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SHADOW REPORT 2017

The 2030 agenda and the Sustainable Development Goals (India)

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Introduction:-

The present progress of India in Healthcare (SDG 3 and other allied SDGs) can be analyzed by assessing the progress and failure with Millennium Developmental Goals as a reference of the past and National Health Policy of 2017 as a meter of the future.[1]

Critical aspects of the MDGs

As with Millennium Development Goals

- A trend reversal in the fight against HIV has been achieved.
- A few targets have been moderately achieved, these being the reduction in child mortality and a significant trend reversal in the fight against malaria.
- A few areas lagging behind are the proportion of people who suffer from hunger, malnutrition, stunting and wasting
- Maternal mortality and sanitation remain major hurdles to the development.

Things learned from the MDGs & progress with the SDGs

The public health problem of India can chiefly be summarized under two ends of a continuum, from **sanitation**to **malnutrition**.

A lot has been happening in the space of hygiene and sanitation by the government through very popular *Swachh Bharat Abhiyan* (**Clean India Campaign**), which will collectively lead to a hygienic community. There have been indications of improvement in the global feeling of health and mental peace. But the implementation is quite recent and hence, not much can be gauged. However, the implications seem constructive.[2] This is surely going to improve the public health issues especially water and food borne diseases and leading morbidity, mortality in India.

Malnutrition leading to stunting,wasting and changes in nutrition pattern leading to increased susceptibility to NCDs (e.g. Coronary Artery Disease amongst age group of 25 -45 years) remain a major public health challenge for India in the upcoming days.

In times post introduction of the SDGs, efforts by Government of India have been seen

- To improve the quality and sanitation standards of existing healthcare facilities,
- Universalizing primary health-care,
- Reducing infant and under-five mortality especially vaccine-prevented diseases associated mortality and morbidity
- Reducing premature deaths due Non-Communicable Disease
- And finally, Health insurances for those below poverty line[3].

The National Health Policy of 2017
has **Its major focus;**

- On collaboration with the currently unregulated private healthcare sector to increase funding.
- It focuses on the 2020 goal for HIV.
- It addresses the growing the burden of NCD's and
- final focus is on increasing Life expectancy and reducing infant mortality.

It fails;

- To focus on geriatric health (great increase in the old population in India over last century),
- In planning to reduce catastrophic health expenditure despite free-for-all health policy,
- Innovative medical research.
- There has been little focus without any considerable impact on tackling tuberculosis and stunting and wasting.

GOAL 2: - End Hunger, Achieve Food Security and Improved Nutrition and Promote Sustainable Agriculture.

The goal is to end hunger by 2030 and the described most common indicator for the same is the prevalence of undernourishment. Efforts have been taken by the government to reduce the hunger through various schemes[4].
This has led to decrease in undernourishment over years, though in few states like Uttar Pradesh and Madhya Pradesh the prevalence remains quite high.[5]
Under focus of this report is the Target 2.2 of Goal 2. It talks about ending all forms of malnutrition, especially those leading to stunting and wasting under the age of 5 [6] , with an extra focus on nutritional needs of the vulnerable population adolescent girls, pregnant and lactating girls, and older persons.
In general, there is a decreasing trend in prevalence of stunting from 48% in 2005-6 to 38.4% in 2015- 16. Prevalence of stunting is more in rural areas than in urban areas.[7]
It is to be noted is **that prevalence of wasting has increased** by 2.2% over a period of ten years and that of severely wasting increased by 1.1%.[7]
One of the major reason for this has been that actual intake of micro & macro nutrients per number of total households has decreased over ten years for there has been a drastic shift in diet from traditional Indian diet to Western diet. The Indian diet is typically rich in fiber derived carbs and Western diet in empty carbs which are often derived from refined sugar.[8]
There has been a decrease in underweight children under the age of five of about 6.5-7% over a period of ten years with heavy prevalence in rural than urban areas.[7]

To decrease stunting and wasting, food security, illiteracy especially in women, sanitation, early marriage, breastfeeding practices and access to health care facilities, needs to be improved. [4]

There are about five existing intervention policies.

