3

GOOD HEALTH AND WELL-BEING

ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

I. SUMMARY

Remarkable gains have been made in many health outcomes in the Asia and Pacific region in recent years, particularly in the area of sexual, reproductive, maternal, newborn, child and adolescent health and for few communicable diseases. There has been a significant reduction in maternal, neonatal and child mortality, and many countries are on-track to achieve the related SDG targets. However, marked inequities within countries in access to essential health services and availability of affordable and high-quality healthcare threaten to hinder comprehensive progress for all population groups, including poorer, rural and less educated communities.

Although communicable disease still persists in the region, there is a declining trend in HIV, TB and Malaria incidence. Of concern, however, are increasing trends of new HIV infections in some countries of the region, particularly in key population groups, in Afghanistan, Bangladesh, Malaysia, Fiji and Papua New Guinea, Pakistan and Philippines.[1] For non-communicable diseases (NCDs), premature deaths are declining, but progress is lagging and other NCDs risk factors such as blood pressure and obesity are rapidly increasing across the region. On core capacity for the International Health Regulation,[2] in 2019, all countries reported using the new State Parties Annual Self-Assessment Reporting (SPAR) tool. There was an increase in the preparedness index score for most countries, however, emergency preparedness and response, including health systems, are currently being challenged in an unprecedented manner by the ongoing COVID-19 pandemic.

All the countries in the Asia and Pacific region have increased access to essential health service coverages since 2010. However, the COVID-19 pandemic has disrupted many of these services such as antenatal care, childbirth delivery care, postnatal care, vaccinations, TB, malaria and HIV treatments, and overwhelmed the health system impacting countries' acceleration towards universal health coverage (UHC). In today's scenario, it is more important than ever to enhance public funding for health with strategic and targeted investments to increase and sustain the health sustainable development goals (SDGs) gains made and address the unmet needs. Well-functioning delivery of quality health care and essential services cannot be compromised even in the context of the COVID-19 pandemic, if most of today's health needs are to be safely met.

The COVID-19 pandemic has also highlighted the strong links between human health and environmental health. All scientific evidence available indicates that COVID-19 is most likely a zoonosis, i.e. transmitted from animals to humans. Zoonoses are being largely driven by environmental degradations and an increased interface between wild and farmed animals and humans. As such, mitigating the risk for zoonoses also involves making progress on the environmental front.

II. CURRENT STATUS

The Asia-Pacific region has made remarkable gains in past decades to improve health and well-being for its population. However, while some positive results have been sustained and continue to improve (e.g., ensuring access to essential health services, and reduction in newborn, child and maternal mortality), overall progress has been uneven, with key issues remaining prominent (communicable and non-communicable diseases, access to Sexual Reproductive Health and Rights (SRHR) services including modern family planning methods, and inequalities in access to health). In the past year, the COVID-19 pandemic has been compounding these challenges and threatening serious setbacks for the health of the population in the region.

According to latest estimates,[3] the indirect effects of the COVID-19 pandemic had a considerable impact on child mortality due to disruptions to critical interventions such as antenatal care, childbirth delivery care, postnatal care, vaccinations, and early childhood preventative and curative services. In 32 countries in the Asia Pacific region, more than half a million additional children under five years of age could lose their lives over six months in the worst-case scenario (coverage reductions of 39.3–51.9% and increase of wasting by 50%), and this number doubles to more than one million deaths in 12 months. Notably, these deaths are additional to the deaths that would have occurred without COVID-related service disruptions. However, these estimates are not meant to convey an exact number of deaths since these scenarios are based on assumptions about critical intervention disruptions.

The consequent disruption of services on already overstretched health systems, and the diversion of resources from essential health services, threaten the progress made so far in achieving the 2030 SDG 3.1 target to reduce maternal mortality ratio to less than 70/100,00 live births. An analysis conducted across the 14 high burden countries in Asia-Pacific[4] has estimated how, in 2020 only, the maternal mortality ratio in these 14 countries[5] could increase, for the best and worst-case scenarios respectively, reaching 214/100,000 or 263/100,000, compared to a projected baseline of 184/100,000 in 2020. The disruption of essential sexual and reproductive health services could also increase 40% on unmet need for modern family planning methods in the worst-case scenario (from 18% to 26%).

In addition, a survey of 29 key informants and practitioners from the Asia-Pacific region was conducted by UN ESCAP in December 2020, to assess the perception of progress towards the achievement of SDG 3 in the region. The respondents were from national governments, civil society organisations, including NGOs, the UN and academia or think tanks. When asked to reflect on the progress of the Asia-Pacific region towards the targets of the SDG 3, almost half (48%) of respondents considered the progress to be "Good",

but a sizeable percentage perceived the progress to be either "Poor" (14%) or "Very poor" (9%). Reasons for these ratings included the fact that the gap between poorer and richer groups of population within countries was still a major concern to be addressed, only made worse by the ongoing pandemic.

The COVID-19 pandemic was considered to have had a "Negative" or "Strongly Negative" impact on the achievement of SDG 3 by 43% of respondents, and this perception of COVID-19's impact on progress was not limited to the goals of SDG 3: when asked how confident they were in the ability of countries of the region to achieve the 2030 Sustainable Agenda as a whole, despite the pandemic, around 28% of respondents declared to be "Not Confident" the Asia-Pacific region could achieve the objectives of the 2030 Agenda. Some critical issues identified as threats to progress in the region included: disruptions to public health systems brought about by the COVID-19 pandemic, particularly for accessing essential treatments other than for COVID-19 such as SRHR services; deepening of existing inequalities and challenges in service provision for vulnerable groups, made worse by increasing poverty levels; and lastly, rise in non-communicable diseases as well as mental health issues, particularly relevant as the region will be experiencing marked ageing of its population in the next decades.

