EAST AFRICAN COMMUNITY

CONCEPT NOTE

1ST EAC HEADS OF STATE SUMMIT ON INVESTMENT IN HEALTH AND JOINT INTERNATIONAL HEALTH SECTOR INVESTORS AND DONORS ROUNDTABLE MEETING: 27TH TO 30TH NOVEMBER 2017, COMMONWEALTH SPEKE RESORT HOTEL & CONFERENCE CENTER, MUNYONYO, KAMPALA, UGANDA.

INVESTING IN HEALTH SYSTEMS, INFRASTRUCTURE, HEALTH SERVICES AND RESEARCH FOR ACCELERATED ATTAINMENT OF UNIVERSAL HEALTH COVERAGE (UHC) AND HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS (SDGS) IN THE EAC BY THE YEAR 2030

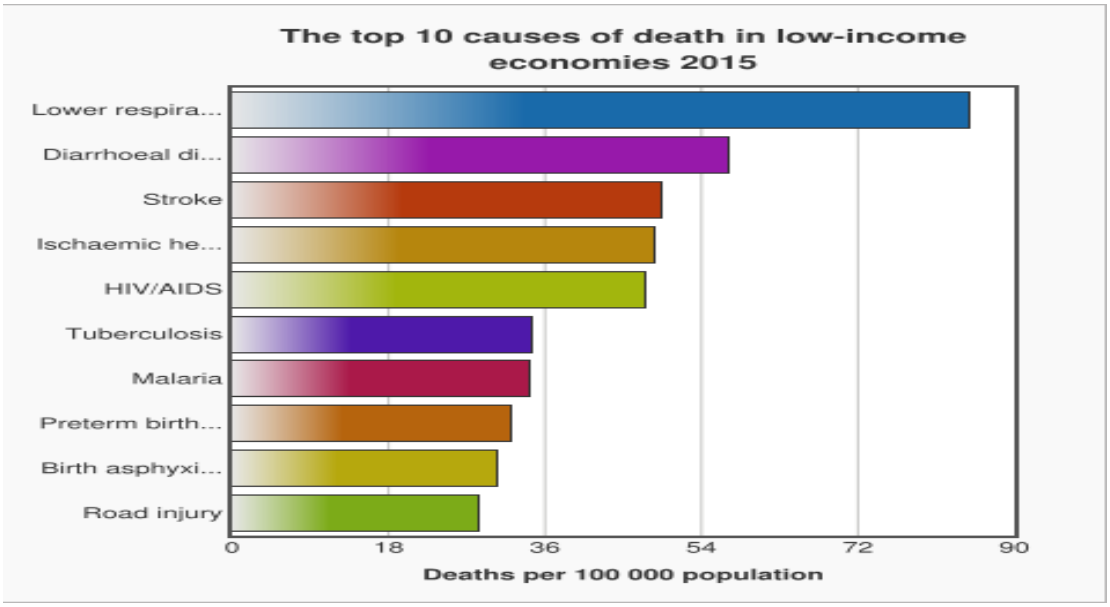
CONSIDERED AND APPROVED BY THE 35TH ORDINARY MEETING OF THE EAC COUNCIL OF MINISTERS ON 4TH APRIL 2017 – REPORT REF. NO: EAC/CM/35/2017.

1.0 Introduction

1.1 Background

The East African Community (EAC) is undergoing major public health transformations fueled by increasing human-animal-environmental interactions and conditions, in which people are born, grow, work, live and age. For the first time in history, the region, like the rest of the low and middle- income countries is experiencing a concurrent triple burden of infectious diseases such as malaria, HIV/AIDS and Tuberculosis; non-communicable diseases such as high blood pressure, diabetes and cancers; and diseases related to increasing globalization, trade and climate change like epidemics and pandemics. In 2015, Non-communicable diseases (NCDs) caused 70% of deaths globally, ranging from 37% in low-income countries to 88% in high-income countries[1].

The graph below shows the top 10 leading causes of death in low-income countries in 2015.