- **ICDS** (Integrated Child Development Services) focuses on immunization and other healthcare aspect,[9]
- **NRHM** (National Rural Health Mission) focuses on nourishment through pre-cooked meals at anganwadis and with the involvement of ASHA workers,[10]
- **Mid-Day Meals** program ensures one-time well-nourished meal in schools,[11]
- **RGSEAG** (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls) for adolescent girls[12]and
- **IGMSY** (Indira Gandhi Matritva Sahyog Yojana) focuses on wage compensation for pregnant and lactating women for first two live births.[13]
- Vitamin A prophylaxis program is also under implementation[14].

There has been a gradual decline in the prevalence of clinical signs of VAD (Vitamin A Deficiency) among Under-Five children from 1975 to 2012. The overall prevalence of Bitot's spot (BS) among preschool

children has declined from 1.8% (1975) to 0.2% (2012), which is ≥0.5% and is, thus no more a public health problem in India.[15]

There are too many programs with questionable and inefficacious implementation.[16] There is a need for a central integrated program monitoring system for every vulnerable group.[16] Children under 5 are under focus for reducing stunting and wasting followed by pregnant and lactating women for proper nourishment and decrease in anemia.

There is a need for an increased focus on adolescent girls. Prevalence of anemia in the nonpregnant girls/women from the age group of 15 to 49 has decreased minimally from 55.2% to 53.1% over a period of ten years.[7] The Iron and Folic acid Prophylaxis Program should develop strategies to check implementation, progress and finally, impact.[17]

The second vulnerable group that needs to be focused is the elderly population. With the increase in lifespan over the years, the elderly population in India is on a rise. Elderly people are susceptible to NCDs and micronutrients deficiencies.[18]

The main objective of the National Policy on Older Persons[19] is to provide the preventive, curative and rehabilitative services to the elderly people at the various level of health care delivery system[19].The irony is that this policy for elders is in its infant phase still being under construction (since 2011-13) .The implementation is pending[19].

GOAL 3: Ensure Healthy lives and promote well-being for all the ages

Maternal Mortality

The first target of Goal 3 is the reduction in global maternal mortality ratio to less than 70 per 100,000 live births. Maternal mortality ratio is the indicator of access to and quality of health care system[20].
Antenatal check-ups in the first trimester have increased from 43.9% 2005-6 to 58.6% in 2015-16. Percentage of Mothers who had at least 4 antenatal care visits has increased from 37% in 2005-6 to 51.2% in 2015-16.
This little growth has had some positive impact (e.g. as reflected in eradication of neonatal tetanus in 2015).[21]
Pregnant women who have received iron and folic acid supplements for 100 days or more has increased from 15.2% to 30.3%. The number of institutional deliveries has increased from 38.7% to 78.9%. The number of births assisted by a midwife, doctor or nurse has increased from 46.6 % to 81.4%.In urban areas 90% of the birth are assisted by a professional, it is 78% in rural areas.[7]

To achieve the target of maternal mortality ratio of less than 70 per 100,000 live births, there needs to be an improvement in coverage of 4 antenatal check-ups.[7]

The improvement of MMR in various states of India has been uneven. States like Kerala, Maharashtra, Andhra- Pradesh and Tamil Nadu have already achieved the target whereas the majority of the other states are still struggling to achieve the target.[22]

Health in India is an area of the State focus rather than one of the Central Government. In recent years the Central Government has often been under scrutiny for the spending of just 1.25% of the total GDP on healthcare[1].The Central Government plans to increase it to 2.5%. The State Governments continue to underfund the health sector (e.g recently government of Maharashtra reduce the budget of medical and public health sector by more than 600 crore rupees)[23][24] despite the fact that State Governments plays major goal in improving the health of India[25] . This little interest by the State Government is reflected in the lopsided achievement of the maternal mortality goals by them.

Few other important aspects of maternal mortality are:-
Safe Abortion, Family Planning, and Adolescent Birth rate:-
Safe Abortion :- About 68 lakh pregnancy terminations take place every year and out of the total, about 10 women die of unsafe abortion every day in India as of 2017.[26] Medical Termination of Pregnancy should be made more accessible and taboo-free.[27]
Family Planning: - Number of health-workers ever talked to female nonuser about family planning (i.e. even after multiple birth haven't used any family planning methods) through informal counselling has increased from 10.1 to 17.7% (over ten years from 2005 to 2015)
The percentage of women being explained about side effects through formal counselling has increased from 34.4% to 46.55%

over ten years. On the contrary, the usage of family planning methods over a decade has marginally decreased (56.3% to 53.5%).

