Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region

2022 update

SDGs, UHC and financial protection:
Leaving no one behind

World Health Organization
South-East Asian Region

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ISBN: 978-92-9020-988-1

Suggested citation. Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2022 update. New Delhi: World Health Organization, Regional Office for South-East Asia; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Printed in India

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Foreword

It is a pleasure to introduce this seventh Annual Report on Monitoring progress towards universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs) in the South-East Asia Region. Monitoring progress towards UHC and the health-related SDGs is crucial to understand where we are now, where we are likely to be in 2030, and what is needed to accelerate progress.

This year's report provides a comprehensive overview of the status and trends of selected health-related SDG targets across all 11 Member States. It follows the same format as in earlier years; however, the thematic focus is on financial protection.

Part 1 of the Report highlights progress towards UHC and health-related SDG targets. It shows that while the Region has witnessed an increase in the service coverage index – from 47 in 2010 to 61 in 2019 – the pace of improvement is inadequate to achieve the minimum essential service coverage index of 80 by 2030. The greatest progress has been in reproductive, maternal, newborn and child services, whereas accelerated progress is needed in service capacity and access, and noncommunicable diseases (NCDs).

Part 2 of the Report provides a comprehensive overview of the status of financial protection. The South-East Asia Region has the highest level of out-of-pocket (OOP) spending as a share of current health expenditure (CHE) among all WHO regions. Out-of-pocket spending is predominantly driven by spending on medicines. Several countries have a high proportion of households that incur catastrophic health care expenditure and/or get pushed into poverty or further into poverty. The good news is that between 2000 and 2017, the total population in the Region impoverished and further impoverished due to OOP health spending has substantially decreased, from almost 30% to about 6%, respectively. But despite this outcome, the overall number of people with impoverishing health spending in the Region remains high, at 117 million in 2017.

There is an urgent need to increase public spending on health, especially on medicines and to support the poorest segments of the population. Domestic government spending on health in the Region is low, comprising an average 35% of current health expenditure. Adequate levels of government spending on health is associated with a lower incidence of financial hardship. In spite of a difficult macro-fiscal environment – which involves reduced government revenues, increased spending as well as deficit financing and higher debt levels – it is critical that countries prioritize public financing for health, make health financing more efficient, and allocate public resources for health more equitably.

Part 3 of the Report is on Member States' SDG profile, reporting on health and health-related SDG indicators using nationally reported data and estimates. Most Member States have made considerable progress in reducing maternal and child mortality and improving childhood immunization. The Region has also achieved remarkable improvements in the

control and elimination of communicable diseases such as malaria. However, several areas require accelerated effort. Tuberculosis (TB), NCDs, and the social and environmental determinants of health are all major concerns. There is also rising concern about the double burden of malnutrition among children under 5 years of age.

In the ongoing COVID-19 response and recovery, all countries of the Region have prioritized the need to invest in and reorient health systems towards strong primary health care to achieve UHC, enhance health security, and address determinants of health, as well as to promote health equity, human rights and gender equality, and to empower communities. I urge all countries and partners to utilize the data and analysis herein to make concerted efforts to accelerate progress towards achieving our Regional Flagship Priorities and the health-related SDG targets.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
ART	antiretroviral therapy
DALY	disability-adjusted life year
DTP3	third dose of diphtheria, tetanus toxoid and pertussis-containing vaccine
DESA	Department of Economic and Social Affairs
DHS	Demographic and Health Survey
HEPI	health emergencies protection index
HIP	health information platform
HIV	human immunodeficiency
HALE	healthy life expectancy
HRH	human resources for health
HPOP	Healthier Populations (Billion target)
IAEG	United Nations Inter-Agency and Expert Group
INLA	Integrated nested Laplace approximation
MCV2	second dose of measles-containing vaccine
MICS	Multiple Indicator Cluster Survey
NCD	noncommunicable disease
OOP	out-of-pocket payments
PHC	Primary health care
RTA	road traffic accident
RMNCH	reproductive, maternal, newborn and child health
SDG	Sustainable Development Goal
SE Asia Region	South-East Asia Region
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
TAG	technical advisory group
TB	tuberculosis
UHC	universal health coverage
WASH	water, sanitation and hygiene

PART 1

Progress towards universal health coverage and health-related SDGs in the WHO South-East Asia Region: highlights

Monitoring progress towards health-related SDGs and UHC is essential to identify trends, measure impact and inform effectiveness of programmes and policies. This section provides a comprehensive overview of the progress towards health-related SDGs and universal health coverage. It further provides information on the current status of select health-related SDG indicators across all 11 Member States and indicates a need for accelerated progress through improved strategies and focused action towards achieving the SDG targets by 2030.

Universal health coverage

Universal Health Coverage (UHC) aims to ensure that all people obtain the health services they need of sufficient quality to be effective without suffering financial hardship. This requires a strong, efficient, and equitable health system; a system for financing health services; reliable and timely health information system, access to essential medicines and technologies; and well-trained and motivated health workers.

In the SDG monitoring framework, UHC has two dimensions: provision of essential health service-as measured by UHC service coverage index (indicator 3.8.1); and financial protection as measured by catastrophic health expenditure (indicator 3.8.2). This section provides information on progress made by countries and the Region covering both the dimensions of UHC.

Box 1: Tracking universal health coverage (UHC)

There are two indicators for tracking UHC: the UHC service coverage index (indicator 3.8.1) and catastrophic health expenditure (3.8.2). The UHC service coverage index is a new summary measure of coverage that has been under development by WHO and the World Bank for several years. It offers a concise way of tracking progress across a range of key services, over time, within a country and reflects the importance of and linkages with other health-related SDG indicators. As a composite index, it is based on 13 indicators of four groups, which are 1) Reproductive, maternal, newborn and child health (RMNCH); 2) communicable diseases; 3) noncommunicable diseases; and 4) service capacity and access (listed at Annex A.). The catastrophic health expenditure is defined as a proportion of population with household expenditure on health larger than 10% of total household expenditure/income.

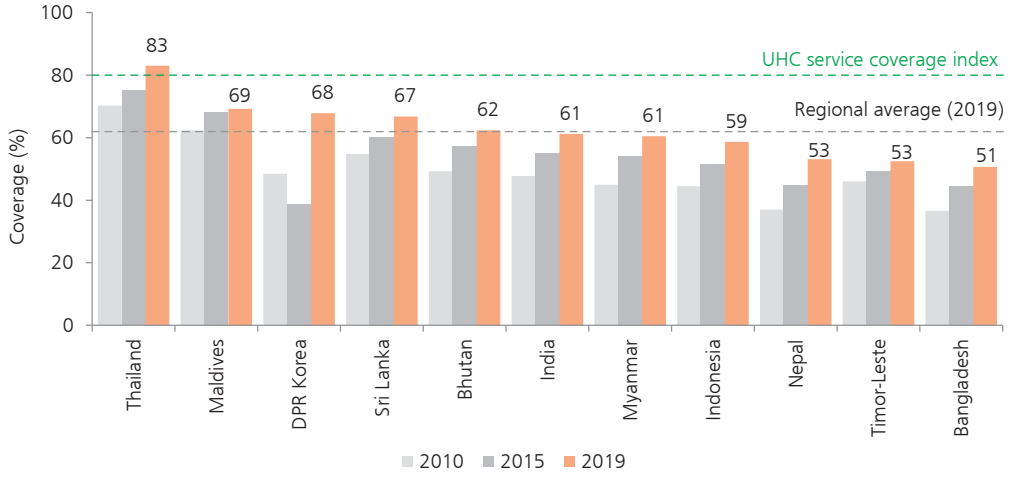
A sharper focus on the health service coverage and financial protection indicators will be valuable for countries to accelerate progress towards UHC. Without such information, decision-makers cannot say where they are, and set a course for where they want to get to. They cannot know whether their policies and strategies are making a difference.

UHC service coverage

The UN Inter-Agency and Expert Group (IAEG) has endorsed that the coverage of essential health services is measured using the "UHC service coverage index". The index continues to evolve and has been revised in this report, to reflect updates from the Tracking universal health coverage: 2021 Global Monitoring Report and to ensure global consistency and comparability[1]. Any change in a country's index can be due to a real change in service coverage but may also be influenced by adjusted methods and data available. However, no index can fully summarize all the health services required across all levels of care to achieve UHC.

The SE Asia Region has made significant progress in improving the service coverage index from 47 in 2010 to 61 in 2019. However, the progress is not fast enough to achieve the minimum essential service coverage index score of 80 by 2030. There is high variation in service coverage index between Member States ranging from 51 to 83 (Fig. 1). Attention should be given also to the coverage disparities among population groups at subnational level (*see* Fig. 8 as an example).

Fig. 1. **Trend in coverage of essential health services in Member States of the SE Asia Region, 2010–2019**



Source: WHO Global Health Observatory, accessed 5 May 2022.

The greatest progress in the essential health services sub-index has been driven by interventions in the group of reproductive, maternal, newborn and child services. Enhanced progress is particularly needed in the areas of service capacity and access, where seven countries' coverage ranges between low to medium (Table 1).

Table 1. **Essential health services sub-index, 2019**

	RMNCH	Infectious diseases	NCDs	Service capacity and access
Bangladesh	59	46	56	44
Bhutan	83	63	47	61
DPR Korea	90	54	74	58
India	72	71	63	44
Indonesia	83	51	53	53
Maldives	65	68	65	80
Myanmar	70	77	51	49
Nepal	77	60	58	30
Sri Lanka	77	66	62	63
Thailand	89	85	70	89
Timor-Leste	70	54	56	36
SE Asia Region	73	66	61	47

Very high coverage (>80) | Medium coverage (40–59) | Very low coverage (<20)
High coverage (60–79) | Low coverage (20–39)

Source: WHO global health observatory accessed 5 May 2022.

Box 2: Service disruption due to COVID-19

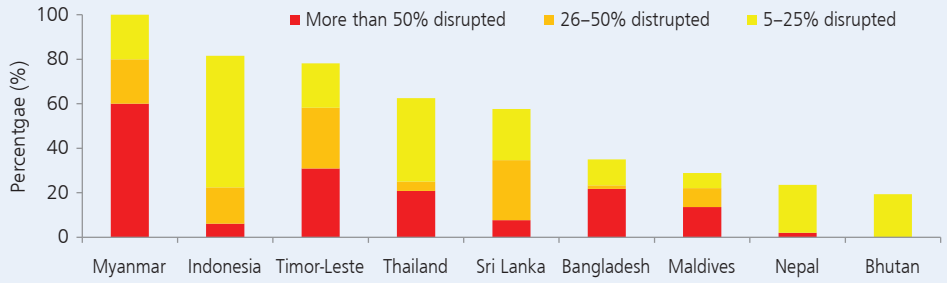
More than two years into the pandemic, disruption in essential health services delivery is still an issue of concern. The Region has witnessed recovery in service delivery from the first year of the pandemic; however, almost all countries still reported some level of disruptions in essential service delivery in 2021[2]. Although SE Asia Region countries' health systems are rapidly responding to overcome service disruptions and recover quality services, more needs to be done, especially to attain the UHC goal.

Covid-19 has affected health care at all settings and all service delivery platforms, particularly first-contact services. About one third or more countries reported increased backlogs in multiple health services during the second half of 2021, including NCD and rehabilitative care.

Key actions undertaken to mitigate consequences and promote service recovery include:

- Home-based care and catch-up visits
- Change in care modalities; including use of tele-medicine
- Recruitment, training and support to health workers
- Procurement of surge commodities
- Community engagement and communication
- Several health financing strategies

Percentage of services disrupted per country, 2021



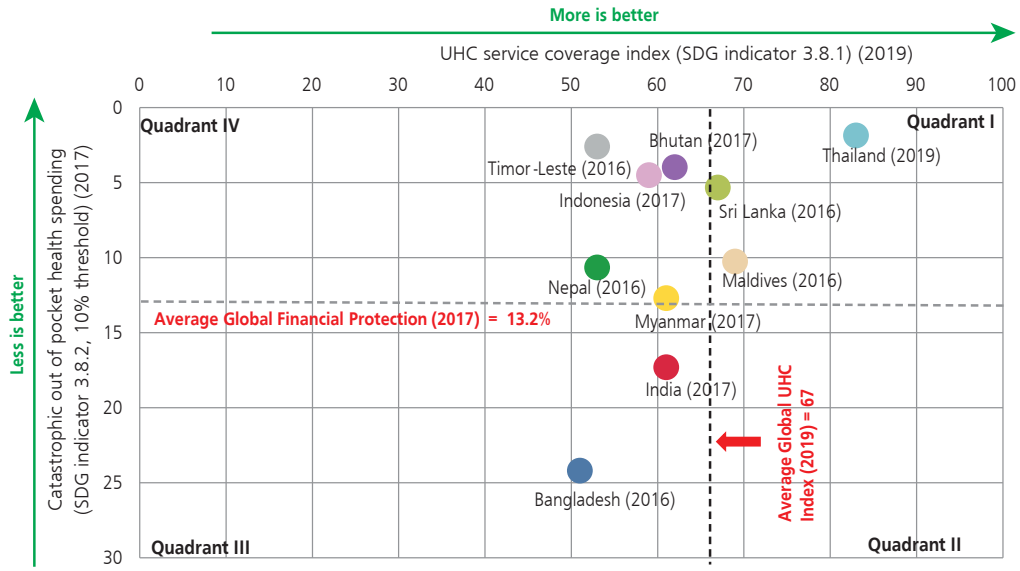
Note: Data not available for India and DPR Korea
Source: WHO Pulse Survey round 3.

Financial protection

Financial protection, critical to achieving UHC, is measured as a proportion of the population facing financial hardship as a result of catastrophic health expenditure. A major concern for the Region is that the level of catastrophic health spending has increased from 12.6% in 2000 to 15.2% in 2017[1]. More recent data is unavailable from several countries because of delays in conducting household expenditure surveys. Catastrophic health care expenditure is expected to further worsen because of the COVID-19 pandemic and the ensuing economic crisis as well as additional shocks such as geopolitical tensions (including the Russia-Ukraine conflict in Europe); supply disruptions and energy and food insecurity.

In the SE Asia Region, Thailand, Sri Lanka, and Maldives have achieved relatively high levels of service coverage and low levels of catastrophic health spending (Fig. 2) while Bangladesh, India and Myanmar, however, continue to experience high levels of catastrophic health spending and relatively low level of service coverage.

Fig. 2. **Comparison of health services coverage and catastrophic health expenditure in Member States of the SE Asia Region**



Source: WHO Global Health Observatory accessed 5 May 2022. Note: Dashed lines represent global incidence for each indicator based on Global incidence of catastrophic health spending (2017) =13.2% and UHC coverage index (2019) = 67.

Monitoring health-related SDGs and UHC service coverage and financial protection: current data challenges and future directions

An effective and actionable way to monitor the health-related SDGs and UHC service coverage continues to be a challenge in the SE Asia Region due to the lack of a robust routine information system that produces timely and reliable data across health services. Moreover, many countries in the SE Asia Region rely on household surveys which have not been conducted on a regular basis leading to data lag thereby impacting continuous and timely monitoring of the health-related SDGs and the UHC services. Recognizing this limitation, the Regional Office is working closely with Member States to strengthen their health information systems including civil registration and vital statistics (CRVS) to produce high quality, timely and best possible data; as well as supporting them in the analysis of household expenditure surveys.

Health-related SDG targets: regional highlights

This section provides information on progress in the Region towards achieving the health-related SDG targets. It summarizes the recent trends and levels across health and health-related SDG targets covering the areas of (i) reproductive, maternal and child health, (ii) communicable diseases, (iii) noncommunicable diseases and its risk factors, (iv) injuries, (v) mental health, (vi) environmental determinants of health, (vii) health workforce, and (viii) health security.

Reproductive, maternal and child health

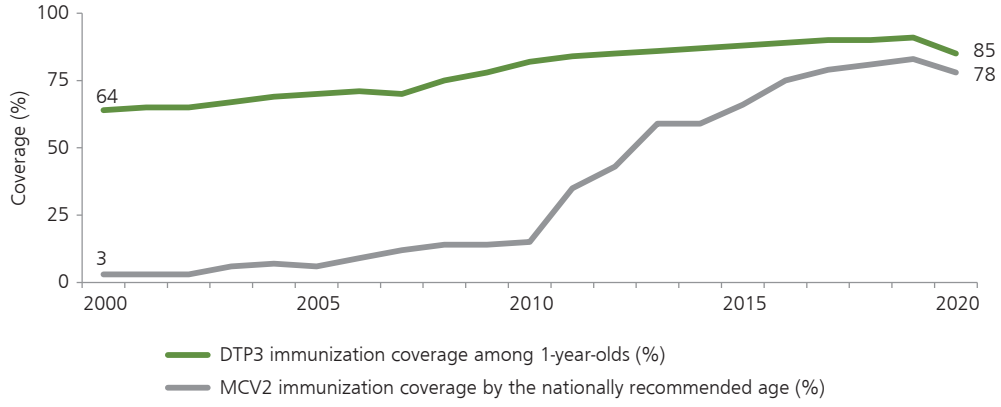
The Region continues to make significant progress towards reducing maternal and child mortality. Between 2000 and 2017, the Region has achieved remarkable reduction in maternal mortality ratio (MMR) of 57% from 355 in 2000 to 152 in 2017. Similarly, the Region continues to witness a decline in under-five mortality rate (81 in 2000 to 30 in 2020) and neonatal mortality rate (38 in 2000 to 18 in 2020).

Five countries (DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand) have already achieved the global under-five mortality rate target of less than 25 deaths per 1000 live births, and Bangladesh, Bhutan, India and Nepal are expected to achieve the target by 2030 if they continue with the current trajectories. Four countries (DPR Korea, Maldives, Sri Lanka and Thailand) have already achieved the global SDG target for neonatal mortality rate of less than 12 deaths per 1000 live births and four other countries (Bangladesh, Bhutan, Indonesia and Nepal) are expected to reach the target by 2030. However, disruption of essential maternal and child health services and nutrition and immunization campaign on account of COVID-19 could wipe out the hard-earned gains in several countries[3].

Immunization coverage for diphtheria—tetanus—pertussis vaccine third dose (DTP3) and measles-containing-vaccine second dose (MCV2) remains relatively high in the Region. But there has been a decline in both DTP3 and MCV2 immunization coverage in 2020 compared to the previous year. DTP3 immunization rate dropped from 91% in 2019 to 85% in 2020 and MCV2 immunization coverage dropped from 83% in 2019 to 78% in 2020 (Fig. 3).

In 2020, seven of the 11 Member States in the Region, namely, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Timor-Leste witnessed a decline in DTP3 immunization from the previous year ranging from 2%–9%. Similarly, a drop in MCV2 immunization was witnessed in five Member States namely, India, Indonesia. Nepal, Sri Lanka and Timor-Leste. This decline could have been due to lockdowns and service disruption during the COVID-19 pandemic. It is important for Member States to fully revive its services and continue ensuring delivery of essential health services like childhood immunization which protects children against infectious disease that can cause serious illness and fatality[4].

Fig. 3. **Trends in DTP3 and MCV2 immunization coverage in SE Asia Region, 2000–2020**



Source: WHO Global Health Observatory accessed 5 May 2022.

Infectious diseases

The Region continues to witness high burden of major infectious diseases: tuberculosis (TB), hepatitis, malaria and HIV/AIDs. In 2020, the Region had the highest share (43%) of total tuberculosis cases globally, with an estimated 4.3 million TB cases[5]. Between 2000 and 2020, the Region witnessed a 30% decline in TB incidence from 303 to 211 in 2020. Despite the progress, the decline in TB incidence is not fast enough. The Region did not meet the 2020 milestones of end TB strategy and is not expected to meet the global SDG target of 80% reduction in TB incidence (from 2015 baseline) by 2030.

Moreover, the pandemic has further halted or even reversed the progress made towards TB elimination in several countries. In 2020, nearly half of those people who fell ill with TB missed out on access to care and were not reported[5]. Regional TB treatment coverage declined to 60% in 2020 from 78% in 2019 (Fig. 4). Similarly, the number of people provided with treatment for drug-resistant TB and TB preventive treatment dropped significantly.

For the first time in over a decade, TB deaths have increased because of reduced access to TB diagnosis and treatment in the face of the COVID-19 pandemic. Based on current trends, no country in the SE Asia Region is expected to achieve the global target. As we move forward, early case detection, treatment and prevention programmes continue to be key to accelerate progress towards TB reduction.

The Region continues to make substantial progress towards malaria elimination, with reduction in malaria cases by 78% from 23 million in 2000 to 5 million in 2020 whereas malaria deaths reduced by 75%[6]. The malaria case incidence (SDG 3.3.1) has significantly reduced from approximately 18 cases per 1000 population at risk in 2000 to about 3 cases in 2020 while over the same period, the malaria mortality rate reduced by 81%, from 2.8 to 0.5 per 100 000 population at risk.

All the Member States have met the 2020 global technical strategy for malaria milestone of 40% reduction both in malaria case incidence and malaria mortality rate except Bhutan and Indonesia where the reduction was less than 25%. Further, against the SDG target of 90% reduction of malaria incidence and malaria mortality rate of base line 2015, the SE Asia Region has attained the reduction of 64% in malaria incidence and 65% in malaria mortality rate[6].

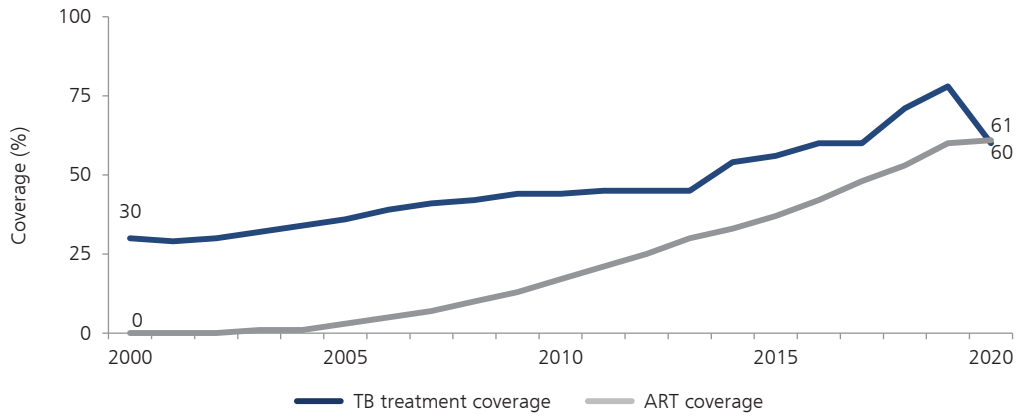
Malaria has been eliminated from Maldives and Sri Lanka while five other countries, namely, Bhutan, DPR Korea, Nepal, Thailand and Timor-Leste are close to eliminating it. Further, during the COVID-19 pandemic in 2020, there were no major increases in the malaria burden in the SE Asia Region. Even though countries faced service disruption due to the pandemic, many countries have innovatively integrated malaria services in their COVID-19 response activities, such as screening for both malaria and COVID-19 using integrated surveillance approach, which benefited both the programmes and has helped ensure progress towards malaria elimination in the Region[6].

Between 2010 and 2020, the number of AIDS-related deaths decreased by 64% and the number of new HIV infections (SDG 3.3.1) per 1000 uninfected population) declined by 50% from 0.1 in 2010 to 0.05 in 2020[7]. HIV antiretroviral treatment (ART) coverage has increased in the Region from 17% in 2010 to 61% in 2020 (Fig. 4). However, HIV response is currently not up to the optimal level, indicating a need for innovative approaches and community engagement tools to ensure progress. Addressing health inequity as well as stigmatization and discrimination especially among key population groups, are a crucial way forward to achieve the SDG targets.

With regards to viral hepatitis, in 2019, the number of people dying from hepatitis B infection was estimated at 180 000 and hepatitis C infection was 38 000[7]. Within the SDG framework, hepatitis B incidence is measured by surface antigen (HBsAg) prevalence among children under five years of age (SDG 3.3.4).

Based on the latest data (2019), 7 of the 11 Member States (Bhutan, DPR Korea, India, Maldives, Nepal, Sri Lanka and Thailand) have already achieved the 2025 target of less than 0.5% HBsAg prevalence. Currently, there is no historical trend data to assess progress towards the 2030 global target of 0.1% HBsAg prevalence. Despite low infection, the Region continues to face the challenge of treatment and low access to diagnosis with just 10.5% of those with hepatitis B and 6.9% with hepatitis C knowing their status. Member States are being supported to strengthen their surveillance system with better data collection and develop cost effective analysis to generate evidence for strategic plans and programmes that focus on elimination.

Fig. 4. **Trends in treatment coverage for TB and HIV (ART), 2000–2020**



Source: WHO Global Health Observatory accessed 5 May 2022.

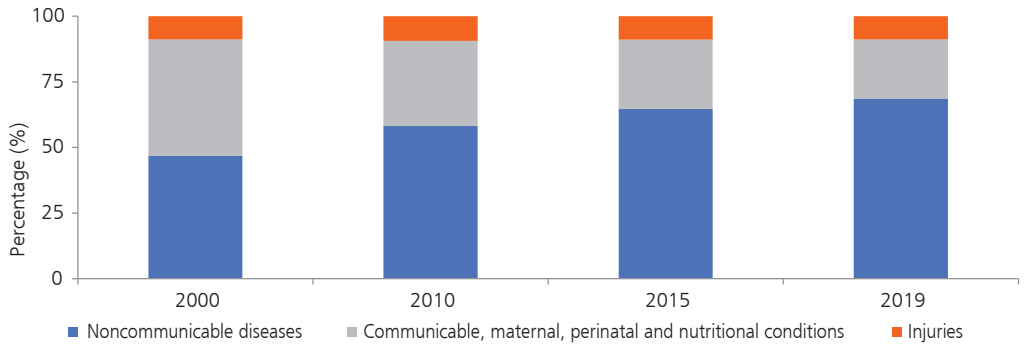
Noncommunicable diseases and their risk factors

During the last two decades, the SE Asia Region has witnessed the epidemiological transition, shown in Fig. 5 Noncommunicable diseases (NCDs) are responsible for 69% of all deaths in the Region, accounting for an estimated 8.5 million deaths annually due to four major NCDs (cardiovascular diseases, cancer, diabetes and chronic respiratory diseases)[8]. Of these, 52.4% deaths are premature i.e. before 70 years.

Further, the premature mortality rate from four major NCD (SDG 3.4.1), the Region continues to witness a slow decline. Only three countries in the Region namely, Maldives, Sri Lanka and Thailand are expected to or already have achieved the SDG target of 1/3rd reduction in global premature deaths compared to 2015 baseline.

Prevention and control of noncommunicable diseases is a top priority in the Region, more so after the 2018 political commitment by the Member States to address the global NCD epidemic. WHO has developed "best buys" – a set of 16 practical and cost-effective interventions for prevention and control of NCDs. It emphasizes promoting health and preventing diseases including increasing tobacco taxes, restricting alcohol marketing, reformulating food products with less salt, vaccinating girls against cervical cancer, and treating hypertension.

Fig. 5. **The proportion of cause of deaths in SE Asia Region, 2000–2019**



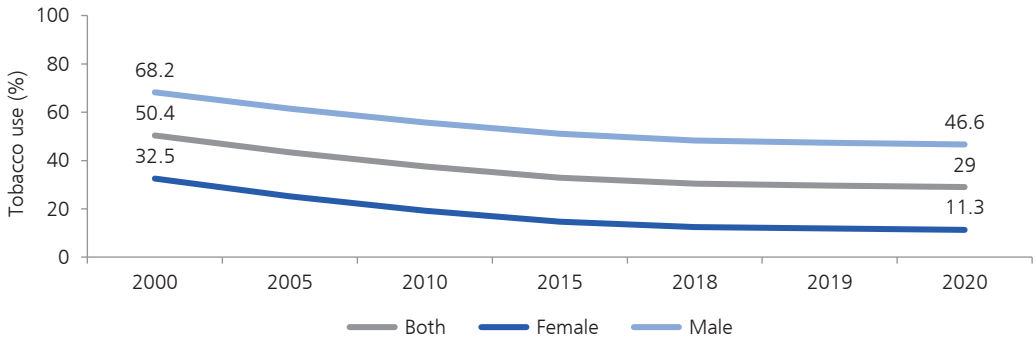
Source: WHO Global Burden of Disease 2019, accessed 5 May 2022.

Risk factors for noncommunicable diseases

Majority of NCD burden is attributed to four main risk factors, which are tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets. The SE Asia Region has witnessed a sharp decline in tobacco use from 50.4% in 2000 to 29% in 2020 owing to stronger tobacco control supported by improved tobacco surveillance mechanisms[9]. Prevalence of tobacco use, however, is still unacceptably high in some geographical settings and population groups, while gender difference in tobacco prevalence is four times higher among males (Fig. 6).

The picture is less positive for other risk factors such as alcohol use, obesity and hypertension. The Region is observing an increase in levels of obesity and hypertension; these are expected to rise further based on current trends. Similarly, alcohol consumption (total per capita) in the Region increased from 2 litres in 2000 to 4.3 litres in 2020.

Fig. 6. **Trends in tobacco use by sex, 2000–2020**



Source: WHO Global Health Observatory accessed 5 May 2022.

Mental health

Mental health is an integral part of SDG 3 and has major implication on SDG target 3.4 to promote mental health and well-being. Mental health problem is the leading cause of Years Lived with Disability (YLD) globally with depressive disorders being the largest contributor[10]. Within the SDG framework, suicide mortality rate is the indicator for SDG target 3.4. Crude suicide mortality rates (per 100 000 population) have declined from 13.59 in 2000 to 10.07 in 2019.

However, the progress needs to be faster to achieve the SDG goal of reducing the suicide mortality rate by one third of baseline in 2015. Mental health is directly and indirectly linked to many other health related SDGs such as SDG target 3.5 (strengthen the prevention and treatment of substance abuse), SDG target 3.a (strengthen tobacco control) and SDG target 3.8 (achieving UHC). If the Region is to make full progress towards the SDGs, then there is need for accelerated focus on promotion and protection of mental health.

Injuries

Injuries account for 8.8% of all deaths and 10% of disability-adjusted life years (DALYS) from all causes in the Region[11,12]. Among all types of injuries, road injury accounts for the highest proportion of death (23.4%) and DALYS (33%). The Region is not expected to meet the global SDG target of reducing road traffic mortality rate (SDG 3.4) by half in 2030. There has been a slow decline in road traffic mortality rate (per 100 000 population) of 17.07 in 2020 to 15.84 in 2019. Based on latest data (2019), road traffic mortality rates varied widely between SE Asia Region Member States in the Region, ranging from 1.63 in Maldives to 32.21 in Thailand.

Moreover, four Member States (Bhutan, DPR Korea, Myanmar and Nepal) in the Region have shown a reverse trend or no change in road traffic mortality rate in the past 10 years. Much work is needed in the area of reducing road traffic injuries if global target is to be achieved by 2030.

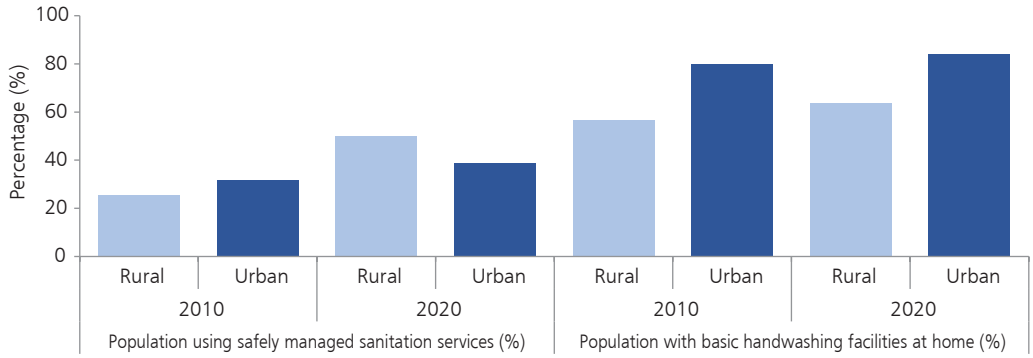
Environmental determinants of health

COVID-19 has highlighted the importance of environmental risk factors such as adequate access to water, sanitation and hygiene (WASH) for preventing and protecting people against infectious diseases. With less than half the population having access to safely managed sanitation services (SDG 6.2.1a) the Region is not likely to reach the global target. Further, not all Member States have data for this SDG target and none of the six countries with data availability namely Bangladesh, Bhutan, India, Myanmar, Nepal and Thailand will meet the global target.

For SDG target 6.2.1b, proportion of population with basic handwashing facilities at home have increased from 64.4% in 2010 to 71.5% in 2020. Proportion of population with basic handwashing facilities varies widely between Member States from 28% in Timor-Leste to 96% in Maldives. Although no country is expected to achieve universal access, with accelerated effort countries like Bhutan, Indonesia and Maldives can meet

the global target. As progress is being made, it is equally important to examine with an equity lens to ensure no population subgroup are being left behind. Fig. 7 highlights that large disparity continues between rural and urban populations in access to basic handwashing facility and there is an urgent need to increase access to the underserved population.

***Fig. 7.* Access to safely managed sanitation and handwashing facilities in SE Asia Region by place of residence, 2010–2020**



Source: WHO Global Health Observatory accessed 5 May 2022.

Health workforce

In contrast to the prior decade, the SE Asia Region has witnessed a significant increase (30.5%) in the availability of doctors, midwives and nurses per 10 000 population (SDG 3.c.1) since 2014. Three Member States, namely DPR Korea, Maldives and Indonesia, have surpassed the global indicative threshold of 44.5 doctors, midwives and nurses per 10 000 population to achieve the SDGs. All Member States have shown improvement in availability of doctors, nurses and midwives. However, focused effort is needed to strengthen human resources for health information systems, including focus on capturing all occupations that contribute to health needs and strengthened linkage with routine health information systems.

Health security

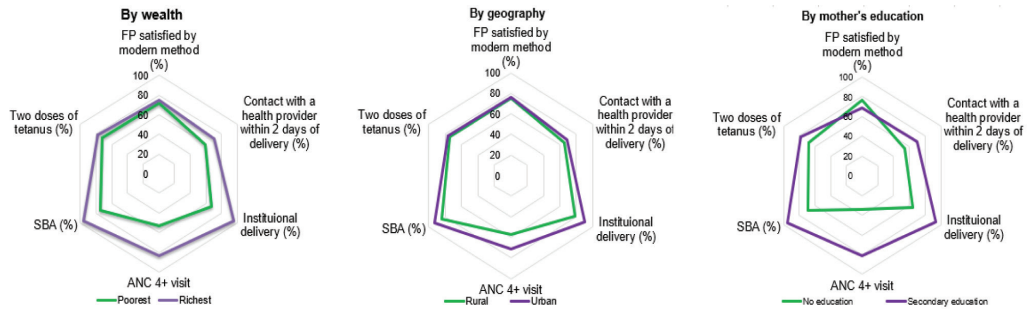
The COVID-19 pandemic has highlighted the importance of health security as a fundamental pre-requisite to ensure basic health and to achieve UHC. Health security is measured through International Health Regulations (IHR) framework (2005) using State Party self-assessment annual reporting (SPAR) form. On IHR (2005), average IHR core capacity score the Region is making steady progress since 2018 with average IHR core capacity score of 63 in 2020. Further, every core capacity except for point of entry capacity has witnessed improvement since 2018. As we build back better and stronger from the pandemic, Member States in the Region must continuously monitor and strengthen core capacities for health emergency preparedness and response, such that there is timely detection, assessment and response to future public health emergencies.

Monitoring health equity in the Region

Health-related inequities continue to persist despite improvements in the Region. Fig. 8 shows variation in service coverages by three different equity stratifiers (wealth, geography and maternal education). Although service coverages have improved among the disadvantaged sub-group, service coverage is still much higher among the advantaged group compared to the disadvantaged subgroup. For instance: proportion of households with access to basic hand washing facility is more than 50% higher among the richest quintile compared to the poorest quintile. Fig. 8 highlights the importance of going beyond national average to advance health equity.

To achieve health equity, it is crucial to know who is being left behind from services to inform appropriate programmes, policies and practices, and achieve UHC. Monitoring health equity continues to be a Regional priority. To identify those who are left behind requires a strong national health information system that not only produces but also uses disaggregated data. The availability of high-quality and timely disaggregated data is lacking in the Region. The Regional Office continues to work with Member States not just to improve availability of data but also build capacity to analyze and monitor health-related equity to improve policies and programmes.

Fig. 8. **Variation in service coverage in SE Asia Region by income, place of residence and mother's education**



Source: DHS-MICS 2011–2019, NFHS-5 2019–2021.

Heath and health-related SDGs 2030: Where are we? What is next?

Table 2 provides an overview of the current status for selected health-related SDG indicators in South-East Asia Region Member States. The table provides information on only 20 selected health-related SDG indicators which have historical trend data and global 2030 target. It illustrates countries' progress towards the 2030 targets available through color coded cell. Green cell indicates that the country has already achieved the global target and must sustain its momentum. The light blue cell indicates status that a country is expected to achieve the 2030 target if it can maintain its current trend. The dark blue cell indicates that with the current trend projection, country will miss the 2030 global target, and therefore needs to intensify measures to accelerate progress. The red cell indicates the status of high concern as country is having a reverse trend and going further off track in achieving the global SDG target.

While interpreting trajectories, it is important to remember that not all health-related SDG indicators have the same global and national targets (Box 3). All projections are derived by R statistical computing software using time-series model with integrated nested Laplace approximation (INLA) wrappers developed by WHO and/or average annual rate of reduction where appropriate.

