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THE HEALTH AND POPULATION POLICY OF UTTARAKHAND: A REVIEW

Application of the Policy Implementation Assessment Tool

AUGUST 2009
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EXECUTIVE SUMMARY

In December 2002, Uttarakhand became the first state in India to adopt an integrated *Health and Population Policy*. The policy is designed to improve the health status and quality of life of the population; alleviate inequalities in access to healthcare; address leading and emerging health concerns; and, eventually, stabilize growth of the population. Population-related objectives include reducing the total fertility rate from 3.3 children per woman to 2.1 (replacement-level fertility) by 2010; achieving a corresponding increase in the modern contraceptive prevalence rate (CPR) from 40 percent to 55 percent of married women ages 15-45 by 2010; reducing infant, child, and maternal mortality; and increasing life expectancy. The policy outlines 28 interventions that address organizational issues, planning, finance, training, service delivery and quality, drug availability, women's empowerment, equity, the private sector, and other concerns. Implementation of the policy in the state has evolved into a dynamic process, guided by the Reproductive and Child Health (RCH)-II program and the National Health Rural Mission (NRHM) (both launched in 2005).

About the Study. In 2008, with two years remaining to achieve the state policy goals (2010) and four years for the NRHM (2012), stakeholders recognized the benefits of assessing the implementation of the *Health and Population Policy*. The objectives of the assessment were to explore the nature of policy implementation over the past six years; assess progress and achievements; identify barriers and facilitators to implementation; and catalyze policy dialogue on ways to strengthen implementation to promote further progress toward achieving health outcomes. In-state stakeholders also felt the need to assess the relevance and the utility of the policy in the present context, in which the state is in the midst of implementing the NRHM. Thus, with high-level support from the Government of Uttarakhand, the USAID | Health Policy Initiative, Task Order 1, formed a core team to plan and oversee application of the Policy Implementation Assessment Tool. Researchers used the tool to gather information on seven dimensions of policy implementation:

1. The Policy, Its Formulation, and Dissemination
2. Social, Political, and Economic Context
3. Leadership in Policy Implementation
4. Stakeholder Involvement
5. Planning for Implementation and Resource Mobilization
6. Operations and Services
7. Feedback on Progress and Results

Data collection involved gathering input and feedback from stakeholders at three levels (state, district, and community) and from across the spectrum of the policy implementation process—from policymakers involved in the design of the policy and operational plans; to state- and district-level implementers who execute programs and monitor progress in the field; to community-based workers and the clients or end users. The researchers conducted 36 key informant interviews with five policymakers, 10 state-level implementers, and 21 district-level implementers. The researchers also organized 32 focus group discussions (FGDs) with 179 community-based workers and representatives of Panchayati Raj Institutions and 208 clients. In all, 423 people participated in the assessment. Additionally, the Health Policy Initiative conducted a text analysis of the policy and related annual plans to further understand implementation processes, outcomes, and challenges and to inform the design of the assessment.

Progress to Date. Over the past six years, the state has carried out several strategies and innovative approaches to improve healthcare quality and access (see Box 1). Examples of the innovations and reforms undertaken include promoting the policy and strategic framework; addressing infrastructure deficiencies; ensuring availability of healthcare service delivery manpower; increasing the accessibility and availability of healthcare services, with special focus on disadvantaged groups; enhancing the quality

of healthcare services provided; and strengthening governance and establishing viable institutional arrangements to foster convergence of services.

These interventions have helped to improve health outcomes, as shown by the 2005/06 National Family Health Survey data. The CPR, the number of women seeking three antenatal care (ANC) visits, and the number of institutional deliveries through the Janani Suraksha Yojna program have all increased. Yet behind the indicators, there are often disparities in health status and service access between the rich and poor, urban and rural populations, and scheduled castes and tribes and other groups. A slight increase in the infant mortality rate also raises concerns.

BOX 1. INNOVATIONS IN UTTARAKHAND

- Increasing capital investment for infrastructure
- Providing subsidies to private providers to set up clinics and specialist units in underserved areas
- Hiring doctors and para-medical staff on a contractual basis
- Providing mobile phones to auxiliary nurse midwives for improved communication and monitoring
- Using a voucher scheme and network of private providers to increase access to maternal and child health services for below poverty line families
- Using mobile health vans in underserved areas
- Strengthening community outreach through ASHA Plus
- Establishing training centers for auxiliary nurse midwives
- Supporting referral transportation
- Setting up the emergency ambulance service number—108
- Launching a telemedicine service

Key Findings from Policymakers and Implementers. Some of the major findings from the interviews with policymakers, senior state administrators, state- and district-level implementers, as well as the FGDs with community-based representatives include the following:

- Policy interventions are needed to address issues related to geriatrics and mental health.
- The timeframe for achieving the policy objectives is not sufficient due to the severe human resource crunch.
- The policy's participatory formulation process was not followed by effective policy dissemination and discussions on putting the policy into practice in the field.
- Due to the shortage of human resources, personnel have multiple roles and responsibilities, affecting the overall delivery of programs.
- The involvement of other departments is limited; however, good practices are emerging with effective coordination between auxiliary nurse midwives and Anganwadi workers.
- Financial and management training is needed for functionaries (whose expertise is in medicine, not program management) to improve program implementation.
- Although there appear to be sufficient funds for implementation, implementers face difficulties in expending the funds—due to lengthy approval procedures and lack of clarity on how funds can be used (which leads to fear of audits and reluctance to use available resources).
- The quantity and quality of human resources for service delivery is insufficient, and the infrastructure and supplies are inadequate.
- The management information system is not being utilized optimally for sound decisionmaking.
- Interdepartmental communication is inadequate.
- There is low motivation among functionaries at various levels due to difficult working conditions, inadequate infrastructure, and lack of recognition for good performance.
- Socio-religious factors and gender inequality pose barriers to access to and use of services.

- Proactive leadership is needed from political leaders, who are viewed as neutral or being neither strongly for nor against health program improvements.
- The decentralization process has facilitated policy and program implementation.

Key Findings from Clients. According to clients, health service access and facility quality have improved to some degree, and accredited social health activists have become an important source of information about health issues and available services. However, clients continue to encounter challenges, including poor quality of care, especially for marginalized groups. Due to limited time and provider attitudes, clients do not receive sufficient information from service providers about their ailments. Out-of-pocket expenditures on medicines, supplies, and lab tests are high; and the availability of these services is not guaranteed—even in district hospitals. For people belonging to scheduled castes and tribes and living below the poverty line, these costs are unaffordable. Lack of transportation and distance to facilities are challenges, especially in hilly areas. Women also cited provider behavior as a barrier, making them reluctant to go for institutional deliveries or ANC visits due to fear of poor treatment by providers.

The Way Forward. In assessing implementation of the *Health and Population Policy*, it is clear that policymakers and implementers are highly committed to finding solutions to enhance the effectiveness of health programs in the state. Stakeholders agreed on the relevance of and need for the state policy. While the NRHM, as an umbrella initiative, covers a range of health issues, such as RCH issues and infectious diseases, there are areas—such as mental health, lifestyle diseases, and geriatrics—that are emerging health concerns for the state. A policy framework is necessary to ensure that current and emerging health issues are regularly identified and addressed using a strategic approach. Opportunely, the introduction of RCH-II and NRHM in 2005 created major shifts in program priorities and has resulted in additional flexible resources. These changes necessitate reviewing the state policy's objectives, adding and modifying strategies, assessing implementation mechanisms and barriers, and devising appropriate measures to improve effectiveness.

Based on the assessment's findings, key recommendations to help achieve policy objectives include

- Strengthening decentralized planning and implementation;
- Encouraging integrated approaches and expanding the scope of convergence with more departments;
- Preparing guidelines and conducting training on financial resources, uses, and management;
- Fostering evidence-based planning for infrastructure development;
- Conducting a health human resources planning exercise to address the acute shortages of human resources; and
- Strengthening partnerships with private providers and formulating a public-private partnership policy to clearly articulate the objectives, mechanisms, and contractual and regulatory framework for effective partnerships.

The Health Policy Initiative presented the assessment's findings and recommendations at a multisectoral stakeholder meeting in Dehradun in November 2008, organized in collaboration with the Government of Uttarakhand, USAID/India, and the USAID-funded Innovations in Family Planning Services II Technical Assistance Project. The meeting provided an opportunity to review the state's health indicators, learn from innovative programs in the state, and discuss the policy assessment's key findings. Additional recommendations that emerged from the discussions included the following:

- "Contracting out" health institutions to the private sector;
- Redeploying human resources to underserved areas for optimal and judicious use of both public and private sector providers;
- Designing strategies to reduce infant mortality, including adolescent health education to encourage delaying the first birth and the healthy timing and spacing of pregnancies to reduce high-risk pregnancies;
- Expanding strategies to increase equity to improve the overall health status of the poor;
- Evaluating and scaling up innovations;
- Encouraging demand and health-seeking behavior among communities through large-scale information, education, and communication and school-based education;
- Bolstering confidence in and reliability of public health institutions among the people;
- Partnering with nongovernmental organizations to provide healthcare services in remote areas; and
- Fostering the motivation of staff by establishing a performance-based reward system.

The assessment of Uttarakhand's *Health and Population Policy* reinforced high-level commitment to the policy's goals, facilitated dialogue on challenges and emerging issues, and explored potential next steps to ensure that the policy is put into practice to improve the health status of the state's population. Stakeholders reiterated the benefits of updating the *Health and Population Policy* in response to the introduction of the RCH-II and NRHM programs. As a result, the Health Policy Initiative will provide technical assistance to the government and other stakeholders to update the policy based on findings from this assessment, the latest health data and situational analysis, and lessons learned from innovative pilot programs. A key component of this effort will be to establish regular policy monitoring mechanisms to identify and address barriers to achieving the policy goals.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ANM	auxiliary nurse midwife
ASHA	accredited social health activist
AWW	Anganwadi worker
AYUSH	Ayurveda, Unani, Siddha, and Homeopathy
BCC	behavior change communication
BPHC	block primary health center
BPL	below poverty line
CHC	community health center
CPR	contraceptive prevalence rate
DOHFW	Directorate of Health and Family Welfare
DOTS	Direct Observation Treatment, Short Course
FGD	focus group discussion
FRU	first referral unit
GOI	Government of India
HIV	human immunodeficiency virus
ICDS	Integrated Child Development Scheme
IEC	information, education, and communication
IFA	iron and folic acid
IFPS	Innovations in Family Planning Services
IMR	infant mortality rate
ITAP	IFPS II Technical Assistance Project
IUCD	intrauterine contraceptive device
JSY	Janani Suraksha Yojna
MIS	management information system
MO	medical officer
MOIC	medical officer in-charge
NFHS	National Family Health Survey
NGO	nongovernmental organization
NRHM	National Rural Health Mission
PHC	primary health center
PIP	Project Implementation Plan
PNC	postnatal care
PPP	public-private partnership
PRI	Panchayati Raj Institution
RCH	reproductive and child health
RDI	Rural Development Institute
SC	scheduled caste
SHRC	State Health Resource Center
ST	scheduled tribe
TB	tuberculosis
USAID	United States Agency for International Development
VHSC	Village Health and Sanitation Committee

SECTION 1: INTRODUCTION

As of November 9, 2000, Uttarakhand became the 27th state of the Indian republic. In December 2002, it became the first state in India to adopt an integrated *Health and Population Policy*. The USAID-funded POLICY Project provided technical assistance to draft the policy and facilitate stakeholder participation. The consultations brought together more than 100 participants from international organizations, national institutions, the Directorate of Health and Family Welfare (DOHFW) of Uttarakhand, other state departments, nongovernmental organizations (NGOs), and the private sector. Forty-five papers were presented on issues related to fertility, contraceptive use, reproductive and child health (RCH), gender and empowerment of women, intersectoral coordination, NGO partnership, and program management. The deliberations paved the way for the state to develop its own policy framework. The state policy articulates the needs of women, children, and marginalized populations, such as the poor and scheduled castes and scheduled tribes (SCs/STs). The policy also demonstrates the government's commitment to the health and overall well-being of its people.

1.1 Purpose of the Assessment

During the six years since the policy's adoption, the state has carried out various initiatives to improve the quality of and access to healthcare services. Implementation of the policy has been an evolving, dynamic process, guided by the RCH-II program strategies and, currently, by the National Health Rural Mission (NRHM). In 2008, with two years remaining to achieve the state policy goals (2010) and four years for the NRHM (2012), stakeholders recognized the benefits of assessing the policy's implementation. The objectives were to explore the nature of policy implementation over the past six years; assess progress and achievements; identify barriers and facilitators to implementation; and catalyze policy dialogue on ways to strengthen implementation to promote further progress toward achieving health outcomes. While NRHM activities are guided by the overall framework of the *Health and Population Policy*, the government deemed it important to understand how relevant the policy is in the present context and if any policy revisions are required. Thus, the Government of Uttarakhand wanted to assess progress and, more important, identify gaps and limitations to be addressed so that the state achieves its health and population goals by 2010.

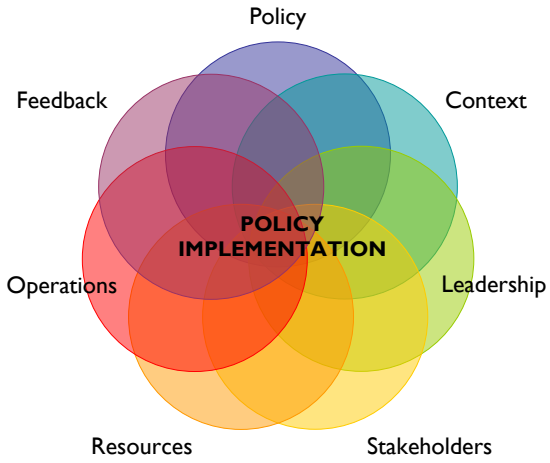
1.2 Methodology

The USAID | Health Policy Initiative, Task Order 1, with support from the Government of Uttarakhand, led the assessment. In undertaking the review, the project applied its Policy Implementation Assessment Tool. The tool comprises two questionnaires that explore the perspectives of policymakers and program implementers/other stakeholders on the overall operationalization and implementation of policies and plans. The questionnaires are organized around seven dimensions of policy implementation (see Figure 1):

1. The Policy, Its Formulation, and Dissemination
2. Social, Political, and Economic Context
3. Leadership in Policy Implementation
4. Stakeholder Involvement
5. Planning for Implementation and Resource Mobilization
6. Operations and Services
7. Feedback on Progress and Results

The questionnaires elicit Likert-like rankings of specific aspects of implementation as well as qualitative information drawn from the key informants' experiences. The rankings help gather standardized information that can be tracked over time and used to compare the perspectives of policymakers and implementers. The qualitative information on perceptions and experiences with various aspects of implementation help elucidate, by way of specific examples, the nature and form in which a specific policy is being implemented.