Due to the unprecedented burden of disease, most of the health related Millennium Development Goal (MDG 4, 5 and 6) targets such as maternal mortality ratio, under-five mortality and HIV/AIDS were not met thereby requiring revamping of new investments in ways of doing business during the era of the Sustainable Development Goals (SDGs). Progress is further curtailed by the rapid population growth rate and a huge dependency ratio, which outstrips investments in health. For example, the Republic of Burundi, The United Republic of Tanzania, and Republic of Uganda are among the 10 countries in Africa whose population is likely to increase five-fold between 2015 and 2100[2].

[1] WHO. 2015. The top 10 causes of death. http://www.who.int/mediacentre/factsheets/fs310/en/index1.html
[2] United Nations, Department of Economic and Social Affairs, Population Division (2015) World Population Prospects: The 2015 Revision. New York: United Nations.

In an effort to address the growing burden of disease, the EAC Partner States are collaborating in development of robust health services in line with Article 118 of the treaty for the establishment of the EAC, which calls for regional cooperation on health. The Partner States are currently operationalizing the following regional centers of excellence for health care training, research and services among other regional initiatives;

i. The East African Center of Excellence for Kidney Diseases in the Republic of Kenya
ii. The East African Center of Excellence for Heart Diseases in The United Republic of Tanzania
iii. The East African Center of Excellence for Cancer in the Republic of Uganda
iv. The East African Center of Excellence for eHealth, Biomedical Engineering and Health Rehabilitation Sciences in the Republic of Rwanda; and
v. The East African Center of Excellence for Vaccines, Immunization and Health Supply Chain Management in in the Republic of Rwanda

Efforts are underway to establish the **"East African Center of Excellence for Nutritional Sciences"** in the Republic of Burundi.

Further, the EAC has drafted a number of policy and strategy instruments to operationalize Article 118 of the treaty for the establishment of the EAC. Examples of these include: the EAC Health Policy, EAC Health Sector Strategic Plan 2015-2-20, East African Health Research Commission Strategic Plan 2016-2021; EAC HIV/AIDS and Sexually Transmitted Infections Strategic Plan 2015-2020, EAC Reproductive Maternal New-born Child and Adolescent Health (RMNCAH) Policy Guideline 2016-2030, EAC RMNCAH Strategic Plan 2016-2021 and the EAC Regional Contingency Plan for Epidemics due to Communicable Diseases, Conditions and other Events of Public Health Concern (2015 – 2020). Efforts are underway, to develop strategies for medicines, food safety and health technologies and disease prevention and control.

1.2 Investing in Universal Health Coverage and People Centered Health Services

Universal Health Coverage (UHC) means everyone (including the poorest and most vulnerable) can access the full range of essential health services, including prevention, treatment, hospital care and pain control they need without financial hardship irrespective of their ability to pay. As illustrated in the figure below[3], UHC means the progressive increment on the proportion of the populations covered by an increasing scope of essential health services at a cost they can pay for using pooled funding mechanisms such as health insurance or government subventions.

3Boerma T, Eozenou P, Evans D, Evans T, Kieny M-P et al. (2014) Monitoring Progress towards Universal Health Coverage at Country and Global Levels. PLoS Med 11(9): e1001731. doi:10.1371/journal.pmed.1001731).