Box 3. Health-related SDG targets: global vs national target

The 2030 health SDG targets are comprehensive and ambitious. The targets are defined as aspirational and global. Unlike the Millennium Development Goal (MDG), the SDG is inclusive and universal in nature, it provides an opportunity for every Member State, regardless of income level and development status, to set its own targets guided by the context of national health plans and priorities. It is recommended that each country should explore what is feasible and achievable given the country context based on evidence.

Currently, not all countries in the Region have set national targets for all health-related SDG indicators. WHO continues to work closely with its Member States in the Region to provide guidance and recommendation around the principles of setting targets. As national targets become available for more health-SDG indicators, the 2030 health-SDGs projections will continue to include them allowing Member States to measure progress towards achieving the health-related SDGs and national health priorities.

All Member States of the Region are making positive advances towards achieving the 2030 health-related SDG targets. Every country is in a different stage of progress and there is wide variation between Member States. For example: Proportion of population with primary reliance on clean fuels and technologies (%) (SDG 7.1) varies widely between 14% and 97% among all 11 Member States.

The detailed 2030 trend trajectories to assess progress against the global and national SDG targets where available are listed in Annex C. The trajectories will help inform Member States whether they are on track to meet the SDGs and if not, how far off-track they are and also inform programmes the amount of effort needed to achieve the targets. Further, to better understand the extent of disruptions to health and other-health related SDGs caused by COVID-19, WHO is continuously updating analysis with most recent available data and assessing the impact of COVID-19 on achieving the health-related SDGs.

Table 2. **Current status of selected health-SDG indicators, and progress towards 2030 global target**

SDG indicator	SDG target	Year	Global target	BAN	BHU	DPRK	IND	INO	MAV	MMR	NEP	SRL	THA	TLS
Maternal mortality ratio (per 100 000 live births)	3.1.1	2017	70 per 100 000 live births	173	183	89	145	177	53	250	186	36	37	142
Proportion of births attended by skilled health personnel (%)	3.1.2	2015–2021	100%	59	96	100	89	95	100	60	77	100	99	57
Under-five mortality rate (per 1000 live births)	3.2.1	2020	25 per 1000 live births	29	28	16	33	23	6.5	44	28	7	9	42
Neonatal mortality rate (per 1000 live births)	3.2.2	2020	12 per 1000 live births	17	15	9	20	11.7	4	22	17	4	5	19
New HIV infections (per 1000 uninfected population)	3.3.1	2020	0.025 per 1000 uninfected pop.		0.09		0.04	0.10			0.03	<0.01	0.10	0.10
Tuberculosis incidence (per 100 000 population)	3.3.2	2020	28.4 per 100 000 pop.	218	165	523	188	301	37	308	235	64	150	508
Malaria incidence (per 1000 population at risk)	3.3.3	2020	5.89 per 1000 pop. at risk	0.43	0.04	0.18	3.20	2.87	Malaria free	2.55	0.03	Malaria free	0.23	0.003
Probability of dying from any CVD, cancer, diabetes, CRD (aged 30–70) (%)	3.4.1	2019	12.30%	18.9	18.5	23.9	21.9	24.8	11.6	24.9	21.5	13.2	13.7	19.9
Suicide mortality rate (per 100 000 population)	3.4.2	2019	6.3	3.7	4.6		12.7	2.4	2.7	2.9	9	14	8.8	3.7
Road traffic mortality rate (per 100 000 population)	3.6.1	2019	7.32	15.4	16.2	24.2	15.6	11.3	1.6	20.4	16.3	19.7	32.2	11.9
Demand for family planning satisfied with modern methods (%)	3.7.1	2019	100%	73	79	86	73	81	31	77	61	73	90	49
UHC essential service coverage (%)	3.8.1	2019	80	51	62	68	61	59	69	61	53	67	83	53
Tobacco use (%)	3.1.1	2020	19.1%	34.7		17.4	27.2	37.6	25.2	44.1	30.4	22	22.1	39.2

SDG indicator	SDG target	Year	Global target	BAN	BHU	DPRK	IND	INO	MAV	MMR	NEP	SRL	THA	TLS
DTP3 immunization coverage among 1-year-olds (%)	3.b.1	2020	90%	98	95	97	85	77	99	84	84	96	97	86
MCV2 immunization coverage by the nationally recommended age (%)	3.b.1	2020	90%	93	93	99	81	49	96	90	74	96	87	78
Children under 5 years who are stunted (%)	2.2.1	2020	25.2%	30.2	22.4	18.2	30.9	31.8	14.2	25.2	30.4	16	12.3	48.8
Children under 5 years who are wasted (%)	2.2.2	2015–2021	5%	9.8		2.5	19.3	10.2	9.1	6.7	12	15.1	7.7	24
Children aged under 5 years who are overweight (%)	2.2.3	2020	1.6%	2.1	5.2	1.9	1.9	11.1	4.6	1.5	1.8	1.3	9.2	2.6
Proportion of population using safely managed drinking-water services (%)	6.1.1	2020	100%	59	37	66				59	18			
Proportion of population using safely managed sanitation services (%)	6.2.1	2020	100%	39	65		46			61	49		26	
Proportion of population using hand-washing facility (%)	6.2.2	2020	100%	58	92		68	94	96	75	62		85	28
Proportion of population with primary reliance on clean fuels and technologies (%)	7.1	2020	100%	25	80	12	68	85	99	31	35	32	84	14

Already achieved the global SDG target

Expected to achieve the global SDG target by 2030

Need to accelerate current efforts

Showing reverse trend since 2015 and will not achieve the SDG

Source: WHO Global Health Observatory accessed 5 May 2022.

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(11) WHO Global health estimates: leading cause of Deaths.

(12) WHO Global health estimates: leading cause of DALYS.

PART 2
Financial protection: Leaving no one behind

This section provides a comprehensive overview of the progress towards SDG target 3.8.2 on financial protection.

Financial hardship is a key consequence of inadequate financial protection

Financial protection is at the core of universal health coverage[1]. It is achieved when: (i) there are no financial barriers to access; and (ii) direct payments required to obtain health services (also referred to as out-of-pocket health spending or OOP) are not a source of financial hardship[2]. Financial hardship is tracked with two metrics: the incidence of catastrophic health spending, defined as the percentage of the population with a large share of their household budget[a] dedicated to healthcare, i.e., exceeding 10% or 25% for the Sustainable Development Indicator 3.8.2 monitoring. But the poor and the near poor may be forced to divert spending on necessities to spend on health, even if their OOP health spending is not relatively large in absolute values or in proportion to their household budgets. When that happens, they reduce their non-medical consumption to below or further below the level indicated by a poverty line. The total population with impoverishing health spending is identified as the sum of those impoverished and further impoverished due to OOP health payments. For the former, OOP health spending exceeds the shortfall between the poverty line and their total consumption. The latter identifies poor people spending any amount on health OOP as a proportion of the total population[3].

This chapter complements the evidence presented on catastrophic health spending for almost all Member States in the Region, with indicator of impoverishing health spending. The line of extreme poverty (PPP$ 1.90 a day per person) is used to link financial hardship in health with the SDG target 1.1 about eliminating extreme poverty. Evidence on financial barriers to access is not yet as systematically available for all Member States. When it is, it is based on self-reported information collected in household surveys. More efforts are needed to track this critical consequence of inadequate financial protection mechanisms[3].

Countries in the SE Asia Region made mixed progress towards reducing financial hardship before the COVID-19 pandemic, and in many countries, the poorest were the most affected by financial hardship

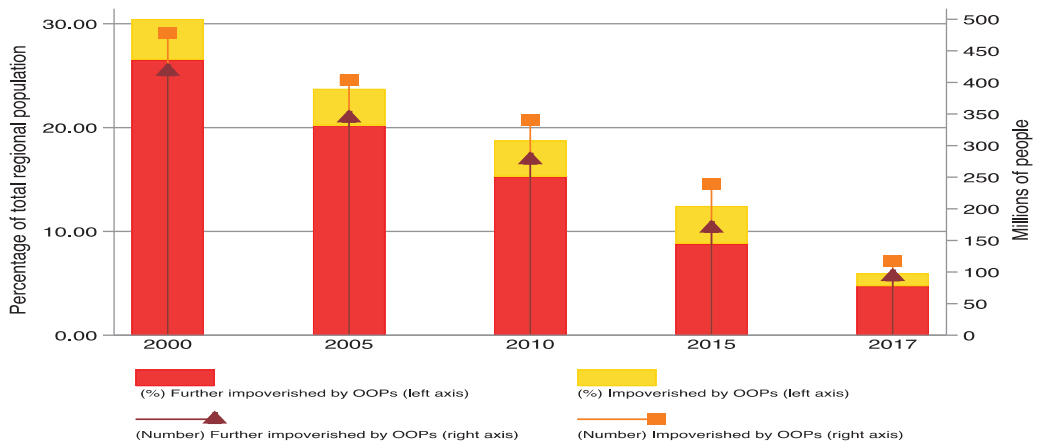
How many people experienced financial hardship, and who experienced it?

The total population both impoverished and further impoverished due to OOP health spending (living with less than PPP$ 1.90 a day per person) decreased drastically in the Region from almost 30% in 2000 to about 6% in 2017. The fastest reduction occurred between 2015 and 2017 when the rate halved (Fig. 9). The overall reduction occurred during rapid economic growth, coupled with large-scale

a Defined as total household consumption.

poverty reduction programs[4] and reforms aiming to improve service coverage while reducing financial hardship[5,6]. Nevertheless, it is important to note that until 2015, the decrease was driven by fewer people being further impoverished (i.e., fewer poor people spending any amount on health out of their pocket) while the number of non-poor pushed into extreme poverty continued to increase, although at a much lower rate. Their rates declined only after 2015, and despite such a positive outcome, the overall number of people with impoverishing health spending in the Region remained high (117 million in 2017) making it the second highest compared to other WHO regions.

Fig. 9. **Trends at the regional level in impoverishing OOP health spending at the PPP$ 1.90 poverty line between 2000 and 2017**



Source: Data from the global database on financial protection assembled by WHO and the World Bank, 2021 update[7,8]. *Notes: PPP*=Purchasing Power Parity.

Across countries, rates of impoverishing health spending ranged from less than 1% in the Maldives (2016), Sri Lanka (2016) and Thailand (2019) to more than 10% in India (2011), Nepal (2016) and Bangladesh (2016) (Table 3). OOP health spending can exacerbate poverty[9]. In the Region, the poor spending any amount on health OOP (those further impoverished by OOPs) accounted for at least two-thirds of the total population incurring impoverishing health spending. This was the case in five out of the ten countries where such rate exceeded 1% (Table 3). These people are forced to divert spending from non-medical necessities further below minimum living standards. When such reduction concerns food it might negatively impact their health. When the poor and near poor reduce spending below the poverty line, they are likely to enter an un-ending cycle of poor health condition which might lead to more OOP spending in the future.

Table 3. **Population with impoverishing health spending at the PPP$ 1.90 per day poverty line across countries in the Region, the latest available year**

Time period	Country (Year)	(%) Further Impoverished by OOPs	(%) Impoverished by OOPs
2010–2014	Timor-Leste (2014)	7.83	0.80
	India (2011)	16.16	4.71
2015–2018	Maldives (2016)	<0.01	<0.01
	Thailand (2019)	<0.01	<0.01
	Sri Lanka (2016)	0.20	0.08
	Bhutan (2017)	0.34	1.17
	Myanmar (2017)	0.88	1.22
	Indonesia (2017)	4.42	0.44
	Nepal (2016)	8.52	1.87
	Bangladesh (2016)	7.68	3.72

Source: Data from the global database on financial protection assembled by WHO and the World Bank, 2021 update[7,8]. Numbers in India are relatively higher compared to other countries, but they refer to a less recent year (2011) than other Member States with more recent estimates. In upper-middle-income countries, impoverishing rates based on the extreme poverty line are very low (below 0.01%).

Catastrophic health spending has increased almost continuously at the regional level since 2000 and across most countries, but some have managed to stop its rise. Between 2000 and 2017, the incidence of catastrophic health spending as measured by SDG indicator 3.8.2 at the 10% threshold increased from 12.6% to 15.2% of the population, and from 2.8% to 5.4%, using the 25% threshold. However, when looking at the trends across countries, some countries managed to decrease the incidence of catastrophic health spending (Fig. 11). Thailand is a notable example, where the proportion of the population spending more than 10% of a household budget on health OOP decreased continuously from 5.6% in 2000 to 2.2% in 2017, and further to 1.9% by 2019. This happened while increasing population healthcare service coverage and providing a comprehensive benefits package to the whole population (Box 5). Sri Lanka managed to stop the rise in large OOP expenditures between 2005 and 2016 while increasing government priority to health. More recently, Maldives (2009 to 2016) and Myanmar (2015 to 2017) also managed to stop the rise in the incidence of catastrophic spending. Over such periods, Maldives' public spending on health more than doubled and was channelled through a social health insurance scheme covering over 94% of the population by 2016[11]. Bhutan (2003 to 2017) and Timor-Leste (2003 and 2014) managed to stop a significant rise in the incidence of catastrophic health spending, which was concurrent with an increase in government priority to health measured by government spending per capita, which increased in Bhutan from current US$ 26 to US$ 73, and in Timor-Leste from US$ 7 to US$ 46 between 2003 and 2016[11].

Fig. 10. **catastrophic and impoverishing spending in the SE Asia Region, 2017**

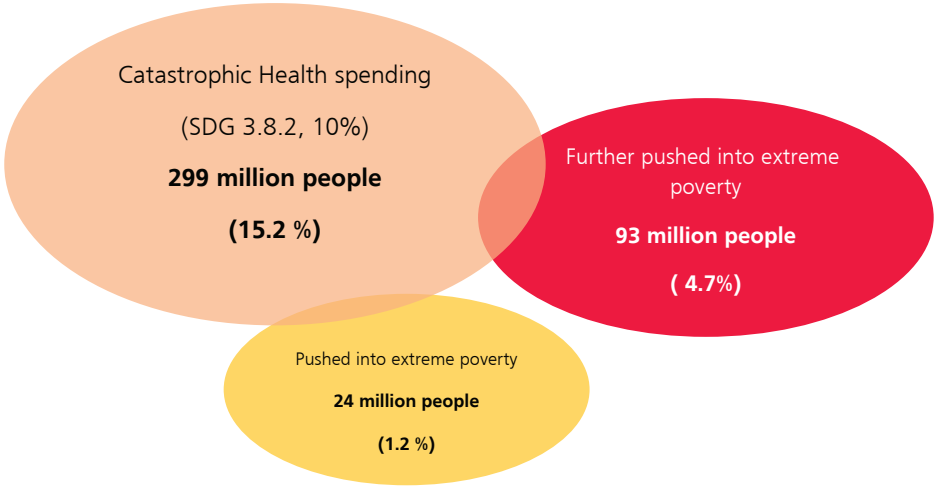
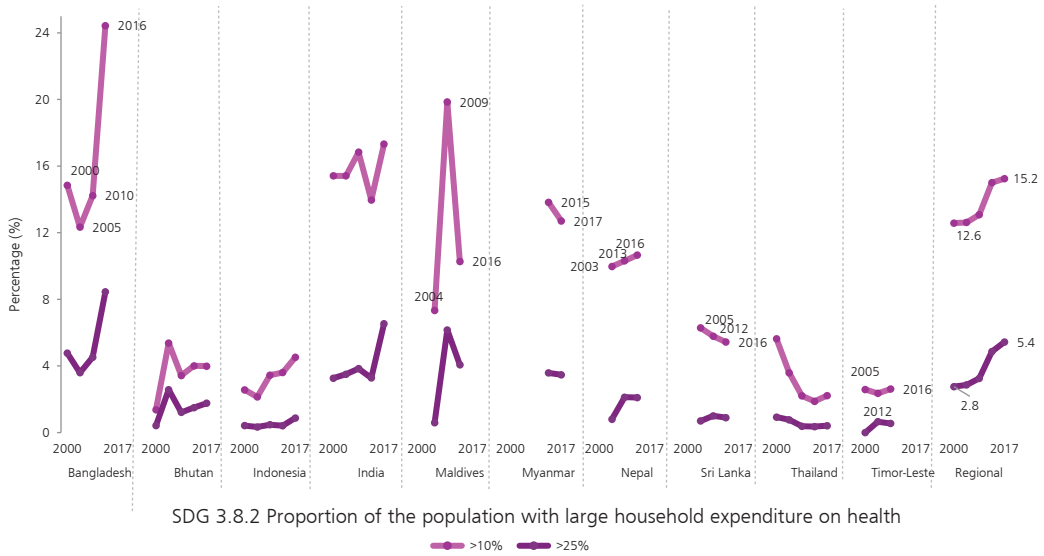


Fig. 11. **Trends in catastrophic health spending as tracked by SDG indicator 3.8.2, regional and countries (2000–2017 period, years indicated for countries with few point estimates).**



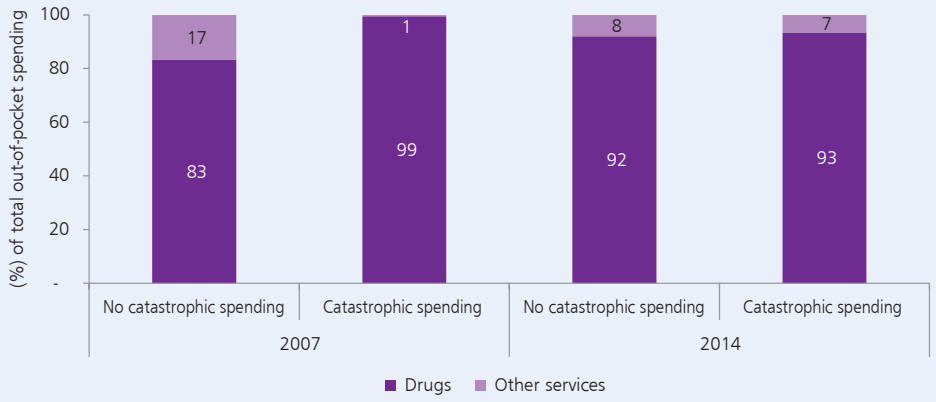
Source: Data from the global database on financial protection assembled by WHO and the World Bank, 2021 update[7,8]. *Note:* The regional average is estimated based on methods described in the global report.

Box 4. Timor-Leste government commitment to improve financial protection

In Timor-Leste, the UHC service index increased substantially between 2000 and 2017, from 33% to over 50%. Between 2003 and 2017, public spending on health increased both per capita (current US$ 7 to US$ 57) and as a share of GDP (1.3% to 4.5%)[11]. While the incidence of catastrophic health spending (10% threshold) fluctuated between 2.4 and 2.6 between 2001 and 2014, and the proportion of the population incurring larger expenditures (25%) on health reached 0.7% at most in 2007. A study showed that medicines were the main drivers of OOP health spending[12], especially for those in the lowest consumption quintile who reported minimal spending on health services. This result is consistent with how health services are funded in Timor-Leste, i.e. predominantly through public resources where services are provided free at the point of service at both public and private facilities[13].

However, between 2007 and 2014, for those in the poorest quintile, spending on medicines increased for those without catastrophic health spending, while it decreased for those with catastrophic health spending. The reduction occurred while policies aiming to improve the accessibility and affordability of medicines were introduced, such as the *National Drug and Medicines Policy in 2010*. In 2019, Timor-Leste launched a health financing strategy with the objective to make further progress on financial protection. Through the strategy, Timor-Leste aimed to leverage financing mechanisms, including strategic purchasing, and improve efficiencies to reduce inequities[14]. More recent data is needed to examine the impact of the health financing strategy on financial protection.

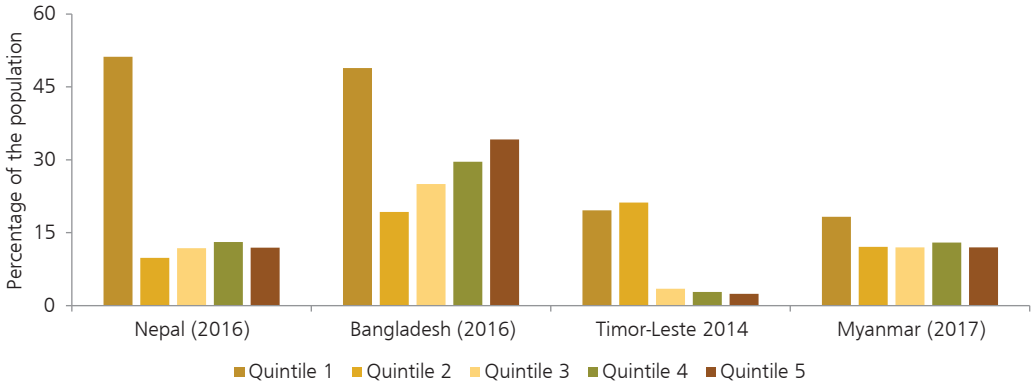
Composition of OOPs for people in the poorest quintile with and without catastrophic health spending as tracked by SDG indicator 3.8.2 at the 10% threshold, between 2007 and 2014.



Source: Background data prepared by WHO for the 2021 update of the WHO and World Bank global financial protection database.

Overall, people in the poorest and near poor quintile faced the highest rates of financial hardship in countries with impoverishing health spending exceeding 2% (Fig. 12). Incidence rates in the first quintile ranged from less than 20% of the population incurring financial hardship due to OOP health spending in Myanmar (2017) and Timor-Leste (2014) to over 45% in Nepal and Bangladesh (2016). By contrast, in the richest consumption quintile, the incidence did not exceed 15%, except in Bangladesh (2016), where the rate was high at 34.2% even in the richest quintile (Fig. 12).

Fig. 12. **Incidence of financial hardship* across per capita consumption quintiles, most recent estimate available, selected countries**

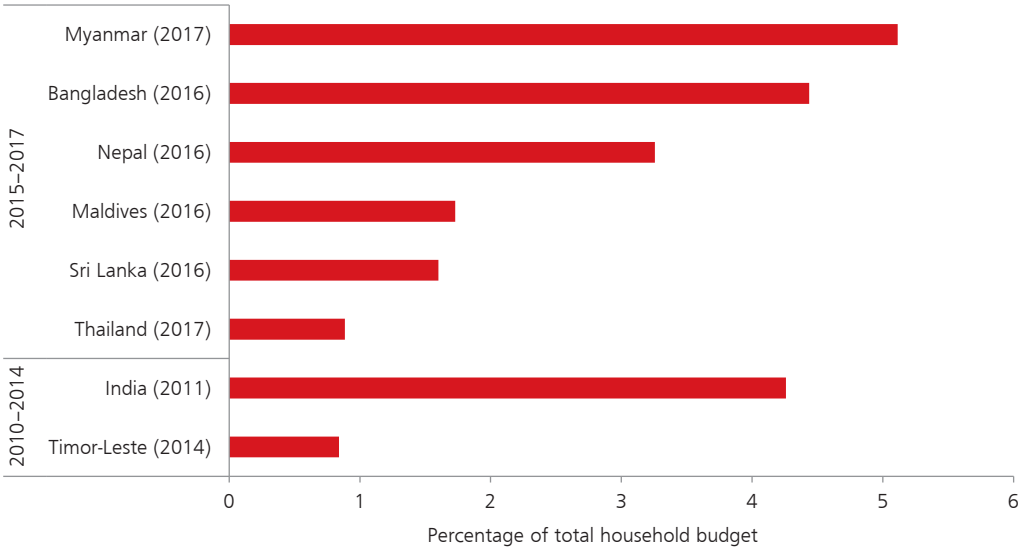


Source: Background data prepared by WHO for the 2021 update of the WHO and World Bank global financial protection database.
Note: Q=Quintile*Incidence of financial hardship is defined as the proportion of the population incurring catastrophic health spending (SDG indicator 3.8.2 at the 10% threshold), impoverishing health spending or both without double counting. All countries in this figure had rates of impoverishing health spending exceeding 2% (see Table 3).

How much was spent on health OOP by the poorest quintile, and for what type of health service or product?

In all countries in the Region, households in the poorest quintile spent on average less than 10% of their household budget on health, highlighting the need to track any amount spent on health OOP for the worse-off, even when they are not relatively large (Fig. 13) and also foregone care. Fig. 13 shows that the average amount spent on health as a share of the total household budget varied from less than 1% in Timor-Leste (2017) and Thailand (2017) and exceeded 3% in four countries, including three with the highest rates of impoverishing health spending prior to COVID-19 (Table 3).

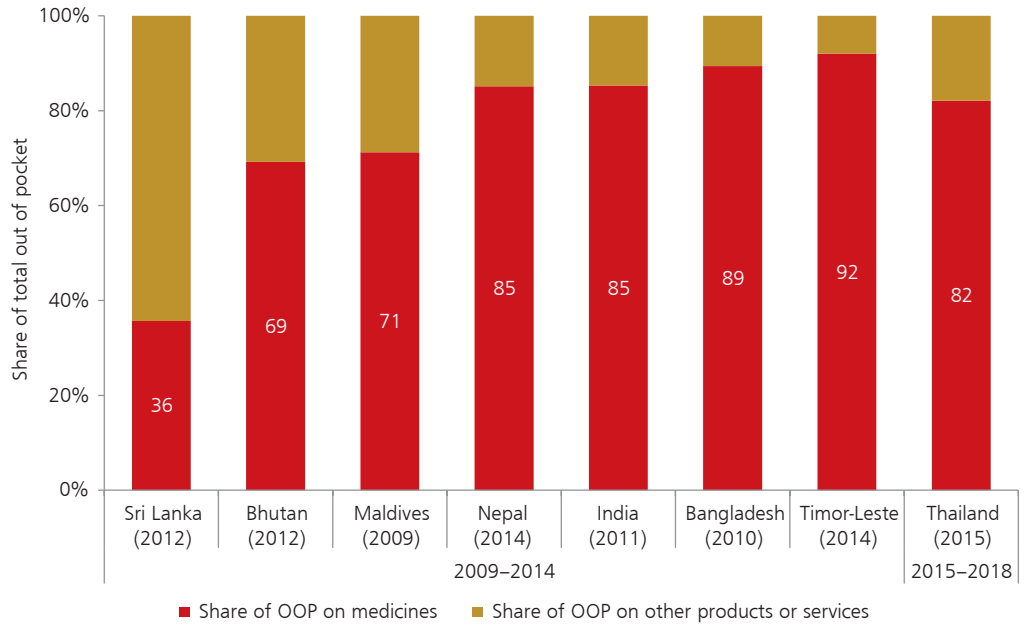
Fig. 13. **Average health expenditure budget share for those in the poorest quintile in select countries, latest available year**



Source: Background data prepared by WHO for the 2021 update of the WHO and World Bank global financial protection database.

Evidence on the drivers of OOP health spending for those in the poorest quintile shows that in the SE Asia Region, the worse-off were spending mostly on medicines (Fig. 14). Evidence on the importance of OOP spending on medicines is available for eight countries in the Region. However, the data is outdated- for some countries it is over ten years old; so more recent evidence is much needed. Nevertheless, it clearly shows the predominant role of medicines on household OOP spending. Its share in the poorest quintile of each country exceeded on average 69% in all countries but Sri Lanka (2012). It also shows that households in richer quintiles spent less on medicines compared to the poorest quintiles[12], which could be explained by the greater reliance on pharmacies instead of accessing health services (e.g. health clinics or individual physicians for consultation and diagnostic) for the poorest quintile compared to the richest quintile[15,16].

Fig. 14. **Average composition of OOP spending for the lowest quintile, sub-sample of countries, latest available evidence**

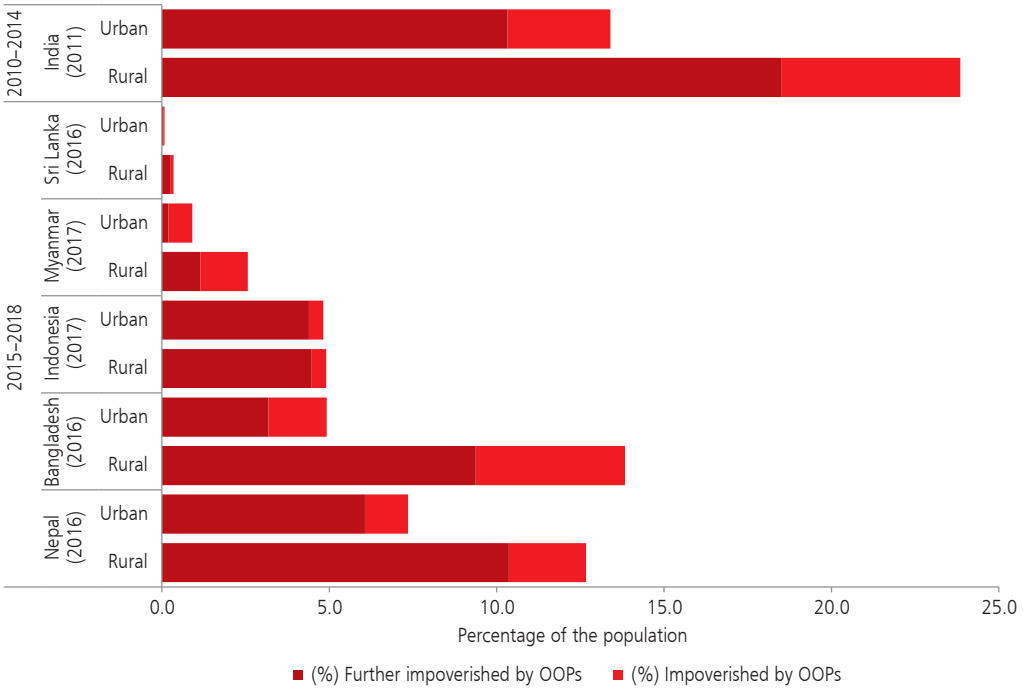


Source: Data extracted from Table 7 in[12] and data for Timor-Leste based on background data prepared by WHO for the 2021 update of the WHO and World Bank global financial protection database.

Where did the people facing financial hardship live?

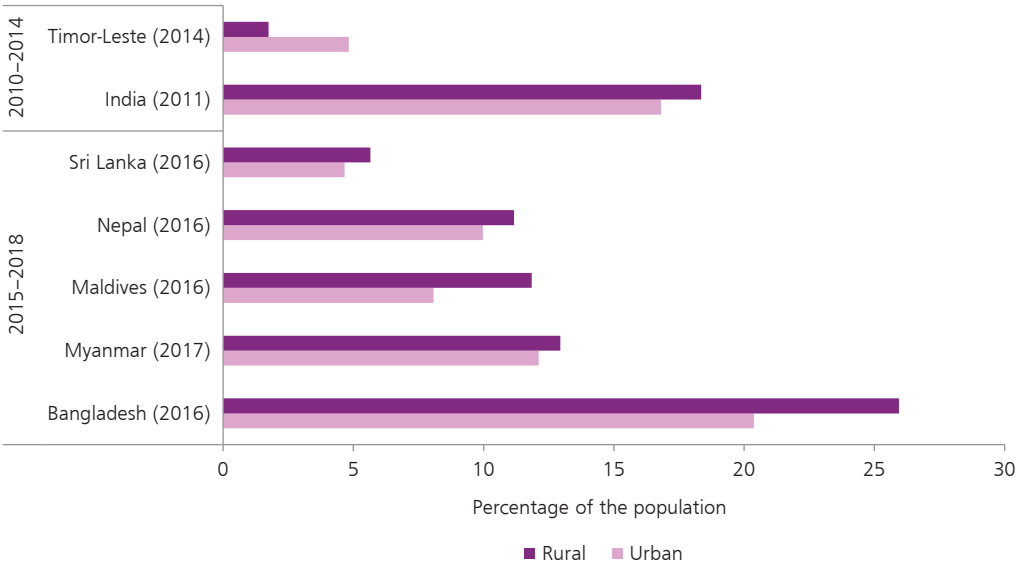
People living in rural areas had higher rates of impoverishing OOP health spending as compared to people living in urban areas. In 2017, the share of the population living in rural areas ranged from 38% to 50% in Indonesia, and Thailand to between 70% to 82% in Timor-Leste, Myanmar, Nepal and Sri Lanka, and remained roughly the same proportions by 2021 with 1–2 percentage point decreases in Bhutan, Bangladesh, Indonesia, Maldives, and India[17]. The rate of people impoverished and further impoverished due to OOP was consistently higher among rural residents than urban ones, but with varying relative differences within countries (Fig. 15a). Sri Lanka (2016) had the lowest rural rates at 0.3% which were still three times higher than the urban proportion. Myanmar (2017) and Bangladesh (2016) were among the countries with the highest rural/urban inequalities in the incidence of impoverishing OOP health spending. It was followed by India (2011), and Nepal (2016). In countries where the incidence of catastrophic health spending exceeded 5%, rural residents also faced the highest rates (Fig. 15b). However, urban residents were the most affected by catastrophic health spending in countries with low national rates (Timor-Leste-2014, Indonesia-2017 and Thailand-2019). With higher levels of financial hardship experienced by rural residents, people living in rural areas in the Region tend to have lower coverage of essential health services and lower access to healthcare[18]. One study in Bangladesh found that self-medication practices were notably high among individuals with poor access[19]. Similarly, a study in India showed that self-medication practices were driven by financial barriers to access health care providers[20].

Fig. 15a. **Incidence of impoverishing due to health spending at the extreme poverty line (PPP$ 1.90 per day) by areas of residence, latest available estimates**



Note: In upper-middle-income countries, impoverishing rates based on the extreme poverty line are very low (below 0.1%). Hence, the values for Maldives 2016 and Thailand 2019 are not visible.

Fig. 15b. **Incidence of catastrophic health spending (SDG indicator 3.8.2 at 10% threshold) by areas of residence, latest available estimates**

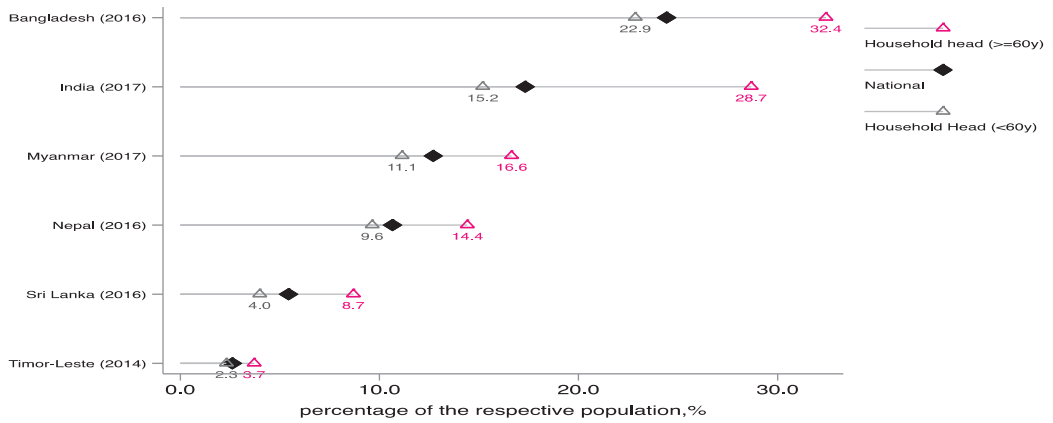


Source: Data from the global database on financial protection assembled by WHO and the World Bank, 2021 update[6,7].

Were there inequalities in the incidence of financial hardship by the age of the householder?

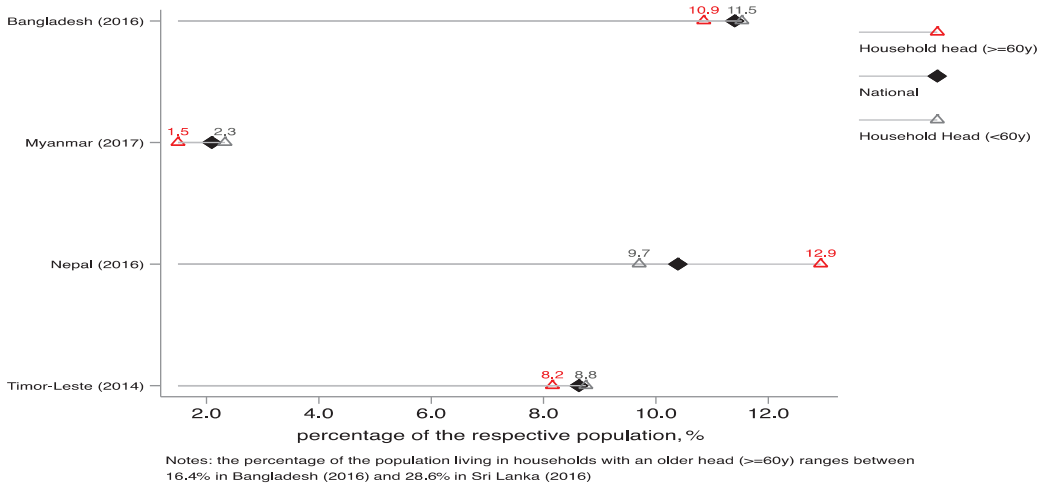
In countries with available data, people living with a household head older than 60 faced higher rates of catastrophic spending (Fig. 16a), while those living with householders younger than 60 faced higher rates of impoverishing health spending (Fig. 16b). Inequalities by the age of the householder were more substantial for the incidence of catastrophic health spending than for impoverishing health spending. People living with older heads of household (aged at least 60 years old) represented between 16.4% (Bangladesh, 2016) and 30.9% (Sri Lanka, 2016) of the total population. In four of the six countries with data on the incidence of catastrophic health spending by the age of the household head, inequalities were marked (Fig. 16a), with incidence rates systematically higher among those living with older household heads, between 1.4 (Bangladesh, 2016) and 1.9 (India, 2017) times greater and even more than doubled in Sri-Lanka (2016) compared to the rates among those living with household heads younger than 60. This is especially important given the rise in the proportion of the population over 65[5] and the tendency of older adults to have higher rates of noncommunicable diseases[21]. Many of the adverse NCD risk factors are concentrated among the low-income people, which may increase the disease burden among the poorest segments of the population[22]. Nepal (2016) is the only country where the incidence of impoverishing health spending was also higher among those living with older household heads (Fig.16b). In Timor-Leste (2014), Bangladesh (2016) and Myanmar (2017), the incidence of impoverishing health spending was higher among those living with younger heads (below 60) relative to those living with older head of household but the level of inequality across these two groups vary between these three countries. It is the highest in Myanmar 2007 and the lowest in Timor-Leste (2014).