Figure 1. Dimensions of Policy Implementation



The Health Policy Initiative, with support from the DOHFW, formed a core team to guide the assessment and oversee adaptation of the research tools to the state context. The core team comprised representatives from the DOHFW, State Health Resource Center (SRHC), and NGOs. The Rural Development Institute (RDI)—a research unit of the Himalayan Institute Hospital Trust based in Dehradun—assisted with data collection and analysis. In partnership with the core team, the project also used the questionnaires to inform the design of focus group discussion (FGD) guides to gather input from community-level functionaries and clients of services. Additionally, the project conducted a desk review of the policy and related annual plans and progress reports to further understand implementation processes, outcomes, and challenges and to inform the design of the assessment.

1.3 Scope of the Field Work

The core team decided to conduct the assessment at three levels: state, district, and community (see Tables 1a and 1b). Key informants for interviews included senior policymakers, officials of the DOHFW, senior medical officers, program managers, and NGO functionaries. In all, 36 interviews were conducted with policymakers and implementers at the state and district levels. Additionally, at the community level, the researchers organized 32 FGDs with frontline workers, including auxiliary nurse midwives (ANMs), Anganwadi workers (AWWs), accredited social health activists (ASHAs), and representatives of Panchayati Raj institutions (PRIs). A major addition to the scope of work was to include the participation of clients or end users of health services; thus, discussions were also organized with beneficiaries in rural and urban areas, which included members belonging to scheduled castes.

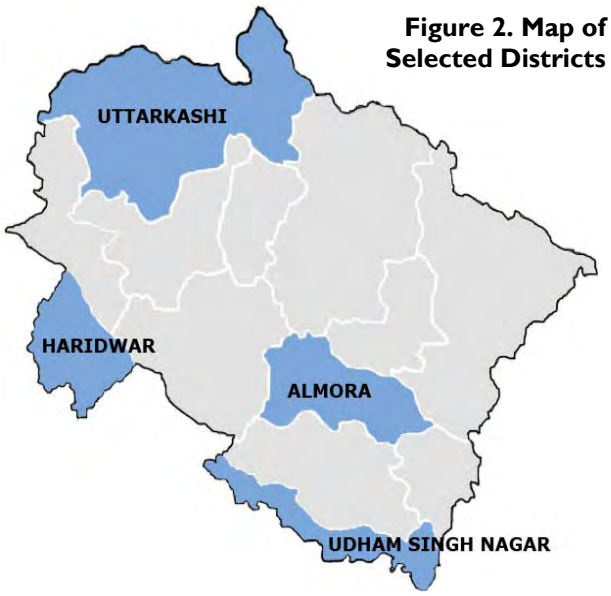
The Health Policy Initiative and RDI collected the data. The project first oriented RDI on the purpose of the review, methodology, and tools. The researchers then conducted the interviews and FGDs from June–July 2008; input feedback into the database; and began analyzing the responses for key themes.

TABLE 1a. IN-DEPTH INTERVIEWS	
Stakeholder Group	**Number**
Policymakers	5
State-level implementers	10
District-level implementers (e.g., medical officers and superintendents, NGO staff, and community development officers)	21
Total interviews = 36	

TABLE 1b. COMMUNITY-LEVEL FOCUS GROUP DISCUSSIONS		
Stakeholder Group	**Number of FGDs**	**Number of Participants**
Auxiliary nurse midwives	4	179 total
Anganwadi workers	4	
Accredited social health activists	4	
Panchayati Raj institution representatives	4	
Women in urban slums	4	208 total
Men in urban slums	4	
Women from rural areas and scheduled castes	4	
Men from rural areas and scheduled castes	4	
Total	**32**	**387**

The core team selected four districts for the district- and community-level fieldwork: Almora, Haridwar, Udham Singh Nagar, and Uttarkashi (see Figure 2). These districts represent Uttarakhand's three regions: upper Himalayas, middle Himalayas, and the plains. Two districts from the plains were chosen because more than half of the state's population (55%) resides in the region. Other factors considered were program performance, geographical access, and the population density. Corresponding blocks in the above districts included Laksar, Purola, Bhatwari, Jaspur, and Chokhotiya to ensure representation of both rural and urban areas.

Figure 2. Map of Selected Districts



1.4 Review Process

The multisectoral core team played a key role in finalizing the parameters and expectations of the review, adapting the questionnaires, identifying key informants for interviews, and selecting sites for the

fieldwork. Once the data collection was complete, the core team reviewed the data and emerging themes, began to identify potential recommendations, and provided feedback to facilitate dissemination of the findings. The Health Policy Initiative presented the assessment's findings at a policy dialogue and dissemination workshop for state-level government and NGO stakeholders in Dehradun in November 2008. At the policy dialogue workshop, participants discussed various recommendations and identified strategies for future actions.

1.5 Organization of the Report

This section introduced the rationale for the assessment and the methodology. Section 2 reviews the state's health indicators, objectives of the *Health and Population Policy*, mechanisms for implementation, and progress to date. The section also summarizes findings from the desk review of the policy and related annual plans and progress reports. Section 3 presents the key assessment findings and identified issues, which are organized around seven dimensions of policy implementation. Finally, based on the assessment as well as discussions during the policy dialogue and dissemination workshop, Section 4 outlines recommendations for strengthening implementation.

SECTION 2: BACKGROUND

2.1 State Profile

Uttarakhand is a small state with a population scattered throughout small, rural settlements. It comprises 13 districts: Almora, Bageshwar, Chamoli, Champawat, Dehradun, Haridwar, Nainital, Pauri Garhwal, Pithoragarh, Rudraprayag, Tehri Garhwal, Udham Singh Nagar, and Uttarkashi. Geographically, the state is divided into three broad zones: the upper Himalayas, middle Himalayas, and plains. The total population, according to the 2001 census, is 8.5 million, with an annual growth rate of 2 percent. The population size of the districts varies considerably. Four districts (Dehradun, Haridwar, Nainital, and Udham Singh Nagar) account for 55 percent of the state's population. If the three districts of Almora, Pauri Garhwal, and Tehri Garhwal are added, these districts account for 79 percent of the population. The population size of Haridwar is 1.4 million, followed by Dehradun at 1.3 million. Between 1991 and 2001, there was a decline in the population growth rate; however, the density of the state increased from 133 persons per square kilometer in 1991 to 159 in 2001.

TABLE 2. UTTARAKHAND AT-A-GLANCE

Background Characteristics	Number or %
Geographic Area (in Sq. kms)	53,484 sq. kms
Number of Divisions	2
Number of Districts	13
Number of Blocks	95
Size of Villages (2001 Census)	
Number of villages	16,826
1–500	13,460 (80%)
501–2,000	2,679 (17%)
2,001–5,000	426 (3%)
5,000+	NIL
Number of Towns	31
Total Population (2001)	8,479,562
Urban	21.8 lakhs
Rural	63.1 lakhs
Sex Ratio (F/M*1000)	
Population Sex Ratio	964
Child Sex Ratio	927
Decadal Growth Rate	19.2%
Density – People per sq. km.	150
Literacy Rate (6+ Pop)	73%
Male	84%
Female	60%
% SC/ST Population	
SC	15%
ST	3%
Source: 2001 census	

About 17 percent of villages have a population ranging between 500 and 1,999, and only 3 percent of villages have a population above 2,000; thus, 80 percent of the population lives in hamlets with less than 500 people and many are in difficult to reach hilly areas (see Table 2). The scheduled caste population is scattered in the districts, reaching 20 percent in Almora, Haridwar, Pithoragarh, and Uttarkashi and varying between 13 and 17 percent in other districts. Scheduled tribes constitute a small proportion of the population and are concentrated in Dehradun and Nainital. Hinduism is the dominant religion, with the Muslim population having a significant presence only in Dehradun, Haridwar, and Nainital.

Uttarakhand's literacy rate, at 73 percent, is one of the highest in the country. There has been a greater increase in female literacy than in male literacy. There are significant inter-district variations in literacy rates. Nainital, followed by Dehradun, has the highest literacy rate, and Haridwar, followed by Udham Singh Nagar, has the lowest. In five districts—Champawat, Haridwar, Tehri Garhwal, Udham Singh Nagar, and Uttarkashi—the literacy rate is below the state average. The overall sex ratio, according to the 2001 census, is 964 females for every 1,000 males.

2.2 Goals of the State Health and Population Policy

The districts that formed Uttarakhand in 2000 had performed better in terms of health, population, and development indicators than the other districts of the original parent state of Uttar Pradesh. Upon its formation, the state immediately set up systems to manage various departments for effective program governance. The state identified healthcare as a priority and soon initiated development of the policy guidelines. It also continued to implement the RCH-I program, which was in operation throughout the country. The state recognized that the population could not be stabilized without improvements in the health status of the people and vice versa. In December 2002, Uttarakhand became the first state to formulate an integrated *Health and Population Policy*, which provided policy directions to initiate health reforms in the state. The overall mission of the policy includes efforts to improve the health status and quality of life of the population; alleviate inequalities in access to healthcare; address leading and emerging health concerns; and, eventually, stabilize population growth. The policy's key health and population objectives are listed in Table 3.

TABLE 3. OBJECTIVES OF THE HEALTH AND POPULATION POLICY (2002)

Health	▪ Eradicate polio by 2005 ▪ Reduce the leprosy level per 10,000 population by 2004 ▪ Reduce mortality on account of tuberculosis and vector-borne diseases by 50% by 2010 ▪ Reduce prevalence of blindness from 1 to 0.3% by 2010 ▪ Reduce the iodine deficiency disorder by 50% by 2010 ▪ Reduce reproductive tract infections by 50% in men and women by the end of 2007 ▪ Increase awareness of HIV and AIDS from the present 36% to 70% by the end of 2005 ▪ Achieve zero level of growth in HIV infection by 2007 and launch curative care for those living with HIV ▪ Establish an integrated system of surveillance for health by 2007 ▪ Increase state health spending to 8% by 2010
Population Objectives	▪ Reduce the total fertility rate from the current estimated level of 3.3 to 2.6 by 2006 and further to 2.1 by 2010 ▪ Reduce the crude birth rate from 26.0 in 2001 to 22.6 in 2006 and further to 19.9 by 2010 ▪ Increase the contraceptive prevalence rate from 40% to 49% by 2006 to 55% by 2010 ▪ Reduce the infant mortality rate of 50 per 1,000 live births to 40 by 2006 to 28 by 2010 ▪ Reduce the child mortality rate of 19 per 1,000 live births to 17 by 2006 and further to 15 by 2010 ▪ Reduce the maternal mortality ratio to 250 per 100,000 live births by 2006 and further to below 100 by 2010 ▪ Increase life expectancy at birth from 63 years old in 2001 to 67 in 2006 to 70 in 2010

The *Health and Population Policy* outlines 28 policy interventions that address organizational issues, planning, finance, training, service delivery and quality, drug availability, women's empowerment, equity, the private sector, and other concerns. One proposed area of intervention addresses the replacement-level fertility goal and focuses on the concept of unmet need for family planning. It notes that more than one in five married women in the state have an unmet need for family planning services but have not adopted modern methods—either due to a lack of access to these methods or a lack of informed choice. The policy recommends greater access to family planning and appropriate behavioral change communication (BCC) to convert unmet need to actual use.

2.3 Mechanisms for Policy Implementation

The policy articulates the state's goals, identifies key actions, and provides the overall direction in which the state health and population outcomes are to be achieved. The policy calls for development of an operational plan to implement activities in support of the policy strategies; establishment of a State Health and Population Policy Coordination Committee to coordinate and provide guidance for various departments' activities; and formation of a State Health and Population Policy Implementation Committee to ensure implementation of the operational plan.[1] However, policy implementation is not a linear process; it is dynamic and can change over time along with the ground realities.

In 2003/04, the government, within the overall framework of the *Health and Population Policy*, initiated preparation of the RCH-II state Program Implementation Plan (PIP)—to be executed from April 2005 to March 2010. The RCH-II PIP was designed to improve services by increasing access to high-quality services and strengthened infrastructure facilities; promote partnerships with private sector and civil society organizations; increase public health investments; reduce gender discrimination; and involve elected representatives and the community at-large. Further, the state prepared an Annual Action Plan for 2006/07 for RCH-II in December 2004 to outline annual targets and indicators to help implement the program and monitor progress.

While the state was planning and operationalizing the RCH-II program, the Government of India (GOI) launched the NRHM in 2005. The NRHM's objective is to expand access to high-quality healthcare for rural populations. The NRHM integrated the Family Welfare and National Disease Control Programs under one umbrella. It further built on the strategies of the RCH-II by

- Strengthening outreach services by involving village health workers (ASHAs);
- Facilitating community involvement through the formation of health and sanitation committees at the village, block, and district levels;
- Registering Rogi Kalyan Samitis for improving hospital management;
- Strengthening and upgrading the public health infrastructure to comply with Indian Public Health Standards; and
- Consolidating the District Program Management Unit contracting professional staff to provide program and financial management support to the chief medical officers in implementing programs at the district level.

In Uttarakhand, the NRHM—formally launched on October 27, 2005—aims to accelerate achievement of health- and population-related goals. The state has prepared annual state PIPs and District Health Action Plans to foster effective decentralized planning and implementation. The NRHM PIP integrates components of RCH-II, Routine Immunization, and the National Disease Program, and calls for intersectoral convergence. Thus, the objectives of the *Health and Population Policy* are now embedded within the NRHM PIP for the state. Under the NRHM, the state has received a two-year extension to meet the policy's objectives by 2012.

