

# Health and Population Policy *of* Uttaranchal

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Department of Medical Health and Family Welfare  
Government of Uttarakhand



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Narayan Dutt Tiwari  
Chief Minister



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## Message

The development of a State is closely linked to the physical and mental well being of the people of the State. I have always firmly believed that Uttarakhand has immense potential to be a leading State of this great Nation. There is an urgent need to exploit this potential and for that purpose attention should be given to the improvement of human resources. Sustainable development and prosperity depends on three cardinal principles, which include human well being, literacy and environment. The health indicators of the people of Uttarakhand are better than many of other States but this is no reason for complacency. We are still far behind compared to many other States in the South, not to talk about reaching the standard of developed Nations. I would like to say here that sustained efforts are required, over a period of time, to educate people about their health rights, to improve quality of health delivery systems and to influence direct and indirect determinants of health. Making health services accessible to people living in small sized villages in difficult terrain is a daunting task but achievable if we have determination and evolve innovative, sustainable and cost effective strategies.

Formulation of health and population policy is a major step in this direction for it provides clear direction to the objectives to be achieved and actions to be initiated to achieve the objectives. I am happy to inform that the Uttarakhand State has adopted a holistic approach while formulating its integrated Health and Population Policy. We realize that Population Stabilization can not be achieved without improvement in health status of people and health status of people can not be improved, particularly that of children and women, without small and planned families. This policy, therefore, places special emphasis on integrated approaches to reach out to women, children, elderly and disadvantaged sections of the society.

I would like to dedicate the State Health and Population Policy to the people of Uttarakhand, urging them to cooperate and encouraging them to participate in all aspects of its implementation. I hope implementation of this policy would lead to an improved quality of life of the people of the State and usher in an era of modern and vibrant Uttarakhand.

(Narayan Dutt Tiwari)



Tilak Raj Behar  
Health Minister



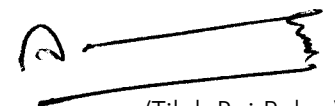
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## Message

Uttarakhand faces the double burden of communicable and non-communicable diseases including emerging diseases such as HIV/AIDS. Communicable diseases are a result of wide spread poverty and low quality primary health care services. Non-communicable diseases are on the rise due to changing life styles. To improve the health status, people should realize that health is their fundamental right and take interest and participate in health programme implementation. Without cooperation and involvement of people, no health programme would succeed, however well designed it might be. Uttarakhand Health and Population Policy has examined the health and population stabilization issues in an integrated and holistic fashion and arrived at strategies that are specific and precise and can be implemented.

The health and population policy has taken into account the complexity of health care problems and diversity of health care providers. Uttarakhand, given its meagre resources, cannot improve the quality of life of its people if population stabilization is not achieved. There are specific and time bound objectives set for health indicators, replacement level fertility and contraceptive prevalence. To achieve the policy objectives, more emphasis has been given to primary health care and innovative ways of programme implementation. Other issues that have been addressed in the policy include motivation and commitment levels of staff, efficiency and effectiveness of service delivery systems, health infrastructure, building partnerships with private sector, and linkages with other departments. Special emphasis has been given to reaching out to women, children and disadvantaged groups.

Formulation of the Health and Population Policy of Uttarakhand is a major mile stone in the health sector of Uttarakhand. I am sure that the implementation of Health and Population Policy would lead to better health status of people of Uttarakhand, which in turn would help to usher in faster economic growth and sustainable development.



(Tilak Raj Behar)

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Madhukar Gupta  
Chief Secretary


## Message

We are living in a world of rapid changes that have profound implications for our lives and also significant consequences for the way governments function. While the inevitability of globalization, rapid changes in information technology, and explosion of knowledge have propelled the process of development and growth, environmental deterioration, high levels of energy consumption, and emerging diseases such as HIV/AIDS pose a threat to the society. In an atmosphere full of challenges, governments should look for opportunities to review and steer existing policies, formulate new policies and strengthen policy management. We must inject competition into our service delivery system and achieve greater levels of efficiency, encourage innovation and transform the rule driven organizations. Result oriented governments have to concentrate on outputs, encourage flexibility, build partnerships with private sector and reward performance. These cardinal principles should be the driving force of any modern service delivery organization.

Uttarakhand being a new state has decided to make a determined effort to revamp its traditional service delivery systems, orient them to client needs and empower communities by making them aware of their own rights and responsibilities. The health system in this State faces several challenges and obstacles. Some of the main obstacles in providing sufficient, appropriate and quality health service delivery in Uttarakhand include; lack of sufficient resources, both human and financial; inadequate infrastructure facilities; and, a scattered population widely dispersed over difficult terrain. Together these obstacles seem and are, in fact, formidable. They are not, however, insurmountable; and, together as a State, we can and must address them urgently. The issues of health, population development and quality of life are closely and integrally related. A variety of factors present in Uttarakhand provide reason for optimism that this integral relationship can actually be realized in a meaningful manner.

It is this quest to find solutions to problems and a way forward in a rapidly changing and a competitive world that has led us to formulate an integrated and holistic Health and Population Policy. The processes followed to formulate the policy were open and participatory and involved different stakeholders. The thrust of the policy is to improve access to and quality of health services with the help of strategic planning and innovative approaches. Community involvement, building partnerships with other sectors, convergence of service at grass roots level, coordination linkages with other departments, special attention to disadvantaged groups particularly women and children, are some key policy interventions.

I take this opportunity to congratulate officers of the Department of Health and Family Welfare for their tireless efforts and high level of commitment in formulation of this policy. We shall spare no effort to ensure that all components of this Policy are implemented in a specified time period so that citizens of this beautiful nascent State can hope for a better quality of life.

  
(Madhukar Gupta)



Alok Kumar Jain  
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## Message

Health and Population Policy development is a complex process particularly for a new State like Uttarakhand, which has difficult terrain, scattered and small rural settlements, and poor communication facilities. Policy should not be mere statements of intent but should deal with interventions that are pragmatic and result oriented. Identification of policy interventions to improve health status of people in a State should be broad based, involving all development departments and all partners. Keeping this in view, the process followed to formulate the health and population policy for Uttarakhand was open, consultative and participatory, involving all stakeholders. Consensus building is a difficult task but is fruitful in the long run.

