



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

2017 HLPF Thematic Review of SDG3: Ensure healthy lives and promote well-being for all at all ages¹

1. Status of progress

Goal 3 seeks to ensure health and well-being for all, at all ages; and in all settings, including humanitarian and fragile. The Goal addresses all major health priorities, including sexual, reproductive, maternal, newborn, child and adolescent health, communicable, non-communicable and environmental diseases, universal health coverage and access for all to safe, effective, quality and affordable medicines and vaccines. It also calls for more research and development, increased and diversified health financing, enhanced health workforce and strengthened capacity of all countries in health risk reduction and management. Universal health coverage (UHC) acts as key driver for achieving all targets. Investment in all the health related targets in the 2030 agenda is a prerequisite as the health focus moves to contend with the double burden of long held priorities in communicable diseases, the unfinished MDG agenda and emerging issues such as NCDs and injuries.

WHO has reviewed the status of 31 health and health-related indicators in World Health Statistics 2016 and updated the information in World Health Statistics 2017. The 2017 publication provides an assessment of evidence regarding inter-sectoral action and reducing inequalities. The available data show that, in spite of progress made during the MDG era, major challenges remain in terms of reducing maternal, newborn and child mortality, improving nutrition, ensuring universal access to sexual and reproductive health and rights, and making further progress in the battle against communicable diseases such as HIV/AIDS and other sexually transmitted infections, tuberculosis, malaria, neglected tropical diseases and hepatitis. Weak health systems remain an obstacle in many countries, resulting in deficiencies in coverage and utilization for even the most basic health services and inadequate preparedness for health emergencies. Pervasive violence against women and girls reinforces gender inequities in health and access to services. Provision of quality care is uneven, often failing to protect, promote and respect the rights and dignity of those who seek it, particularly women and girls. Migrant and refugee populations, which are often exposed to multiple health risks, also largely lack access to health services. Inequities in access exist within and across countries due to structural disparities by income level, group characteristics, residence, experience of conflict or humanitarian disasters, by age and by sex.

Like all the SDGs, Goal 3 is interwoven throughout the 2030 Agenda, with its targets directly linking to targets in other goals. Among these are 2.2 (end all forms of malnutrition), 4.1 (free, equitable and good-quality secondary education), 4.2 (good-quality early childhood development), 4.7 (knowledge and skills for sustainable development), 5.2 (eliminate all forms of violence against women and girls in the public and private spheres), 5.3 (eliminate all harmful practices, including female genital mutilation), 5.6 (universal access to sexual and reproductive health and reproductive rights), 6.1

¹ This background note has been developed by members of ECESA Plus as a coordinated contribution by the UN system to the 2017 HLPF in depth review of SDG 3. Co-leads: WHO and UNFPA with contributions from UNHCR, UN-Women, UNAIDS, ILO, IOM, World Bank Group, ITU, UNICEF and UN-DESA.



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

(access to drinking water), 6.2 (access to sanitation), 7.1 (access to modern energy services), 9.5 (enhance scientific research /increase number of R&D workers), 11.6 (air quality and municipal waste), 13.1 (resilience to natural disasters), and 16.1 (reduce violence and related death rates). These interlinkages confirm that progress in health outcomes will only be achieved with progress in other related sectors, including fiscal and finance policy (e.g. taxing schemes to discourage unhealthy behaviors), nutrition, water and sanitation, air quality, road safety, education, gender equality and the empowerment of all women and girls, migration and peace and security.

In addition, health employment plays a critical role in eradicating poverty (SDG 1), achieving better health equity (SDG3) and promoting decent work and economic growth (SDG 8). The Global Strategy on Human Resources for Health and the High-Level Commission on Health Employment and Economic Growth established by the UN Secretary General in 2016 recognizes that health workers are the backbone of Universal Health Coverage (UHC), strong and resilient health systems and a significant driver to the realization of all the health targets throughout the 2030 agenda.

Several promising initiatives illustrate how targets can also be met through a rights-based, gender responsive, equity and integrated approach with cooperative action at the national, regional, and global levels. One such is the Global Strategy for Women's, Children's and Adolescents' Health which takes a life course approach that covers 11 SDGs – all the targets in Goal 3, and specific Targets across 10 others (1-7, 9, 10, 16 and 17). Others include UNFPA's Flagship "State of the World Population Report 2016: 10 - How our future depends on a girl at this decisive age"; the UNAIDS Strategy On the Fast-Track to end AIDS, which is organized around five SDGs that represent the most strategic areas for the AIDS response (3, 5, 10, 16 and 17) and also addresses interlinkages with other relevant SDGs (e.g. 1, 2, 4, 8 and 11); and UNICEF's "State of the World's Children 2016", which focuses specifically on equity.