Over the past six years, the state has carried out several strategies and innovative approaches to improve healthcare quality and access (see Box 1). Examples of innovations and reforms undertaken include promoting the policy and strategic framework; addressing infrastructure deficiencies; ensuring the availability of healthcare service delivery manpower; increasing the accessibility and availability of healthcare services, with special focus on disadvantaged groups; enhancing the quality of healthcare services provided; and strengthening governance and establishing viable institutional arrangements to foster convergence of services.

[1] A government order established the committees, but the committees did not meet regularly after formation.

BOX 1. INNOVATIONS IN UTTARAKHAND

- Increasing capital investment for infrastructure
- Providing subsidies to private providers to set up clinics and specialist units in underserved areas
- Hiring doctors and paramedical staff on a contractual basis
- Providing mobile phones to ANMs for improved communication and monitoring
- Using a voucher scheme and network of private providers to increase access to maternal and child health services for below poverty line families
- Using mobile health vans in underserved areas
- Strengthening community outreach through ASHA Plus
- Establishing training centers for ANMs
- Supporting referral transportation
- Setting up the emergency ambulance service number—108
- Launching a telemedicine service

2.4 Health Outcomes

Data from the 1998/99 National Family Health Survey (NFHS-2)[2] and the 2005/06 NFHS-3 show that the state has experienced overall improvements in the health of its population (see Table 4). For example, the contraceptive prevalence rate (CPR) has increased, unmet need for family planning has been reduced by nearly 10 percentage points, and fertility has declined, though marginally. Other trends, such as a slight increase in the infant mortality rate (IMR), show cause for concern.

TABLE 4. INDICATORS AND GOALS FOR UTTARKHAND

	1998/99 NFHS-2	2005/06 NFHS-3	2010 GOAL*
Total fertility rate	2.61	2.55	2.1
Contraceptive prevalence rate (modern)	40	56	55
Unmet need for family planning	21	11	N/A
Infant mortality rate (per 1,000 live births)	38	41	28
Antenatal care (three or more visits) (%)	20	45	N/A
Institutional deliveries (%)	21	36	59
Births assisted by trained personnel** (%)	35	42	74
Mothers receive postnatal care from trained personnel** (%)	N/A	30	N/A
Children fully immunized (ages 12–23 months)	41	60	75

*Source of goal is the *Health and Population Policy* or the RCH-II PIP
**Trained personnel include doctors, nurses, lady health visitors, ANMs, and other healthcare providers
N/A = not available

[2] Data from the 1998/99 NFHS-2 refer to those districts in Uttar Pradesh that became the state of Uttarakhand in 2000.

The data indicate the following progress and concerns:

- **Decline in fertility.** Uttarakhand's total fertility rate has declined marginally from 2.61 children per woman in the late 1990s to the current 2.55 in 2005/06 (note: the national average is 2.7).
- **Increase in infant mortality rate.** There has been a marginal increase in the IMR from 38 infant deaths per 1,000 live births to 43 between 1998/99 and 2005/06. An issue of particular concern is that the IMR is three times higher in rural areas than in urban areas. Similarly, child mortality is more than twice as high in rural areas than in urban areas. These trends are also true for child mortality among SCs/STs.
- **Increase in access to family planning and RCH services.** Forty-five percent of women have received at least three antenatal care (ANC) checkups—more than double the 20 percent in 1998/99. The proportion of women who delivered in a health institution increased from 21 percent in 1998/99 to 36 percent in 2005/06. Although there is considerable improvement, two-thirds of births still take place at home and are more prevalent among those who have not received ANC, older women, women with less education, and women in the three lowest wealth quintiles. Use of postnatal care (PNC) is very low; it is accessed by only 30 percent of women and is common among women who deliver at a health facility. A large proportion of women (63%) do not get PNC—thus putting the mother and the newborn at increased risk of postpartum health complications or even death.
- **Significant uptake in contraceptive use.** The modern CPR, which is currently 56 percent, has increased by 16 percentage points since 1998/99. Men reported lower contraceptive use at last sex (52%), compared with women, who reported 59 percent. Female sterilization is still the most common and preferred method of family planning; it accounts for more than half (54%) of family planning use—although it has declined from 63 percent in 1998/99. However, the increase in CPR has been slow to translate into reduced fertility. This may be due to the preference for female sterilization, as women typically opt for sterilization later in life after they have had several children. Improved access to spacing methods and a balanced contraceptive method mix are needed to help reduce overall fertility.
- **Reduction in the unmet need for family planning.** The state reduced the unmet need for family planning from 21 percent to 11 percent between 1998/99 and 2005/06, resulting in 85 percent of the current demand for family planning being met.
- **Increase in complete immunization.** Three out of five children ages 12–23 months are fully immunized against six major childhood illnesses, according to the NFHS-3 in 2005/06—up from 41 percent in 1998/99. Between the first and third doses, the dropout rate is higher for DPT (18%) compared with polio drops (10%). Thus, most children are at least partially vaccinated. However, about one out of 10 children (9%) has not received any vaccinations at all.
- **Improvement in feeding practices.** Breastfeeding is nearly universal in the state. However, only three out of 10 children under six months are exclusively breastfed, as per the World Health Organization recommendations. In addition, only 71 percent are put to breast within the first day of life; thus, about 30 percent of infants are deprived of colostrum, which is high in antibodies and nutrients.
- **Increase in the level of awareness of HIV.** More than two-thirds of the women surveyed had heard of HIV/AIDS in 2005/06, which is a significant increase from 1998/99, when only one-third were aware of HIV/AIDS. Almost all (90%) men are aware of HIV/AIDS as reported in the NFHS-3 in 2005/06.
- **Unequal access.** The NFHS-3 survey results highlight the disparities in access to health services faced by the poor, SC/ST populations, and rural populations. For example, 36 percent of

women in rural areas receive three ANC visits, compared with 71 percent of their urban counterparts. About 59 percent of women in urban areas deliver in institutions, compared with only 29 percent of women in rural areas. Contraceptive use is much higher, at 68 percent, for women from the highest wealth quintile, while it is only 45 percent in the lowest wealth quintile. Contraceptive use is also lower for women belonging to minorities and SC/ST groups.

It is clear that some health indicators are moving in the desired direction; however, there is still much room for improvement to alleviate inequalities in access to and use of health services.

2.5 Findings of the Desk Review of the Policy and Related Implementation Plans and Progress Reports

Table 5 summarizes key findings from the desk review of the *Health and Population Policy* and the major related implementation plans and progress reports. The table includes planned strategies in the policy (Column 1) and the RCH-II PIP (Column 2), as well as documented outcomes (Column 3). The desk review helped to identify issues to be further explored during the key informant interviews and FGDs (Column 4). The desk review was also a vital component of the policy implementation assessment because it demonstrated that, despite not having an operational plan for the policy, the state has implemented several policy interventions under RCH-II. While not being an exhaustive evaluation, the desk review also helped to begin to compare stated goals against the achievements to date.

Key materials for the desk review included the 2002 *Health and Population Policy*, RCH-II PIP 2005–2010, *Physical Progress Report for NRHM 2007–2008*, *Rapid Assessment of the Functionality of First Referral Units and 24x7 Primary Health Centers in Uttarakhand* (2007), and *Financial Expenditure Report of Uttarakhand 2007–2008*.

TABLE 5: DESK REVIEW OF THE STATE POLICY, IMPLEMENTATION PLANS, AND PROGRESS REPORTS

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
ORGANIZATIONAL STRUCTURE			
▪ Review the organizational structure ▪ Redefine the roles and responsibilities of medical officers (MOs) and paramedical staff ▪ Orient doctors on public health and primary healthcare approaches ▪ Introduce performance reward/ incentive systems to improve productivity	▪ Review the organizational structure with particular reference to coordination and integration ▪ Prepare job functions and expected performance levels of different categories of staff ▪ Develop a cadre of public health managers ▪ Develop performance-based reward systems for various categories of staff	▪ Draft guidelines developed for performance appraisal by Health System Development Project ▪ Revised organizational structure has been developed but not yet approved	➢ Impact of vacancies on service delivery ➢ Adequacy and impact of staff supervision, performance appraisals, and other human resource policies
HUMAN RESOURCES PLANNING AND DEVELOPMENT			
▪ Identify human resource gaps ▪ Review human resource development policies to improve motivation and work environment ▪ Deploy human resources through an effective policy on transfer	▪ Identify human resource gaps and recruit/deploy key staff ▪ Ensure that 90% of staff have undertaken relevant in-service training by FY2008 ▪ Implement an effective performance appraisal system ▪ Ensure the availability of revised cadre transfer and posting policies, including committed tenure of certain key positions	▪ Review of human resource systems and guidelines developed on posting and transfers ▪ Contractual appointment of medical doctors and paramedical staff to fill gaps ▪ Walk-in interviews and same day appointments ▪ Financial incentives to private providers in difficult regions ▪ Special Non-Practicing Allowance for MOs in difficult hill areas ▪ Higher compensation to district program managers/paramedical posts in remote areas	➢ Extent of staff shortages in remote areas ➢ Adequacy of policies and procedures regarding postings and transfers ➢ Availability and adequacy of training for staff (on health services as well as finance and management issues) ➢ Adequacy and impact of staff supervision, performance appraisals, and other human resource policies ➢ Effectiveness of recruitment and retention policies, including contractual mechanisms

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
IMPROVING EFFICIENCY AND QUALITY OF HEALTH SERVICES			
▪ Identify the minimum standards for high-quality services at health institutions ▪ Evaluate the public health institutions ▪ Increase use of the under-utilized health institutions	▪ Prepare guidelines for healthcare service provision, including treatment, performance management, minimum standards for healthcare delivery, client satisfaction monitoring ▪ Outline accreditation criteria for private facilities ▪ Upgrade health institutions ▪ Improve accountability of healthcare organizations through training, monitoring, feedback from patients, and community involvement	▪ Health Resource Center set up to provide technical support ▪ Standard treatment guidelines/ protocols prepared ▪ Service providers trained ▪ Rogi Kalyan Samitis established in community health centers (CHCs) ▪ Subcenters strengthened through provision of Rs. 10,000 as untied funds and annual maintenance grant ▪ Primary health centers (PHCs) and CHCs strengthened with annual maintenance ▪ Rapid assessment of the functionality of first referral units (FRU) and 24x7 PHCs ▪ Quality Assurance Unit in the health department is proposed to ensure sustainable implementation of quality assurance initiatives on a long-term basis	➢ Functionality of the FRUs ➢ Adequacy and use of financial resources, especially untied funds at the local level ➢ Adequacy of infrastructure, drugs, and commodities ➢ Functionality of the Rogi Kalyan Samitis ➢ Degree to which client feedback is solicited to improve services
IMPROVING ACCESS TO HEALTH SERVICES			
▪ Conduct geographical mapping of inaccessible areas in each district ▪ Design a master communication plan, including road connectivity, in coordination with the Public Works Department, Rural Development Department, and PRIs	▪ Increase access through supply- and demand-side strategies ▪ Mobilize link workers to generate awareness and demand for health services ▪ Train *dais* to improve safe deliveries	▪ 9,923 ASHAs selected and four rounds of training completed ▪ ASHA Plus program piloted in difficult to reach blocks ▪ Mother NGOs contracted to set up ASHA resource centers ▪ Subcenter day organized and integrated RCH camps to increase	➢ Availability of staff, including ANMs at subcenters and female service providers to offer RCH services ➢ Capacity and skill level of human resources at the FRUs and 24x7 services

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
▪ Promote safe motherhood and primary healthcare by training select women from villages and providing training on midwifery and primary healthcare ▪ Strengthen obstetric care services at CHCs and block primary health centers (BPHCs) ▪ Launch mobile services and telemedicine to improve access in remote areas ▪ Pilot innovative approaches in primary healthcare	▪ Provide incentives to *dais* for promoting institutional deliveries ▪ Provide financial compensation to below poverty line (BPL) women for delivering in public institutions under Janani Suraksha Yojna (JSY) ▪ Upgrade PHCs to provide 24-hour delivery services ▪ Upgrade CHCs to be fully functional by 2010 ▪ Approve accreditation of private hospitals and compensate them for providing services to BPL families	the accessibility ▪ 120 PHCs converted to provide 24x7 services ▪ 23 CHCs identified for upgradation to Indian Public Health Standards, 10 CHCs upgraded ▪ 5 CHCs upgraded to be functional FRUs ▪ Skilled birth attendant training completed at state level ▪ Facility survey conducted ▪ Approximately 41,000 institutional deliveries performed through December 2007 under JSY ▪ Increase of 125.5% in outpatients and 19.2% in inpatients among various hospitals between 2001 and 2007 ▪ Healthcare delivered through mobile medical units in underserved blocks ▪ Mobile phones provided to ANMs for improved communication ▪ Medical care provided through telemedicine	➢ Impact of the distance to the health facilities on service access and use ➢ Quality of public health services and facilities ➢ Level and impact of out-of-pocket expenses for clients, especially BPL families ➢ Impact of new functionaries, such as ASHAs and link workers
REACHING REPLACEMENT-LEVEL FERTILITY TO ACHIEVE POPULATION STABILIZATION			
▪ Improve awareness among couples ▪ Implement BCC strategies ▪ Promote social and commercial marketing of contraceptives ▪ Increase outreach	▪ Train ANMs on clinic-based intrauterine contraceptive device (IUCD) insertion ▪ Organize integrated RCH camps ▪ Promote social marketing of contraceptives	▪ Awareness and behavior change through ASHAs ▪ Increased demand for family planning services through BCC campaign	➢ Availability of adequate supplies of reversible contraceptives ➢ Client preferences regarding spacing and limiting methods ➢ Level of male involvement in family planning

