Work Programme on SDGs

Research and Information System for Developing Countries (RIS), in collaboration with the Ministry of External Affairs (MEA), Government of India and NITI Aayog, Government of India, and with support from the UN in India, is spearheading a programme of national consultations among lawmakers, policymakers, academia, private sector and the civil society on the Sustainable Development Goals (SDGs). Under this work programme, in its first phase, RIS organised a series of Consultations on SDGs in India ahead of the formal adoption of the 2030 Agenda for Sustainable Development in September 2015 by the UN General Assembly. Panel discussions were organised on Southern perspectives alongside the Third International Conference on Financing for Development (FfD3) in Addis Ababa, Ethiopia in July 2015 and the UN General Assembly (Sustainable Development Summit) in September 2015 in New York.

NITI Aayog in partnership with RIS and UN in India organised the National Consultations on SDGs with first consultation focussing on Health and Education (SDGs 3 and 4) in February 2016; second focussing on Industrialisation and Employment (SDGs 8 and 9) and third on Sustainable Management of Water and Sanitation For All (SDG 6) in August 2016 in New Delhi. RIS has also organised eminent person lecture by H.E. President of Liberia, Madam Ellen Johnson Sirleaf and thematic dialogues on: WTO and SDGs (November 2015); nutrition and food security (February 2016); and Technology Facilitation Mechanism (March 2016) in partnership with key national and international think-tanks. RIS and UN have also launched this special volume on SDGs to explore perspectives from India and the Global South. For more information on RIS Work Programme on SDGs visit: http://sdg.ris.org.in/ or email at: dgoffice@ris.org.in.
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Health for All by 2030: An Indian Perspective

Introduction
In India, achievement of health for all is a constitutional obligation of the State. The Directive Principles of State Policy of the Constitution of India, which are fundamental in the governance of the country specifically provide for “improvement of public health” as one of the primary duties of the State. There are other Principles that set the various parameters for achieving health for all within the limitations of a newly independent country. Article 39 enjoins the State that it should secure for all its citizens, “men and women equally, have the right to have an adequate means of livelihood”, that “children are given opportunities and facilities to develop in a healthy manner”, and that it should “raise the level of nutrition and the standard of living”. The Directive Principles, though not enforceable in a court of law, unlike the case with the Fundamental Rights, are, nevertheless, “binding on the various organs of the State” They along with the Fundamental Rights, constitute the “conscience” of the Constitution and, therefore, is of equal importance.

Over the years, through various judicial interpretations, the right to health acquired almost the same status of a Fundamental Right (see Box 1).

Despite the constitutional provisions and the case laws on the subject, India’s progress towards, universal health care has been rather tardy. At the time of its Independence in 1947, the key indicators of public health were very low. Life expectancy was around 32 years in 1948, slightly improving to 36.7 in 1951. Infant mortality rate (IMR) was 146 in 1951; crude death rate 25. There was wide spread presence of infectious diseases such as TB, leprosy, small pox, Malaria, etc.

Even in 2000, at the beginning of the current millennium, India’s record in public health was not enviable. Life expectancy was 64.6; IMR 70 and crude death rate 8.7. However, it had some remarkable achievements such as eradication of small pox by 1981, reduction of malaria cases to 2.2 per million, leprosy cases 3.74 per 10,000. It had also eradicated guinea worm cases by 2000 and brought down polio cases to 265.

In fact, most of the developing countries had this challenge of providing proper health care within national economic development plan, rather than be a sick populace nursing its own wounds. Post World War II, the concept of welfare state had many adherents in most countries, though the two economic models that predominated the second half of the twentieth century caused political cold war between the two blocs. In order to have concerted action among all countries in the fight against ill health and diseases, the World Health Organisation (WHO) was set up in 1948, since “the health of all people is fundamental to the attainment of peace and security”, and “unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger”, which cannot be tackled by states separately. Meanwhile, the Universal Declaration of Human Rights was also adopted by the United Nations (UN) in 1948, which clearly declared “every one has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services …” as one of the common standard of achievement for all peoples and all nations.
When diplomats met to form the United Nations Organisation (UNO) in 1945, one of the things they discussed was setting up a global health organisation and the result is the World Health Organisation (WHO). Its constitution came into force on 7 April 1948. The WHO contributed significantly to the improvement of health in several developing and least developed countries (LDCs) with focussed programmes. It was also able to sensitise government functionaries to the need and importance of focussing on programmes for improving the health status of the people in every country.

From MDGs to SDGs
During the second half of the twentieth century, governments around the world started paying more attention than in the past to the goal of achieving health for all. New developments in the field of medical sciences such as new vaccines and new medicines for several diseases and the antibiotic revolution helped this process. There was a general realisation that more focussed attention with specific achievable targets is required to achieve universal health care. The world leaders, finally, signed in September 2000, a declaration committing themselves to fight, among others, diseases that were seriously affecting global public health. Out of the total eight Millennium Development Goals (MDGs), three are specifically about health, reflecting the concern of the global community. The goals are reduction of under five mortality by two-thirds and maternal mortality ratio (MMR) by three quarters, between 1990 and 2015, achievement of universal access to reproductive health, and halt and reverse the spread of HIV/AIDS, malaria and other diseases by 2015, and achievement of universal access to treatment for HIV/AIDS for all those who need, by 2010. It also had proposed the goal to increase health expenditure as a percentage of GDP from the then existing 0.9 per cent to 2 per cent by 2010.

By 2012, countries around the world realised that the achievements in MDGs, though good, were not sufficient and that it is necessary to carry them forward in a more sustainable way. This led to the drafting of the SDGs which were approved on 25 September 2015. Out of the 17 goals of SDGs, Goal No. 3 “Ensure healthy lives and promote well being for all at all ages” is specifically about health, but there are other SDGs which are indirectly about health. Ending hunger, achieving food security and improved nutrition in Goal No 2, ensuring availability and sustainable management of water and sanitation for all in Goal No. 6, and ensuring access to affordable, reliable, sustainable and modern energy for all in Goal No. 7 have great relevance for achieving the health for all goal. This can also be perceived from the targets under different goals, which directly or indirectly impact the health goal (see Box 2).

