



INFORMING EQUITABLE HEALTH POLICY REFORM:

Policy Implementation Assessment Inspires Action in Uttarakhand, India

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The state of Uttarakhand is a pioneer in health policy development in India. Early in the new state's history, in 2002, the government formulated an integrated Health and Population Policy. To do so, the state carried out a participatory process that engaged various stakeholders to review health indicators, explore best practices, and debate proposed strategies. Representatives from diverse sectors commented on the draft policy, which went through several iterations to consider different viewpoints and observations. The National Planning Commission lauded the integrated policy that emerged from this participatory process as a model for other states to emulate.

This case study documents how Uttarakhand again took a pioneering step—by revisiting the policy to assess its implementation and take further policy action to fortify strengths and address barriers. As a result, the government appointed the Uttarakhand Health and Family Welfare Society to oversee the drafting of an addendum to the policy. The addendum outlines new goals through 2017, aligns the policy with programs and guidelines developed since the policy's adoption, and provides guidance to promote more equitable health services. Key concerns in the addendum are reducing disparities found between Uttarakhand's plains and hills districts, as well as improving health service access and use for women, children, the poor, and other underserved and vulnerable populations. The Principal Secretary for Medical Health and Family Welfare and the Cabinet are currently reviewing the addendum for final approval.

BACKGROUND

In 2000, Uttarakhand became India's 27th state, formed from the northern districts of Uttar Pradesh. Two years later, Uttarakhand became the first state to adopt an integrated *Health and Population Policy*, recognizing that small, planned families are integral to improving the health status of the population—especially women and children—and vice versa. The policy specified objectives to reach by 2010, including achieving replacement-level fertility (2.1 children per woman); increasing modern contraceptive prevalence to 55 percent; reducing the maternal and infant mortality rates; and reducing mortality due to malaria, tuberculosis, and other diseases. To achieve its goals, the policy outlined interventions related to training, service delivery and quality, drug availability, empowerment of women, equity, the private sector, planning and financing, and other concerns.

The government of Uttarakhand has worked to put the policy into practice, for example, by expanding services under the central government's Reproductive and Child Health (RCH) II Program and the National Rural Health Mission (NRHM), both launched in 2005. Further, all districts have created district action plans to better coordinate local health services. The state has also carried out several innovative pilot approaches to implement the state policy, including public-private partnerships (PPPs) and recruitment measures to fill human resource shortages in remote areas. The central programs, as well as innovative initiatives in Uttarakhand, have brought about new strategic thrust areas, especially greater emphasis on decentralization and local autonomy, integration across health programs and government departments, involvement of local elected leaders and community-level partners, and new service delivery models.

In 2008, with two years remaining to achieve the state policy goals (2010) and four years for the NRHM (2012), in-state stakeholders recognized the value of assessing the implementation of the *Health and Population Policy*. This endeavor aimed to explore the nature of policy implementation; identify facilitators and barriers to effective implementation; and catalyze policy dialogue on ways to promote further progress. Stakeholders were also interested in assessing the policy as it relates to the centrally-supported, comprehensive NRHM program.

PARTICIPATORY, EVIDENCE-BASED POLICY REFORM APPROACH

The USAID | Health Policy Initiative, Task Order 1, helped the Directorate of Health and Family Welfare (DoHFW) to assess policy implementation, facilitate policy dialogue, and analyze evidence to prepare an addendum to address key opportunities and challenges identified through the process. To design the original policy, the state—with support from the USAID-funded POLICY Project¹—had engaged various stakeholders to review health indicators, explore best practices, and debate proposed strategies. Representatives from diverse sectors commented on the draft policy, which went through several iterations to consider different viewpoints and observations. Building on this tradition, the DoHFW was again interested in considering various inputs, from health indicators to implementers' and clients' perspectives. In response, four major components were undertaken:

- **Situation analysis** of health and demographic indicators based on the latest available data.
- **Policy review and implementation assessment**, which involved applying the Policy Implementation Assessment Tool to gather input from more than 400 participants across levels (state, district, community) to identify facilitators and barriers to achieving the policy's goals.
- **High-level policy dialogue** to share findings from the situation analysis and policy implementation

TABLE 1. INDICATORS AND GOALS FOR UTTARAKHAND

	1998-99 NFHS-2	2005-06 NFHS-3	2010 GOAL*
Total fertility rate	2.61	2.55	2.1
Modern contraceptive use	40	56	55
Unmet FP need	21	11	N/A
Antenatal care (three or more visits) (%)	20	45	N/A
Institutional deliveries (%)	21	36	59
Births assisted by trained personnel** (%)	35	42	74
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, auxiliary nurse midwives, and other healthcare providers

N/A = not available

¹ The POLICY Project (2000–2006) is the predecessor to the USAID | Health Policy Initiative, Task Order 1.

assessment, review results of innovative state programs, and foster consensus on next steps.

- **Preparation of an addendum to the policy** to fortify strengths in the policy, alleviate barriers to full implementation of the policy, provide additional policy guidance on new thrust areas and service delivery mechanisms, and address emerging priority health issues.

HEALTH SITUATION IN UTTARAKHAND

When the original policy was written in 2002, Uttarakhand-specific data were limited because the state's districts had been subsumed within the parent state of Uttar Pradesh. Recent surveys—such as the 2005-06 National Family Health Survey (NFHS-3), 2007-08 District Level Household Survey (DLHS-3), and Sample Registration System (SRS)—and other special studies provide new state-specific data to inform decisionmaking in Uttarakhand. Thus, the Health Policy Initiative assisted in conducting secondary data analyses of existing data to assess progress toward achieving health goals. Moreover, a key concern at this stage was to determine any inequalities in health indicators, especially by region, gender, and socioeconomic status.

Highlights of the situation analysis are described below.

Some health indicators are moving in the desired direction.

According to the NFHS, between 1998-99 and 2005-06, the total fertility rate declined slightly (2.61 to 2.55) and contraceptive prevalence (modern methods) increased (40% to 56%) (see Table 1). Further, the percentage of pregnant women receiving at least three antenatal care (ANC) visits more than doubled. And, in 2005-06, about three of five children (ages 12–23 months) were fully immunized.

Yet, there is still much room for improvement.

For example, the infant mortality rate (per 1,000 live births) increased slightly from 42 to 44 (SRS, 2004-08). In 2005-06, only about one-third of deliveries took place in an institutional setting and nearly three of five births were *not* assisted by trained professionals.

There are wide disparities in health status and service access

between the wealthiest and poorest, urban and rural populations, and for scheduled castes and tribes (SCs/STs). For example, according to NFHS-3, child mortality is more than twice as high in rural areas than urban areas. Women from the lowest wealth quintile are less likely to use contraceptives (45%) than

those from the highest quintile (68%). Overall, rural women are about half as likely (36%) to receive at least three ANC visits as their urban counterparts (71%). However, a closer look at the data shows that the urban poor are less likely than the rural poor to receive an ANC checkup (33% vs. 53%, respectively). These indicators reinforce the urgency of meeting the health needs of underserved populations, in both rural areas and urban slums.

POLICY IMPLEMENTATION ASSESSMENT

Complementing quantitative indicators with qualitative information about the process and nature of policy implementation can help stakeholders to identify strengths, weaknesses, facilitating factors, and barriers to current approaches and make adjustments to help ensure further progress. Thus, the state government, with technical assistance from the Health Policy Initiative, formed a core team to plan and oversee application of the Policy Implementation Assessment Tool, which explores seven dimensions that influence policy implementation (Bhuyan et al., 2010) (see Box 1). The core team comprised representatives from the DoHFW, State Health Resource Center, and nongovernmental organizations (NGOs). The Rural Development Institute of the Himalayan Institute Hospital Trust assisted with data collection and analysis. The assessment gathered feedback from 423

people through interviews with policymakers and state- and district-level implementers, as well as focus group discussions with community-level functionaries, elected officials, and clients (including women and men from rural and urban areas). Key findings are summarized below, according to the seven dimensions covered by the tool (for the full report, please see Health Policy Initiative, 2009).

