
Country Report

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Is India on track to achieving the Sustainable Development Goal on Health?

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Executive Summary

Achieving good health and well-being is a critical part of the Sustainable Development Goals (SDGs). This objective is reflected directly in SDG 2 (No Hunger), SDG 3 (Good Health and Well-Being) and SDG 6 (Clean Water and Sanitation). While India has made significant progress in improving health and nutrition outcomes as well as providing access to water and sanitation for a larger part of the population, there is still a long way to go. The government has launched various key initiatives over the last few months to accelerate progress in these areas, however, the private sector and civil society also need to play a bigger role in developing innovative solutions for tackling longstanding challenges like undernutrition and tuberculosis as well as emerging threats such as non-communicable diseases and antimicrobial resistance.

SDG-3 (Good Health and Well-Being)

Over the last two decades, India has made noteworthy strides in health. We have eliminated Polio as well as maternal and neonatal tetanus. Infant Mortality Rate has registered a substantial decline, from 57 per 1000 live births to 34 per 1000 live births in 2016. There has been a major drop in the birth cohort, which for the first time has fallen below 25 million.

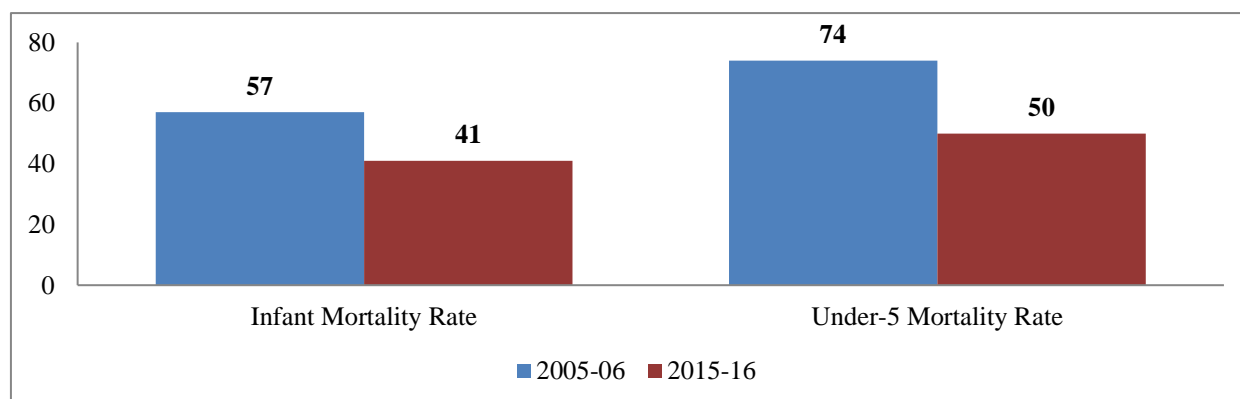
We have made tremendous progress on immunization as well. As part of *Mission Indradhanush*, more than 25 million children and 6.9 million pregnant women have been immunized during the four rounds of immunization over two years. After the two rounds of Intensified Mission Indradhanush, 3 million children and 0.7 million pregnant women have been immunized. Further, we have made remarkable progress in containing HIV infections.

Given the sheer size, complexity and diversity of our country, none of these are small accomplishments. However, we can do much better on several counts.

Key health challenges

Firstly, the decline in key health indicators (Figure 1) such as Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and Under-5 Mortality Rate (U5MR) has been better than the global average. However, this rate of decline has remained slower than that of countries like Bangladesh, Nepal, Cambodia and Kyrgyzstan, countries that are at similar stages of development and levels of spending on health.