Fig. 16a. **Incidence of catastrophic spending as tracked by SDG 3.8.2, 10% threshold by the age of the householder, most recent estimate, across countries.**



Notes: the percentage of the population living in households with an older head (>=60y) ranges between 16.4% in Bangladesh (2016) and 30.8% in Sri Lanka (2016)

Fig. 16b. **Incidence of impoverishing health spending (impoverished and further impoverished) at the extreme poverty line (PPP$ 1.90 per day) by the age of the householder, most recent estimate**



Source: Background data prepared by WHO for the 2021 update of the WHO and World Bank global financial protection database.

How is financial hardship related to public investment in health?

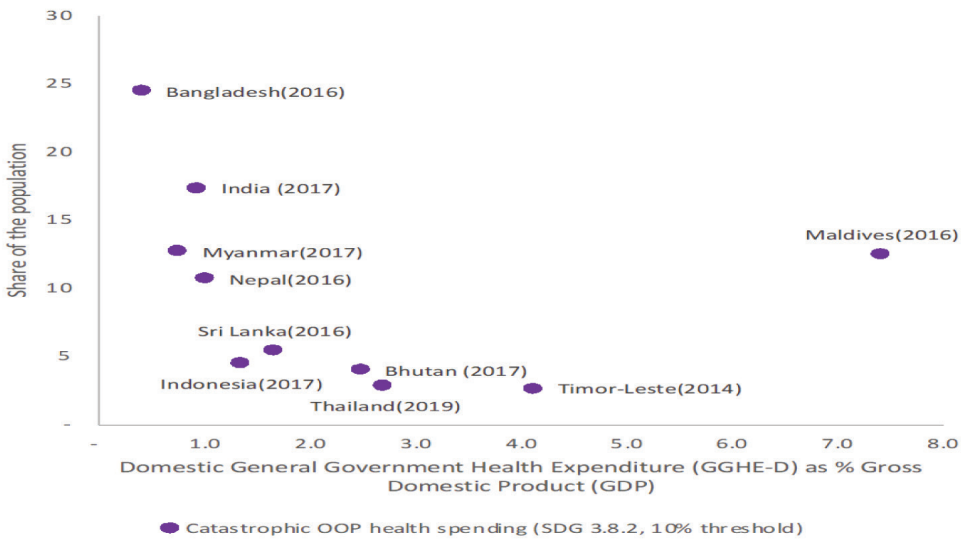
Higher public spending on health is critical and associated with lower financial hardship. As shown in (Fig. 17a) higher government spending on health as a share of GDP is associated with lower financing hardship. In the region, government spending on health as a share of GDP ranged from 0.41% in Bangladesh (2016) to 7.4% in the Maldives (2016). In Bhutan, Maldives, Thailand and Timor-Leste, where over 2% of public funding is spent on health as a share of GDP, it seems to be associated with a lower than 4% average incidence of catastrophic spending. Whereas countries with less than 1% of their GDP spent on health by public sources, the incidence of catastrophic spending tended to be higher than 10%. In Indonesia (2017) and Nepal (2016), almost all poor people incur OOP health spending, and public spending is less than 1.5% of GDP. In India (2011), Timor-Leste (2014) and Bangladesh (2016), there are high rates of extreme poverty, and between one-third and two-thirds of poor people are spending on health OOP, and public spending on health is low.

Beyond fiscal capacity: Public spending reflects health priority, which is a political choice[23]. Countries with higher income tend to have higher fiscal capacity, and governments tend to spend more in general[23]. However, within countries in the Region with the same income levels and fiscal capacity, the extent to which public funding is allocated to health is a political choice. The amount of money available reflects prioritization and commitment, and all countries can commit to reducing financial hardship at all income levels. Thailand is an example that financial hardship can be reduced regardless of income status, as Thailand introduced a large-scale financial protection scheme for the poor and those in the informal sector (UCS) in the aftermath of the 1997 financial crisis (Box 5).

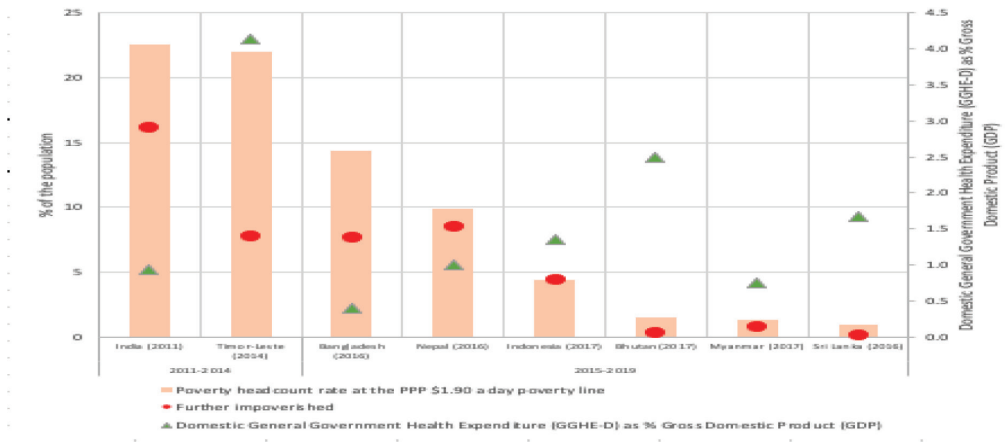
Higher public spending on health is necessary but not sufficient to reduce financial hardship: how it is spent also matters. Efficient use of funds and additional and effective coverage policies are critical (Fig. 17). Among countries with a similar level of government spending on health (e.g. India 2011, Myanmar 2017 and Nepal 2015 in Figure 17 panel b), the incidence of impoverishment and impoverishing OOP health spending varied, showing that reducing financial hardship goes beyond increasing public spending. For example, due to gaps in the coverage of medicines which is the main driver of OOP in the Region. Therefore, how public funds are spent also matters. Also, how funds are spent across the population matters. For example, in countries with poverty rates below 2% such as Bhutan, Myanmar and Sri Lanka, identifying the poor and implementing policies targeted at the poor is essential to eliminate the possibilities of these population groups being further pushed into extreme poverty by OOP health spending.

Fig. 17. **Financial hardship versus. public spending on health, the latest year available**

(a) Incidence of catastrophic health spending versus public spending on health as a share of GDP



(b) Proportion of the population further impoverished (poverty rates at the PPP$ 1.90 a day poverty line) and public spending on health as a share of GDP



Source: Data from the global database on financial protection assembled by WHO and the World Bank, 2021 update[7,8] and public spending indicators extracted from the Global Health Expenditure Database[11]
Notes: In upper-middle-income countries of Maldives and Thailand, impoverishing rates based on the extreme poverty line are very low (below 0.1%). Hence their values are not visible in the Figure. GDP=Gross Domestic Product, PPP=Purchasing Power Parity.

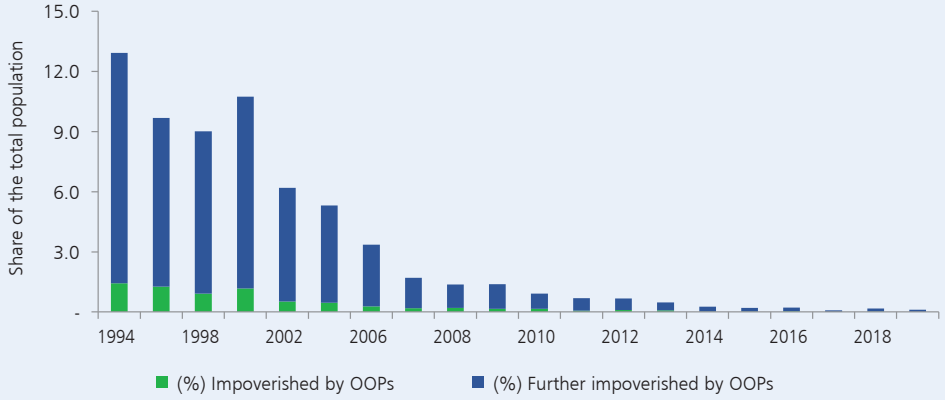
Box 5. Thailand reform to increase financial Protection

Since 2002, Thailand has used three different public-funded health insurance schemes to cover all of its population[24]: a Civil Servant Medical Benefit Scheme (CSBMS) for government employees and retirees and their dependents; a Social Health Insurance (SHI) for employees in the formal private sector ; and (3) the Universal Coverage Scheme (UCS) for the remaining and vast majority of the population who were not covered by CSMBS and SHI[6]. Thailand's UCS scheme design comprised a comprehensive benefits package and zero co-payment at the point of service[6,24]. Government spending in Thailand accounted for over 50% of current health spending in 2000 and reached 71.2% in 2019[11]. Overall, Thailand reduced the incidence of catastrophic spending by more than 70%, from 6.7% in 1994 to 1.9% in 2019. A similar pattern is observed in the share of the population pushed and further pushed below the poverty line, which was 2% in 1994 and reduced to less than 0.1% in 2019.

Catastrophic spending in Thailand between 1994 and 2019

Source: Data from the Global database on financial protection assembled by WHO and the World Bank, 2021 update[7,8].

Share of the population pushed and further pushed under the $ 1.90 poverty line, 1994 and 2019



Source: Data from the Global database on financial protection assembled by WHO and the World Bank, 2021 update[7,8].

To what extent is it important to reduce financial hardship on the path to UHC?

In the SE Asia Region, service coverage increased over the past 17 years, with a paradox trend where more people incurred catastrophic spending but less impoverishing expenditure at the extreme poverty line ($ 1.90) (Fig. 2 and Fig. 9). In the SDG monitoring framework, service coverage is tracked with a score based on 13 indicators aggregated to indicate an average level in a country. On average, UHC service coverage index of health services increased from 30 in 2000 to 61 in 2019, while catastrophic spending was lagging behind. The incidence of the latter worsened from 12.6% of the population in 2000 to 15.2% in 2017. While the improvements in service coverage were impressive, the regional pace remained below the global progress and is inadequate to reach the SDG target score of 80. However, as tracked by related SDG indicators, starting points and trajectories on the path to UHC varied substantially within the region between 2000–2017 (the period for which data are available for both indicators).

Five countries made progress in reaching relatively high service coverage levels while maintaining relatively low rates of catastrophic health spending (Fig. 2). Within this group, Thailand was the only country to continuously increase service coverage and exceed both the global and regional 2017 values while decreasing the incidence of catastrophic health spending[3]. Most recently, Bhutan, Maldives and Sri Lanka also increased service coverage while stopping the rise in catastrophic health spending rates. Although Indonesia has experienced a steady increase in SDG indicator 3.8.2, it managed to keep it below 5%. Indonesia and Bhutan while they remain in Quadrant IV, were making progress in reaching quadrant I before the pandemic. While Nepal and Timor-Leste improved service coverage, they experienced stagnant trends in catastrophic health spending rates.

Despite increases in service coverage, Bangladesh and India were experiencing difficulties in preventing increases in catastrophic health spending rates – based on the latest available data: 2016 for Bangladesh and 2017 for India. The two countries had the highest incidence consistently in the Region. This means that service coverage expansion could be driven by increased incomes but that has not yet translated to improved financial protection in India and Bangladesh.

What has the COVID-19 pandemic meant for countries' trajectories towards improved financial protection?

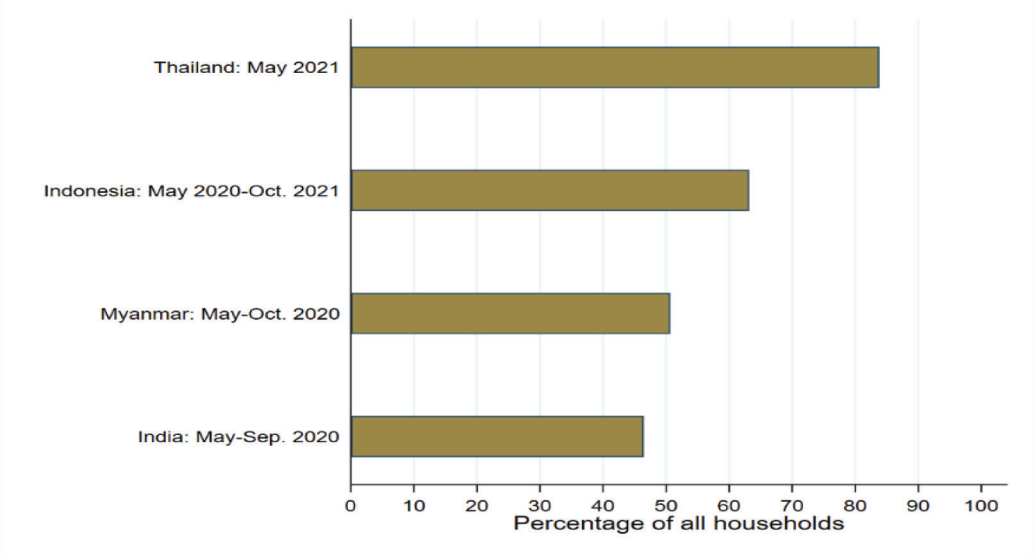
The Coronavirus Disease (COVID-19) pandemic has affected the economy, health, poverty, employment and other sectors globally. A pressing issue emerging during the pandemic due to the reduced economic activity is the high rates of extreme poverty[25]. While some countries in South-East Asia have started to recover economically, this is not consistent across countries. And where it is happening, recovery has still not reached pre-pandemic levels, fluctuations are expected in line with the emergence of COVID-19 variants[25], and effects are exacerbated by the war in Ukraine and the rise in inflation[26]. As a result, supply chain pressures translate into limited production capacity and transportation restrictions leading to global shortages of critical medical products[27]. Additionally, low-middle income countries did not have sufficient access to vaccines and treatment, which had economic implications[28].

During the COVID-19 pandemic, close to 50% of households reported reduced consumption of goods (essential or non-essential) during the pandemic, at a particular period. This reduction ranged from 40–50% of households in India and Myanmar to over 80% in Thailand (Fig. 18). This reduction in consumption overall can have an impact on financial hardship due to healthcare payments and driving impoverishment due to the reduction in households' capacity to pay. Also of concern is foregone healthcare due to reduced capacity to pay.

Given the COVID-19 pandemic, there is limited data on OOP health spending and its drivers from nationally- representative household budget surveys during 2020/21. However, there is evidence that many households were foregoing care for financial reasons. Fig. 19 shows that between 1% and as much as 13% of the households in need across five countries in the Region faced financial barriers. This could be due to two likely scenarios. One, the levels of OOP might have declined, and forgone care may have increased due to social distancing measures, service disruption, especially for NCD care as seen in India[29]; or by fear of seeking care, transportation limitations and other barriers, as seen in Nepal[30]. Second, worsening poverty and drops in households' income might also lead more people to face financial barriers to accessing needed services.

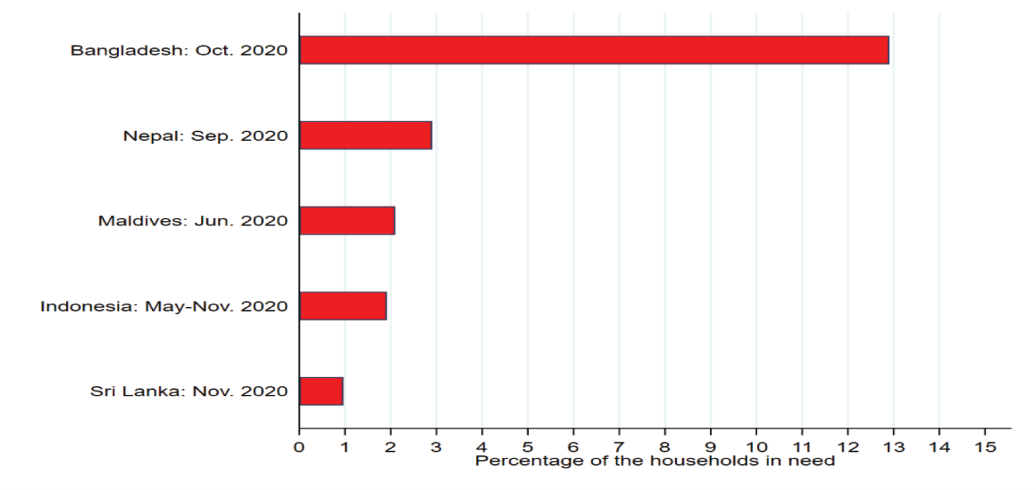
For those seeking care, financial hardship could increase. Some types of spending could also increase further such as self-medication, and new demand for OOP spending related to COVID-19 preventive, diagnostic and treatment measures, including vaccination, might also increase for the whole population[31]. One study in India provides

Fig. 18. Reducing consumption of (essential or non-essential) goods during COVID-19 (2020 and 2021)



Source: The High-Frequency Phone Survey-based estimates and in the case of India, figures are based on COVID-19-related shocks survey in rural India 2020. Accessed May 2022. *Note:* Countries are included based on data availability. The average percentage of households over multiple waves is used except for Thailand; the rate corresponds to 2021.

Fig. 19. Financial barriers to access health care within 2020/2021: proportion of households in need unable to receive medical attention due to lack of money



Source: World Bank COVID-19 Household Monitoring Dashboard (Accessed May 2022). *Note:* Countries included based on data availability. Rates are based on the first wave except in Indonesia, for which average across multiple waves were conducted.

insight into other possible drivers of catastrophic spending during the pandemic. It found that the incidence of catastrophic expenditure for non-COVID hospitalizations increased compared to pre-pandemic rates and was significantly higher among the poor, possibly due to the overcharging practiced by private hospitals[32].

The increase in forgone care and the increase in financial hardship due to OOP among health spenders suggests that progress towards UHC will be detrimentally impacted by COVID-19. Even if financial hardship decreases, it will likely represent foregone care rather than actual improvement in financial protection.

What are the policy implications of the available evidence for the Region?

This Part of the report has provided a regional overview of progress towards SDG target 3.8.2 on financial protection. The evidence suggested that prior to COVID-19 pandemic:

- Health systems in the WHO SE Asia Region were largely funded through out-of-pocket health spending - with more than half of the countries in the region spending more than one third of their current health spending from household out-of-pocket, in 2019[1].
- On average, public spending accounted for 35% of current health spending, with a wide variability across countries from 16% to 79%[11].
- The number of people incurring impoverishing health spending had decreased in the past decade, yet it remains high. As of 2017, 117 million people in the Region were pushed or further pushed under the PPP$ 1.90 (purchasing power parity) a day poverty line due to out-of-pocket payments (Fig. 1).
- In 2017, 299 million people (poor and non-poor) faced catastrophic health spending as their OOP absorbed more than 10% of their household budget.
- Catastrophic health spending has increased almost continuously at the regional level since 2000 and across most countries, but some have managed to stop its rise.
- Out-of-pocket spending was predominantly driven by spending on medicines[12].
- People living in rural areas, in the lowest income quintile and in households with adults older than 60 years experienced a higher rate of financial hardship due to out-of-pocket health spending.
- Adding to financial hardship, available evidence suggests that rates of foregone care were high among the poorer segments of the population in several countries in the region[33,34].

During the COVID-19 pandemic it was observed that:

- Data on out-of-pocket spending and its drivers from nationally representative household budget surveys is limited in the region. This makes timely monitoring of progress on financial protection a challenge where the latest information available is till 2016–2017 for most countries; and for two countries it is between 2010 and 2014. The Region therefore faces a gap in information on trends in financial hardship since the onset of the COVID-19 pandemic.

- Between 2020 and 2021, based on data for four countries in the region, almost 50% of households reported reducing consumption of goods (essential or non-essential) during the pandemic, which means less capacity to pay for healthcare. Data for five countries shows that many households did not seek care due to financial reasons between 2020 and 2021. This might have caused an increase in forgone care. At the same time, less capacity to pay for health care might lead to more people impoverished by out-of-pocket health spending and/or higher rates of catastrophic health spending among those paying out-of-pocket for health.
- In 2022, two years since the start of the pandemic, countries in the Region have begun to recover economically. However, recovery has still not reached pre-pandemic levels, fluctuations are expected in line with COVID-19 variants[25], and some countries and population groups are struggling more than others to recover. This has further implications for continued: foregone care due to financial barriers and greater financial hardship due to OOP, especially among vulnerable groups.

In this context, critical policy implications related to the rates of financial hardship in the region to be considered by Member States in the Region include but are not limited to:

1. **Increasing public spending on health to continue promoting a decline in OOP, especially on medicines and targeted on the poorest segments of the population[35, 36, 37].** Government spending on health has been associated with a lower incidence of financial hardship[38]. In the SE Asia Region, pre-pandemic trends showed a heavy reliance on OOP health spending and low public spending on health among several countries in the region. Specifically, almost all poor people in Indonesia and Nepal incurred OOP health spending. Hence, public spending should be prioritized to reduce the financial hardship experienced by the poorest first. Additional public funds are needed for a significant reduction in OOP since public spending on health ranges between 1.1% and 1.4% of GDP, respectively. In Bangladesh, India and Timor-Leste where there were low levels of public spending, high rates of extreme poverty and between one and two-thirds of poor people spending on health OOP: increasing public spending is critical. In order to maintain their health spending growth at pre-pandemic rates, most countries will need to significantly increase the share of their government spending on health, especially among countries with lower pre-pandemic levels of public spending on health[39]. To reduce OOP on medicines, increasing public financing for medicines through prepayment mechanisms is critical[40,41].

2. **Enhancing fiscal policies that support health outcomes and can generate additional revenues:** Health taxes, for example taxes on consumption that is harmful for health, such as the consumption of alcohol, tobacco, sugar; but also reduced subsidies on fossil fuels and a tax on carbon emissions – could be introduced or significantly scaled up[35]. In times of economic crisis, these fiscal policies may play an important role in increasing public revenues, even though the main objective of health taxes are to improve health by addressing risk factors[78]. These could be win-win policy avenues for Members States to navigate their way through the tightened macro-fiscal environment they are experiencing.

3. **Improving efficiency and reducing fragmentation in the health systems while moving towards strategic purchasing mechanisms can contribute to financial protection[37].** Improving efficiency is even more critical now with the detrimental effects of the pandemic and the politico-economical turmoil globally and given limited fiscal capacity in several countries in the Region. Several countries in the Region face fragmentations within their health care systems, leading to inequities in financial protection across population groups[42,43]. Effective provider payment mechanisms have been associated with efficiency improvements and can reduce financial constraints on the health system[6,24,38]. However, purchasing across the Region tends to remain passive, except in Indonesia, Thailand, and India, which are moving towards more strategic purchasing mechanisms[35]. Specifically, in Thailand, a comparison across schemes suggests that effective management of the strategic purchasing function can contribute to financial risk protection and to a reduction in spending overall[44,45]. Identifying sources of waste or suboptimal spending and reducing fragmentation can also allow more fiscal space for health[37]. Sri Lanka which faces the largest economic crisis since its independence, with limited fiscal space for health due to pre-COVID economic factors further exacerbated by the COVID-19 pandemic would benefit from sustaining the current levels of health spending and focusing on improving the efficiency and reducing fragmentation of its health system. For instance, by continuing the planned "Cluster Reform" - a PHC-focused reform bringing in the management of NCDs, preventive care, and ensuring patient-centered continuity of care. These would provide opportunities for integration at the primary care level and added efficiency gains[46]. Improvements in public financial management, including digitalization of procedures among other measures, can also contribute to making health systems more efficient and expanding fiscal space for health[47].

4. **Public investment in health systems is crucial but insufficient for reducing financial hardship: how the money is spent also matters.** OOP health spending can still be high if a health financing system does not offer comprehensive coverage or benefits across the population or if high co-pays are required for costly services[48]. Before the pandemic, there were still gaps in coverage across several countries in the Region[49,50]. In Bhutan, Myanmar and Sri Lanka, where there are relatively low levels of extreme poverty, it is not only the overall level of public spending that matters in reducing impoverishment due to OOP health spending, but targeted approaches are more relevant in those countries. However, overall, across all countries in the Region, there is a need to not only increase government spending on health but to ensure such increases are accompanied by effective health financing policy reforms that lead to expansion of coverage, including but not limited to:

   - **Increasing government allocation to PHC financing, which is more equitable and efficient.** Investing in PHC has been associated with health system efficiency and improved health outcomes and equity[51]. In the Region, spending on PHC ranges from 37% in Sri Lanka to 69% in Timor-Leste of current health spending[11]. Although there is no specific target for PHC spending, across LMICs it is found insufficient and/or funds are not spent

efficiently and equitably. Public funds for PHC should be allocated equitably across geographical regions and services[51].

- **Where feasible, introducing targeted policies to overcome barriers to access healthcare services, including eliminating OOP health spending for the poorest and near-poor segments of the population to ensure they are not paying for healthcare or foregoing care and a consideration of unconditional cash transfers to promote access.** Reducing OOP health spending or financial barriers is essential to protect households against financial risk and will contribute to eradicate poverty. Among the poorest households, even relatively small OOP spending on health is a source of financial hardship. Relying predominantly on public financing rather than on OOP health spending and exempting vulnerable population groups from contributions (where feasible) is especially important for achieving UHC[42] and higher degrees of financial protection. The requirement to pay OOP for health can lead to foregone care among the poorest segments of the population; the removal of user fees and co-pays at the point of service has been shown to positively affect access to healthcare services[52,53], if complemented by increases in government health spending that also focuses on expenditure flexibility[54]. In addition to financial barriers, geographical barriers (travel time, distances) have been identified as a challenge in certain countries in the Region[27,55,56], as well as other factors such as: uneven distribution of health services[27], lack of trust in public facilities, limited opening hours[46] and/or long wait times[27]. Several of these barriers have been associated with self-medication. In the region, the practice of self-medication is prevalent[19,20,57], and self-medication[15,16,41] may be driving spending on medical products. Therefore, overcoming these barriers to healthcare service access can reduce financial hardship. In addition to eliminating financial barriers, promoting access through unconditional cash transfers has led to increased health service utilization in several countries during times of crises[58].

- **Reducing OOP health spending on medical and other health products, especially by the poor and rural population, by developing and implementing cost-effective[b] benefits packages and pharmaceutical policies such as:**
  - Include essential medicines in the benefits package design[37].
  - Increase availability of quality medical products in public health facilities, make prescribed medicines available preferably without co-payments, prioritize generic medicine[59,60] and improve price transparency.
  - Structure incentives that encourage providers, dispensers and patients to make efficient and effective use of medicines and expand payment coverage in the private retail pharmacy[37].
  - Where feasible, considering the WHO guidelines on country pharmaceutical pricing policies[61].

b Including health technology assessments, especially in countries with systems in place to translate the evidence generated into policy.

A study in India showed that reducing OOP payments for medical products can significantly reduce impoverishment due to OOP payments for healthcare[62] therefore, targeted pharmaceutical policies can reduce financial hardship. Most countries in the region have defined and regularly updated their essential medicines list and state their intention to provide medicines free-of-charge in public healthcare facilities[12]. However, consistently across several countries, most people in South-East Asia report purchasing medicines at private pharmacies[63]. Several Member States in the Region have a large pharmaceutical industry and private retail sectors, such as in Bangladesh, India, Indonesia and Nepal[64,65]. Yet many of these countries still struggle with high levels of financial hardship. In countries such as Bhutan and Timor-Leste where there is no local production capacity and small private sectors[66], lack of availability in the public health facilities may result in no alternative options to access needed medical products. Furthermore, low volume requirements and fluctuations in importation costs impact the price of medical products. Relying on high prices of medicines in the private sector is a crucial driver of financial hardship for households in the region. Structuring appropriate incentives for providers, dispensers, and patients could also reduce OOP on medical products. For example, in certain countries in the region, potentially inappropriate medication has been identified as a concerning issue[67,68,69,70] driven by poor prescribing practices, inappropriate medication selection, supplier-induced demand[67,68], due to limited access to formally trained providers[70] or aggressive marketing of the pharmaceutical companies – such as in Bangladesh[71]. Further to provider practices, pharmaceutical policies can play a role in keeping medicine prices affordable such as encouraging the use of generics, given that patients often prefer to purchase pricier branded products over generics with the perception that generics are of inferior quality[72,73]; and in settings where the quality, safety and efficacy of drugs produced domestically is not subject to stringent controls by National Regulatory Authorities, providers and dispensers also tend to prescribe branded drugs as well.

- **Targeting policies and benefits package design: including essential medicines needed for managing chronic conditions[28] in response to demographic and epidemiological shifts and ensuring coverage of the health needs of people living in older or multigenerational households is needed, especially among the poorest population groups considering fiscal feasibility and service delivery reforms and orientation.** As the South-East Asia Region population is ageing rapidly, where it is expected that the population 60 years and above will be 20.3% by 2050[74], it is important to consider the policy implications of ageing. Therefore, it is critical to adapt to the changing demographics and extend or further target benefit packages for this population to reduce exposure to financial hardship and foregone care of older adults, particularly those in poorer segments of the population. As well as focusing on slowing the increase in noncommunicable diseases by targeting health promotion and disease prevention strategies to reduce costs in the longer term[75].

5. **Continuous monitoring of financial protection is critical to understanding the impact of health reforms prior to the pandemic and the effects of COVID-19 on financial hardship.**

   According to pre-pandemic data, countries in the Region have maintained high levels of financial protection over time (e.g., Thailand[24]) while others have implemented policy reforms more recently but rather rapidly (e.g., Indonesia[34,76,77]. On the other hand, others still lack data to be able to monitor the effects of more recent policy changes (e.g., India and Maldives[10]). As it can be evidenced by the frequency of data and latest data estimates for certain countries, there were already delays in obtaining pre-pandemic financial protection data, which will only be exacerbated by the pandemic. Regular and frequent household surveys are critical to provide financial risk protection data and ascertain the impact of policies and programmes. Till then, it is important to track OOP over time at the macro level and mapping it with aggregate household consumption.

What next?

1. **To mitigate the effects of low public spending on health in the Region coupled with the impact of COVID-19, there is a need to shift from a heavy reliance on OOP spending to increasing and efficiently using public spending on health accompanied by robust coverage policies and targeting to reduce the financial burden on households, especially among the poor and vulnerable. Enhancing fiscal policies that include the introduction or scale up of health taxes, reduced fossil fuels subsidies and carbon taxes can be a win-win in terms of population health and government revenues.**

2. **Since OOP spending in the Region is primarily driven by expenditure on medical products, there is an urgent need to implement effective policies that ensure access to essential medicines and diagnostics. Specifically:**

   2.1. Increase government budget allocations for medical products, including for procurement in the public sector and through insurance schemes and pilot schemes to trial or expand reimbursement of medical product costs in the private sector;

   2.2. Strengthen national and sub-national procurement agencies for efficient public procurement and strengthen supply chain management systems;

   2.3. Structure incentives in a manner that encourages providers, dispensers and patients to make efficient and effective use of medicines;

   2.4. Support implementation and monitoring of generic policies and generic substitutions;

   2.5. Strengthen the National Regulatory Authority to ensure the quality, safety and efficacy of medical products;

2.6. Improve price transparency and implementation of medicines pricing policies.

2.7. Improve access to essential diagnostics particularly at the primary level to reduce wastages and unnecessary medication.

3. **Reliable and timely monitoring of the incidence of financial hardship is critical to guide response policies that will not leave vulnerable groups behind, especially under crisis conditions including an exploration of new modalities to obtain data.**

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PART 3
Country-specific UHC and SDG data profiles

This section provides country-specific data profiles of the 11 Member States of the WHO South-East Asia Region. A total of 49 health and health-related SDG indicators along with four additional GPW13 indicators are present (list in Annex B).

Each four-page country profile includes sections that address the latest demographics, overall progress using healthy life expectancy (HALE), equity analysis, and a summary of UHC and health-related SDG indicators, including several with trend data. For the first time this year, the country profile reports on the following new indicators:

- SDG 3.d.2.1 — Percentage of bloodstream infections due to methicillin-resistant *staphylococcus* aureus.
- SDG 3.d.2.2 — Percentage of bloodstream infection due to *Escherichia coli* resistant to third-generation cephalosporin.
- SDG 5.2.2 — Proportion of ever-partnered women and girls aged 15 years and above subjected to physical, sexual or psychological violence by a current or former intimate (%).
- SDG 6.3.1 — Proportion of safely treated domestic wastewater flows (%).

The country profiles provide comprehensive list of references with data source and year. The profiles are presented in alphabetical order:

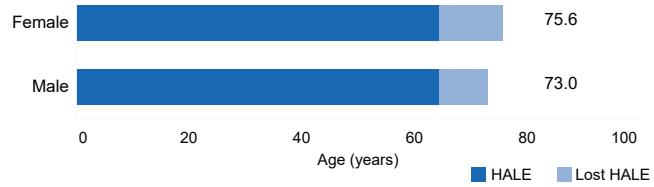
- Bangladesh
- Bhutan
- Democratic People's Republic of Korea
- India
- Indonesia
- Maldives
- Myanmar
- Nepal
- Sri Lanka
- Thailand
- Timor-Leste

Bangladesh

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
167 886	39.7%	14.3%	1846.4	2.5%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 2.6 years of longer life expectancy and 0.2 years of more HALE than males.

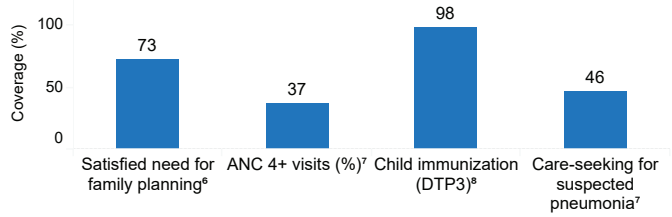
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

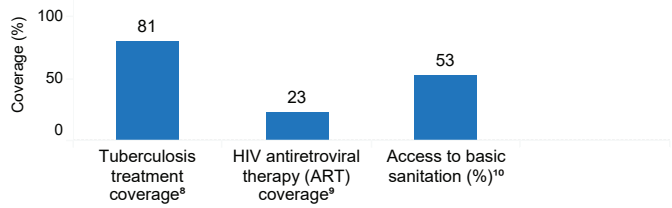
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

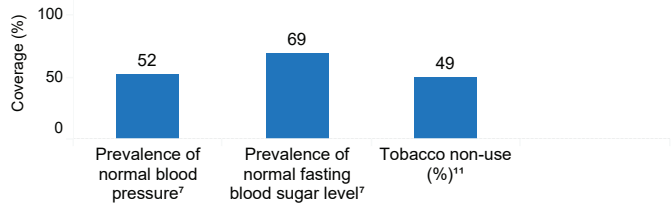
Reproductive, maternal, newborn and child health (RMNCAH)



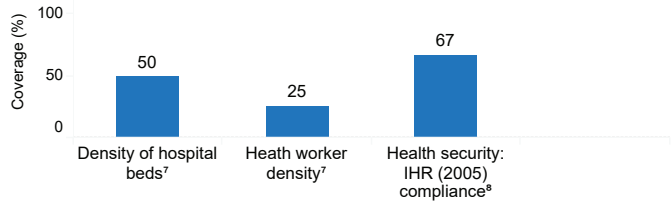
Infectious diseases



Noncommunicable diseases



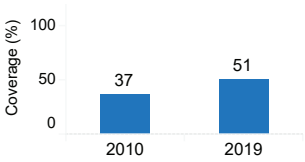
Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.

