018



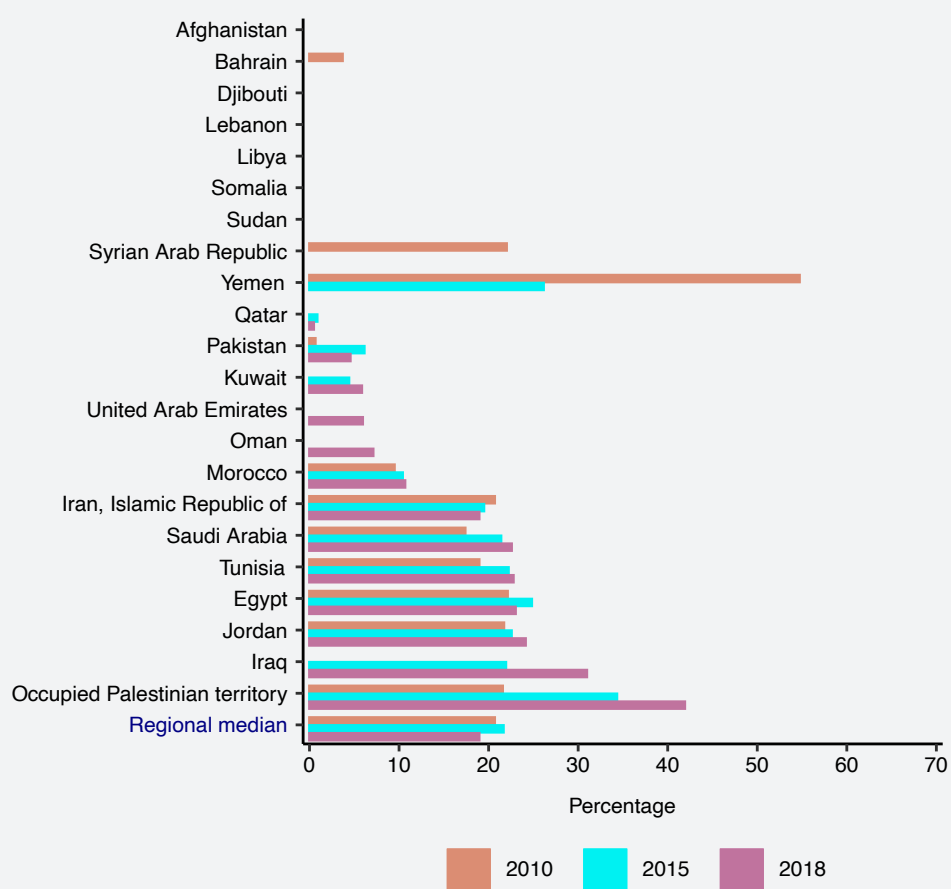
- In 2018, the unemployment rate for males ranged from 0.1 per 1000 population in Qatar to 22.4 per 1000 population in the occupied Palestinian territory; whereas for females it ranged from 0.5 per 1000 population in Qatar to 41.9 per 1000 population in the occupied Palestinian territory.

8.5.2 Unemployment rate, males, 2010–2018



- The unemployment rate for females in all of the countries of the Region with estimates available between 2015 and 2018 was below 41.9 per 1000 population.
- The unemployment rate for females in half of the countries of the Region with estimates available in 2018 was below 18.9 per 1000 population.

8.5.2 Unemployment rate, females, 2010–2018



Challenges

- The Region has one of the highest rates of youth unemployment worldwide, and this has been worsened by the COVID-19 pandemic.
- The pandemic has had a negative impact on both formal and informal employment, especially among women, with UN Women estimating that 700 000 women will lose their jobs in the Region (32).
- Sociocultural norms and lack of childcare facilities and safe transport restrict women's access to work, while unequal wages, restrictive labour laws and lack of social protection also hinder gender equality within the workforce.
- Poverty reduction activities undertaken by countries of the Region prior to the COVID-19 pandemic will be greatly impacted by the ongoing pandemic and this could push vulnerable households into poverty.
- Limited availability of data on employment/unemployment rates, especially in fragile and conflict-affected settings in the Region.

Steps for accelerated action

- Improve the collection of data on employment and unemployment disaggregated by sex and age, with a specific focus on vulnerable populations (such as people living with disabilities, migrant workers, refugees and internally displaced persons).
- Introduce minimum wage legislation in all countries of the Region, as well as legislation to ensure equal pay to reduce wage gaps.
- Develop labour market programmes that create formal employment opportunities with a particular focus on the engagement of young people and women in the labour market.

Key references

- Gender equality in the Arab States [website]. International Labour Organization: https://www.ilo.org/beirut/areasofwork/equality-discrimination/WCMS_712089/lang--en/index.htm
- Achieving gender equality in the Arab Region amidst the changing world of work. Tripartite Arab meeting on the future of work. Beirut, 3 April 2017. International Labour Organization: http://ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_549618.pdf, accessed 11 December 2020.
- Opening doors: Gender equality and development in the Middle East and North Africa. Washington, DC: World Bank; 2013: <https://openknowledge.worldbank.org/handle/10986/12552>

» GOAL 11: MAKE CITIES AND HUMAN SETTLEMENTS INCLUSIVE, SAFE, RESILIENT AND SUSTAINABLE

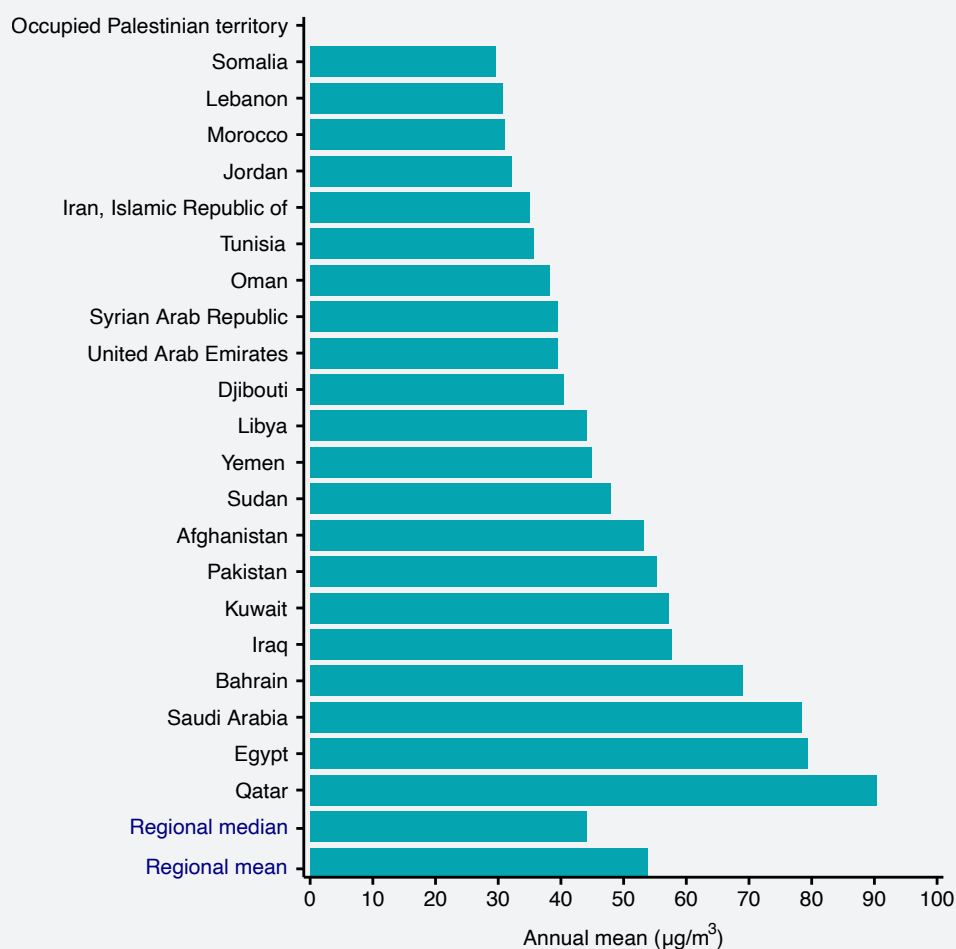
Target 11.6: By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management

Indicator 11.6.2: Annual mean levels of fine particulate matter (e.g. PM_{2.5} and PM₁₀) in cities (population weighted)

Current situation

- The annual mean level of fine particulate matter in cities in countries of the Region in 2016 ranged from 29.5 $\mu\text{g}/\text{m}^3$ in Somalia to 90.3 $\mu\text{g}/\text{m}^3$ in Qatar, with an average of 54 $\mu\text{g}/\text{m}^3$.
- The annual mean level of fine particulate matter in cities in half of the countries of the Region in 2016 was below 54 $\mu\text{g}/\text{m}^3$.
- More than 92% of the population of the Region are breathing polluted air exceeding the WHO recommended level. Of the annual mean level of air pollution in the Region, 10 $\mu\text{g}/\text{m}^3$ originates from natural sources such as sand, dust and sea salt, with the remainder generated by human activity (transport and industry).

11.6.2 Annual mean levels of fine particulate matter in cities, 2016



Challenges

- Limited available studies on air pollution to quantify the main sources and the health outcomes.
- Increased population and air-pollution-generating activities, including the expansion of transportation and industrial sectors.
- Limited national capacity to monitor and report air pollution and its health impacts.
- Poor commitment and coordination between the different related sectors.
- Weak health surveillance systems and lack of health-based standards in almost all countries of the Region.
- Emergencies, including conflict and prolonged civil unrest.

Steps for accelerated action

- Conduct time series and chemical apportionment and other relevant apportionment studies to identify sources of air pollution.
- Countries must address the major sources of air pollution in different contexts and resource settings. This may involve:
 - » gathering evidence of the health impacts of natural air pollution (dust and sea salt particulate matter) and enhancing relevant mitigation interventions to allow for the development and management of national air quality standards;
 - » rapidly phasing out health-harmful subsidies for dirty fuels and polluting industries, and introducing penalties for polluters and/or taxes on pollution;
 - » adopting and strictly enforcing emissions standards for all pollutants in all relevant sectors, including industry, energy, transport, waste and agriculture;
 - » redirecting investment to health-promoting and accessible alternatives including clean transport and renewable energy; and
 - » improving housing conditions and ensuring access to clean energy sources for indoor cooking, heating and lighting.

Available guidance/tools

- WHO Guidelines for indoor air quality: household fuel combustion: [https://www.who.int/airpollution/guidelines/household-](https://www.who.int/airpollution/guidelines/household-fuel-combustion/en/)

[fuel-combustion/en/](https://www.euro.who.int/__data/assets/pdf_file/0009/128169/e94535.pdf); and WHO Guidelines for indoor air quality: selected pollutants: https://www.euro.who.int/__data/assets/pdf_file/0009/128169/e94535.pdf

- Road map for an enhanced global response to the adverse health effects of air pollution: https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_10Add1-en.pdf
- Data Integration Model for Air Quality (DIMAQ) [online database]: <https://www.who.int/airpollution/data/modelled-estimates/en/>

Key references

- Karagulian F, Belis CA, Dora CFC, Prüss-Ustün AM, Bonjour S, Adair-Rohani H et al. Contributions to cities' ambient particulate matter (PM): a systematic review of local source contributions at global level. *Atmospheric Environment*. 2015;120:475–483: https://www.researchgate.net/publication/299286604_Contributions_to_cities'_ambient_particulate_matter_PM_A_systematic_review_of_local_source_contributions_at_global_level
- WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide. Global update 2005. Summary of risk assessment. Geneva: World Health Organization; 2006: https://www.who.int/phe/health_topics/outdoorair/outdoorair_aqg/en/
- Progress report on the regional plan of action for implementation of the roadmap for an enhanced global response to the adverse health effects of air pollution. Regional Committee for the Eastern Mediterranean. Sixty-fourth session. Provisional agenda item 2(d). EM/RC64/INF. DOC.3. August 2017: https://applications.emro.who.int/docs/RC_technical_papers_2017_inf_doc_3_20013_en.pdf?ua=1
- Accelerating regional implementation of the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, 2018. Regional Committee for the Eastern Mediterranean. Sixty-sixth session. Provisional agenda item 3(e). EM/RC66/7. September 2019: https://applications.emro.who.int/docs/RC_Technical_Papers_2019_7_en.pdf?ua=1
- Arab Strategy and Framework of Action on Health and Environment 2017–2030. A regional strategy on health and environment for Arab states and an action guideline. League of Arab States in collaboration with WHO and the United Nations Environment Programme. Amman, Jordan 2017: <http://www.shorturl.at/IKPV6>

» GOAL 16: PROMOTE PEACEFUL AND INCLUSIVE SOCIETIES FOR SUSTAINABLE DEVELOPMENT, PROVIDE ACCESS TO JUSTICE FOR ALL AND BUILD EFFECTIVE, ACCOUNTABLE AND INCLUSIVE INSTITUTIONS AT ALL LEVELS