A. AREAS WHERE GOOD PROGRESS IS MADE

Reduction in maternal mortality ratio (MMR)

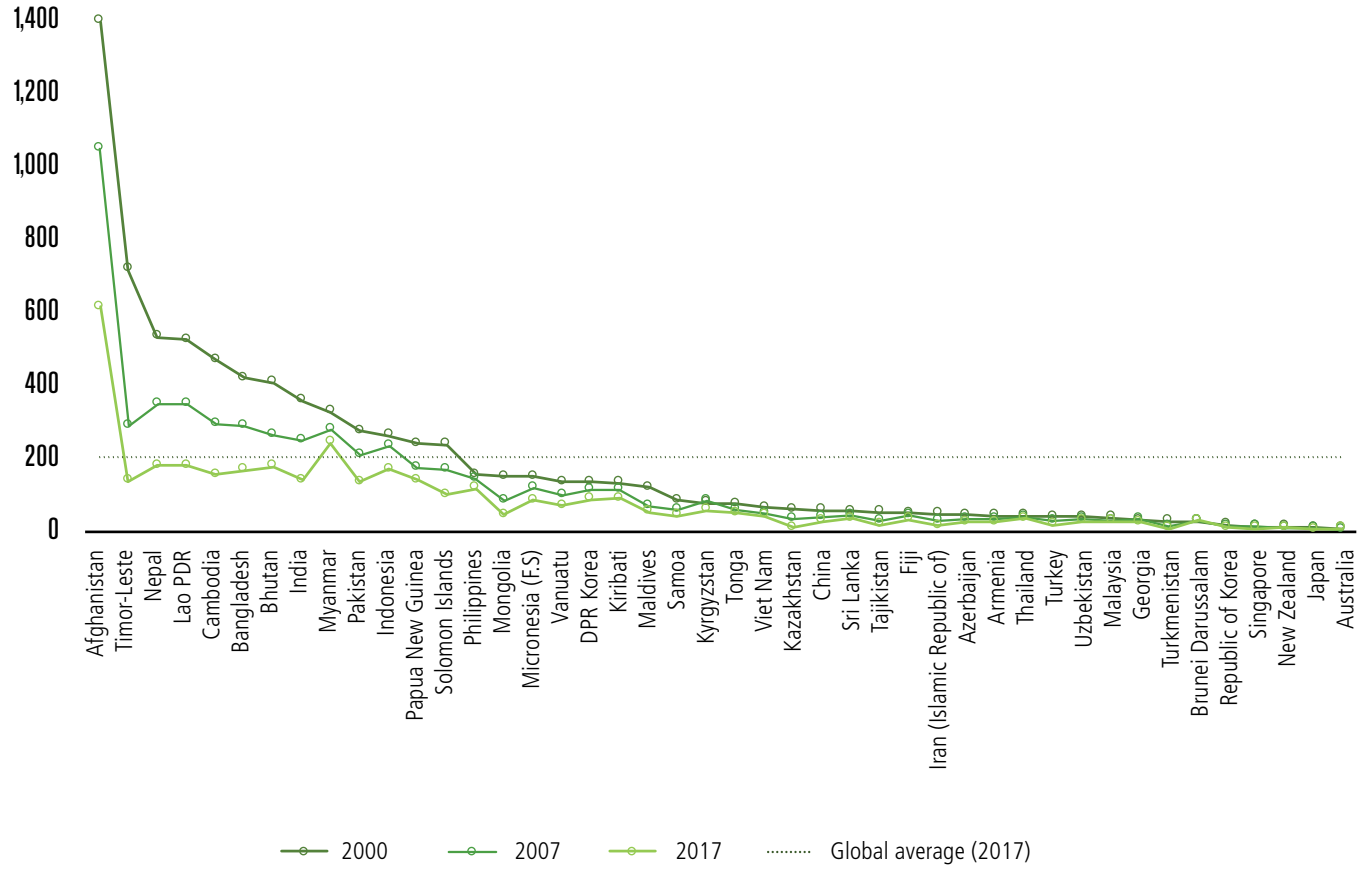
SGD target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

Overall, there has been significant reduction in maternal mortality ratio (MMR) (SDG indicator 3.1.1) since 2000. In 2017, twenty-seven countries in the Asia and Pacific region had already achieved the global target of less than 70 deaths per 100,000 live births.[6] Fourteen countries, however, remain high-burden countries for maternal mortality, with MMR above 100 deaths per 100,000 live births, and it is estimated that around 80,000 women die each year in the region.[7] Of the high-burden countries, Cambodia, Lao PDR, Nepal and Timor-Leste have made progress in reducing their MMR by two-thirds since 2010, but an acceleration in rates of reduction is required for the region as a whole to achieve the SDG target.

The reduction in maternal mortality ratios is inextricably linked to the increase in access to high-quality prenatal and obstetric care, and to ensuring that births are attended by skilled health personnel (SDG indicator 3.1.2). Across the region, the proportion of births attended by skilled midwives or other health personnel has been consistently increasing, with many countries (23) above the 95% mark.[8] Several of the high-burden countries for maternal mortality, however, report rates of skilled assistance during childbirth still below optimal levels: for example, Afghanistan, Myanmar, Nepal and Timor-Leste, among others. A concerted effort to invest in midwifery education according to international standards, and in the deployment, retention and training of midwives and skilled health personnel is required in order to achieve increased coverage and ensure all women receive the care they need during pregnancy and childbirth.

To meet the target of reducing maternal mortality to less than 70 deaths per 100,000 live births by 2030, efforts must accelerate in a number of countries. South and South-West Asia, in particular, must prioritize this issue, as they lag the furthest behind with 152 deaths per 100,000 live births (sub-regional groupings according to ESCAP classification).