UHC service coverage index*



FINANCIAL PROTECTION

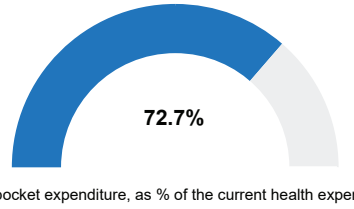
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **3.7%** or **approximately 6 211 782** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **24.4%** of people spent more than 10% of their household's total expenditure on health care.[12]

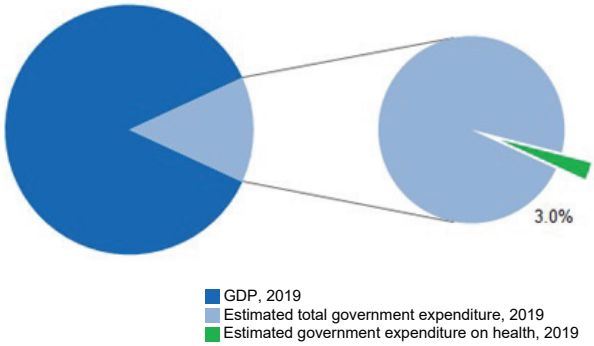
Out-of-pocket expenditure[4]

In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Public spending on health[4]

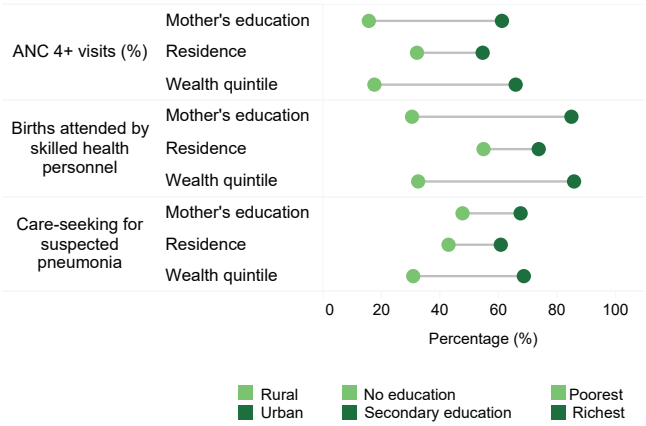
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



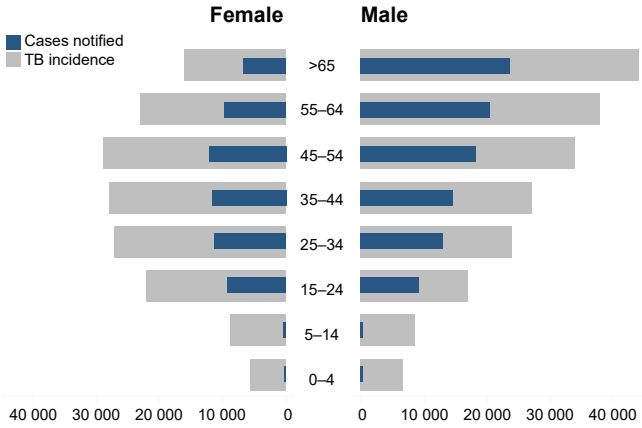
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

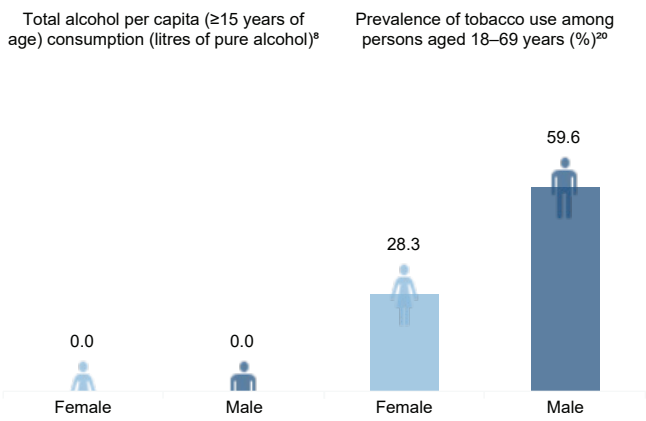
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



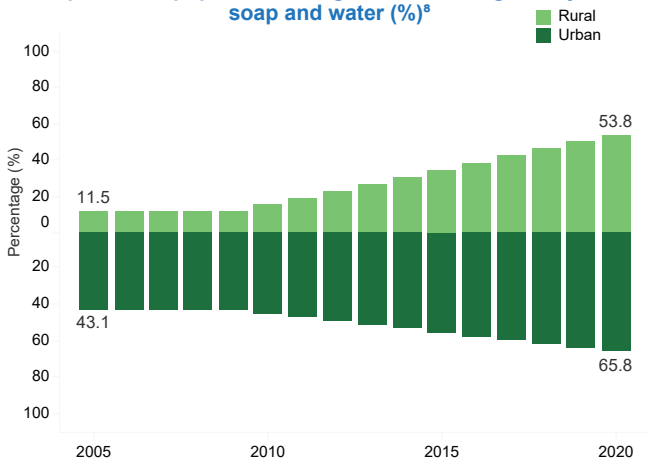
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,20]

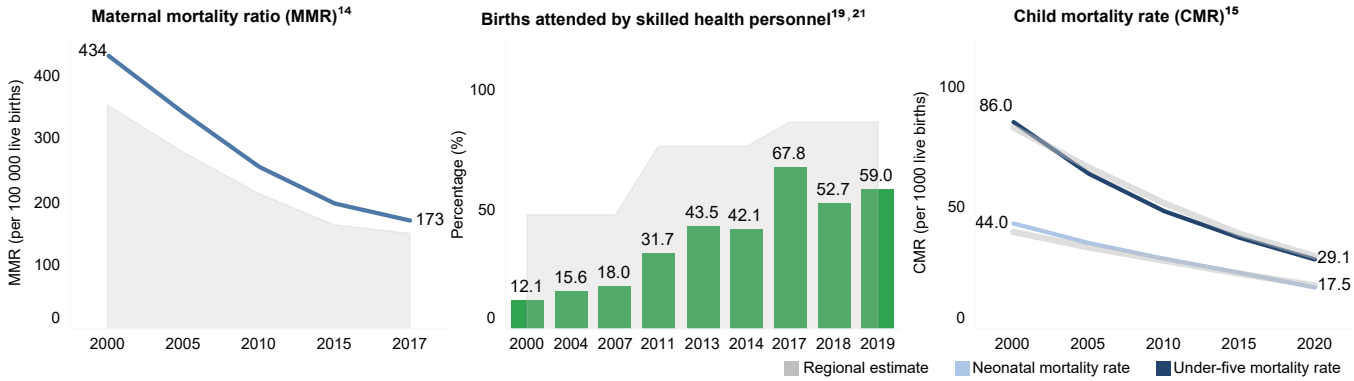


Proportion of population using a handwashing facility with soap and water (%)[8]

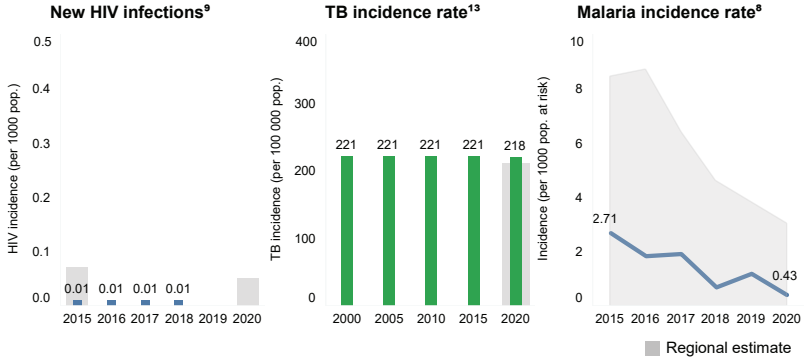


SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)



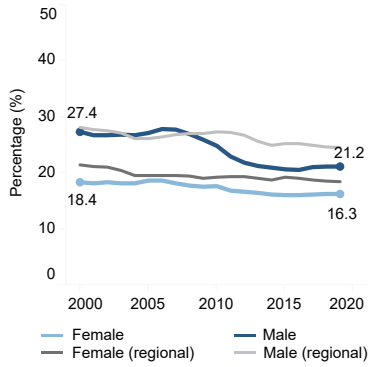
Communicable diseases (SDG target 3.3)



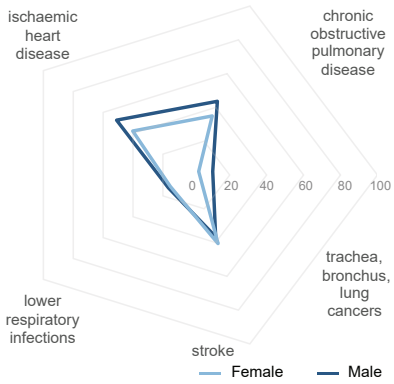
Indicator	Year	Bangladesh	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.51	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	56 339 394	938 873 025

Indicator	SDG target	Year	Bangladesh	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	18.9	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	3.7	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	0	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	15.3	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2019	77.4	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2019	83	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	149	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	11.9	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0.3	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 18–69 years (%)[20]	3.a.1	2018	43.7	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	98	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	93	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	99	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	1.99	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	9.9	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	70	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	0	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	71	–

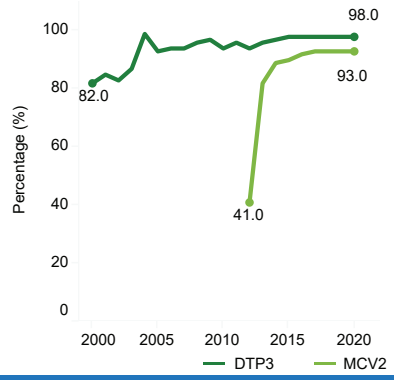
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

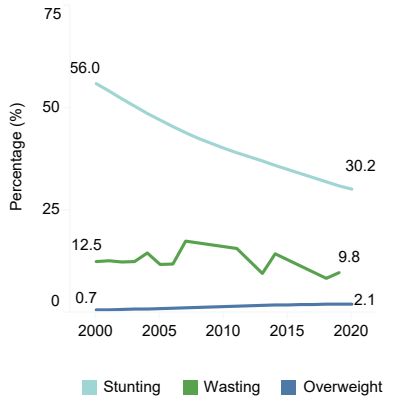


Other health-related SDGs

Indicator	SDG target	Year	Bangladesh	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	3	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	30.2	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2019	9.8	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	2.1	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	36.7	46.6
Intimate partner violence				
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[16]	5.2.1	2018	23	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	50	33

Note: En dash (–) implies relevant data are not available

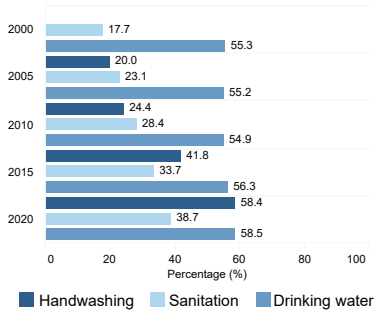
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



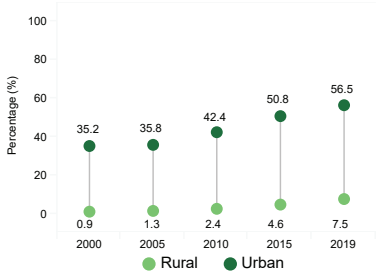
Indicator	SDG target	Year	Bangladesh	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	58.5	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	38.7	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	58.4	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	16	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	273.9	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	25	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	64.1	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	2.8	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2019	56	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]

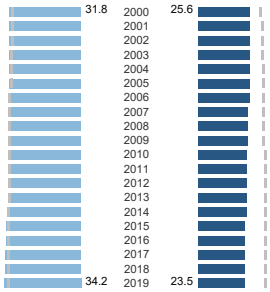


Additional SDG indicators used to monitor GPW13 impact

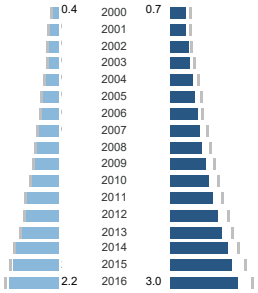
Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

No cases have been reported in the past 5 years

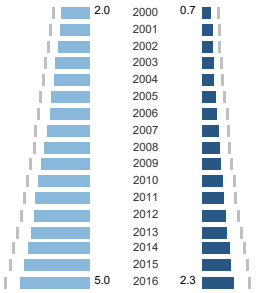
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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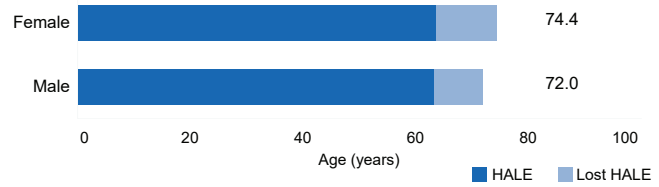
Bhutan

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
788	43.7%	1.5%	3214.9	3.6%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 2.4 years of longer life expectancy and 0.3 years of more HALE than males.

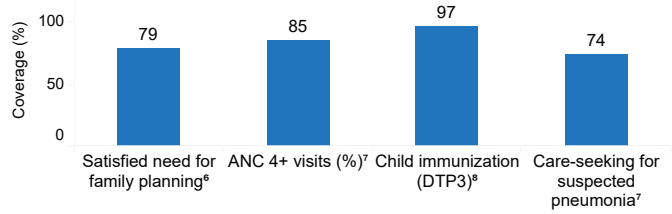
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

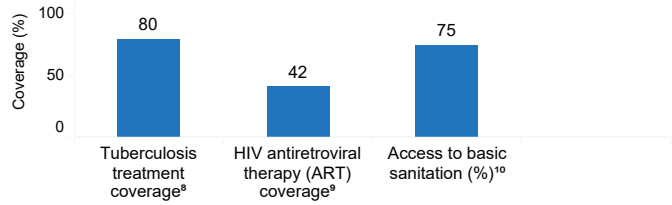
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

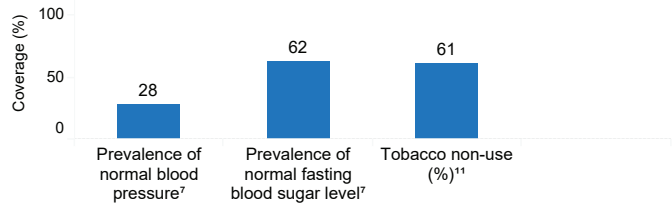
Reproductive, maternal, newborn and child health (RMNCAH)



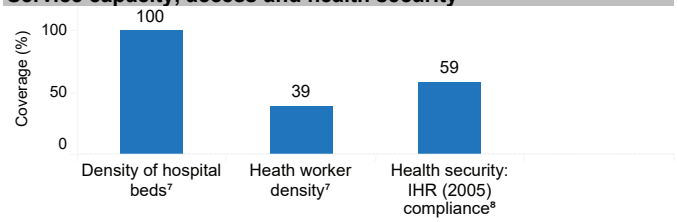
Infectious diseases



Noncommunicable diseases

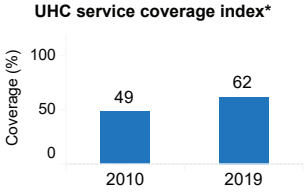


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

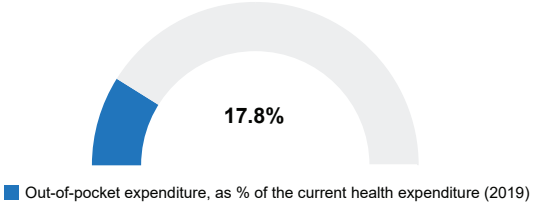
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **1.2%** or **approximately 9 456** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **4.0%** of people spent more than 10% of their household's total expenditure on health care.[12]

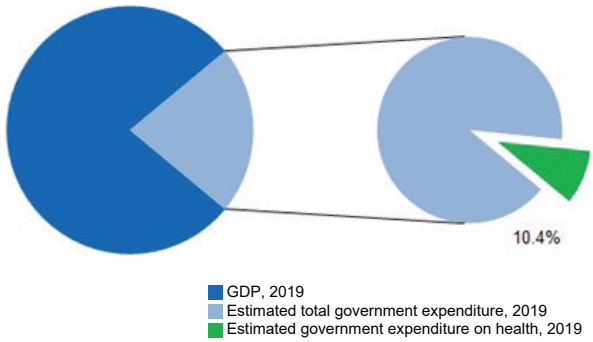
Out-of-pocket expenditure[4]

In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Public spending on health[4]

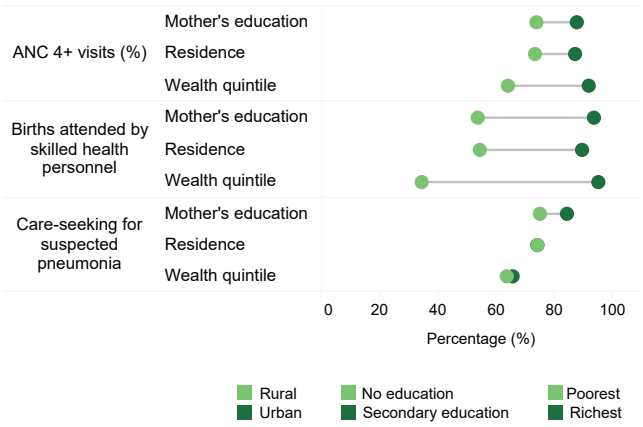
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



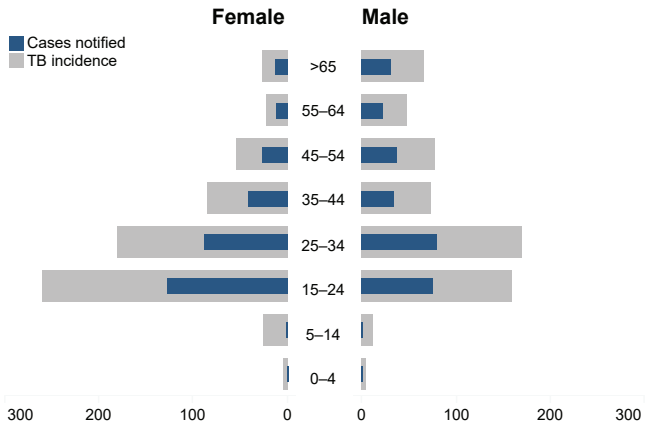
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

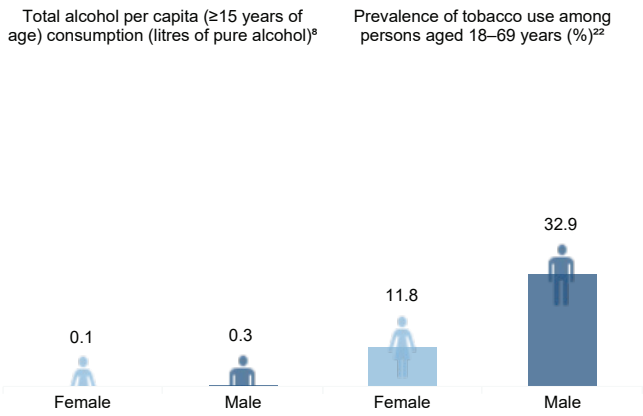
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



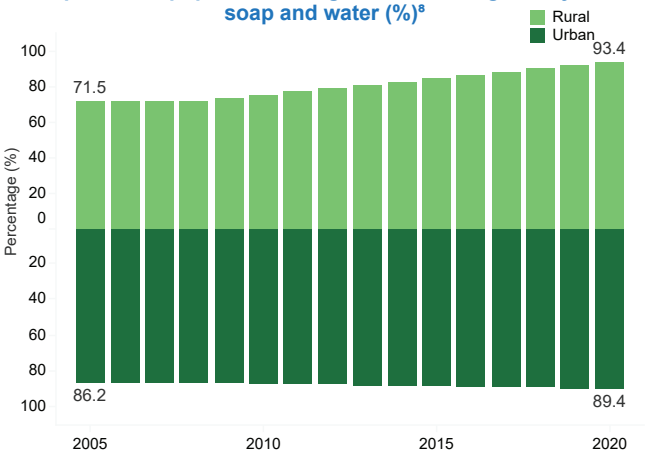
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,22]

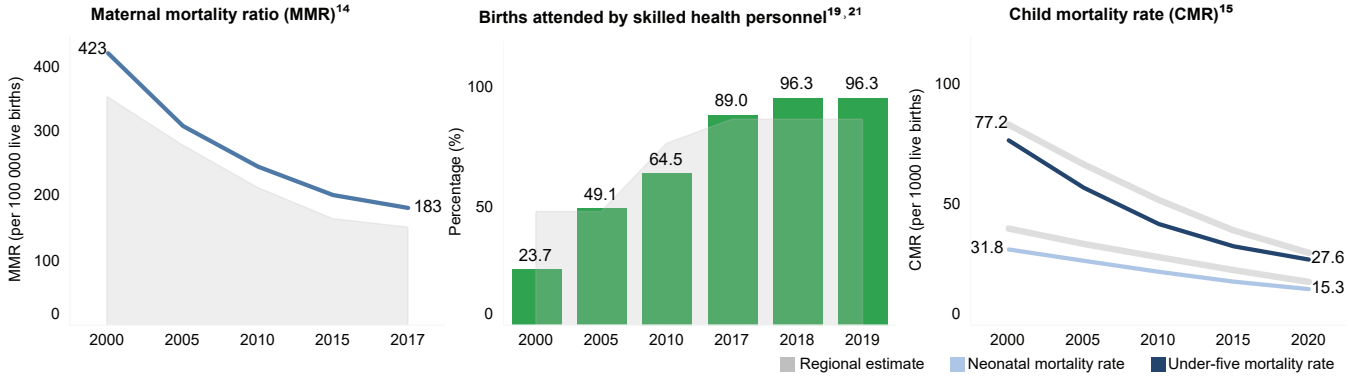


Proportion of population using a handwashing facility with soap and water (%)[8]

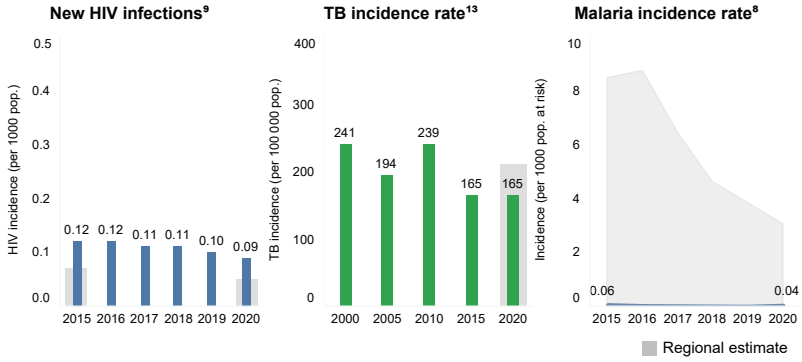


SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)



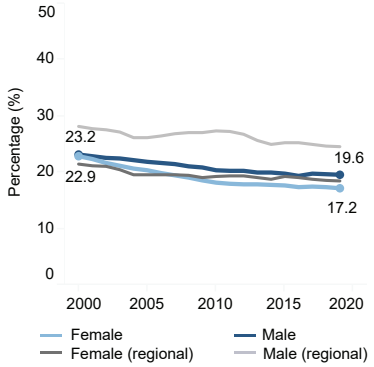
Communicable diseases (SDG target 3.3)



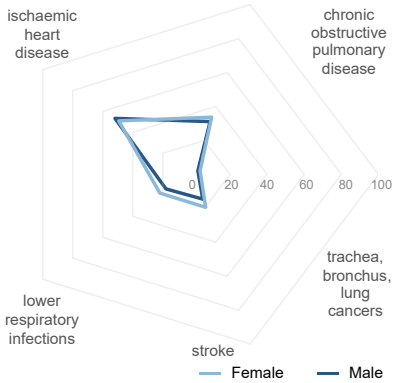
Indicator	Year	Bhutan	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.14	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	229 837	938 873 025

Indicator	SDG target	Year	Bhutan	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	18.5	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	4.6	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	0.2	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	16.2	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2010	84.9	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[20]	3.7.2	2010	28.4	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	124.5	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	3.9	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0.2	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 18–69 years (%)[22]	3.a.1	2019	23.9	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	95	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	93	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	90	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	81	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	20.21	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	22.8	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	71	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	12	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	54	–

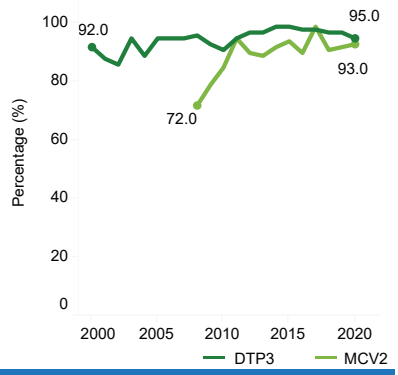
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

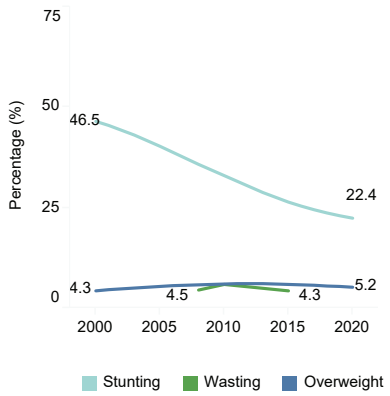


Other health-related SDGs

Indicator	SDG target	Year	Bhutan	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	10.4	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	22.4	30.1
Prevalence of wasting in children under 5 years (%)[23]	2.2.2	2015	4.3	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	5.2	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	38.6	46.6
Intimate partner violence				
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[16]	5.2.1	2018	9	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	22	33

Note: En dash (–) implies relevant data are not available

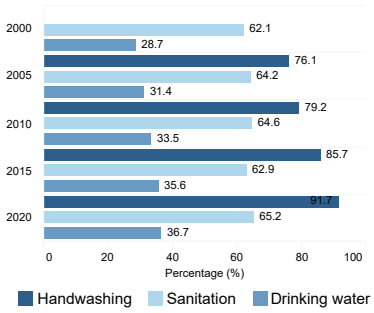
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18, 23]



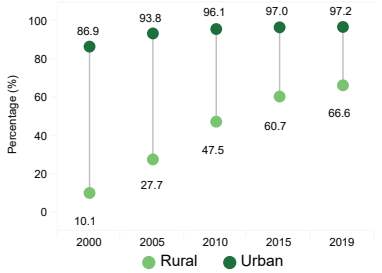
Indicator	SDG target	Year	Bhutan	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	36.7	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	65.2	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	91.7	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	41	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	12.4	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	80.2	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	36.9	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	2.4	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2010	99.9	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



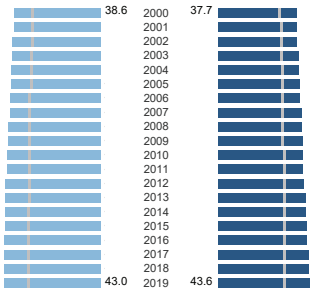
Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]



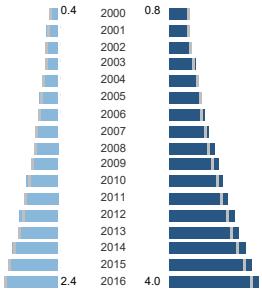
Additional SDG indicators used to monitor GPW13 impact

Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

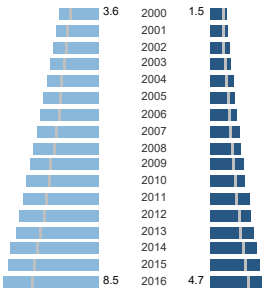
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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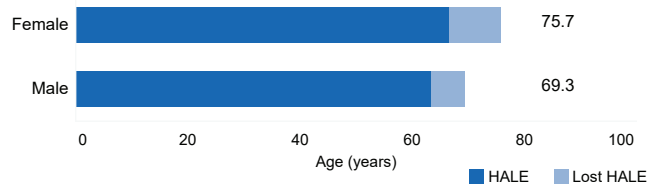
Democratic People's Republic of Korea

Population (000s)[1]	Urban population[2]	Poverty[3]	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
25 991	62.9%	(ppp <US$1.90 a day) Relevant data not available	Relevant data not available	Relevant data not available

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 6.4 years of longer life expectancy and 3.3 years of more HALE than males.

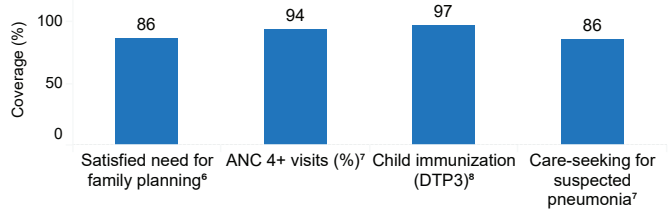
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

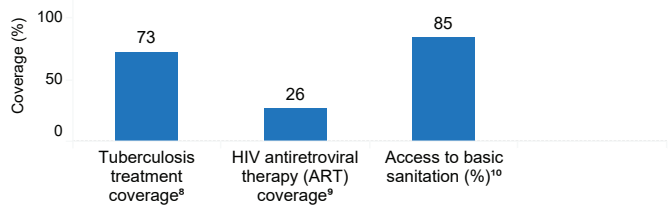
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

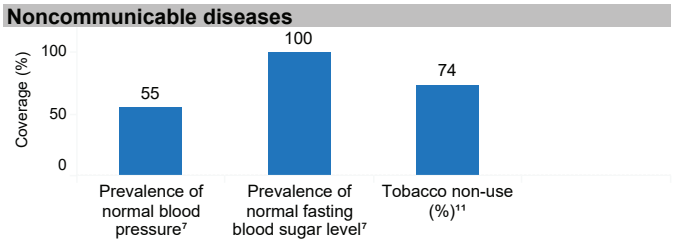
Reproductive, maternal, newborn and child health (RMNCAH)



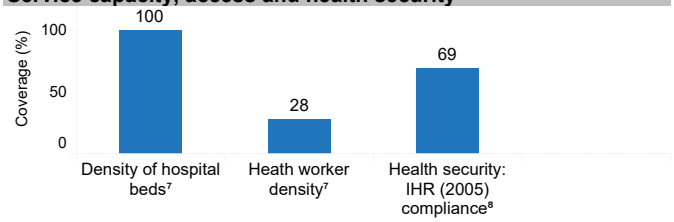
Infectious diseases



Noncommunicable diseases



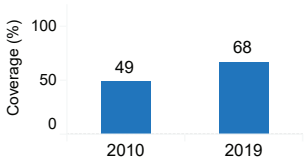
Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.

UHC service coverage index*



FINANCIAL PROTECTION

Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: Insufficient data.[12]

Catastrophic expenditure on health: Insufficient data.[12]

Out-of-pocket expenditure[4]

In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.

Current data is insufficient for analysis

Public spending on health[4]

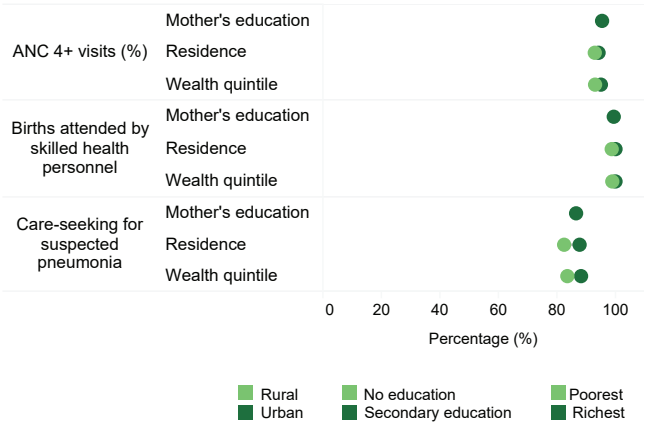
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.

Current data is insufficient for analysis

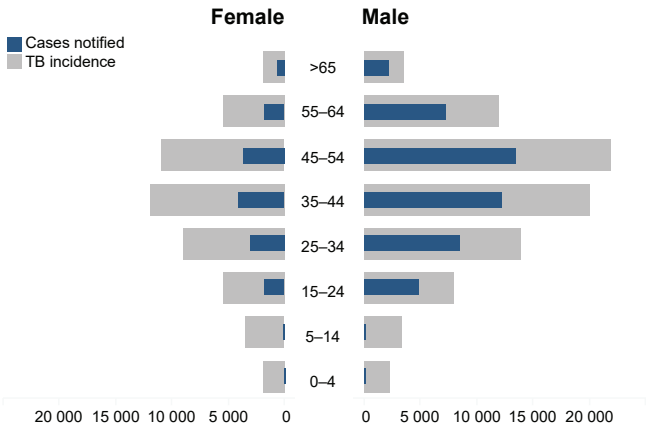
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

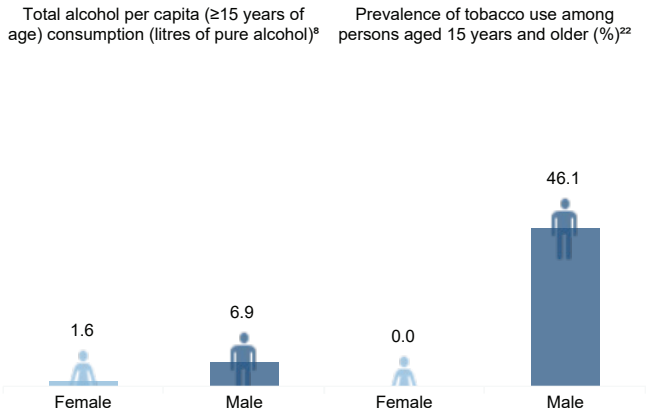
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,22]

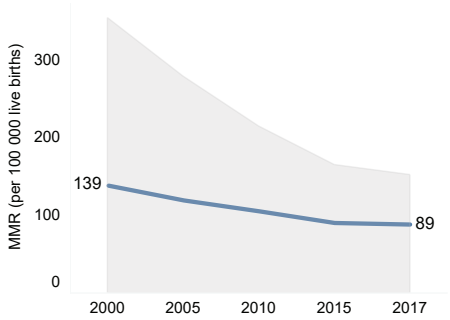


Proportion of population using a handwashing facility with soap and water (%)[8]

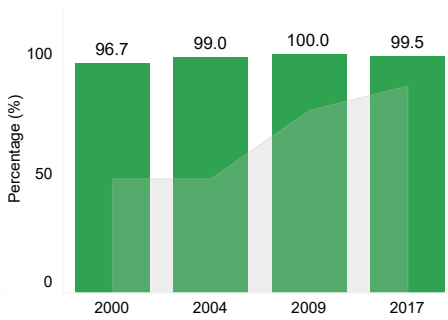
SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)

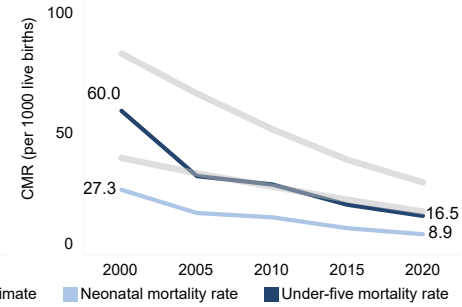
Maternal mortality ratio (MMR)[14]



Births attended by skilled health personnel[19,20,21]

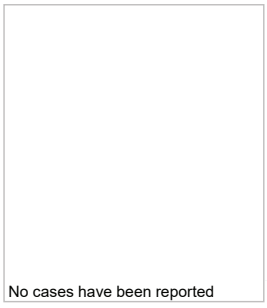


Child mortality rate (CMR)[15]

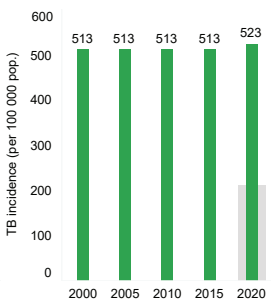


Communicable diseases (SDG target 3.3)

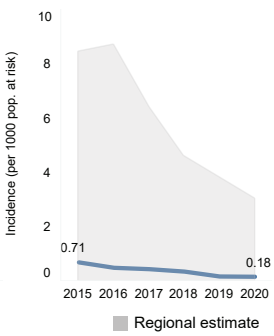
New HIV infections[9]



TB incidence rate[13]



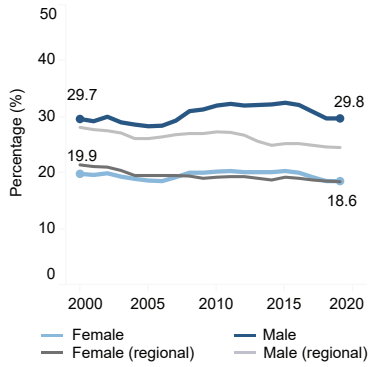
Malaria incidence rate[8]



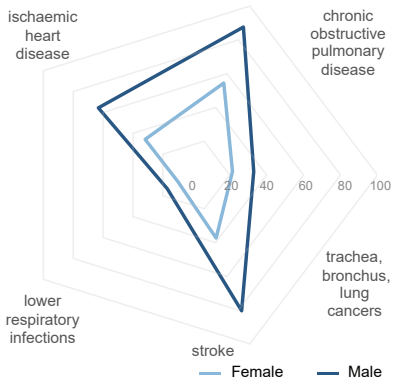
Indicator	Year	DPR Korea	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.20	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	5 337 343	938 873 025

Indicator	SDG target	Year	DPR Korea	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	23.9	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	–	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	4.2	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	24.2	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2017	89.7	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2017	1	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	207.2	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	1.4	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	1.4	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 15 years and older (%)[22]	3.a.1	2017	22	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	97	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	99	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	–	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	0.36	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	81.8	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	70	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	–	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	–	–

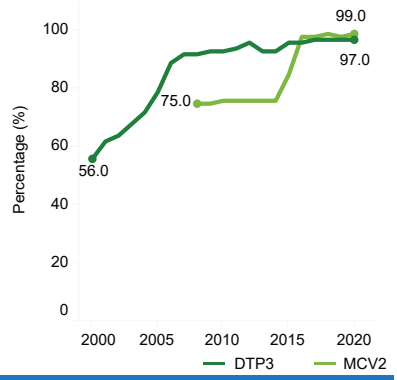
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

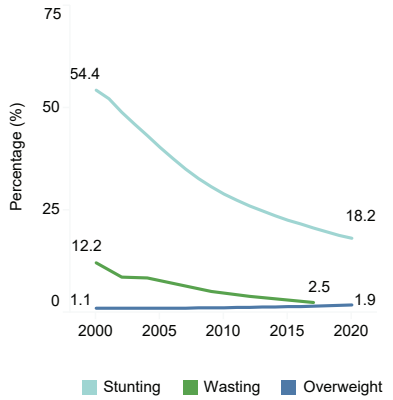


Other health-related SDGs

Indicator	SDG target	Year	DPR Korea	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	-	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	18.2	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2017	2.5	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	1.9	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	33.9	46.6
Intimate partner violence				
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[16]	5.2.1	2018	-	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	-	33

Note: En dash (–) implies relevant data are not available

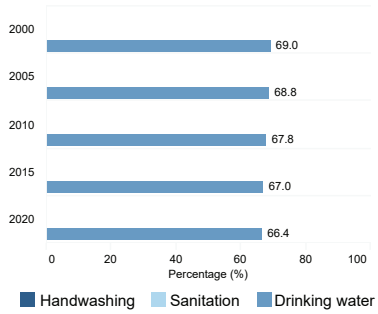
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



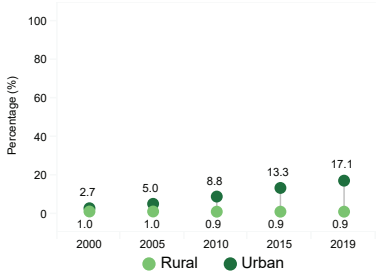
Drinking water services and sanitation				
Indicator	**SDG target**	**Year**	**DPR Korea**	**Regional estimate**
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	66.4	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	–	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	–	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	–	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	0.2	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	11.5	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	39.7	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	4.2	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2017	–	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]

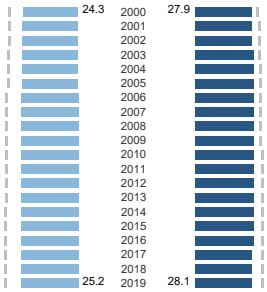


Additional SDG indicators used to monitor GPW13 impact

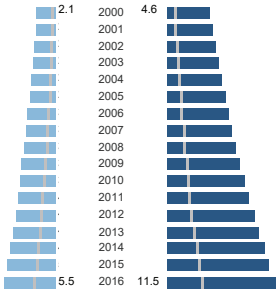
Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

No cases have been reported in the past 5 years

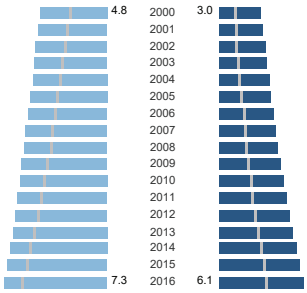
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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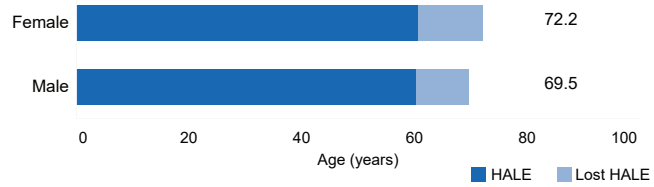
India

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
1 406 632	35.9%	22.5%	2115	3.0%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 2.7 years of longer life expectancy and 0.1 years of more HALE than males.