Two workshops were held, nearly 45 papers were presented by national and international experts and the Health and Population Policy issues specific to Uttarakhand have been identified. I was privileged to be the chairperson of a working group constituted by the government of Uttarakhand for preparing a draft of Health and Population Policy. The other members of this working group were Dr. I.S.Pal, Director General of Health and Family Welfare, as member secretary, Mrs. Manisha Panwar, Director, Women Empowerment and Child Development, Dr. Gadde Narayana, Director, The POLICY Project, The Futures Group International and Dr. Rameshwar Sharma, Consultant, as members. The draft Policy was discussed in a series of consultation meetings with the Members of Legislative Assembly representing different political parties and representatives of NGOs, private sector and officers of the Health and Family Welfare department. The draft document has been revised several times taking into consideration the suggestions and observations made by various individuals. We are thankful to all those who have participated in the discussion, contributed to the identification of policy issues and suggested policy interventions relevant to Uttarakhand.

The Uttarakhand Health and Population Policy has a well defined mission, broad policy directions and specific policy interventions to improve health status of the people of the State and to achieve population stabilization. We would like to implement all elements of this Policy in a time bound and phased manner involving all partners from all sectors. Every effort will be made to encourage people's participation and to educate and involve them in policy implementation. The ultimate purpose of this Policy is to make people understand their health needs and rights so that they follow risk free behaviour and seek quality health care whenever required.

(Alok Kumar Jain)



# 1 Introduction

## 1.1 Profile

Uttaranchal came into existence on the 9<sup>th</sup> of November 2000 and constituted the 27<sup>th</sup> state of the Republic of India. The state has been carved out from the erstwhile state of Uttar Pradesh by combining the hill districts of Uttarkashi, Chamoli, Rudra Prayag, Tehri Garhwal, Dehradun, Pauri Garhwal, Pithoragarh, Bageshwar, Almora, Champawat, and Nainital, with the districts of Udham Singh Nagar in the Terai region and Hardwar in the foothills. Blessed with the enchanting beauty of nature, and for historical and mythological reasons, the state has its own uniqueness. About 63 percent of the area is covered by forests and is rich with numerous species of trees and herbs. About 93 percent of the area is hilly, and the remaining 7 percent is covered by plains. Nature has endowed this land with so much beauty and spiritual bliss that it is also known as “*Dev Bhoomi*” – the Abode of Gods.

From the administrative point of view, the state comprises of 13 districts, 49 tehsils, 95 blocks, and 16,414 villages. The state has 86 cities/towns of which only five are major cities with a population of more than 100,000.

## 1.2 Intra-state Variations

As per the 2001 census, the population of Uttaranchal is 8.5 million with a population density of 159 persons per square kilometre. The districts in the plain areas are densely populated in comparison with hilly areas. Four densely populated districts account for more than half of the state’s population. The population size of districts varies from a minimum of 200,000 to a maximum of 1.4 million. The decadal growth rate of the state between

1991–2001 was 19.2 percent with substantial inter-district variations.

Uttaranchal is predominantly rural with about 74 percent of the population living in 16,414 rural settlements. Of the total villages, more than four-fifths are small villages with population less than 500 persons. Another 10 percent have population sizes ranging between 500 and 999 persons and the remaining 6 percent are villages with over 1,000 population. Small-sized, scattered villages without road connectivity pose a major challenge to health service delivery. Hill districts are at a disadvantage compared with districts in the plain areas.

As per the 2001 census, Uttaranchal has a sex ratio of 964 females per 1,000 males. The sex ratio among districts ranged from a minimum of 868 to a maximum of 1,147 females per 1,000 males. Females outnumbered males in five districts according to the 1991 census, and this has increased to eight districts in 2001. The hilly regions have a higher female population compared with the plains. While the sex ratio for the state as a whole is 964, the sex ratio for the juvenile population (0–6 years) is 906.

The Scheduled Castes (SCs) constitute 17 percent of the population, and the proportion of the Scheduled Tribes (STs) population is insignificant (3 percent).

The literacy rate in Uttaranchal is among the highest in the country. About 73 percent of the population in the state is literate, and the literacy rate is better in the hill districts than in the plains. Eighty-four percent of males are literate compared with 60 percent of

females. There are substantial differences in male and female literacy rates.

In sum, the hill districts of Uttarakhand, although sparsely populated and with a large number of small, scattered villages, are better off than the plain districts in terms of the sex ratio and literacy in general.

### **1.3 Health Infrastructure**

Uttarakhand has an expansive network of government health institutions of different systems of medicine. There are 1525 subcentres, 84 main centres (MCs) attached to block PHCs, 326 allopathic dispensaries, 3 mobile dispensaries, 171 additional PHCs, 26 CHCs, and 61 BPHCs. Further, it has 37 rural female hospitals and 33 District hospitals/Base hospitals/combined hospitals catering to both men and women.

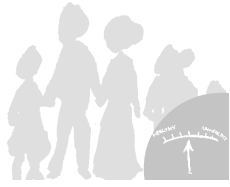
In urban areas, there are 24 postpartum centres (PPCs) of which 10 are located in the district headquarters while the remaining are found at the tehsil level. To cater to specific diseases, the state has 12 TB hospitals/clinics, two TB sanatoriums, three leprosy hospitals, nine urban leprosy centres, and five infectious disease hospitals. In addition to

these institutions, the state has nine health posts under revamping scheme and seven urban family welfare centers.

In regard to the other systems of medicine, Uttarakhand has 385 Ayurvedic dispensaries, 60 Homeopathy dispensaries, and only three Unani dispensaries. Besides the public health institutions, there are other public sector undertakings catering to the health needs of specific segments of the population.

There are two regional family planning training centres (RFPTC) and six training institutions for auxiliary nurse midwives (ANMs). In addition to these training institutions, there are two training centres for nurses. Uttarakhand has only one medical college in the private sector and two Ayurvedic colleges in the public sector.

Improving the quality of services is a daunting task because of the large number of vacancies in public health institutions, especially for medical officers, supervisors, and technicians, and the poor infrastructure including lack of equipment and inadequate facilities.