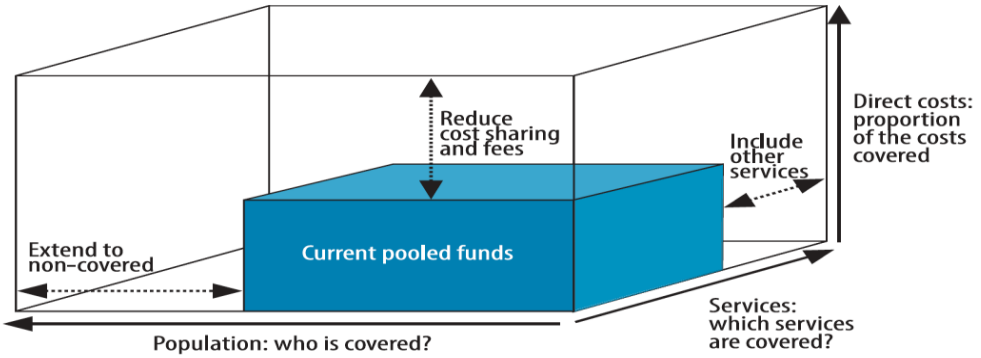


Figure 1. Progressive realization of universal health coverage.
doi:10.1371/journal.pmed.1001731.g001

All the 194 World Health Organization (WHO) member countries endorsed UHC as a guiding principle in improving health services in 2011, a decision that was subsequently endorsed by the United Nations in December 2012[4]. Target 3.8 of the Sustainable Development Goal 3 on ensuring healthy lives and promoting well-being for all at all ages seeks to 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.

UHC calls for strengthening of health systems to deliver quality services to all people, when and where they need them by ensuring effective alignment of the various facts of the system namely financing mechanisms; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities/infrastructure; quality medicines and technologies and effective leadership and governance systems. These elements must work in a seamlessly integrated and sustainable manner to make the health systems resilient even in the face of major emergencies including epidemics like Ebola.

The Sixty-Ninth World Health Assembly (WHA) in May 2016 adopted resolution WHA 69.24 on **"Strengthening integrated people-centred health services"** in support of the **"World Health Organization (WHO) Framework on Integrated People-Centred Health Services" and in effect the Universal Health Coverage (UHC) agenda.** Integrated people-centred health services represents a fundamental shift in the way health services are designed and managed while putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active role in their own health. The framework recognizes clients and communities as co-creators of health services and thus the need to involve them throughout the health value chain.

Sustainable health financing is at the center of efforts to attain UHC[5]. Building on the

[4]WHO (2014) The Global Push For Universal Health Coverage.
http://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf.
[5] Chatham House Report (2014) Shared Responsibilities for Health A Coherent Global Framework for Health Financing: Final Report of the Centre on Global Health Security Working Group on Health Financing.

recommendations of the WHO Commission on Macroeconomics and Health (CMH 2001), the (high-level) Taskforce on Innovative International Financing for Health Systems (HLTF 2009) and the World Health Report 2010, the Centre on Global Health Security Working Group on Health Financing recommends that in order the attain UHC, countries need to spend at least 5 per cent of gross domestic product (GDP) on health and spend at least US$ 86 per person per year. Between 2000 and 2014[6], the Total Health Expenditure (THE) per capita in the EAC Partner States in US$ increased as follows: 7 to 27 in Burundi; 19 to 67 in Kenya; 9 to 71 in Rwanda; 19 to 50 in Uganda; and 10 to 49 in the United Republic of Tanzania.

Maximizing investments in health calls for progressive increase in domestic financing; adoption of innovative financing options such as ear marked taxes; adoption of efficiency measures and borrowing for capital projects[7]. Optimizing and sustaining health financing requires effective partnerships and compacts between governments, investors, donors and other key stakeholder constituencies.

"Universal Health Coverage (UHC) is the single most powerful concept that public health has to offer."— Margaret Chan, Director-General, WHO, 21st May 2012.

"Achieving Universal Health Coverage (UHC) and equity in health are central to reaching the global goals to end extreme poverty by 2030 and boost shared prosperity." — Jim Yong Kim, President, World Bank Group, 6th December 2013.

1.3 Investing in Health Research

Health generated evidence required to inform policies, programmes and innovations in various areas such medicines, vaccines, infrastructure and models of service delivery. Despite this central role of research in healthcare, the World Health Organization reports that Africa accounts for only 1.3% of global health research in 2014 although the region accounts about 24% of the global burden of disease. A joint report by the World Bank and Elsevier (2014) shows that 39% of all East African researchers are non-local, and the nature of the research is transitory; that is, they spend less than two years with the research institutions. Related to this reality, external organisations contribute 70% of the funding for health research in the region. Besides funding constraints, research in the region is significantly affected by inadequate research capacity and inadequate prioritisation of health research in national and regional health programmes.