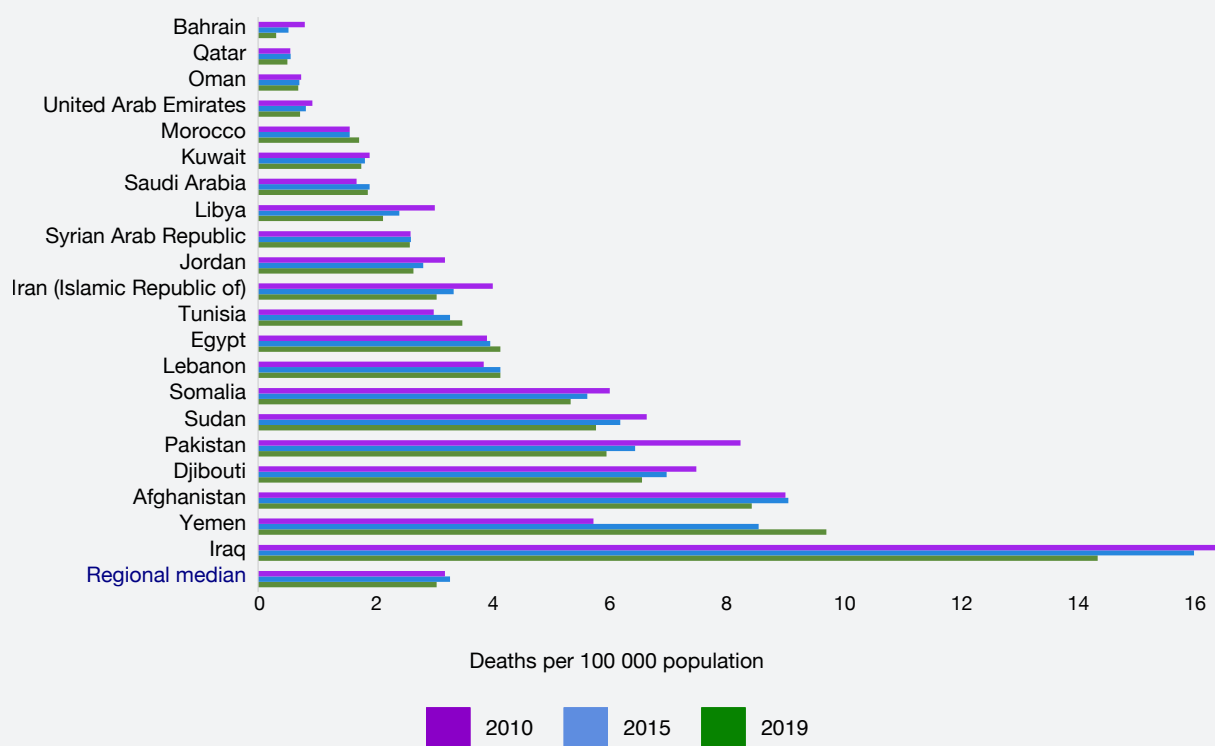
Target 16.1: Significantly reduce all forms of violence and related death rates everywhere

Indicator 16.1.1: Estimates of rates of homicides per 100 000 population, 2010–2019

Current situation

- There were reductions of more than 0.5 percentage points in estimated rates of homicides in Iraq and Afghanistan between 2015 and 2019.
- Over the same period, there was an increase of more than 0.5 percentage points in the estimated rate of homicides in Yemen.
- Iraq had the highest estimated rate of homicides in the Region during the period 2010–2019.
- In 2019, the estimated rates of homicides in the Region ranged from 0.3 deaths per 100 000 population in Bahrain to 14.4 deaths per 100 000 population in Iraq.
- In half of the countries of the Region the estimated rates of homicides was below 3.3 deaths per 100 000 population in 2015 and below 3.1 deaths per 100 000 population in 2019.

16.1.1 Estimates of rates of homicides, 2010–2019



Challenges

- SDG 16.1 target aims to ‘Significantly reduce all forms of violence and related death rates everywhere’ and is measured by, among other indicators, two mortality indicators: the number of victims of intentional homicide per 100 000 population and the number of conflict-related deaths per 100 000 population.
- In this report, the estimated rates of homicides are presented.
- These estimated rates are based on data provided by countries from police and vital registration sources; data from UNODC’s global studies on homicide; and data from WHO’s Mortality Database. The estimation process used observed data on homicide rates, and, for countries without sufficient data availability or quality, regression modelling, to compute comparable estimates of homicide rates and numbers across countries.

Steps for accelerated action

- Strengthen institutions and structures that create and sustain peaceful societies including a well-functioning government, sound business environment, and legal and cultural norms, recognizing the crucial importance of basic human rights, positive external relations, free flow of information, skilled human capital, low levels of corruption to enhance trust in institutions and the equitable distribution of resources (see Global Peace Index 2020 below).

Available guidance/tools

- WHO Emergency Medical Teams Initiative [website]: <https://extranet.who.int/emt/>
- World report on violence and health: Abstract. Geneva: World Health Organization; 2002: https://www.who.int/violence_injury_prevention/violence/world_report/en/abstract_en.pdf

Key references

- UNODC, Global Study on Homicide. Vienna: United Nations Office on Drugs and Crime; 2019: <https://www.unodc.org/documents/data-and-analysis/gsh/Booklet2.pdf>
- Global Peace Index 2020. Measuring peace in a complex world. Sydney: Institute for Economics & Peace; 2020: https://www.visionofhumanity.org/wp-content/uploads/2020/10/GPI_2020_web.pdf

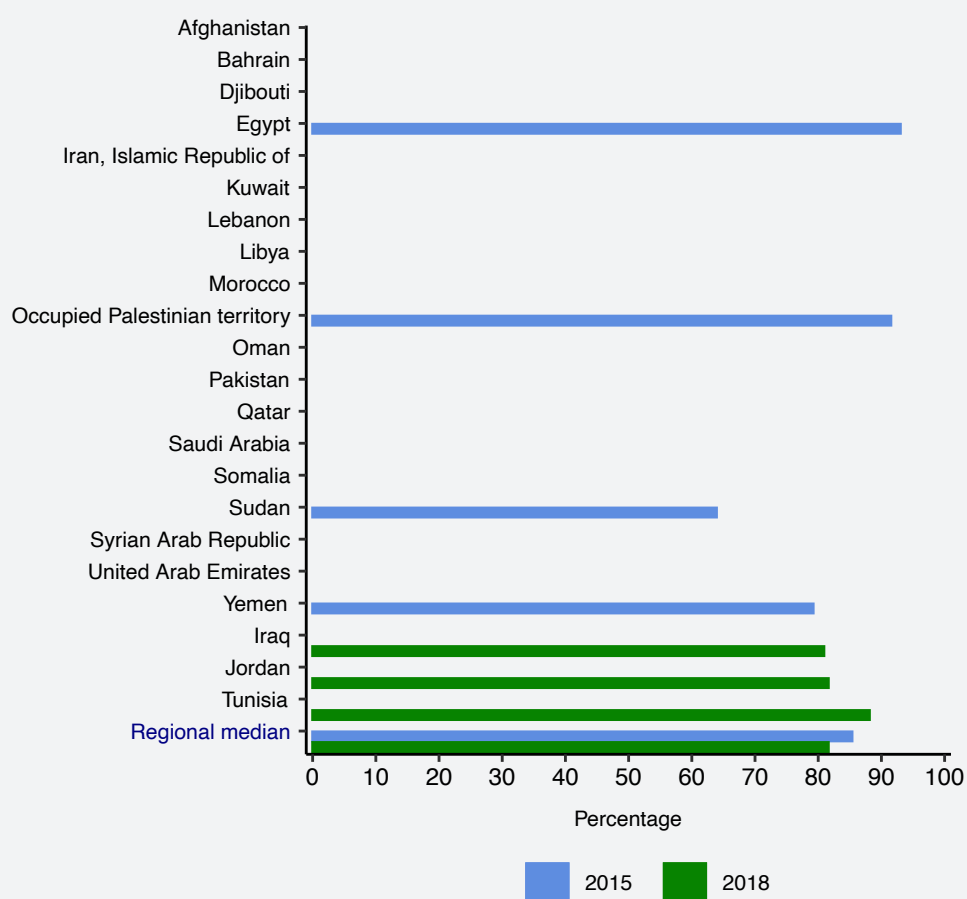
Target 16.2: End abuse, exploitation, trafficking and all forms of violence against and torture of children

Indicator 16.2.1: Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month

Current situation

- In the four countries of the Region with estimates available for 2015 (three countries with data from 2014 and one with data from 2013), the proportion of children aged 1–17 years who had experienced physical punishment and/or psychological aggression by caregivers in the past month ranged from 63.9% in Sudan to 93% in Egypt.
- In the four countries with estimates for 2018, the proportion of children aged 1–17 years who had experienced physical punishment and/or psychological aggression by caregivers in the past month ranged from 80.9% in Iraq to 88.1% in Egypt.

16.2.1 Proportion of children aged 1–17 years who experienced physical violence, 2015–2018



Challenges

- While many countries in the Region have mechanisms and funded plans to support national violence-prevention efforts, only one third of such countries have measurable targets.
- Inadequate administrative data systems that report child homicides through official sources such as vital registry and police records.
- Selective implementation of the INSPIRE strategies.⁽³⁾ Approaches related to implementation and enforcement of laws, response and support services, norms and values, and education and life skills are more supported than those on safe environment, income strengthening, and parent and caregiver support. Even where such approaches are supported, they have not yet reached all (or nearly all) of those who need them.
- Laws on violence against children are widely enacted but often inadequately enforced.
- The high burden of collective violence in the Region tends to draw attention away from the violence of everyday life that affects children and families.

Steps for accelerated action

- Promote good governance and coordination to strengthen the potential of multisectoral action to prevent violence against children.
- Prioritize data collection on key violence-related indicators as part of regular SDG reporting and use these to set measurable targets in data-driven national action plans.
- Strengthen legislative frameworks and optimize their effectiveness in helping to end violence against children.
- Use evidence to enhance the effectiveness of prevention and service programming based on the INSPIRE strategies that provide a collection of both proven and promising approaches.
- Ensure adequate funding for evidence-based approaches to ending violence against children embedded in medium-term expenditure frameworks at national and subnational levels.

Available guidance/tools

- Global partnership to end violence against children [website]: <https://www.end-violence.org>
- INSPIRE: Seven strategies for ending violence against children: <https://www.who.int/publications/i/item/inspire-seven-strategies-for-ending-violence-against-children>
- INSPIRE Handbook: action for implementing the seven strategies for ending violence against children: <https://www.who.int/publications/i/item/inspire-handbook-action-for-implementing-the-seven-strategies-for-ending-violence-against-children>
- INSPIRE Indicator Guidance and Results Framework: https://www.who.int/violence_injury_prevention/violence/inspire-package/inspire-indicator/en/
- WHO Guidelines for the health sector response to child maltreatment: <https://www.who.int/publications/i/item/who-guidelines-for-the-health-sector-response-to-child-maltreatment>
- Responding to children and adolescents who have been sexually abused. WHO clinical guidelines: <https://www.who.int/reproductivehealth/topics/violence/clinical-response-csa/en/>
- Child maltreatment prevention course [online resource]: https://www.who.int/violence_injury_prevention/capacitybuilding/courses/child_maltreatment/en/
- WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children: <https://apps.who.int/iris/handle/10665/252785>

Key references

- Global status report on violence prevention 2014. Geneva: World Health Organization; 2014: <https://www.who.int/publications/i/item/9789241564793>
- Global status report on preventing violence against children 2020. Geneva: World Health Organization; 2020: <https://www.who.int/publications/i/item/9789240004191>

⁽³⁾ INSPIRE serves as a technical package and handbook for selecting, implementing and monitoring effective policies, programmes and services to prevent and respond to violence against children. It comprises seven evidence-based strategies on: Implementation and enforcement of laws; Norms and values; Safe environments; Parent and caregiver support; Income and economic strengthening; Response and support services; and Education and life skills. For more details please visit: https://www.who.int/violence_injury_prevention/violence/inspire-package/en/

SUMMARY OF FINDINGS

19 of the 50 health-related SDG indicators profiled showed some progress between 2015 and 2019 (or the nearest years)

- The high proportion of births attended by skilled health personnel has been sustained (98% to 99%).
- Vaccination coverage rates have improved although remain suboptimal (DTP3: 80% to 82%; MCV2: 68% to 75%; and PCV3: 50 to 52%).
- There has been an increase in the number of health care personnel per 10 000 population (nurses: 20 to 33; and physicians: 14.2 to 18.2).
- Progress in reducing mortality due to unintentional poisoning was made (2030 target: substantial reduction; 2010: 1.8; 2015: 1.6; and 2019: 1.5 per 100 000 population).
- Fewer children are malnourished, with wasting among children under 5 years of age falling from 7.5% to 3.8%.
- Increased proportion of children in primary school (93% to 97%) and young people who are literate (95% to 97%).
- Decreased rate in unemployment for both men (9% to 8%) and women (22% to 19%).

Progress has been slow for 10 indicators

- Slightly more women have had their need for family planning met (55% to 57%).
- Minimal improvement in coverage of health services (2015: 53; and 2017: 57) despite a UHC service coverage index 2030 target of > 80.
- Progress in reducing the maternal mortality ratio (2030 target: < 70 deaths per 100 000 live births; 2015: 175; and 2019: 164), child mortality rate (2030 target: < 25 deaths per 1000 live births; 2015: 52; and 2019: 46) and neonatal mortality rate (2030 target: < 12 deaths per 1000 live births; 2015: 27; 2019: 25) is moving too slowly for the Region to meet global targets.
- Progress in reducing mortality due to road traffic injuries (2010: 23.5; and 2015: 21.8 per 100 000 population) is also too slow for the Region to meet the global target of halving the 2010 rate by 2020.
- There was a decline in the reported number of new cases of TB but progress falls far short of the target (2030 target: end the epidemic: 2015: 118; 2019: 115).
- Although some progress has been made in improving access to improved drinking-water

and sanitation facilities it is too slow to meet global targets and is leaving 46.7 million people still practising open defecation and 245.7 million people without basic sanitation services.