While successful implementation of the 2030 agenda at national levels can be monitored through various mechanisms, global challenges differ by region and initiatives such as the Africa Health Strategy 2016-2030 and Maputo Plan of Action 2016-2030 can be valuable complementary frameworks to support national action. Expanding such strategic initiative to other regions is worth consideration and should be supported by the UN development system.

2. Implementation

Target 3.1

Maternal mortality ratio (MMR) stood at 216 per 100 000 live births globally in 2015, meaning around 303,000 women and girls died due to complications during pregnancy or childbirth. Achieving target 3.1 will require a huge acceleration in the annual rate of reduction of at least 7.3%, which is more than triple that attained between 1990 and 2015. Most maternal deaths are preventable as the necessary health interventions exist and are well known. Therefore increasing pregnant women's and girl's access to quality care before, during and after childbirth is critical, alongside ensuring quality contraceptive services are available to prevent unwanted pregnancies. A lack of skilled care is one of the main obstacles to better health for women and girls during pregnancy and delivery, which is aggravated by a global shortage of qualified health workers, particularly midwives. In all countries that have achieved reduction in maternal death, professionally trained midwives and others with midwifery skills have been a key to success. Only 76% of women in developing regions benefit from skilled care during childbirth. This means that millions of births



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

are not assisted by a midwife, a doctor or a trained nurse. The unequal status of women and girls remain an underlying cause for the inability or delay in care seeking. Lack of access to knowledge, decision making and financial powers, often due to discrimination in law and practice, as well as violence against women and girls and gender stereotypes, are social barriers that need to be addressed alongside health system interventions.

Complications in pregnancy are the leading cause of death among adolescent girls in developing countries (second cause globally). Pregnant adolescents are at increased risk of obstructed labor, a life-threatening obstetric emergency. Delay in treatment can lead to obstetric fistula or uterine rupture, hemorrhage and death of the mother and/or newborn. The global rate for adolescent births is 50 per 1000 adolescents aged 15-19 years, but the figure increases in high fertility settings such as sub-Saharan Africa to approximately 100 per 1000. Adolescent girls with unwanted pregnancies are more likely than adults to seek and obtain unsafe abortions of which an estimated three million occur every year among girls aged 15-19.

Target 3.2

Globally the risk for children to die before their 5th birthday was reduced by 44 per cent since 2000, reaching 43 deaths per 1,000 live births in 2015. Still a large number of preventable deaths remain, with about 16,000 children under the age of five dying every day in 2015. The neonatal mortality rate declined from 31 deaths per 1,000 live births in 2000 to 19 deaths per 1,000 live births in 2015. Neonatal mortality was highest in Southern Asia and sub-Saharan Africa, with around 29 deaths per 1,000 live births. The main causes of neonatal mortality are intrapartum complications (including birth asphyxia), prematurity, sepsis, congenital anomalies and pneumonia. Though neonatal mortality is decreasing, its proportion of the global under-five mortality is increasing, signaling a need to ramp up focus on antenatal care programs, raising rates of births assisted by qualified and skilled birth attendants, secure access to basic neonatal resuscitation facilities and sanitary delivery conditions as well as early nutritional guidance and support.

Huge disparities exist across and within countries, with under-five mortality rates ranging from 2 to 157 deaths per 1,000 live births. The countries with the highest rates were concentrated in sub-Saharan Africa and South Asia. The main causes of under-five mortality are pneumonia, diarrhea, injuries and NCDs. Social determinants greatly impact on child survival and death as children from the poorest households are, on average, nearly twice as likely to die before the age of five as children from the richest households as shown by survey data from some 50 countries. Similarly children to mothers who lack education are 2.8 times as likely to die as those whose mothers have at least a secondary education. These stark differences underline the importance of disaggregated child mortality data in order to better tailor and implement effective interventions and the need for multi-sectoral approaches to combat remaining child mortality.