Health in India: Key Indicators
Though India’s response towards international efforts on health stemmed from its constitutional obligations and developmental demands, as stated above, progress towards universal health has been rather slow. Even at the time of formulation of its 10th Five Year Plan (FYP) in 2002, India had a big health deficit as could be seen
from its share in global health problems projected by the Planning Commission. Even though its share in world population was 17 per cent only, it had a share of 23 per cent in child deaths, 26 per cent in childhood vaccine preventable deaths, 20 per cent in malarial deaths, 68 per cent in leprosy cases, and 30 per cent in tuberculosis cases. Even in the number of HIV infected persons, a disease of comparatively recent origin, it had a 10 per cent share. These obviously were not matters of pride. During the years succeeding the position has not altered much.

**An Assessment of India’s MDG Efforts**

The UN Development Group (UNDG) in 2003 provided a framework of 53 indicators for measuring the progress towards individual targets. Subsequently the Inter-Agency and Expert Group (IAEG) on MDGs drew up in 2008 a revised framework with more targets and indicators, but India never endorsed the revised one. However, it took various measures to achieve the targets as set in 2003. The fact that the MDG targets gelled with India’s 11th FYP health indicators in areas like lowering maternal and infant mortality, malnutrition among children, anaemia among women and girls, fertility rate, and raising the child sex ratio contributed to this. At policy level, India came out with a new National Health Policy in 2002, which expounded the directions in which health programmes were to be targeted. Some of the goals set in this policy included eradication of Polio and Yaws by 2005, elimination of Leprosy by 2005, Kala-azar by 2010 and Lymphatic Filariasis by 2015. It also had achievement of zero level growth of HIV/AIDS by 2007, reduction of mortality on account of Tuberculosis (TB), Malaria and other vector and water borne diseases by 50 per cent by 2010, reduction of IMR to 30/1000 and MMR to 100/lakh by 2010.

Through implementation of the National Health Policy of 2002 and the efforts made by the country to achieve the MDG goals of reduction of child and maternal mortality rates, India has achieved some progress in certain selected indicators relating to mother and neo-natal care, which are basic to health care as captured in the graphs in Figures 1-5.
## Box 2: SDG Health related Targets

<table>
<thead>
<tr>
<th>SDG 3 Targets</th>
<th>Other Linked Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births</td>
<td>2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round</td>
</tr>
<tr>
<td>3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births</td>
<td>2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons</td>
</tr>
<tr>
<td>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</td>
<td>5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed, in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences</td>
</tr>
<tr>
<td>3.4 By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being</td>
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<td>3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol</td>
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<td>3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents</td>
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<td>3.7 By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes</td>
<td></td>
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<tr>
<td>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</td>
<td></td>
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<tr>
<td>3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination</td>
<td></td>
</tr>
<tr>
<td>3.a Strengthen the implementation of the World Health Organisation Framework Convention on Tobacco Control in all countries, as appropriate</td>
<td></td>
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<tr>
<td>3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</td>
<td></td>
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<tr>
<td>3.c Substantially increase health financing and recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States</td>
<td></td>
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<tr>
<td>3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.</td>
<td></td>
</tr>
<tr>
<td>3.7 By 2030, ensure universal access to sexual and reproductive health and reproductive rights as agreed, in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences</td>
<td></td>
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<tr>
<td>6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all</td>
<td></td>
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<tr>
<td>6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations</td>
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<tr>
<td>6.3 By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally</td>
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<tr>
<td>7.1 By 2030, ensure universal access to affordable, reliable and modern energy services</td>
<td></td>
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<tr>
<td>11.2 By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons.</td>
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As per the data collected by the Office of the Registrar General of India (RGI) through the Sample Registration System (SRS), under five mortality ratio (U5MR) was estimated at 125 deaths per 1000 live births in 1990. This was required to be reduced to 42 by 2015. It had been brought down to 52 by 2012 (SRS). Given the trend, it was likely to reach 49 by end of 2015, thus India missing the target. The figure for 2013 was 49 (India Country Report, 2015, P.68).

The rural areas fair badly compared to the urban areas. In 2013, the U5MR has been 55 in rural areas compared to 29 in the urban areas. Although there has been better decline rate in the rural areas in the recent past, it is the rural figures that keep the average below the target. Similarly, the male-female divide shows a disadvantage for females with the figure at 53 for them and for males at 47.

India being a large country with considerably varied demographic profile, what matters is how different states or regions have performed. In this respect, what one finds is that there is wide disparity between states, as could be seen in Figures 6-9.

As per the data collected by the Office of the Registrar General of India (RGI) through the Sample Registration System (SRS), under five mortality ratio (U5MR) was estimated at 125 deaths per 1000 live births in 1990. This was required to be reduced to 42 by 2015. It had been brought down to 52 by 2012 (SRS). Given the trend, it was likely to reach 49 by end of 2015, thus India missing the target. The figure for 2013 was 49 (India Country Report, 2015, P.68).

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India being a large country with considerably varied demographic profile, what matters is how different states or regions have performed. In this respect, what one finds is that there is wide disparity between states, as could be seen in Figures 6-9.

In the case of post-natal mortality rate, there has been significant progress in reducing the disparity between the rural and urban areas.

In this case also the rural-urban divide continued without much diminishment.

The decline of still birth rate has thrown up a result which shows the rural sector overtaking the urban sector in the matter of achievement having reduced from 11.9 per cent in 1990 to 4.0 per cent in 2013, overtaking urban sector.