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
	▪ Provide clinic training for female and male sterilization services ▪ Train providers on emergency contraceptives ▪ Conduct BCC activities for males	▪ RCH services provided through camps ▪ No-scalpel vasectomy promoted ▪ Clinical training of MOs for female and male sterilization services ▪ CPR increased to 56% by 2005/06 (NFHS-3)	
URBAN HEALTH SYSTEMS: PRIMARY HEALTHCARE FOR URBAN SLUMS			
▪ Develop urban health systems		▪ 24 PNC centers (10 centers functioning at District Headquarters and remaining at Tehsil Headquarters) ▪ 12 tuberculosis hospitals and 2 sanatoriums ▪ 3 leprosy hospitals, 9 urban leprosy centers ▪ Infectious diseases hospitals ▪ 9 health posts under revamping scheme and 7 urban family welfare centers	➢ Access to and quality of services for the urban poor
DECENTRALIZATION			
▪ Build the capacity of elected representatives	▪ Prepare a comprehensive plan to build capacities of the PRI members ▪ Prepare district action plans	▪ Formation of village health and sanitation committees (VHSCs) ▪ Orientation of Pradhans ▪ District Health Action Plans formulated ▪ Annual NRHM PIPs developed ▪ Urban plans for Dehradun and Haridwar developed	➢ Functionality of VHSCs ➢ Role of PRIs in promoting and monitoring health programs ➢ Process undertaken to prepare district strategies and plans, including degree of participation and nature of issues considered in planning

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
CONVERGENCE WITH INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS)			
▪ Facilitate convergence of services with ICDS ▪ Train AWWs to promote maternal and child health services ▪ Organize regular meetings between ANMs and AWWs and foster linkages at all levels	▪ Foster convergence strategies with the Department of Women Empowerment and Child Development ▪ Improve district-level coordination and convergence ▪ Improve block- and village-level coordination	▪ Intersectoral convergence institutionalized with ICDS and PRI systems ▪ Village health and nutrition day organized jointly by both departments ▪ Joint working and coordination meetings at various levels organized ▪ Formation of VHSCs	➢ Lessons that can be learned from the coordination between the ICDS and health functionaries at the field level
INTEGRATION WITH OTHER SYSTEMS OF MEDICINE			
▪ Orient and train Ayurveda MOs ▪ Establish referral system between ayurvedic dispensaries and allopathic institutions ▪ Equip Ayurvedic institutions as depot holders for condoms, oral pills, and iron and folic acid (IFA) tablets		▪ AYUSH wings set up in 13 district hospitals ▪ PHCs/CHCs upgraded to provide AYUSH services ▪ Training and orientation of Ayurveda and Homoeopathic Officers in Clinical and Minimum Intervention Package of Healthcare Services ▪ Resource mapping of the existing infrastructure of 469 Ayurvedic and 71 homoeopathic facilities ▪ 26 CHCs selected for setting up AYUSH units	➢ Extent of and challenges to integration with other systems of medicine
HEALTHCARE FINANCING			
▪ Review and simplify the cost recovering measures and procedures on generating and	▪ Launch a community health insurance scheme	▪ Autonomy to 29 district and subdistrict hospitals through establishment of Chikitsa	➢ Adequacy of resource allocation ➢ Barriers to expending funds

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
expending funds ▪ Have institutions retain revenue ▪ Provide health insurance for poor people	▪ Provide cross-subsidies for BPL families	Prabandhan Samitis	➢ Barriers to clients using schemes to improve access to the poor
MEDICAL EDUCATION AND TRAINING			
▪ Set up two medical colleges and an Ayurvedic college ▪ Encourage private sector participation to set up training institutes ▪ Establish the State Institute of Health and Family Welfare ▪ Build linkages with the Indian Scientific Research Organization and Indira Gandhi National Open University for distance learning programs ▪ Evaluate trainings to strengthen medical education	▪ Reactivate training centers for ANMs, nurses, and MOs ▪ Revive the male health worker service	▪ Government Medical College in Srinagar is being set up ▪ Three ANM training centers renovated and operational ▪ Loan subsidy given to 26 MBBS students for higher education to build a skilled workforce ▪ State Institute of Health and Family Welfare being set up at Haldwani	➢ Adequacy of training infrastructure and programs for various classifications of staff ➢ Impact of training (or lack of training) on quality of service delivery
HEALTH INFORMATION SYSTEM			
▪ Strengthen the management information system (MIS) ▪ Train implementers to use the MIS	▪ Computerize the MIS ▪ Provide computers at PHCs and CHCs ▪ Train functionaries to fill formats ▪ Train district staff to use the computerized MIS system	▪ Health MIS being developed by Health System Development Project ▪ RCH-II software implemented (already in use in Gujarat by National Informatics Center; data entry by the respective districts in process)	➢ Degree to which data are collected and used in program planning and decisionmaking ➢ Impact of changes in the MIS formats ➢ Level of capacity building needed by various functionaries to engage in effective monitoring and reporting

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
SURVEILLANCE AND RESEARCH			
▪ Participate in the national surveillance network ▪ Conduct research to strengthen program planning and management ▪ Conduct research on Ayurveda in the private and public sectors	▪ Conduct maternal death audits ▪ Create a performance-based evaluation system	▪ Implementing the national integrated disease surveillance project ▪ Conducting maternal death audits	▪ Degree to which data are collected and used in program planning and decisionmaking
DRUG POLICY			
▪ Prepare the essential drugs list system to ensure transparent procurement of drugs and commodities	▪ Strengthen logistics management systems	▪ Drug purchase policy and essential medicines list developed to improve materials management	➢ Adequacy of procurement procedures for drugs and commodities ➢ Degree to which implementers or clients face stockouts of IFA tablets and oral contraceptive pills
GENDER SENSITIVITY AND EMPOWERMENT OF WOMEN			
▪ Reduce differentials in male and female literacy through school curriculum to promote values related to gender equality ▪ Form self-help groups and facilitate use of healthcare services	▪ Mainstream gender equity ▪ Sensitize providers to needs of women clients ▪ Encourage informed choice and the rights of the women to access health services	▪ Gender budgeting	➢ Socio-cultural and gender barriers to service access ➢ Experiences of female clients in accessing services
EQUITY			
▪ Ensure the provision of basic healthcare services—irrespective of caste, religion, economic class, or region ▪ Design special packages for improving the healthcare of disadvantaged groups	▪ Incorporate equity-related reporting in MIS ▪ Provide management incentives to provide equitable healthcare ▪ Create a state-level healthcare equity forum	▪ BPL health cards issued to the identified BPL families ▪ Reimbursement to hospitals for treatment of BPL patients ▪ Approximately 30 lakh rupees reimbursed to the hospitals ▪ State Illness Fund for BPL families,	➢ Level and impact of out-of-pocket expenses for clients, especially BPL families ➢ Quality of services ➢ Use of services by lower quintile wealth groups

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
	▪ Conduct training on gender and equity mainstreaming ▪ Investigate social and gender equity in health status and healthcare use ▪ Conduct a medical curriculum review ▪ Cross-subsidize user charges for BPL families at the healthcare institutions	as well as those afflicted by particular identified fatal diseases and accidents	➢ Ease in accessing benefits under special schemes for the poor
BEHAVIOR CHANGE COMMUNICATION			
▪ Design a state-specific communication strategy and communication package ▪ Support the Information, Education, and Communication (IEC) Bureau to implement an IEC strategy ▪ Train outreach workers on interpersonal skills and IEC materials	▪ Adapt the national BCC strategy to state-specific issues ▪ Conduct annual evaluation of the different campaigns ▪ Organize training programs for improving the interpersonal communication and counseling skills of health workers and medical professionals	▪ In process of finalizing an integrated BCC strategy comprising different national programs ▪ Mass media campaign launched at a state level to promote RCH services	➢ Adequacy of counseling training ➢ Level of awareness of health services among clients ➢ Main mechanisms through which clients receive information on available health services
ROLE OF PRIVATE SECTOR			
▪ Develop a comprehensive information base on private sector practitioners, clinics, and hospitals ▪ Establish mandatory registration of private hospitals and clinics ▪ Design regulatory mechanisms to improve quality standards of private medical units	▪ Pilot and scale up PPP models, such as the voucher scheme, contracting out, and health insurance ▪ Approve the accreditation of private facilities ▪ Build capacity and monitor activities ▪ Train private and public providers	▪ Voucher scheme piloted in two blocks of Haridwar where RCH services are provided to BPL families through a network of private providers ▪ 2,200 BPL pregnant women registered, 860 availed normal delivery package, and 158 cesarean deliveries conducted ▪ Subsidy provided to private	➢ Role of private providers ➢ Availability of private sector providers across districts ➢ Effectiveness of pilot programs and ability to scale up ➢ Facilitators and barriers to PPPs

Policy Intervention as per the Health and Population Policy	Strategies/Activities as Planned in the RCH-II PIP	Outputs/Outcomes of Policy Implementation	Areas for Further Exploration through the Policy Implementation Assessment
▪ Facilitate public-private partnerships (PPPs) ▪ Encourage private sector participation in setting up hospitals in secondary and tertiary sectors		providers to establish general clinics and specialist units in remote areas ▪ Draft PPP policy	
ROLE OF OTHER DEPARTMENTS			
▪ Improve collaboration between health and education departments to revitalize school health programs ▪ Revise school and college curricula to introduce family life education ▪ Coordinate among various departments	▪ Outline a convergence and coordination strategy with the departments of education, women and child development, rural development, and urban development ▪ Establish an Executive Committee at the state level, and district- and block-level coordination committees ▪ Launch school health programs for children ▪ Implement family life education through Nehru Yuva Kendra ▪ Organize a joint drive for increasing literacy	▪ School health programs in the primary schools conducted by ANMs ▪ Health cards provided to students with the help of the education department	➢ Degree to which common workplans and frameworks have been established
INVOLVEMENT OF CIVIL SOCIETY			
▪ Create a directory of NGOs that can be involved in health service delivery ▪ Create an NGO cell within the DOHFW to build partnerships ▪ Build the capacity of NGOs	▪ Involve NGOs in generating demand for RCH and family planning services ▪ Promote social franchising for increased availability of contraceptives ▪ Build capacity of AWWs and link workers	▪ Providing preventive and limited curative healthcare services through NGO involvement ▪ 38 field NGOs are working in 76 un-served and underserved subcenters in 10 districts	➢ Capacity and reach of NGOs ➢ Nature of partnerships with NGOs

SECTION 3: KEY FINDINGS

The assessment's findings are based on responses from key informant interviews with policymakers and state- and district-level implementers and service providers, as well as from FGDs with community-based workers, PRI representatives, and clients. The findings are consolidated around seven key dimensions of policy implementation. When relevant, this section includes programmatic recommendations based on the respondents' feedback. Overarching policy recommendations are presented in Section 4.

3.1 Relevance of the Policy, Its Formulation, and Dissemination

The starting point for a policy implementation assessment is, naturally, the policy itself. The policy's content, the formulation process, and the extent of its dissemination to different stakeholders and levels help determine whether the necessary groundwork is in place to support effective implementation.

Adequacy of Issues in the Policy

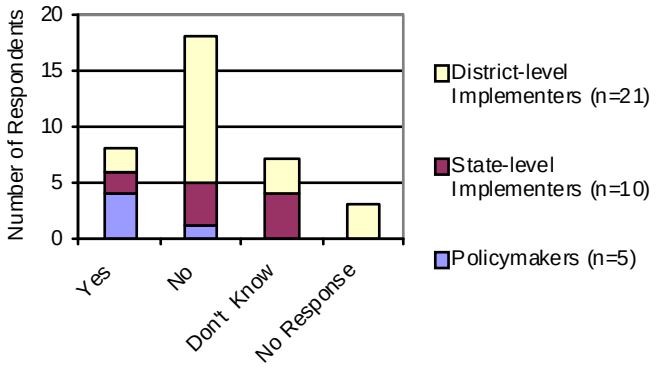
There was consensus among policymakers and implementers that the policy was relevant and comprehensive, covering most key health issues in the state at all levels. Almost all policymakers thought that issues of geriatrics and mental health are increasingly becoming important for the state and, even though the policy mentions them, these issues need specific interventions. An estimated 7 percent of the state's population is elderly, and it is imperative that specific need-based programs be developed. Discussions with community-level functionaries revealed that, in some districts, many of the elderly are left in ashrams to take care of themselves.

> **"The state Health and Population Policy is extremely comprehensive and has excellent guidelines for the state to refer to, for the next fifty years, as it minutely and scientifically looks into all issues faced by the state."**
>
> ***—Senior State Administrator***

Timeframe for Achieving the Policy Objectives

Regarding the timeframe, the opinions differed (see Figure 3). Most policymakers thought that the timeframe is sufficient for the state to achieve the desired targets. The implementers, who face on-the-ground issues, were less convinced that the targets are achievable within the specified timeframe. The state- and district-level implementers agreed that, even though the state is committed and determined to reach the objectives, the timeframe set for the policy may not be sufficient. Some of the reasons cited were a severe human resource crunch (in terms of number and capacity) and inaccessibility of certain areas. According to the implementers, the state has initiated several innovative schemes, such as appointing medical doctors on contractual basis, to overcome lack of resources. However, the state has not been able to fill crucial positions, which may create problems in achieving the state's goals.

Figure 3. Achievability of the Policy Goals in the Given Timeframe

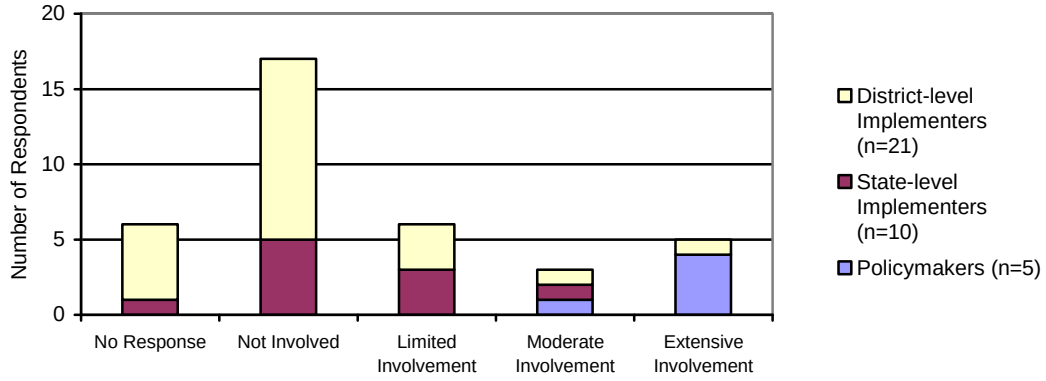


Stakeholder Involvement in Policy Formulation

Most policymakers reported extensive stakeholder involvement during the policy formulation process (see Figure 4). All the policymakers interviewed were part of the policy formulation consultations. Key

stakeholders involved included representatives from the DOHFW, Integrated Child Development Scheme (ICDS), Department of Education, Chief Medical Officers, NGOs, PRIs, and others.