Target 3.3

Globally in 2015, the rate of new HIV infections among all people was 0.3 new infections per 1,000 people, with 2.1 million becoming newly infected. Due to the success of national HIV programmes, the HIV incidence rate among children (less than 15 years of age) declined by 59% to 0.31 new infections per 1,000 children between 2010 and 2015, yet still 150 000 children were born with HIV in 2015. The incidence of HIV was highest in sub-Saharan Africa, with 1.5 new infections per 1,000 people. Among adolescents and adults aged 15-49 years in sub-Saharan Africa the incidence rate declined by 18% between 2010 and 2015 and was 2.44 among men and 3.22 among women. Young



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

women aged 15-24 years are at a particularly high risk of HIV infection, accounting for 20 % of new infections among adults globally in 2015. In sub-Saharan Africa young women represented 25 % of new HIV infection among adults. Overall, AIDS remains the leading cause of death among women aged between 15 and 49 years.

Furthermore, approximately 1800 young people are newly infected with HIV every day. This underscores the importance of ensuring that young people can fully exercise their rights to access sexual and reproductive health and HIV information, commodities and services, including knowledge of HIV prevention and power to negotiate condom use, and comprehensive sexuality education free from discrimination, coercion and violence. At the same time, key populations, including sex workers, people who inject drugs, transgender people and men who have sex with men remain at much higher risk of HIV infection and require access to comprehensive prevention services, including harm reduction.

Tuberculosis (TB) is a treatable and curable disease, but remains a major global health problem. In 2015, there were an estimated 10.4 million new TB cases (1 million of which were under age 15) , corresponding to 142 cases per 100 000 population. The incidence rate varied widely between countries, and declined by 1.5% since 2014. More than 67 million healthy children have latent TB infection and are at risk of developing the disease. There were 1.4 million deaths from TB and an additional 0.4 million deaths resulting from TB disease among HIV-positive people. The European region carries the highest rates of drug resistant TB (16% of new and 48% of previously treated cases) and over 20% of the global burden of multi-drug resistant TB (MDR/RR-TB).

In 2015, the malaria incidence rate was 91 per 1000 persons at risk, representing a 41% decrease globally between 2000 and 2015. Rates of decline in sub-Saharan Africa – where 90% of malaria cases occur - lagged behind most other regions. Reductions in incidence rates need to be accelerated in countries with the highest numbers of cases. Malaria remains a major cause of death for children under age 5 and account for 5% of under 5 mortality globally and 10% in sub-Saharan Africa.

Global deaths attributable to hepatitis are estimated to be around 1.3 million in 2015. Global coverage with three doses of Hepatitis B vaccine, a priority intervention, reached 84% among infants in 2015. In the same year 1.59 billion people were reported to require mass or individual treatment and care for neglected tropical diseases (NTDs), down from 2.0 billion in 2010. The 583 million people requiring treatment and care in least developed countries (LDCs) represented 61% of those countries' populations, down from 78% in 2010. More than 1 billion people living outside of the group of LDCs still required treatment and care for NTDs. All regions have made progress in reducing the percentages of their populations requiring treatment and care in the period 2010-2015.

Target 3.4

In 2015, a total of 40 million deaths due to non-communicable diseases (NCDs) occurred (70% of the global total of 56 million deaths). The majority were caused by the four main NCDs: 17.7 million were from cardiovascular diseases, 8.8 million from cancers, 3.9 million from chronic respiratory diseases, and 1.6 million from diabetes. The risk of dying from the four main NCDs between ages 30 and 70 decreased from 23% in 2000 to 19% in 2015. Adults in Oceania (excluding Australia and New Zealand) had the highest probability of dying from the four main NCDs (34%), while those in Australia and New Zealand had the lowest (9%). Men had higher risks than women in all regions. Nearly 800,000 suicide deaths occurred in 2015, representing the 2nd leading cause of injury death



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

after road traffic injuries. Men are nearly twice as likely to die from suicides as women and suicide is a major cause of death for adolescents, accounting for 6% among 15-19 year olds. Suicide mortality rates are highest in the European region, at 14.1 per 100 000 and lowest in the Eastern Mediterranean region (3.8 per 100 000).

Improving mental health requires a multi-sectoral approach – a whole of government and whole of society response. Worldwide 10-20% of children and adolescents experience mental disorders. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide, particularly for women.

Target 3.5

Worldwide alcohol consumption in 2016 was projected to be 6.4 litres of pure alcohol per person aged 15 and older. Consumption is increasing in the Western Pacific and South East Asia regions, while remaining relatively stable in others. Available data is inadequate and much further work is needed to improve the measurement of treatment coverage for alcohol and drug use disorders.