India might have achieved most of the MDG health targets from a statistical point of view going by the trends during the last few years as projected in the India Country Report 2015 on MDGs. However, the progress has not been to the desired level as in all these indicators we should have reached a level that would ensure near nil MMR, SBR and IMR. Considering the socio-cultural and economic diversity of the country, and the population size, more disaggregated indicators are needed to assess the actual ground situation in the case of India. These include apart from the rural-urban divide highlighted above, gender and state-wise statistics also.
In the case of Infant Mortality Rate, Goa (9), Manipur (10) and Kerala (12) have levels so enviable compared to Madhya Pradesh (54), Assam (54) and Odisha (51) which are far above the national average of 40 in the year 2013. In regard to maternal mortality ratio, the states of Kerala (61) and Maharashtra (68) lead among major states while Assam (300), Uttar Pradesh (285) and Rajasthan (244) lag way behind. The position is not much better in Odisha (222) and Madhya Pradesh (221) and Bihar (208). The all India average for MMR works out to 167 in the period 2011-13, as per the above report.

Between rural and urban areas also there is wide variation. The urban areas return a figure of 27 as against 44 in the rural areas in IMR. Kerala has IMR of 7 for males and 10 for females with an average of 10 in urban areas, figures that are comparable to those in most developed countries. However, the figures for rural areas in Kerala are 11, 14 and 13 respectively. In the poor performing states also, the urban areas have done better than the rural areas. In Madhya Pradesh, the urban average is 37 compared to the rural average of 57. Similar is the case with Assam which has a rural IMR of 56 as compared to an urban IMR of 32.

There are also variations in the figures for the two sexes in the matter of IMR. All across, the rates are lower for males compared to females with the widest variation in the case of Nagaland where the IMR for males is 14 compared to 33 for females, followed by Lakshadweep with Figures of 19 and 29, respectively, Andaman and Nicobar islands with 20 and 28, respectively. Among the big states the variation is maximum in Rajasthan with 45 and 49 respectively. Generally a variation of 2-3 is observable in almost all states, reflecting better attention to male infants.

The worst hit are the rural females with the highest IMR of 59 in Madhya Pradesh followed by 58 in Assam, 54 in Odisha and Uttar Pradesh and 53 in Rajasthan. Certainly the figures for urban children are also poor in these states, but there is a wide variation in rates being lower by about 20 between rural and urban in Madhya Pradesh and Assam.

There appears to be a link between receipt of medical attention at the time of delivery and IMR. In the states where the rates of deliveries under medical supervision or in hospitals were higher, the MMRs and IMRs showed improvement compared to other states with Kerala and Goa having 99.8 per cent live births attended by skilled health personnel and having IMRs of 12 and 9, respectively. In the case of states like Jharkhand and Bihar the percentages of live births attended by skilled health personnel were 47.3 and 53.3, respectively and they were having IMRs of 37 and 42, respectively. This is one reason why the rural mortality figures are higher compared to the urban ones.

What comes out clearly is that the rural urban divide and male–female divide need to be addressed to improve the health profile of India.

In the matter of fighting particular diseases also, the same pattern is visible. Malaria cases were the maximum in Odisha in 2014 with 388,451 cases followed by Chhattisgarh with 122,480 cases. However, in the matter of deaths due to Malaria in
2014, Tripura is the worst with 96 deaths followed by Meghalaya with 78. Odisha has a number of 73. However, overall, the number of cases and deaths due to Malaria has been declining over the years up to 2013 with the figures going up in 2014.

In other social indicators like education also the states of Kerala, Goa, etc., out-perform states like Rajasthan, Odisha, Uttar Pradesh and Assam. While in Kerala and Goa though the rural females are behind male counter parts and urban counter parts in their own states, they are better than general population in the other states. Generally states who have done well in health indicators have an above national average in literacy rate, thus bringing out a link between literacy and health (see Figure 10).

Figure 10: State-wise Trends in Literacy (1999-2013)

![Figure 10](image)

Source: Census of India 2011, Registrar General of India

One reason for the low performance of certain states is the low priority to public health accorded by those states since the per capita public health expenditure in them were low compared to the better performing states (Hooda, 2015: 8). The per capita public expenditure on health had been a measly Rs. 210 in Bihar, Rs. 312 in Madhya Pradesh, Rs. 372 in Uttar Pradesh in 2009-10 (Argade, 2016). In fact, this had been the state for long. Of late, Rajasthan has started spending more on public health and the results are also showing. The states will have to allot more funds for health care.

India had initiated certain specific programmes for achievement of the MDGs. These included the National Health Mission which had two separate Missions within it, namely, the National Rural Health Mission and the National Urban Health Mission. National Rural Health Mission, launched in 2005, provides financial assistance to the States and Union Territories for strengthening the health systems. It aims at improving the infrastructure, human resources and availability of drugs and equipment. To meet the health care needs of the urban population, National Urban Health Mission was launched in 2014 with the focus on addressing the needs of urban poor and vulnerable sections. There has been general improvement in provision of health care infrastructure and human resources but perhaps more was needed as could be seen from India’s failure to reach many of the targets. India had achieved total elimination of polio and significant reduction in leprosy cases and incidence of Kala-azar and Lymphatic filariasis [Draft National Health Policy 2015 (NHP)]. In fact, given its status as an emerging economy and home to a large generic pharmaceutical industry, and the constitutional provisions and the commitments made in the National Health Policy 2002, it should have surpassed the targets much before 2015. Though many specific programmes were undertaken, some of them in Mission mode, the status of health in the country is still way below the world average. That leaves questions about the implementation strategies of these programmes.

India and Other Countries

In order to make a proper assessment of India’s efforts towards MDGs, it is also necessary to have a comparative picture of the health status in comparable countries. For this purpose, Pakistan and Sri Lanka, the two neighbouring countries with similar histories and Brazil and China, two countries with large population and comparable economic problems have been taken. Table 1 presents the status of certain health indicators in these countries in 1990 and 2000. The comparative figures for these countries in 2015 are also presented in Table 1.

What emerges from Table 1 is that in almost all indicators Sri Lanka, Brazil and China had achieved fairly good progress by 2000. In the matter of adult mortality rate while India, Pakistan and Sri Lanka had comparable status in 2000, Brazil and China had comparable status between them. Post MDG, Sri Lanka, Brazil and China made significant progress in life expectancy, IMR, MMR and adult mortality rate whereas Pakistan and India are lagging behind.
In IMR and U5MR, India has done much better than Pakistan during 2000-2015, but Pakistan did better in Adult Mortality Rate. It is interesting to note that in several indicators, India in 2015 is at the level that China was in 1990, pointing to the need for greater focus on health by the country to leapfrog from 1990 to 2030. The better performing countries have been spending comparatively more public funds on health as compared to the low performing ones, as could be seen from the World Bank data on public spending as a percentage of GDP and U5MR and MMR percentage reductions from World Health Report depicted in Figure 11.