## 2 | Health Status

The health status of Uttaranchal in terms of aggregate gains in infant mortality and under five child mortality is better than its parent state of Uttar Pradesh and the national average. Despite this advantage, the state faces challenges of combating communicable diseases like tuberculosis (TB), malaria, leprosy, and HIV/AIDS, as well as non-communicable diseases on the one hand and the emerging lifestyle diseases on the other. To add to the challenges, completion of the demographic transition in the near future will lead to the problem of an aging population, which has profound health, social, and economic implications.

### 2.1 Communicable Diseases

Amongst the communicable diseases, TB poses a major challenge in the state. The prevalence of TB is estimated to be 1,225/100,000 population in Uttaranchal while at the national level it is 544/100,000. TB cases in the state are uniformly distributed across all districts. Malaria in the state as a whole has been on the decline, yet two districts – Hardwar and Udham Singh Nagar – are highly vulnerable and account for 79 percent of the malaria cases. Uttaranchal is considered as a low endemic state for leprosy (2.23/10,000), but the disease is more prevalent in Hardwar and Udham Singh Nagar, where the prevalence rates are 5.1 and 3.4, respectively. Prevalence of leprosy, like malaria, is area-specific and mostly confined to the plains. Skin infections, particularly scabies, are a problem in all areas. The seasonal surge in communicable diseases such as gastroenteritis, typhoid, and different types of hepatitis is due to unhygienic practices and unavailability of safe drinking water. One-third of currently married women suffer from reproductive tract infections (RTIs) and 19 percent from urinary

tract infections. Uttaranchal has very low prevalence of HIV/AIDS but has all the conditions that could rapidly spread the disease to epidemic proportions. The recent re-emergence of the plague in Uttaranchal may be a sporadic event, but it emphasizes the need to have an effective surveillance system.

### 2.2 Non-communicable Diseases

Amongst non-communicable diseases, iodine deficiency diseases continue to be a challenge in the state. All districts in the state have been identified as iodine deficient, the deficiency affecting 3.5 to 40 percent of the population in these districts, which has now come down. Anaemia is yet another major problem confronting the state. Overall, 46 percent of women have some degree of anaemia – 13 percent being moderately / severely anaemic – and over three-quarters of children age 6–35 months are anaemic. Malnutrition is common amongst both women and children. The prevalence of blindness in the state (below 1 percent) is less than the national average (1.4 percent).

Nationwide, the changes in social systems have increased the incidence of lifestyle diseases, such as coronary heart diseases, diabetes mellitus, mental health disorders, cancer, and so forth. Changes in dietary habits, excessive consumption of alcohol and chewing tobacco, smoking, increasing pollution, stress and strain related to work culture, and irreversible changes in the family structure have a direct influence on lifestyle diseases.

Substance abuse, especially of tobacco and alcohol, is a decades-old problem, but it has increased due to easy access to and excessive advertising of these products, which generates further demand through

market penetration and expansion. In Uttaranchal, one-fourth of adult men and 3 percent of adult women smoke, 14 percent of adult men and 2 percent of adult women chew *paan masala* or tobacco and a significant proportion of men drink alcohol. A combination of tobacco use, dietary errors, and sedentary lifestyle leads to the evolution of chronic diseases, especially diabetes and coronary heart diseases, as well as cancer and cerebrovascular diseases.

Mental health disorders are emerging as another issue that has not been given due recognition. Uttaranchal does not have sufficient number of trained mental health specialists and institutions to treat mental health disorders. Violence (be it domestic or general), stress, depression, and so forth are common mental health problems.

Uttaranchal, given its difficult terrain, has a high incidence of accidents either due to landslides or to

rash driving. Emergency services to treat accident cases and to provide trauma care services are grossly inadequate in the state.

### 2.3 Inter-relationships

It is important not only to look at the diseases as distinct entities but also to understand the inter-relationships among them as well as the complex medico-social syndromes. For example, the prevalence of RTIs/STIs enhances the risk of HIV/AIDS, which in turn leads to increased incidence of TB. High prevalence and incidence of malaria leads to anaemia of different grades. Iodine deficiency not only leads to goitre but also to cretinism. There is a strong inter-relationship between diseases and malnutrition, each reinforcing the other.

Given the complexity of the relationships among diseases, health determinants, and other factors, it is necessary to have a holistic and area-specific approach towards improvement of health status.



# 3 Fertility, Mortality and Contraceptive Use

## 3.1 Fertility

The fertility levels in Uttaranchal have always remained lower than its parent state, Uttar Pradesh. Historically, the crude birth rate (CBR) for the period 1951–56 was 48, steadily declining to 35 during 1976–81, and further to 26 during the period from 1994–2001. Among the districts, Pauri has the lowest CBR while Hardwar has the highest. The total fertility rate (TFR), which is the number of births a woman would have on average in her reproductive life span, has been estimated to be higher than five until 1971–76, and declining rapidly thereafter to 3.3 by 2001. Inter-district variations have narrowed over the same period of time. Urban-rural differentials in CBR and TFR are significant and still persist. Son preference is found to be strong, and this would have a substantial influence in determining the future course of fertility in the state. In general, the hill districts have lower birth rates compared with the plains areas. About one-fourth of women give birth within 24 months of the previous birth, and a little less than half (46 percent) of women have births which are higher order births (parity 3 +). About 42 percent of births in Uttaranchal fall in the high-risk category.

## 3.2 Mortality

In the absence of information on mortality exclusively for Uttaranchal, it is difficult to comment on the trends and patterns in mortality decline over time. As per the Sample Registration System (SRS) estimates, the crude death rate (CDR) for Uttaranchal was estimated to be 7 per 1,000 population during 2000, which is lower than the national-level estimate of 9 per 1,000. Death rates in rural Uttaranchal (10)

are twice that of urban Uttaranchal (4). The infant mortality rate (IMR) in the state in 2000 was 50 deaths per 1,000 live births, which is significantly lower than the national rate of 68. Of the total number of infant deaths, nearly two-thirds occur during the neonatal period. The child mortality rate is 19 per 1,000 live births in Uttaranchal. No data on the maternal mortality rate (MMR) for the state are currently available. However, the MMR in the state is expected to be quite high because of the physiographic features and inaccessible terrain.

Communicable diseases such as acute respiratory infection, diarrhoea, and so forth are the leading causes of deaths during infancy and childhood. Due to changes in lifestyles ushered in by modernization and urbanization, non-communicable diseases are also emerging as leading causes of deaths.