1.4 Justification/Rationale

There have been many achievements in improving access to and delivery of health care in the EAC region, however much more still needs to be done in terms of quality of care,

[6] WHO (2014) http://apps.who.int/gho/data/node.main.78?lang=en.Health expenditure per capita, all countries, selected years)
[7] WHO (2010) World health report 2010 - Health systems financing: the path to universal coverage)

making evidence based services, availability of proper health infrastructure and adequate human resources for health to ensure better health outcomes for the east Africans.

Sustainable Development Goal (SDGs) 3 target 3.8 seeks achieving Universal Health Coverage including financial risk protection, access to quality essential health care services and access to safe water, effective, quality and affordable essential medicines and vaccines for all further reaffirms the need for renewed commitment to invest in health. we need to also focusing on Sustainable and reliable financing which will enable the population to access services without financial difficulties regardless of their socioeconomic status..

Further, the region is challenged with below average Health infrastructure development, inadequate human resources for health, Catastrophic out of pocket heath expenditure (ranging from 18% in Tanzania; 20% Rwanda; 27% Burundi; 29% in Kenya; and 39% in Uganda) which leads to impoverishment for families, hindering access to health services, and contributing to observed poverty levels, among others. . The region still experiences higher than global average infant and maternal mortality as well as malnutrition in spite of the many global and regional policy frameworks guiding on how to bridge the gap.

Whereas the private sector has contributed immensely to increasing access to quality health services in the region, the sector can play even a bigger role in increasing access to specialized health services that are unavailable but limited in our facilities (both public and Private) but are commonly sought abroad at exorbitant costs. These are also accessible to few who can afford to pay the bills. As the region aspires to reduce inequalities in our health system, improve quality of care in both public and private facilities, to promote health research, boost our human resources we note the following challenges that need to be addressed:

i. Unfavorable climate for investment in the health sector due to restrictive legal and policy frameworks for private sector investors;
ii. Inadequate human resource, low retention rates, an insufficient number of quality management of hospitals; perceived lack of fit between health professionals and the world of work, the inability of the system to replace its specialist's work force in public health sector and, the inadequate integration of health research in health systems; and
iii. Inadequate government budget support for health services and health research.

Investing in UHC is important for lifting people out of poverty, driving economic growth and the attainment of the Sustainable Development Goals (SDGs)[8]. It has the potential of reducing the number of people who do not have access to essential health services; reducing vulnerability to ill health, lost productivity, and pushing of 17% of the global population to less than $2/day poverty line due to a combination of these as well as borrowing and or

[8] WHO (2014) the Global Push for Universal Health Coverage. http://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf.

selling of assets for treatment from out of pocket. It concurrently improves coverage of essential services, quality and equity. Health improvements drove 24% of full-income growth in developing countries between 2000 and 2011. Evidence suggests that every US$1 invested in health is projected to return US$9-US$20 over the next 20 years[9,10].

2.0 Convening of the "1st EAC Heads of State Summit on Investment in Health and Joint International Health Sector Investors and Donors Roundtable Meeting and Trade Exhibition"

The East African Community (EAC) in collaboration with leading national, regional and international Partners is organizing the first ever **"1st EAC Heads of State Summit on Investment in Health and Joint International Health Sector Investors and Donors Roundtable Meeting and Trade Exhibition"** as part of proceedings of the 19th Ordinary Summit of the EAC Heads of State from **27th to 30th November 2017** at the **Commonwealth Speke Resort Hotel & Conference Center, Munyonyo, Kampala, Uganda**. The Theme of the Summit and Round Table Meeting and Trade Exhibition is **"Investing in Health Systems, Infrastructure, Health Services and Research for accelerated attainment of Universal Health Coverage (UHC) and health-related Sustainable Development Goals (SDGs) in the EAC by the year 2030".** The event will incorporate an International Trade Fair and Open Air Exhibitions.