Figure 1: Maternal mortality ratio, by country, 2000-2017



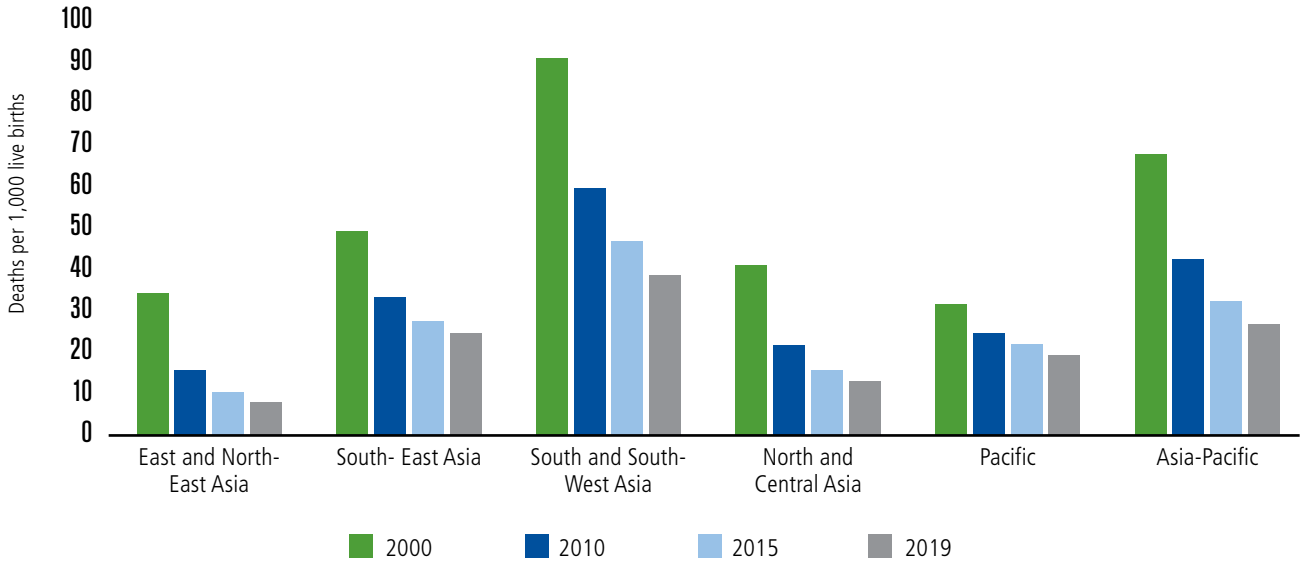
Source: Global SDG Indicator Database, last accessed 9th December 2020[9]

Reduction in under-five mortality rate (U-5MR) and neonatal mortality rate (NMR)

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

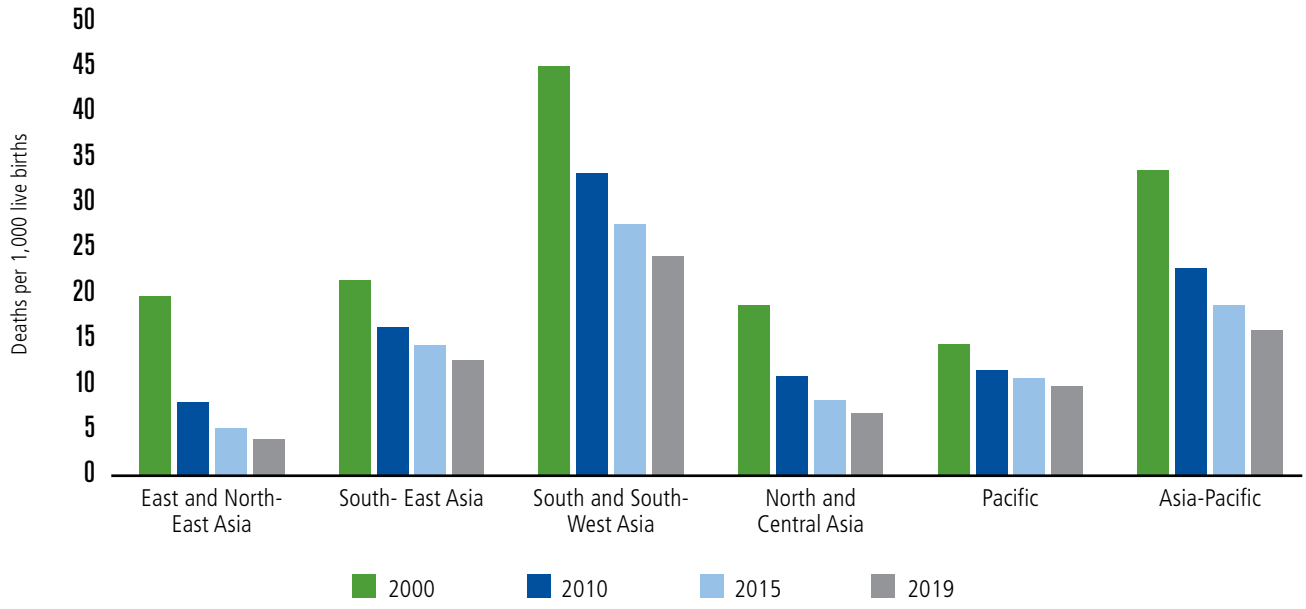
The majority of countries in the ESCAP region have made progress in reducing under-five mortality (SDG indicator 3.2.1) and neonatal mortality (SDG indicator 3.2.2).[10] The under-five mortality rate of reduction ranges from 1 to 50 percent, while the neonatal mortality rate of reduction ranges from 9 to 60 percent between 2010 and 2019. Three ESCAP sub-regions, East and North-East Asia, North and Central Asia, and the Pacific, have already achieved the 2030 targets at the sub-regional level. The countries with the largest rates of reduction in U-5MR and NMR since 2010 are Kazakhstan (49% and 60%, respectively) and China (50% and 54%, respectively). Thirty-one of 58 Asia-Pacific countries have already achieved the target for U-5MR, and 29 countries have achieved the target for NMR. At the current rate of progress, the Asia-Pacific region is on track to reach SDG target 3.2 by 2030. While maintaining gains and accelerating progress towards the SDG targets, countries should focus on reducing disparities across sub-populations within countries.

Figure 2: Under-5 mortality has declined in Asia-Pacific between 2010 and 2019



NOTE: UN ESCAP sub-regional estimates for under-5 mortality rates include data from the following countries: East and North-East Asia Sub-Region: China, Democratic People's Republic of Korea, Japan, Mongolia, and Republic of Korea. South-East Asia Sub-Region: Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste, and Viet Nam. South and South-West Asia Sub-Region: Afghanistan, Bangladesh, Bhutan, India, Islamic Republic of Iran, Maldives, Nepal, Pakistan, Sri Lanka, and Turkey. North and Central Asia Sub-Region: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkmenistan, Uzbekistan. Pacific Sub-Region: Australia, Cook Islands, Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

Figure 3: Neonatal mortality has declined in Asia-Pacific between 2010 and 2019



NOTE: UN ESCAP sub-regional estimates for neonatal mortality rates include data from the following countries: East and North-East Asia Sub-Region: China, Democratic People's Republic of Korea, Japan, Mongolia, and Republic of Korea. South-East Asia Sub-Region: Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste, and Viet Nam. South and South-West Asia Sub-Region: Afghanistan, Bangladesh, Bhutan, India, Islamic Republic of Iran, Maldives, Nepal, Pakistan, Sri Lanka, and Turkey. North and Central Asia Sub-Region: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkmenistan, Uzbekistan. Pacific Sub-Region: Australia, Cook Islands, Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

While not an SDG target, stillbirths are an important indicator for the quality of maternal health services and are included in other global frameworks - Every Newborn Action Plan. As per the country-specific stillbirth estimates by the UN Inter-agency Group for Child Mortality Estimation in 2020, stillbirth rates have declined in 48 countries using available data in the Asia Pacific region since 2010.[11] China, Georgia and India have made the greatest gains in reducing the rate of stillbirths, with reductions of 45%, 38% and 31% respectively. However, the estimated stillbirth rate has increased in Brunei Darussalam by 8%, and in Malaysia by 22% since 2010.