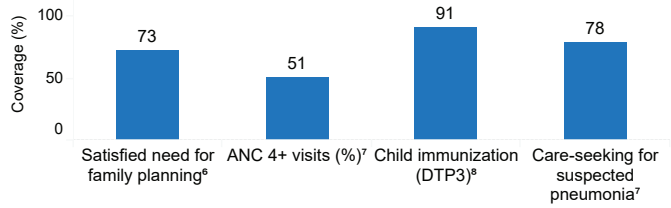
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

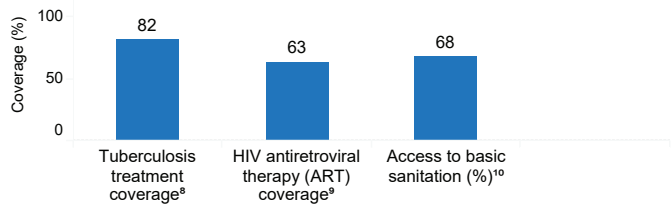
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

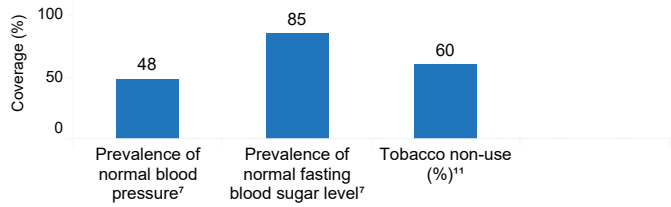
Reproductive, maternal, newborn and child health (RMNCAH)



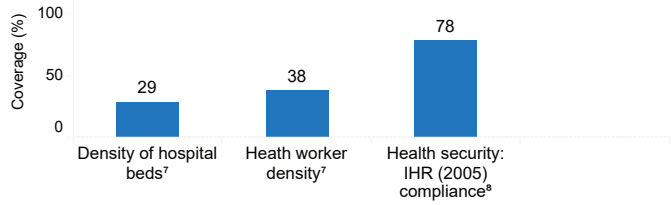
Infectious diseases



Noncommunicable diseases

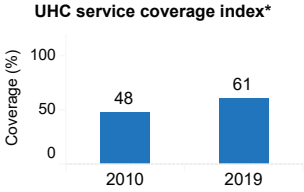


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

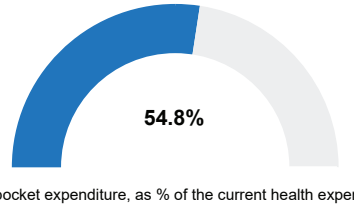
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **4.7%** or **approximately 66 111 704** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **17.3%** of people spent more than 10% of their household's total expenditure on health care.[12]

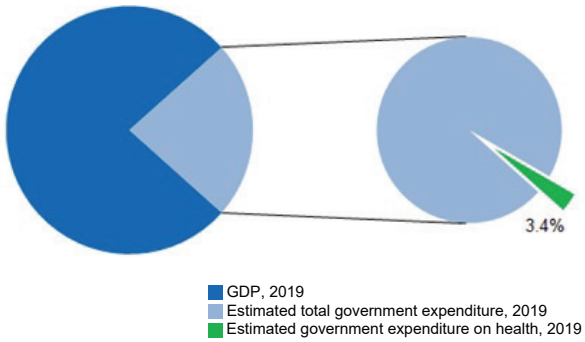
Out-of-pocket expenditure[4]

In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Public spending on health[4]

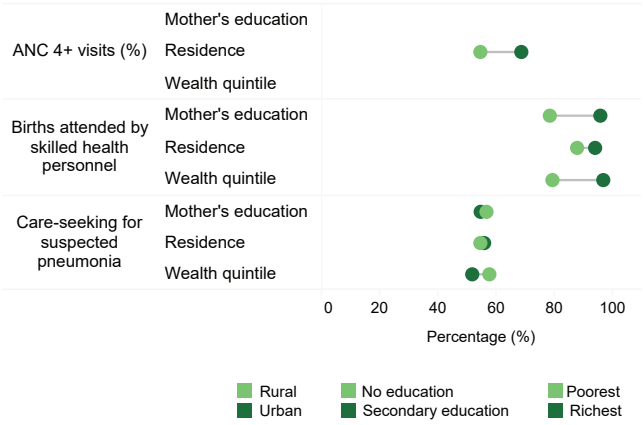
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



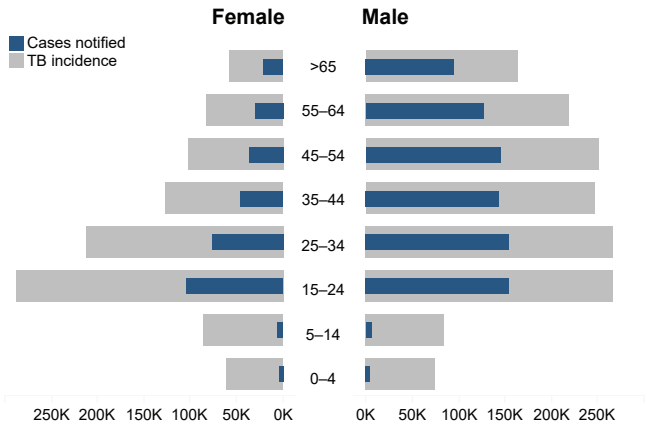
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

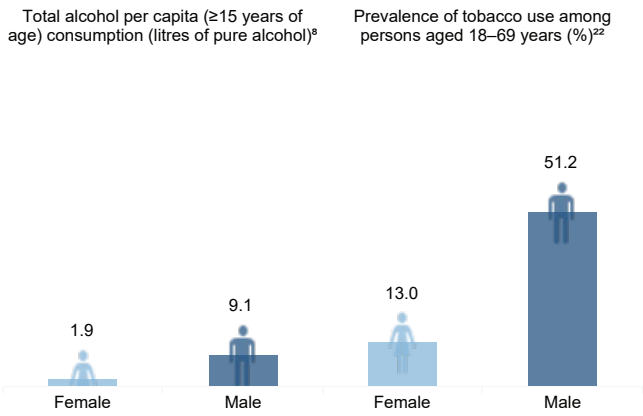
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



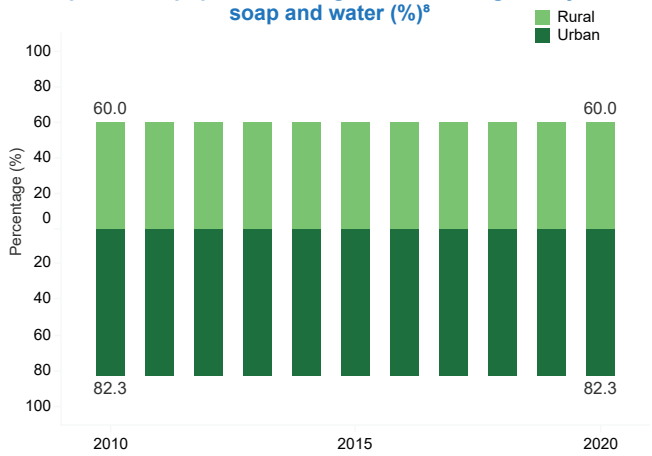
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,22]



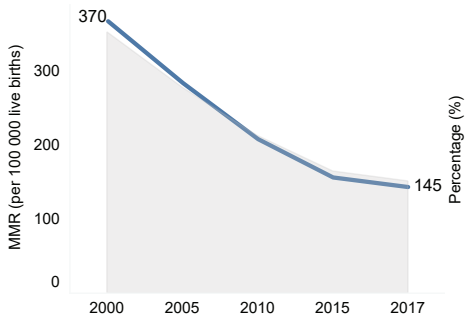
Proportion of population using a handwashing facility with soap and water (%)[8]



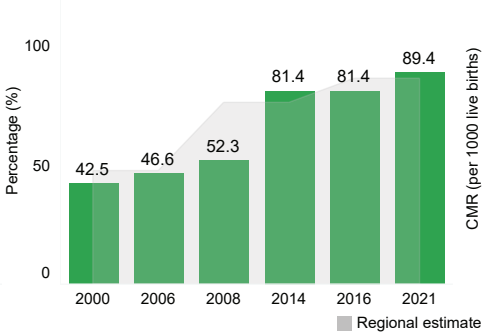
SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)

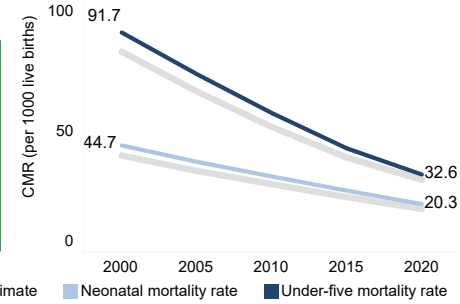
Maternal mortality ratio (MMR)[14]



Births attended by skilled health personnel[19,20,21]

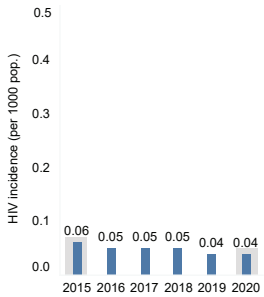


Child mortality rate (CMR)[15]

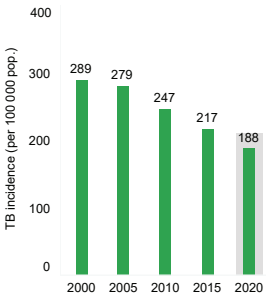


Communicable diseases (SDG target 3.3)

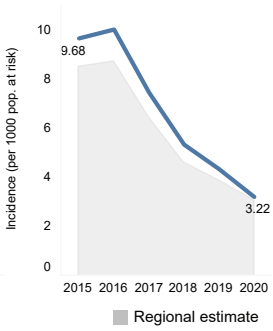
New HIV infections[9]



TB incidence rate[13]



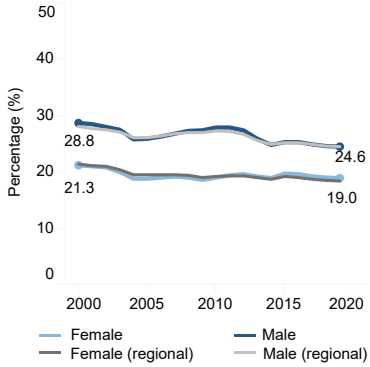
Malaria incidence rate[8]



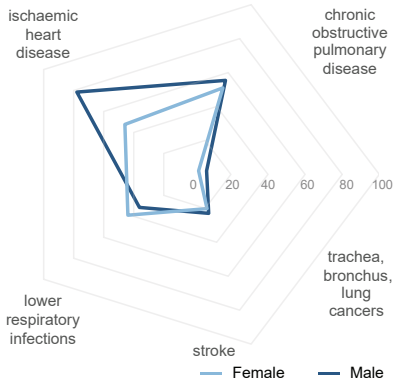
Indicator	Year	India	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.16	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	751 758 629	938 873 025

Indicator	SDG target	Year	India	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	21.9	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	12.7	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	5.6	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	15.6	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2021	74.1	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2021	43	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	184.3	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	18.6	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0.3	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 18–69 years (%)[22]	3.a.1	2018	32.8	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	85	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	81	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	21	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	0.26	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	25.8	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	80	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	65	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	87	–

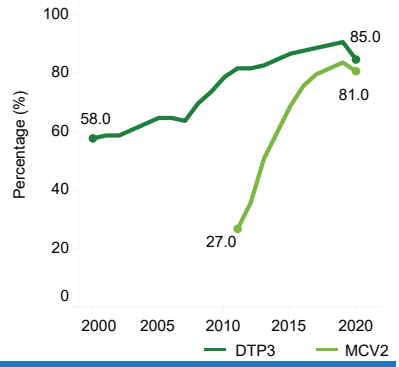
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

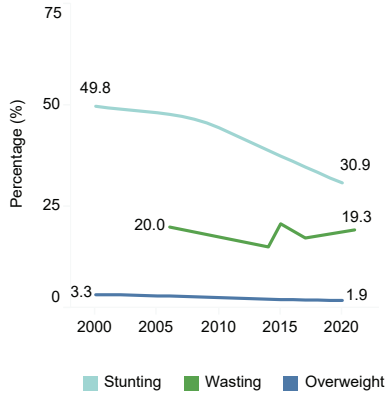


Other health-related SDGs

Indicator	SDG target	Year	India	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	3.4	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	30.9	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2021	19.3	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	1.9	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	53	46.6
Intimate partner violence				
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[16]	5.2.1	2018	18	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	35	33

Note: En dash (–) implies relevant data are not available

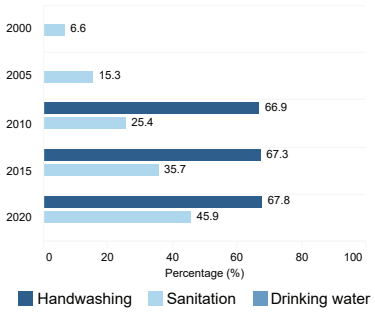
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18,19]



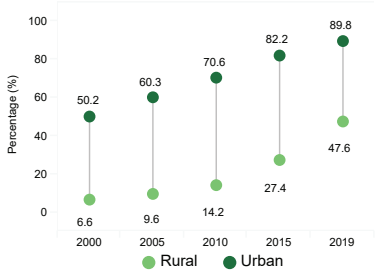
Drinking water services and sanitation				
Indicator	**SDG target**	**Year**	**India**	**Regional estimate**
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	–	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	45.9	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	67.8	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	27	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	305.5	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	67.9	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	78.2	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	3.8	3.8
Birth registration				
Birth registration coverage[23]	16.9.1	2019	92.7	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



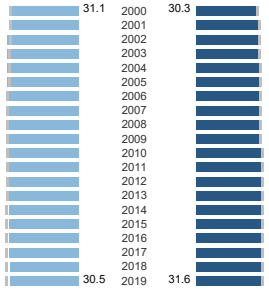
Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]



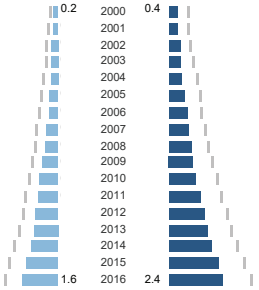
Additional SDG indicators used to monitor GPW13 impact

Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

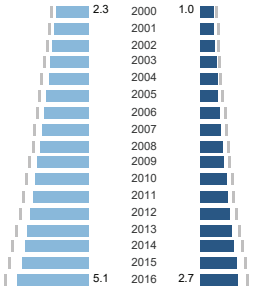
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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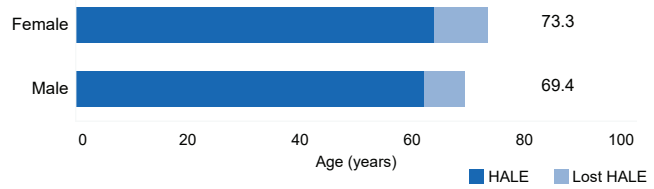
Indonesia

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
279 135	57.9%	2.2%	4135.2	2.9%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 3.9 years of longer life expectancy and 1.9 years of more HALE than males.

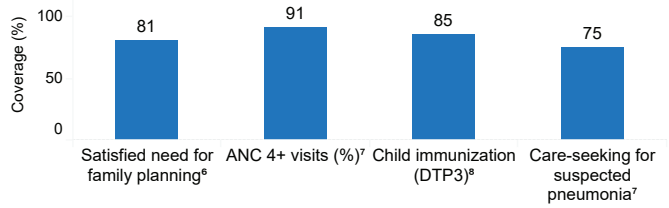
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

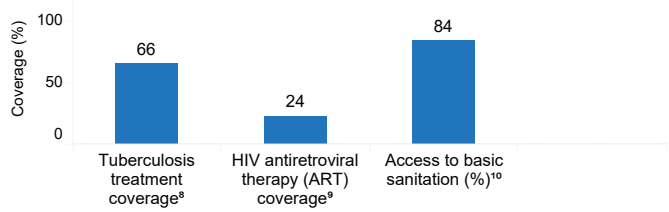
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

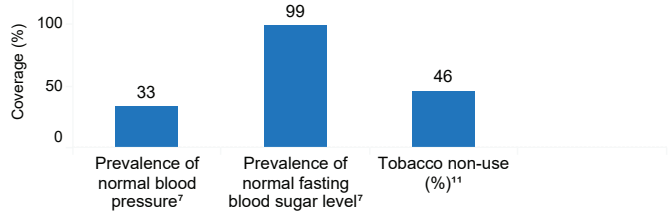
Reproductive, maternal, newborn and child health (RMNCAH)



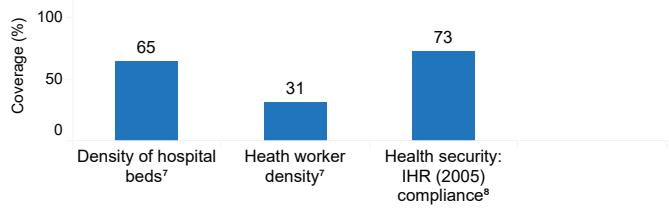
Infectious diseases



Noncommunicable diseases

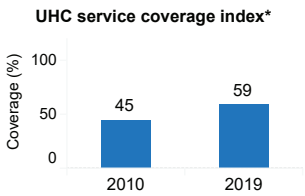


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

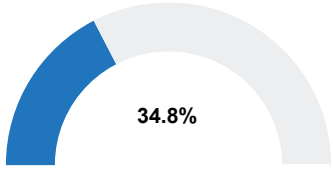
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **0.5%** or **approximately 1 395 675** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **4.5%** of people spent more than 10% of their household's total expenditure on health care.[12]

Out-of-pocket expenditure[4]

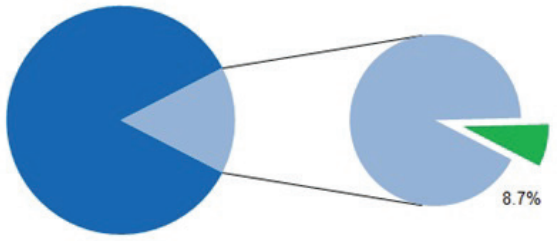
In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Out-of-pocket expenditure, as % of the current health expenditure (2019)

Public spending on health[4]

Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.

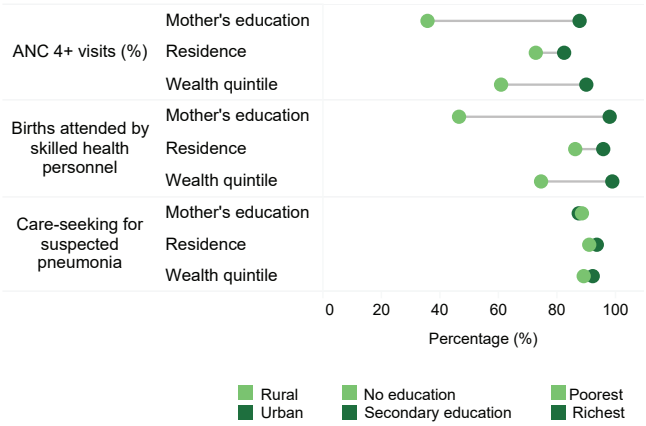


GDP, 2019
Estimated total government expenditure, 2019
Estimated government expenditure on health, 2019

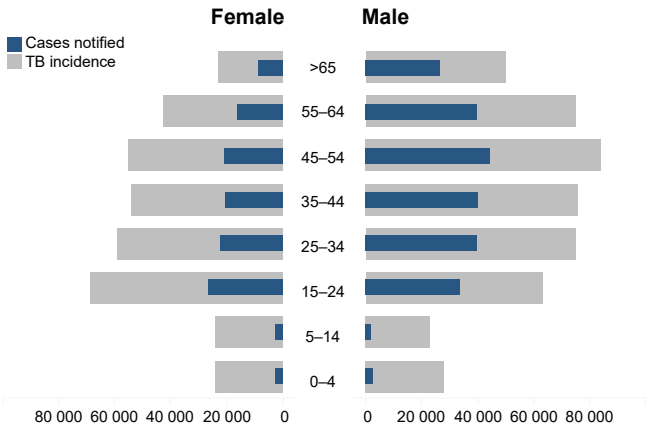
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

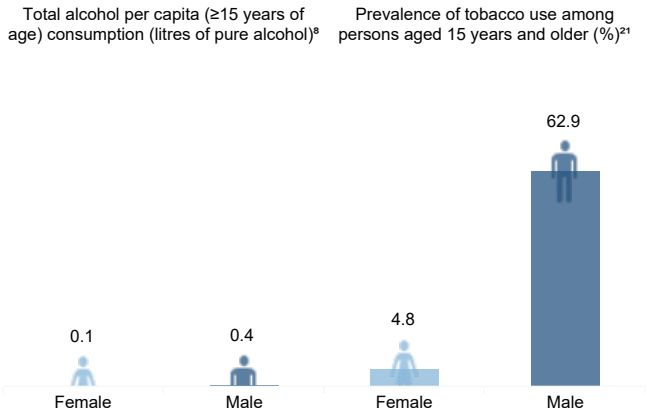
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



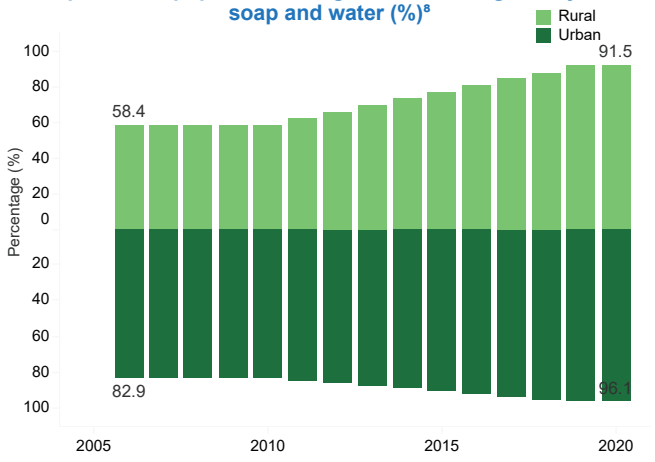
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,21]

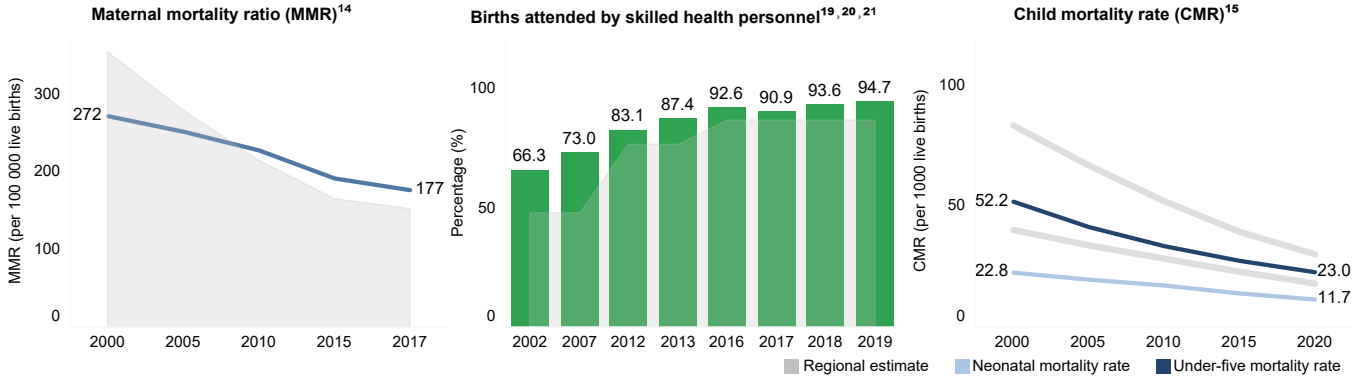


Proportion of population using a handwashing facility with soap and water (%)[8]

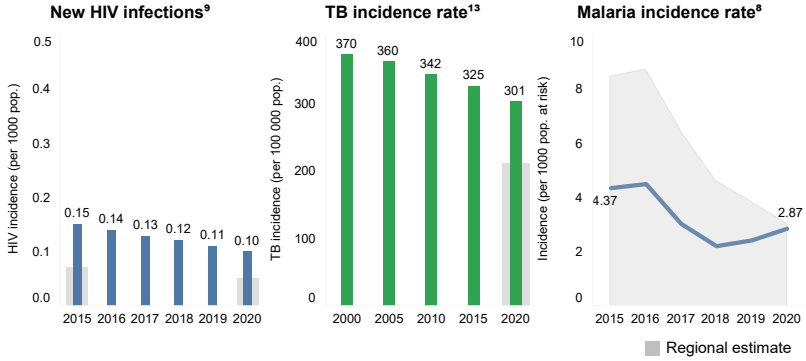


SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)



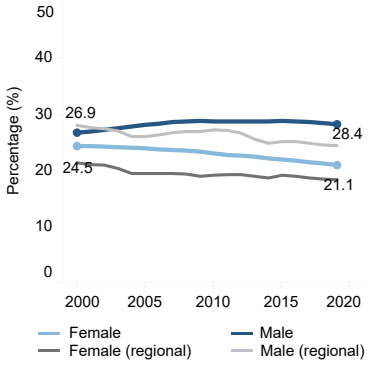
Communicable diseases (SDG target 3.3)



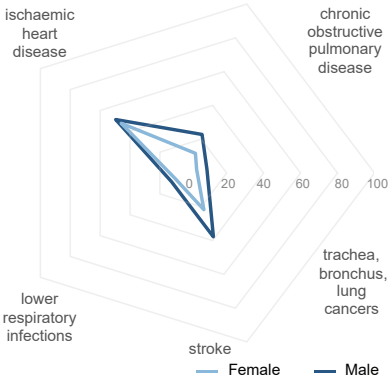
Indicator	Year	Indonesia	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	1.30	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	86 492 939	938 873 025

Indicator	SDG target	Year	Indonesia	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	24.8	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	2.4	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	0.2	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	11.3	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2017	77.1	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2017	36	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	112.4	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	7.1	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0.3	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 15 years and older (%)[21]	3.a.1	2018	33.8	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	77	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	49	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	4	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	7	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	0.32	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	28.4	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	69	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	36	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	76	–

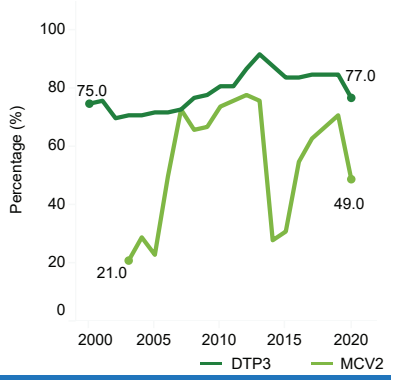
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

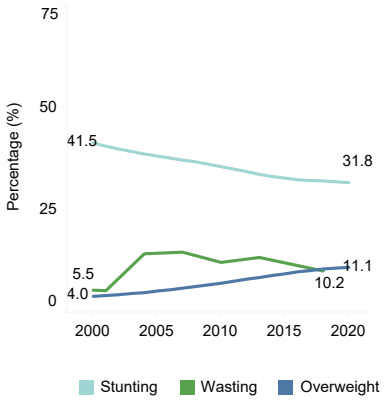


Other health-related SDGs

Indicator	SDG target	Year	Indonesia	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	8.7	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	31.8	30.1
Prevalence of wasting in children under 5 years (%)[21]	2.2.2	2018	10.2	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	11.1	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	31.2	46.6
Intimate partner violence				
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[16]	5.2.1	2018	9	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	22	33

Note: En dash (–) implies relevant data are not available

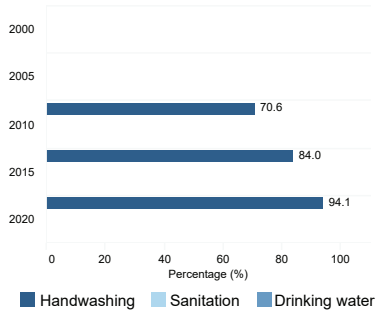
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



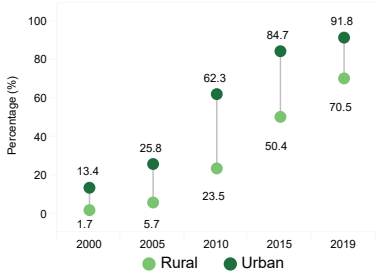
Indicator	SDG target	Year	Indonesia	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	–	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	–	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	94.1	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	–	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	185.3	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	84.5	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	20.7	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	4.3	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2017	77.9	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]

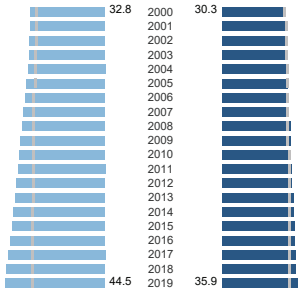


Additional SDG indicators used to monitor GPW13 impact

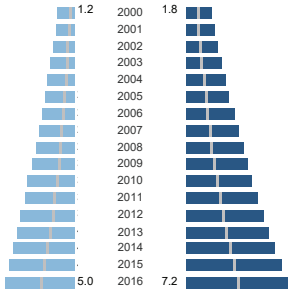
Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

No cases have been reported in the past 5 years

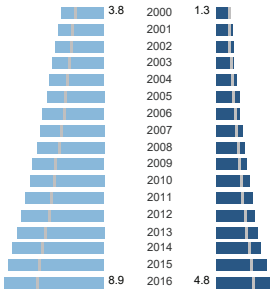
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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See for Proportion of population using safely managed drinking-water services (%), country reported value: 2020=11.9; data source: Indonesia's SDG VNR 2021.
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See for Prevalence of stunting in children under 5 (%), country reported value: 2019=27.7; data source: Indonesia's SDG VNR 2021.
See for Prevalence of wasting in children under 5 (%), country reported value: 2019=7.4; data source: Indonesia's SDG VNR 2021.
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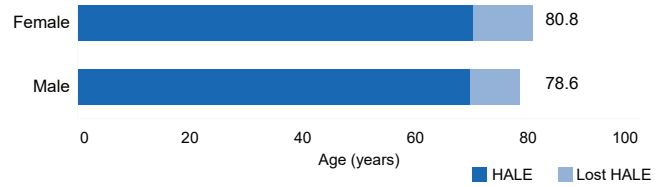
Maldives

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
541	41.5%	6.0%	10626.5	8.0%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 2.2 years of longer life expectancy and 0.3 years of more HALE than males.

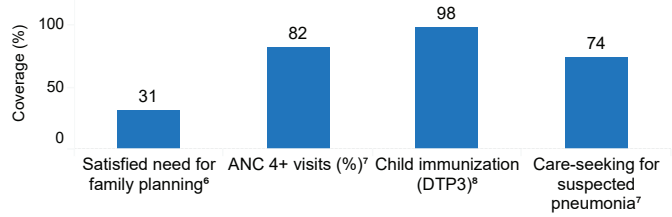
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

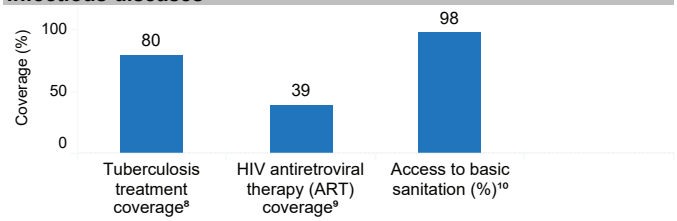
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

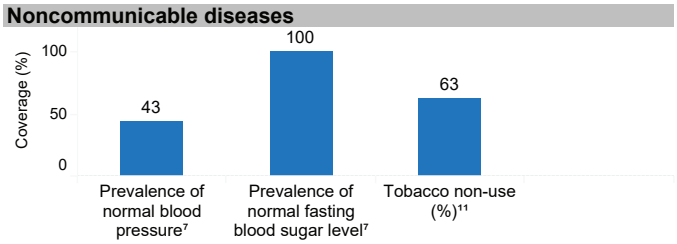
Reproductive, maternal, newborn and child health (RMNCAH)



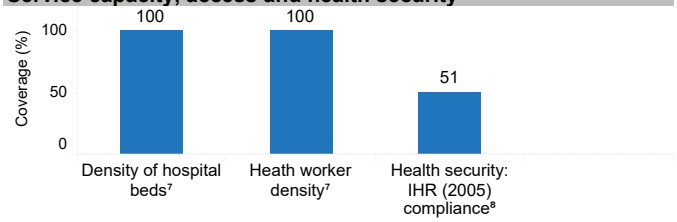
Infectious diseases



Noncommunicable diseases



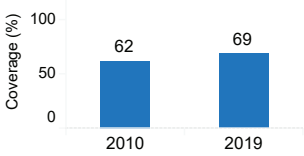
Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.

UHC service coverage index*



FINANCIAL PROTECTION

Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

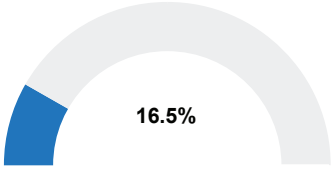
Impoverishment: approximately **0.0%** people** are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **10.3%** of people spent more than 10% of their household's total expenditure on health care.[12]

**Impoverishment data are not reported at PPP US$ 1.90 level

Out-of-pocket expenditure[4]

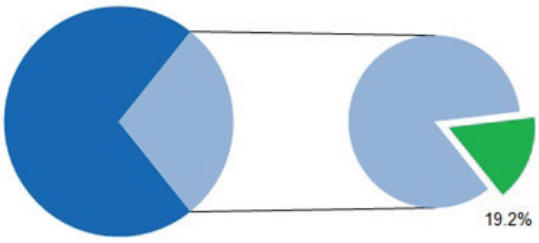
In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Out-of-pocket expenditure, as % of the current health expenditure (2019)

Public spending on health[4]

Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.