Target 3.6

Around 1.25 million people died from road traffic injuries in 2013, with up to 50 million people sustaining non-fatal injuries as a result of road traffic collisions or crashes. Road traffic injuries are the main cause of death among people aged between 15 and 29 years and disproportionately affect vulnerable road users, i.e. pedestrians, cyclists and motorcyclists. Between 2000 and 2013 the number of road traffic deaths globally increased by approximately 13%. The risk of a road traffic death varies significantly by region. The highest rates for 2013 were in Sub-Saharan Africa, while Northern America and Europe, as well as Australia and New Zealand have rates far below the global average of 17.4 per 100 000 population (9.2 per 100 000 population and 5.5 per 100 000 population, respectively). No region is on track to meet the target of a 50% reduction in mortality by 2020.

Target 3.7

Universal access to sexual and reproductive health-care services promotes health and well-being; saves hundreds of thousands of women's and girls' lives every year (with tens of millions of babies born healthy); access to voluntary family planning supporting individuals and couples to make informed choices about if, when and how many children to have, with wider social and economic impact; and places the poorest, most marginalized and excluded women and girls at the forefront in exercising their human rights. Globally, there has been only a slight increase in the proportion of women of reproductive age who were married or in-union who had access to modern family planning methods, from 74.5% in 2000 to 76.7% in 2017. Progress has been substantial in the least developed countries, where the demand satisfied with such methods increased from 39.3% in 2000 to 57.1% in 2017.

However, much remains to be done, as millions of women who want to delay or avoid pregnancy still do not have access to or are not using effective methods of family planning with large gaps remaining across countries and regions. Globally, childbearing in adolescence declined by 21% between 2000 and 2017 and did so by more than 50 per cent in Southern Asia. However, births in sub-Saharan Africa to girls under age 15 are projected to nearly double over the next decade if



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

immediate action is not taken. Overall, the adolescent birth rate remains high, with more than 20 births per 1,000 adolescent girls, in two thirds of the countries of the world. In 2017, an estimated 13 million births will be to girls under age 20. With almost 1.8 billion adolescents and youth globally, investing in their health and well-being is essential to achieve the 2030 agenda. Data collection and monitoring of indicators for the target should include progress made on laws and policies for universal access to sexual and reproductive health care services, integration of reproductive health into national strategies and comprehensive sexuality education.

Target 3.8

The Statistical Commission recently agreed on two UHC indicators for target 3.8, which will provide the first comparable set of monitoring figures for an index of essential health service coverage and the proportion of the population with large household expenditures on health as a share of total household expenditure or income as a measure of financial protection from hardship due to catastrophic health care expenditures. . Recent data availability for tracer indicators within 3.8.1 is over 70%, and 60% of countries have at least one data point for 3.8.2. The number of tracer indicators could present a potential risk that the index may obscure lack of progress for specific child and sexual and reproductive health interventions due to the averaging effect, hence the need for tracking specific individual tracers while monitoring the index. Through the lens of leaving no-one behind, UHC includes migrants and refugees, many of whom may not have legal status or are unaccounted, in financial risk protection schemes and access to equitable health services.

Target 3.9

Globally in 2012, household (indoor) air pollution from cooking with unclean fuels or inefficient technologies led to 4.3 million deaths. Ambient (outdoor) air pollution from traffic, industrial sources, waste burning or residential fuel combustion caused 3.0 million deaths during the same year. Air pollution is the largest environmental health risk for NCDs in particular, causing cardiovascular diseases, stroke, chronic obstructive pulmonary disease and lung cancer. Among children under 5 years of age, household air pollution is estimated to cause half of all pneumonia deaths. Children are particularly susceptible to air pollution as they breathe in more air per unit of body weight than adults and studies suggest that ultrafine pollutant particles may also cause permanent damage to the neurological development of children.

Leading to an estimated 889,000 deaths in 2012, unsafe water, unsafe sanitation and lack of hygiene remain a major risk factor for mortality, disproportionately affecting low-income communities and children under 5 years of age. The death rates from unsafe WASH services are highest in sub-Saharan Africa, Central Asia and Southern Asia, despite important progress made during the last two decades.

Deaths from unintentional poisonings are a reflection of the management of hazardous chemicals throughout the world. Globally, the mortality rate from unintentional poisonings decreased by 33% between the years 2000 and 2015, but still causes 108 000 deaths annually. Many options for improving the sound management of chemicals are available for reducing poisonings, including choosing a safer chemical where available, engineering controls such as ventilation, safe storage and labelling, adequate information about products' hazards, as well as use of personal protection when other options are not feasible.