Increased access to essential health services

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

All countries in the region have significantly increased access to essential health services (SDG indicator 3.8.1) since 2010. Health service coverages in the areas of reproductive health and communicable disease have been increasing. Likewise, case detection and treatment for the non-communicable diseases have also improved. In the area of health systems, the hospital bed density and health workforces are increasing and data availability is also improving. However, the essential health service coverages vary widely across countries in the region. In 2017, Australia and New Zealand had the highest coverage for access to essential health services (87%) whilst Afghanistan had the lowest essential health service coverage (37%).

Despite the gain, the countries need to accelerate their progress in improving access to essential health services to reach the global target. As of 2017, only 7 countries in the region (12%) have 80% or greater essential health service coverage. The COVID-19 pandemic is expected to have disrupted the essential health service coverages in most countries in the region. Therefore, it is more crucial than ever to focus attention on maintaining the delivery of quality essential health services, and continue progress towards achieving the UHC.

B. AREAS REQUIRING SPECIFIC ATTENTION AND ASSOCIATED KEY CHALLENGES

Persistent inequities in access to comprehensive sexual, reproductive, maternal, newborn and child health services remain, hindering progress

SDG target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births and SDG target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Despite sustained efforts over recent decades, an acceleration of progress is required for the region to achieve the targets of the SDG indicators on sexual, reproductive, maternal, newborn and child health. In all countries of the region, pockets of populations who still do not have optimal access to essential Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) services remain. Specific communities, often those living in rural areas, the urban poor, or ethnic minorities, face difficulties in accessing such services.

In the context of maternal health, this can be exemplified by the varying rates of access to comprehensive emergency obstetric care, including emergency caesarean sections, which identify underserved pockets within countries for such services. Coverage of antenatal care, births attended by skilled health personnel and postnatal care is low in Central and South Asia, and lowest among women and newborns in the most marginalized groups, such as in urban slums and humanitarian and fragile settings.[12] Other sexual and reproductive health services, such as access to contraception or STIs treatment and counselling, also

remain uneven between population groups in countries of the region. One population group particularly at risk of reduced access to SRHR services are people living with disabilities.

In 2020, UNFPA conducted a regional assessment in partnership with disabled persons organizations of the impact of COVID-19 on access to sexual and reproductive health and rights for people with disabilities. The assessment will be published in early 2021.[13] Initial key findings from the assessment and community consultations highlighted the significant and disproportionate barriers to accessing SRHR for people with disabilities, as COVID-19 related policies have generally failed to take into account the needs of persons with disabilities. Examples of such limitations included blanket bans on support persons being able to join a person for a medical appointment; and COVID-19 policies deprioritizing access to SRHR services for everyone, including people with disabilities. Overall, during the pandemic there has been less disability-related healthcare available, including mental health counseling and services. Family members have mostly been the primary caregivers and in charge of support, which could be a risk factor for increased violence and mistreatment.

Access to modern contraceptive methods and reduction in adolescent pregnancies

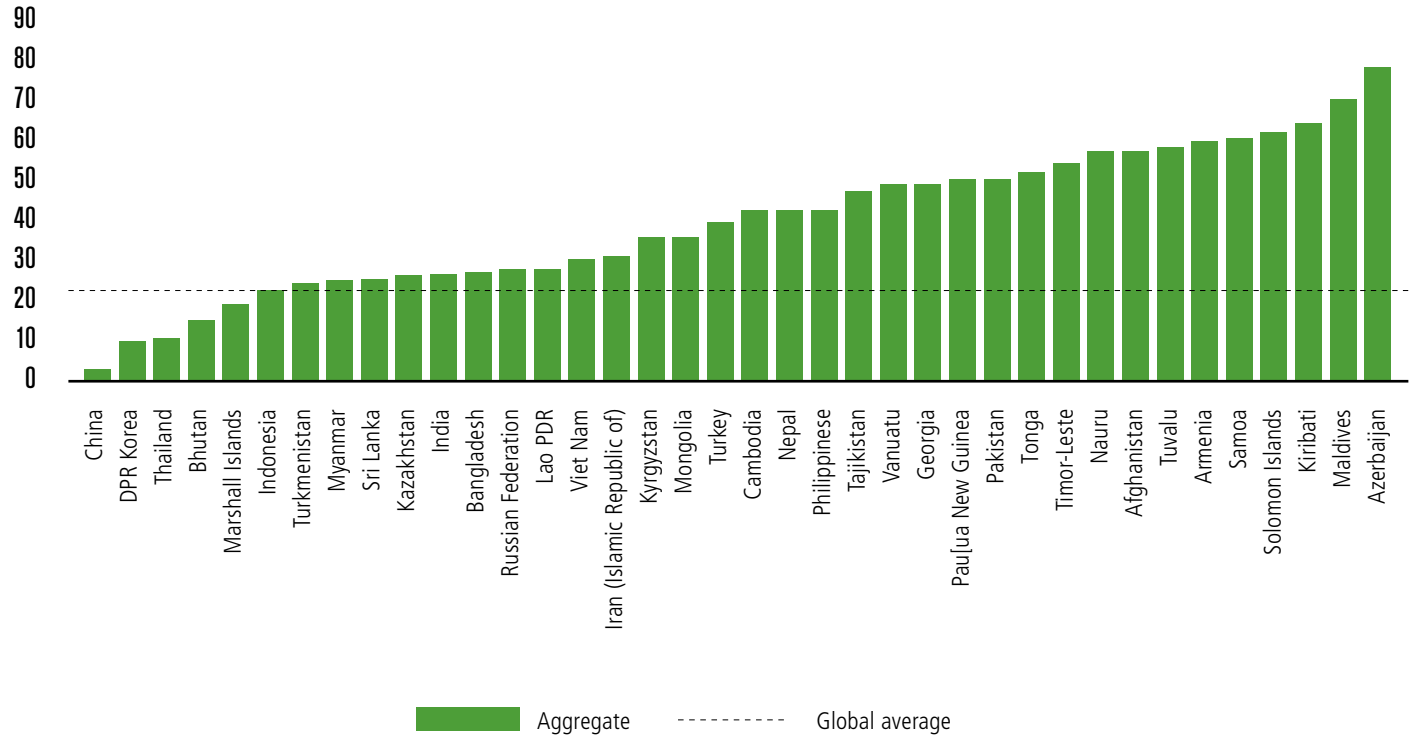
SGD target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Ensuring universal access to SRH services, in particular modern family planning methods, remains challenging throughout the Asia-Pacific region. While some countries report having achieved 75% of demand for family planning satisfied with modern contraceptive methods (SDG indicator 3.7.1), data collection on this indicator is sparse,[14] and overall progress in the region is lagging. Many countries in the region report low percentages of demand satisfied with modern methods and high levels of unmet need for family planning which remain to be addressed. Investments in voluntary access to modern family planning methods are crucial to ensure women and couples can exercise their right to decide when, whether and how many children to have, and opens opportunities for women to complete their education and participate in the labour market.