Progress has stalled on nine indicators

- Although additional countries have almost reached elimination targets, progress in decreasing the incidence of malaria has stalled in four endemic countries (Afghanistan, Djibouti, Sudan and Yemen).
- Progress in reducing mortality rates due to NCDs (2030 target: reduce by one third; 2010: 20.8%; and 2015: 22.0%) and pollution (2030 target: substantial reduction; 2010: 31.6; and 2015: 41.5 per 100 000 population) has not been made despite these being among the major causes of the burden of disease in the Region.
- Progress in reducing the rate of homicides has also stalled (2030 target: significantly reduce; 2010: 3.2; 2015: 3.3; and 2019: 3.1 per 100 000 population).
- Although there are limited data points, progress has also stalled in reducing the percentage of children under 5 years of age who are overweight (target: < 3%; 2015: 8.1%; and 2019: 8.0%), as well as in reducing the percentage of bloodstream infections due to selected antimicrobial-resistant organisms (2017: 58.4%; 2018: 53.4%; and 2019: 59.5%).

Data reflecting trends are not available for more than one in four indicators, which hampers the ability of countries to monitor trends

- Although there has been some progress in health service coverage, a lack of data on financial protection is impeding understanding of the extent to which economic barriers are limiting the achievement of UHC.
- Despite improvements in vaccine coverage, limited information is available to document the prevalence of hepatitis B among children under 5 years of age.
- Little is known about the availability of essential medicines in local health facilities.
- Limited data on poverty, education, conflict-related deaths and gender equality are making it difficult to address the determinants of health.
- Large inter-country differences were observed in data availability across many of the indicators, both in terms of the current status and the progress being made towards achieving the SDGs.

A detailed summary of the extent of progress being made on all of the health-related SDG indicators is presented in Table 1.

Table 1. Summary of progress on the health-related SDGs, 2015 and 2019 (or nearest)

Health-related SDG indicator	2015 (or nearest)	2019 (or nearest)	Status of progress
Mortality			
3.1.1 Maternal mortality ratio (per 100 000 live births) ^a	175	164	Progress made but too slow to meet target
3.1.2 Births attended by skilled health personnel (%)	98	99	Progress fast enough to meet target
3.2.1 Under-5 mortality rate (per 1000 live births) ^a	52	46	Progress made but too slow to meet target
3.2.2 Neonatal mortality rate (per 1000 live births) ^a	27	25	Progress made but too slow to meet target
3.4.1 Probability of dying from NCD (between ages 30 and 69) (%) ^a	20.8	22.0	Progress stalled
3.4.2 Suicide mortality rate (per 100 000 population) ^a	3.9	...	Trend not reported
3.6.1 Mortality rate from road traffic injuries (per 100 000 population) ^a	23.5	21.8	Progress made but too slow to meet target
3.9.1 Mortality rate attributed to household and ambient air pollution (per 100 000 population)	31.6	41.5	Progress stalled
3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (per 100 000 population)	1.8	1.4	Progress
3.9.3 Mortality rate attributed to unintentional poisoning (per 100 000 population)	1.6	1.5	Progress
Morbidity			
3.3.1 New HIV infections (per 1000 uninfected people)	0.06	0.07	Progress stalled
3.3.2 TB incidence (per 100 000 population)	118	115	Progress made but too slow to meet target
3.3.3 Malaria incidence (per 1000 population at risk)	9	10	Progress stalled
3.3.4 Hepatitis B prevalence among children under 5 years of age (per 100 000 population)	1.6	...	Trend not reported
3.3.5 Number of people requiring interventions for leishmaniasis	10 616	15 367	Progress stalled
3.5.2 Harmful use of alcohol (litres of pure alcohol per capita – aged 15 years and older)	0.6	0.5	Progress
3.7.1 Women of reproductive age (15–49 years) who had their need for family planning satisfied with modern methods (%)	55	57	Progress made but too slow to meet target
3.7.2 Adolescent birth rate (per 1000 women aged 15–19 years)	48	41	Progress
Means of implementation			
3.8.1 UHC service coverage index ^a	53	57	Progress made but too slow to meet target
3.8.2 Large expenditures on health as a share of total household expenditure (> 10%)	15.2	...	Trend not reported
3.8.2 Large expenditures on health as a share of total household expenditure (> 25%)	2.3	...	Trend not reported
3.a.1 Prevalence of tobacco use among persons aged 15 years and older (%)	18.5	...	Trend not reported
3.b.1 DTP3 coverage (%)	80	82	Progress
3.b.1 MCV2 coverage (%)	68	75	Progress

Health-related SDG indicator	2015 (or nearest)	2019 (or nearest)	Status of progress
3.b.1 PCV3 coverage (%)	50	52	Progress made but too slow to meet target
3.b.2 Official development assistance for medical research per capita (US\$)	1.0	2.0	Progress
3.b.3 Availability of essential medicines in public health facilities (%)	83.4	...	Trend not reported due to too few data points
3.c.1 Density of physicians (per 10 000 population)	14.2	18.2	Progress
3.c.1 Density of pharmacists (per 10 000 population)	4.5	5.7	Progress
3.c.1 Density of nurses (per 10 000 population)	20	33	Progress
3.c.1 Density of dentists (per 10 000 population)	3.6	3.9	Progress
3.d.1 International Health Regulations (2005) capacity and health emergency preparedness	65.5	...	Trend not reported
3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms (due to ESBL- <i>E. coli</i>)	58.4	59.5	Progress stalled
3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms (due to MRSA)	36.6	46.1	Progress stalled
Risk factors for health (direct effect on health)			
2.2.1 Stunting among children under 5 (%)	26.1	24.2	Progress
2.2.1 Wasting among children under 5 (%) ^a	7.5	3.8	Progress fast enough to meet target
2.2.2 Overweight among children under 5 (%)	8.1	8.0	Progress stalled
6.1.1 Access to improved drinking-water (%) ^a	88	89	Progress made but too slow to meet target
6.2.1 Access to improved sanitation facilities (%) ^a	73	75	Progress made but too slow to meet target
11.6.2 Annual mean levels of fine particulate matter in cities (mg/m ³)	54	...	Trend not reported
16.1.1 Estimates of rate of homicides (per 100 000 population)	3.3	3.1	Progress stalled
16.2.1 Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers (%)	85	...	Trend not reported due to too few data points
Determinants of health (indirect effect on health)			
1.1.1 Proportion of population living below the international poverty line (%)	19.0	...	Trend not reported
4.1.1 Net primary school enrolment ratio (per 100 school-age children)	93	97	Progress but data only available for selected countries
4.6.1 Literacy rate (15-24 years) (%)	95	97	Progress but data only available for selected countries
5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to violence (%)	37	...	Trend not reported
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 (%)	50.5	...	Trend not reported
8.5.2 Unemployment rate, both sexes (%)	11	9	Progress
8.5.2 Unemployment rate, males (%)	9	8	Progress
8.5.2 Unemployment rate, females (%)	21	17	Progress

^a Denotes SDG indicators with explicit targets for 2030

FIVE KEY CHALLENGES

Weak governance

- Weak governance and insufficient action on taking a whole-of-society approach to communicable and noncommunicable disease prevention, and to addressing risk factors to health, including poor nutrition, water and sanitation as well as public health emergencies.
- Limited investment in health, including high donor dependency for specific communicable diseases such as HIV/AIDS, TB, malaria and neglected tropical diseases.
- Limited implementation of regulatory measures and policies to mitigate the impact of climate change and address new targets such as those on NCDs, road traffic injuries and pollution.
- Inefficient public sectors and weak governance limits the ability to address structural issues related to the determinants of health.

Fragmented health care services

- Fragmented health care services with wide variability in accessibility and quality of care between countries of the Region, with evident gaps especially in relation to the new SDG 3 targets, such as comprehensive services for NCDs and post-crash emergency services.
- Suboptimal health workforce production and imbalanced skills mix and geographical distribution present additional challenges to improving the accessibility and quality of care.

Limited data availability

- Multiplicity and fragmentation of data sources, large data gaps (especially for cause-specific mortality, service coverage, risk factors and determinants of health) and poor coordination between relevant stakeholders.
- Limited data disaggregation by sex, age, place of residence and other key variables.
- Lack of epidemiological and operational research, including economic evaluations to guide the policy-making process.

Impact of emergencies (including the COVID-19 pandemic) and of fragile and humanitarian settings on population health

- Most countries in the Region are directly or indirectly affected by conflict, civil unrest, environmental threats and natural disasters, amplified by the COVID-19 pandemic.
- Humanitarian crises and subsequent displacement of populations, interruption of health services provision and increased exposure to risks to health (including food insecurity, limited access to water and sanitation, violence and poverty).

Gender inequality and health disparities

- Structural and sociocultural barriers to gender equality hamper the ability of women to make decisions regarding their own health, limit their access to health services and expose them to increased risk of violence.
- Large health disparities between and within countries, including urban/rural differentials in access to health services, water and sanitation, with low access to services also experienced by most at-risk populations.

WAY FORWARD

Strengthen government leadership and regulatory functions

- Promote good governance of SDG-related activities by implementing strong, effective, integrated and collaborative structures with other sectors that optimize co-benefits for all sectors, ensure policy coherence and effective use of resources, and promote health and well-being for all.
- Ensure sustainable financial investment in basic health services and public health measures that promote health, prevent communicable and noncommunicable diseases, address risk factors to health and build resilient health systems to expedite progress towards UHC.
- Improve cost efficiency within the health sector through greater transparency and accountability, and by institutionalizing analytical tools to guide good governance.
- Strengthen the leadership role of the health sector in multisectoral action to ensure more timely and coordinated preparedness and response to health emergencies in line with IHR (2005), and to address risk factors for health and health determinants.
- Enhance regulatory capacity and adopt regulations, standards and policies that protect and promote health by addressing risk factors for health, particularly in relation to healthy diet, tobacco control, road standards, pollutants, drinking-water and sanitation, and violence, and ensure accountability.

Expand access to health services

- Promote UHC, including in fragile and humanitarian settings, by ensuring quality, equitable and comprehensive integrated essential health services that address communicable and noncommunicable diseases and health across the life-course.
- Institutionalize systems for patient safety, quality, audit and surveillance.
- Strengthen health system capacity to mitigate the health impact of emergencies and to continue to function and respond during emergencies by using the Humanitarian-Development-Peace Nexus approach and advocate for the right to health for affected populations, including for refugees and internally displaced persons.

- Invest in building an appropriately skilled health professional workforce by ensuring that production capacities are guided by national health priorities, human resource information systems and appropriate geographical distribution that would enhance access to services.

Promote intersectoral collaboration and Health-in-all-Policies

- Collaborate with partners in multisectoral action through the health-in-all-policies approach to ensure a comprehensive approach to promoting health security, address risk factors for health and health determinants, and mitigate the health impacts of COVID-19 and climate change.
- Strengthen community engagement and health literacy to empower individuals to care for themselves and their families, address stigma and misconceptions, and improve access to health care.

Invest in health information systems

- Strengthen an integrated disease surveillance system to generate data to monitor health-related SDGs targets and indicators, including through improving the availability and quality of cause-specific mortality data, data on health determinants, risks and morbidity, and data to monitor key components of UHC (for example, health systems, and communicable and noncommunicable diseases).
- Build sustainable capacity for implementing surveys, and for the analysis and utilization of good quality data to guide timely and evidence-based public health actions.
- Engage across sectors to improve statistical capacity and increase data availability, quality and timely reporting of health data, including data disaggregated by sex, age and place of residence.
- Implement key interventions such as those outlined in the SCORE (Survey, Count, Optimize, Review, Enable) for Health Data Technical Package that are critical for attaining robust country health data systems capable of providing evidence-based data for decision-making (33).
- Invest in health system and operational research capacity, including economic evaluations.

Ensure a gender-and equity-sensitive response

- Strengthen health systems and support services focusing on the differential exposures to health risks and barriers to access of men, women and population subgroups to maximize access to services and leave no one behind.
- Empower women to ensure their autonomy in decision-making on their own health through conducive regulatory frameworks, educational and occupational opportunities, and women-centred economic incentives.
- Ensure data disaggregation by age, sex, place of residence and other variables to reduce health inequalities.
- Invest in national research capacity to generate and utilize reliable information through a gender and equity lens to inform public health action and leave no one behind.

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ANNEX 1

DATA SOURCES FOR THE HEALTH-RELATED SDG INDICATORS

1.1.1. Proportion of population living below international poverty line

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
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1.1.1. Proportion of employed population living below international poverty line

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

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

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
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2.2.2. Prevalence of wasting among children under 5 years of age

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
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- Global Database on Child Growth and Malnutrition [online database]. Geneva: World Health Organization (<https://www.who.int/nutgrowthdb/database/en/>, accessed 18 August 2020).