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

Target 3.a

In 2015, over 1.1 billion people smoked tobacco, far more males than females. 6 million deaths are caused annually by tobacco use. The WHO Framework Convention on Tobacco Control has been ratified by 180 Parties representing 90% of the global population. More than 80% of Parties have either adopted new or strengthened their existing tobacco control laws and regulations.

Target 3.b

Global coverage of three doses of diphtheria-pertussis-tetanus immunization, as a proxy of full immunization among children, was 86% in 2015. Data from 2007-2014 show that, for selected essential medicines, median availability was only 60% and 56% in the public sector of low-income and lower-middle-income countries respectively. Access to medicines for chronic conditions and NCDs is even worse than that for acute conditions. Despite improvements in recent decades, innovation for new products remains focused away from the health needs of those living in developing countries. The current landscape of health research and development (R&D) is insufficiently aligned with global health demands and needs. As little as 1% of all funding for health R&D is allocated to diseases that are predominantly incident in developing countries.

Target 3.c

Health workers are distributed unevenly across the globe. Regions with the highest burden of disease have the lowest proportion of health workforce to deliver much needed health services. Available data from 2005-2015 show that around 40% of countries have less than 1 physician per 1000 population and almost half of all countries have less than 3 nursing and midwifery personnel per 1000 population. Even in countries with higher national human resources for health densities, the workforce is inequitably distributed, rural and hard to reach areas tend to be understaffed as compared to capital cities and other regions.

The joint ITU/WHO initiative “Be Healthy Be Mobile” utilizes mobile technology to help countries combat the growing burden of non-communicable diseases and their risk factors (tobacco use, an unhealthy diet, physical inactivity and the harmful use of alcohol). The initiative brings mobile health services to scale within national health systems, by providing technical expertise on implementing mobile health interventions. It also promotes a highly multi-sectoral approach to ensure that the programmes are sustainable and has established partnerships with 8 target countries.

Target 3.d

Until 2016, the International Health Regulations (IHR) monitoring process involved assessing, through a self-assessment questionnaire sent to States Parties, the implementation status of 13 core capacities. 127 (65% of all State Parties) responded to the monitoring questionnaire in 2015. The average core capacity scores of all countries in 2015 was 78%. Despite the evidence of links between spread of diseases and population mobility, migration and cross border movement remain marginally addressed in early warning and risk reduction/management systems. The 2016 IHR review process acknowledged the need to include migration and mobile populations in epidemic and pandemic preparedness and response plans. Pandemic preparedness and global health security requires across the board upscaling of IHR implementation.



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

3. Recommendations

Principles, enablers and multi-sectoral action

The application of a human rights based approach to health is a key requirement for improving the well-being and dignity of all. There is a specific need to invest in multi-stakeholder partnerships in order to remove barriers to equitable health services which are responsive to increasingly diverse population health profiles and needs, and to reach those most further behind first.

Sustained emphasis is necessary to improve multi-sectoral action, strengthen health systems, realize equity and fulfil, protect and promote human rights, promote gender equality and the empowerment of all women and girls, and to secure adequate and sustained financing and investment in scientific research and innovation.

Without addressing violence against women and girls it will be impossible to achieve health targets, such as the elimination of HIV/AIDS, universal access to sexual and reproductive health and rights, or significant reductions in maternal mortality and morbidity. The importance of prioritizing adolescent health, including their sexual and reproductive health, is critical. A multi-sectoral approach to child health in general should go beyond the public health sector, recognizing and integrating the contributions of all sectors to child health while preserving “vertical” programs. There is therefore a need to take a life course approach to child health from preconception to adolescents and to also include the health of women prior to pregnancy.

In other areas such as WASH services, there remains an urgent need to (a) improve coverage of drinking-water supply and safe quality (b) adequate sanitation in households and other settings, (e.g. schools and health facilities) and safe management of fecal waste to reduce human excreta in the environment. These services need to be accompanied by adequate hygiene practices such as handwashing after defecation or before food preparation and intake, and specifically take into account the needs of women and girls.

Human resources for health

The creation of fiscal space for expanding health sector employment and health protection is key, as underfunding has detrimental impacts on population’s health status and contributes to increased inequities in access to health care, and other direct and indirect costs of ill health. Managing the migration of health care workers and implementation of the international code of conduct of recruitment of health personnel needs further promotion, as well as local integration of migrant, refugee and displaced health personnel.