Figure 4. Involvement of Various Stakeholders During the Process of Formulating the Policy



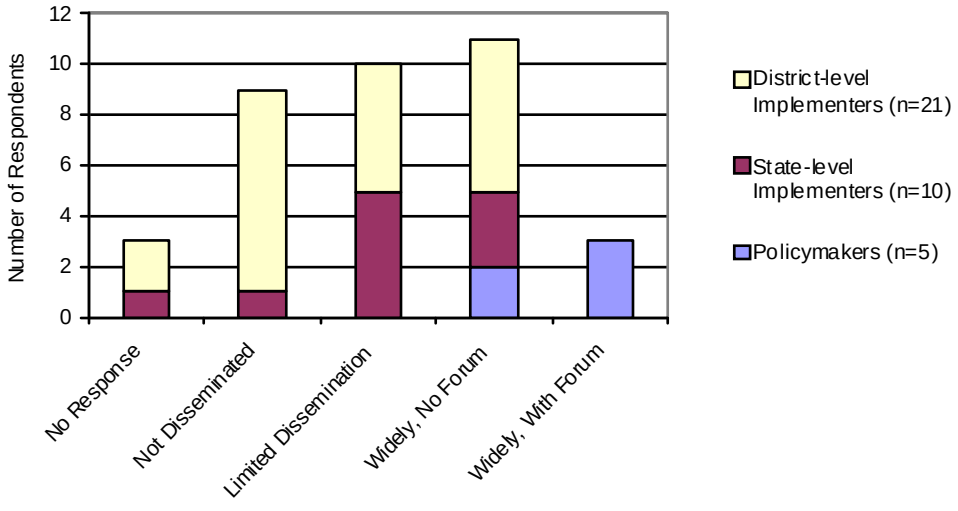
Policymakers and some state-level implementers remember the policy formulation process as highly informative and dialectic. High-level consultations were organized, and the state witnessed the convergence of many experts and specialists from across the country, who presented policies and best practices that could be adapted and incorporated into the state's policies. These consultations brought together program administrators, researchers and scholars, NGOs involved in mobilizing communities, and private sector representatives. This participation increased the ownership base for the policy among stakeholders from all sectors. According to senior-level state implementers, the policy formulation process was useful; it garnered information from various states, provided an exhaustive situational analysis for the state, identified key issues, and suggested policy intervention areas.

Assessing the involvement of district-level implementers was a challenge, as some of the interviewees at the district level were not in their current posts at the time of the policy's formulation. Among those who responded, most stated that the involvement of district-level implementers was limited.

Dissemination of the Policy

Key informants had mixed opinions regarding dissemination of the policy (see Figure 5). Though about one-third of the interview respondents said that the policy was widely disseminated, they thought this was limited to state-level dissemination. While the policy's launch was a highly visible public event and the Chief Minister, post-launch, released the policy, there was no dissemination plan to share the goals of the policy with

Figure 5. Extent of Policy Dissemination to Implementing Partners



the implementers and the end users of services. District-level implementers did report receiving the policy document and associated fliers. However, there were limited discussions on how to put the policy into practice. This finding was reiterated by district-level implementers in a later section of the assessment on implementation planning.

FGDs with the frontline workers—ANMs, AWWs, and ASHAs—revealed that few workers are aware of the policy, and those that are aware have limited recollection of the specific objectives. There has been no policy dissemination targeting the general public. However, the beneficiaries were aware of the programs and services provided in the health centers. Many clients reported being informed through television, newspapers, wall paintings, posters, and radio. Also, per the beneficiaries, since the appointment of ASHAs under the NRHM, considerable information about health services has been made available.

In summary, overall, the policy formulation process at the state level is seen as highly consultative and vibrant. However, differences in perception between people who make policies and plans and those who implement the same are evident. For effective program implementation, a two-way communication process is vital—one where the people who formulate the policies are aware of the ground realities and the people who implement the programs understand the bigger picture in which they operate. Even with regard to policy dissemination, most dissemination has taken place at the state level, while there is a paucity of the same at the district level, as also for the implementers. Unless frontline workers are made aware of the policies and the larger context in which programs are designed, bottom-up planning will not take place. The state should develop mechanisms and forums to promote more interaction among stakeholders at different levels.

3.2 Social, Political, and Economic Context

Policy implementation occurs within a certain social, political, and economic context, which can influence the implementation process. This section attempts to understand if and how these factors facilitate or impede implementation of the state *Health and Population Policy* in Uttarakhand.

Factors Hindering Policy Implementation

- **Socio-religious factors and gender relations impede policy implementation.** Respondents at the state, district, and community levels—including community-level functionaries and clients—reported improvements in the health-seeking behavior of the population. However, social norms and cultural practices still keep people from accessing health services. These social and cultural practices include delivering in cowsheds, keeping the baby in a dark room for religious reasons, and adopting breastfeeding practices that prevent mothers from providing colostrum to the infant or initiating breastfeeding within three days of childbirth. Socioeconomic realities, such as migration, have led to the phenomenon of women-headed households, which puts increased pressure on women, prevents them from taking rest during pregnancy, and deters seeking ANC. These practices were also reported back during the situational analysis undertaken as part of the state policy's formulation process, highlighting the need for more extensive outreach with communities at the ground level.

  According to the interviewees and FGD participants, religious factors also affect the uptake of immunization and family planning services among some populations. The NFHS-3 data support this perception. For example, only 43 percent of Muslim children are completely immunized, compared with 61 percent of Hindu children. The respondents noted resistance, especially in Haridwar District, among Muslims regarding immunization.

Community-level functionaries and clients reported health-seeking behavior changes such as increasingly going to private providers or government facilities. However, some clients, especially in rural areas and among those belonging to the lowest wealth quintile, prefer traditional healers due to cultural and logistic issues.

Gender norms, such as preference for male children, are prevalent across the state. Policymakers and implementers at the state level reported some misuse of the Prenatal Diagnostic Act.[3] According to respondents, the act needs to be strengthened by generating awareness among the public, implementers, and service providers on its intended use and ways to prevent abuse.

Caste is still a factor. Although communities belonging to the scheduled castes are increasingly accessing services, the rate is still low compared with the general population.

On the other hand, some respondents, especially state-level implementers, stated that the use of healthcare services is not affected by socio-cultural practices but rather a lack of information. There is a definite need to increase the awareness of and demand for services. Still, on the whole, the respondents perceive that health-seeking behavior is changing and people are increasingly visiting health facilities.

- **Frequent changes in government have a direct bearing on program implementation.** When government and political leaders change, department staff often change as well, which affects program implementation. Here again, there is a difference in perception between policymakers and implementers. On the one hand, policymakers reported that there is support among the politicians to take the policy forward and that health is a priority issue. On the other hand, implementers said that political leaders' stance toward the policy's implementation is usually neutral (neither for nor against) and that more proactive leadership is needed.

- **Poverty, unemployment, and migration are interlinked and hinder access to healthcare programs and services.** Uttarakhand has been experiencing a large-scale out-migration of men. Initially, most men migrated to join the armed forces. In recent years, they have started taking up employment in the private sector. For this reason, the hill economy is popularly called the "money order" economy due to remittances. In the absence of men, many households are headed by women, thus increasing their responsibilities and affecting their overall access to healthcare for themselves and their children. The state also experiences in-migration of people from Nepal and Bihar to work in the construction industry. Thus, there are populations who work in difficult and hazardous conditions and, as a result of the poor conditions and lack of health services, may become vulnerable to disease. Because they come from outside the state, in-migrants' awareness of and access to healthcare are limited.

Factors Facilitating Policy Implementation

- **Decentralization is seen as a facilitating factor for policy implementation.** Most interview respondents stated that decentralization under the NRHM has improved the quality of interventions. As part of the NRHM, the state has set up state health societies and district health societies, and funds have been transferred from the state to the societies. District-level planning is also complete, with district health action plans having been developed for all 13 districts. Primary

[3] The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, was enacted to check female feticide. The act prohibits determination and disclosure of the sex of the fetus. It also prohibits any advertisements related to prenatal determination of sex and prescribes punishment for its contravention. A person who contravenes the provisions of this act is punishable with imprisonment and a fine.

health centers (PHCs) and subcenters have been empowered through increased funding, greater autonomy over spending, and recruitment of district program managers.

However, the state-level implementers said that, even though powers have been delegated to the district level, there is limited initiative among district implementers to execute these powers and bring about changes. The perception of the district-level implementers is different; they noted numerous operational barriers, including lengthy procurement procedures and systems, as well as a lack of clarity on funding guidelines that prevents them from expending the available funds. At the community level, functionaries, such as the ANMs and PRI representatives, reported that although untied funds of Rs. 10,000 have been made available at the subcenter level, there is a lack of clarity on how these funds can be used. Thus, due to fear of audits, they do not spend the money, resulting in the funds being under-utilized.

In summary, although demand for health services is increasing, people face socio-cultural and economic barriers to access.

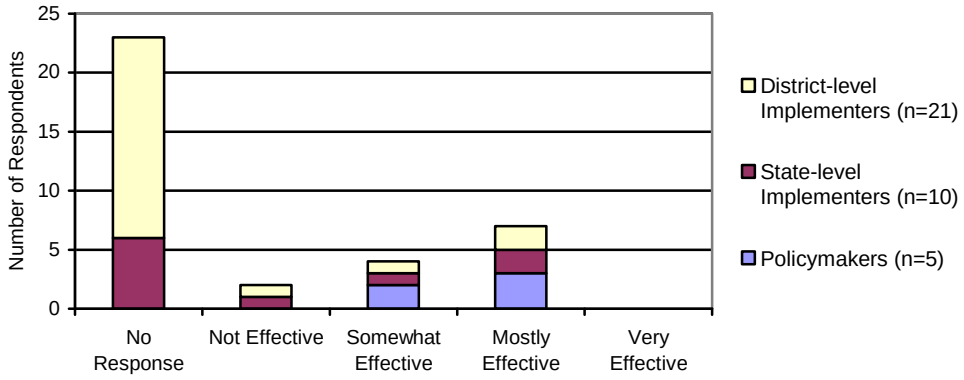
3.3 Leadership in Policy Implementation

This section discusses the level of leadership and commitment for policy implementation, which are essential to ensure the follow-through, resources, and accountability needed to put the policy into practice. It also looks at the involvement of opinion leaders and institutions, and how they support or hinder policy implementation.

The DOHFW is the lead agency responsible for the policy's implementation. The state, in its RCH-II PIP, detailed the institutional arrangements, roles, and responsibilities of all personnel at the state, divisional, and district levels. Respondents reported that this has facilitated clarity in understanding their scope of work. The response on the effectiveness of the institution's leadership was mixed (see Figure 6). Half the respondents at the state and district levels opted not to respond to the question on effectiveness of the institution's leadership in implementing the policy. The responses of the others ranged between somewhat effective to mostly effective. As one state-level implementer remarked, "During initial days, immediately following the formulation of the policy, there were discussions and feedback sessions in the directorate on program implementation. However, over a period of time, these discussions have become non-existent." Factors such as frequent changes in leadership positions[4] and other crucial positions and juggling of multiple roles have also affected the policy's implementation.

[4] It was reported that there are frequent changes in the position of Director General and, during the past few years, no Director General has stayed in office for more than 8–10 months.

Figure 6. Effectiveness of the Lead Institution in Implementing the Policy

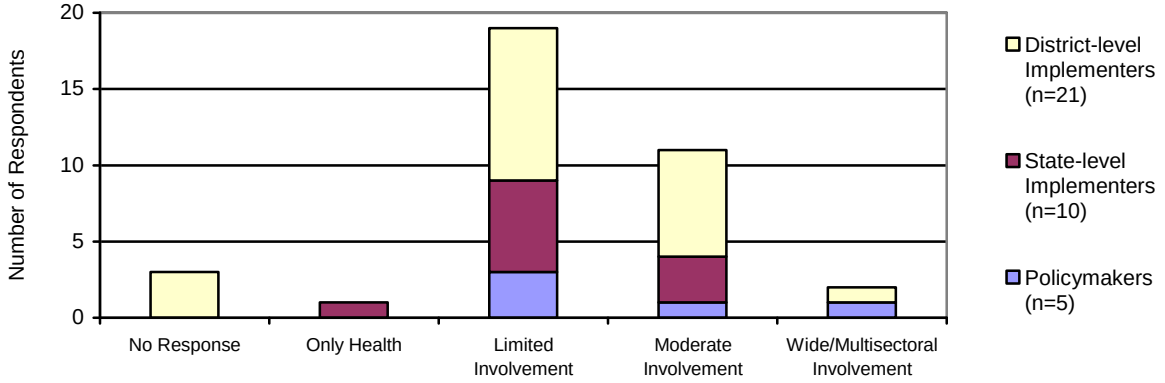


In Uttarakhand, political and religious leaders constitute the main opinion leaders. Most interview respondents said that political leaders support the policy and attend many of the related events but are occasionally critical of the implementation process. However, some respondents stated that policy implementation is not a priority for political parties; hence, there is no overt support or opposition from them. At the community level, frontline workers reported that some Pradhans provide leadership and facilitate mobilization for various health programs. Although religious beliefs were noted earlier as a barrier to the uptake of services, in some cases, religious leaders were reported to be involved in increasing service use, such as participation of Muslims in polio immunization.