## 3.3 Life Expectancy

In the absence of data specific to Uttaranchal, it is difficult to assess the current level of life expectancy at birth in Uttaranchal. It is, however, expected to have increased considerably over time. As a result of increase in life expectancy and the recent decline in fertility, in the years to come, the median age of the population will rise, thereby leading to a higher proportion of elderly population.

## 3.4 Knowledge and Use of Contraception

Knowledge of modern contraceptive methods in Uttaranchal is almost universal. However, the use of contraception is not commensurate with the

knowledge levels. Less than half of currently married women in Uttarakhand (41 percent) use any modern contraceptive method. Modern spacing method use in Uttarakhand is very low. Only 9 percent of couples use any modern spacing methods. Among sterilization method users, an overwhelming proportion has accepted female sterilization (96.2 percent) while male sterilization acceptance is insignificant (3.8 percent). The contraceptive prevalence rate is considerably higher in urban areas than in rural areas. Inter-district differentials are significant with Chamoli District having the highest modern method use (51 percent) and Haridwar, the

lowest (35 percent). After the introduction of the Community Needs Assessment (CNA) approach in 1995, available information suggests that there has been a marginal decline in the use of modern contraception.

One-fifth of the women in Uttarakhand have an unmet need for family planning. The unmet need for spacing (11 percent) and limiting (11 percent) is almost the same. Reaching out to couples with unmet need for family planning is thus one of the major challenges.



## 4 Women's Health

Women's status and the gender norms that are prevalent in a society determine the access to and utilization of health services. Although the median age at marriage among women aged 20-49 years in Uttaranchal is 18 years, more than 1/4 of women in Uttaranchal still marry before reaching the legal age at marriage of 18 years. In general, women in rural areas tend to marry at an earlier age compared with their urban counterparts. Due to the absence of family life education (FLE), particularly for adolescent girls, there are no opportunities to learn about reproductive health issues at an appropriate time. Moreover, general efforts to educate women on health issues have not been a strong focus in the existing programmes in the state. In spite of high female literacy, a sizeable proportion of women face domestic violence. In the case of household expenditure, it is often seen that a higher proportion is allocated to men than women. Similarly, disparities in dietary intake exist where women once again are at a disadvantage compared with their male counterparts. Son preference is also quite high. These differentials in treatment show that women and girl children in Uttaranchal are less privileged, thereby reflecting a low status in society.

### 4.1 Maternal Health

#### 4.1.1 Antenatal Services

Less than half of pregnant women (44 percent) in Uttaranchal have received at least one antenatal check-up compared with 65 percent in India as a whole. The percentage of pregnant women who received at least three antenatal check-ups is as low as 18 percent. Vast urban-rural differentials exist with regard to utilization of antenatal services. In urban

areas of the state, more than three-fourths (78 percent) of pregnant women received at least one antenatal check-up compared with a little more than one-third among rural mothers. Slightly more than one-third (39 percent) of the pregnant women received iron and folic acid tablet supplementation. In the case of tetanus toxoid (TT) injections, 54 percent of pregnant women received the recommended dose of two or more TT injections although this varied from 49 percent in rural areas to 77 percent in urban areas. In general, utilization of antenatal services is lower among illiterate mothers and among those from households with a lower standard of living.

#### 4.1.2 Deliveries

In Uttaranchal, only 21 percent of the deliveries are institutional deliveries; this varies from 42 percent in urban areas to about 16 percent in rural areas. More than 82 percent of deliveries occur at home in rural areas; more than half of these get assistance from *dais*. Even in the urban areas, more than half (56 percent) of the births take place at home. Doctors assist one-quarter of births in Uttaranchal, and trained personnel such as ANMs/nurses/midwives assisted about 10 percent. Only one of seven births (about 14 percent) that occur outside a medical facility receives a postpartum check-up within two months of delivery. Facilities available for emergency obstetric care are grossly inadequate in the state.

### 4.2 Nutritional Status of Women

Almost one-third (32 percent) of women in Uttaranchal are undernourished as per the weight-for-height index or the body mass index. Nutritional deficiency is more prevalent among rural, illiterate

women and women belonging to households with a low standard of living. About 46 percent of the women in Uttarakhand are anaemic compared with 52 percent for India as a whole. Special attention needs to be focused on undernourished, pregnant women in Uttarakhand, as these women are more likely to deliver low birth-weight and premature babies.

### **4.3 Health Issues of Women**

Health issues and needs of women should be looked at from a holistic perspective and should cover the entire life cycle of women from childhood to old age.



## 5 Child Health

### 5.1 Nutrition Status of Children

Improving the health and survival status of young children is an important humanitarian and economic investment. Low birth weight is an important cause for concern in Uttaranchal as 42 percent of the children under three years of age are underweight. Children's nutritional status as assessed by weight-for-age, height-for-age, and weight-for-height shows that a large number of children in Uttaranchal are underweight, stunted, or wasted, thereby revealing that the children are malnourished and undernourished. Undernourishment is more prevalent in rural areas as well as among children belonging to households with low standards of living. Female children are more likely to be undernourished than male children. Only two-thirds of the children under four months of age are exclusively breastfed in Uttaranchal. Over three-fourths of children (aged 6–35 months) are anaemic and over half of children in that age group suffer from moderate to severe anaemia. Male children are more likely to be anaemic than female children.

### 5.2 Childhood Diseases

Children are a vulnerable group and are susceptible to various infectious and parasitic diseases during childhood, including diphtheria, whooping cough, tetanus, diarrhoea, dysentery, skin infections, malnutrition, and accidents – all of which are preventable. The two major common childhood diseases that cause death among young children include acute respiratory infection (ARI) and diarrhoea. In Uttaranchal, about 25 percent of the children under age three, at a given point of time, are ill with fever, 17 percent have ARI problems, and

18 percent suffer from diarrhoea. However, knowledge regarding the appropriate treatment to be taken during an episode of diarrhoea is quite inadequate. Only 56 percent of the mothers of children below three years of age are aware of oral rehydration salt (ORS) packets.