Policy, Formulation, and Dissemination

Respondents agreed that the policy addresses the state's main health issues and objectives. Policymakers and some state-level implementers remember the policy formulation process as a participatory one that included various stakeholders and sectors at the state level. Policymakers believed that the policy's objectives can be achieved within the given timeframe, but implementers held a different view, especially given the state's human resource shortage. Dissemination of the policy occurred mainly at the state level, with limited discussion in the districts on operationalizing the policy. While few community service providers (e.g., ANMs, AWWs, ASHAs) were aware of the policy specifics, clients in rural areas reported that the appointment of ASHAs increased their access to information about available health services.

- *Implementation planning to operationalize the policy at the district level has lacked the participatory approach that enhanced the formulation of the policy at the state level.*

BOX 1. ABOUT THE POLICY IMPLEMENTATION ASSESSMENT TOOL

What: The Health Policy Initiative designed a user-friendly approach and tool for assessing policy implementation. The Policy Implementation Assessment Tool includes two interview guides—one for policymakers, the other for implementers/other stakeholders. The interview guides gather input on seven dimensions that influence policy implementation (see list). For the Uttarakhand study, the core team adapted the master interview guides to the state's context and used them to aid in designing focus group discussion (FGD) guides to explore the perspectives of clients and community-level functionaries.

When: April/May 2008—policy text analysis, adaptation of interview and FGD guides; June/July—data collection; August/September—data analysis, synthesis of findings; November—stakeholder discussion and dissemination.

Who: The study included 423 total respondents: 36 in-depth interviews with policymakers and implementers at the state and district levels; 16 FGDs with 179 community-level functionaries, including auxiliary nurse midwives (ANMs), anganwadi workers (AWWs), accredited social health activists (ASHAs), and representatives of Panchayati Raj Institutions; and 16 FGDs with 208 clients, including women and men from rural and urban areas and from scheduled castes.

Where: Almora, Haridwar, Udham Singh Nagar, and Uttarkashi Districts were selected to represent the state's demographic profile and geographic composition. Corresponding blocks included Laksar, Purola, Bhatwari, Jaspur, and Chokhotiya.

Seven Dimensions of Policy Implementation

- The policy, its formulation, and dissemination
- Social, political, and economic context
- Leadership for implementation
- Stakeholder involvement in policy implementation
- Implementation planning and resource mobilization
- Operations and services
- Feedback on progress and results



Social, Economic, and Political Context

Uttarakhand's citizens are increasingly adopting health-seeking behaviors. However, several socio-cultural and economic factors hinder clinic service use and access. Cultural norms favor at-home births. Son preference is still strong, which affects uptake of family planning and, in some cases, has resulted in misuse of the Prenatal Diagnostic Act. Some religious beliefs discourage contraceptive use and uptake of child immunization. Poverty and unemployment are widespread, leading to limited household resources for healthcare. Due to limited opportunities, some regions face a high level of out-migration of men, with the hill area being commonly known as the “money order” economy due to remittances. This leads to women-headed households, adding to their responsibilities and affecting their ability to access healthcare. The state also experiences in-migration from Nepal and Bihar, resulting in large populations who work in difficult conditions and, as a result of the poor conditions and lack of health services, may be vulnerable to disease.