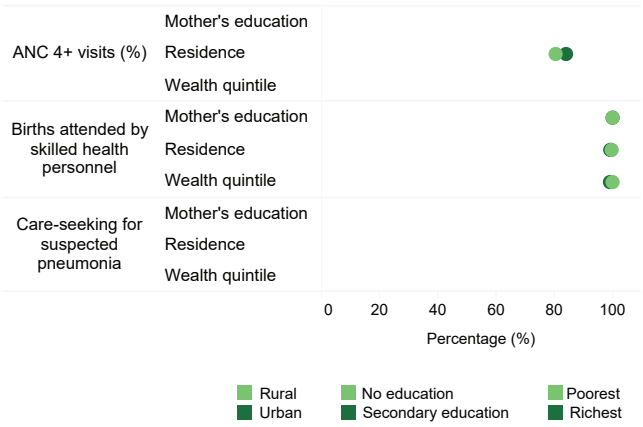


GDP, 2019
Estimated total government expenditure, 2019
Estimated government expenditure on health, 2019

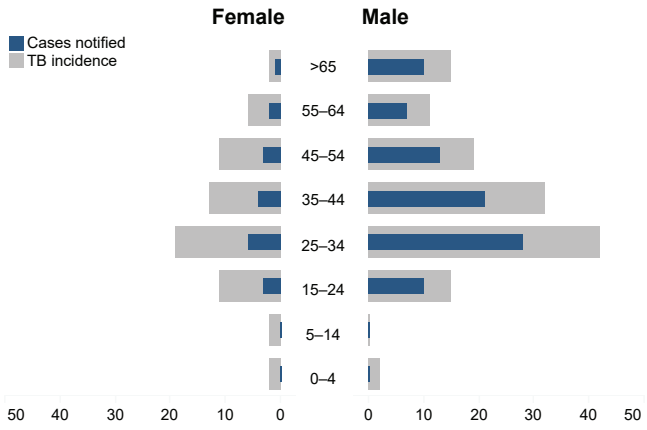
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

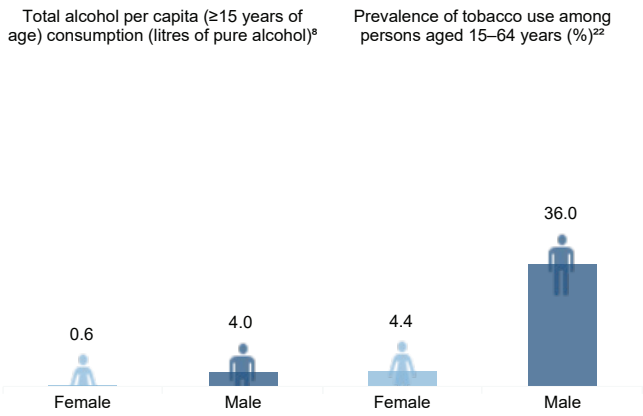
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



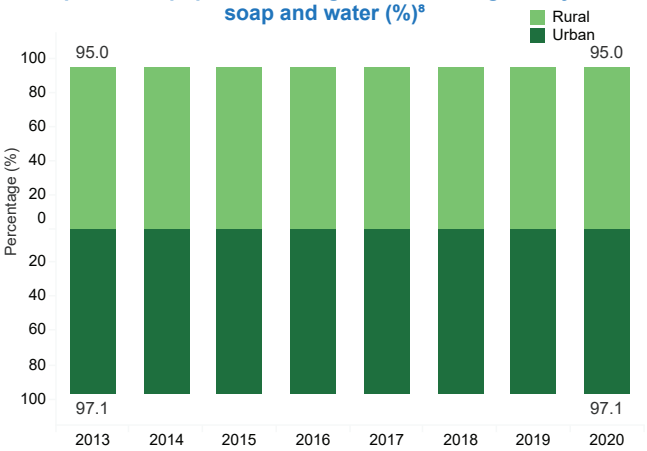
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,22]



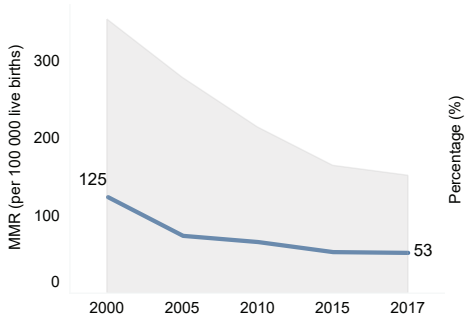
Proportion of population using a handwashing facility with soap and water (%)[8]



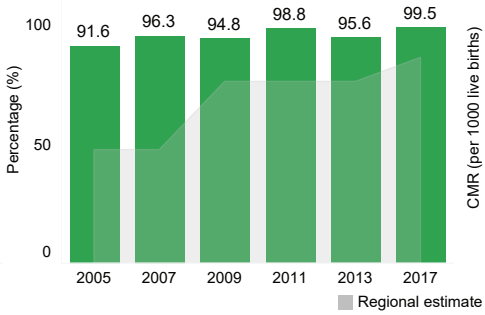
SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)

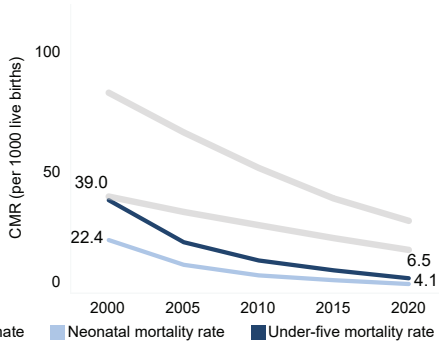
Maternal mortality ratio (MMR)[14]



Births attended by skilled health personnel[19,20,21]

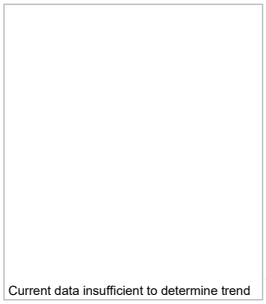


Child mortality rate (CMR)[15]

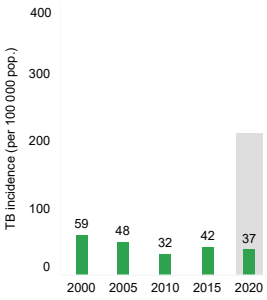


Communicable diseases (SDG target 3.3)

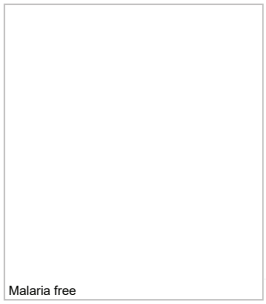
New HIV infections[9]



TB incidence rate[13]



Malaria incidence rate[8]

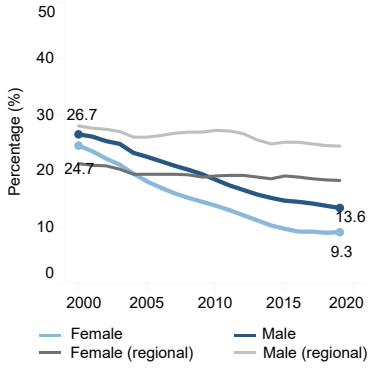


Regional estimate

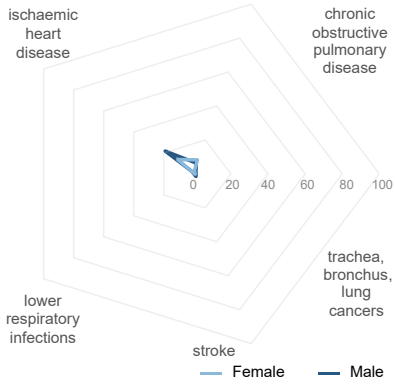
Indicator	Year	Maldives	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.21	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	330	938 873 025

Indicator	SDG target	Year	Maldives	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	11.6	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	2.7	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	2.8	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	1.6	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2017	29.4	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2017	10	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	25.6	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	0.3	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 15–64 years (%)[22]	3.a.1	2011	19.9	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	99	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	96	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	–	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	68	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	69.07	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	109.9	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	47	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	–	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	–	–

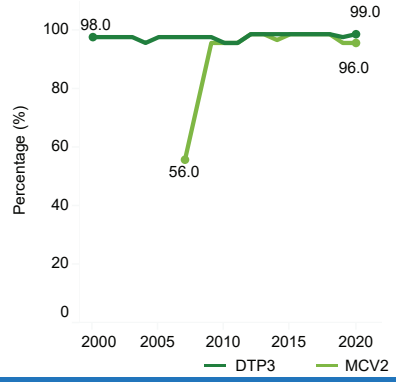
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

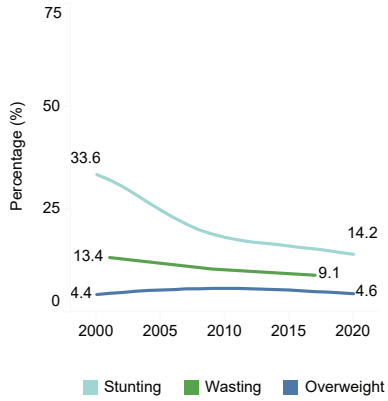


Other health-related SDGs

Indicator	SDG target	Year	Maldives	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	19.1	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	14.2	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2017	9.1	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	4.6	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	52.2	46.6
Intimate partner violence				
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[16]	5.2.1	2018	6	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	19	33

Note: En dash (–) implies relevant data are not available

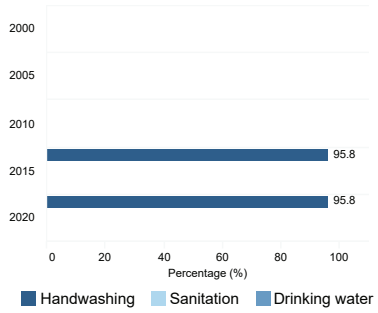
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



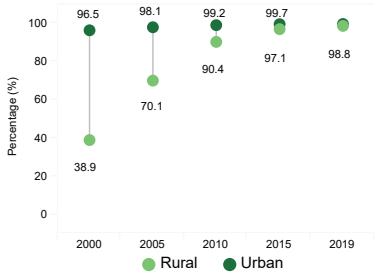
Drinking water services and sanitation				
Indicator	**SDG target**	**Year**	**Maldives**	**Regional estimate**
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	–	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	–	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	95.8	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	–	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	13.7	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	99.2	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	10.4	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	1.9	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2017	98.8	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]

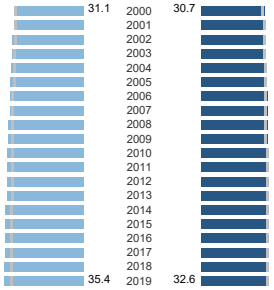


Additional SDG indicators used to monitor GPW13 impact

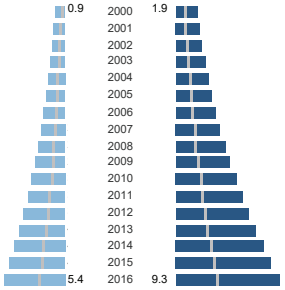
Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

No cases have been reported in the past 5 years

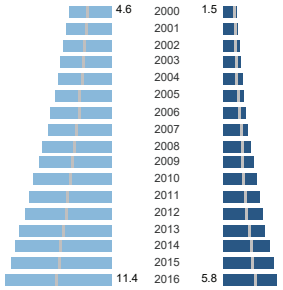
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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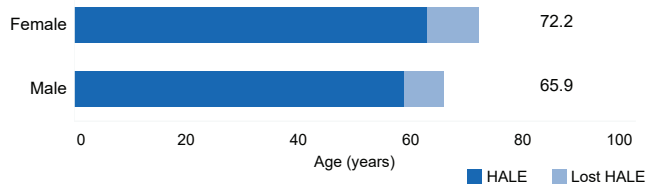
Myanmar

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
55 227	31.8%	1.4%	1282.8	4.7%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



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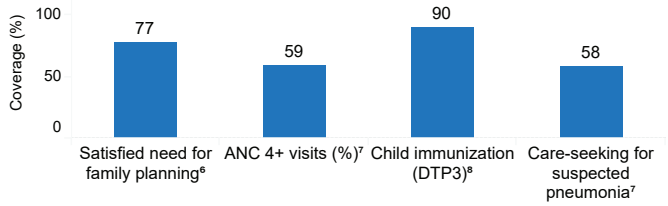
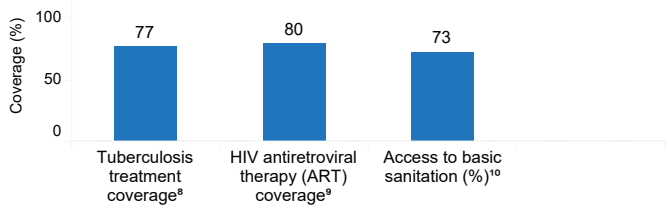
The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

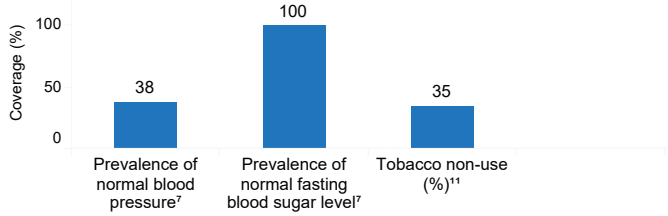
Reproductive, maternal, newborn and child health (RMNCAH)



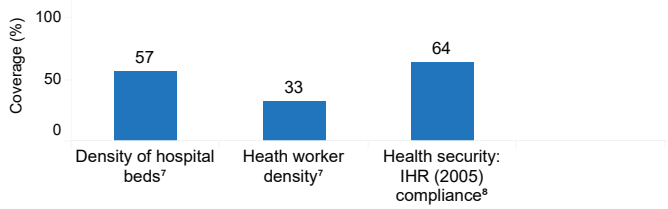
Infectious diseases



Noncommunicable diseases

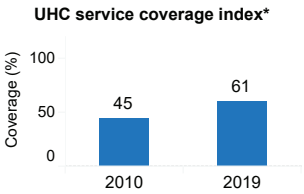


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

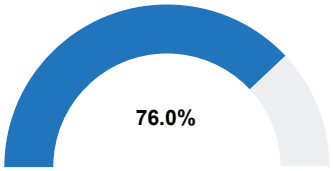
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **1.2%** or **approximately 662 724** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **12.7%** of people spent more than 10% of their household's total expenditure on health care.[12]

Out-of-pocket expenditure[4]

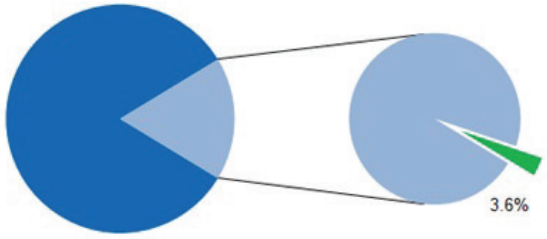
In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Out-of-pocket expenditure, as % of the current health expenditure (2019)

Public spending on health[4]

Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.

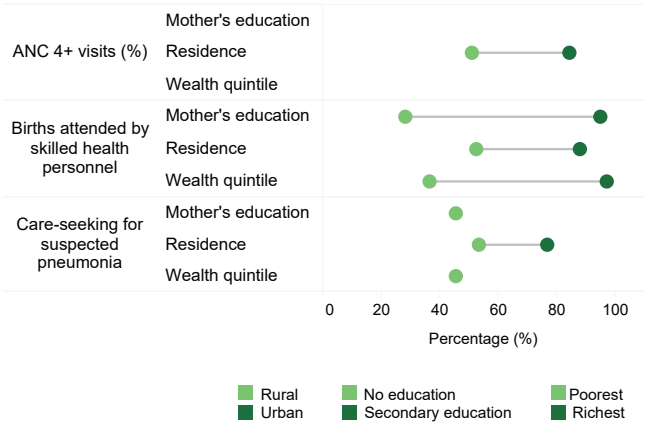


GDP, 2019
Estimated total government expenditure, 2019
Estimated government expenditure on health, 2019

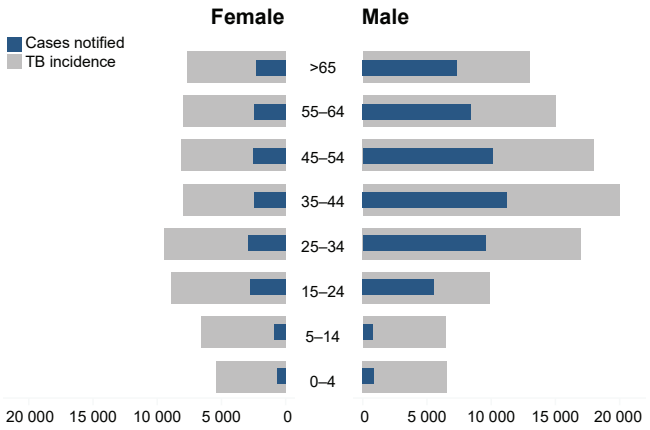
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

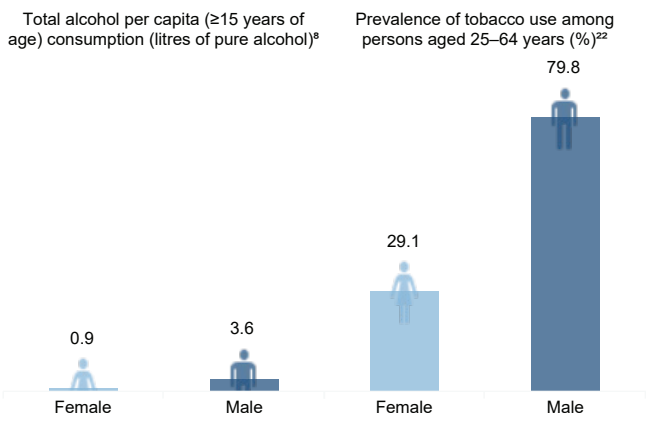
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



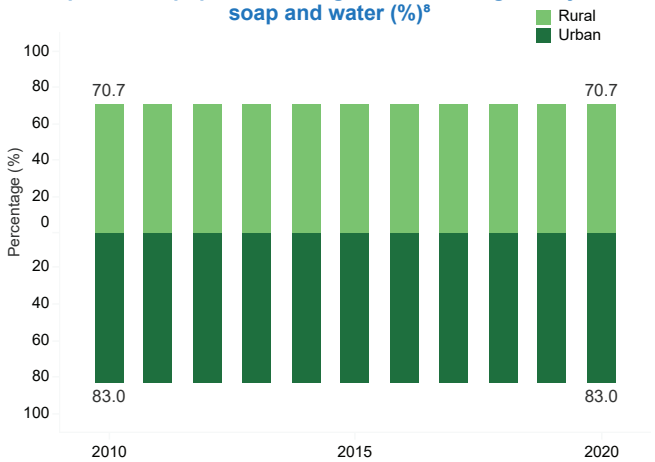
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,22]

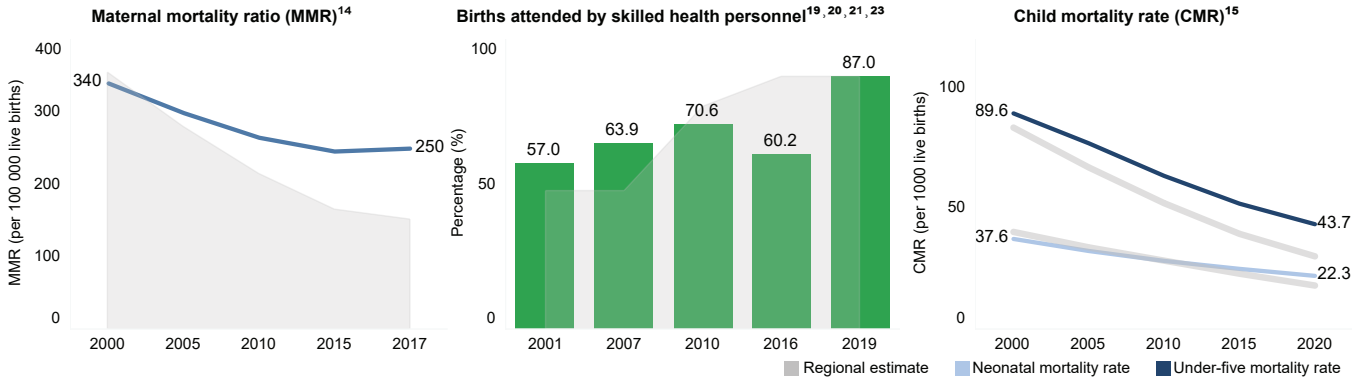


Proportion of population using a handwashing facility with soap and water (%)[8]

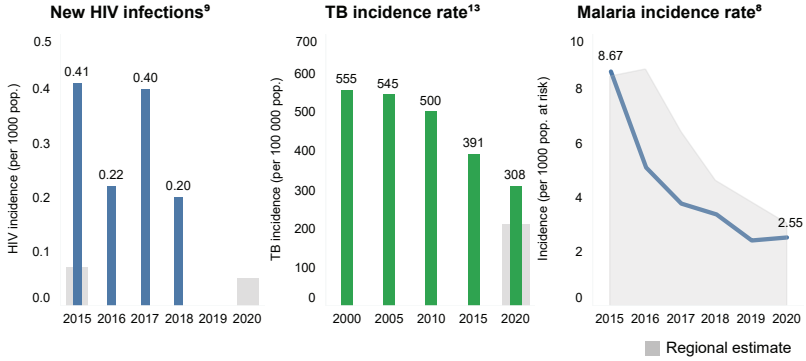


SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)



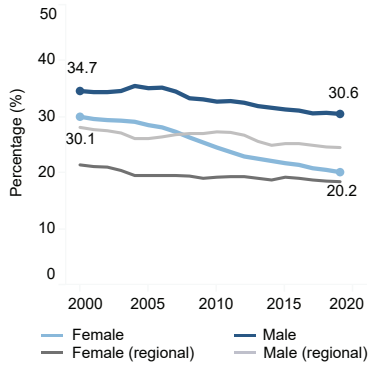
Communicable diseases (SDG target 3.3)



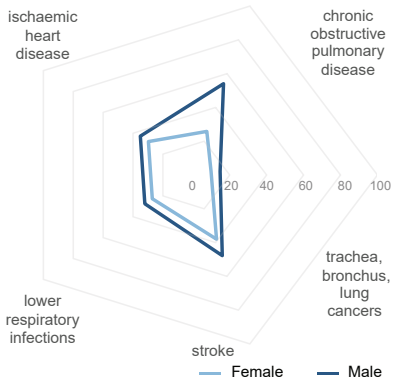
Indicator	Year	Myanmar	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	1.11	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	23 748 613	938 873 025

Indicator	SDG target	Year	Myanmar	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	24.9	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	2.9	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	2.1	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	20.4	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2016	74.9	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2016	36	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	156.4	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	12.6	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	1.3	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 25–64 years (%)[22]	3.a.1	2014	54.4	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	84	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	90	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	86	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	3.63	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	16.8	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	63	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	51	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	81	–

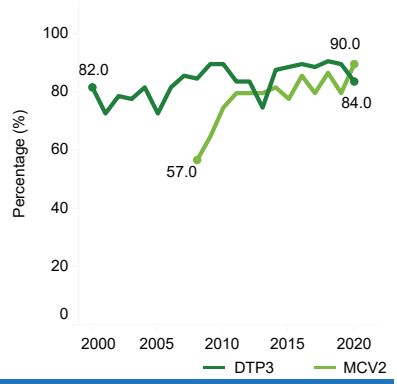
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

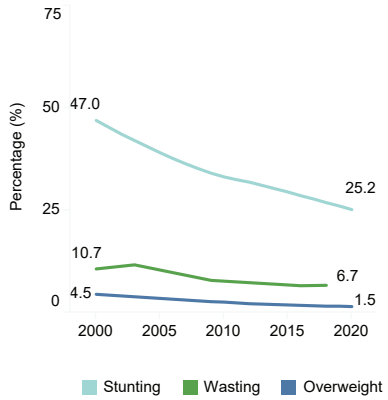


Other health-related SDGs

Indicator	SDG target	Year	Myanmar	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	3.6	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	25.2	30.1
Prevalence of wasting in children under 5 years (%)[24]	2.2.2	2018	6.7	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	1.5	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	42.1	46.6
Intimate partner violence				
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[16]	5.2.1	2018	11	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	19	33

Note: En dash (–) implies relevant data are not available

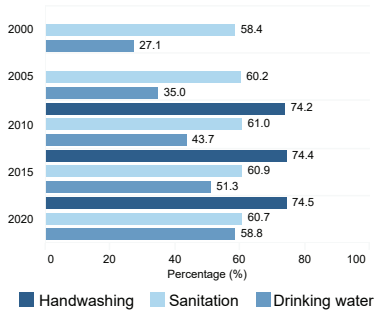
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



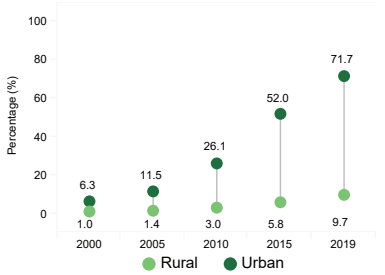
Indicator	SDG target	Year	Myanmar	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	58.8	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	60.7	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	74.5	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	–	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	97.2	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	31.3	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	33.7	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	3.9	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2016	81.3	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]

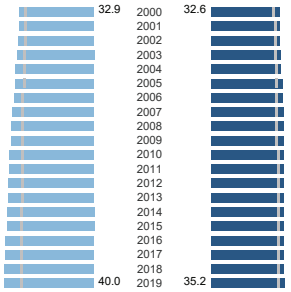


Additional SDG indicators used to monitor GPW13 impact

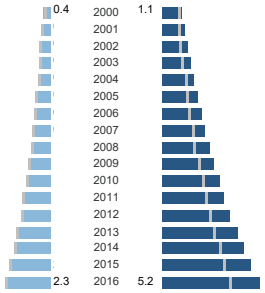
Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

No cases have been reported in the past 5 years

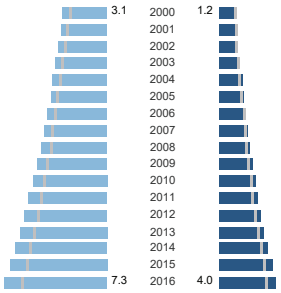
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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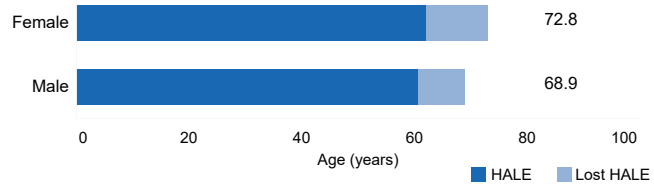
Nepal

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
30 226	21.5%	15.0%	1197.9	4.4%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 3.9 years of longer life expectancy and 1.5 years of more HALE than males.

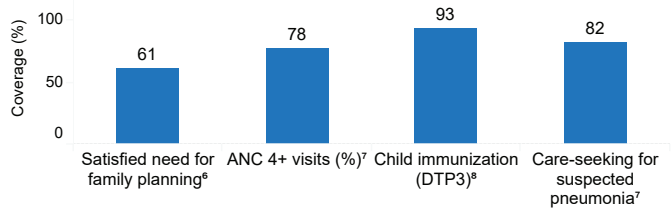
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

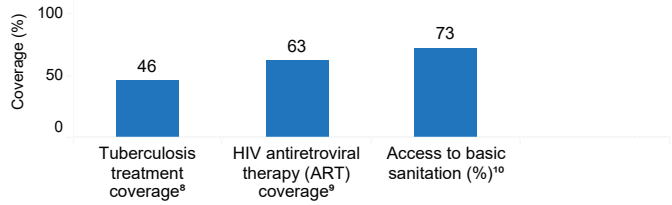
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

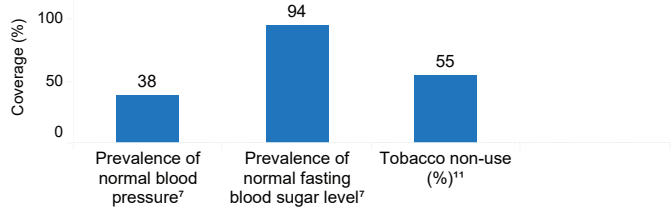
Reproductive, maternal, newborn and child health (RMNCAH)



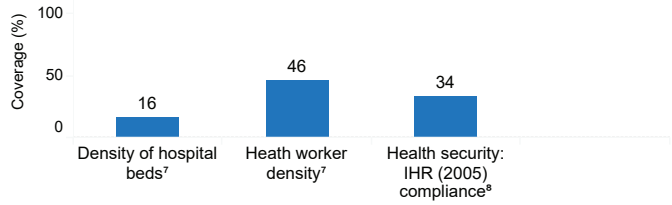
Infectious diseases



Noncommunicable diseases

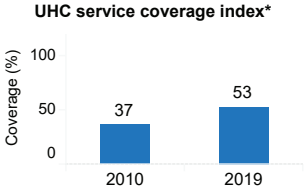


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

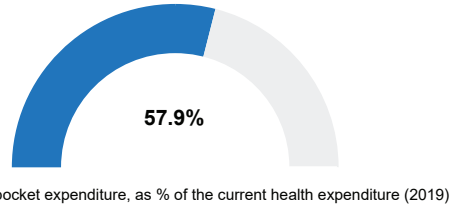
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **1.9%** or **approximately 574 294** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **10.7%** of people spent more than 10% of their household's total expenditure on health care.[12]

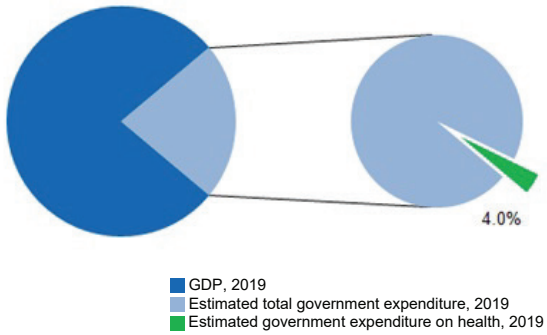
Out-of-pocket expenditure[4]

In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Public spending on health[4]

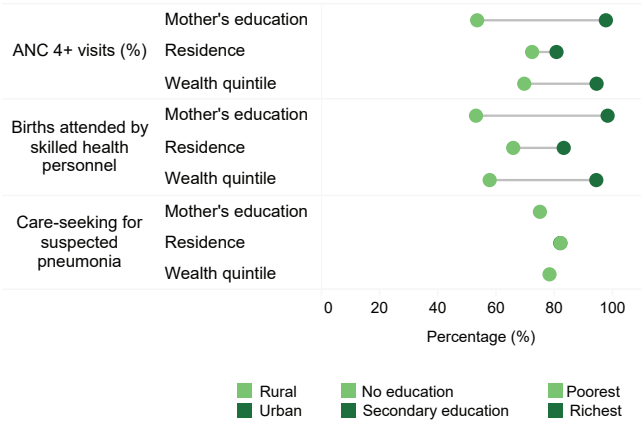
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



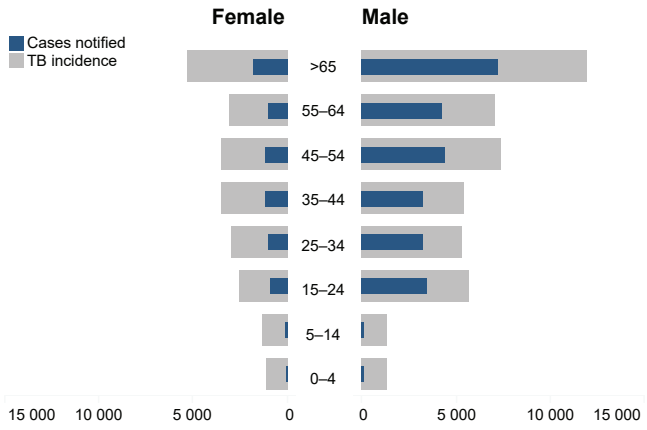
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

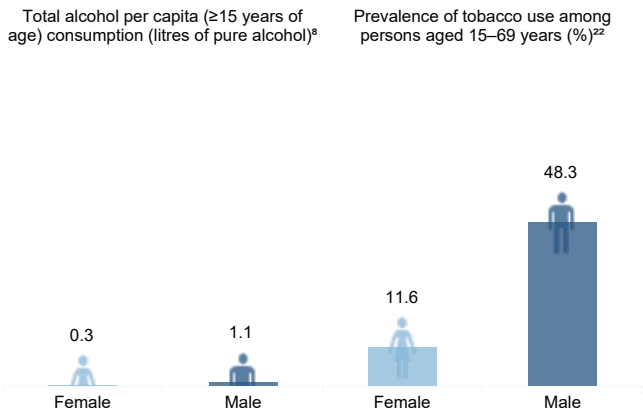
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



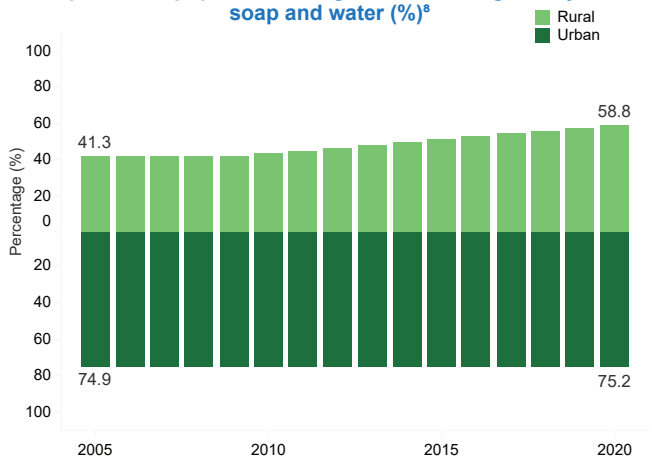
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,22]



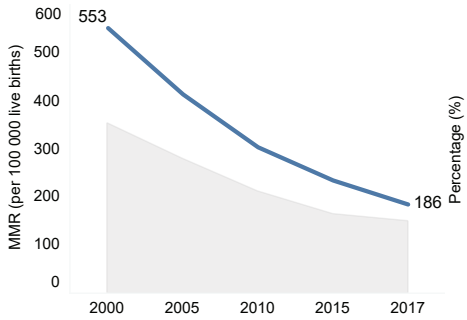
Proportion of population using a handwashing facility with soap and water (%)[8]



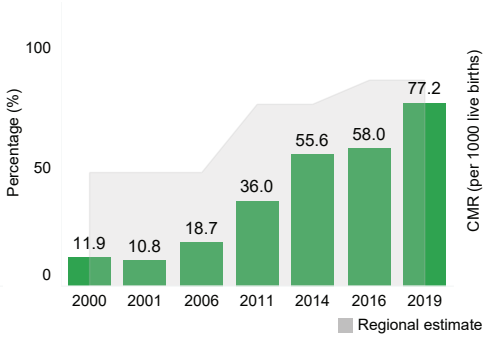
SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)

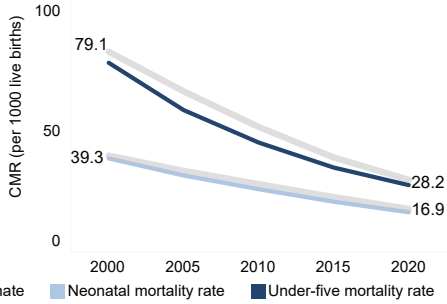
Maternal mortality ratio (MMR)[14]



Births attended by skilled health personnel[19,20,21]

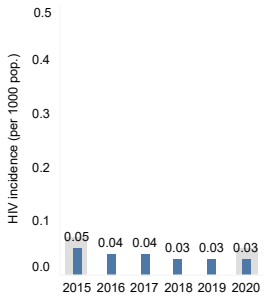


Child mortality rate (CMR)[15]

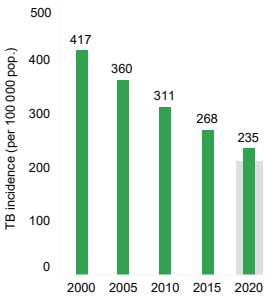


Communicable diseases (SDG target 3.3)

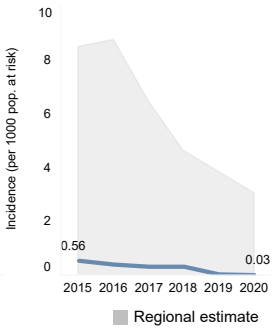
New HIV infections[9]



TB incidence rate[13]



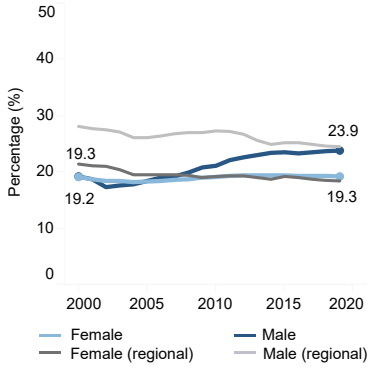
Malaria incidence rate[8]



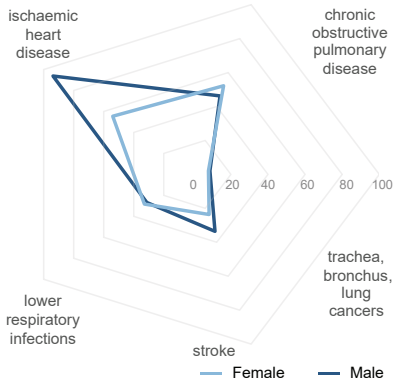
Indicator	Year	Nepal	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.16	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	13 519 533	938 873 025

Indicator	SDG target	Year	Nepal	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	21.5	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	9	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	0.6	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	16.3	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2019	61.9	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2019	63	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	193.8	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	19.8	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	1.7	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 15–69 years (%)[22]	3.a.1	2019	28.9	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	84	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	74	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	80	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	3.38	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	38.6	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	39	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	79	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	73	–

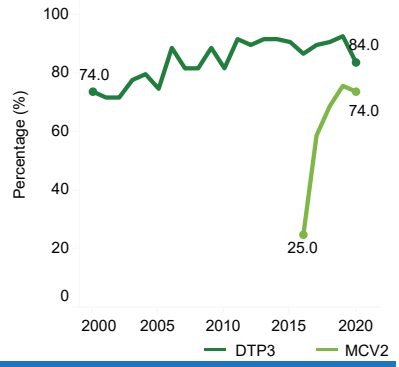
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

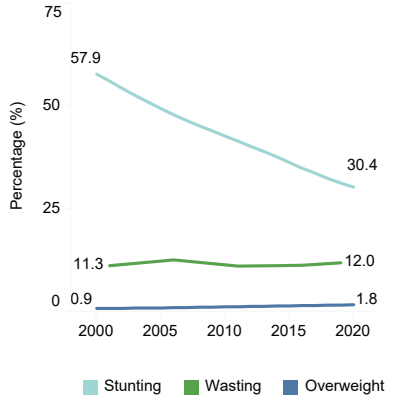


Other health-related SDGs

Indicator	SDG target	Year	Nepal	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	4	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	30.4	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2019	12	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	1.8	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	35.7	46.6
Intimate partner violence				
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[16]	5.2.1	2018	11	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	27	33

Note: En dash (–) implies relevant data are not available

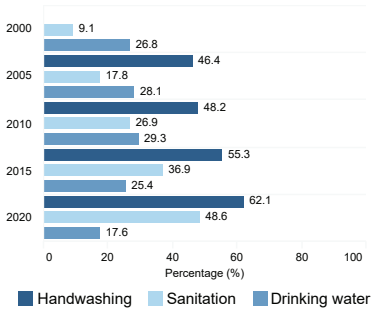
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



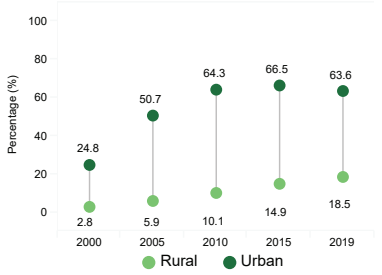
Indicator	SDG target	Year	Nepal	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	17.6	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	48.6	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	62.1	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	37	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	152.5	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	34.8	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	88	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	2.5	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2019	77.2	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



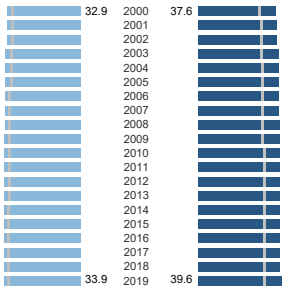
Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]



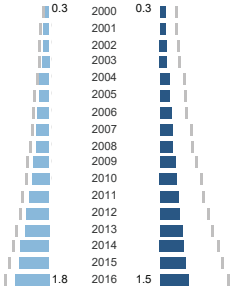
Additional SDG indicators used to monitor GPW13 impact

Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

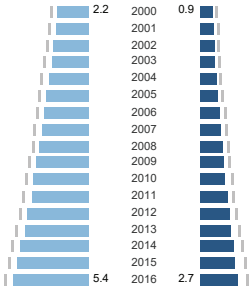
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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See for Malaria incidence rate calculated for confirmed cases: 2015=0.1, 2016=0.1, 2017=0.12, 2018=0.43, 2019=0.09, 2020=0.05; data source: World malaria report.
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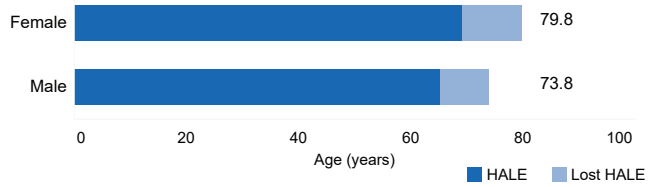
Sri Lanka

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
21 576	19.0%	0.9%	3938.8	4.1%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 6 years of longer life expectancy and 3.9 years of more HALE than males.