2.2.2. Prevalence of overweight among children under 5 years of age

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
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3.1.1. Maternal mortality ratio

- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).
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3.1.2. Proportion of births attended by skilled health personnel

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
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3.2.1. Under-five mortality

- Child mortality estimates [online database]. New York: UN Inter-agency Group for Child Mortality Estimation: <https://childmortality.org/data>, accessed 18 August 2020.
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3.2.2. Neonatal mortality

- Child mortality estimates [online database]. New York: UN Inter-agency Group for Child Mortality Estimation: <https://childmortality.org/data>, accessed 18 August 2020.
- Levels & trends in child mortality. Report 2019: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2019 (<https://www.unicef.org/media/60561/file/UN-IGME-child-mortality-report-2019.pdf>, accessed 11 May 2021).

3.3.1. New HIV infections

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
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3.3.2. Tuberculosis incidence

- Incidence of tuberculosis (per 100 000 population per year) [online database]. Global Health Observatory. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/incidence-of-tuberculosis-\(per-100-000-population-per-year\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/incidence-of-tuberculosis-(per-100-000-population-per-year)), accessed 18 August 2020).

3.3.3. Malaria incidence

- Malaria incidence (per 1 000 population at risk) [online database]. Global Health Observatory. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/malaria-incidence-\(per-1-000-population-at-risk\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/malaria-incidence-(per-1-000-population-at-risk)), accessed 18 August 2020).

3.3.4. Viral hepatitis

- Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years [online database]. Global Health Observatory. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis-b-surface-antigen-\(hbsag\)-prevalence-among-children-under-5-years](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis-b-surface-antigen-(hbsag)-prevalence-among-children-under-5-years), accessed 18 August 2020).

3.3.5. Number of people requiring interventions against neglected tropical diseases [leishmaniasis]

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.4.1. Premature mortality from noncommunicable diseases

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.4.2. Suicide mortality

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

3.5.2. Harmful use of alcohol

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).
- Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018 (https://www.who.int/substance_abuse/publications/global_alcohol_report/gsr_2018/en/, accessed 18 May 2021).

3.6.1. Mortality from road traffic injuries

- Disease burden and mortality estimates. Deaths by cause, age, sex, by country and by Region, 2000–2016 [online database]. Global Health Estimates. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/global_burden_disease/estimates/en/, accessed 18 August 2020).

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

- Estimates and Projections of Family Planning Indicators 2020 [online database]. New York: United Nations, Population Division (<https://www.un.org/development/desa/pd/node/3288>, accessed 18 August 2020).

3.7.2. Adolescent fertility rate

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.8.1. Universal health coverage (UHC) service coverage index

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

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

- Catastrophic out-of-pocket health spending [online database]. Global Health Observatory. Geneva: World Health Organization (<https://apps.who.int/gho/portal/uhc-fp-cabinet-wrapper-v2.jsp?id=1020201>, accessed 18 August 2020).

3.9.1. Mortality rate attributed to household and ambient air pollution

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.9.2. Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.9.3. Mortality rate attributed to unintentional poisoning

- Disease burden and mortality estimates. Deaths by cause, age, sex, by country and by Region, 2000–2016 [online database]. Global Health Estimates. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/global_burden_disease/estimates/en/, accessed 18 August 2020).

3.a.1. Prevalence of current tobacco use among persons aged 15 years and older

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.b.1. Coverage of diphtheria-tetanus-pertussis (DTP3) vaccination

- WHO-UNICEF estimates of DTP3 coverage [online database]. Geneva: World Health Organization (https://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveragedtp3.html, accessed 18 August 2020).

3.b.1. Coverage of measles-containing-vaccine second-dose (MCV2)

- WHO-UNICEF estimates of MCV2 coverage [online database]. Geneva: World Health Organization (https://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveragemcv2.html, accessed 18 August 2020).

3.b.1. Coverage of pneumococcal conjugate 3rd dose (PCV3) vaccination

- WHO-UNICEF estimates of PCV3 coverage [online database]. Geneva: World Health Organization (https://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveragepcv3.html, accessed 18 August 2020).

3.b.2. Total official development assistance to medical research and basic health sectors, by recipient countries

- Official development assistance (ODA) for medical research and basic health sectors as a % of gross national income (GNI) and as a % of all ODA, by donor country [online database]. Global Observatory on Health R&D. Geneva: World Health Organization (https://www.who.int/research-observatory/indicators/oda_gni/en/, accessed 18 August 2020).

3.b.3. Availability of selected essential medicines in public health facilities

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).

Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

3.c.1. Density of physicians per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/data-r>, accessed 18 August 2020).

3.c.1. Density of nurses and midwives per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/data-r>, accessed 18 August 2020).

3.c.1. Density of pharmacists per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/data-r>, accessed 18 August 2020).

3.c.1. Density of dentists per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/data-r>, accessed 18 August 2020).

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

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

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

- Global Antimicrobial Resistance Surveillance System (GLASS) reports [website]. Geneva: World Health Organization (<https://www.who.int/glass/reports/en/>, accessed 19 May 2021).

4.1.1. Net primary school enrolment ratio per 100 school-age children

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

4.6.1. Literacy rate (15–24 years)

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the

Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).

- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

5.2.1. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence

- National demographic health surveys. The DHS Program demographic health surveys [online database] (<https://dhsprogram.com/>, accessed 18 May 2021).

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

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

6.1.1. Proportion of population with access to improved drinking-water services

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

6.2.1. Proportion of population with access to improved sanitation facilities

- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2017. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2017_EN_16766.pdf?ua=1, accessed 18 May 2021).
- Eastern Mediterranean Region. Framework for health information systems and core indicators for monitoring health situation and health system performance 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1, accessed 18 May 2021).
- Monitoring health and health system performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (<https://apps.who.int/iris/bitstream/handle/10665/331953/WHOEMHST245E-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2021).

8.5.2. Unemployment rate, both sexes

SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

8.5.2. Unemployment rate, males

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

8.5.2. Unemployment rate, females

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

11.6.2. Annual mean levels of fine particulate matter in cities

- Ambient air pollution [online database]. Global Health Observatory data repository. Geneva: World Health Organization (<https://apps.who.int/gho/data/node.main.152?lang=en>, accessed 18 August 2020).

16.1.1. Homicides

- Estimates of rates of homicides per 100 000 population [online database]. Global Health Observatory. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimates-of-rates-of-homicides-per-100-000-population>, accessed 28 November 2021).

16.2.1. Physical punishment/and or psychological aggression by caregivers

- SDG indicators [online database]. United Nations Global SDG Database. New York: United Nations, Department of Economic and Social Affairs, Statistics Division (<https://unstats.un.org/sdgs/indicators/database/>, accessed 18 August 2020).

ANNEX 2

SDG INDICATORS AND DEFINITIONS

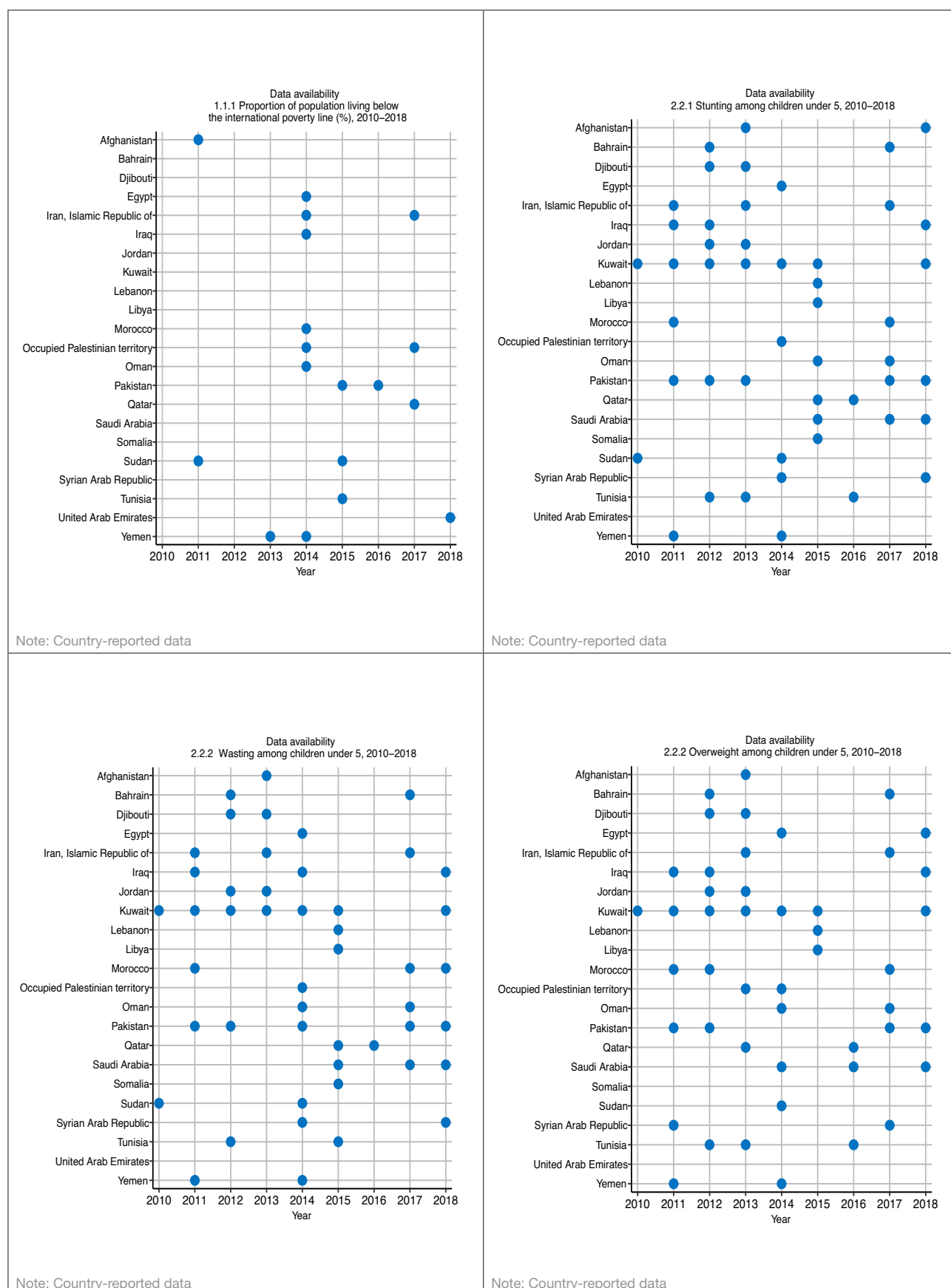
The Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development was developed by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs) and agreed upon at the 48th session of the United Nations Statistical Commission held in March 2017. The detailed list is available at: https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202020%20review_Eng.pdf

The metadata (concepts, definitions and measurement) for the SDG indicators are available at <https://unstats.un.org/sdgs/metadata/> and reflect the latest reference metadata information provided by the United Nations system and other international organizations on data and statistics for the Tier I and II indicators (see: <https://unstats.un.org/sdgs/iaeg-sdgs/tier-classification/>) in the global indicator framework.