**Figure 11: MDG Performance and Public Spending on Health**

![Figure 11: MDG Performance and Public Spending on Health](image)

Lessons from MDG Efforts

The following lessons can be drawn from the efforts that India made during the period 2000-2015 towards achievement of MDGs.

First, considering the diversity of the country, its size and the differential stages of development between regions, it is necessary to draw up local specific strategies and programmes. Many states in India are much larger than most countries of the world. For example, if Uttar Pradesh is an independent country, it would be the fifth most populous country in the world. The issues and problems differ from state to state on account of varied socio-economic conditions.

Second, along with disaggregation, decentralisation is essential. This is necessary, both to ensure local specific programmes and also community participation. Without such involvement of the local communities, achievement of primary health targets is going to be a very difficult proposition. Kerala has been a good example of this. It launched in 1996 the People’s Planning Process and transferred all public health care institutions to the Panchayati Raj (local self governments). They were also provided funds with discretion to use. Most such institutions prioritised achievement of sanitation through provision of both individual and community toilets, provision of safe drinking water and equipping primary and secondary health care institutions.

Third, preventive health care is what the country should focus first, considering its social and economic status and also factors that contribute to ill health. This will be of two types. One will relate to the environment including safe drinking water, hygiene, etc. The second will be disease oriented like vaccination. Concerted efforts can always bring results. India’s experience with the pulse polio vaccination has been a successful example of such concerted efforts. In all the proven vaccine areas, it will have to redouble this effort.

If India has to achieve the SDGs by 2030, it will have to focus on removing the regional and gender disparities. The statistics that drag it down are mainly those of rural females followed by rural males and urban females. The social and economic factors that inhibit reaching out health care facilities to the rural areas and to females particularly to certain vulnerable sections will have to be specifically addressed.
The experience with achievement of MDGs brings out that health cannot be achieved in vacuum. They have to be tackled along with those in other sectors like education women’s empowerment, sanitation, availability of clean drinking water, environmental protection and so on. There is a correlation between literacy and health. Also, availability of clean water is a prerequisite for hygiene. Environmental pollution is fast becoming a major ground of many respiratory diseases. These are the factors that cause ill health and many communicable diseases. In the Indian context, availability of transport facilities in remote areas also plays a significant role in ensuring that patients, including expecting mothers, get timely medical treatment.

There is a steady increase in proportion of NCDs, including mental health in India due to changing economic status of a good percentage of people. Deaths due to NCDs accounted for 41.8 per cent of total deaths in 2010 (IHME, 2012). Recognising this, India had introduced in 2013 the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), and the National Programme for Health Care of the Elderly (NPHCE) (MoH&FW Annual Report, 2016). As per a World Bank report, the disease burden scenario for India in 2020 shows significant increase in HIV. The report predicts rise in number of injuries. But the major burden will be in NCDs and diseases linked with old age.

**Current Status of Health in the country**

The present state of health in India poses major challenges since we have to do much to catch up with the developed world and many other developing countries. The current status of health care in India is presented in Table 2.

The major disease burden of India can be categorised into three groups, namely, infective diseases, injuries and non-communicable diseases (NCDs). Achievements so far have not been able to totally contain communicable disease burden in India. A sample list of the major vector borne diseases is presented in Table 3.

The number of cases and deaths due to accidents including natural disasters is also high with the total number at 400,517 of which traffic accidents accounted for 166,506 deaths.

**Challenges Ahead**

The health sector challenges for India are enormous and complex. The sheer size of the population and the diversity of social, economic, educational and health standards, the status of infrastructure and human resources – all these pose major problems. The diversity gives the country certain advantages also in that the experience of better performing states could be a guide for the others. There are very poor health care facilities in certain areas, and at the same time, there are some world class tertiary care institutions also.

The issues continue to be the same as at the time of announcement of MDGs, as could be deducted from the 12th Plan (2012-17) national health outcome for health system identified by the Planning Commission, namely,

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Year</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy (years) at birth</td>
<td>2014</td>
<td>68.0</td>
</tr>
<tr>
<td>Infant mortality rate (probability of dying by age 1 per 1000 live births)</td>
<td>2015</td>
<td>38</td>
</tr>
<tr>
<td>Under-five mortality rate (probability of dying by age 5 per 1000 live births)</td>
<td>2015</td>
<td>48</td>
</tr>
<tr>
<td>Maternal Mortality Ratio (deaths per 100,000 live births)</td>
<td>2013</td>
<td>190</td>
</tr>
<tr>
<td>Public health expenditure (% of total government expenditure)</td>
<td>2013</td>
<td>4.0</td>
</tr>
<tr>
<td>Public expenditure on health as a percentage of GDP</td>
<td>2014-14</td>
<td>1.2</td>
</tr>
<tr>
<td>Private expenditure on health as % of total expenditure on health</td>
<td>2012</td>
<td>69.5</td>
</tr>
<tr>
<td>HIV Incidence rate (per 100,000 population per year)</td>
<td>2013</td>
<td>11</td>
</tr>
<tr>
<td>TB Incidence rate (per 100,000 population per year)</td>
<td>2013</td>
<td>171</td>
</tr>
<tr>
<td>Malaria Incidence rate (per 100,000 population per year)</td>
<td>2012</td>
<td>1536</td>
</tr>
</tbody>
</table>

• Reduction of Maternal Mortality Rate (MMR) to 75 by 2017
• Reduction of Infant Mortality Rate (IMR) to 19
• Reduction of Total Fertility Rate (TFR) to 21
• Prevention of underweight children to 23 per cent
• Reduction of anaemia among women aged 15-49 years to 28 per cent
• Child sex ratio to 935

Irrespective of the SDGs, in India’s case, these will have to be achieved if it is to ensure health for all.