### 5.3 Immunization Services

Immunization against common childhood diseases has been an integral component of mother and child health services in India. The Universal Immunization Programme (UIP) was launched to protect all infants (0–12 months) against six major but preventable diseases, namely tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles. In Uttaranchal, less than half (41 percent) of the children aged 12–23 months have received all the doses of the prescribed vaccines or, in other words, are fully immunized. This is almost comparable to the national average of 42 percent. About 12 percent of infants received no immunization in Uttaranchal compared with 14 percent at the national level.

Moreover, the high dropout rates among DPT and polio users are a matter of serious concern. The dropout rate between the first and third doses of DPT was about 23 percent while that for polio was about 30 percent. Inter-district variation in immunization coverage also persists.

### 5.4 Child Labour

No reliable data on child labour in Uttaranchal are available. However, it is expected that some children are working in various unorganized sectors of the economy. Children, and especially girls, are expected

to carry out domestic chores; as a result, many are deprived of a good education. The girl child has a lower status and enjoys fewer rights, opportunities, and benefits of family and community resources as well as matters of feeding and health care.

### **5.5 Early Childhood Care**

Investing in early childhood care is vital, and this includes nutrition, immunization, health care, education, protection and care of children, and school health programmes.



## 6 Aging and Disabilities

Improvement in public health measures has resulted in declining mortality rates especially infant and childhood mortality rates. Consequently, the life expectancy at birth has increased. Due to recent decreases in fertility, the proportion of elderly people has also been increasing. The joint and extended family structure that provided necessary social and economic support to the elderly is rapidly undergoing significant changes. This has serious consequences for the welfare of the elderly. Added to this, the public health system is not geared up to cater to the health needs of an aging population, with the exception of a few old age homes created as a welfare measure. In the absence of health insurance schemes, it becomes more difficult for the aged to avail themselves of proper health services on a regular basis.

Given this scenario, it becomes pertinent to address the common health and social problems specific to this segment of the population. Further, diseases acquired through lifestyle attributes also get confounded with problems of old age. Disabilities, such as visual disability primarily due to cataracts, hearing disability, and speech and locomotor disability, are major problems that need to be addressed.

To ensure the care of elderly, there is a need to address their social and health needs. Social needs involve providing practical and emotional support. Health needs include providing both preventive and curative health services.



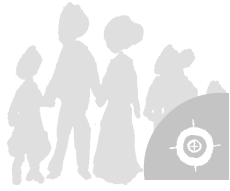
## 7 | The Mission

The Uttaranchal government is fully committed to improve the health status and quality of life of its people; to address inequalities that exist between districts, income groups, and men and women; to focus on prevalent health problems and emerging health issues with the objective of reducing the disease burden in the state; to create an enabling environment for influencing direct and indirect health determinants, such as nutrition, water, sanitation, the environment, and other factors, such as education and employment.

It intends to reach the replacement level of fertility and to stabilize its population size in a specified time

period. Attention would be given to disadvantaged sections, the population living in remote and inaccessible areas, and to women and children.

To improve the accessibility of health services and to provide quality of care, specific efforts will be made to strengthen health infrastructure, to promote partnerships with private sector and civil societies, to increase public health investment, to reduce gender discrimination, to protect human rights, to create a culture of ethical practices and accountability, and to involve elected representatives and communities at large in decision making.



## 8 Policy Objectives

To fulfill this mission, the Uttarakhand government has embarked upon the formulation of a comprehensive, integrated, state-specific health and population policy. Policy formulation was aided by research, information analysis, workshops, and a series of consultation meetings with stakeholders. In addition, several policies of the Government of India, such as the National Health Policy, the National Population Policy, and the National Nutrition Policy, and various other reports prepared by the committees, have been taken into consideration. This policy reflects the needs, aspirations, and views of the people of Uttarakhand.

### 8.1 Health Objectives

Keeping in view the state-specific health issues and priorities and the objectives proposed in the 2002 National Health Policy, the following are the health objectives of Uttarakhand:

- Eradicate polio by 2005
- Reduce the level of leprosy to below 1 per 10,000 population by the end of 2004
- Reduce mortality on account of tuberculosis, malaria, and other vector and water-borne diseases by 50 percent by 2010
- Reduce the prevalence of blindness from around 1 to 0.3 percent by 2010
- Reduce Iodine Deficiency Disorder (IDD) by 50 percent of the present level by 2010
- Reduce RTIs to below 10 percent among men and women by 2007
- Increase awareness of HIV/AIDS from the present level of 36 percent to over 70 percent by 2005
- Achieve zero level of growth in HIV/AIDS infection by 2007 and launch curative services for those having HIV/AIDS
- Establish an integrated system of surveillance for health by 2005
- Increase state health sector spending from the present level to 7 percent of the total budget by 2005 and further to 8 percent by 2010

### 8.2 Population Stabilization Objectives

The first step towards achieving population stabilization is to reach the replacement level of fertility of 2.1 by 2010 without resorting to any forceful or coercive measures. In order to achieve this, specific population stabilization objectives concerning fertility, modern contraceptive prevalence, mortality, and life expectancy are given below:

- 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 by 2006 and further to 19.9 by 2010
- Increase modern contraceptive prevalence from the present level of 40 percent to 49 percent by 2006 and to 55 percent by 2010
- Reduce the infant mortality rate from the present level of 50 per 1,000 live births to 40 by 2006 and further to 28 by 2010
- Reduce the child mortality rate from the present level of 19 to 17 by 2006, and further to below 15 per 1,000 live births by 2010.
- Reduce the maternal mortality rate from the present level to 250 per 100,000 live births by 2006 and further to below 100 by 2010
- Increase life expectancy at birth from 63 years in 2001 to 67 years by 2006 and to 70 years by 2010



## 9 Policy Directions

To achieve the mission and the policy objectives, Uttaranchal considers it necessary to have specific policy directions that provide guidance to various wings of the Medical Health and Family Welfare Department, other development departments, and all partners including the private sector, non-governmental organizations (NGOs), cooperatives, and the organized sector. These policy directions stated in general terms have to be viewed in an integrated perspective.

The Uttaranchal government will give greater priority to integrated public health approach including basic programmes such as water supply, sanitation, pollution control and primary health care, eliminate or control communicable diseases, initiate appropriate measures for lifestyle diseases, and attend to emerging diseases, such as HIV/AIDS.

It will achieve replacement level fertility and population stabilization by looking at the issues from a holistic perspective and by encouraging men to take equal responsibility in the use of contraceptive methods.