The summit and the donor-round table meeting and trade exhibition will provide an opportunity for high level discussions among Partner States, national, regional and international Partners, local investors and other stakeholders aimed at focusing attention on the urgent need for major investments in the health sector, specifically:

i. Promoting investment in health
ii. Global and regional strategies and innovations for promoting and expending investment in human resources for health
iii. **Strengthen primary healthcare, secondary healthcare and tertiary healthcare through the introduction of Universal Health Coverage (UHC)** and **health research** through the full operationalization of the **"Multi-National East African Community Regional Centres of Excellence (CoE) for Skills and Tertiary Education in Higher Biomedical and Health Sciences Education as well as Treatment and Research Programme"**.
iv. Financing health research at national and regional level; and
v. Management and leadership

[9] Dean T Jamison, Lawrence H Summers, George Alleyne, Kenneth J Arrow, Seth Berkley et al. (2013) Global health 2035: a world converging within a generation. Lancet 2013; 382: 1898–955. Published Online December 3, 2013 http://dx.doi.org/10.1016/ S0140-6736 (13)62105-4.
[10] Jesse Bump, Cheryl Cashin, Kalipso Chalkidou, David Evans, Eduardo González-Pier et al. (2015). Implementing pro-poor universal health coverage. Lancet Glob Health 2015 Published Online December 11, 2015 http://dx.doi.org/10.1016/ S2214-109X (15)00274-0.

3.0 Purpose, Objectives and expected outcomes of the "1st EAC Heads of State Summit on Investment in Health and Joint International Health Sector Investors and Donors Roundtable Meeting and Trade Exhibition"

3.1 Purpose

The purpose of the **Summit and Round-Table Meeting and Trade Exhibition** is to renew national and regional commitments on investment in health infrastructure, research, systems and services for accelerated attainment of Universal Health Coverage (UHC) and health-related Sustainable Development Goals (SDGS) in the EAC by the year 2030.

3.2 Objectives

The objectives of the Summit and Round-Table meeting and Trade Exhibition are to:

i. Build consensus on regional health sector investment priorities for the attainment of SDGs by the year 2030
ii. Mobilize investment in the health sector in identified priority areas
iii. Provide an opportunity to revitalize regional partnerships and linkages for improved health outcomes for the EAC Partner States

3.3 Expected outcomes

The expected outcomes of the Summit and Round-Table Meeting and Trade Exhibition are:

i. Communiqué of the 1st EAC Heads of State Summit on Investment in Health and Health Sector Investors and Donor Roundtable Meeting and Trade Exhibition
ii. EAC regional health priorities framework (Partner States and Donors)
iii. Report of the EAC Health Sector investors and Donor Round Table meeting
iv. Investment commitments by Partner States, development partners and investors in identified priority areas
v. Report of the EAC Health Sector investors and Donor Round Table meeting and Trade Exhibition

3.4 Expected Participants

The principal participants of the 1st EAC Heads of State Summit on Investment on Health are the EAC Heads of States and their guests, government official from EAC Partner States' National Ministries, Departments and Agencies (MDAs), Development Partners, Implementing Partners, local and international investors in the health sector, Pharmaceutical Manufacturers, Partner Governments, Parliamentarians from local and national parliaments, Civil Society Organizations, Faith-based Organizations as well as Academic and Research institutions/organizations.

The following Partner Governments and partners are expected to participate in the summit and round-table meeting: USA, EU, Norway, Sweden, Germany, UK, Japan and China, among others, UN Agencies (WHO, UNFPA, UNICEF, UNAIDS, OIE), Multi-lateral

institutions (World Bank, African Development Bank), Development Partners (Bill and Melinda Gates Foundation and GAVI Alliance), African Union Commission (AUC), African Union/NEPAD Planning and Coordinating Agency, African Regional Economic Communities (COMESA, IGAD, SADC, ECOWAS), African Regional Health Organizations (ECSA and WAHO), Private Sector (Pharmaceuticals, Hospitals/Healthcare Institutions and Insurance Agencies/Companies) and Professional Associations (African Health Economic and Policy Association-AHEPA), Universities and various health academic institutions, among others. The number of expected participants is 1,000.