- *Although demand for health services is increasing, people face socio-cultural and economic barriers to access and use.*

Leadership for Implementation

The DoHFW is the state agency responsible for the policy's implementation. The state's RCH-II Program Implementation Plan (PIP) outlines the institutional relationships and responsibilities of personnel at all levels, which, according to respondents, facilitates clarity about roles and duties. However, as is common across India, the frequent changes in leadership positions, transfers of crucial personnel, and juggling of multiple roles have affected the policy's implementation. At the community level, some key leaders, such as Pradhans (elected village leaders) and religious leaders, are reported to be coming forward to advocate for and coordinate programs.

- *Lack of continuity in state- and district-level leadership hinders implementation.*

Stakeholder Involvement in Implementation

At the state level, health and population activities have begun to link with other government departments, such as the State AIDS Control Society, Department of Women Empowerment and Child Development, and Department of Drinking Water/Total Sanitation. Community-level workers reported having good collaboration across departments, especially in organizing village health and nutrition days. However, implementers from the nongovernmental sector—such as NGOs, private providers, and medical colleges—felt

that their involvement in implementation is limited. Often, such partners are contracted to carry out only small-scale projects. These stakeholders felt that more can be done to take advantage of NGOs' presence in remote regions and the ability of both NGOs and private sector groups to provide health services, not simply generate awareness.

- *The private sector and NGOs are under-utilized.*

Planning and Resource Mobilization

The state policy does not have a separate implementation plan, because many activities are integrated into the RCP-II PIP and district action plans for the NRHM roll-out. The lack of such a plan can lead to gaps. For example, respondents reported that interventions to address mental health, geriatrics, and elder care are lacking. Further, while stakeholders were aware of the PIP and district action plans, many state- and district-level implementers reported that they do not frequently refer to the plans in carrying out programs. This points to a crucial gap, as implementers should understand the context, relevance, principles, and priority goals of the state's health and population programs.

Most stakeholders in Uttarakhand felt that the biggest financial constraint in the state is the difficulty in accessing, disbursing, and expending already-sanctioned funds at different levels. Challenges include delays, lack of authorized banks in rural areas, and lengthy procedures (e.g., Pradhan approval for health expenditures). Other challenges include lack of financial management capacity (e.g., clinicians not trained as managers), inflexible procurement procedures, budget line-item restrictions, lack of clarity on expenditure guidelines, and reluctance to use funds due to fear of audits.

- *Uttarakhand lacks efficient management systems and training programs to ensure that the state's existing financial resources can be translated into upgraded facilities, equipment, and staffing.*

Lack of human resources and capacity also emerged as significant barriers to service delivery and quality. Several positions—including senior management, doctors, and lady medical officers—remain vacant. Given the lack of staff, personnel have to fill multiple roles, compromising quality for clients and resulting in staff fatigue. Skills and guidelines—on planning and implementing programs—are lacking; and failure to implement human resource policies (e.g., performance appraisals, professional development, and oversight) leads to lack of motivation among staff.



A medical officer provides services to community members in a rural area. Photo Credit: A. Bhuyan

Many respondents agreed that, overall, the infrastructure and facilities are insufficient. In many areas across Uttarakhand, the population is scattered, thus requiring additional subcenters and primary health centers. Facilities also suffer from non-functioning equipment in the operating theater and labor rooms. District-level implementers reported having sufficient stocks of essential medicines, although ANMs noted stockouts of iron and folic acid tablets and contraceptive commodities.

- *The quantity and quality of human resources for service delivery are insufficient, and infrastructure is inadequate.*

Operations and Services

Overall, respondents believed that decentralization of health services has facilitated the implementation of policies and programs. They identified geographic access and lack of human resources as the major barriers to services. Despite strategies to try to address the human resource issue, shortages persist. Skilled personnel are unwilling to work in underserved areas due to poor transportation, limited accommodations, and lack of infrastructure. With posts vacant, the workload increases on existing staff, causing burnout, low morale, and, ultimately, poorer quality services.

According to clients, health service access and facility quality have improved to some degree, and ASHAs 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 providers about their ailments. Out-of-pocket expenses for medicines, supplies, and lab tests are high; and the availability of these services is not guaranteed, even in district hospitals. For people belonging to SCs/STs 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.