It will follow a life-cycle approach to women's health issues, with special emphasis on safe motherhood, and make reproductive health services more effective in order to reduce maternal morbidity and mortality.

It will give significant emphasis to child health issues including child rights and nutrition, particularly macro- and micro-nutrient deficiencies. Special focus will be given to the reduction of infant mortality by implementing critical child survival interventions.

It will pay special attention to disadvantaged groups, people living in less accessible areas, women, children, and the elderly.

It will strive to achieve equity by addressing the issues relating to inter-district disparities, gender differences, and human rights issues related to health of people in general and women in particular.

It will promote inter-sectoral coordination by systematically involving all development and welfare departments of the government and encouraging the convergence of services at the grassroots level.

It will integrate services of different systems of medicine such as Ayurveda, Unani and Homeopathy to achieve synergy and at the same time will encourage research and development in the field of Ayurveda.

It will build partnerships with NGOs, the private sector, elected representatives of the local bodies, and other community groups, such as women's self-help groups, to plan and implement programmes.

It will promote decentralization for effective planning and implementation of health programmes and, in collaboration with elected representatives, prepare district-specific plans to improve the health status of people, taking district-specific needs and resources into consideration.

It will evolve structures and systems to improve surveillance of diseases, utilization of information for decisions, and access to and quality of services at all levels.

It will revamp and create appropriate education and training systems to upgrade skills of health staff at all levels and to fill in existing health manpower gaps in the state.

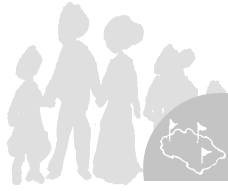
It will streamline the systems to encourage adherence to ethics, openness, accountability, and information sharing in all transactions.

It will ensure and promote ethical practices in medical care and encourage provision of health services at affordable costs in all sectors.

It will encourage greater involvement of private sector especially in secondary and tertiary health care, medical education and training and provide necessary fiscal and other incentives to promote the same.

It will generate resources to improve infrastructure and other facilities in health institutions and at the same time pay utmost attention to the judicious use of resources made available. It will also increase the financial commitment to the health sector, reaching 7 percent of the total budget in 2005 and 8 percent in 2010.

It will largely depend on persuasive measures, avoiding coercion to change the behaviour of people using strategic communication approaches, but at the same time, it will introduce a few legislative measures to control certain patterns of behaviour detrimental to the health of its people.



## 10 Specific Policy Interventions

The foremost challenge before Uttaranchal is to explore new ways to make health and other institutions more effective. At one level, this requires reordering the relationship between the institutions of the state and those of civil society, and at another level, the restructuring of values, roles, and responsibilities internal to the state and civil society institutions, including institutions of the Panchayati Raj. Uttaranchal Government will not merely play the role of prime solver of problems but act as prime organizer of social capacities for development purposes. Keeping this perspective in view, a series of specific policy interventions have been identified in this policy.

### 10.1 Organizational Structure

Reflecting the programme goals and objectives, the organizational structure should help to improve health services on a continuous basis across all geographical areas and for all people in need of health services. Structural constraints at times are major impediments to quality service delivery. Keeping this in view, the Uttaranchal government has decided to review the existing structures and take appropriate measures to make the health service delivery systems more efficient and effective.

- The organizational structure at state, district, sub-district, and peripheral levels will be reviewed and restructured to strengthen planning, coordination, implementation, and monitoring of health programmes.
- The job functions of medical officers and paramedical staff will be redefined keeping in view the policy directions and thrust areas identified.
- Qualifications and skills of health personnel will be matched to the positions that require such skills.
- Medical officers, particularly those serving in primary health centres and community health centres, will be given orientation training in public health and primary health care approaches, and the public health perspective of district and directorate staff will be strengthened.
- At present, the additional PHCs have a meagre role to play in the implementation of health and family welfare programmes in their geographical areas. The roles and responsibilities of these institutions will be redefined to make them functional.
- Performance-based reward/incentive systems will be introduced at all levels to improve productivity and commitment levels of health personnel and their contribution to the achievement of programme objectives.

### 10.2 Human Resource Planning and Development

Being a new state, Uttaranchal has several vacant positions at various levels. Efforts have been made in the past year to fill the vacant positions on a contractual basis. Contractual appointment is a short-term strategy, which will be replaced by the longer-term strategy of appointing highly committed and adequately trained personnel for various positions.

- Detailed human resource planning will be done for the state based on disease patterns, to identify current and future manpower requirements for various categories of services and to identify critical gaps in skilled manpower.
- A motivated and committed workforce is an essential prerequisite to provide quality services. Human resource development policies of the

health and family welfare department will be reviewed and fine-tuned to keep the motivational and commitment levels of its personnel high. This will include review of recruitment, placement, transfers, skills development, promotions, and performance-based reward systems in addition to improvement in work environment, particularly infrastructure and other facilities.

- Personnel and transfer policy will be designed in such a way to ensure and encourage deployment of manpower in remote areas.

### 10.3 Improving Efficiency and Quality of Health Services

To improve utilization of health institutions, there is a need to address issues related to perceived poor quality of services in public sector. In addition, attention needs to be given to appropriate and efficient use of available resources. Inefficient use of resources and poor quality of services is a reflection of provider's behaviour and skills, lack of facilities, overcrowding, long waiting time, and ineffective systems and procedures.

- Minimum standards that need to be maintained to provide quality services at different health institutions will be identified.
- A periodic evaluation of all public health institutions will be carried out and the institutions will be ranked as per the quality standards with particular emphasis on client satisfaction. Efforts will be made to see that all public health institutions reach acceptable quality standards.
- Health institutions with underutilization of resources will be identified and appropriate action will be initiated to improve resource utilization levels.

### 10.4 Improving Access to Health Services

More than three-fourths of population in Uttaranchal live in rural areas. Rural settlements in hilly areas are small sized and scattered. More than half of the villages in the hilly areas do not have road connectivity

and transport facilities. The female health workers at subcentre level often have to cater to 8–10 villages in their jurisdiction. Given these conditions, improving access to health services is a daunting task. All efforts will be made to reach people in the remotest inaccessible areas.