4.0 International Trade Fair and Exhibitions

4.1 Call for Participation

International, regional, national and sub-national public and private sector institutions, including hospitals, colleges, universities and other health professional training and health research institutions, Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs) and Community Based Organizations (CBOs) and individual entrepreneurs are invited to participate in the International Trade Fair and Exhibitions. Participation in the International Trade Fair and Exhibitions will be an excellent opportunity to showcase organizational and institutional profiles, services, and products to various stakeholders, including the international, national and sub-national policy makers, political leaders, academia, the private sector, students, researchers, investors and the general public. The International Trade Fair and Exhibitions will also provide the opportunity for the participants and exhibitors to interact with the best and most ambitious talents in the private sector and the public sector, academia, researchers and various Non-State Actors (NSAs) for the eventual productive engagement between these complimentary systems.

4.2 Requirements for International Trade Fair and Exhibitors

i. 3 m x 3 m exhibition stand with name, lighting, power and internet points at the International Trade Fair and Exhibitions section next to the venue of the Summit (Additional stands will be available on request but at an additional cost of USD 350)
ii. Exhibition furniture, including one table and two chairs
iii. One-page profile in the official forum catalogue (each exhibitor to submit)
iv. Potential Visits by the Guests of Honor and also by other Summit participants and the general public
v. Local and International Media Coverage and Publicity

4.3 Registration Fee for Participation

Registration for participation at the **International Trade Fair and Exhibitions** will be charged at **US$ 350 per Exhibition Booth/Stand/Per Day** to cover costs of exhibition.

The deadline for registration as exhibitors in the **International Trade Fair and Exhibitions** should register at www.eac.int/1st EAC Health Summit by 31st October, 2017.

Annex I: Draft Agenda

"1st EAC Heads of State Summit on Investment in Health and Joint International Health Sector Investors and Donors Roundtable Meeting and Trade Exhibition": Commonwealth Speke Resort Hotel & Conference Center, Munyonyo, Kampala, Uganda – 27th to 30th November 2017

1) Opening address by the Chairperson of the 19th Ordinary Summit of EAC Heads of States

2) **Key Note Address Number 1: ----------** on **"Investing in Health Systems, Infrastructure, Health Services and Research within the context of Universal Health Coverage (UHC) and Health-Related Sustainable Development Goals (SDGs) and Targets by 2030 in the East African Community Partner States"** with a focus on regional, national and sub-national public and private sector investments

3) **Key Note Address Number 2: ---------- on "Promoting and Enhancing the Private Sector Contribution towards Achieving Universal Health Coverage (UHC) and Equity in health to reach the Global Goals to End Extreme Poverty by 2030 and Boost Shared Prosperity."**

4) **Key Note Address Number 3: ----------** on **"Overview and perspectives on the World Health Organization (WHO) Framework and Strategy on Integrated People-Centred Health Services - Transforming integrated health service delivery in the African Region"**

5) EAC Country Specific Public/Private Sector Health Investment Priorities and Strategies and Proposed Road Maps, Work Plans and Budgets by the Year 2030

Session Facilitator: Prof. Khama Odera Rogo, World Bank Group (WBG/IFC)

(i) Republic of Burundi – Hon. Minister for Public Health and Fight Against AIDS
(ii) Republic of Kenya – Hon. Cabinet Secretary for Health
(iii) Republic of Rwanda – Hon. Minister for Health
(iv) Republic of South Sudan – Hon. Minister for Health
(v) Republic of Uganda – Hon. Minister for Health
(vi) United Republic of Tanzania – Hon. Minister for Health, Gender, Community Development, Elderly and Children