- *Human resource shortages, out-of-pocket expenses for clients, and provider attitudes are major constraints.*

Feedback on Progress and Results

The DoHFW is the oversight agency for the state policy's implementation. Senior officials conduct regular monthly meetings with Chief Medical Officers of all districts and receive monthly progress reports on national programs, such as the NRHM. However, implementers noted that reporting procedures are cumbersome, with significant staff time devoted to preparing various forms. Moreover, systematic efforts to analyze the data and provide feedback to the implementers and service providers are lacking.

- *Systematic linkages among monitoring, decisionmaking, and planning processes are lacking.*

Overall Assessment

Respondents agreed that the *Health and Population Policy* is relevant and vital in the present context for the state of Uttarakhand. While NRHM is an umbrella initiative that covers a range of health issues, the state-specific policy framework is necessary to ensure that current and emerging health issues not covered under NRHM are identified and addressed through a strategic approach. Further, respondents reported that the state has implemented a number of innovative approaches that should be taken to scale to have an impact on the health and quality of life of the population (see Box 2).

- *Uttarakhand's commitment to innovations provides a foundation for scaling up successful approaches.*

POLICY DIALOGUE: RENEWED COMMITMENT AND RECOMMENDATIONS

The policy implementation assessment revealed that the state has a solid policy foundation and financial resources—the problems lie in operationalizing, managing, and monitoring services in an efficient and equitable manner, especially in hard-to-reach areas. To share findings of the assessment, the government of Uttarakhand—in collaboration with the Health Policy Initiative, USAID/India, and the USAID-funded ITAP

Project²—organized a high-level policy dialogue event in Dehradun in November 2008. More than 50 participants attended the workshop on “Policy, Innovations, and Experiences in Uttarakhand,” including government leaders, 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.

Recommendations arising from the assessment and the discussions are summarized below.

Extend decentralized planning. Uttarakhand is one of the first states to introduce decentralized district action plans covering all 13 districts in the state. The plans are compiled to inform the state PIPs for RCH and NRHM. This bottom-up approach has improved the ownership of programs 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. Linking villages and blocks with district- and state-level planning would help ensure involvement of elected representatives and other community stakeholders and provide clear guidance to grassroots workers.

Foster integrated approaches. Several health programs are implemented as vertical programs. The NRHM’s strategic vision for integrating programs has not yet taken concrete shape at different levels. Each vertical program has implemented innovative approaches, such as the Directly Observed Treatment, Short-course for tuberculosis; involvement of the private sector in blindness control; and the use of community health volunteers and ASHAs under NRHM. There is a lot to learn from the successes of each program that could be integrated into other areas. Similarly, better-coordinated approaches among social development departments, such as health, the Integrated Child Development Scheme (ICDS), and primary and secondary education, are required. Uttarakhand has introduced joint review meetings between health and ICDS functionaries at different levels. These efforts should be strengthened and expanded to involve additional departments.

Clarify financial guidelines and systems. Financial resources for state health programs are not being used because of delays and lack of clarity on utilization guidelines. Field managers are apprehensive of audits and, thus, do not use the available funds. An important recommendation is to streamline and prepare guidelines for all funding mechanisms and to train managers of these funds on how they can spend the money, maintain accounts, and be accountable for the funds. Once there is clarity on fund utilization, confidence levels will rise and the proportion of money spent will increase.



Health facility in rural area. Photo Credit: S. Sharma.

Expand infrastructure enhancement initiatives. Uttarakhand has made major strides in terms of construction of new health units and renovation of 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 utilization of financial resources has often created new problems rather than solved the existing ones. Uttarakhand has evolved an approach to overcome this issue by 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.