The most important of the challenges is the absence of a pro-health eco system in most states. India faces a huge problem of open defecation. This has been a source of many epidemics. It, as per an estimate, needs to build 87,584,706 modern toilets in the next three years. The Swachh Bharat Abhiyan (Gramin) launched in 2014 aims at achieving a 100 per cent Open Defecation Free India by 2019.

Coupled with sanitation is the issue of non-availability of safe drinking water to a majority of the population. The extent of this problem can be gauged from the fact that only 30.8 per cent of the rural households had access to piped water supply.

In Himachal Pradesh 88.70 per cent rural households have piped water supply whereas in Bihar it is a mere 2.60 per cent only. The immediate challenge is to ensure that all households in the country have access to water with adequate availability of safe drinking water for all. The National Rural Drinking Water Programme envisages that by 2022, at least 90 per cent of rural households are provided with piped water supply. Piped or not, without adequate supply of water, sanitation and hygiene cannot be improved.

Lack of adequate infrastructure, both in health sector and in the supporting sectors like transport, is another problem. According to the Rural Health Statistics 2014, there is a 23 per cent shortfall in Primary Health Centres (PHCs), that is, the required number of PHCs is 29,337 and only 25,020 are in position. A similar trend follows in the case of Community Health Centres (CHCs), wherein states like Delhi and Bihar have a shortfall of 100 per cent and 91 per cent respectively. This is way below the national average of 32 per cent. Coupled with this is the inadequacy of human resources.

Availability and accessibility of affordable medicines and diagnostics is also an issue. Despite having a strong generic pharma industry, the country faces the problem of access to affordable medicine by

Table 3: Incidents of Major Vector Borne Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Cases</th>
<th>No. of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>10,70,513</td>
<td>535</td>
</tr>
<tr>
<td>Chikungunya Fever</td>
<td>15,445</td>
<td>NA</td>
</tr>
<tr>
<td>Kala-azar</td>
<td>9,241</td>
<td>11</td>
</tr>
<tr>
<td>Acute Encephalitis Syndrome</td>
<td>10,834</td>
<td>1,716</td>
</tr>
<tr>
<td>Japanese Encephalitis</td>
<td>1,652</td>
<td>292</td>
</tr>
<tr>
<td>Dengue</td>
<td>1,462</td>
<td>1</td>
</tr>
<tr>
<td>Cholera</td>
<td>969</td>
<td>5</td>
</tr>
<tr>
<td>Acute Diarrhoea</td>
<td>1,16,73,018</td>
<td>1,323</td>
</tr>
<tr>
<td>Typhoid</td>
<td>17,07,312</td>
<td>429</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>4,071</td>
<td>104</td>
</tr>
<tr>
<td>Acute Respiratory infections</td>
<td>3,48,14,636</td>
<td>2,932</td>
</tr>
<tr>
<td>Measles</td>
<td>23,348</td>
<td>33</td>
</tr>
<tr>
<td>Viral Hepatitis</td>
<td>1,39,662</td>
<td>407</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>7,09,298</td>
<td>2,661</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>14,43,942</td>
<td>NA</td>
</tr>
<tr>
<td>Leprosy</td>
<td>95,042</td>
<td>NA</td>
</tr>
</tbody>
</table>

Source: National Health Profile 2015
large sections of people. More grave than medicines, is the cost of diagnostics. Regulatory systems in health sector leave much to be desired. Unless such systems function effectively, quality and access suffer. This includes the medical councils.

As stated above, India faces massive and diverse disease burdens and by virtue of its large numbers, unless India achieves the SDGs, the global goals will not be achievable. It continues to have high percentages of communicable diseases like TB, Malaria. HIV and so on and also, at the same time, rising share of non-communicable diseases like diabetes, blood pressure, cardio-vascular diseases and so on. India is still primary economy in many respects with agriculture still being the mainstay. Consequently animals and humans interact a lot. As per an estimate, over 50,000 people die daily in India of diseases that emerge from pathogens and animals. India accounts for most of the infant deaths globally. Diarrhoea and pneumonia continue to be the biggest killers in children. Dengue and Chikungunya are also on the increase (Draft National Health Policy, 2015). NCD incidences are also increasing. A study by ICMR projects 17.3 lakh new cases of cancer and over 8.8 lakh deaths due to the disease by 2020.

Malnutrition is a cause of ill health and morbidity. It is behind 55 per cent of TB cases. As per the District level Health Survey of 2013-14, even in a state like Tamil Nadu, which has made good progress in health sector, 49.2 per cent women between the ages of 15 and 49 are anaemic. Naturally, these women in reproductive age group are likely to give birth to under-weight children. Though there have been programmes to address the issue since Independence, the reduction has only been 20 per cent (Planning Commission). It remains a major challenge, “a national shame” (UNICEF, 2013). The U5MR may also be linked with this (Ramachandran, 2010).

The Resolution adopted by the UN General Assembly on 21 October 2015 has set 13 targets for achieving the goal of ensuring healthy lives and promoting well-being for all at all ages. These, inter alia, include reducing maternal mortality ratio to less than 70 per 100,000 live births, reducing Infant Mortality rate to 12 per 1000 live births and U5MR to 25 per 1000 live births. They also mention about ending epidemics like AIDS, TB, and Malaria and combating water-borne and Neglected Tropical Diseases (NTDs) and other communicable diseases, reducing by 1/3rd premature mortality from NCDs, halving deaths and injuries from road traffic accidents. It also targets integrating reproductive health into national strategies and programmes, something which India has already done.

Another important target is providing Universal Health Care. This has a significant impact on the delivery of health services. The targets also speak about supporting R&D of vaccines and medicines for diseases that primarily affect developing countries and make a specific mention about providing “access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all” (Target 3.b). Prevention and treatment of mental health and well being and also reducing deaths and illnesses from environmental pollution also are targets. Increase in health financing is also a target though without any specific percentage.

Way Forward
For the achievement of SDG 3 attention will have to be paid to preventive health care, provision of health care infrastructure and human resources, and financial resources for health care.