This is particularly important for adolescent girls, who often drop out of formal education and employment opportunities due to pregnancy and childbirth. SDG indicator 3.7.2 aims to measure trends in adolescent births occurring in the region: in 2019, there were an estimated 3.7 million births to 15-19 year old girls in UNFPA's Asia-Pacific region. This is one in six adolescent girls in the Pacific, 1 in 8 in South Asia, and 1 in 14 in Southeast Asia who have commenced childbearing by the age of 18, according to a recent study by UNFPA (publication forthcoming in 2021).[15]

Despite progress in reducing adolescent fertility, particularly in countries where births occur in the context of traditional child or early marriage (for example, adolescent fertility has declined by more than 60% in South Asia since 2000, most notably in India in the context of falling rates of child marriage), adolescent fertility in some South Asian countries (Bangladesh, Afghanistan and Nepal) remains very high, driven by low decision-making autonomy of girls with respect to SRH, and low use of effective contraception. In Southeast Asia (Philippines and Viet Nam), some Pacific countries, and Mongolia adolescent fertility has increased since 2000, while rates have stalled in Thailand, Cambodia, Indonesia and Malaysia. In these settings, up to a third of adolescent pregnancies are conceived before marriage, many are unintended, and occur in context of high unmet need for modern contraception for this population group.

Figure 4: Proportion of women of reproductive age (15-49 years) who do not have their need for family planning with modern methods satisfied, latest available year (percentage)



Source: SDG Indicator Database, last accessed 9th December 2020

Increased catastrophic expenditure on health

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

In the past two decades, most countries have witnessed increase in catastrophic expenditure on health i.e., population with large household expenditure on health (>10%) (% of population) (SDG indicator 3.8). The catastrophic expenditure on health by households ranges from 1.8% to 29.2% in the Asia and Pacific region. Georgia and Bangladesh have the highest proportion of population with >10% household expenditure on health; and these countries' catastrophic expenditure on health have increased by 57.3% and 66.9% respectively since 2000. Most countries also need to improve data availability on financial protection indicators so that trend analysis can be conducted and progress towards financial protection can be monitored.

High mortality rate attributed to household and ambient pollution

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

In 2016, the age-standardized mortality rate attributed to household and ambient pollution (SDG indicator 3.9.1) varied widely across countries in the region. The mortality rate from household and ambient pollution (per 100,000 population) ranged from 7 to 211. There were seventeen countries with mortality rates greater than global average of 114.1 deaths per 100,000 population. Countries with high mortality rates from household and ambient population were Afghanistan, DPR Korea and Nepal. Due to lack of

multiple year data, trend analysis could not be conducted nor progress monitored. Also, going forward having information on mortality rate from household and ambient pollution by residence would help inform programs and policies to reduce inequalities and achieve the SDG goal.

Increased harmful use of alcohol

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

In the past two decades, twenty-six countries have witnessed an increase in alcohol per capita consumption (litres per annum, population aged 15+) (SDG indicator 3.5.2). In 2018, countries with highest consumption of alcohol per capita are Russian Federation, Lao PDR and New Zealand. Only Bangladesh has reported no consumption of alcohol per capita. Alcohol is a major risk factor for both communicable diseases (tuberculosis) and non-communicable diseases (cardiovascular diseases, liver cirrhosis, obesity)[16] including mental health problems such as depressive and anxiety disorders and road traffic injuries. In 2016, more than two in five road traffic deaths were attributable to alcohol in Asia-Pacific. Australia has the highest proportion of road traffic deaths associated with alcohol in the region, followed by New Zealand, Singapore and the Republic of Korea.[17] Although many countries have set age limits on alcohol consumption and purchase, lack of enforcement and easy access leads to increased alcohol consumption and consequently health risks.