The unmet need for family planning has decreased marginally from (women not using contraception but wish to space or stop child birth) 6.1% to 5.7% (over ten years).[7]

It is important that in the upcoming general census the government charts out the demographic distribution of preference and increases the awareness for various family planning services to tackle the unmet need.[28]

Adolescent pregnancies: - In the age group between 15-19 years the pregnancies are currently 23 per 1000 women of that age and has decreased from 51 in 2005. Increase in education and criminalizing marriage before the age of 18 yrs for the girls has been a major factorial in this progress.[29]

The total maternal mortality in adolescent population is estimated to be 6920 annually.[30]

Introduction of comprehensive sex education and increasing awareness of contraception shall play a major role in coming days, it is time that the government overcomes its taboo about sex and starts educating the adolescent population with regards to safe sexual practices.[31]

Innovative practices[32], good implementation, holistic approach and focus on every cause of maternal mortality and finally, improved timely evaluation[25] is necessary for the timely achievement of the maternal mortality target.

India, a tropical and developing country, faces a cocktail of health issues, resulting from a huge population and underfunded health systems. Communicable diseases are proving difficult to eradicate and the burden of non -communicable disease including mental health illness is ever-increasing .

India's Voluntary Review and even the National Health policy of 2017 talks in detail about Non-Communicable Diseases.[1]

Here in this shadow report, **we would like to throw light on communicable diseases especially Tuberculosis, and Mental health.**

Single- person single-card and a national database if established with proper data privacy measures shall help monitor the health of the nation centrally and effectively.[1]

Mental Health

Currently, a lot of stigma is associated with mental health, the Mental Policy of 2014 had a focused promotion and prevention aspects of mental health[35].
The aim of enhancing the understanding of mental illness amongst the general population has been achieved to a certain extent but not much.[36]
Moving from the year 2015 to 2016, prescriptions for clinical depression has increased significantly by about 10.6 lakhs; competitive lifestyle and increasing awareness are top reasons for the same[37].

As a general trend, prevalence of depression and other mental illness is 2 to 3times more in urban metros than rural areas. Depression in urban metros is 5.2% and in low-income group it is about 3.5%.[36]

Currently, there is 1 psychiatrist every 3.4-lakh people as compared to developed countries where there is typically one psychiatrist per 10,000 people and less than 1% of the total health budget is spent on mental health. According to WHO's Mental Health Atlas 2014 Survey, governments spend an average of 3 per cent of their health care budgets on mental health, to about 5 per cent in high-income countries.[38]
The general structure of the policy is good but the implementation is not proper and thus impact is much below expected[38].
As per 2017, there are about 1,70,000 suicides per year. [39]

The Mental Health Bill of 2017 has decriminalized suicide. This has been a major development.[38]
Greater funding, appropriate implementation, and promotion are going to be the need of the upcoming times.[38]
Good reliable government public advertisements shall help increase the awareness as it did for polio.

On the bright side the Mental Health Policy focuses on capacity building by increasing the creation of specialist through public financing, incentives to those willing to work in public system, to create a network of community members to provide psychosocial support at primary level, leverage digital technology and to make access to psychologists and psychiatrists easier.[38]

There has been a prevalence of 10.7 million drug users in India by 2004. There had been 5 times increase in the drug users in three years between 2011 and 2013.[40]
As in regards to substance abuse and addiction, there has been a timely increase on the taxes on alcohol and tobacco. There has been an increase in the minimal age for buying alcohol in a few states. There has been the implementation of ban on the sale of alcohol within 500 meters of national highways. The statutory warning before the public screening of movies are in place. **There needs to be an increase and focus on de-addiction and its compliance.** In all tertiary healthcare centres, there should be counselling for de-addiction.