Preventive Health Care
The old adage, prevention is better than cure holds good in the case of health care. The approach of focussing primarily on delivery of curative services, which may help in achieving some of the statistical targets, will neither be economical in the long term nor contribute significantly to human wellness, which is the ultimate goal. Most of the communicable diseases (CDs) are on account of unhygienic practices and environment. In order to ensure that people do not fall prey to infectious diseases, sanitation facilities, clean air and safe drinking water will have to be ensured. Initiatives like Swachh Bharat Abhiyan will have to be implemented seriously. The fundamental interconnectedness of animal, human and environmental health and systems
is a must in drawing up programmes for SDG 3. Provision of sanitation, safe drinking water, etc., has significant economic impact also. Inadequate sanitation costs India Rs. 2.44 lakh crore or Rs. 2180 per person mostly in health expenditure.

There has been significant reduction in cases of malnutrition in India during the period 2006-2012 but has to be totally eradicated. The programmes addressing Anaemia are being administered by different Ministries such as Women and Child Development, Health and Family Welfare, etc. Convergence between programmes of different Ministries will contribute to economy in administration and better results.

Among disease specific preventive measures, the most important ones are immunisation and vaccination. However, such programmes sometimes can come across major hurdles as had happened in the case of Routine Immunisation (RI) programme, in many states. At the same time, there have also been great successes like smallpox, polio and diphtheria vaccinations. In all cases of diseases, for which vaccines are available, vaccinations should be carried out in a mission mode all across the country.

Provision of Health Care Infrastructure and Human Resource

Health Care Facilities

In the provision of global standard health care facilities, the country has to make serious efforts. Although financing would be a major problem, research and development for innovating low cost devices needs to be taken up on priority. There are already examples of such innovations. Popularisation of available devices and R&D to develop more such devices are needed. At the same time, Information Technology can be used to provide healthcare facilities at less expense than at present. Access to super specialists who are ordinarily in big metros can be made available to both doctors and patients in villages and towns through electronic network.

There is need to build huge medical infrastructures in the country. There is only one bed per 1050 patients in India while the United States there is one bed for every 350 patients. India’s current ratio of 0.7 doctors and 1.5 nurses per 1000 people is lower than the global average of 2.5 doctors and nurses per 1000 people. This has to be at three levels -- primary, secondary and tertiary. Primary health care will have to be provided at village or hamlet levels. Every village or habitation needs to have a primary health centre under a qualified medical practitioner. This will have to be provided in the government sector, since private sector motivation for doing so will be rather low, though Corporate Social Responsibility (CSR) programmes can, to some extent, be geared for this, at least in urban areas. The Public Private Partnership (PPP) model can also be experimented in that the government sets up the basic infrastructure and then entrusts the service provision to private players, but this will have to be under strict regulatory regimes.

Local Manufacture of pharmaceuticals

This is an area that needs to be considered as an essential tool for achieving health related SDGs. The statistics of the developing countries like India reflect not a healthy picture in this area. Non-complementary dependence on imports for medicines, particularly bulk drugs or Active Pharmaceutical Ingredients (APIs) can have adverse consequences when problems occur in the supply chain (James, 2015). Health is an essential item like water and food and no country should be at the mercy of others since trade flows can get affected by other factors thereby putting lives of people at risk. Appropriate measures to channelise the provisions of the TRIPS Agreement towards this should be taken. This is required to provide affordable access to medicines to all, a sine qua non for achievement of SDG 3.

Diagnostic and Treatment Facilities

Modern medical care is highly dependent on diagnostic devices. This sector is protected by intellectual property rights leading to monopolistic practices in manufacture and supply. The prices of these devices remain high thereby making the diagnoses costly. As in the case of medicines, here also indigenous R&D and innovation should focus on more user-friendly, less expensive, new cheaper and better devices that will make the process of diagnoses cheaper and accessible to all. Swasthya Slate (Health Tablet) developed by an Indian institution which is being used in by Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs) in several Indian states and also in certain other countries, is an example. There is also
need to extensively employ information technology in the provision of health care particularly in remote areas, by providing access to specialists in metros. It can also be widely used in diagnostic care.

**Human Resources**

Human resources are crucial for achievement of health for all. Developing countries have large populations but the number of qualified health work force is very limited. India is one among the many countries which is facing critical shortage of health care workers. For example, Community Health Centres (CHCs) are the major specialised medical care in the rural areas. Even with the existing infrastructure, there is a shortfall of 83.4 per cent of Surgeons, 76.3 per cent of Obstetricians & Gynaecologists, 83 per cent of Physicians and 82.1 per cent of Paediatricians (Rural Health Statistics, 2015, p. 20).

Medical Education and training of all levels of health personnel need up gradation, both in numbers and quality. As per the WHO guidelines of one doctor per 1000 people, India’s proportion of 0.7 physicians per 1000 patients is significantly lower than required. In order to attain the target of doctor-patient ratio of 1:1000, an estimate projects that 187 new government medical colleges will have to be established by 2022 in India.

Unlike the case with other professions, the medical profession provides a vital service that is required by human beings from birth to death and without any distinction of class or gender and rich or poor. Both technical capability building through knowledge impartation and development of social commitment through attitude-making programmes have to be built into the medical education. They have to be innovators, with strong public interest perspective, that is rooted in their local conditions.

**Development of Technological Capacity: R&D and Innovation**

This is very important for the achievement of the health related goals by all countries. Current status of R&D and innovation in developing countries, except in a few countries, is very low. While the industrialised countries have developed the technological capability and has been investing greatly in R&D, their focus, naturally, has been on drugs that are required in those countries. At the stage of developing the inventions of new chemical entities into medicines, the private pharmaceutical companies play significant roles. But these companies decide their innovation and R&D programmes from the angle of company profit. Since the paying capacity of the population of the South is much less than that of the North, the diseases that affect the South more, get neglected. Therefore, those countries of the South, which have the technological capability, like India, should pay special attention in R&D to diseases like TB, malaria and so on.