3.4 Stakeholder Involvement in Implementation

This section focuses on stakeholders' engagement and participation in implementing the policy. The assessment sought to explore the involvement of other departments within the state government as well as nongovernmental stakeholders (see Figure 7). Some of the departments included the State AIDS Control Society, Department of Women Empowerment and Child Development, Department of Drinking Water/Total Sanitation Campaign, the Panchayati Raj Department, and the Department of Education.

Figure 7. Involvement of Various Government Departments in Policy Implementation



More than half of the respondents reported that the departments' involvement is limited or only includes the health sector. As one implementer put it, "It is transient integration and limited to participation in meetings. There is insufficient understanding on the objectives of the integration, and since priorities of the departments are different, no one owns the integration objectives."

"Despite a complete section devoted to 'integration with other systems of medicine,' in the policy document, nothing much has been done. The directions of the policy for AYUSH need to be fully implemented in letter and spirit."

—Senior State Administrator

Some respondents reported synergies between the ICDS and DOHFW due to common activities and planning and monitoring efforts. The synergies are particularly effective at the grassroots level. However, dissatisfaction was expressed on the pace of integration work between the directorate and the Department of Ayurveda, Unani, Sidha, and Homeopathy (AYUSH).

The opinions of district-level respondents varied, reporting limited to moderate department involvement. At the community level, the functionaries reported a good understanding of common activities, as well as collaboration with different departments of the government and NGOs to plan and organize village health and nutrition days.

Most respondents thought that there is limited involvement of nongovernment stakeholders, including NGOs, private providers, and medical colleges, among others. Initiatives to engage these stakeholders include providing subsidies to private doctors/agencies for establishing general clinics and specialist units in geographically inaccessible, difficult, and un-served areas. Additionally, the state has identified and contracted mother NGOs in each district; these umbrella groups provide technical support and monitor the implementation of other, smaller NGOs in the region. However, the involvement of NGOs is often limited to awareness generation and behavior change. An NGO representative stated that the directorate is not taking advantage of NGOs' presence in the difficult regions. At the implementer level, respondents recognized the outreach capacity of NGOs and their potential to help address human resource shortages. However, some respondents stated that NGOs need supervision and training to increase their capacity to implement the projects.

Overall, the operational plans have adhered to the policy guidelines for stakeholder involvement. The NRHM Annual PIP includes a dedicated section on intersectoral convergence, with specific time-bound activities. On the ground, the attempts have taken off; however, the full potential of these inter-linkages has not been realized. There is a need to build on the successes of convergence with ICDS, which as respondents reported, has led to effective coordination at the community level among ANMs, ASHAs, and AWWs in organizing village health and nutrition days.

Partnerships with NGOs have helped to generate the demand for and provision of basic curative services in some hard-to-access regions. These partnerships need to be strengthened by involving more and diverse NGOs in program implementation. Tapping into the potential presented by alliances with other departments requires more dialogue and, as stated by a state-level implementer, "A common vision needs to identified and implemented." It may be useful to institutionalize partnerships with departments and create opportunities and mechanisms to foster the participation of those groups benefiting from the actions at the state and regional levels.

The state is initiating public-private partnerships (PPPs) for improving access to high-quality reproductive health services and—with support from the USAID Innovations in Family Planning Services (IFPS) II Technical Assistance Project (ITAP)—is piloting models such as a voucher system and mobile health vans. The state is also strengthening the existing community-based health activities launched under the NRHM by involving NGOs and reaching the difficult terrains of hilly Uttarakhand.

A system is needed to collect end user feedback and solicit suggestions for improving the service delivery of various providers.

3.5 Implementation Planning and Resource Mobilization

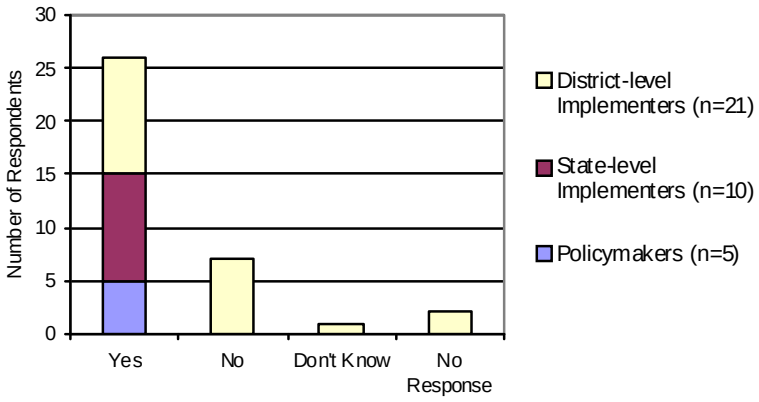
This section focuses on the planning, resources, and capacity necessary to facilitate policy implementation. Different facets of planning and resource mobilization were investigated, such as the new roles and responsibilities arising from the policy; the organizational changes required; the adequacy of capacity building for implementing the policy; the usefulness of guidance provided for implementation; and the quality and quantity of resources (e.g., human, infrastructure, equipment, information) available for implementation.

Planning

The state did not develop an operational plan for implementing the *Health and Population Policy* per se. The strategies and activities were detailed and implemented through the RCH-II PIP, and subsequently, the PIP and district health action plans formulated under the NRHM.

All policymakers and state-level implementers are aware of the existing implementation plans (see Figure 8). Each policymaker believes that the PIPs refer to the policy goals and outline specific strategies and activities, timelines, and roles and responsibilities. The PIPs thus provide a good reference for the implementers to execute health and population programs and monitor progress. The operational plans also mention specific strategies for the poor, such as issuing health cards that enable below poverty line (BPL) families to access free health services.

Figure 8. Number of Respondents Familiar with the PIPs and/or District Action Plans



Even though there is agreement on the relevance of the plans, some state implementers reported that they have not read the plans. At the district level, about half of the respondents were unaware of the PIPs and other strategy documents developed by the directorate. In cases where the respondents were aware of the PIPs, they report not often referring to them for implementation, which has a direct bearing on the achievement of desired goals. This points to a crucial gap, as implementers in the field might not have a clear understanding of the relevance of the larger context, principles, and priority goals of the state's health and population programs.

"We do not have a copy for the PIP and district action plans. It will help with the implementation, if we can get a copy."

—State-level Implementer

The state-level implementers corroborated this finding, saying that district- and block-level functionaries should take more ownership by being proactive during the planning process and suggesting strategies that can work in their areas. Although planning is a "bottom-top" process under the NRHM, according to state-level respondents, the level of initiative needs to be further raised through capacity building of the local implementers.

Respondents also reported that the mechanisms for inter-departmental information sharing and dissemination of plans and strategies are inadequate.[5] To address this issue, the state could organize forums to facilitate the review and monitoring process, as well as strengthen the implementers' overall understanding of the programs, strategies, inter-linkages, implementation processes, and their role in achieving outcomes. The state could draw on lessons learned from the National AIDS Control Program-III rollout. The rollout plan included standard operating procedures; operational guidelines for each component to ensure clarity and uniformity in implementation; intensive orientation; and induction exercises for personnel at national, state, and district levels.

Capacity Building

Implementers understand their roles and responsibilities. The state has conducted trainings for functionaries at different levels and has developed and included a training plan in all its plans (RCH-II/NRHM Annual Action Plan). The RCH-II PIP, for example, included an exhaustive list of 54 trainings related to maternal and child health, fertility, family planning, adolescent health, and other components. The majority of respondents reported participating in some kind of training. However, the state-level implementers thought the trainings were mostly effective, while the district-level implementers thought they were either ineffective or partially effective because of short timeframes, theoretical (as opposed to practical) curricula, and non-participatory methodology. The district-level implementers expressed the need for more support to build their managerial capacity for program implementation (see Table 6).

At the community level, ANMs reported that over the past few years, numerous trainings have been conducted on family planning, immunization, Direct Observation Treatment, Short Course (DOTS) for tuberculosis (TB), emergency contraceptives, and other topics. They were satisfied with the content and quality of the trainings. However, the ANMs stated that their formal training is outdated and they need to have refreshers to keep pace with the changing service delivery systems.

ASHAs, new recruits in the health worker cadre, reported being trained by the medical officers in-charge (MOICs) and ANMs at PHCs but are not completely satisfied with the information received. In villages where there are no health facilities, communities have started identifying ASHAs as service providers. ASHAs are asked to give advice on basic ailments and give medication. When accompanying a pregnant mother on the way to the hospital to have an institutional delivery, the ASHAs reported feeling apprehensive of mishaps. The mother's family views the ASHA as being solely responsible for the welfare of the mother, putting a lot of pressure on the ASHA. The health assistants would like to build their skills in the areas of community mobilization, management of basic ailments, and communication and interpersonal relations to encourage health-seeking behaviors in communities.

This assessment highlights the issue of capacity building—not only in technical terms but also in terms of the existing backlog in trainings, as the State Institute of Health and Family Welfare is not operational.

[5] A district-level chief medical officer reported not receiving the final copy of the District Action Plan from the directorate. A state-level implementer reported that he/she does not have access to the PIP.

TABLE 6. SELF-REPORTED CAPACITY-BUILDING NEEDS		
District-level Officials	**ANMs**	**ASHAs**
▪ Orientation on the integrated approach of the NRHM for clarity of roles and greater information ▪ Refreshers on communicable and non-communicable diseases ▪ Financial management ▪ Hospital management	▪ Management of complications during delivery and newborn care ▪ Insertion of IUCDs ▪ Use of reporting systems ▪ Management of untied funds	▪ Management of common ailments ▪ Community mobilization ▪ Communication and interpersonal skills

Program Example: Best Practices for Capacity Building

A good example for the state to refer to is the training provided under the ASHA Plus program. Uttarakhand has adopted the "ASHA worker" model, as enunciated in the NRHM, which is adapted to address the issue of difficult geographical terrain, scattered habitations, poor road connectivity, and poor access to transportation. The ASHA Plus program is implemented in the highly difficult blocks of Munsiyari and Munakot in Pithoragarh, Purola, and Bhatwari in Uttarkashi, and Karnaprayag and Joshimath in Chamoli. ASHA Plus, piloted under the USAID-funded ITAP Project, provides comprehensive capacity building to ASHA Plus workers. The training curriculum is based on GOI guidelines; however, the state program is unique in its methodology and additional components. It includes a life cycle approach and life skills education, uses a participatory approach, and provides materials and job aids to build the technical and communication skills of ASHAs. Feedback from the ASHA Plus workers and NGOs highlight the quality of training and improved skills in communication and social mobilization.

Budgets

Program funds flow from three main sources: central allocations under the NRHM, state allocations, and external aid allocations. District allocations are based on population characteristics. The state recently introduced performance-based budgeting; although it has not been fully operationalized, use of the available funds will be considered in allocation decisions. The state follows GOI guidelines to monitor the use of resources. Financial expenditures are discussed at monthly meetings with all the state- and district-level implementers. Physical monitoring has also been initiated, where state-level implementers visit the districts to verify and cross-check reported expenditures.

Respondents generally agree that the financial resources allocated for program implementation are sufficient. The state budget for health and family welfare has increased from 3.06 percent in 2002/03 to 5.42 percent in 2007/2008. The NRHM funds are routed to the Uttarakhand Health and Family Welfare Society and then to the district health societies. Through e-transfer facilities, the state has streamlined the system of transferring funds from the state to the district, enabling funds to reach the district level more quickly.

Expenditure and Use of Funds

According to most respondents, the biggest financial constraint in the state is the difficulty in accessing, disbursing, and expending already-sanctioned funds at different levels. Respondents agreed that use of the allotted funds for various activities has not occurred as planned. District-level implementers cited the following reasons:

- **Limited banking facilities.** Ensuring that funds reach the block level and end users is still a problem, as authorized banks are not available in remote and rural areas. Several Janani Suraksha Yojna beneficiaries also reported facing difficulty in opening bank accounts to avail the benefits, which may discourage people from using healthcare services. To ensure sufficiency of funds at the block level, it is recommended to have buffer money, so that payments are made on time and healthcare is not affected.
- **Limited financial management capacity of the managers.** Clinicians reported that they are medical service providers by training and lack the capacity for financial management, which is a barrier to expending funds.
- **Lack of clarity on the procurement procedures and inflexible procedures.** For example, for a remote block primary health center (BPHC), obtaining the required quotes for procurement is typically a challenge because there are few contractors working in the region, leading to delays in procurement. Another example is that, as per the guidelines, all payments to functionaries are to be made by check, yet this is a problem because, in remote areas, there are limited or non-existent banking facilities.
- **Budgetary restrictions within line items.** To cite an example, the transport allowance for an MOIC to take a monitoring trip is fixed at an insufficient amount, and there is no provision to adjust this amount within the overall budget in case of higher expenses. Such restrictions discourage managers from monitoring service delivery in the field.
- **Lack of supervision and support** to facilitate physical monitoring of financial expenditures.
- **Lengthy procedures.** Obtaining the required approvals can be an extensive exercise. Even "simple approvals" require signatures from five officials, which results in delays in work and expenditure. At the block level, in some cases, obtaining signatures from Pradhans takes a long time due to their unavailability.

NGOs supported by the directorate also reported delays in accessing funds, which were largely due to lengthy procedures, frequent changes in the officials whose permission is needed to gain access to funds, and the government's lack of faith in the NGOs.

At the subcenter, ANMs reported the under-utilization of untied funds. Reasons cited during the FGDs included lack of clarity on how the money can be expended; reluctance to spend due to fear of audits; and mistrust of Pradhans, who are joint signatories and, in some cases, expect a part of the fund for themselves. Several ANMs reported that this additional financial responsibility takes too much time away from patient care and there is always the fear surrounding whether the funds have been spent as per the guidelines.

Strengthening capacity in financial management at various levels is needed if the quality, reliability, and timeliness of expenditures are to be improved. Although the state has invested in planning and mobilizing resources and has allocated funds to improve the quality of healthcare, use of these funds is not optimum and needs to be streamlined and strengthened.