Communicable diseases (HIV, Malaria and Tuberculosis) still persists in the region

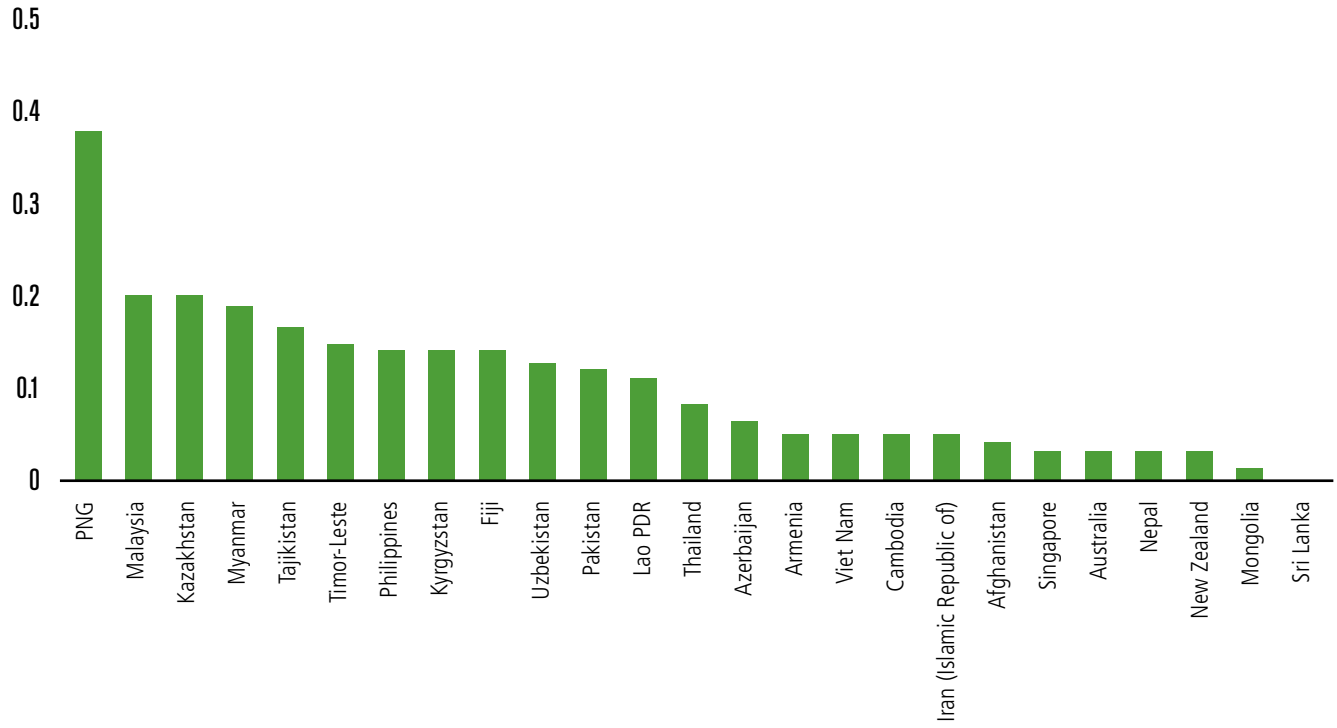
SDG target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

In the past two decades, most countries in the region have observed continued decline in new HIV infection (SDG indicator 3.3.1). While no countries have reached zero elimination yet, there has been significant progress related to mother to child transmission of HIV and congenital syphilis. Four countries, Thailand, Malaysia, Maldives and Sri Lanka, achieved elimination of mother to child transmission of HIV and congenital syphilis. Young people are disproportionately at risk of HIV infection. Significant prevention, testing and treatment service gaps remain among the young key populations, and policy and legal barriers deter them from accessing health services. Especially concerning is the escalating epidemic among young men who have sex with men, which account for 29% of new HIV infections in the region.[18]

Tuberculosis continues to be prevalent in the Asia-Pacific countries. In 2018, five countries (India, China, Indonesia, the Philippines and Pakistan) in the Asia-Pacific region accounted for 56% of the estimated TB cases globally.[19] Moreover, the region has thirteen countries that account for high-burden TB countries, and the TB incidence rate (SDG target 3.3.2) among these countries has a slow decline over the past decade. Although there are fifteen countries that have reported no malaria incidence (SDG target 3.3.3), malaria is still found in remaining countries.

Due to the COVID-19 pandemic, HIV, TB and malaria service are expected to have disrupted and affected the lives of many. The region still faces important challenges in HIV, TB and malaria control, including providing services to the poor and vulnerable. Therefore, the countries will need to continue their efforts in reduction of HIV, TB and malaria; and likewise focus on early detection and treatment to prevent onward transmission and mortality.

Figure 5: HIV incidence per 1,000 population, countries where data is available



Source: UNAIDS 2020 HIV estimates

Rise of the non-communicable diseases (NCDs)

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

The non-communicable diseases (NCDs) are increasing and are responsible for the majority of the deaths. Of the NCDs, cardiovascular disease (CVD) is the leading cause of death in Asia-Pacific. In 2016, an estimated 9.4 million deaths were due to CVD in the WHO South-East Asia and Western Pacific regions.[20] Furthermore, ischaemic heart disease (IHD) and stroke are the most common form of CVD and comprised of 87.8% of all CVD deaths in WHO's Western Pacific and South-East Asian region countries and territories.[21] Most CVD can be prevented through detection and treatment of risk factors such as hypertension, high blood glucose, high blood cholesterol and obesity. However, increase in prevalence of these risk factors across most countries highlights the need for risk factor management and accelerated efforts to improve lifestyle. It is also worth noting that as the proportion of older people increases in the Asia-Pacific, the health care demand will increase and the type of care that CVD patients require will change.

Another area that countries will need to urgently respond to is the mental health consequences of the COVID-19 pandemic. The COVID-19 pandemic has resulted in implementation of lockdowns, physical distancing and just drastic changes in people's daily routine as well as their livelihoods which could have adverse impacts on the physical and mental health of populations and exacerbate health inequalities, especially in people with pre-existing mental health disorders.[22] The COVID-19 pandemic revealed the stark realities of the significant gaps in mental health and psychosocial support (MHPSS) services and the barriers preventing vulnerable groups from accessing services. Countries need to focus on increasing availability and accessibility to mental health care as well as promote mental wellness to ensure well-being of the larger population.

C. INTEGRATION OF HUMAN RIGHTS AND GENDER EQUALITY CONSIDERATIONS

SDG 3 relates in particular to the right to health, which includes a right to health care, goods, services and facilities, that should be both available, financially and geographically accessible on the basis of non-discrimination; acceptable and of good quality. Health care is a clear focus of SDG 3, while another dimension of the right to health - the underlying determinants of health, such as access to water and sanitation, adequate food, housing and safe occupational conditions, a clean and safe environment, access to health-related education and information, also relate to other SDGs. In addition, participation, transparency, accountability, equality and non-discrimination are essential elements of the right to health.