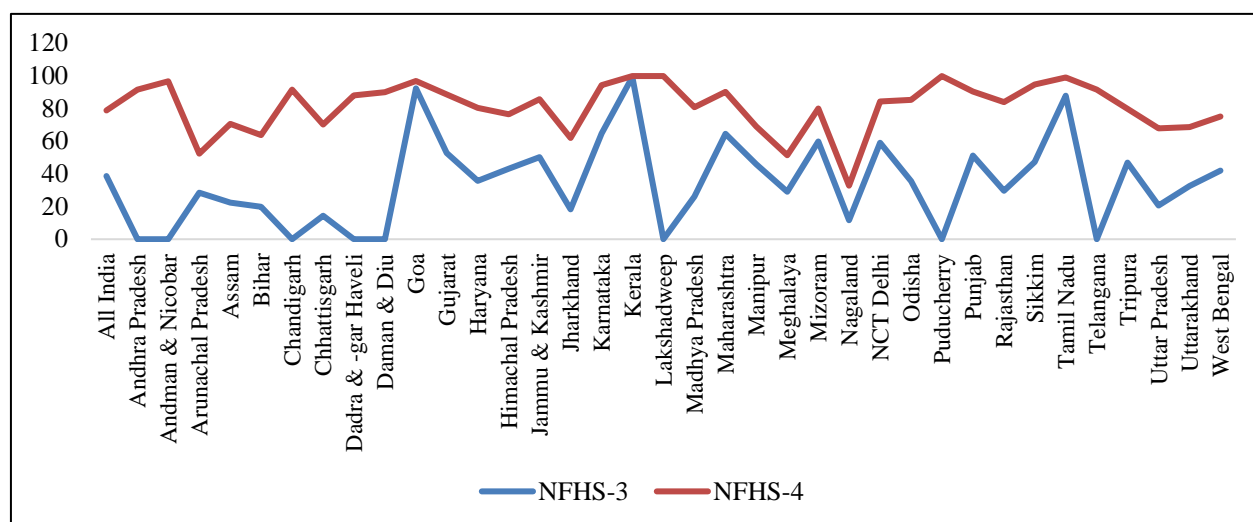
Figure 1: Reduction in Infant & Child Mortality Rates (Per 1,000 Live Births)



Second, even though several indicators have progressed in the right direction, significant inter and intra state disparities persist. For instance, while the percentage of institutional deliveries has increased from 38.7% in 2006-06 to 78.9% in 2015-16 at the national level, there is considerable inequity between states (Figure 2).

Levels of service coverage and health outcomes also differ significantly by [socio-economic groups](#) and levels of education. For instance, according to National Family Health Survey-4 (NFHS-4) data, approximately half of the children belonging to Scheduled Tribe communities did not receive the recommended vaccination doses. Similarly, mothers who had completed school till the secondary level or beyond were more likely to utilize 4 or more antenatal visits (68%) as compared to mothers who had not been to school (28%).

Figure 2: Inter-state Disparity Pertaining to Institutional Deliveries



Third, India faces the challenge of a double burden of disease. Communicable diseases still account for a significant proportion of disease burden [33% of Disability Adjusted Life Years (DALYs) lost]. In addition, a rising morbidity and mortality cost is attributed to non-communicable diseases (55% of DALYs lost) and injuries (12% of DALYs lost). However, as per NFHS-4 data, the levels of awareness (Figure 3) about and screening for communicable as well as non-communicable diseases (Figure 4) requires significant improvement.

Figure 3: Comprehensive Knowledge of HIV/AIDS (%)