6) Remarks by the following International Collaborating Development Partners/Donors: -

(i) **Hon. Minister,** German Ministry of Economic Development and Cooperation (BMZ)

(ii) ---------- World Bank Group (WBG)
(iii) **Dr. Ibrahim Assane Mayaki,** Chief Executive Officer (CEO), African Union-NEPAD Planning and Coordinating Agency,
(iv) ---------- Bill and Melinda Gates Foundation (BMGF),
(v) **Chair,** International Federation of Pharmaceutical Manufacturers and Associations
(vi) **Chair,** Federation of the East African Pharmaceutical Manufacturers Ltd,
(vii) Others to be confirmed

7) Plenary Discussions on **" Investing in Health Systems, Infrastructure, Health Services and Research for the Accelerated Attainment of Universal Health Coverage and Health-Related Sustainable Development Goals in the EAC by the year 2030" -** led by the Chair of the 19th Ordinary Summit of the EAC Heads of State.
8) Drafting and signing of the Joint Communiqué of the 19th Ordinary Summit of EAC Heads of State on the **"1st EAC Heads of State Summit on Investment in Health and Joint International Health Sector Investors and Donors Roundtable Meeting and Trade Exhibition"** highlighting commitments of the 19th Ordinary Summit of the EAC Heads of States and Development Partners and Public/Private Sector Investors.

Annex II: Sustainable Development Goal 3: Targets and Indicators

Goal 3: Ensure healthy lives and promote wellbeing for all at all ages

Target	Indicators
3.1 by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births	17. Maternal mortality ratio (MDG Indicator) and rate 3.1. Percentage of births attended by skilled health personnel (MDG Indicator) 3.2. Antenatal care coverage (at least one visit and at least four visits) (MDG Indicator) 3.3. Post-natal care coverage (one visit) (MDG Indicator) 3.4. Coverage of iron-folic acid supplements for pregnant women (%) 3.29. Percentage of health facilities meeting service specific readiness requirements.
3.2 by 2030 end preventable deaths of newborns and under-5 children	11. Percentage of infants under 6 months who are exclusively breastfed 18. Neonatal, infant, and under-5 mortality rates (modified MDG Indicator) 19. Percent of children receiving full immunization (as recommended by national vaccination schedules) 3.1. Percentage of births attended by skilled health personnel (MDG Indicator) 3.2. Antenatal care coverage (at least one visit and at least four visits) (MDG Indicator) 3.3. Post-natal care coverage (one visit) (MDG Indicator) 3.5. Incidence rate of diarrheal disease in children under 5 years 3.10. Percentage of children under 5 with fever who are treated with

	appropriate anti-malarial drugs (MDG Indicator)
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	19. Percent of children receiving full immunization (as recommended by national vaccination schedules) 20. HIV incidence, treatment rate, and mortality (modified MDG Indicator) 21. Incidence, prevalence, and death rates associated with all forms of TB (MDG Indicator) 22. Incidence and death rates associated with malaria (MDG Indicator) 26. [Consultations with a licensed provider in a health facility or in the community per person, per year] – to be developed 27. [Percentage of population without effective financial protection or health care, per year] – to be developed 3.5. Incidence rate of diarrheal disease in children under 5 years 3.6. Percentage of 1 year-old children immunized against measles (MDG Indicator) 3.7. Percent HIV+ pregnant women receiving PMTCT 3.8. Condom use at last high-risk sex (MDG Indicator) 3.9. Percentage of tuberculosis cases detected and cured under directly observed treatment short course (MDG Indicator) 3.10. Percentage of children under 5 with fever who are treated with appropriate anti-malarial drugs (MDG Indicator). 3.11. Percentage of people in malaria-endemic areas sleeping under insecticide-treated bed nets (modified MDG Indicator). 3.12. Percentage of confirmed malaria cases that receive first-line antimalarial therapy according to national policy. 3.13. Percentage of suspected malaria cases that receive a parasitological test. 3.14. Percentage of pregnant women receiving malaria IPT (in endemic areas) 3.15. Neglected Tropical Disease (NTD) cure rate 3.16. Incidence and death rate associated with hepatitis 3.34. Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV
3.4 by 2030 reduce by one-third pre-mature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote	23. Probability of dying between exact ages 30 and 70 from any of cardiovascular disease, cancer, diabetes, chronic respiratory disease, [or suicide] 44 mental health and wellbeing 24. Percent of population overweight and obese, including children under 5 26. [Consultations with a licensed provider in a health facility or in the community per person, per year] – to be developed 28. Proportion of persons with a severe mental disorder (psychosis, bipolar affective disorder, or moderate-severe depression) who are using services 30. Current use of any tobacco product (age-standardized rate)