Develop the human resource base. Uttarakhand faces a severe shortage of medical professionals. Organizing district-level walk-in interview days for medical officer positions has led to faster recruitment and appointment of staff on a contractual basis and has helped to fill some positions. However, retention of such staff is low and, therefore, does not offer a permanent solution. Given this, Uttarakhand has to

² ITAP is the Innovations in Family Planning Services II (IFPS-II) Technical Assistance Project, implemented by Futures Group India.

prepare a clear strategy on how it is going to tackle the situation. One immediate recommendation 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 efforts to fill gaps in the short term.

Evolve a strategy for fostering PPPs. Uttarakhand has 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. A PPP policy would help 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, uniform application of PPP mechanisms for all regions in the state is not possible. For instance, there is hardly any private health sector presence in the hilly regions of the state. Identification and mapping of local partner resources before prescribing partnership mechanisms are essential to promote relevant and workable partnerships.

“Contract out” 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.

Deploy 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 the public health sector. Concurrently, in the hills area, public and private sector service providers are scarce. The human resources planning exercise recommended above could shed light on how to equitably redeploy the state’s health professionals.

Address infant mortality. In recent years, infant mortality in Uttarakhand has increased marginally, in contrast to the declining trend witnessed earlier. 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 for both married and unmarried young people would help to

educate them on the importance of delaying the first birth and ensuring proper birth spacing. This effort should be further strengthened by renewed rigor in promoting modern spacing methods.

Strengthen 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.

Evaluate and scale up innovations. As noted above, the state has undertaken a series of pilot projects to address equity, geographic access, and quality issues (see Box 2). 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.

BOX 2. UTTARAKHAND’S INNOVATIONS

- Capital investment for infrastructure
- Subsidies to private providers to set up clinics and specialist units in underserved areas
- Appointment of doctors and paramedical staff on a contractual basis
- Mobile phones for ANMs to improve communication and monitoring
- Voucher scheme and network of private providers to increase the poor’s access to maternal and child health services
- Healthcare provision through mobile health vans
- Community outreach through ASHA Plus
- Training centers for ANMs
- Support for referral transportation
- Emergency ambulance service number—108

In concluding the discussions, stakeholders reiterated the benefits the state could draw from updating the *Health and Population Policy* in light of the changes resulting from the introduction of the RCH-II and NRHM programs.

REVISING THE POLICY

To address the issues and recommendations that emerged from the participatory process, the government decided to prepare an addendum to complement the existing well-designed *Health and Population Policy*. In April 2009, the DoHFW constituted a Policy Revision Coordination Committee, composed of members of the

The Uttarakhand Health and Family Welfare Society formed in 2002 with the aim to serve as an umbrella society for all health programs and to promote health sector reforms with the assistance of external funding agencies.

Uttarakhand Health and Family Welfare Society and chaired by the Principal Secretary, Medical Health and Family Welfare. The committee provided direction and oversight

for preparing the addendum and organized a series of one-on-one discussions, interviews, and meetings with key policymakers, senior state administrators, and civil society groups. These interactions expanded on the earlier findings on opportunities and barriers identified during the interviews and focus group discussions as part of the policy implementation assessment and gathered further perspectives on specific policy directions.

The Health Policy Initiative also helped the committee to review the latest available survey data for the state; program implementation plans of various health initiatives (e.g., HIV/AIDS, tuberculosis, malaria, reproductive and child health); pertinent documents on proposed central programs (e.g., the National Urban Health Mission); and pilot programs in the state (e.g., on urban health, adolescent health) to identify areas for alignment with the state policy.

In addition, the DemProj and FamPlan computer models, contained in the Spectrum Suite of Policy Models,³ were applied to consider different scenarios and timeframes for achievement of policy goals. These projections considered the progress required to reach desired goals by milestones such as 2015, 2017, and 2020. With these projections, the Policy Revision Coordination Committee could assess the goals to be achieved and set realistic timeframes. Through dialogue and discussion, the committee determined specific policy goals and set the target date as 2017.⁴

Based on the policy implementation assessment, the review of innovative approaches, data analysis and projections, and consultations with in-state stakeholders, the committee prepared the draft addendum, which was finalized in March 2010.