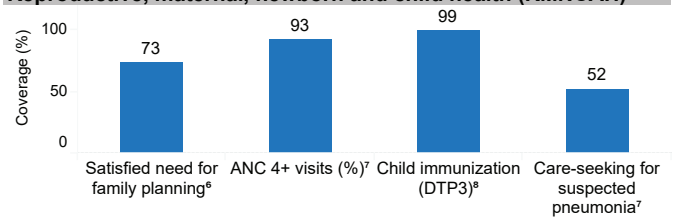
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

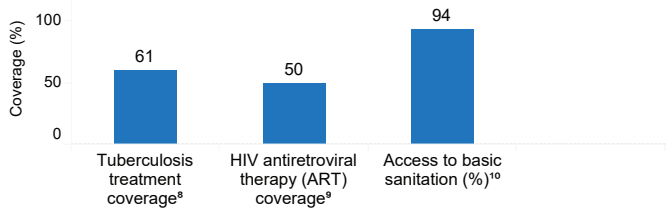
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

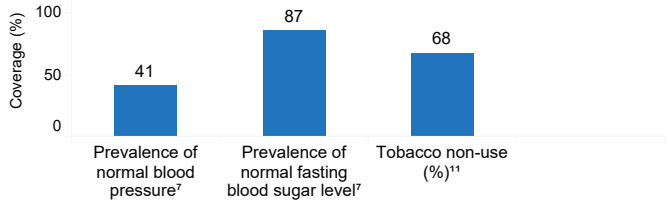
Reproductive, maternal, newborn and child health (RMNCAH)



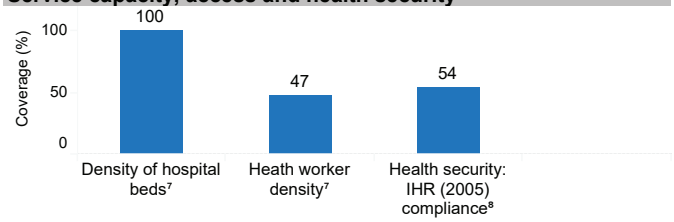
Infectious diseases



Noncommunicable diseases

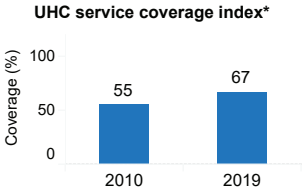


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

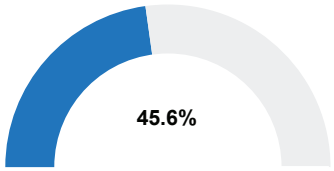
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **0.1%** or **approximately 21 576** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **5.4%** of people spent more than 10% of their household's total expenditure on health care.[12]

Out-of-pocket expenditure[4]

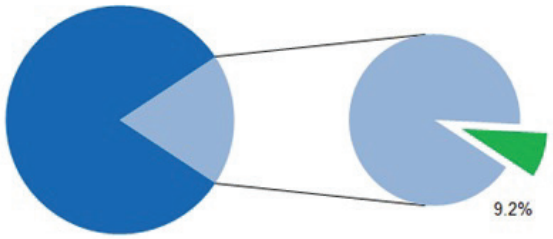
In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Out-of-pocket expenditure, as % of the current health expenditure (2019)

Public spending on health[4]

Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



GDP, 2019
Estimated total government expenditure, 2019
Estimated government expenditure on health, 2019

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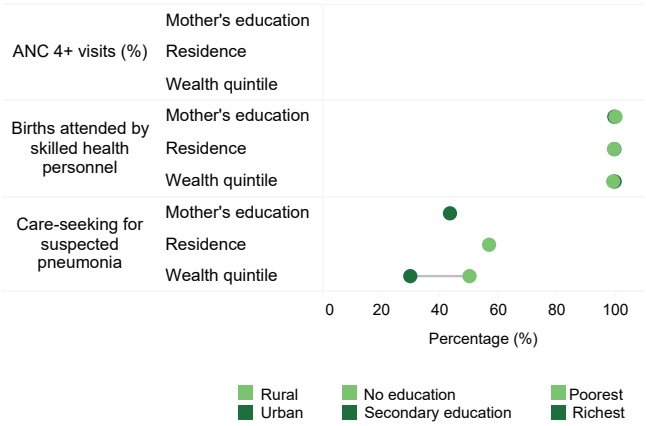
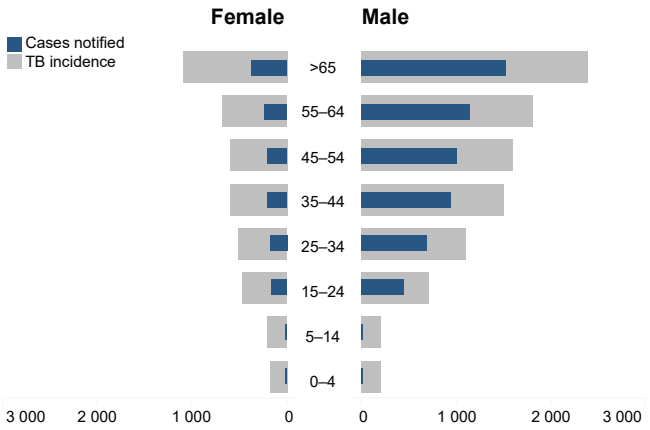
Health equity: leaving no one behind

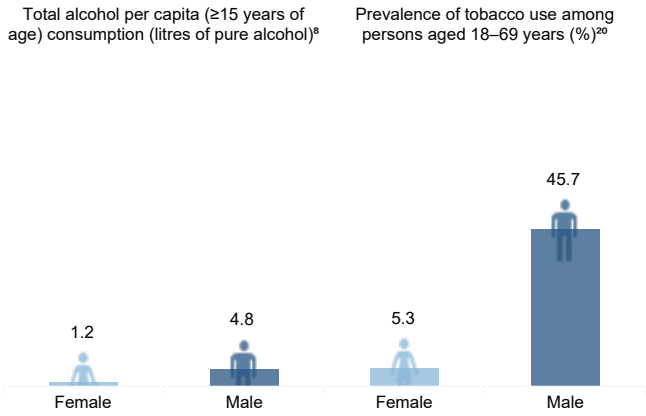
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



TB incidence, notified cases by age group and sex[13]



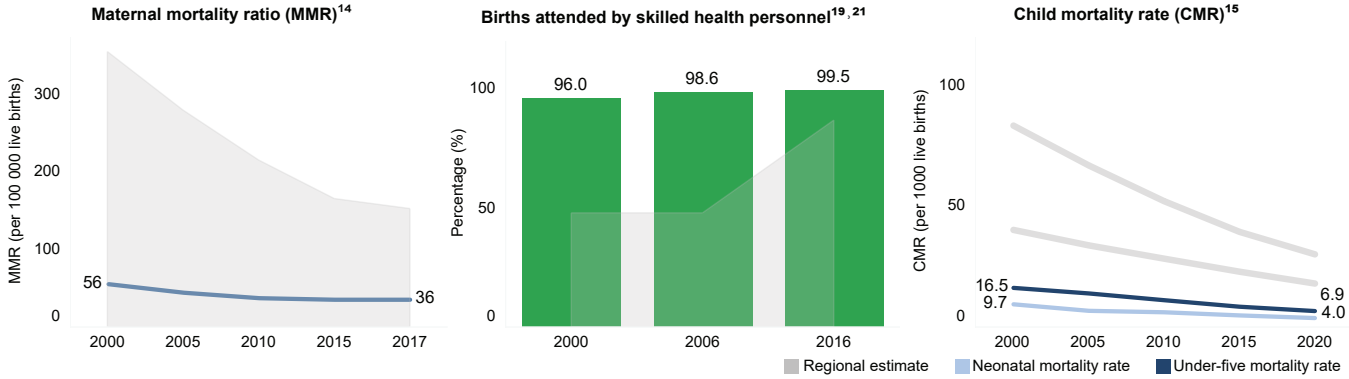
Tobacco use and alcohol consumption[8,20]



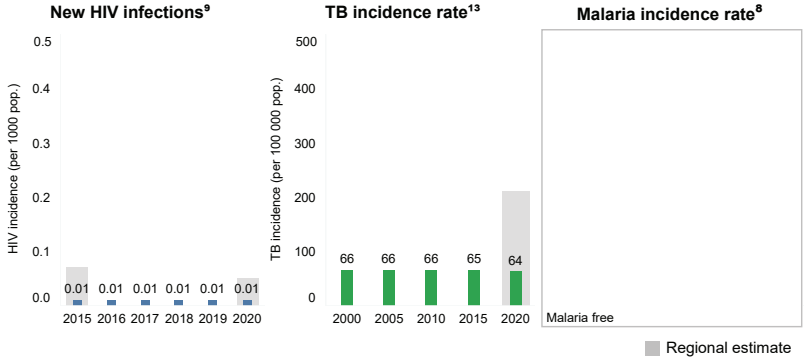
Proportion of population using a handwashing facility with soap and water (%)[8]

SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)



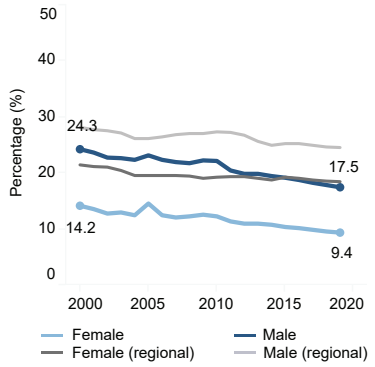
Communicable diseases (SDG target 3.3)



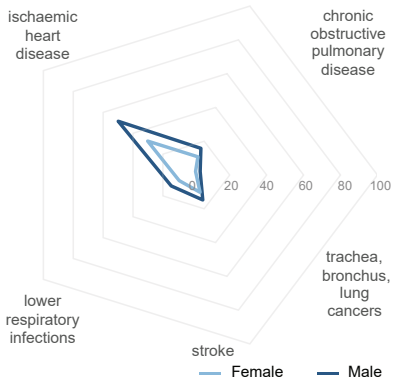
Indicator	Year	Sri Lanka	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.34	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	34 498	938 873 025

Indicator	SDG target	Year	Sri Lanka	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	13.2	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	14	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	2.9	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	19.7	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2016	74.2	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2016	21	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	79.8	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	1.2	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0.4	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 18–69 years (%)[20]	3.a.1	2015	25.8	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2020	96	85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2020	96	78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	–	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	51	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	0.67	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	68.3	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	31.8	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	62	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	53	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	62	–

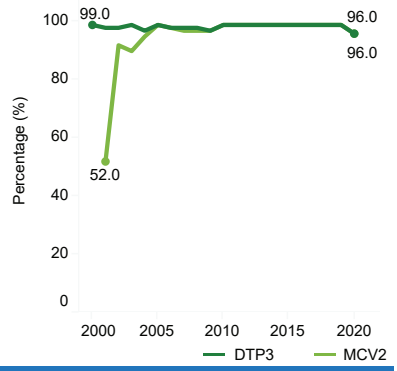
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

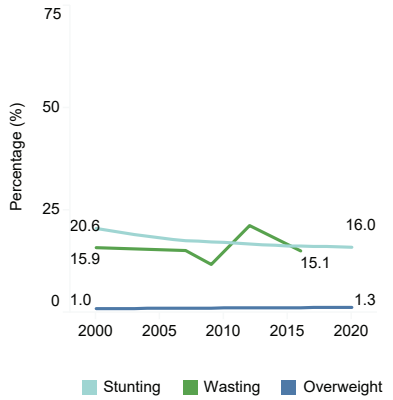


Other health-related SDGs

Indicator	SDG target	Year	Sri Lanka	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	9.2	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	16	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2016	15.1	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	1.3	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	34.6	46.6
Intimate partner violence				
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[16]	5.2.1	2018	4	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	24	33

Note: En dash (–) implies relevant data are not available

Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



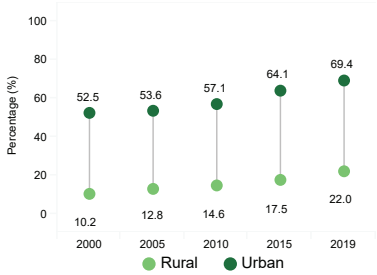
Drinking water services and sanitation				
Indicator	**SDG target**	**Year**	**Sri Lanka**	**Regional estimate**
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	–	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	–	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	–	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	–	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	132	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	32.2	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	16.8	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	2.3	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2016	–	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and hand-washing facility (6.1, 6.2.1, 6.2.2)[8]

Insufficient data for estimation

Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]

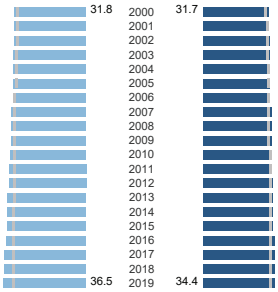


Additional SDG indicators used to monitor GPW13 impact

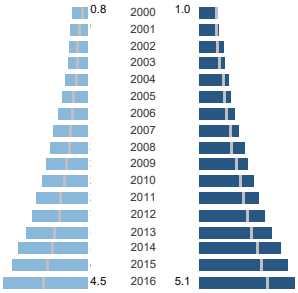
Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

No cases have been reported in the past 5 years

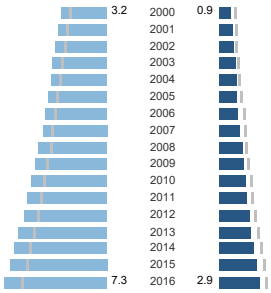
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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See for Malaria incidence rate calculated for confirmed cases: 2015=0.7, 2016=1.4, 2017=1.4, 2018=0.54, 2019=0.41, 2020=0.29; data source: World malaria report.
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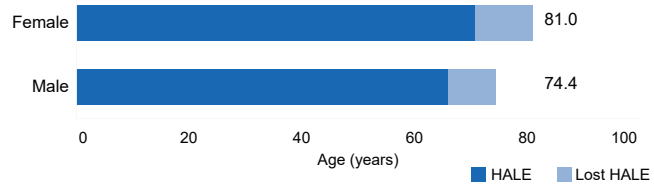
Thailand

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
70 078	52.9%	0.0%	7816.2	3.8%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 6.6 years of longer life expectancy and 4.7 years of more HALE than males.

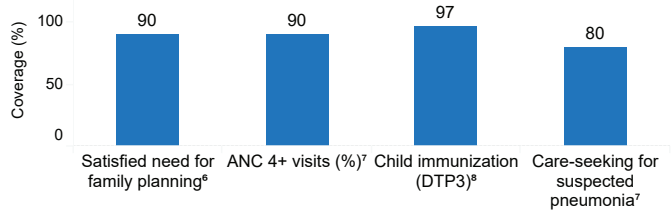
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

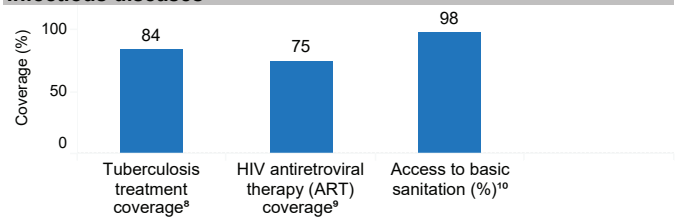
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

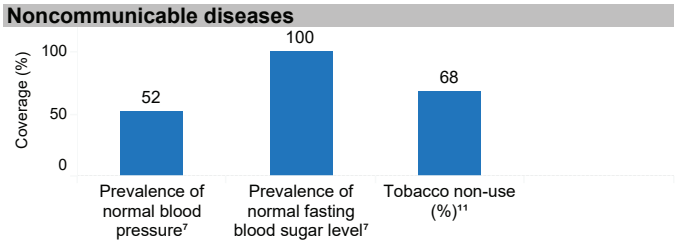
Reproductive, maternal, newborn and child health (RMNCAH)



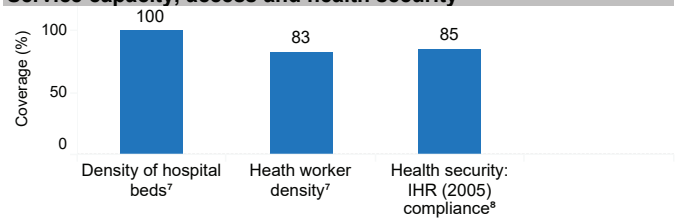
Infectious diseases



Noncommunicable diseases



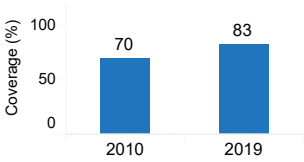
Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.

UHC service coverage index*



FINANCIAL PROTECTION

Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

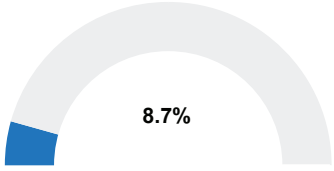
Impoverishment: approximately **0.0%** people** are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **1.9%** of people spent more than 10% of their household's total expenditure on health care.[12]

**Impoverishment data are not reported at PPP US$ 1.90 level

Out-of-pocket expenditure[4]

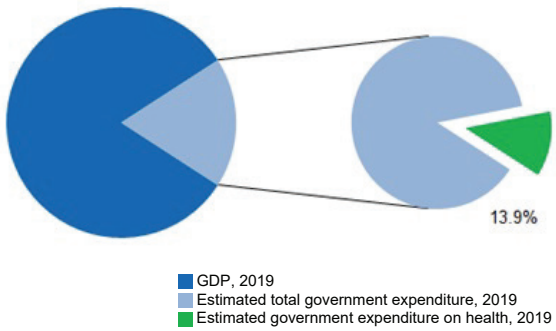
In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Out-of-pocket expenditure, as % of the current health expenditure (2019)

Public spending on health[4]

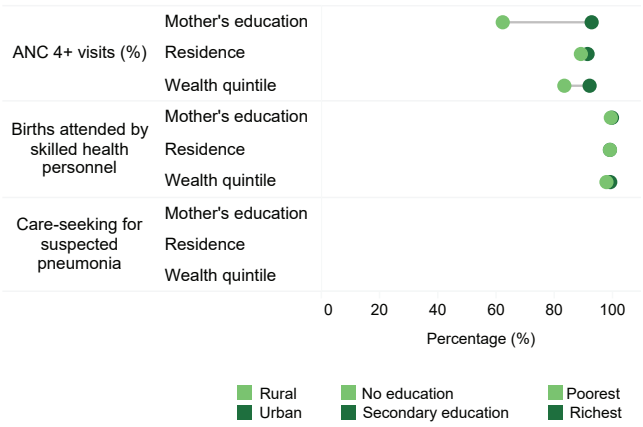
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



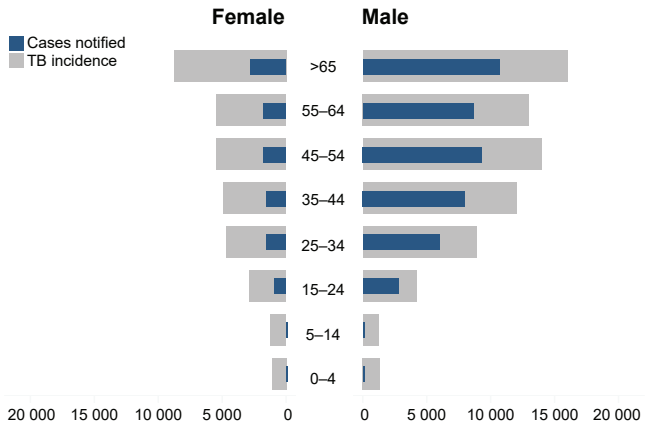
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

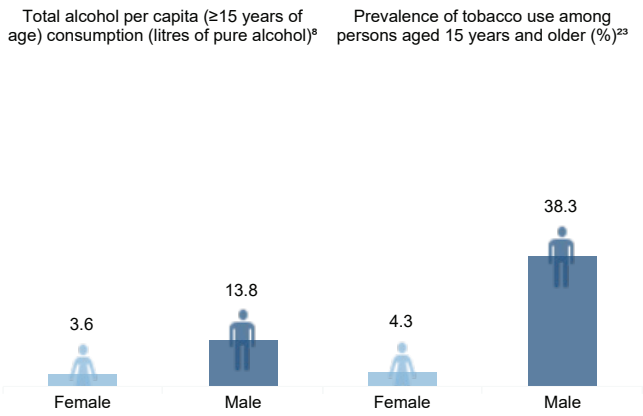
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



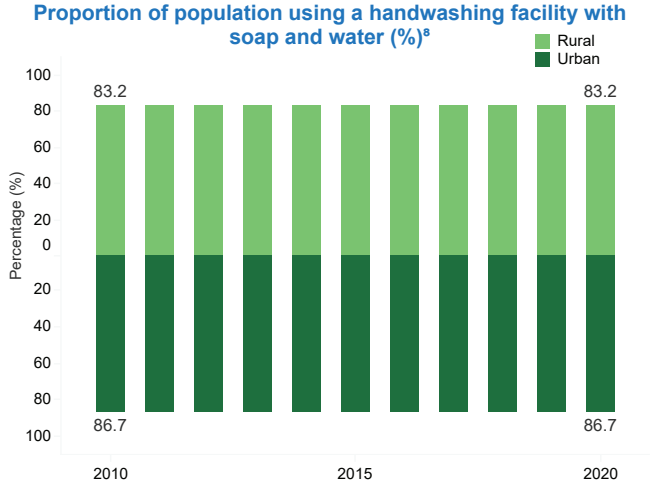
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,23]

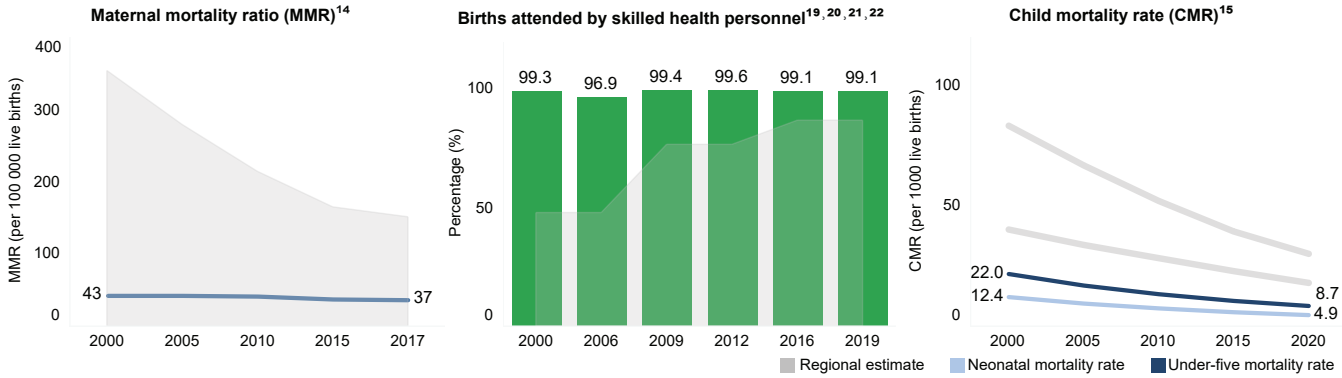


Proportion of population using a handwashing facility with soap and water (%)[8]

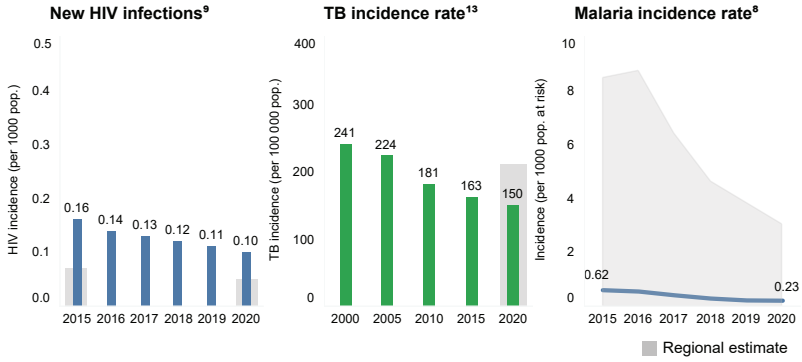


SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)



Communicable diseases (SDG target 3.3)



Indicator	Year	Thailand	Regional estimate
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Number of people requiring interventions against neglected tropical diseases[16]	2020	50 131	938 873 025

Indicator	SDG target	Year	Thailand	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	13.7	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	8.8	10.1
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Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	32.2	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2019	88	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2019	23	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	61.5	165.8
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Tobacco use				
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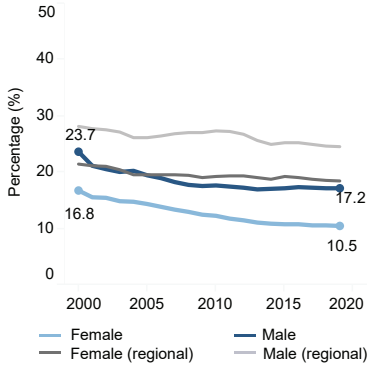
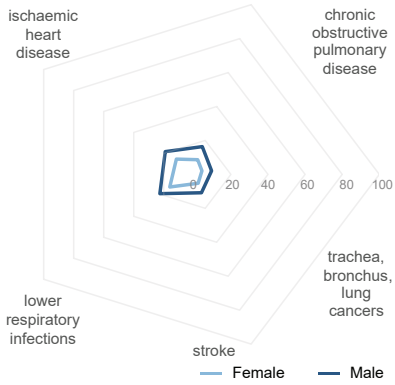
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	–	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	0.12	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	35.6	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	85	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	11	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	39	–

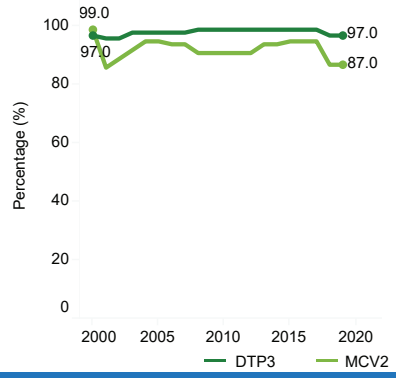
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

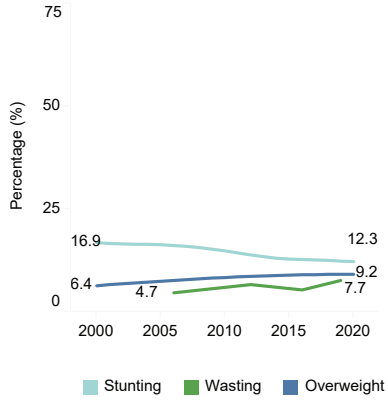


Other health-related SDGs

Indicator	SDG target	Year	Thailand	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	13.9	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	12.3	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2019	7.7	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	9.2	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	24	46.6
Intimate partner violence				
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[16]	5.2.1	2018	9	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	24	33

Note: En dash (–) implies relevant data are not available

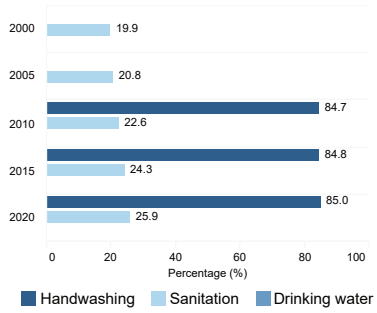
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18]



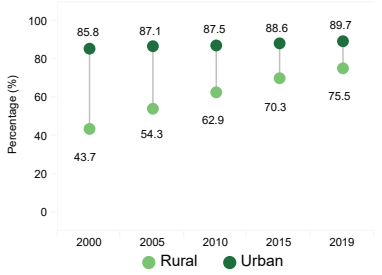
Indicator	SDG target	Year	Thailand	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	–	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	25.9	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	85	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	24	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	1.5	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	83.6	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	31.9	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	4.3	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2019	99.8	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



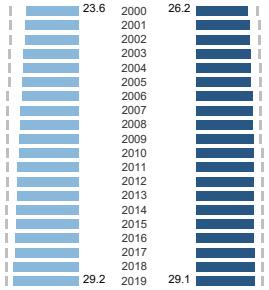
Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]



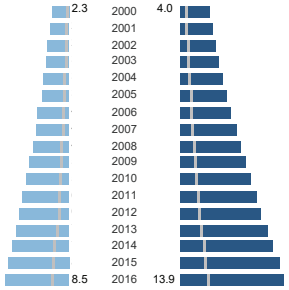
Additional SDG indicators used to monitor GPW13 impact

Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

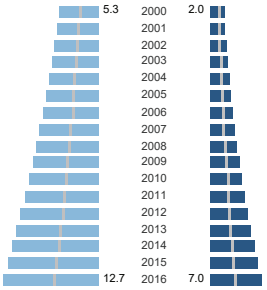
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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See for Malaria incidence rate calculated for confirmed cases: 2015=0.7, 2016=1.4, 2017=1.4, 2018=0.54, 2019=0.41, 2020=0.29; data source: World malaria report.
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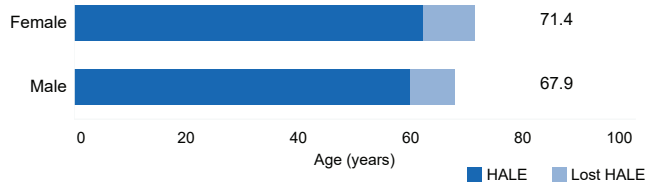
Timor-Leste

Population (000s)[1]	Urban population[2]	Poverty[3] (ppp <US$1.90 a day)	GDP per capita[4] (current US$)	Current health expenditure as share of GDP[4]
1 369	32.1%	22.0%	1294.5	7.2%

Monitoring the health SDG goal: Indicator of overall health and well-being

Life expectancy at birth[5]



Life expectancy measures the average number of years that a newborn is expected to live. Healthy life expectancy (HALE)[5] represents the number of years of living in good health without disease or injury.

Females have 3.5 years of longer life expectancy and 2.2 years of more HALE than males.

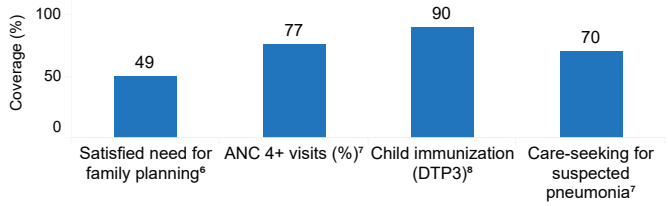
Universal health coverage (UHC): At the centre of health-related SDGs

The goal of UHC is that all people and communities receive the health care they need, without suffering financial hardship. Monitoring UHC requires measuring **health service coverage** and **financial protection** (SDG target 3.8).

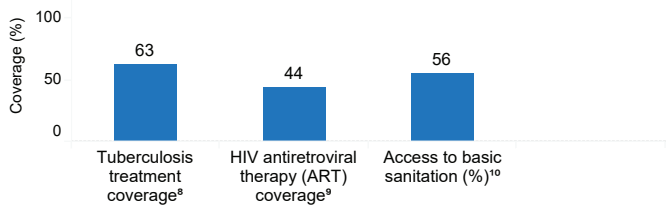
HEALTH SERVICE COVERAGE

The summary measure of essential health service coverage is the *service coverage index* of sub-indicators in four main areas: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) noncommunicable diseases; (4) service capacity, access and health security.

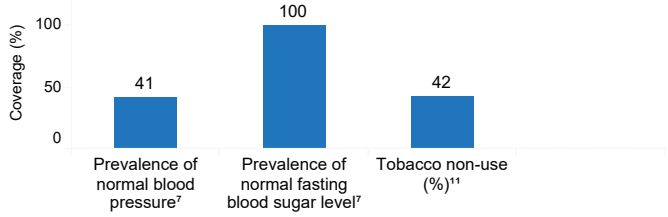
Reproductive, maternal, newborn and child health (RMNCAH)



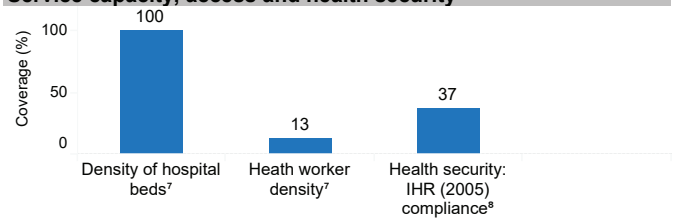
Infectious diseases



Noncommunicable diseases

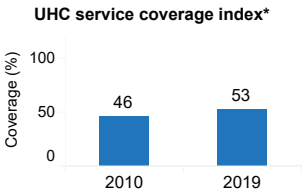


Service capacity, access and health security



UHC service coverage index of essential health services

To provide a summary measure of coverage, an index of national service coverage is computed by taking the geometric mean of service coverage values across the sub-indicators. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage across a range of services.



FINANCIAL PROTECTION

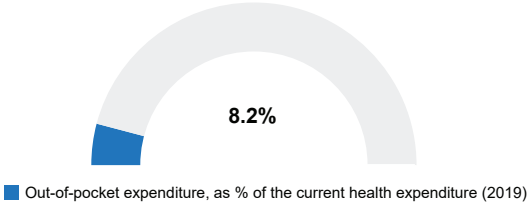
Financial protection is commonly measured through two indicators: (1) impoverishment, and (2) catastrophic health expenditure.

Impoverishment: **0.8%** or **approximately 10 952** people are being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending.[12]

Catastrophic expenditure on health: **2.6%** of people spent more than 10% of their household's total expenditure on health care.[12]

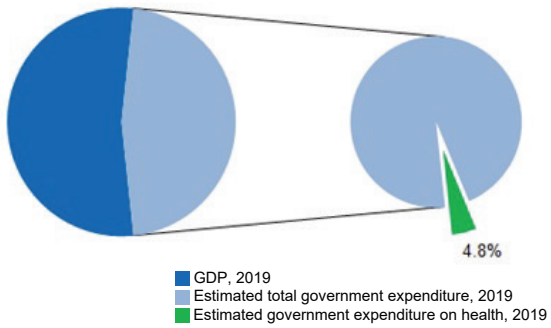
Out-of-pocket expenditure[4]

In most cases, a high percentage of out-of-pocket expenditure out of the current health expenditure is associated with low financial protection.