Sufficiency of Human Resources

Respondents at all levels agreed that the human resources are insufficient both in quantity and quality. There are large-scale vacancies in senior management positions as well as in service provider categories, including doctors, lady medical officers, lab technicians, and supervisory staff. This resource crunch affects overall program implementation in the state.

"A few years back there used to be 3–4 doctors at our PHC, now there is only 1, even though the workload has increased."

—Auxiliary Nurse Midwife

The shortage of skilled personnel directly affects the quality of service delivery. It was reported that in one district, there are only three lady medical officers despite the sanctioned number of 13. These doctors have to perform numerous sterilizations, which leads to tremendous pressure and, in the process, quality and time spent with patients may be compromised. The situation is similar in other districts as well.

Due to lack of adequate staff, existing personnel have multiple roles and duties. Medical officers are increasingly taking on management responsibilities. The lack of adequate management skills to plan, implement, and monitor programs—combined with inefficient systems, particularly management information systems—hampers information-based decisionmaking, which is essential for achieving policy and program objectives. Another issue cited was low staff motivation due to lack of implementation of human resource policies, which should cover performance appraisals, placement of staff, tenure, and job descriptions. As a block-level provider explained, "There are no opportunities for growth. You join as a medical officer and continue doing that for the rest of your life." The ANMs also stated that they have been working on the same issues, year after year, and there is no recognition of their work or any opportunity for advancement.

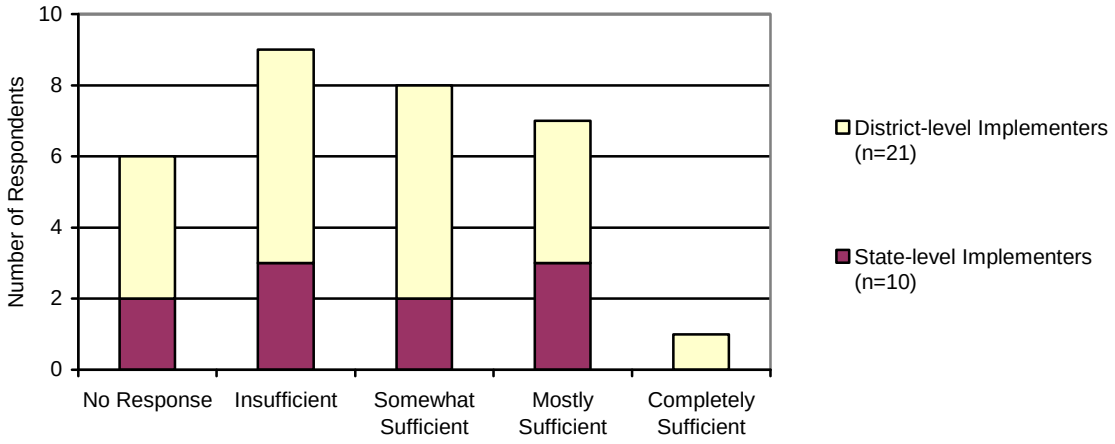
The state faces both a shortage of human resources and declining motivation levels of its overworked staff—both of which affect program implementation. With posts vacant, the workload increases on existing staff, causing burnout, low morale, and, ultimately, poorer quality services. While the state may have to work under the constraints of not being able to adhere to transfer guidelines, it can explore other options—such as motivational workshops, exposure visits, and a clear-cut mechanism for performance-based rewards—to build staff morale.

Sufficiency of Infrastructure

Most state- and district-level implementers said that the infrastructure and facilities are insufficient or somewhat sufficient and need to be strengthened to improve service delivery (see Figure 9). Due to its scattered populations, respondents reported that Uttarakhand needs more subcenters and PHCs, even above those already sanctioned by the government. In addition, the lack of accommodation for health personnel was cited as a barrier. The rapid assessment of first referral units (FRUs) and 24x7 facilities[6] shows gaps in infrastructure and facilities: more than 30 percent of the facilities have non-functional equipment in the operation theater and only 44 percent of district hospitals, 46 percent of community health centers (CHCs), 22 percent of BPHCs, and 17 percent of PHCs have functional equipment in the labor room. Other facilities, such as blood banks and storage units, are also limited in number. On a positive note, for the current year, the state has made a significant allocation to build new infrastructure and upgrade existing facilities. However, even with improved physical structures, the lack of human resources prevents the public health system from being fully functional (see Table 7).

[6] ITAP. 2007. *Rapid Assessment of the Functionality of First Referral Units and 24x7 Primary Health Centers in Uttarakhand*. Delhi: Futures Group India, ITAP.

Figure 9. Sufficiency of the Infrastructure (Quantity)



Note: Only implementers were asked this question.

TABLE 7. INFRASTRUCTURE AND HUMAN RESOURCE NEEDS

Description	Sanctioned	In Position	Shortfall
Subcenter	1294	1765	-
Primary Health Center	214	232	-
Community Health Center	53	49	4
Female ANM at Subcenters and PHCs	1997	1785	212
Health Worker (Male) and Multi-purpose Workers (Male) at subcenters	1765	656	1109
Health Assistant (Female)/Lady Health Visitors at PHCs	232	159	63
Health Assistant (Male) at PHCs	232	417	-
Doctor at PHCs	232	182	50
Obstetricians and Gynecologists at CHCs	49	37	12
Physicians at CHCs	49	4	45
Pediatricians at CHCs	49	21	28
Total Specialists at CHCs	196	79	117
Radiographers	49	30	19
Pharmacist	281	281	0
Laboratory Technicians	281	32	249
Nurse/Midwife	575	129	446

Source: Ministry of Health and Family Welfare, Government of India. 2007. *Reproductive Health Survey Bulletin, March 2007*. Delhi: Ministry of Health and Family Welfare, Government of India.

Equipment and Essential Drug Supplies

To ensure the availability of equipment and essential drugs, 60 percent of procurement is done at the state and district levels, while 40 percent is done by the chief medical officer based on local needs. The procurement procedure involves inviting tenders and arriving at a "rate contract" for goods and items, which are identified as common user items and are needed on recurring basis, such as medicines and contraceptives. The state-level procurement rates can also be used at the district level. Apart from the districts, the chief medical superintendents of the district hospitals, base hospitals, and combined hospitals purchase medicine/equipment for their respective hospitals. GOI supplies are also received at the state level and then sent to the districts.

District-level implementers reported that, in general, there is enough stock of essential drugs and medicines; however, some ANMs reported lack of iron and folic acid (IFA) tablets and oral contraceptives during the last few years. The end users, too, reported that only some medicines are available in health institutions; other medicines have to be purchased from outside the health facility, increasing the out-of-pocket expenditures of the end users. The assessment on functionality of FRUs and 24x7 services also confirmed that there are shortages of drugs and injections.

Monitoring Reports

A management information system (MIS) has been set up, although its computerization is in process. Field data are captured in monthly, quarterly, and annual reports. The central government provides these formats, which capture indicators for RCH. The state measures its progress against a set of key development, progress, and financial indicators. The implementers reported that physical monitoring is also done. Monthly meetings of functionaries are organized at various levels to track progress. However, district-level implementers reported receiving little feedback from the directorate on their reports. It will be vital to use the information to plan for future programs and not just track the progress of the programs.

While efforts to improve overall planning and resource mobilization for policy implementation have been adequate, additional areas require attention, including

- Soliciting inputs from the grassroots and local functionaries during planning;
- Improving clarity among managers and functionaries on resource use so as to increase the quality of healthcare delivery;
- Strengthening financial management capacity at district, block, and community levels;
- Establishing a system of rewards and incentives for good performance to build the morale and motivation of the existing workforce; and
- Ensuring effective use of the data for planning and resource allocation.

3.6 Operations and Services

This section assesses the capacity of and coordination among individuals and organizations charged with delivering services outlined in the policy. It also looks at the positive changes and challenges faced while delivering those services.

Inter-organization Coordination

The respondents shared that although the policy document and subsequent plans have outlined the rationale for coordination, such coordination is not often occurring. At the state level, there is limited understanding among the departments on how the work they undertake is interconnected and can be strengthened. It was reported that ensuring the participation of all representatives in meetings is also

difficult, because all departments are busy implementing their own programs. One bright spot is that the directorate and ICDS have integrated their activities to a large extent.

Challenges in Implementation

The implementers acknowledged numerous challenges, including external factors such as geographical access, poor transportation systems, and social and cultural practices. The following internal factors within the directorate were also cited:

- **Shortage of human resources.** This has been the biggest challenge for the state. Despite a number of strategies to tackle the problem, the situation has not been resolved. The shortages have affected program and service delivery. A key issue is increased workload on existing personnel, which affects the quality of services, leading to client dissatisfaction.
- **Unwillingness of the people to work in underserved areas** due to non-availability of infrastructure.
- **Low motivation of the service providers**, especially in the context of inadequate implementation of a human resource policy. There are no systems of incentives and rewards for good performance.
- **Politically driven transfers and postings**, leading to dissatisfaction among those providers who have been serving in underserved areas.
- **Poor infrastructure of subcenters and inadequate availability of accommodation** for ANMs and doctors, discouraging health providers from taking postings in the remote and difficult-to-reach areas, thus leaving many posts vacant.
- **Programs guided by the center and then by the state, leaving little flexibility for implementers.** There is no culture of seeking clarification on how programs are designed. The implementation is mostly top-down.
- **Inadequate system of information flow** to ensure that functionaries and stakeholders involved in implementation are aware of the programs and schemes.

3.7 Feedback on Progress and Results

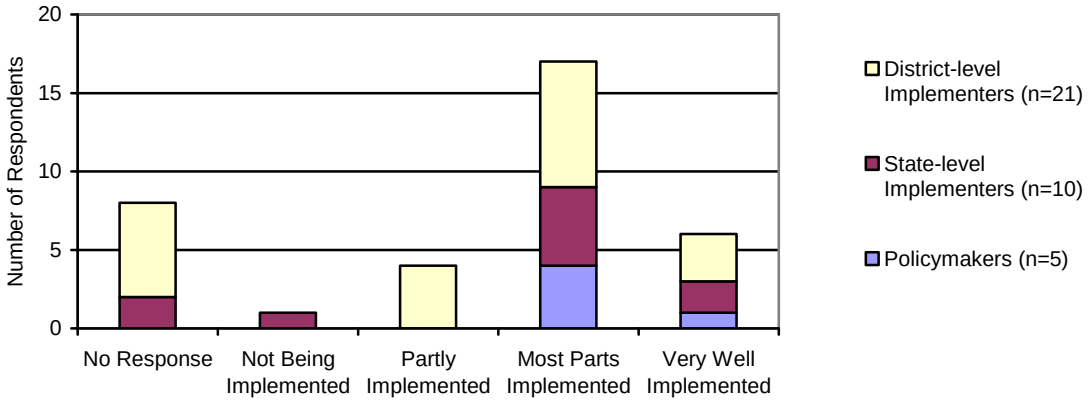
The DOHFW is the nodal agency responsible for monitoring the policy's implementation and related programs. The agency generates monthly progress reports, which also serve to inform the objectives of the NRHM. Senior officials also have monthly meetings with all the district-level chief medical officers. Achievement of the targets set under various programs is monitored; however, the feedback is more verbal in nature, specifically when comparisons are made between districts in monthly meetings. There are no dedicated institutional arrangements at the managerial levels to analyze the information received and provide feedback to implementers. Implementers noted that reporting procedures are cumbersome, with significant staff time devoted to preparing various forms. The Uttarakhand Health Systems Development Project is developing a health MIS, which could help to streamline monitoring and evaluation processes in the future.

At the field level, to improve monitoring and provide feedback to implementers and service providers, more resources are needed for monitoring and, further, specific strategies need to be drawn from among the different departments to improve physical monitoring and feedback into the programs.

3.8 Overall Assessment

The overall assessment responses were mixed (see Figure 10). Most respondents stated that many parts of the policy are being implemented. However, some policymakers were critical of the state implementers and asserted that the state needs to be more proactive in strategizing its own programs and not simply following what is being provided by the central government.

Figure 10. Overall Assessment of How Well the Policy Is Being Implemented



According to respondents, some positive outcomes of policy implementation are an improvement in the state health indicators; eradication of leprosy; an increase in complete immunization; and increases in CPR, ANC/PNC, and institutional deliveries. The number of people accessing out-patient departments has also increased.[7] Healthcare services have also begun to improve through the introduction of pilot programs.

At the community level, with the outreach of functionaries, FGD participants noted a shift in people's health-seeking behavior. People prefer to go to the health facility to access healthcare; ANMs and ASHAs are in regular contact with the people, spreading awareness about the services. The areas that need to be addressed are human resource shortages, gaps in urban healthcare services, lack of adolescent health programs, and lack of capacity among the existing functionaries.

3.9 End User Feedback on Health Service Access and Quality

In reviewing the state *Health and Population Policy*, it is important to gauge end users' perception of the level of access to and quality of healthcare services, especially the perceptions of marginalized populations, such as SCs/STs, women, children, and the poor. The policy and the plans have included strategies for everyone but specifically for these groups. The perspectives summarized below are drawn from 16 FGDs conducted with women and men from rural/urban areas, as well as SC and BPL groups.

The demand for healthcare services has increased. End users feel that the awareness programs have generated increased demand for healthcare facilities and services. Some main channels of communication have been radio, newspapers, and television. Recently, ASHAs have become an important source of information for people in villages. This increase in demand has increased the volume of people who visit public health facilities. Communities appreciate the ASHAs for mobilizing people, especially in

[7] This sentiment is supported by the *Financial Expenditure Report of Uttarakhand 2007–2008,* which shows an increase of 126 percent in outpatients and 19 percent in in-patients among various hospitals from 2001–2007.

blocks where the ASHA Plus program is being implemented through NGOs. According to clients, continuous outreach by ASHAs, ANMs, and AWWs has increased awareness on issues such as immunization and ANC, leading to more people availing these services.

Interestingly, respondents from the urban slums of Haridwar reported not having enough information and awareness about the existing health services being provided by the government. The main reason cited is fewer visits made by ANMs and ASHAs in the community. The group also stated that ANM and ASHA motivation in the hills is higher than in plains, where the visits are once a month or less. The respondents also suggested that the awareness of health issues is limited in the plains due to higher illiteracy levels. The NFHS-3 findings corroborate this statement by showing that compared with hill districts, which have higher literacy rates, districts such as Haridwar have weak health indicators.