ANNEX 3

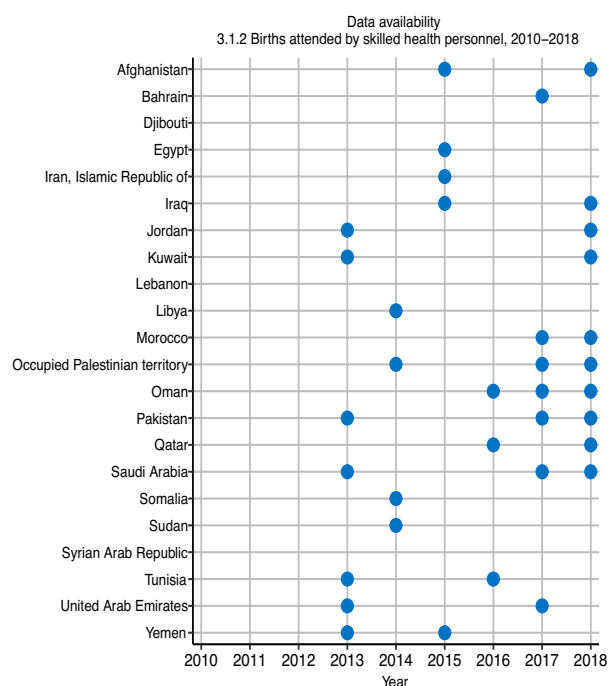
DATA AVAILABILITY BY HEALTH-RELATED SDG INDICATOR AND COUNTRY

Note: Refer to Annex 1 for a detailed description of each source of data

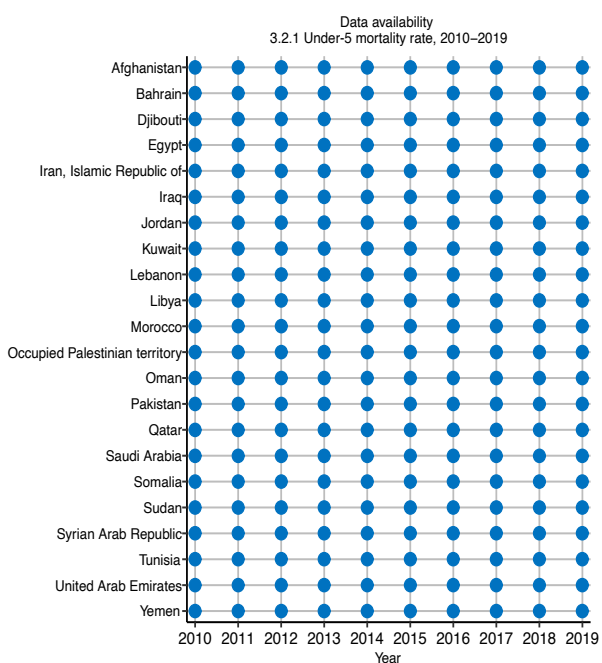




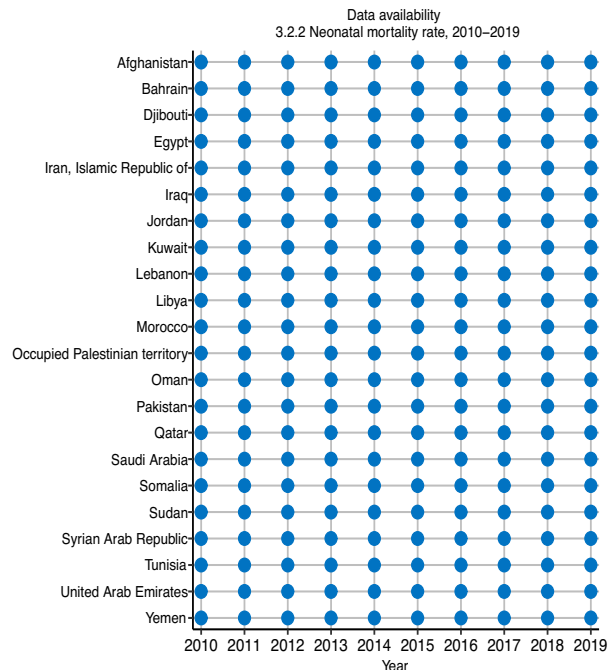
Note: Data from global estimates



Note: Country-reported data



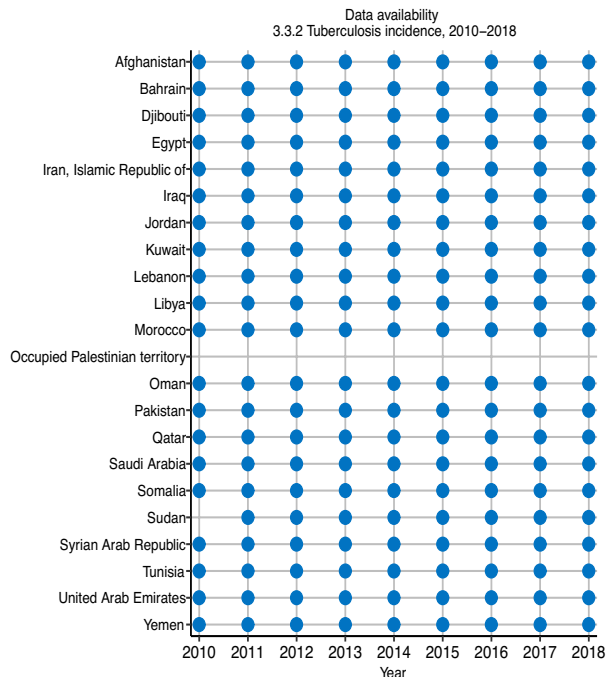
Note: Data from global estimates



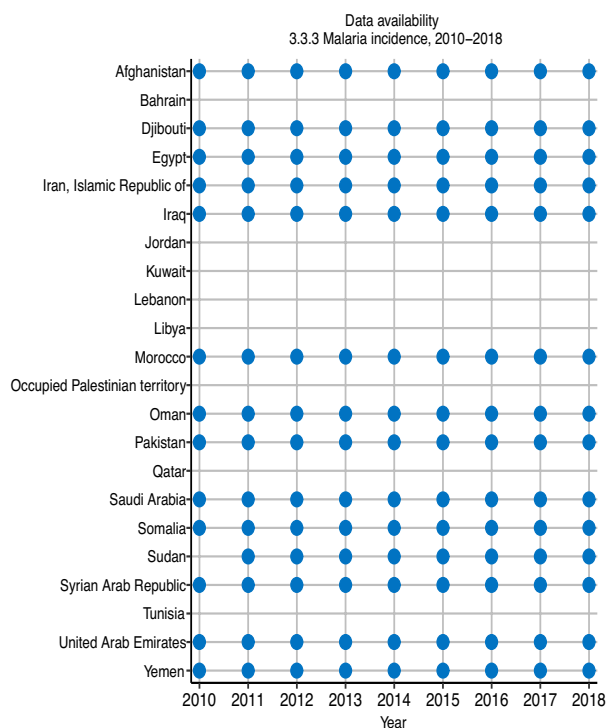
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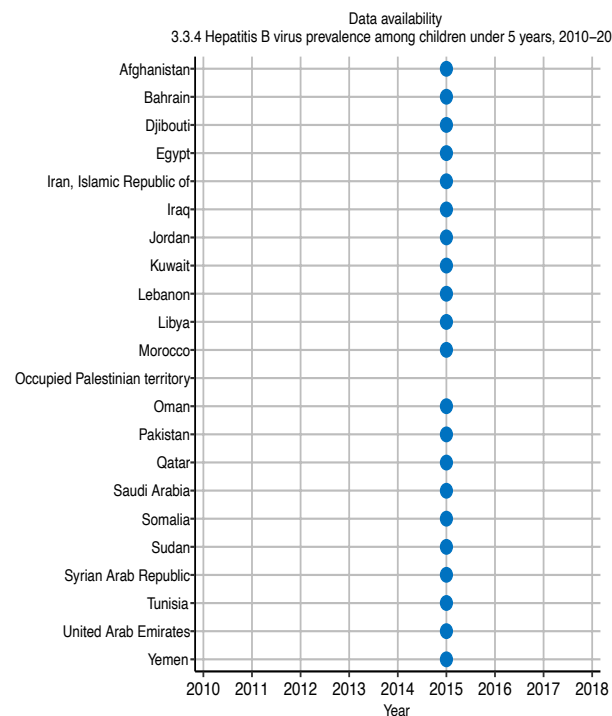
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Note: Country-reported data

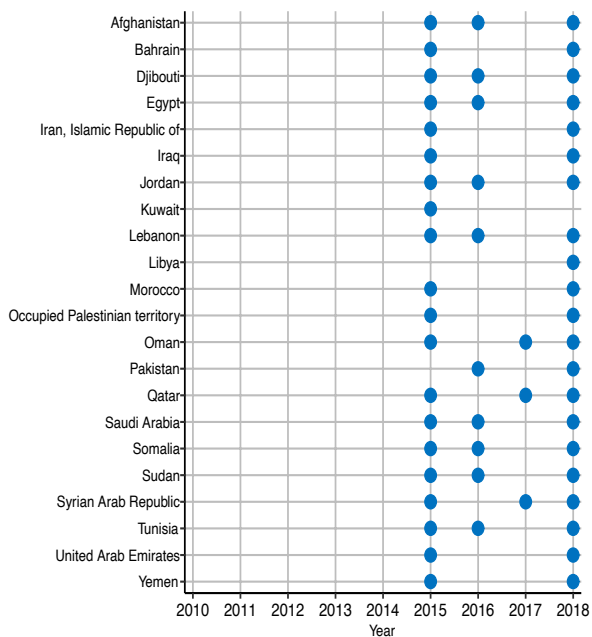


Note: Data from global estimates



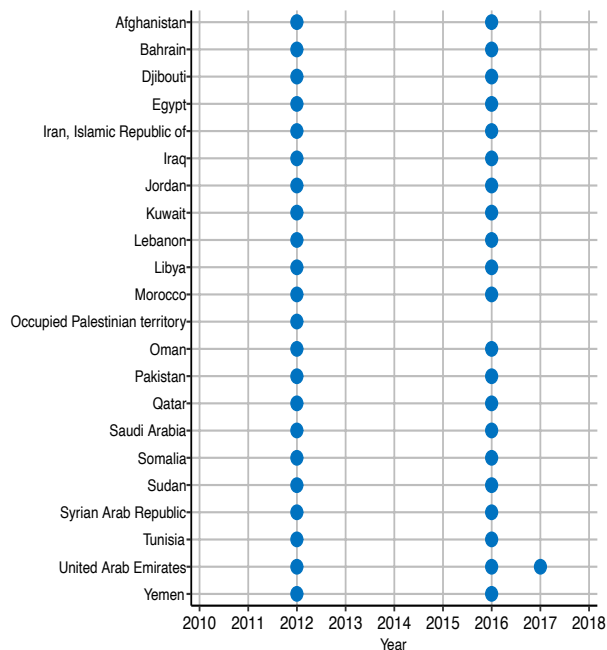
Note: Data from global estimates

Data availability
3.3.5 Number of people requiring interventions against leishmaniasis, 2010–2018



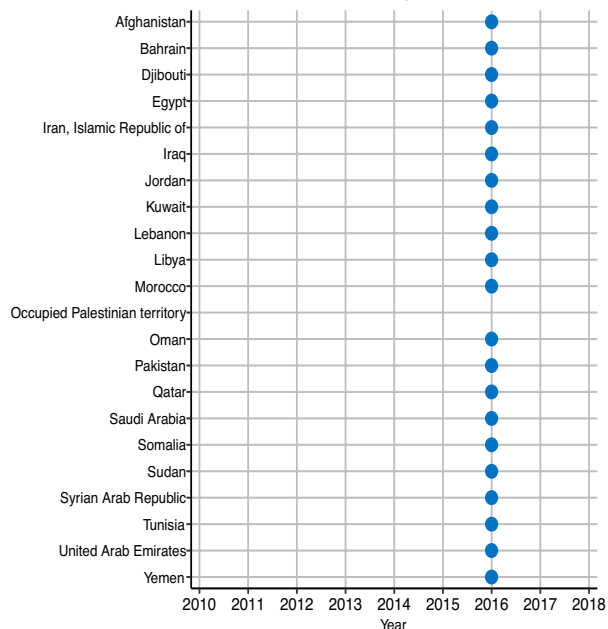
Note: Country-reported data

Data availability
3.4.1 Probability of dying from any cardiovascular disease, cancer, diabetes chronic respiratory diseases between age 30 and exact age 70, 2010–2016



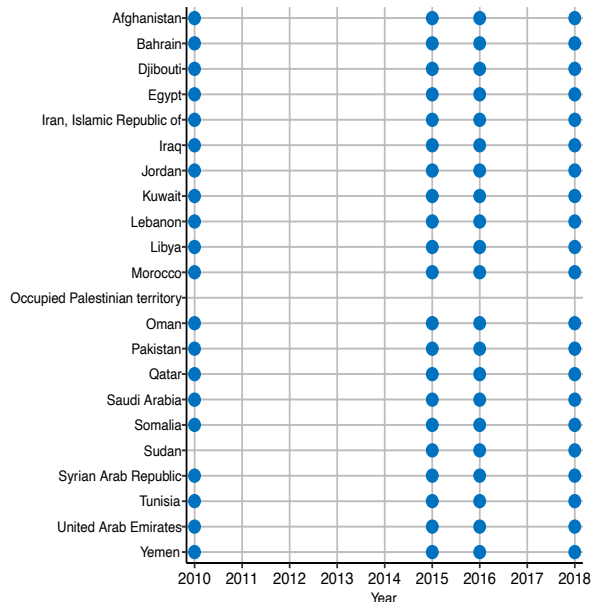
Note: Country-reported data

Data availability
3.4.2 Suicide mortality rate, 2010–2018

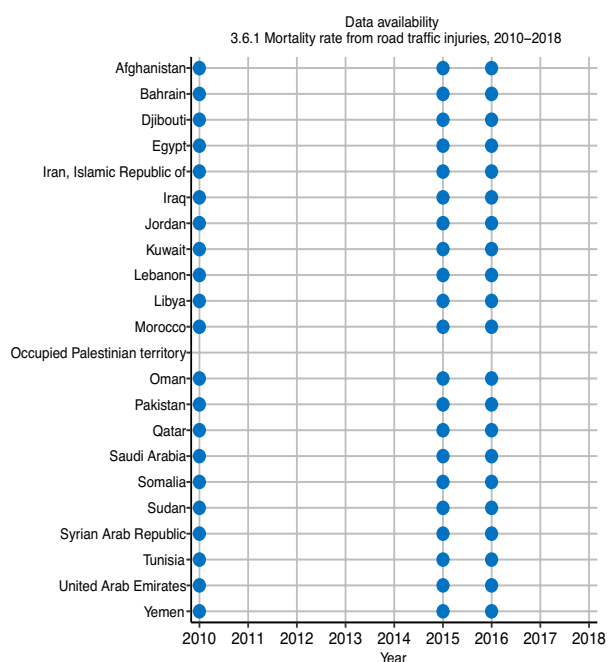


Note: Data from global estimates

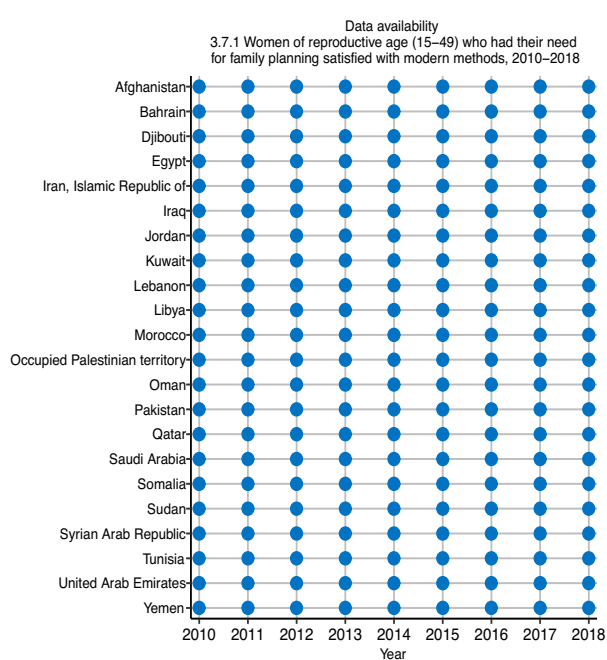
Data availability
3.5.2 Harmful use of alcohol, 2010–2018