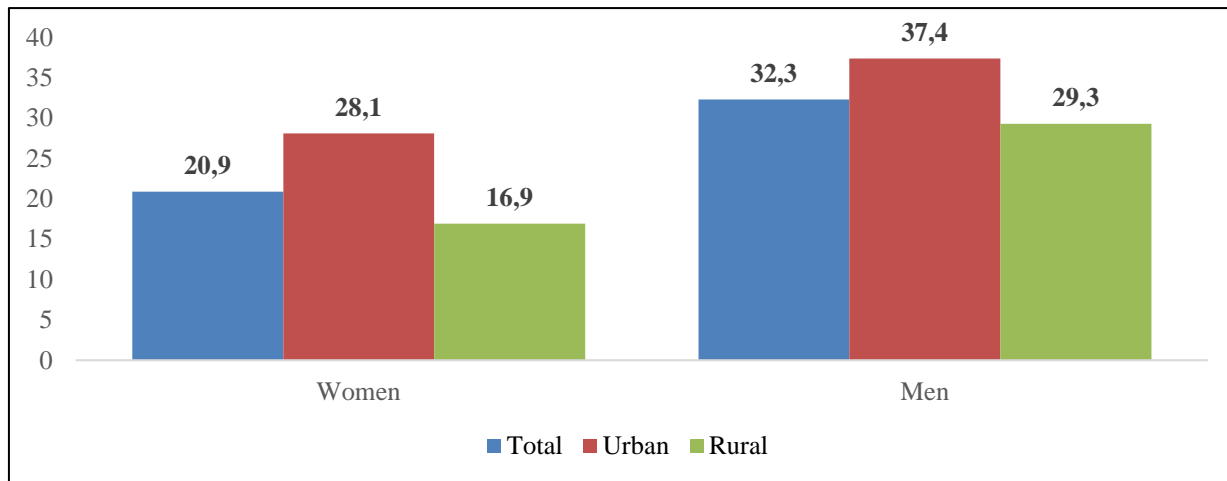
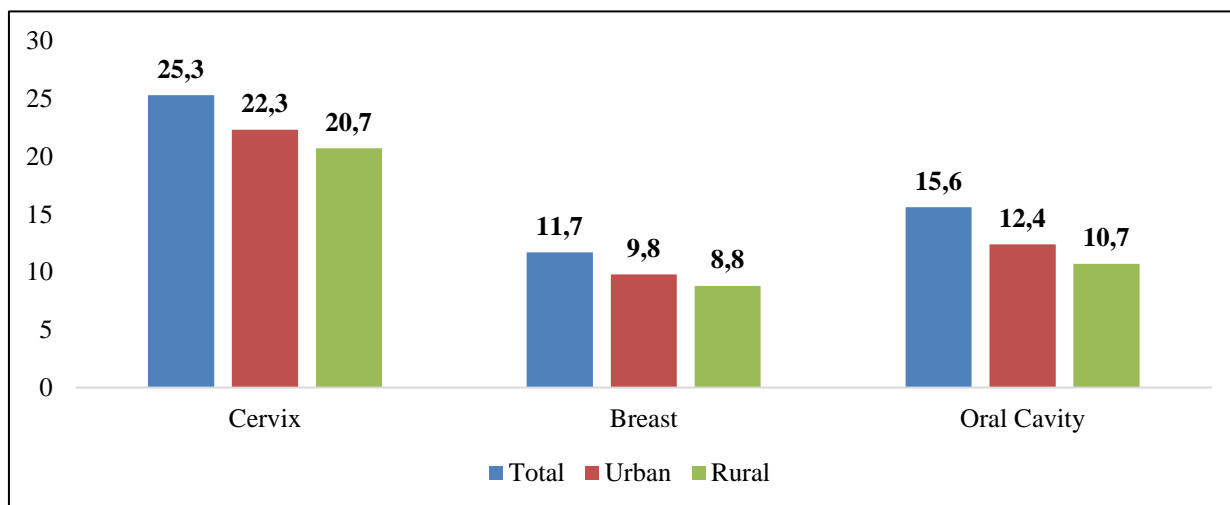


Figure 4: Examination of Women Between 15-49 Years (%)



Fourth, public financing in health remains at approximately 1.15% of GDP, which is amongst the lowest in the world. Less than 50% of the 12th Five-Year Plan allocations have been budgeted. This has caused severe limitations to the strengthening of existing programs as well as halted the launch of innovations such as pilots for Universal Health Coverage (UHC). Private Out-of-Pocket Spending (OOPS) at the point of care still contributes 62.4% of the total health expenditure in India. Worse still, the OOPS has been skewed towards the poorest two quintiles. As a result, catastrophic health expenditures are pushing roughly 60 million into poverty every year. This is estimated to increase poverty by approximately 3.6% and 2.9% in rural and urban areas respectively.

Fifth, within the investments that are made, health prevention and promotion has been deprioritized compared to curative care. Moreover, the government has hitherto focused almost exclusively on providing health care through a network of facilities in the public sector instead of paying adequate attention to the stewardship of organizing the health sector in its entirety, including leveraging its potential as a mixed health system.