Finally, increasing the capacity of the caregivers, training Anganwadi workers and school teachers shall be helpful.[38]

With the current level of little importance for mental health especially in the latest national health policy, it is of primordial importance to realize that availability and access of minimum mental health care at primary health care is important and is a major challenge.[41]

It is also very important that in particular to mental health, according to the local needs various local indicators are developed.

Tuberculosis

Communicable disease has been a major problem in India for a very long period. Prevalence of communicable diseases is most often commonly related to sanitation and undernutrition.

India, in recent times, has been successful in eradicating polio[42], has done a phenomenal job in reducing the burden of HIV and is making sure that almost every patient gets antiretroviral therapy[43]
Over the last few years, Tuberculosis has proven to be a menace.[44]

The incidence of TB cases in total in the year (2015) has been 217 per 100,000 population and was 289 per 100,000 population in the year 2000. Mortality with TB has been 58 per 100,000 population in 2015 to 49 per 100,000 in 2000. The incidence of MDR TB has greatly increased from 79,000 in 2015 to 1.3 lakh in 2017.[45] Extensively resistant TB (XDR-TB) has become a threat to control of TB in India, but its prevalence is not yet known due to lack of surveillance(reference needed on priority).[46] [47]
India has **RNTCP**(Revised National Tuberculosis Control Program) specifically targeting Tuberculosis.
Over the years, a greater focus has been shifted to Microbiology-based diagnosis than controversial serology.[48]

Guidelines have been often revised one of the major shift was from **NTCP** (National Tuberculosis Control Program) to **RNTCP** (Revised National Tuberculosis Control Program) in the year 1997.The impact of RNTCP has to lead to decrease in TB cases from 289/100,00 in 2000 to 217/100,000 in 2015. Ironically, the latter has lead Two major causes being to **development of M/XDR-TB.**

1) **Acquired drug-resistant TB** due to inadequate TB treatment, due to patient's failure to keep to proper TB treatment regimes, prescription of wrong/ substandard TB drugs.
2) **Primary or transmitted drug-resistant TB**, resulting from the direct transmission of drug-resistant TB from one person to another. The occurrence and prevention of primary drug-resistant TB has largely been neglected during the development of global programs to end TB.[49][50]
The weakly structured tuberculosis treatment regimen is contributing to the emergence of the resistance.[51]

Many revisions in policies have been implemented recently and there is an upcoming survey in 2017-18, the government is expecting positive results in this and the data herein shall be of primordial importance deciding if TB can be eliminated from India by 2030.[52]
Rational and regulated collaboration with the private sector for uniform tuberculosis treatment are the need of the time.[52]
5825 crore rupees has been demanded for the period between 2012-17, only 4500 Crore have been approved. The ground reality is that **there is shortage of drugs labs, slow diagnostic tools, inadequate**

management of treatment, lack of trained personnel and underpayment of the staff. [53]
With the emergence of antibiotic resistant tuberculosis, it is very important that endemic areas have well functional diagnostic labs with PCR facility.[53]
Patient compliance has been a major problem for complete cure of TB. **Patient compliance is especially low in patients with little knowledge of Tuberculosis treatment and side-effects of the same.** Other factors contributing to the patient compliance has been

- Poor faith in the therapy,
- Long commute to the health center.(DOTS:- Directly Observed Treatment, Short-course for tuberculosis)
- And lack of interaction with the concerned caregiver.

The development of call-center based DOTS is in its pilot project phase. Its impact needs to be monitored closely for scaling up the project if positive trends in compliance are observed[54]

The emergence of MDR and XDR TB has led to the implementation of WHO-suggested daily TB treatment regimen in 5 states already.[53]There has been introduction of new antitubercular drug, Bedaquiline for MDR.[53]

It is important that secondary drug-resistant cases are completely eradicated and primarily developed drug resistance is brought under control. There should cautious use of the new drug bedaquiline to prevent the drug resistance of the same.[55]

RNTCP (Revised National Tuberculosis Control Program) focuses a lot on diagnosis than treatment.[48]
We need to focus on treatment compliance, better treatment, and prevention combined with rapid diagnosis.[53]
At the current stage (2017) control of the menace named tuberculosis is more important than expensive eradication, RNTCP needs to be strengthened.