Information and Communication Technologies have the potential to deliver incredible advances across the whole of the global healthcare ecosystem. Further investments are needed to increase coverage and accessibility, as connectivity provided by data and telecommunication networks enable health workers to be connected to information and diagnostic services and allow them to form support networks and communicate with doctors and nurses within clinics and hospitals. The benefits are wide ranging - mobile phones allow community health workers to learn and prepare for disease outbreaks, identify patient symptoms, follow established treatment protocols, perform remote diagnostics, access expert support, refer patients to clinics, send patient reminders, record delivery of health services, and receive mobile payments for those services. Social media helps to provide advice and support, and allows health workers and patients alike to benefit from shared



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

best practice, and to obtain important information about disease outbreaks and the availability of health services.

Equitable access

There is an urgent need to develop and implement inclusive and resilient health protection schemes, as part of broader social protection policies such as national social protection floors (SDG 1), in order to provide equitable access to quality health services for all. The right to health extends to all societies, including migrants and displaced communities. Being healthy is a fundamental precondition for migrants to work, be productive and contribute to the social and economic development of communities of origin and destination

Enhancing data

Similarly, monitoring and evaluation has to be scaled up and data availability and quality improved. Increased efforts are needed to support national statistical capacity to follow, track and utilize health indicator data to inform policies and programs. For SDG 3, the MDG legacy contributes to a relatively strong foundation of data and reporting frameworks. SDG 3 also benefits from targets and indicators that are largely quite clear and tangible. There are still significant gaps in some of the disaggregated data needed to monitor SDG3, and while the data needed for measuring individual targets is often clear, there are ongoing debates over the best way to assess the success in achieving the goal itself—whether to use “life expectancy” or “healthy life expectancy” as the defining measurement, for instance.

The challenges of accurate data, disaggregated by age, sex, income, disability, geographic location, education and other social characteristics are not only evident in terms of SDG3, but particularly relevant to linkages with SDGs 1, 4, 5, 10, 16 and 17 from the perspective of addressing the highest needs of vulnerable populations and leaving no-one behind. Efforts to improve complete and accurate civil registration and vital statistics systems need to be stepped up significantly. The lack of data for maternal mortality of girls under 15 years of age amplifies the challenge, with an estimated 2 million giving birth every year. Adolescents and young people are significant drivers of robust economic growth and poverty reduction.

Partnership

The Global strategy for Women’s, Children’s and Adolescents Health, under the Every Woman Every Child (EWEC) Platform and the joint UN health organizations group (H6), as well as the Partnership for Maternal, Newborn, Child and Adolescent Health and the Special Program for Human Reproduction (HRP), plays an important role in the harmonization, alignment of partnerships and technical support to countries in materializing the universal access to sexual and reproductive health services, as well as upholding mechanisms for holding countries and donors accountable.

In monitoring implementation of the 2030 agenda several UN entities with health related mandates can provide valuable contributions through a more systematic overview by their governing bodies. Some specific initiatives which are being considered are (a) the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, as well as (b) the Special Program for Research and Training in Tropical Diseases (TDR) which has proposed models for pooled financing that would support research and development to control neglected diseases.



HIGH-LEVEL POLITICAL FORUM ON SUSTAINABLE DEVELOPMENT

Growing challenges

Emerging threats such as Anti-Microbial Resistance, which is not fully captured in the 2030 agenda, threatens not only gains made in addressing infectious diseases, but is a silent crisis which will impact adversely on SDGs beyond health, specifically those related to the environment, food and agriculture, water, sanitation, research and development, and economic growth. If not addressed it is estimated that AMR could result in a cumulative global cost of \$100 trillion by 2050.

Current estimates are that mental health conditions will affect one in four people throughout their lifetime. There is a strong link between mental health and poverty, as well as between mental health conditions and the economic hardship resulting from the inadequate realization of economic, social and cultural rights, as well as the rights to education, work, housing, food and water. These and other rights are also underlying determinants of mental health and the failure to adopt policy approaches which take account of these and other determinants is a major barrier to the realization of the right to mental health. Despite the impact of mental health conditions on individuals, families and communities, there is insufficient investment of both financial and human resources in the area of mental health. Global annual spending on mental health is less than \$2 per person and less than \$0.25 per person in low-income countries. In the context of health, the concept of parity of esteem refers to valuing mental health equally with physical health. The strong relationship between physical and mental health calls for an approach which accords equal value to both. Measures to address mental health in accordance with human rights norms and standards are crucial for the achievement of SDG 3 and the 2030 agenda as a whole.