Last but definitely not the least we need to put in place comprehensive policies for ensuring adequate numbers of skilled and motivated human resources for health. The National Medical Commission Bill, 2016 has been approved by the Union Cabinet and if enacted it has the potential to revamp medical education in the country. Reforms along similar lines are needed in the councils governing nursing, dentistry and pharmacy education.

Steps taken by the government

In this context, the National Health Policy, 2017, which was formulated following extensive consultations with state governments and various other stakeholders recommends important measures in various areas. These include emphasizing disease prevention, delivering comprehensive primary healthcare, ensuring access to affordable secondary and tertiary care services, building a strong human resource backbone, empowering citizens and leveraging India's innovation and ICT capabilities. A critical element of the Policy is raising public expenditure on health to 2.5% of the GDP by 2025.

As far as the private sector is concerned, the Policy recognizes that there are many critical gaps in public health services which could be filled by strategic purchasing. In the government's endeavor to cultivate a healthy and fair partnership with the private sector, the Policy goes beyond strategic purchasing to also include elements such as the need for training and skilling many small private providers, especially those working in rural and remote areas, to help them serve the community better.

NITI Aayog's 3-Year Action Agenda also outlines the priorities for the health sector including the creation of a focal point for public health in the Union Health Ministry, development of a dedicated public health cadre, making central fund transfers to state governments more output and outcome based as well as setting up National and State Health Authorities for strategic purchasing of health services by the government.

Several initiatives have been launched by the government in the recent past to tackle our health challenges. For instance, the 'India New-born Action Plan' has been formulated for achieving the targets in the global 'Every New-born Action Plan' by 2030, five years prior to the global deadline. The 'Test and Treat Policy for HIV' was launched earlier this year. As per this policy, any individual who is found to be HIV positive will get anti-retroviral treatment irrespective of the stage of his or her disease.

Further, several innovative technology interventions have also been rolled out. For instance, the Swasth Bharat Mobile Application launched last year, is an important innovation that enables citizens to access detailed information about healthy lifestyles, diseases and public health alerts. After all, an essential part of moving from sick care to wellness is empowering citizens with relevant health information.

Similarly, the mCessation initiative supports those who are willing to quit tobacco use by sending text messages on mobile phones. It is the first mHealth effort of its kind in the world that provides such a two-way service and is far more cost-effective than various traditional options for counseling patients to give up the tobacco habit. To leverage the potential of mobile telephony for the prevention and management of diabetes, we have launched mDiabetes. Through this initiative, citizens can get access to all relevant diabetes related information through a simple missed call.

In addition to generating awareness about health problems, technology innovations are also enabling us to streamline, strengthen and monitor the implementation of various programmes. For instance, the e-RaktKosh is a centralised inventory management system that helps to track the blood stock across various blood banks. The tablet-based application, ANMOL, allows ANMs to enter data for beneficiaries in a prompt manner.

Need for private sector innovation

While the government has a critical role to play, India's evolving healthcare sector calls for innovation on the part of all stakeholders for translating intent into implementation. The need of the hour is to develop an innovation ecosystem. Tuberculosis is a case in point. India's National Strategic Plan 2017 for TB elimination aims to achieve and maintain a cure rate of 85% in new sputum positive patients for TB and reduce the incidence of new cases to reach elimination status by the year 2025. Historically, notification of TB cases in the private sector has been a major challenge. This is due to the largely disconnected manner in which private health providers and establishments have dealt with TB. Uprooting TB in such a scenario requires a wide surveillance net to be cast for the identification and monitoring of cases.

Two areas, in particular, have tremendous scope for private sector innovation. Firstly, non-communicable diseases which now account for 50% of India's disease burden, present both a tremendous challenge as well as an opportunity. The National Health Policy, 2017 emphasizes the operationalization of Health and Wellness Centres for providing a comprehensive package of primary care services including screening for the most prevalent non-communicable diseases with secondary prevention. Innovation is required along the entire spectrum of non-communicable disease management including screening, detection, treatment and palliative care. Second, we urgently need to develop more customized indigenous drugs and medical devices. India is known as the pharmacy to the developing world, however, we need greater focus on drug and device innovations for catering to the health priorities of our own population.