Implementation Of National Strategic Programme for 2012- 17 is not on track.[56]Projected increase in case detection by the RNTCP has not occurred. About 2/3rd recommendations by the Joint TB Monitoring Mission (an RNTCP annexe) 2012 have not been implemented.[56]
There is the lack of primary public-funded healthcare infrastructure and its link to tuberculosis.[57]

New guidelines, as per 2015, propose one TB unit/block per 1.5-2.5 lakh population (the population has been reduced from a unit per 5 lakh people as in the previous guideline).[56]**Additional funding of about 750 crore rupees is needed**. [56]

HIV-TB integration for concurrent therapies is slow. RNTCP needs collaboration with the private sector.[58]
The National Health Policy and the government have successfully identified this need. **Policy changes have been made from time to**

time but their implementation is poor especially at the central level.[56]

Conclusion

India is one of the countries spending the least on healthcare with major dependence on the private sector.
The hurdles for achieving Goal 3 can be rightfully summarized as:-
* Poor primary health-care infrastructure,
* Poor doctor-patient ratio,
* Poorly implemented health-care policy,
* Mixed and ever increasing load of communicable and noncommunicable diseases,
* Extremely complicated and non streamlined medical system.

There are more than 300 million poor in India. The traditional 5-year plans have overtly focused on economic growth, albeit not sustainable. Hence, it has created deep crevices of disparity amongst the so- called "rich and poor". Thus, the Indian government is mainly focusing on SDG 1.[59]
But it must be remembered that all the SDGs are inter-sectoral and transcend all the differences for the attainment of a common goal.

And despite being unable to attain the MDGs at an optimal level, the Indian government, seems to be robust enough to attain the magnitude of integrity which is been demanded this time.[59]

For ages many of the health problems have been targeted vertically through the individual program, infrastructure and focus, of lately an integrated approach has been introduced (e.g. ICDS Integrated Child Development Services IDSP Integrated Disease Surveillance Project).

It is time that horizontal approach of universal healthcare is brought into focus. Currently, in India, there is a major lack of public - based healthcare system. The public healthcare system remains static as compared to private sector.

In 1947, when India became independent, public healthcare contributed about 60% as compared to 40% by the private sector. Of lately, public health sector has reduced to 10% and private healthcare sector has expanded to a whooping 90%.[60]
There is an obvious urgent **need to move away from incrementalism and acknowledge the complexity of rebuilding the existing inefficient health system.**

For a very long time, Healthcare did not receive much political attention or budgetary support in terms of orientation.[60]Also, there has been techno-managerial approach to disease-control rather than tackling the causative factor. [61]Hence, the social determinants of the health aren't addressed aptly. Health-spending is largely financed by out-of-pocket expenditure, pushing people to poverty.[62]
Another major problem is the doctor/patient ratio.
India produces the largest number of doctors per year but as a reality in rural India, only 18.8% are qualified allopathic doctors. **As of May 2016, there is only 1 doctor for 1681 people.** It has improved from

1 per 2000 as of 2010-11.[63] **Training of new doctors and capacity building of the existing doctors is the solution. Today, India is still short of 500,000 doctors.**[64]

It is important that government invests in publicly-funded medical colleges, and education as private medical colleges in India have repeatedly failed to maintain standard, barring a few.[65]

* More government-funded and standardized medical colleges,
* Streamlined medical entrance exams,
* An opportunity for every medical graduate for specialization

and finally,

* Government jobs to serve the population

are the needs of the time we as medical students from India would like to highlight.

The policies and strategies should be evidence-based, embedded within the socio- economic context of the country and geographical differences should be taken into consideration, they should be devised on the basis of a close study of past failures and an uncompromising commitment to equity and fairness.

The policy implemented in reality is more beautiful than just being limited to paper. Prevention is better than cure. We must not forget that the health system in India cannot be understood in isolation and is a reflection of the paradoxes of the country's development since independence (15th August, 1947). Sustainable Development Goals can only be achieved if **Local Action by individuals and citizen groups is involved. Also, media and media-built public awareness plays a very important role in the building of a nation at large.**

With increased general public interest of the nation supported by government initiatives, the nation ought to have good health.

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