A major factor affecting access to medicines in developing countries is the price barrier. Even where medicines are available for diseases, they are priced so high that most populations of the South cannot afford to pay for it. This is the case not only with neglected diseases but also in case of non-communicable diseases like cancer, cardiac problems, etc. The only way to get the price reduced is through competition in drug discovery and manufacturing. Unless, countries of the South invest hugely in pharmaceutical R&D, this cannot be achieved. Basic research cannot be left to private companies who would have no interest in the same. Such R&D has to come from these countries themselves. India with a large scientific community and public research institutions are in a better position than most other developing countries to take the lead in this. The ICMR itself has 32 scientific organisations all across the country. However, the research projects of ICMR have been facing funds crunch (The Hindu, 15 January 2016.). R&D is a costly matter and the institutions need cutting edge technologies, according to the ICMR chief. More R&D in drugs and medical devices needs to be facilitated if India is to reach its health related targets.

India also should make use of its rich traditional knowledge base to develop new drugs, like Nobel laureate Youyou Tu did for developing the Malaria drug Artemisinin, based on traditional Chinese medicine. Government policies and procedures should facilitate such product development efforts.

**Clinical Trials**

Clinical trials (CTs) are also an important part of pharmaceutical R&D. Of late, the number of clinical trials, which in India touched 529 approvals in 2010 has been declining since then, though global trends are in the upswing. Specific remedial measures will have to
be taken to make the CT Guidelines user friendly both for investigator and patient. For diseases like Kala-azar which is a sub-continental phenomenon, unless CTS are done in the subcontinent, new vaccines and drugs will not be innovated.

**Effective Use of ISMs**

India has a very sound Indian Systems of Medicine (ISMs), namely Ayurveda, Siddha and Unani, which are based on scientific and logical principles (Chaturvedi, *et al.*, 2014). In the onslaught of modern medicine, the practical role that traditional medicines like the ISMs can play in health care has been generally neglected. There are 7.9 lakh AYUSH (Ayurveda, Yoga, Unani, Siddha and Homoeopathy) practitioners registered in India. They, however, have not been effectively used in health care, though some states like Rajasthan have taken initiatives in this regard under the National Rural Health Mission. Very often there are cost effective cures for many widely prevalent local diseases in these systems. The systems also require innovative inputs and generation of new medicines, novel methods of treatment and so on. Research and innovation has to focus on these areas.

**Financial Resources**

The major hurdle in achieving health for all is health care expenditure. It is an expensive activity from the individual perspective. Being rather of a necessity, people incur expenses on this even when they find themselves in an unaffordable situation. In a country where average per capita GDP is US$ 1581.5 during 2011-2015, that is equivalent to 10 per cent of the world average, the burden that can be borne by individuals is limited. India’s Out of Pocket (OOP) health spending rate is one of the highest in the world with 89.2 per cent of private expenditure pushing millions to poverty every year.

In 2012, India’s total share in health care expense as a percentage of GDP was 4.05 per cent compared to the world average of 10.14 per cent (Kalam and Singh, 2015, p. 69). Even after adjusts to purchase power parity, except South Asia all other regions and most countries have been spending more on health care than India. The US expenditure was more than 125 times that of India. The per capita health expenditure in India during 2014 was US$ 75 whereas in the USA it was US$ 9403.

Also the share of public health care expenditure in overall health expenditure in India at 30.5 per cent is one of the lowest in the world, the global average being 59.8 per cent; even the US has a figure of 46.4 per cent. The total public health investment has been low during the last many decades hovering around one per cent of the GDP (National Health Policy 2002 and Draft National health Policy 2015).

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>66</td>
<td>65</td>
<td>69</td>
<td>75</td>
</tr>
<tr>
<td>Pakistan</td>
<td>37</td>
<td>33</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>96</td>
<td>93</td>
<td>120</td>
<td>127</td>
</tr>
<tr>
<td>China</td>
<td>279</td>
<td>329</td>
<td>375</td>
<td>420</td>
</tr>
<tr>
<td>Brazil</td>
<td>1055</td>
<td>985</td>
<td>993</td>
<td>947</td>
</tr>
</tbody>
</table>

*Source: World Bank.*

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>27.1</td>
<td>27.0</td>
<td>28.4</td>
<td>30.0</td>
</tr>
<tr>
<td>Pakistan</td>
<td>30.6</td>
<td>36.9</td>
<td>36.8</td>
<td>35.2</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>42.1</td>
<td>38.0</td>
<td>57.2</td>
<td>56.1</td>
</tr>
<tr>
<td>Brazil</td>
<td>45.2</td>
<td>44.3</td>
<td>45.1</td>
<td>46.0</td>
</tr>
<tr>
<td>China</td>
<td>55.9</td>
<td>56.0</td>
<td>55.8</td>
<td>55.8</td>
</tr>
</tbody>
</table>

*Source: data.worldbank.org*
While successive governments, both at central and state levels, were committed to provide health care facilities at an affordable rate to all citizens and have announced many policy and programmes, competing priorities of development of a developing economy made adequate public funding for health difficult. The economy has now reached a stage where the governments can devote maximum funding for social sectors that affect human development such as health, education and so and allow the private players to take care of the manufacturing and service sectors. The private sector has also emerged as a major provider of health services such as diagnostic centres and hospitals, particularly tertiary level specialty care.

Allocation of financial resources for health sector should be weighed in with the possible adverse impact of ill health on economic growth. Number of studies have brought out that diseases cause a burden on the economy in the form of loss of productive capacity of the people. As per a study, India lost 3.10 crore years of healthy life to mental illness (Dementia, Anxiety Syndrome, Substance Use and Epilepsy) in 2013 alone.

The dominance of private out-of-pocket expenditure in the cost of health care is bound to be regressive (Srinivasan, n.d.). The 12th Plan envisaged reduction of households’ out-of-pocket expenditure from 71 per cent to 50 per cent of total health care expenditure by 2017.

Comparison with the four countries referred to earlier shows that per capita health expenditure in India has remained the lowest except for Pakistan consistently since 1996 (see Tables 4 and 5). China has shown significant increase over the years, naturally resulting in better health indicators.