³ Spectrum models are available online at

<http://www.healthpolicyinitiative.com/index.cfm?id=software>.

⁴ In a few cases, the committee set 2012 and 2015 as the target date for achieving goals in order to be consistent with the NRHM and Millennium Development Goals, respectively.



An ASHA (left) and pregnant woman in a hilly district. Photo Credit: S. Sharma.

KEY ELEMENTS IN THE POLICY ADDENDUM

The policy addendum presents the situational analysis of health indicators, a review of strategies implemented since the policy's adoption in 2002, updated policy goals, and priority policy directions and strategies for the future. In doing so, the addendum seeks to alleviate barriers to full implementation of the original policy, provide additional policy guidance on new thrust areas and service delivery mechanisms, and address emerging priority health needs. The document contains and elaborates on many of the recommendations discussed above, including strategies to map human resource needs, design a PPP strategy, and clarify financing mechanisms. Other highlights include the following:

- In addition to broad health and population policy-level goals (updated from the 2002 policy), the addendum specifies goals for maternal, neonatal, and child health and health systems strengthening.
- Equity—in terms of geographic region, residence, socioeconomic status, gender, and age—is a key concern. Thus, the addendum includes not only state-wide indicators but also indicators to encourage equity (e.g., increase the proportion of safe deliveries to 65 percent state-wide by 2017 and to at least 60 percent in rural areas).
- The addendum recognizes the diversity in the state's geography, populations, and distribution of health facilities and personnel. In response, the addendum encourages flexibility in tailoring central and state programs to the district needs and calls for developing strategies suited to the rural plains (higher population density, low service use), hills (scattered population, remote areas, limited

transportation), and urban areas (including urban slums). The addendum also includes strategies for reaching underserved populations, such as adolescents and the elderly.

- In terms of family planning and reproductive health, the situation analysis found that, despite reaching the goal for modern contraceptive use, the state has yet to achieve replacement-level fertility. One possible reason is the heavy reliance on female sterilization—which accounts for more than two-thirds of modern contraceptive use according to the 2007-08 DLHS-3 and typically occurs in older, higher parity women. In response, the addendum calls for providing a balanced method mix, with an emphasis on increasing information on and access to a variety of methods, generating demand, fostering choice and informed consent, and encouraging constructive male engagement in reproductive health.

THE WAY FORWARD

The addendum is now with the Principal Secretary and Cabinet for final approval. Upon approval, the state government will disseminate the addendum so that program managers, implementers, and service providers understand the policy changes. The state will also integrate new provisions into the annual program implementation plans.

The process of assessing the implementation of Uttarakhand's *Health and Population Policy* has renewed high-level commitment to achieving the policy's goals, facilitated dialogue on challenges and emerging issues, and identified next steps to ensure that the policy is put into practice to improve the health status of the state's population.

A key lesson learned from the assessment is the need to tailor policy and programmatic responses to the local context, especially the needs of the underserved populations. Promoting equity involves several dimensions—geographic region, area of residence, socioeconomic status, gender, age, and so on—and using evidence is crucial for understanding the needs and barriers of these diverse groups to design appropriate, responsive strategies. Specifically, the use of the Policy Implementation Assessment Tool provided a way for clients, especially poor women and

men, to voice their concerns, which informed the government's decisionmaking.

The policy process in Uttarakhand also reinforced the notion that the "life" of a policy does not end with its creation, which is in fact, only the first step in the policy-to-action continuum. Policies should be considered "living documents." They require various inputs to help thrive and fulfill their goals. These inputs include clear guidelines and implementation plans, strong leadership, multisectoral stakeholder involvement, adequate and accessible resources, and effective feedback and monitoring systems. Through broad stakeholder engagement, regular check-ups, and renewed commitment, policies can keep on track toward achieving policy goals.

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