Note: Data from global estimates



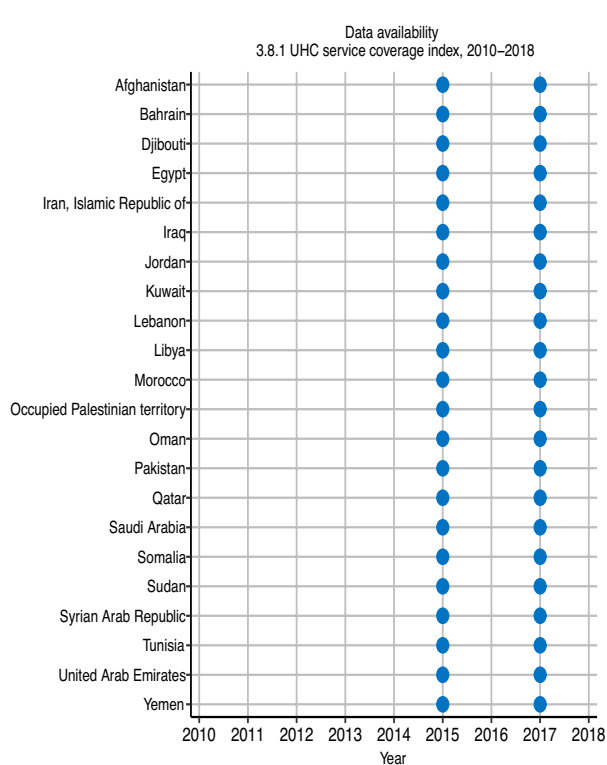
Note: Data from global estimates



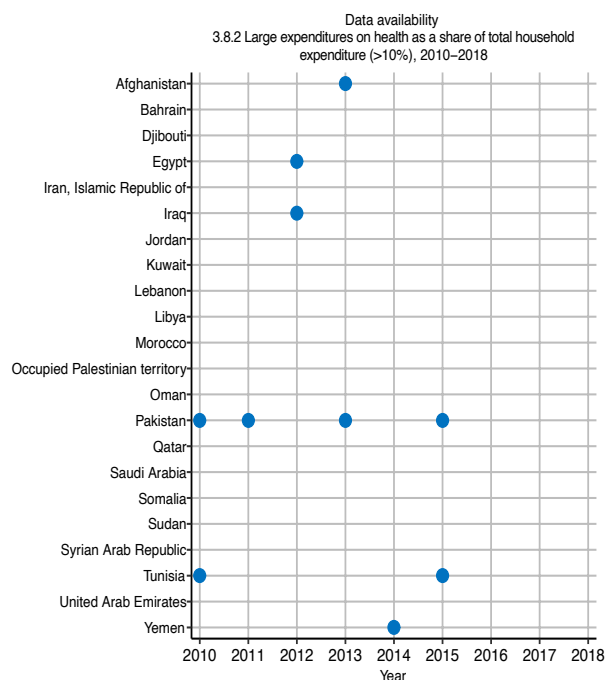
Note: Data from global estimates



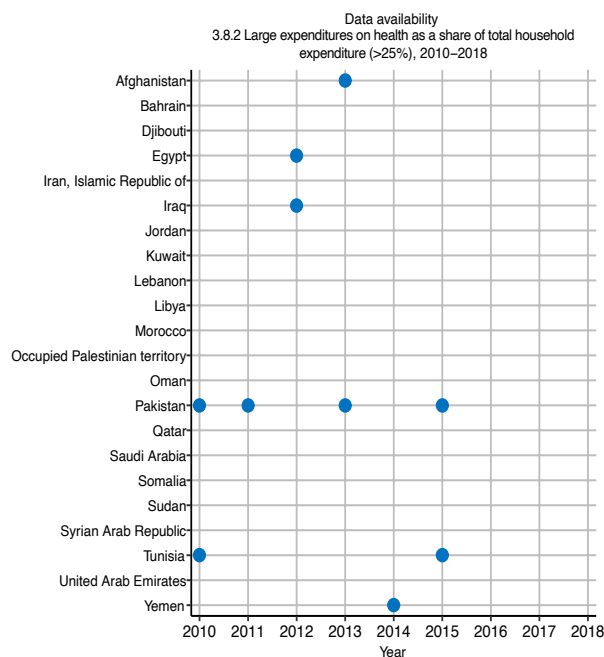
Note: Country-reported data



Note: Data from global estimates



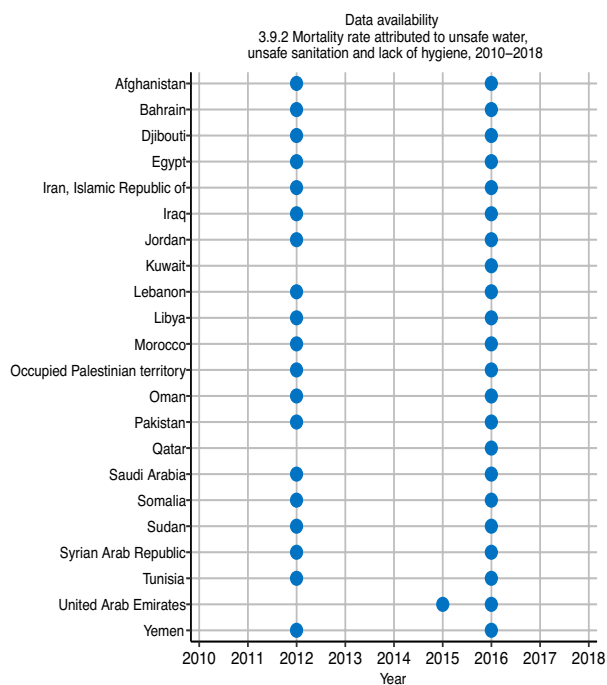
Note: Country-reported data



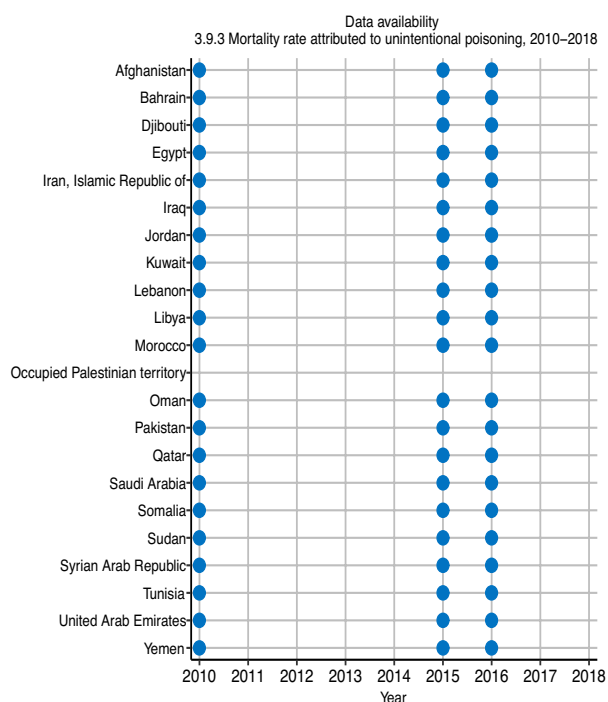
Note: Country-reported data



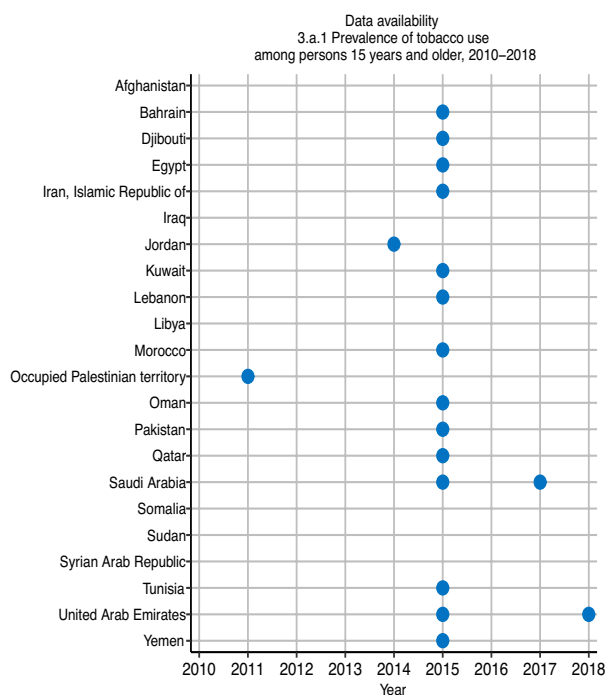
Note: Country-reported and global estimates



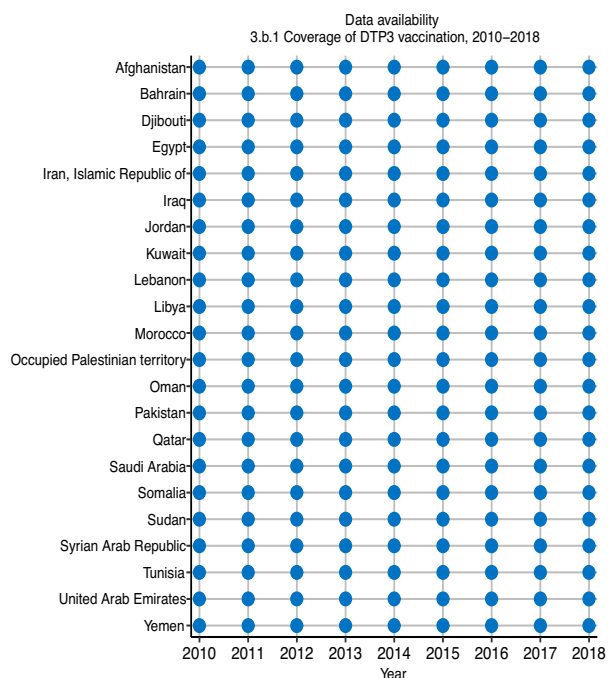
Note: Country-reported data and global estimates