Connectivity and lack of transport limit access to healthcare. End users in the upper Himalayas shared that poor availability of road transport and connectivity are barriers in accessing healthcare services, which also includes pregnancy-related healthcare. Even though the number of institutional deliveries is increasing in the state, respondents shared that women, especially from rural areas in the upper Himalayas, are attended to by friends/relatives or untrained *dais* and they deliver at home. According to NFHS-3 data, 74 percent of the deliveries in rural areas take place in homes, with the majority being assisted by traditional birth attendants, friends, and family. Transport and distance were cited as major barriers during discussions.

Some respondents, however, were happy about the performance of the emergency hotline response services initiated by the government. They shared that services like these are very good for people living in difficult areas.

Poverty is a barrier for accessing health services. Respondents in both urban and rural areas reported that poverty is a key barrier for people seeking healthcare services. Daily laborers from Gadinegi, Jaspur, said health does not figure on their list of priorities. They also cannot comment on the quality of services, as they do not even have the money to use them. Going to a health facility is the last option and is not exercised unless absolutely necessary. BPL respondents from Chaukutiya districts said that many extremely poor families are not listed under the BPL category and, hence, are not eligible for the special government-initiated schemes. For those who have the BPL cards, they often are not able to get services when required due to lack of information on where or how to avail these services.

The time cost to access healthcare services is high. Respondents from the plains in Haridwar reported that they spend, on average, 4–5 hours in the health facility to obtain any services, which leads to loss in income. In the hills, this time cost ranges from a few hours to a few days, depending on the distance of the village from the facility.

"Only in case of emergencies do we take the person to Dehradun because there are no facilities available in public hospitals in Uttarkashi, but this takes 2–3 days."

—Male respondent from rural block in Uttarkashi

"The behavior of doctors including other hospital staff is not good. They behave indifferently and don't speak to us properly."

—Male respondent from US Nagar

Inadequate quality of services. The FGD participants feel that the facilities are not well-maintained, there is inadequate provision of toilets and drinking water, and the behavior of the doctors and the support staff is not affable. Numerous women cited the behavior of the providers as a major reason for not accessing ANC and not preferring institutional deliveries. Many women reported that they do not go for ANC checkups for fear of being scolded and ridiculed by the providers. There is little

interaction and conversation during the consultation and beneficiaries feel dissatisfied with the lack of information provided on their ailments. Clients from the upper Himalayas noted a lack of doctors available in the PHCs; as a result, pharmacists and ANMs become the medicine dispensers and give medicine based on their experience, without consultations.

Out-of-pocket expenditure on medicine is high. The expenditure on medicines and other diagnostics is high and the availability of these services is not guaranteed, even in district hospitals. Some basic medicines are available at the pharmacy, but most drugs have to be purchased by the clients. The clients reported that even in district hospitals, advanced diagnostics and tests, such as ultra-sound and X-rays, are not available and they have to pay for them. The FGD findings are supported by those of the rapid assessment on the functionality of FRUs and 24x7 services; undertaken by the state, the findings indicated a lack of sufficient drugs and supplies in the surveyed facilities.

"For getting the delivery by my daughter-in law done in a hospital, I had to spend Rs. 1,800, most of which I spent on transport, food, and medicines for her in the hospitals. From where can poor people afford such kind of money for deliveries? That is why most women prefer to deliver at home."

—Female respondent from Uttarkashi

Respondents belonging to SC and BPL groups said that even though consultations are free, the cost in terms of time, medicines, tests, and other expenses are unaffordable.

The respondents stated that, on several occasions, government doctors asked them to come to their private clinics for consultations, and those who get services there are provided better quality consultations.

Clients in urban areas have the option of going to private providers, whereas rural clients have only the public health system. The type of provider clients sought for treatment varies by region. In the upper and mid-Himalayas, there is almost a total dependence on the public sector. However, in the plains, men and women from the districts of Hardwar and Dehradun also go to the private sector. This is primarily because of the concentration of private providers in urban areas compared with rural areas, where there are few private providers.

Outreach services by ANMs are limited in the upper Himalayas. Respondents noted that due to difficult terrain, ANM field visits are infrequent—which limits outreach, especially for immunization and maternal health services. Also, the recruitment of ASHAs is viewed to have further reduced the frequency of ANM field work.

SECTION 4: RECOMMENDATIONS FOR STRENGTHENING IMPLEMENTATION

The *Health and Population Policy*, formulated in 2002, deals with a wide range of health issues and recommended strategic approaches to achieve stated objectives in a stipulated time period. The DOHFW has implemented several policy recommendations and achieved significant results, particularly in improving health outcomes (as is evident from the NFHS-3 survey results). While these achievements are laudable, several issues still must be addressed. In addition, the introduction of the RCH-II program and the NRHM in 2005 has resulted in major shifts in program priorities and the availability of flexible resources. These changes necessitate reviewing the policy's objectives, adding and modifying strategic approaches, assessing implementation mechanisms, and suggesting appropriate measures to improve effectiveness.

4.1 Recommendations from the Assessment

The following key actions would help to address some of the policy concerns and strengthen program implementation mechanisms to achieve the policy objectives.

Decentralized Planning

Uttarakhand is one of the first states to introduce decentralized district action plans covering all 13 districts. These plans have been integrated to create the State Program Implementation Plan for RCH and the NRHM. The bottom-up approach has improved program ownership and made the plans more relevant to local needs. A step further in this direction would be to introduce the concept of micro-planning at the village and block levels. For instance, the ASHA Plus pilot, introduced in three districts of the state, includes eco-mapping exercises that are helpful for micro-planning. Linking villages and blocks with district- and state-level planning is vital for the success of decentralized planning. Such a planning process ensures the involvement of elected representatives and other community stakeholders and provides clear guidance to grassroots workers.

Integrated Approaches

Several communicable disease programs and the reproductive health program are implemented as vertical programs. The NRHM's strategic vision for integrating and better coordinating efforts has not yet taken concrete shape at different levels. Each vertical program has implemented innovative approaches, such as the DOTS for tuberculosis; involvement of the private sector in blindness control; and the use of community health volunteers and ASHAs under the NRHM. There is a lot to learn from the successes of each program that could be integrated into other areas. For example, ASHAs could serve as DOTS supporters, as well as adopt the direct observation approach at the household level to ensure uptake of IFA tablets by pregnant women. Integration and convergence of programs promotes synergy, helps conserve resources, and facilitates the achievement of objectives. Similarly, better coordinated approaches among social development departments, such as health, ICDS, and primary and secondary education, are required. Uttarakhand has introduced joint review meetings between health and ICDS functionaries at different levels. This is a step in the right direction, but coordination efforts should be further strengthened and expanded to support convergence and involve additional departments.

Financial Guidelines and Systems

The financial resources for health programs are not being utilized because of a lack of clear guidelines. Field managers are apprehensive of audits and thus do not use the available funds. An important recommendation is to prepare guidelines on all the funding mechanisms available to an institution and to train the managers of these funds on how they can spend the money, maintain accounts, and, in general,

be accountable for the funds. Once there is clarity on resource use, confidence levels will rise and the proportion of money spent will increase.

Infrastructure Development

Uttarakhand has made major strides in constructing new health units and renovating old health centers with funds from the Health Systems Development Project. However, many additional health units require similar attention. In some cases, there has been no link between resource allocation and what health units actually need in terms of resources. Inefficient use of financial resources has often created new problems rather than solved the existing ones. Uttarakhand has developed an approach to overcome this issue—surveying selected health facilities; identifying gaps in equipment, utilities, and physical infrastructure; and preparing budget estimates based on the requirements of each health unit. This approach identifies the financial resource requirements for each surveyed institution and helps to ensure appropriate allocation and use of resources. If expanded to include additional facilities, this approach would help address infrastructure deficiencies.

Human Resource Planning and Development

Uttarakhand is facing a severe shortage of medical professionals, including generalists, specialists, and particular categories of paramedical staff. Organizing district-level walk-in interview days for medical officer positions has led to speedier recruitment and appointment of staff on a contractual basis and has helped to fill some positions. However, retention of such staff is low. Because government pay structures are not on par with private health units, job seekers do not prefer the public sector. Uttarakhand government health units cannot provide high-quality health services without an adequate number of qualified providers. Therefore, Uttarakhand has to prepare a clear strategy on how it is going to tackle the situation. One immediate action is to do a health human resources planning exercise for the next two decades—identifying the number of medical and paramedical personnel required for both the government and private sectors in the state; the number graduating from the existing institutions (e.g., medical colleges, nursing schools); and ways to bridge the gaps. This is a long-term strategy that must be complemented by short-term strategies.

Public-Private Partnerships

Given the serious human resource constraints, PPP mechanisms have become more attractive. The RCH-II strategy emphasizes the need for PPPs to help achieve program objectives. Uttarakhand has already implemented several PPP mechanisms, such as mobile health vans, a voucher system, NGO involvement, and "contracting in" private sector staff to provide selected non-clinical services in the public health facilities. The state should finalize a PPP policy to clearly spell out objectives, identify suitable PPP mechanisms, and establish an appropriate contractual and regulatory framework for effective partnerships. Because of Uttarakhand's geographic division between hills and plains, there is no possibility of a uniform application of PPP mechanisms for all regions in the state. For instance, there is barely any private health sector presence in the hilly regions. Identifying and mapping local partner resources before prescribing partnership mechanisms are essential to promote relevant and workable partnerships.

4.2 Additional Recommendations from Stakeholder Discussions

On November 19, 2008, the Health Policy Initiative—in collaboration with the Government of Uttarakhand, USAID/India, and the USAID-funded ITAP[2] Project—organized a high-level policy dialogue event in Dehradun. More than 50 participants attended the workshop on "Policy, Innovations, and Experiences in Uttarakhand,"[3] including government officials, NGOs supervising the ASHA projects, donors, and civil society and private sector partners. The workshop provided an opportunity to review the state's health indicators; learn from innovative programs in the state; present and discuss the key findings

of the policy implementation assessment; and renew commitment to health sector reforms and innovations. Additional recommendations that emerged from the discussions included the following:

- **"Contracting out" of health institutions to the private sector.** Lack of health personnel is one of the biggest problems facing the state. The neighboring state of Uttar Pradesh is undertaking initiatives to "contract out" health institutions to the private sector, which could provide models that can be adapted in Uttarakhand.

- **Redeploying human resources to ensure optimal and judicious use of public and private sector providers.** Currently, most medical professionals are concentrated in the plains, where there is a greater demand for private doctors, leading to under-utilization of public health sector services. Concurrently, in the hills area, public and private sector service providers are scarce. The aforementioned human resources planning exercise could shed light on how to equitably redeploy the state's health professionals.

- **Addressing infant mortality.** Over the past three years, infant mortality in Uttarakhand has increased marginally in contrast to the declining trend witnessed previously. This is a cause for concern. The reasons could be many, and the recent findings from the infant death audit will help to discern causes and design interventions. Based on NFHS data, it is clear that the infant mortality rate is highly correlated with short intervals between births and early marriages. Adolescent health education of both married and unmarried young people would highlight the importance of delaying the first birth and ensuring proper birth spacing. This effort has to be further strengthened by renewed rigor in promoting modern spacing methods. For example, the intrauterine contraceptive device 380-A could be positioned as both a spacing and limiting method. Promotion of injectables is another option that should be explored.

- **Expanding strategies to increase equity and improve the overall health status of the poor.** The NFHS-3 findings reveal weak health indicators among people in the lowest two quintiles. Uttarakhand needs to strengthen its existing strategy for equity so more poor people have access to family planning and other health services. The pilot Universal Health Insurance Scheme is one such program that can benefit the poor and should be expanded across the state.

- **Evaluating and scaling up innovations.** As noted above, the state has undertaken a series of pilot projects to address equity, geographic access, and quality issues. The next step is to evaluate the innovations to identify those that have and have not worked. Based on the evaluations, the state can formulate scale-up plans for effective pilot projects.

Program Example: Addressing Equity

The Government of Uttarakhand, with technical support from the USAID-funded ITAP Project, is piloting a voucher system in two rural blocks of Haridwar. Through vouchers, BPL families are provided ANC, delivery, postnatal care, and neonatal and family welfare services through accredited private facilities. The scheme has increased use of ANC, PNC, institutional delivery, and neonatal health services among BPL families. The state plans to scale up the scheme to four districts.

Other recommendations included encouraging demand and health-seeking behavior among communities through large-scale information, education, and communication and school-based programs; bolstering confidence in and reliability of public health institutions; partnering with NGOs to

provide healthcare services in remote areas; and fostering staff motivation by establishing a system of performance-based rewards.

4.3 Conclusion and Next Steps

Uttarakhand's *Health and Population Policy* forms the foundation of the state's health programs. State implementers used the policy as the underlying framework to develop operational plans for RCH-II and the NRHM. The state policy has provided consistency in terms of program directions in an ever-changing political and operational environment. The *Health and Population Policy* is relevant and vital in the present context for the state of Uttarakhand. While the NRHM, as an umbrella initiative, covers a range of health issues, such as RCH issues and infectious diseases, there are areas—such as mental health, lifestyle diseases, and geriatrics—that are emerging health concerns for the state. A policy framework is necessary to ensure that current and emerging health issues are regularly identified and addressed using a strategic approach.

The assessment of Uttarakhand's *Health and Population Policy* reinforced high-level commitment to the policy's goals, facilitated dialogue on challenges and emerging issues, and explored potential next steps to ensure that the policy is put into practice to improve the health status of the state's population. Stakeholders reiterated the benefits of updating the *Health and Population Policy* in response to the introduction of the RCH-II and NRHM programs. As a result, the Health Policy Initiative will provide technical assistance to the government and other stakeholders to update the policy based on findings from this assessment, the latest health data and situational analysis, and lessons learned from innovative pilot programs. A key component of this effort will be to establish regular policy monitoring mechanisms to identify and address barriers to achieving the policy goals.

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