Public spending on health[4]

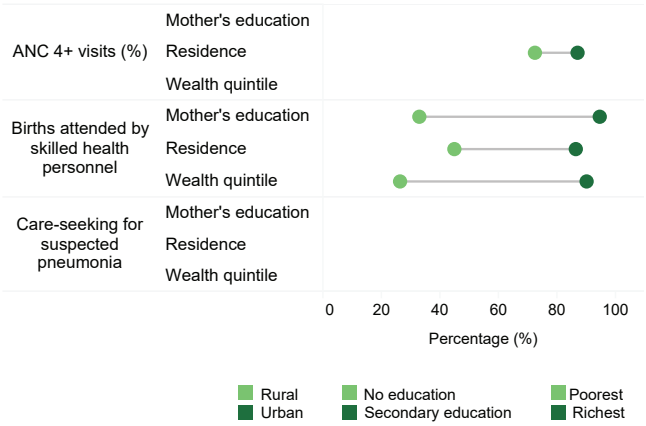
Is determined by the capacity of the government to raise revenues and the level of priority it attaches to the health sector.



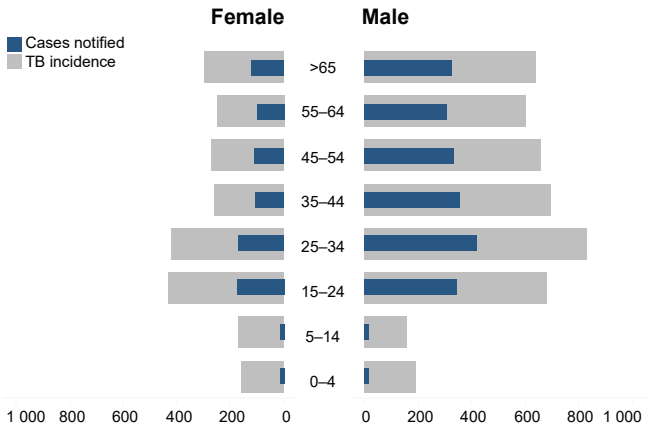
This profile provides an overview of the current status of progress towards the 13 targets under the health Sustainable Development Goal 3 (SDG 3) plus other selected health-related indicators. Twenty-five of the indicators are noted with an asterisk(*), which Member States in the WHO South-East Asia Region have designated to be the most common indicators of importance for the Region and for which historical data are available. This profile also includes all of the SDG indicators for the WHO Thirteenth General Programme of Work 2019–2023 (GPW13)

Health equity: leaving no one behind

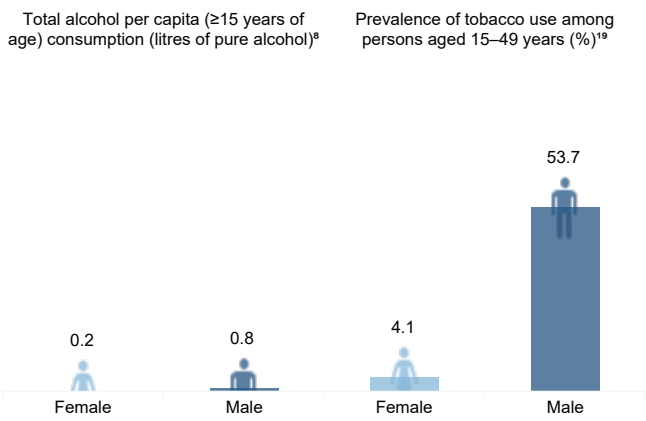
ANC 4+ (%), births attended by skilled health personnel and care-seeking for suspected pneumonia[19]



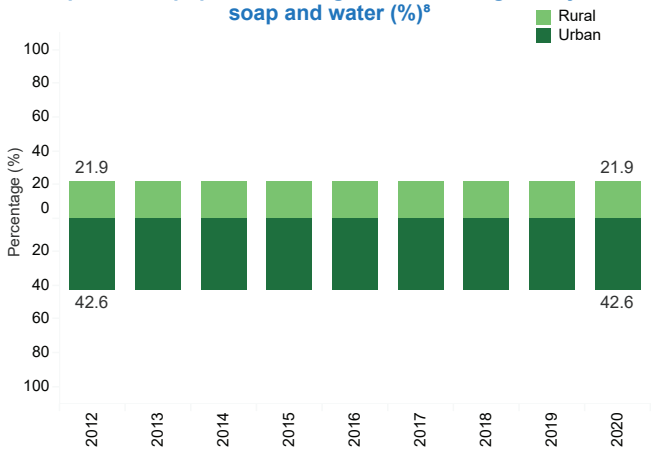
TB incidence, notified cases by age group and sex[13]



Tobacco use and alcohol consumption[8,19]



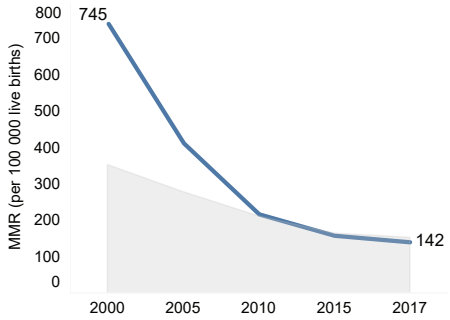
Proportion of population using a handwashing facility with soap and water (%)[8]



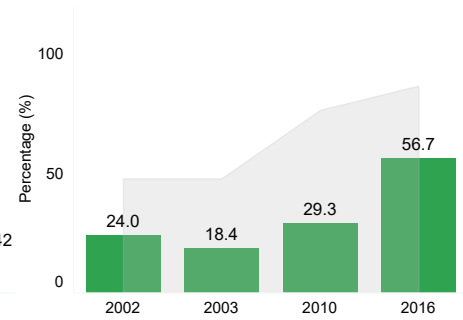
SDG 3: Health targets

Maternal and child mortality (SDG target 3.1, 3.2)

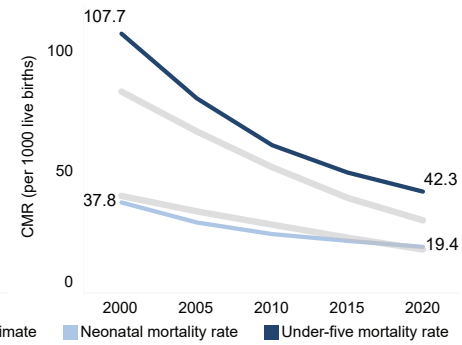
Maternal mortality ratio (MMR)[14]



Births attended by skilled health personnel[19,20]

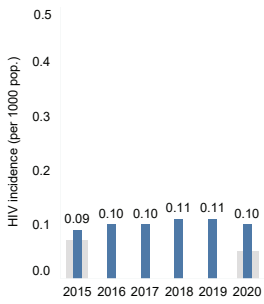


Child mortality rate (CMR)[15]

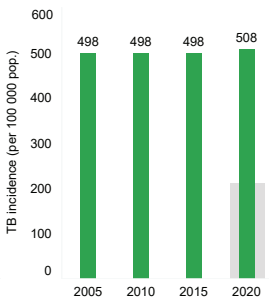


Communicable diseases (SDG target 3.3)

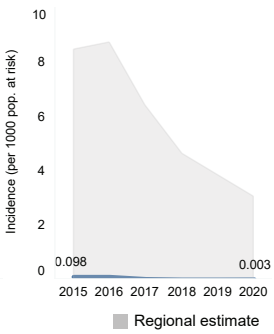
New HIV infections[9]



TB incidence rate[13]



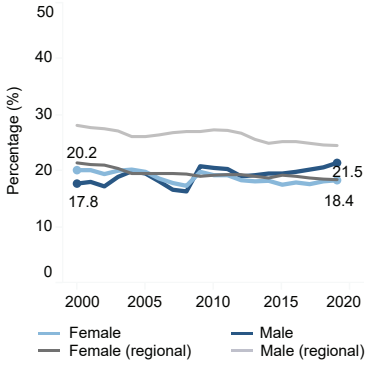
Malaria incidence rate[8]



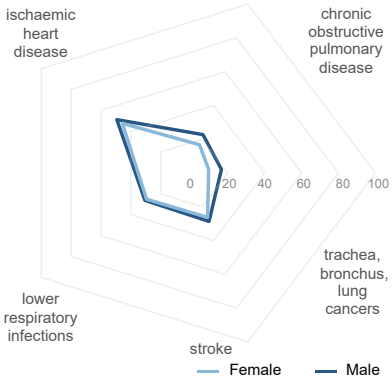
Indicator	Year	Timor-Leste	Regional estimate
Hepatitis B surface antigen prevalence among children under 5 years of age (%)[16]	2020	0.72	0.38
Number of people requiring interventions against neglected tropical diseases[16]	2020	1 361 778	938 873 025

Indicator	SDG target	Year	Timor-Leste	Regional estimate
Noncommunicable diseases and injuries				
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%)[8]	3.4.1	2019	19.9	21.6
Suicide mortality rate (per 100 000 population)[16]	3.4.2	2019	3.7	10.1
Total alcohol per capita (≥15 years of age) consumption (litres of pure alcohol)[8]	3.5.2	2019	0.5	4.3
Road traffic mortality rate (per 100 000 population)[16]	3.6.1	2019	11.9	15.8
Sexual and reproductive health				
Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)[19]	3.7.1	2016	46.9	75.3
Adolescent birth rate (per 1000 women aged 15–19 years)[19]	3.7.2	2016	42	26.1
Mortality due to environmental pollution				
Age–standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)[8]	3.9.1	2016	139.8	165.8
Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)[16]	3.9.2	2016	9.9	15.4
Mortality rate attributed to unintentional poisoning (per 100 000 population)[16]	3.9.3	2019	0.4	0.3
Tobacco use				
Prevalence of tobacco use among persons aged 15–49 years (%)[19]	3.a.1	2016	48.6	–
Essential medicines and vaccines				
DTP3 immunization coverage among 1-year-olds (%)[8]	3.b.1	2019 2020	90 86	91 85
MCV2 immunization coverage by the nationally recommended age[8]	3.b.1	2019 2020	80 78	83 78
PCV3 immunization coverage among 1-year-olds (%)[16]	3.b.1	2020	–	27
HPV immunization coverage estimates among 15-year-old girls (%)[16]	3.b.1	2020	–	2
Total net official development assistance to medical research and basic health per capita (US$)[16]	3.b.2	2020	12.33	0.58
Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)[16]	3.b.3	2019	–	–
Health workforce				
Health worker distribution (per 10 000 population)[17]	3.c.1	2018	23.9	26
National and global health risks				
Average of 13 International Health Regulations core capacity scores[16]	3.d	2020	42	63
Percentage of bloodstream infections due methicillin-resistant staphylococcus aureus (%)[16]	3.d.2.1	2020	21	–
Percentage of bloodstream infection due to escherichia coli resistant to 3rd-generation cephalosporin (%)[16]	3.d.2.2	2020	62	–

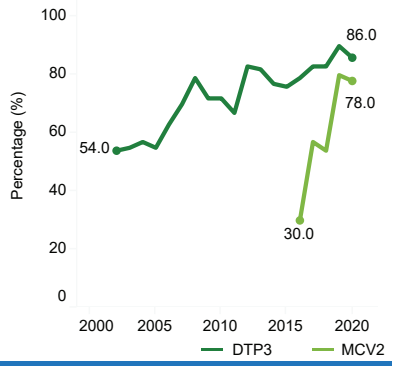
Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and age 70 (%) (3.4.1)[8]



Mortality rate attributed to household and ambient air pollution (3.9.1) – cause wise[8]



Immunization coverage (3.b.1)[8]

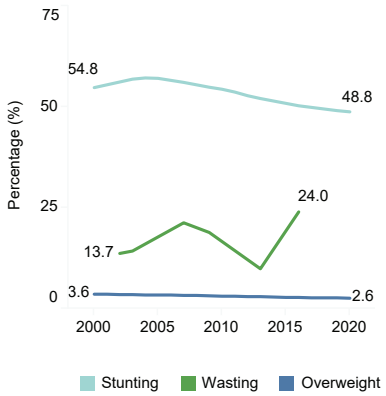


Other health-related SDGs

Indicator	SDG target	Year	Timor-Leste	Regional estimate
General government health expenditure				
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)[4]	1.a	2019	4.8	8
Child nutrition				
Prevalence of stunting in children under 5 years (%)[18]	2.2.1	2020	48.8	30.1
Prevalence of wasting in children under 5 years (%)[19]	2.2.2	2016	24	14.5
Prevalence of overweight in children under 5 years (%)[18]	2.2.3	2020	2.6	3.3
Prevalence of anaemia in women of reproductive age (15–49 years) (%)[16]	2.2.4	2019	29.9	46.6
Intimate partner violence				
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[16]	5.2.1	2018	28	17
Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence[16]	5.2.2	2018	38	33

Note: En dash (–) implies relevant data are not available

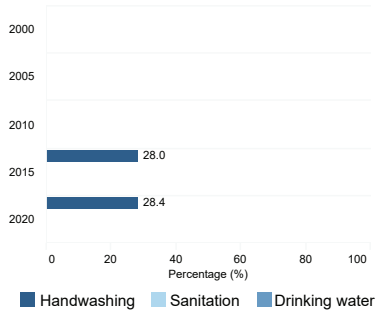
Prevalence of stunting, wasting and overweight in children under 5 (2.2)[18,19]



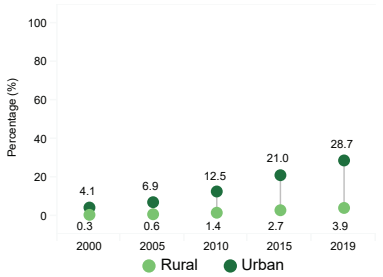
Indicator	SDG target	Year	Timor-Leste	Regional estimate
Drinking water services and sanitation				
Proportion of population using safely managed drinking water services (%)[8]	6.1	2020	–	–
Proportion of population using safely managed sanitation services (%)[8]	6.2.1	2020	–	46
Proportion of population using a handwashing facility with soap and water (%)[8]	6.2.2	2020	28.4	71
Proportion of safely treated domestic wastewater flows (%)[16]	6.3.1	2020	–	–
Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2016 US$ millions)[16]	6.a.1	2020	3.9	1178
Clean household energy				
Proportion of population with primary reliance on clean fuels and technology (%)[8]	7.1	2020	13.6	64.5
Ambient air pollution				
Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3)[8]	11.6.2	2016	17.7	61.1
Homicide and conflicts				
Mortality rate due to homicide (per 100 000 population)[8]	16.1	2019	4.7	3.8
Birth registration				
Birth registration coverage[19]	16.9.1	2016	60.4	–
Cause-of-death data				
Completeness of cause-of-death data (%)[8]	17.19	2019	–	–

Note: En dash (–) implies relevant data are not available

Drinking water services, sanitation and handwashing facility (6.1, 6.2.1, 6.2.2)[8]



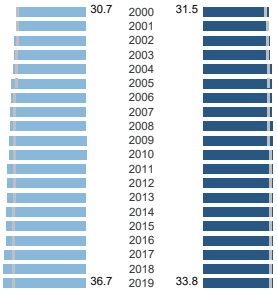
Proportion of population with primary reliance on clean fuels and technology (%) (7.1)[8]



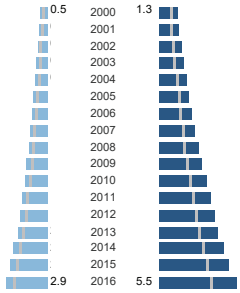
Additional SDG indicators used to monitor GPW13 impact

Number of cases of poliomyelitis caused by wild poliovirus (WPV)[16]

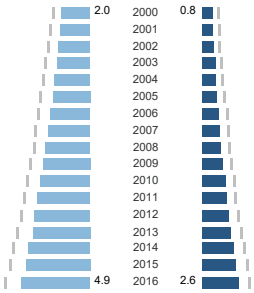
Age-standardized prevalence of hypertension among adults aged 30–79 years (%)[8]



Prevalence of obesity among children and adolescents (5–19 years) (%)[8]



Age-standardized prevalence of obesity among adults (18+ years) (%)[8]



Female Male Regional

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Annexures

Annex 1
Universal health coverage essential health services index list

Globally, the essential health service coverage indicators are developed using only 14 indicators due to limitations on availability of data. The WHO SE Asia Region uses 13 of the essential health service coverage indicators as use of insecticide-treated nets is not included because no country of the Region is considered at high-risk for malaria.

Tracer area	Tracer indicator	Population	Type
Reproductive, maternal, newborn and child health			
Family planning	Demand satisfied with modern methods	Married women aged 15–49	Service coverage
Pregnancy and delivery care	ANC, 4+ visits	Women with a live birth in past 2 or 5 years	Service coverage
Child immunization	DTP3 immunization	1-year-old children	Service coverage
Child treatment	Care seeking behavior for suspected pneumonia	Children <5	Service coverage
Infectious diseases			
Tuberculosis treatment	TB treatment coverage	TB incident cases	Service coverage
HIV therapy	HIV ART coverage	People living with HIV	Service coverage
Water and sanitation	Population with access to at least basic sanitation	All	Service coverage
Noncommunicable diseases			
Prevention of CVDs	Prevalence of raised blood pressure	Adults aged 30+	Proxy
Management of diabetes	Mean fasting blood plasma glucose	Adults aged 18+	Proxy
Tobacco control	Tobacco use	Adults aged 15+	Proxy
Service capacity and access			
Hospital access	Hospital beds density	–	Proxy
Health workforce	Health worker density: comprising physicians, psychiatrists and surgeons	–	Proxy
Health security	IHR core capacity index	–	Proxy

Annex 2
Health and other health-related SDG indicator list

Annex 2 lists health and other health-related SDG indicators is provided in country profile

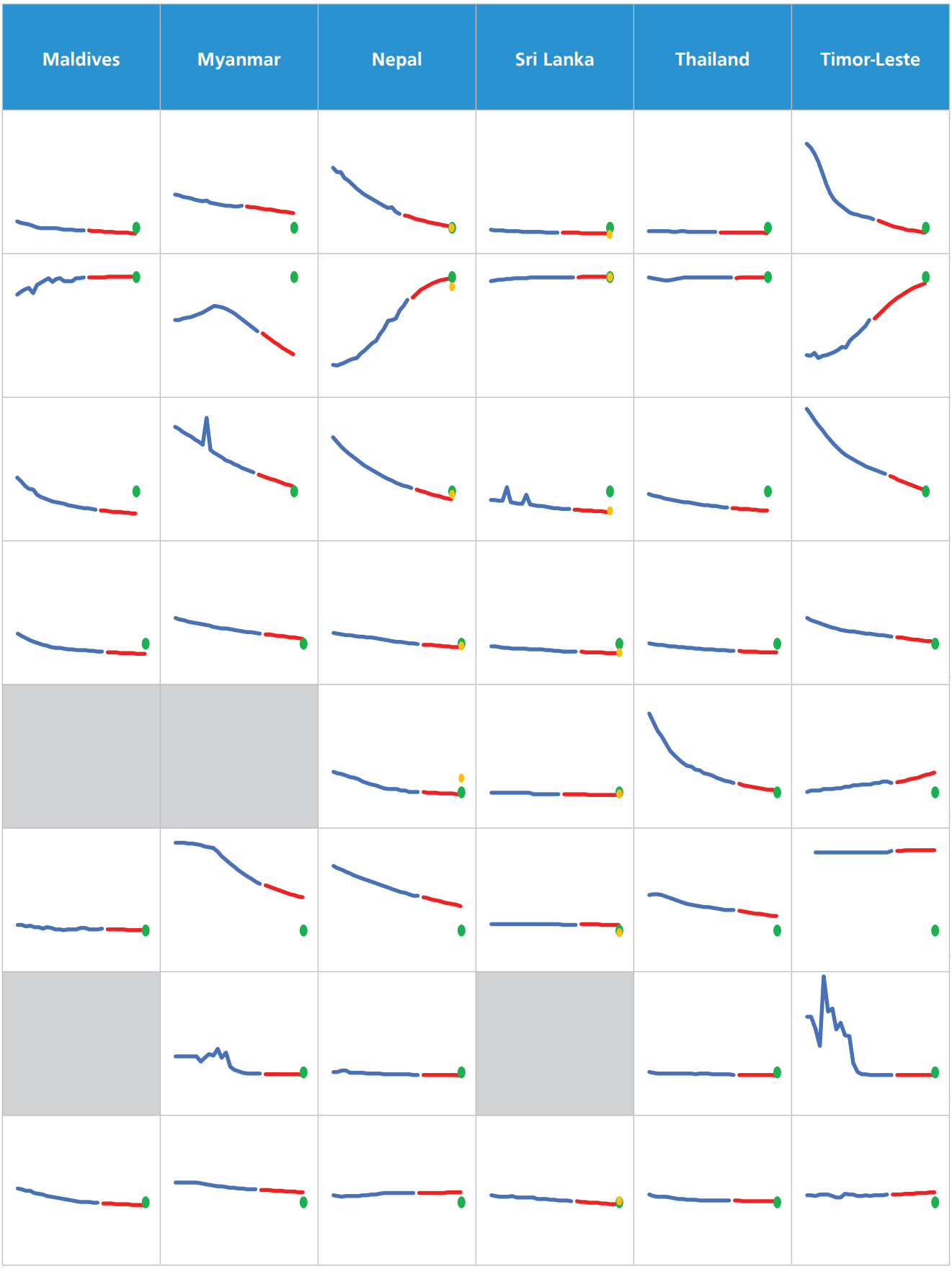
S.No.	SDG target	Indicator
1	3.1.1	Maternal mortality ratio (per 100 000 live births)
2	3.1.2	Proportion of births attended by skilled health personnel (%)
3	3.2.1	Under-five mortality rate (per 1000 live births)
4	3.2.2	Neonatal mortality rate (per 1000 live births)
5	3.3.1	New HIV infections (per 1000 uninfected population)
6	3.3.2	Tuberculosis incidence (per 100 000 population)
7	3.3.3	Malaria incidence (per 1000 population at risk)
8	3.3.4	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years of age (%)
9	3.3.5	Reported number of people requiring interventions against neglected tropical diseases (NTDs)
10	3.4.1	Probability of dying from any CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)
11	3.4.2	Suicide mortality rate (per 100 000 population)
12	3.5.2	Total alcohol per capita (≥15 years of age) consumption (liters of pure alcohol)
13	3.6.1	Road traffic mortality rate (per 100 000 population)
14	3.7.1	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods (%)
15	3.7.2	Adolescent birth rate (per 1000 women aged 15–19 years)
16	3.8.1	UHC: Service coverage index
17.1	3.8.2	Population with household expenditures on health >10% of total household expenditure or income (%)
17.2	3.8.2	Population with household expenditures on health >25% of total household expenditure or income (%)
18	3.9.1	Age-standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)
19	3.9.2	Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)
20	3.9.3	Mortality rate from unintentional poisoning (per 100 000 population)
21	3.a.1	Age-standardized prevalence of tobacco use among persons 15 years and older (%)
22	3.b.1	Diphtheria—tetanus—pertussis (DTP3) immunization coverage among 1-year-olds (%)
23	3.b.1	Measles—containing—vaccine second dose (MCV2) immunization coverage by the nationally recommended age (%)
24	3.b.1	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year olds (%)
25	3.b.1	Human papillomavirus (HPV) immunization coverage estimates among 15-year-old girls (%)
26	3.b.2	Total net official development assistance to medical research and basic health sectors per capital (US$), by recipient country
27	3.b.3	Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%)
28	3.c.1	Health worker distribution (per 10 000 population)
29	3.d	Average of 13 International Health Regulations core capacity score

S.No.	SDG target	Indicator
30	3.d.2.1	Proportion of bloodstream infections due to methicillin-resistant *staphylococcus aureus* (%)
31	3.d.2.2	Proportion of bloodstream infection due to *escherichia coli* resistant to 3rd-generation cephalosporin (%)
32	1.a	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%)
33	2.2.1	Prevalence of stunting in children under 5 years (%)
34	2.2.2	Prevalence of wasting in children under 5 years (%)
35	2.2.3	Prevalence of overweight in children under 5 years (%)
36	2.2.4	Prevalence of anaemia in women of reproductive age (15–49 years) (%)
37	5.2.1	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months (%)
38	5.2.2	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime (%)
39	6.1	Proportion of population using safely managed drinking water services (%)
40	6.2.1	Proportion of population using safely managed sanitation services (%)
41	6.2.2	Proportion of population using a handwashing facility with soap and water (%)
42	6.3.1	Proportion of safely treated domestic wastewater flows (%)
43	6.a.1	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan (constant 2020 US$ millions)
44	7.1	Proportion of population with primary reliance on clean fuels and technology (%)
45	11.6.2	Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (μg/m3)
46	16.1	Mortality rate due to homicide (per 100 000 population)
47	16.9.1	Birth registration coverage
48	17.19	Completeness of cause-of-death data (%)
49	GPW13	Number of cases of poliomyelitis caused by wild poliovirus (WPV)
50	GPW13	Age-standardized prevalence of hypertension among adults aged 30–79 years (%)
51	GPW13	Prevalence of obesity among children and adolescents (5–19 years) (%)
52	GPW13	Age-standardized prevalence of obesity among adults (18+ years) (%)

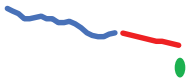
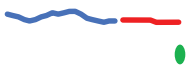
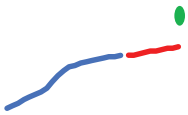
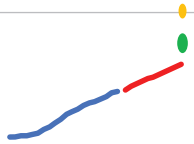
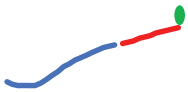
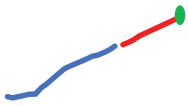
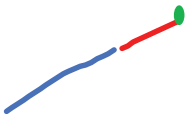
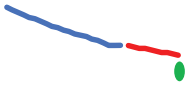
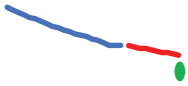
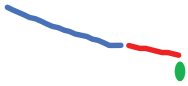
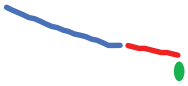
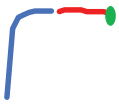
Annex 3
Trends and estimated projections for selected health-related SDG indicators, 2000–2030

SDG target	SDG Indicator	Bangladesh	Bhutan	DPR Korea	India	Indonesia
3.1.1	Maternal mortality ratio (per 100 000 live births)					
3.1.2	Proportion of births attended by skilled health personnel (%)					
3.2.1	Under-five mortality rate (per 1000 live births)					
3.2.2	Neonatal mortality rate (per 1000 live births)					
3.3.1	New HIV infections (per 1000 uninfected population)					
3.3.2	Tuberculosis incidence (per 100 000 population)					
3.3.3	Malaria incidence (per 1000 population at risk)					
3.4.1	Probability of dying from any of CVD, cancer, diabetes, CRD (aged 30–70) (%)					

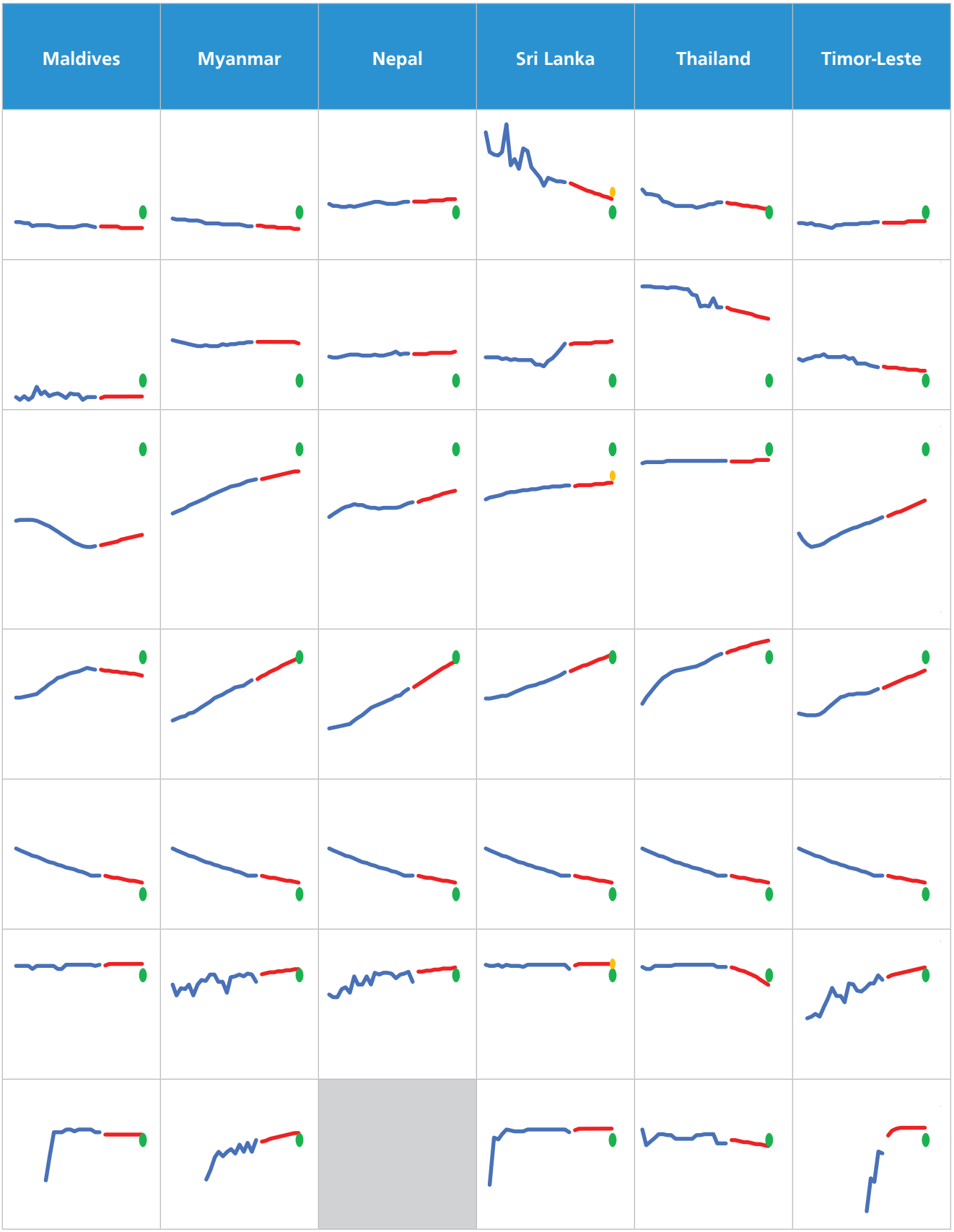
Source: WHO Global Health Observatory (GHO)



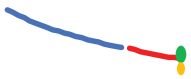
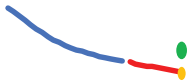
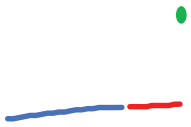
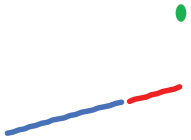
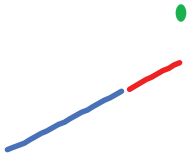
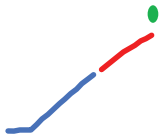
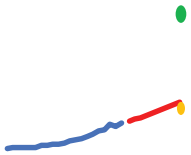
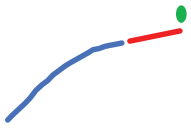
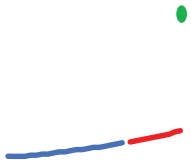
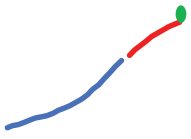
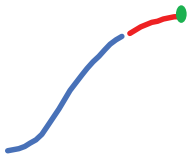
Estimated/Reported Projected Global target National target

SDG target	SDG Indicator	Bangladesh	Bhutan	DPR Korea	India	Indonesia
3.4.2	Suicide mortality rate (per 100 000 population)					
3.6.1	Road traffic mortality rate (per 100 000 population)					
3.7.1	Married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)					
3.8.1	UHC essential service coverage (%)					
3.a.1	Tobacco use (%)					
3.b.1	DTP3 immunization coverage among 1-year-olds (%)					
3.b.1	MCV2 immunization coverage by the nationally recommended age (%)					

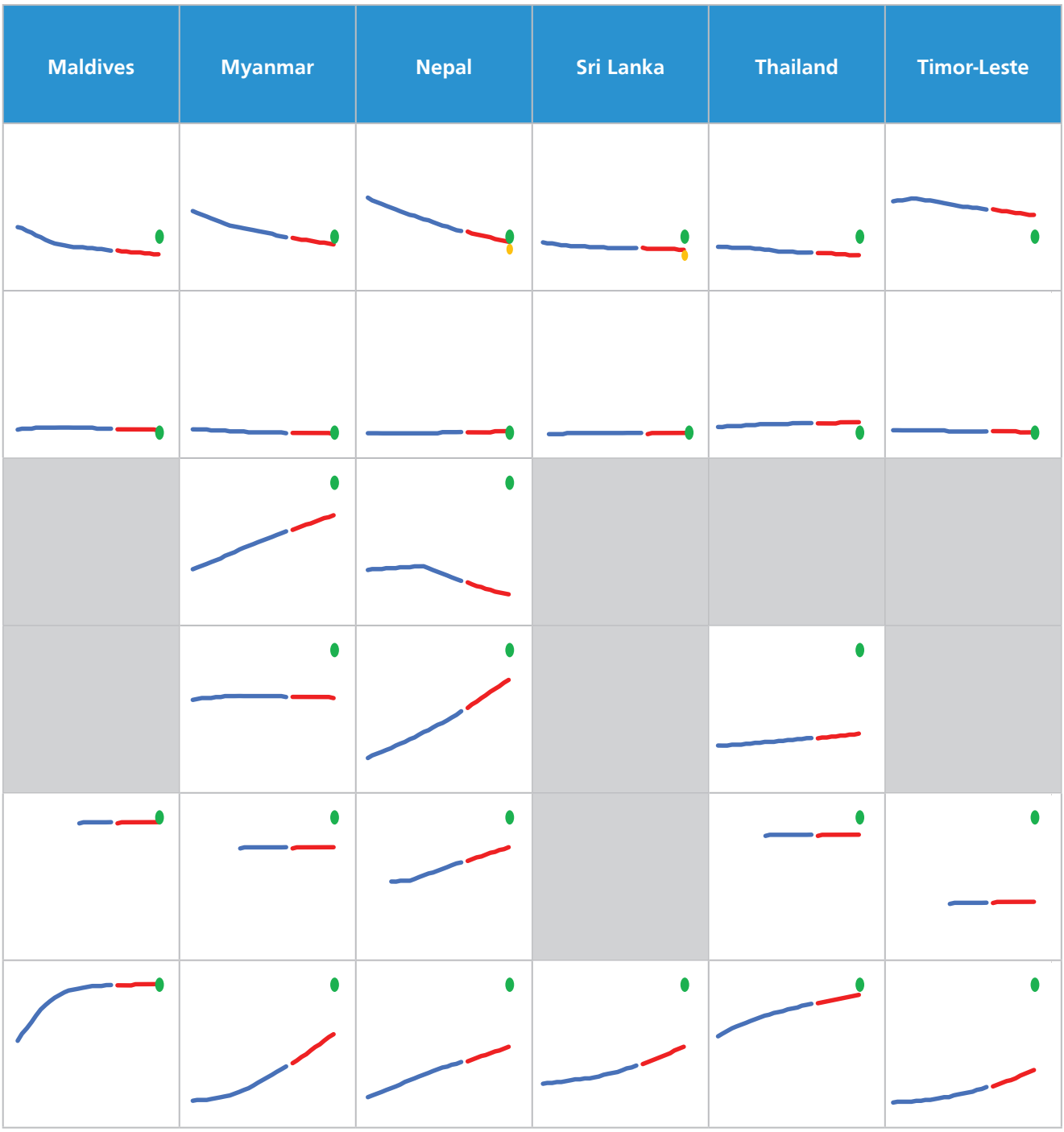
Source: WHO Global Health Observatory (GHO)



Estimated/Reported Projected Global target National target

SDG target	SDG Indicator	Bangladesh	Bhutan	DPR Korea	India	Indonesia
2.2.1	Children under 5 years who are stunted (%)					
2.2.3	Children aged under 5 years who are overweight (%					
6.1.1	Proportion of population using safely managed drinking-water services (%)					
6.2.1	Proportion of population using safely managed sanitation services (%)					
6.2.2	Proportion of population using hand-washing facility (%)					
7.1	Proportion of population with primary reliance on clean fuels and technologies (%)					

Source: WHO Global Health Observatory (GHO)



Estimated/Reported Projected Global target National target

Annex 4
List of previous publications 2016–2021

Year	Publication title	Thematic focus
2016	Health in the Sustainable Development Goals: where we are now in the South-East Asia Region? What next?	
2017	Monitoring health in the Sustainable Development Goals	
2018	Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2018 update	Strengthening SDG monitoring, with a focus on mortality statistics
2019	Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2019 update	Frontline health services: a snapshot
2020	Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2020 update	Quality of health care: a snapshot
2021	Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2021 update	Health equity: who is being left behind in the WHO SE Asia Region?

The seventh annual report on *Monitoring progress towards Universal Health Coverage and the health-related Sustainable Development Goals in the South-East Asia Region* provides an overview of 'where we are' and 'what is needed' to achieve universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs) by their target dates. The report highlights achievements and progress by Member States of the Region in the areas of reproductive, maternal and child health, infectious diseases, noncommunicable diseases and risk factors, mental health, injuries, environmental health, health workforce, and health security.

Every year this progress report focuses on one health-related theme apart from monitoring overall progress towards UHC and the SDGs. This year's theme is 'status of financial protection in the SE Asia Region', which is critical for universal health coverage. The highlight of this report is the SDG profile of Member States with latest information and data on health and health-related indicators. Information and analysis provided in this report can be utilized to sustain and accelerate progress towards achieving the Regional Flagship Priorities and the health-related SDG targets.

World Health Organization
South-East Asian Region

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