The COVID-19 pandemic brought into sharp focus the importance of other rights for progress in SDG 3, including the critical role of access to information and how longstanding discrimination and inequalities have contributed to leaving segments of the population particularly vulnerable. This highlights the necessity to combat inequality and discrimination as major contributors to poor health outcomes. The UN Special Rapporteur on the right to health has concluded that the impact of COVID-19 is determined more by public health policy, leadership, socio-economic inequality, systemic racism, and structural discrimination than by biological factors.[23] From a human rights perspective, States therefore need to strengthen their focus on their obligation to address a range of barriers arising from inequality and discrimination that impede access to health care and underlying determinants of health. As with other economic, social and cultural rights, the right to health is to be progressively realized, which means that States have an obligation to use maximum available resources and to take deliberate, concrete and targeted steps, towards the full realization of the right. This will be important to recall also as the region takes action to build back better in a context where different sectors compete for resources.

Gender has a significant impact on all aspects of health and wellbeing. Gender norms influence the structural determinants of health, access and utilization of health services. Restrictive and harmful gender norms result in inequalities in health across the life course and generations. An analysis of gender inequalities in health across the first two decades of life from 40 countries in the Asia-Pacific region,[24] shows significant variation across countries in gender inequality during childhood and adolescence. The analysis found that girls aged 15–19 years were at excess risk of nutritional disease and girls aged 10–14 years experienced higher rates of morbidity due to self-harm compared with boys in most countries. Girls aged 15–19 years (ever partnered) also faced a high level of physical or sexual intimate partner violence in the past 12 months particularly in South Asian countries. The prevalence of high child marriage across several countries in the region also has severe negative impact on the girls. In terms of MMR, though there has been significant decline, there is a need to give increased attention to ensure provision of respectful maternal health care services in the facilities.[25] The health needs and challenges faced by gender non-conforming communities also need increased attention to address the inequities in access and utilization of health services. In order to achieve the SDGs, it is quite important to address gender-based inequities across the life cycle.

III. PROMISING INNOVATIONS AND BEST PRACTICES

- **Strengthened Midwifery education and support to Midwifery Education Faculty:** despite the restrictions related to the COVID-19 pandemic, UNFPA implemented a training programme to strengthen midwifery education through a virtual e-learning platform and online course. The course connected midwifery education experts with midwifery faculty members and educators from 17 countries in the Asia-Pacific region, allowing them to complete a 7-weeks online Module on Midwifery Curriculum and Development according to international standards. 70 faculty members and educators from the Asia-Pacific region completed the Module, and are on track to enroll in the subsequent 5 Modules of the

course. Tapping into virtual technologies and alternative methods of learning will ensure that training and continuing professional development for the health workforce can continue amid the response to the pandemic.

- **Telehealth:** during COVID-19 countries have made new efforts to ensure populations have access to care including remote contacts for antenatal and postnatal care, chronic disease management, e-prescriptions, and telemedicine support from specialists to health providers in remote locations. Examples of telehealth projects that were implemented or scaled up during the pandemic include the eSanjeevani Consultation Service of the Ministry of Health and Family Welfare of India, which has already conducted over one million teleconsultations between patients and healthcare providers and virtual consultations for case management between healthcare providers; as well as rural and remote telemedicine services allowing for consultations for case management between healthcare providers at various levels of the healthcare systems in Thailand, Nepal, Bhutan, Sri Lanka and Bangladesh.

- **Community volunteers** are identified as key stakeholders in the COVID-19 Strategic Preparedness and Response Plan for risk communication and community engagement. Partnerships between governments, United Nations, volunteers and volunteer-involving organizations are crucial in delivery of health services and often complement roles to support medical professionals especially for the most vulnerable and in local communities.[26] For example, in Thailand more than 1,040,000 Village Health Volunteers with the Department of Health Service stepped forward in providing support across the country and an additional 15,000 public health volunteers in Bangkok were conducting home visits, creating health awareness, delivering medicine, and providing reports to public health authorities. In Indonesia, community volunteers were mobilized in 75,000 villages to assist the government in increasing public awareness programmes of the COVID-19 pandemic; while community radio volunteers in Lao PDR have been disseminating government information on preventive measures to more than 300,000 people in their own ethnic languages. It is crucial that volunteers are integrated in health-related and other development plans at the national level as indispensable resilience mechanisms, and are involved from the beginning and throughout all the stages of preparedness, response and recovery.

- **Strategic public investment in health** plays a significant role in helping countries progress towards the Universal Health Coverage (UHC) by reducing out-of-pocket and catastrophic health expenditure. Thailand has prioritized government health spending within the public budget and now has low catastrophic expenditure and financial protection above the global average.

- **Global and regional commitment to monitor the progress of health SDGs:** At the global level, WHO annually publishes global health estimates for the health-related SDGs indicators through the World Health Statistics report. Dashboards and Global Health Observatory databases are also available for data on latest global health estimates. At the regional level, WHO South-East Asia regional office publishes an annual review of progress, providing easy access to UHC and health-related SDG data and indicators, query and analytical tools, and monitoring dashboards, and which is supported through an online health information platform. The data is based on best available country reported data.

- **Increased attention to improving quality of care.** All countries in WHO South-East Asia Region have national structures and plans for improving quality of care with initial focus on healthcare of women, newborns children and adolescents. A range of interventions are being implemented for quality of care like adoption of standards of care, assessments and accreditation, capacity building in quality improvement at health facility level. However, countries need to adopt a systemic approach for sustained activities for people-centered good quality care at all level of healthcare.

IV. Priorities for Action

Sustain the progress of the SDG agenda related to sexual, reproductive, maternal, newborn, child and adolescent health. **Attention should be paid to inequities in access to services and gender inequalities, including in fragile and vulnerable settings. Attention must also be given to improving the quality of care for all**, including gender non-conforming communities, disadvantaged groups, people living with disabilities and those left furthest behind.

Countries should directly focus on health systems strengthening, including improving equitable coverage and quality of the health workforce, implementing strategies and plans to increase the number, distribution, mentoring and retention of health personnel, particularly investing in midwifery and specialized care for obstetric and neonatal emergencies.

Strengthen the primary health care: a well-functioning PHC is the key to achieving UHC as it addresses comprehensive health needs at the community level.[27] Improved government health spending on primary health care along with quality health services can help countries provide efficient and equitable care; and meet the majority of the health needs of most people. Ensure the timely procurement, equitable distribution and access, appropriate use and maintenance of essential medical commodities and products (equipment, technologies, diagnostics and lifesaving medicines) to facilitate the delivery of high-quality health services.