	3.17 Percentage of women with cervical cancer screening 3.18. Percentage with hypertension diagnosed & receiving treatment 3.21. Waiting time for elective surgery 3.22. Prevalence of insufficient physical activity 3.23. Fraction of calories from saturated fat and added sugar 3.24. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years 3.25. Prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day 3.26. Percentage change in per capita [red] meat consumption relative to a 2015 baseline 3.27. Age-standardized (to world population age distribution) prevalence of diabetes (preferably based on HbA1c), hypertension, cardiovascular disease, and chronic respiratory disease.
3.5 strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	30. Current use of any tobacco product (age-standardized rate) 3.19. Harmful use of alcohol
3.6. by 2030 halve global deaths from road traffic accidents	25. Road traffic deaths per 100,000 population
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 programs	7. Total fertility rate 29. Contraceptive prevalence rate (MDG Indicator) 44. Met demand for family planning (modified MDG Indicator) 5.4. Adolescent birth rate (MDG Indicator) 5.5. Percentage of young people receiving comprehensive sexuality education
3.8 achieve universal health coverage (UHC), 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	19. Percent of children receiving full immunization (as recommended by national vaccination schedules) 26. [Consultations with a licensed provider in a health facility or in the community per person, per year] – to be developed 27. [Percentage of population without effective financial protection or health care, per year] – to be developed 3.20. Healthy life expectancy at birth 3.21. Waiting time for elective surgery 3.29. Percentage of health facilities meeting service specific

	readiness requirements. 3.30. Percentage of population with access to affordable essential drugs and commodities on a sustainable basis 3.31. Percentage of new health care facilities built in compliance with building codes and standards 3.33. Ratio of health professionals to population (MDs, nurse midwives, nurses, community health workers, EmOC caregivers) 45
3.9 by 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination	69. Mean urban air pollution of particulate matter (PM10 and PM2.5) 3.28. [Mortality from indoor air pollution] – to be developed 12.3. [Indicator on chemical pollution] – to be developed
3.a strengthen implementation of the Framework Convention on Tobacco Control in all countries as appropriate	30. Current use of any tobacco product (age-standardized rate)
3.b support 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 which affirms the right of developing countries to use to the full the provisions in the TRIPS agreement regarding flexibilities to protect public health and, in particular, provide access to medicines for all	3.30. Percentage of population with access to affordable essential drugs and commodities on a sustainable basis 3.32. Public and private R&D expenditure on health (% GNP) 17.5. [Indicator on technology sharing and diffusion] – to be developed
3.c increase substantially health financing and the	96. Official development assistance and net private grants as percent of GNI

recruitment, development and training and retention of the health workforce in developing countries, especially in LDCs and SIDS	95. Domestic revenues allocated to sustainable development as percent of GNI, by sector 3.32. Public and private R&D expenditure on health (% GNP) 3.33. Ratio of health professionals to population (MDs, nurse midwives, nurses, community health workers, EmOC caregivers) 3.d strengthen the capacity of all countries, particularly developing countries, for early warning, risk reduction, and management of national and global health risks 96. Official development assistance and net private grants as percent of GNI 95. Domestic revenues allocated to sustainable development as percent of GNI, by sector 3.32. Public and private R&D expenditure on health (% GNP)