What comes out clearly is that public health expenditure as a percentage of total health expenditure is the lowest in India. This is not at all a desirable status and the country will have to take earnest measures to rectify the situation. Without government bearing at least fifty per cent of the health expenditure, the country is not going to achieve the SDG 3.

Investment in health is the cornerstone of development. The requirement of finances for India to achieve the health goal has been estimated at Rs. 55 lakh crore. But if the budget allocations continue as per the present trends, an estimated gap of Rs. 19 lakh crore has been projected (Technology and Action for Rural Achievement, 2015: 66). This is a huge difference and needs to be bridged. But policymakers should realise that investment in health is an investment in the future of the country and will be a big saving for the economy by reducing loss of productivity on account of illness.

**Conclusion**

Provision of health care being a constitutional responsibility, the central and state governments have to give it the highest priority. India’s commitment to the achievement of SDG in health is to be seen not only from the angle of an international declaration but from the government’s basic duties. Investment in health sector in the long term makes good economic sense too. The SDGs provide an ambience and an international justification for governments to take pro-active health measures. Considering the primacy of health and wellness of all human beings, this should be an opportunity for the governments to take stock of provisions in other treaties and make changes, if any, required in them to facilitate the progress toward a healthy world.

Post the UN Sustainable Development Summit, India has put forward an ambitious Draft National Health Policy in 2015, which covers health care delivery services very well. It talks about programmes for addressing CD and NCDs with the laudable aim of “the attainment of the highest possible level of good health and well-being, through a preventive and promotive health care orientation in all development policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.” It recognises the salience of preventive and promotive health, integration of AYUSH with mainstream, and ensuring adequate investment. What is needed is concrete and comprehensive programmes on these lines. Unless that is done, the SDGs will remain a distant dream. As the policy itself recognises, “a policy is only as good as its implementation.”

**Endnotes**

1. Article 47 of the Constitution of India.
2. Article 39 (a) ibid.
3. Article 39 (f) ibid.
4. Article 47 ibid.
India and Sustainable Development Goals: The Way Forward

India accounted for 23 per cent of global cases and most deaths (220,000) due to TB in 2014. As per that report an estimated 2.2 million people suffer from TB in India.

The data does not include that relating to Jammu & Kashmir due to non-reporting, as per the data sources.

The 2015 data is not available.

The Lancet, 18 May 2016.

Economics of Non-Communicable Diseases in India. World Economic Forum.

The Lancet, 18 May 2016.

P. 9.

Para 3.1 of the draft National Health Policy.

References


Development Alternatives. 2016. Tracking the Global Goals in India.


Rao, Sujatha, n.d. Inter-State Comparisons on Health Outcomes in Major States and a Framework for Resource Devolution for Health. Centre for Economic and Social Studies, Hyderabad.


Srinivasan, R. n.d. Health Care on India.”


Srinivasan, R. n.d. Health Care on India.”


UN. 2015. *India and the MDGs: Towards a Sustainable Future for All.*


## Goal 3: Ensure healthy lives and promote well-being for all at all ages: Targets and Indicators

| 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births | 3.1.1 Maternal mortality ratio  
3.1.2 Proportion of births attended by skilled health personnel |
| 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births | 3.2.1 Under-five mortality rate  
3.2.2 Neonatal mortality rate |
| 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases | 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations  
3.3.2 Tuberculosis incidence per 1,000 population  
3.3.3 Malaria incidence per 1,000 population  
3.3.4 Hepatitis B incidence per 100,000 population  
3.3.5 Number of people requiring interventions against neglected tropical diseases |
| 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being | 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease  
3.4.2 Suicide mortality rate |
| 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol | 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders  
3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol |
| 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents | 3.6.1 Death rate due to road traffic injuries |
| 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes | 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods  
3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group |
| 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all | 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)  
3.8.2 Number of people covered by health insurance or a public health system per 1,000 population |
<table>
<thead>
<tr>
<th>3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</th>
<th>3.9.1 Mortality rate attributed to household and ambient air pollution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)</td>
<td>3.9.3 Mortality rate attributed to unintentional poisoning</td>
</tr>
<tr>
<td>3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate</td>
<td>3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older</td>
</tr>
<tr>
<td>3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</td>
<td>3.b.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis 3.b.2 Total net official development assistance to medical research and basic health sectors</td>
</tr>
<tr>
<td>3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States</td>
<td>3.c.1 Health worker density and distribution</td>
</tr>
<tr>
<td>3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks</td>
<td>3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness</td>
</tr>
</tbody>
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Work Programme on SDGs

Research and Information System for Developing Countries (RIS), in collaboration with the Ministry of External Affairs (MEA), Government of India and NITI Aayog, Government of India, and with support from the UN in India, is spearheading a programme of national consultations among lawmakers, policymakers, academia, private sector and the civil society on the Sustainable Development Goals (SDGs). Under this work programme, in its first phase, RIS organised a series of Consultations on SDGs in India ahead of the formal adoption of the 2030 Agenda for Sustainable Development in September 2015 by the UN General Assembly. Panel discussions were organised on Southern perspectives alongside the Third International Conference on Financing for Development (FfD3) in Addis Ababa, Ethiopia in July 2015 and the UN General Assembly (Sustainable Development Summit) in September 2015 in New York.

NITI Aayog in partnership with RIS and UN in India organised the National Consultations on SDGs with first consultation focussing on Health and Education (SDGs 3 and 4) in February 2016; second focussing on Industrialisation and Employment (SDGs 8 and 9) and third on Sustainable Management of Water and Sanitation For All (SDG 6) in August 2016 in New Delhi. RIS has also organised eminent person lecture by H.E. President of Liberia, Madam Ellen Johnson Sirleaf and thematic dialogues on: WTO and SDGs (November 2015); nutrition and food security (February 2016); and Technology Facilitation Mechanism (March 2016) in partnership with key national and international think-tanks. RIS and UN have also launched this special volume on SDGs to explore perspectives from India and the Global South. For more information on RIS Work Programme on SDGs visit: http://sdg.ris.org.in/ or email at: dgoffice@ris.org.in.