- Geographical mapping of the inaccessible areas in each district will be carried out with an aim to improve access to health services.
- A master communication plan including a master road connectivity plan will be prepared in coordination with the Public Works, Rural Development and Panchayat Raj Departments to cover all villages. Where ever road connectivity is not feasible, a plan to construct bridle pathways will be worked out so that people in such remote villages have access to health services especially during emergencies.
- To promote safe motherhood and primary health care, appropriately selected women from villages, will be trained in midwifery and primary health care and will be given necessary logistical support to provide quality services.
- Essential and emergency obstetric care services will be strengthened in all community health centres and block primary health centres.
- To improve access to medical services in remote areas, telemedicine and mobile services will be introduced.
- Innovative approaches in primary health care delivery will be encouraged on a pilot basis especially for remote areas.

### 10.5 Reaching Replacement Level of Fertility to Achieve Population Stabilization

Uttaranchal has a very high unmet need for family planning. One in every five currently married women in the State would like to use either terminal or modern spacing methods but is unable to adopt them either due to lack of informed choice or lack of access to these methods. Conversion of this need into actual demand and its fulfilment is a challenging task and

would certainly help the State to reach replacement level of fertility by 2010 and then to stabilize population. Promotion of use of family planning methods is important not only for population stabilization but also for improvement of health of women. Increased spacing between births and less number of children helps to reduce maternal mortality and morbidity and also infant mortality.

- Couples will be encouraged to adopt family planning methods and for this purpose informed choice and access to these methods will be promoted.
- Appropriate behavioural change communication strategies will be developed to address the unmet need and to convert unmet need to actual demand.
- Social and commercial marketing of modern spacing methods will be encouraged and health benefits of use of family planning methods will be the central theme of communication campaigns of social marketing.
- Overall access to Family Welfare Services will be increased through outreach sessions and camps.

### **10.6 Primary, Secondary, and Tertiary Health Care and Referral Systems**

With increasing demand for secondary and tertiary health care systems, particularly in urban areas, primary health care and public health programmes have not received the attention they deserve. The Uttaranchal government is fully committed to reverse this trend and place more emphasis on public health programmes with special emphasis on primary health care.

- Low-cost public health interventions with emphasis on primary health care would help to reduce mortality and morbidity rates among the less privileged segments of society.
- Partnerships with NGOs, particularly in primary health care delivery, will be encouraged.
- The high costs associated with secondary and

tertiary care will be shared with people seeking such services.

- Referral systems in the state will be strengthened so that the secondary and tertiary hospitals do not have to spend time and resources on providing primary health care or treating minor ailments. The functional referral system will help to achieve systematic and rational utilization of technical resources available within the health and family welfare department.

### **10.7 Urban Health Systems: Primary Health Care for Urban Slums**

About 26 percent of the total population of Uttaranchal live in urban areas, and this proportion is likely to increase. Growth in the urban population will be largely due to migration from rural to urban areas, and these migrants often live in urban slums without basic facilities. The urban health system is one of the most neglected areas. Except for the location of major hospitals in urban areas, there has been no systematic effort to provide primary health care to urban populations, particularly to those living in urban slums. The result is that the population living in urban slums often has higher mortality and morbidity rates.

- The Uttaranchal government will make every effort to develop urban health systems to cater to the health needs of the population living in urban slums.
- Focus of urban health systems will be to improve the health status of the urban slum population and disadvantaged segments of the urban population.
- Coordinated efforts will be made in collaboration with other departments to provide basic amenities, such as sanitation and safe drinking water, to the urban slum population.

### **10.8 Disaster Management and Trauma Care**

Given its unique geographical features and topography, Uttaranchal has been prone to natural disasters like earthquakes landslides, flash floods, and

forest fires. In addition this state has several famous pilgrimage and tourist centers, which attract lakhs of pilgrims/tourist every season. Because of this large scale traffic movement the frequency of minor/major road accidents has shown an increasing trend. Accordingly, there is a strong need to strengthen the capability of the Health System to provide an immediate and effective response in disaster situations as well as during major road accidents.

- Geographical areas where disasters/accidents usually occur will be identified and accordingly health facilities will be strengthened to provide immediate medical assistance in disaster situation needs. Hospital preparedness for mass casualties will be developed. Search and rescue units and mobile hospitals will be established at strategic locations. All medical and paramedical staff of such facilities will be trained to improve their emergency response qualities.
- Trauma centers will be established at suitable locations with all necessary facilities in order to attend to trauma cases .
- Coordination linkages will be established with the State Disaster Mitigation and Management Center and Emergency Operation Center (EOC) at the State level and the District Control Room (DCR) at the district level.

### 10.9 Decentralization

Given the inter-district variations in terms of available infrastructure, health needs, and performance levels, it is essential to have decentralized systems. The Constitutional amendments, giving a wide range of responsibilities to the elected members of panchayati raj institutions, have paved the way for decentralization.

- To realize the full benefits of decentralized systems, capacity building of elected representatives is necessary. All elected representatives will be oriented and their involvement in health care planning and implementation will be sought to improve access to and quality of services at all levels.

- To reduce the inter-district differentials in health status, decentralized district plans will be prepared keeping in view the health needs of the district and the resources available.

### 10.10 Convergence with ICDS

At present, Uttaranchal has 4,243 *anganwadi* centres with *anganwadi* workers (AWWs) drawn from and serving the communities. An additional 1,415 *anganwadi* centres are to be established in the near future. These centres have several complementary and overlapping functions with health subcentres, but each work in relative isolation. Uttaranchal, fortunately, has integrated health and family welfare and women empowerment and child development departments at the secretariat level. Convergence of these two departments has to be carried out all the way down to the community level. This calls for complete reorientation of both departments.

- To begin with at the grassroot level, all efforts will be made to achieve convergence of services between *anganwadi* workers of ICDS and health and family welfare field staff, particularly male and female multi-purpose workers.
- *Anganwadi* workers will be trained and given the responsibility to identify pregnant women in the villages they are serving, provide appropriate support to antenatal care services, help ANMs to accomplish universal and complete immunization of children, and act as depot holders for condoms and oral pills.
- ANMs and AWWs working as a team collaborating with each other would help to accomplish the objectives of both health and family welfare and ICDS programmes. Regular meetings of ANMs and AWWs will be held to encourage them to work as a team and to review their performance.
- Coordination linkages will be established at all levels of the health and family welfare department and the women empowerment and child development department.