Faced with a double burden of disease and ever evolving health challenges, India certainly has its task cut out as far as achieving SDG 3 is concerned. Several efforts are being made by the government to move us in that direction. However, if we are to achieve the goal, all stakeholders, including the private sector, civil society and citizens will need to pull together. Government action alone cannot get us there.

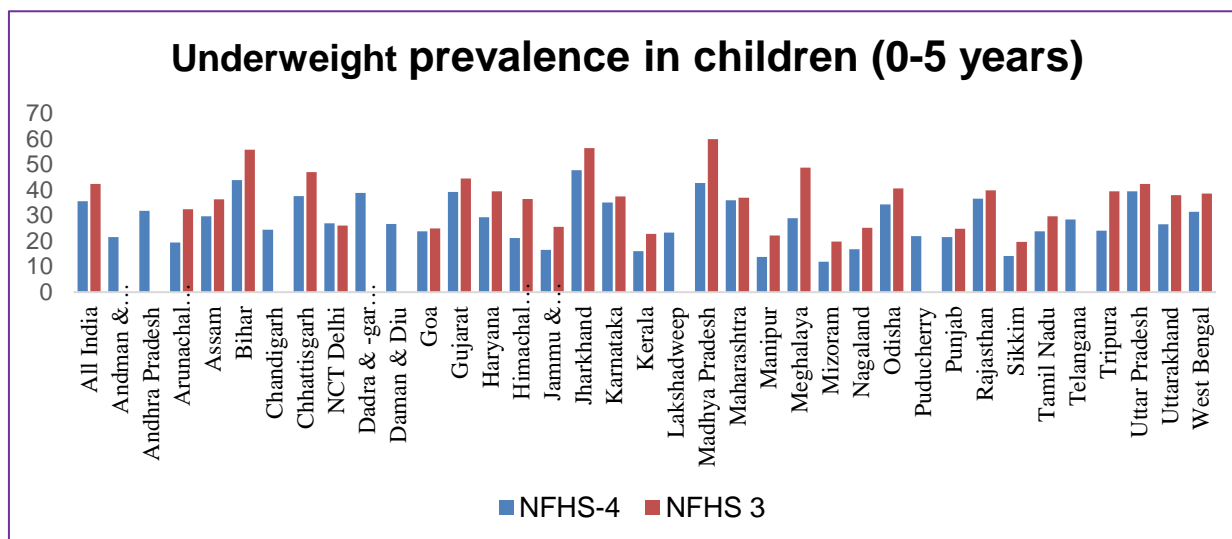
SDG-2 (Zero Hunger)

As far as nutrition is concerned, several indicators have progressed in the right direction.

According to the National Family Health Survey-4 (NFHS-4), the prevalence of anemia in children between 6-59 months has declined from 69% in 2005-06 to 58% in 2015-16. Similarly, stunting among children less than 5 years has declined from 48% to 38.4% between 2005-06 and 2015-16. During the same period, the percentage of underweight children has also declined from 42.5% to 35.7%.

The absolute levels of stunted and underweight children, however, remain high. Additionally, among adolescents, it is estimated that 11% are overweight while 2% are obese. In the 15-19 age group, 56% of girls and 30% of boys are anemic. Adults also face a double burden of malnutrition. While the Body Mass Index (BMI) of 33% of ever-married women and 28% of men in the 15-49 age group is below normal, 15% of women and 12% of men are overweight or obese. Moreover, 58% of pregnant women and 24% of ever-married men suffer from anemia in this age bracket. Currently, India is home to the third largest number of overweight and obese people in the world.

A major challenge is the large disparity in nutritional outcomes between states as well as population groups (Figure 1). For instance, according to NFHS-4 data, states that have the maximum population of undernourished people are Bihar and Madhya Pradesh. The problem of overweight people, on the other hand, is more acute in Andhra Pradesh, Sikkim and Goa. Anemia levels in women range from 45% in Karnataka to 63% in Haryana.