Note: Data from global estimates



Note: Country-reported data



Note: Country-reported data



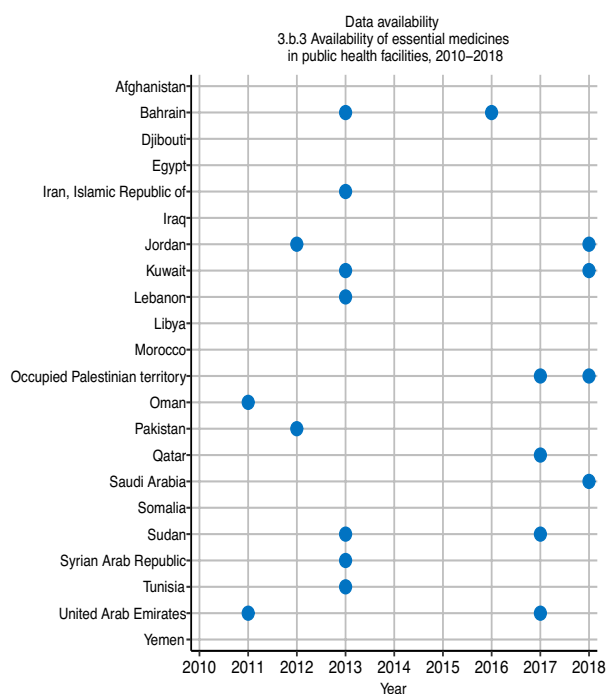
Note: Country-reported data



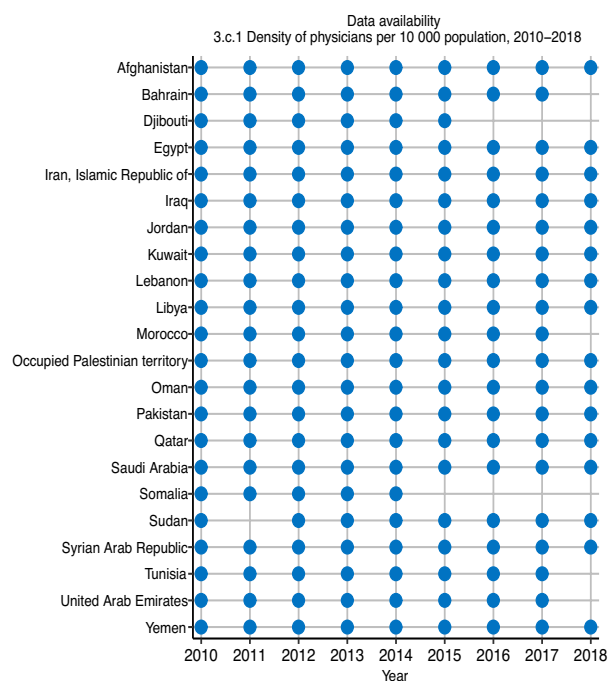
Note: Country-reported data



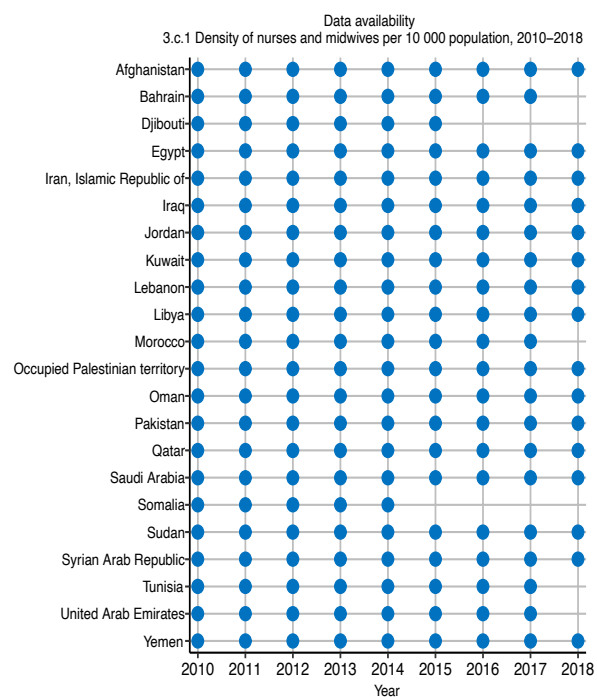
Note: Country-reported data



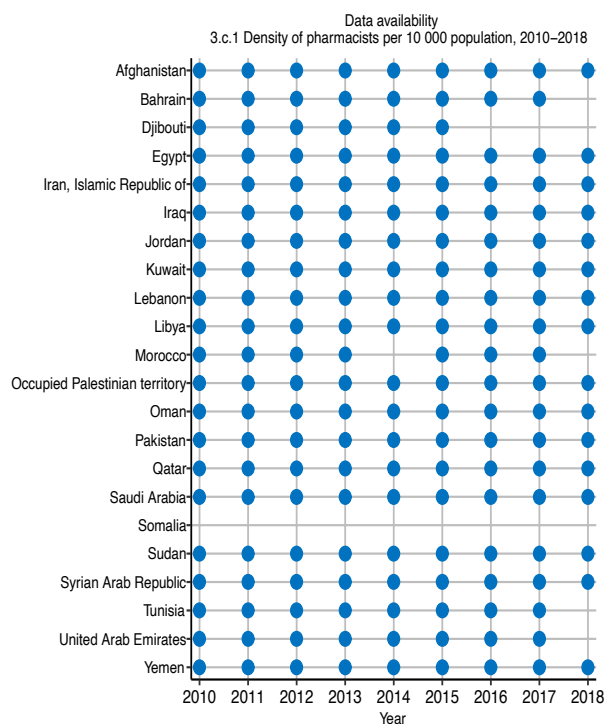
Note: Country-reported data



Note: Country-reported data



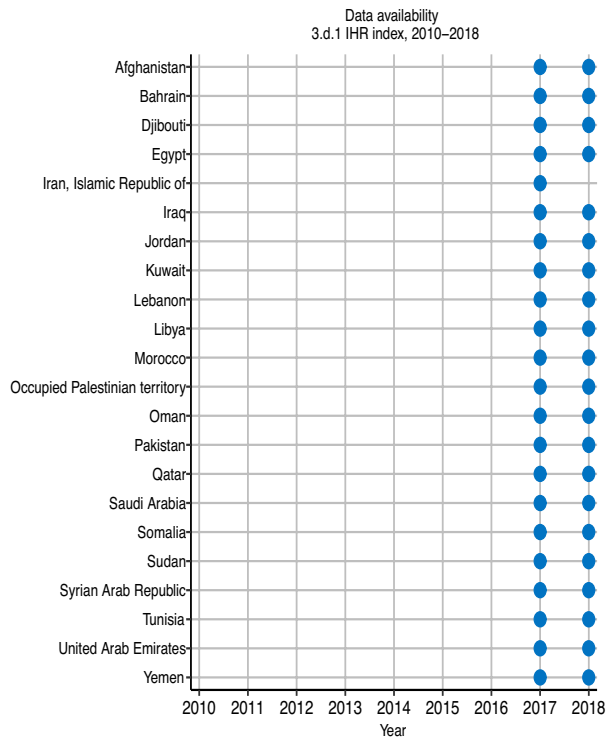
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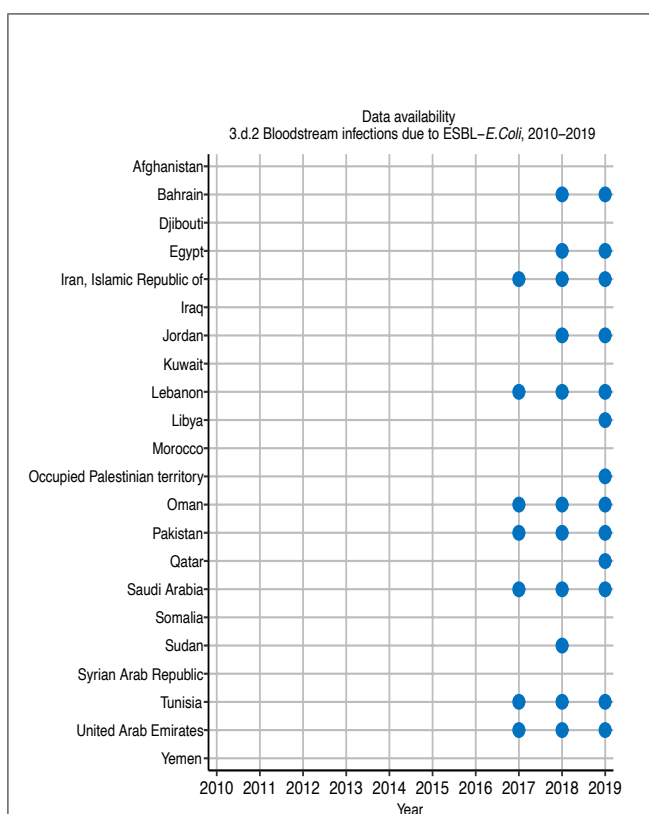
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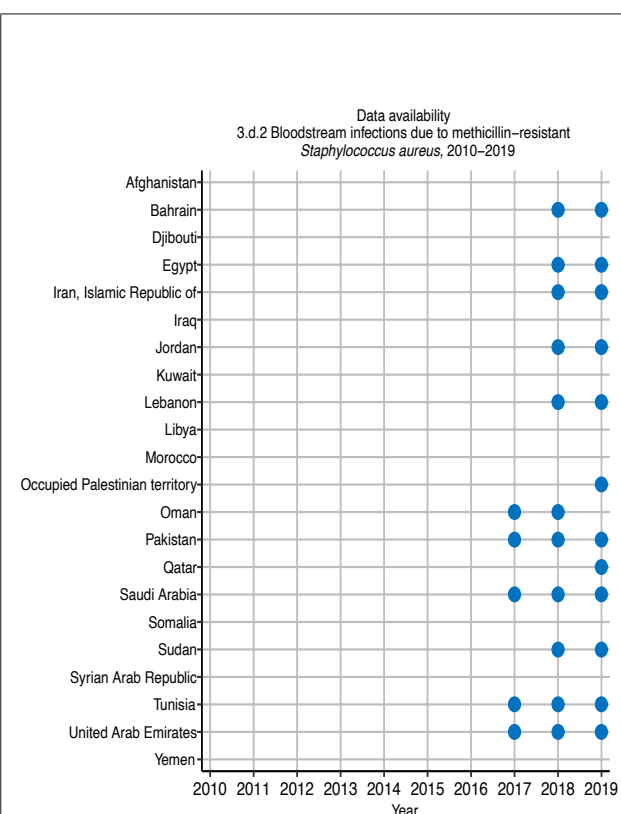
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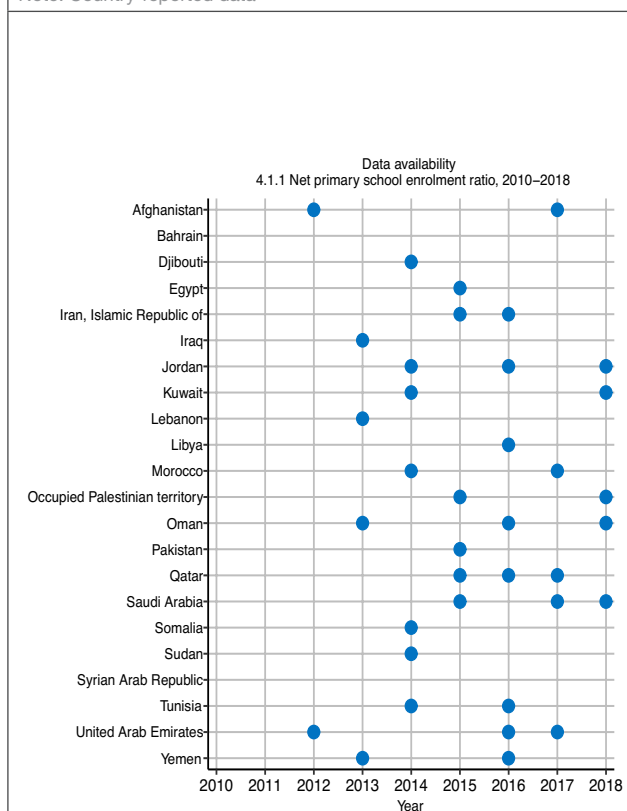
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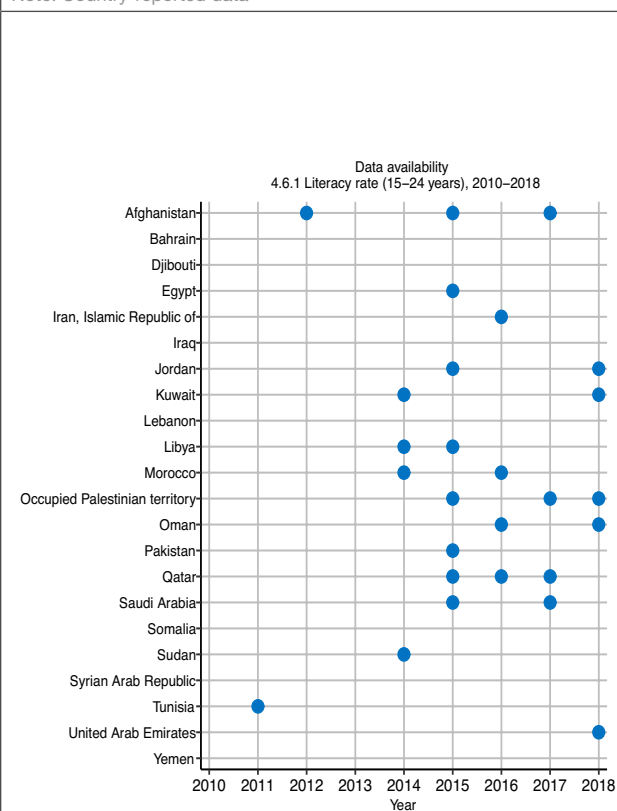
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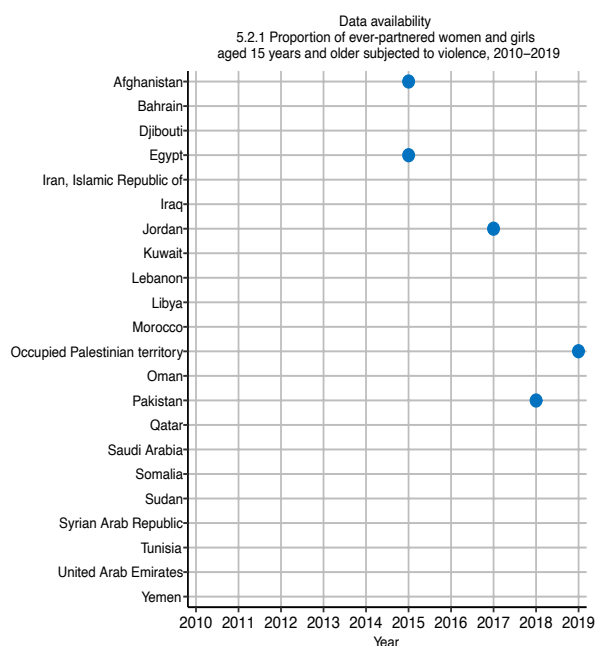
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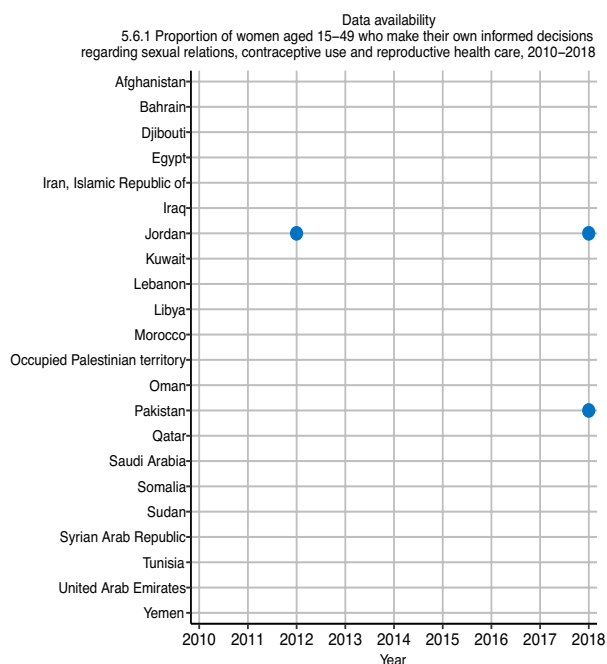
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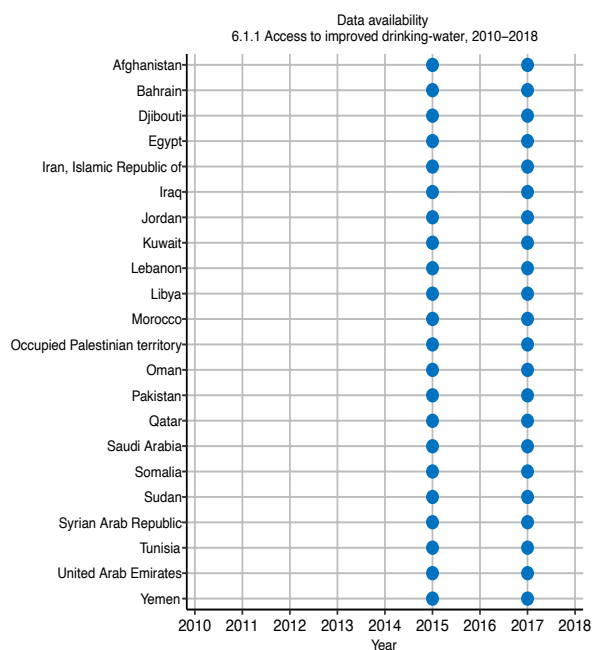
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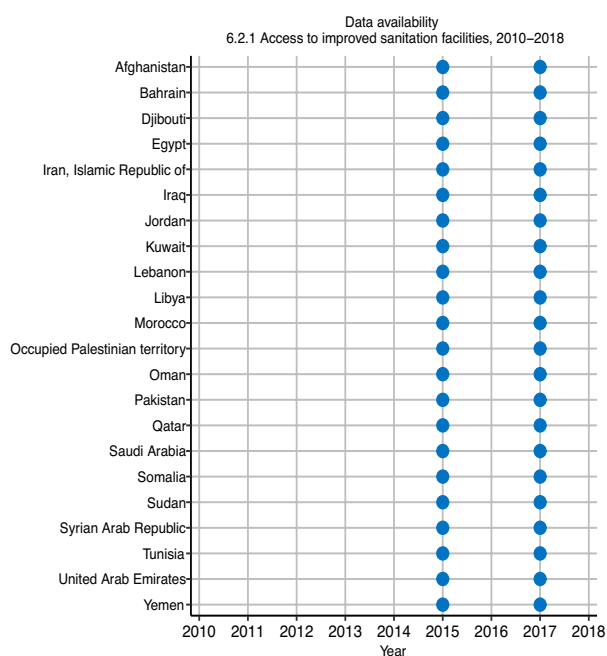
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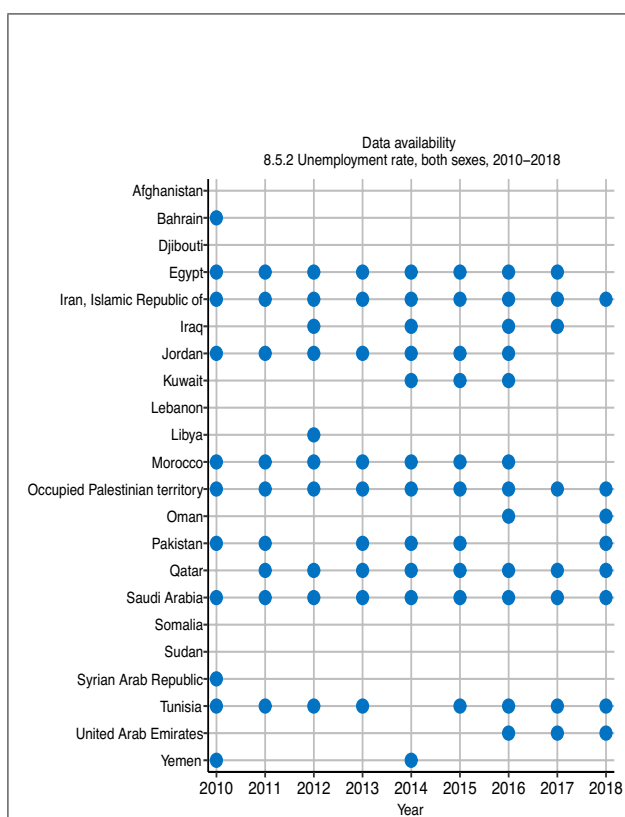
Note: Country-reported data