Increased attention should be paid **to continuous quality improvement of healthcare across the life-course and at all levels of services.** The Lancet Commission on High Quality Health Systems has reported that more deaths are caused by poor quality of care compared to non-access to care, presently.

Increased attention should be paid to new technologies and other innovations for self-care and community-based services: optimising current methodology and applying modern technology for capacity building (eLearning/mLearning), virtual delivery (telemedicine), self-care (self-awareness, self-screening/testing and self-management), and accountability focusing on PHC and midwifery led continuity of care models.

Increase domestic health expenditures and ensure that all countries have allocated sufficient domestic and international resources to strengthen their health systems and implement their national health plans.

Expand access to essential health services coverage, particularly in the context of the COVID-19 pandemic, by reducing out-of-pocket and catastrophic health expenditures and improving financing and financial protection and increased government investments in health preferably through domestic budgets.

Response and resilience: countries should have a preparedness and response plan that includes preventive measures to pandemics and other emergencies, ensuring procurement of emergency supplies and monitoring survival and health outcomes.

Increase engagement and awareness among stakeholders in the health and non-health sector: health is linked to many other SDGs; achieving the SDG3 will directly and indirectly depend on the progress in other SDGs. For an example: reduction in child malnutrition (SDG target 2.2) or access to clean water and sanitation (SDG target 6.1) will lead to positive health outcomes. Addressing harmful gender and social norms will contribute to reducing inequities in access and utilization of health care services. The SDGs have provided countries with an opportunity to promote “health in all policies” – a coherent approach to public policies across all sectors that take into account health implications, seeks collaborations and avoids harmful health impacts and addresses the social determinants of health.

Support the adoption of integrated approached between environmental health and human health: as human health and environmental health are closely linked, as the COVID-19 pandemic highlighted. It is important to adopt integrated policy frameworks that take into account those links at the national and regional level, such as the approaches used in Planetary Health.

Strengthen data quality and improve availability of disaggregated data: countries need to continue improving the availability, quality and comparability of SDG3 data such that SDG progress can be measured and strengthen accountability. There are few indicators such as the availability and accessibility of essential medicine in health facilities (SDG indicator 3.b.1) that have limited data availability. Lack of disaggregated data also continues to be a challenge. Countries need to significantly increase their efforts to collect disaggregated health data by equity stratifiers such as gender, age, income and other population subgroups. This will allow us to identify those who are left behind and inform equity-oriented programs, policies and practices, and help countries attain health for all.

ANNEX

The official indicator framework for SDG 3 proposes the targets and indicators below:

Target	Indicator	Status of indicator (Tier)	Latest data avaliable	Comments (Proxies)
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio	I		Data availability reviewed in Nov. 2017 (classified as Tier I)
	3.1.2 Proportion of births attended by skilled health personnel	I		
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-5 mortality rate	I		
	3.2.2 Neonatal mortality rate	I		
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	I		Data availability reviewed in Nov. 2018 (classified as Tier I) IAEG-SDG 3rd meeting: Lack of sufficient data coverage (classified as Tier II)
	3.3.2 Tuberculosis incidence per 100,000 population	I		
	3.3.3 Malaria incidence per 1,000 population	I		

Continued ▼

	3.3.4 Hepatitis B incidence per 100,000 population	I		Data availability reviewed in Nov. 2018 (classified as Tier I)
	3.3.5 Number of people requiring interventions against neglected tropical diseases	I		
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	I		Data availability reviewed in Nov. 2017 (classified as Tier I)
	3.4.2 Suicide mortality rate	I		Data availability reviewed in Nov. 2017 (classified as Tier I)
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	I		Reviewed at 10th IAEG-SDG meeting (classified as Tier II)
	3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	I		UNSC 51 refinement
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries	I		
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	I		
	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	I		Data availability reviewed in Nov. 2018 y (classified as Tier I) IAEG-SDG 3rd meeting: Lack of sufficient data coverage (classified as Tier II)

Continued ▼

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services	I		UNSC 51 refinement Proposed methodology update reviewed at Jan. 2019 WebEx: continue to use already existing methodology to report on this indicator. Request further work on new methodology to be completed before considering replacing existing methodology with proposed methodology. Data availability reviewed in Nov. 2018 (classified as Tier I) Reviewed at 7th IAEG-SDG meeting (classified as Tier II) IAEG-SDG 6th meeting: Because indicator 3.b.3 is a component of this indicator and is a Tier III indicator, indicator 3.b.3 must have agreed methodology prior to indicator 3.8.1 being upgraded Fast Track; Reviewed at 5th IAEG-SDG meeting: Request additional work on aggregation method at regional and global levels
	3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income	I		Data availability reviewed in Nov. 2018 (classified as Tier I) UNSC 48 refinement, Reviewed at 5th IAEG-SDG meeting: Data coverage for some regions is limited (classified as Tier II)
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution	I		

Continued ▼

	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	I		Data availability reviewed in Nov. 2017 (classified as Tier I)
	3.9.3 Mortality rate attributed to unintentional poisoning	I		Data availability reviewed in Nov. 2017 (classified as Tier I)
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older	I		
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1 Proportion of the target population covered by all vaccines included in their national programme	I		Data availability reviewed in Nov. 2018 (classified as Tier I) Reviewed at Webex meeting in Nov. 2017 following 6th IAEG-SDG meeting (classified as Tier II) UNSC 48 refinement; Reviewed at 5th IAEG-SDG meeting (classified as Tier III)
	3.b.2 Total net official development assistance to medical research and basic health sectors	I		
	3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	II		Reviewed at 8th IAEG-SDG meeting (classified as Tier II) UNSC 48 refinement; Reviewed at 5th IAEG-SDG meeting (classified as Tier III)

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3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution	I		
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness	I		Data availability reviewed in Nov. 2017 (classified as Tier I)
	3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms	II		Refinement of the indicator name approved by the Inter-agency and Expert Group on SDG Indicators (IAEG-SDGs) on 13 March and 2 April 2020. Final approval pending the 52nd session of the Statistical Commission in March 2021 UNSC 51 addition included in the 2020 comprehensive review

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