Source: Data from National Family Health Survey Rounds 3 (2005-06) and 4 (2015-16)

Given that direct nutrition interventions (adequately scaled up) can account for reduction in stunting by only 20% with the balance resulting from indirect interventions such as access to water, sanitation or health services, an appropriate governance structure must reflect the many overlapping factors that affect the nutritional status of an individual or household. This can be achieved through the National Nutrition Mission (NNM) that has been launched recently with representation from relevant Ministries and Departments. The mandate of the NNM is providing policy and programmatic guidance to the relevant sectors and states, facilitating multi-sectoral planning, monitoring commitments, catalyzing resource mobilization, developing a surveillance system for nutrition as well as providing mentoring support to high burden states and districts.

Other measures that will be essential for achieving this goal include developing a comprehensive data system for nutrition that is synergized with sectors like health and sanitation, ensuring convergence between interventions in agriculture and nutrition as well as promoting physical exercise by making it compulsory in schools, for instance.

SDG-6 (Clean Water and Sanitation)

India has made considerable progress in ensuring access to drinking water and sanitation for its citizens. According to NFHS-4 data, 89.9% of households have access to an improved source of drinking water as compared to 87.6% of households as per NFHS-3. With respect to sanitation, NHFS-4 data reveals that 48.4% of households have access to an improved facility like a toilet linked to a piped sewerage system or septic tank, pit latrine, biogas latrine or composting toilet which is not shared with another household. As per the latest data of the Ministry of Drinking Water and Sanitation, the coverage is 74.22%. This is a significant improvement over NFHS-3 according to which only 29.1% of households had access to an improved sanitation facility.

Several challenges, however, persist. The definition of an improved drinking water source is very broad and includes piped water at the household level, public tap, tube well, borehole, protected dug well, protected spring, rainwater and a community reverse osmosis plant. Research has shown that water from 'improved sources' was rendered unfit for drinking at the point of consumption for several reasons. These include mixing of water from various sources at the household level, unhygienic storage and handling practices as well as inadequately treated piped water supply.

Moreover, in several cities, especially in the slum areas, the quantity of water accessed by a household is not adequate. In slums, water is often obtained from a public tap or tube well which impacts adequacy adversely in addition to causing other inconveniences such as long waiting times for collection. Further, in areas where the water distribution system is inadequate, transmission losses occur. Water metering is lacking in several places which makes it difficult to assess the requirements and ensure appropriate allocation. As a result, only a few parts of the country receive a regular supply of water. Similarly, in rural areas, there continues to be an over reliance on hand pumps accompanied by the manual transport of water. This naturally limits the quantity of water that can be consumed.

Additionally, water quality is problematic in many areas due to an excessively high content of fluoride, arsenic and iron. The issue of viral and bacteriological contamination also exists. The situation is exacerbated by 'slippage' in rural areas, where the predominant sources of water are tube wells and hand pumps. It refers to a situation in which drying up of sources occurs, the equipment fails or there is a fall in the quality of water. Preventing slippage requires maintenance and monitoring of a high standard which is often difficult for water supply departments to ensure. The problem of suboptimal water access is complicated by weak planning, an overwhelming emphasis on creating infrastructure as opposed to service delivery and a reduction in the levels of groundwater. Moreover, the absence of adequate sewage disposal results in contamination of water sources.

Urban India depends to a great extent on proximate surface water bodies or subsurface water. Some households depend on groundwater aquifers which are polluted in many cities. In fact, as a result of overexploitation, groundwater quality has deteriorated considerably posing significant dangers to the health of people, especially in rural areas. Data from the Central Ground Water Board indicates that water in 276 districts across 20 states is contaminated with fluoride. As far as arsenic is concerned, 86 districts across 10 states are badly affected. Districts in some states suffer from contamination with multiple pollutants, namely Fluoride, Arsenic, Iron and Nitrate.

Thus, going forward, particular attention will need to be paid to ensuring that households have access to continuous uninterrupted water supply. Additionally, the treatment of arsenic and fluoride affected habitations will need to be prioritized. As far as sanitation is concerned, behavior change has started becoming discernible, however, sustaining it will be a challenge. Moreover, beyond access to clean drinking water and sanitation, basic hygiene practices such as handwashing with soap and menstrual hygiene management will need to be promoted widely.