Note: Data from global estimates



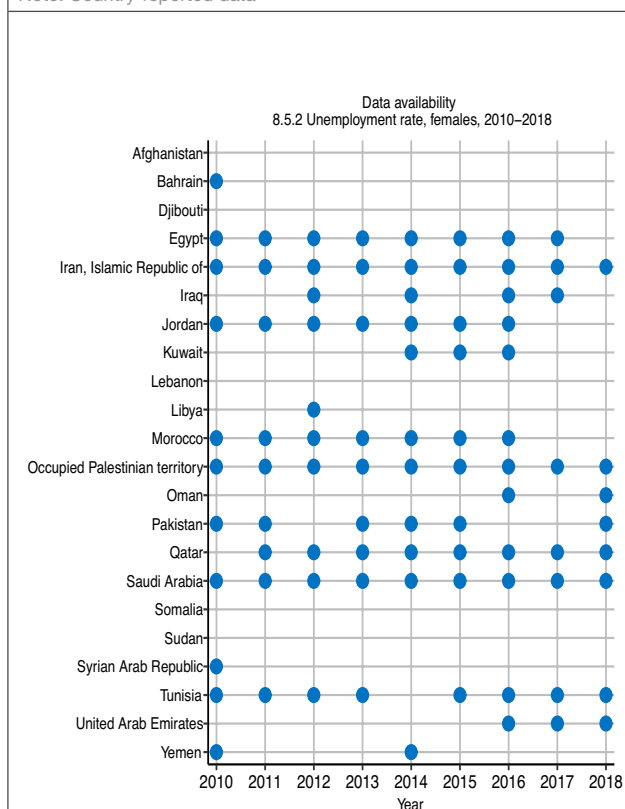
Note: Data from global estimates



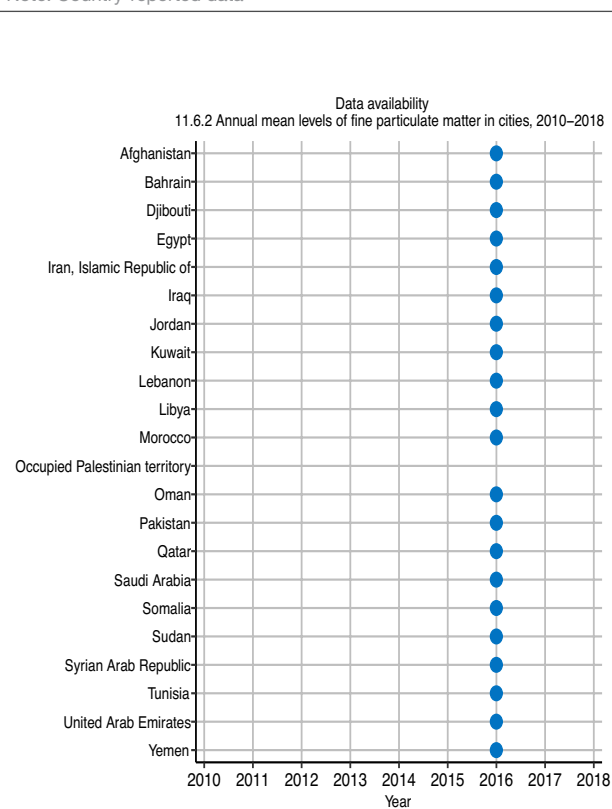
Note: Country-reported data



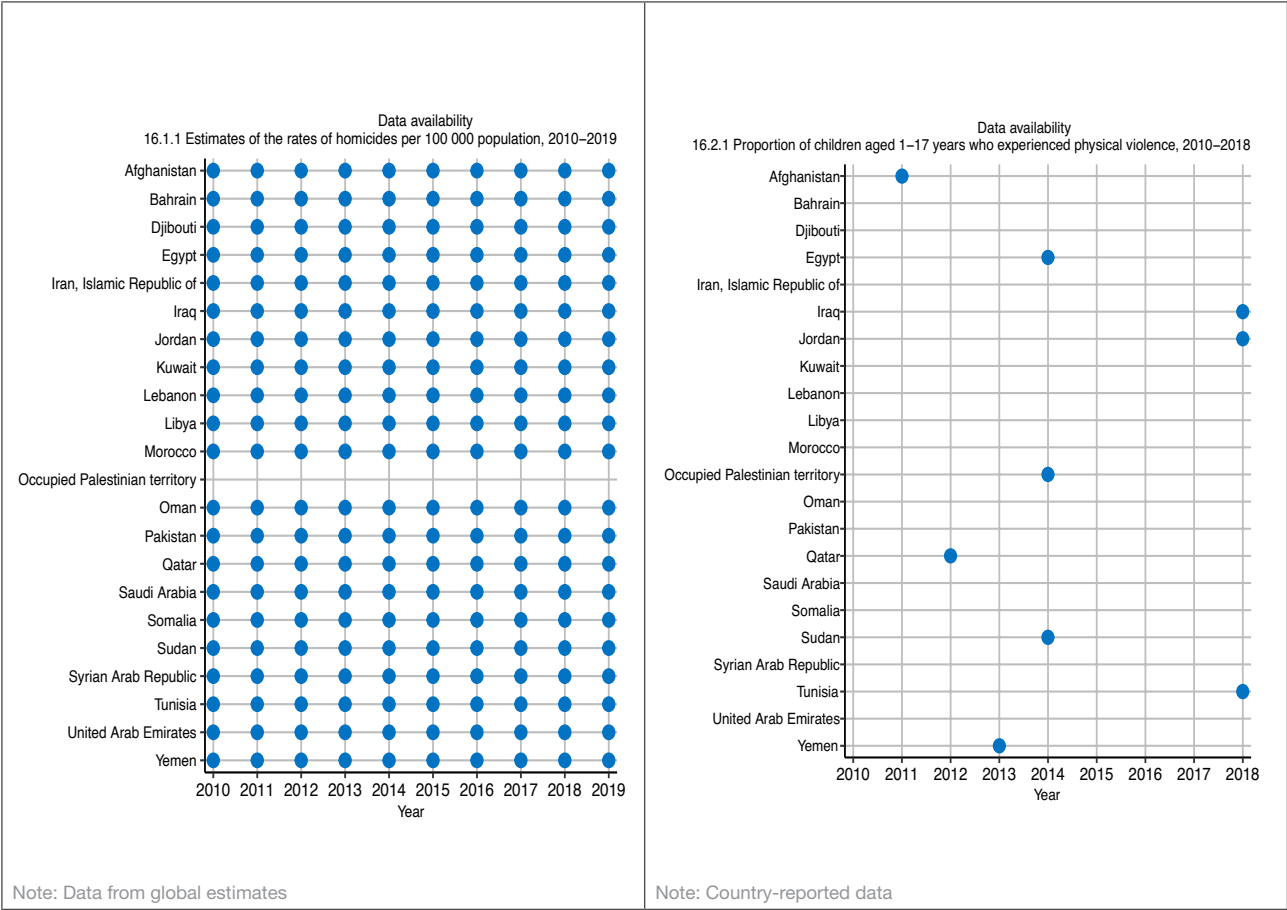
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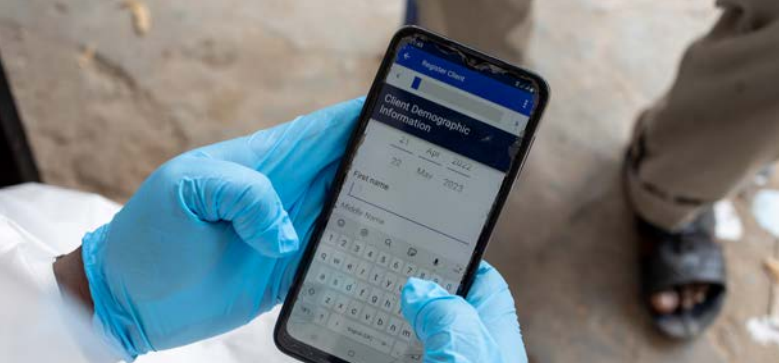


Note: Country-reported data



Data from global estimates





The 2030 Agenda for Sustainable Development includes a vision of healthy lives and well-being for all at all ages. This major report is the first comprehensive attempt to chart progress towards the health-related Sustainable Development Goals (SDGs) in the WHO Eastern Mediterranean Region. It presents regional trends between 2015 and 2019 for 50 health-related SDG indicators using available data from WHO and estimates from other United Nations agencies. The report reveals encouraging progress in some areas, but also many gaps and weaknesses in health-related services and outcomes as well as the data needed to measure them. As such, it will be critical reading for everyone working to plug those gaps and realize the vision of the 2030 Agenda.