### 10.11 Integration with Other Systems of Medicine

In Uttarakhand, there is a separate department of Ayurveda in the Ministry of Health and Family Welfare. It has 385 Ayurvedic health institutions. However, this vast network of institutions has not been put to effective use in promoting primary health care. The Ayurveda department also does not have an efficient logistics system or management information system. Ayurvedic institutions have no demarcated geographical areas for providing services. Given their proximity to and acceptance by the communities, Ayurveda medical officers have a pivotal role to play in promoting health care.

- The functions of Ayurveda practitioners will be redefined to enable them to make a significant contribution to maternal and child health services, particularly in rural areas. All Ayurveda medical officers will be given reorientation training.
- Coordination and performance monitoring linkages will be established between health and Ayurveda departments with strengthened logistics and management information systems and joint meetings at regular intervals.
- A referral system will be introduced by linking Ayurvedic dispensaries and hospitals with allopathic institutions.
- Ayurvedic institutions will act as depot holders for condoms, oral pills, and IFA tablets. They will also extend full support to ANMs in immunization of children, antenatal services, and health education.

### 10.12 Infrastructure Development

Many of the health institutions in Uttarakhand do not have adequate health infrastructure to provide quality services. Lack of infrastructure and essential equipment are also major barriers to improving access to services. This has led to increased health care costs to people and less dependence on health institutions in the public sector. Improving infrastructure and providing equipment involve huge costs to the

government. Budget allocations are not sufficient to overcome these problems.

- Innovative measures have to be in place to improve infrastructure and other facilities in health institutions. Uttarakhand has already initiated the process of private sector participation in providing diagnostic services in selected major hospitals. Similar measures will be explored to reduce the financial burden on the government. At the same time, effective measures will be taken to reduce wastage in utilization of financial resources.
- Possibilities of mobilizing resources from the donor agencies, philanthropic organizations and other sources will be explored to strengthen health infrastructure particularly in remote areas.
- A detailed and comprehensive survey will be conducted to create a database on infrastructure and other facilities, and gaps will be identified.

### 10.13 Health Care Financing

The Uttarakhand government will give more importance to public health programmes particularly primary health care. The costs associated with secondary and tertiary health care are high and the government alone will not be able to shoulder the burden. Cost recovery measures have already been introduced in hospitals with more than 30 beds by charging clients for the services provided. Persons belonging to households below the poverty line and disadvantaged groups will be given services free of cost. The revenue generated through the cost recovery measures will, to some extent, be useful for improving the infrastructure facilities in health institutions and providing quality services.

- Cost recovery measures will be reviewed, user fees for various services will be rationalized, and procedures to generate and expend financial resources will be simplified.
- At present, half of the revenue generated by health institutions is retained at the institutional level and the remaining amount is deposited in

the Treasury. Over a period of time, health institutions will be allowed to retain the total amount generated. This would provide more flexible financial resources to the health institutions and act as a motivating factor for service providers.

- Few people in Uttarakhand have health insurance policies. With the opening up of health insurance in the private sector, the number opting for health insurance is likely to increase in the near future. For poor and disadvantaged groups who cannot pay insurance premiums, the government will explore the feasibility of providing health insurance coverage.

### 10.14 Medical Education and Training

Uttarakhand has only one medical college in the private sector in the entire state and an insufficient number of training institutions for induction and in-service training for medical officers and other paramedical staff. The number of nursing, pharmacy, dental colleges, and other health institutions are also insufficient. Sufficient numbers of trained and adequately skilled persons are required to provide quality services.

- Two medical colleges and one Ayurvedic University will be established in the public sector.
- Private sector participation in establishing medical, dental, nursing, and pharmacy colleges will be encouraged. State also envisages establishment of institutions in the private sector for training of physiotherapists, radiographers, lab technicians and other paramedical personnel
- The State Institute of Health and Family Welfare will be established as an autonomous body and all training institutions, such as regional health and family welfare training centres and ANM training centres, will be linked to the state institute. These institutions will reorient all health staff in primary health care approaches.
- Full advantage of Indian Space Research Organization (ISRO) satellite facilities and Indira Gandhi National Open University (IGNOU)

distance learning programmes will be taken to strengthen the orientation of health staff.

- The quality of medical education and health training will be upgraded and periodically evaluated, and steps will be taken to maintain high-quality standards.

### 10.15 Health Information Systems

Efficient and effective health information systems are essential for informed decision making and for judicious use of available human, material, and financial resources. Management information systems currently in use have several deficiencies such as the lack of complete, reliable, and adequate information. Utilization of data for decision making at various levels in the organization is also low.

- Revamping and strengthening of health management information systems will be done immediately, and medical and paramedical staff will be oriented on the utilization of information in service provision and decision making.
- The information system will be comprehensive, covering performance, personnel, infrastructure, logistics, and transport.
- Information will be computerized at district and directorate levels and feedback systems will be established.

### 10.16 Surveillance and Research

A disease surveillance system is essential to control the seasonal outbreak of diseases, to predict and prevent epidemics, and to control communicable diseases. Surveillance is almost non-existent in Uttarakhand. Similarly, continuous research is required not only to improve service delivery systems but also to assess the effectiveness of innovative approaches, to prepare scaling up strategies, and to discover new drugs.

- Uttarakhand will participate in the national surveillance network proposed in the National Health Policy and will effectively implement all components as envisaged as part of the surveillance system.

- Research will be given a prominent position and will form an important component of programme management. Key areas requiring research will be identified and the findings will be used to improve service delivery systems and the quality of services, to conserve scarce resources, and to improve the training curriculum.
- Uttarakhand is rich in several herbs of medicinal use. Research and development in Ayurveda will be encouraged in both private and public sectors.

### 10.17 Drug Policy

Drug shortage is a constant problem in all health institutions. Usually, drug needs are identified on an ad hoc basis and essential drugs are often in short supply. A considerable portion of the budget intended for medicines is spent on expensive drugs. The costs of drugs are expected to rise further after the patent regime comes into force in 2005. By changing its procurement policies in the past year, Uttarakhand has initiated several steps to ensure supply of high-quality drugs. There is scope for further rationalization of drug policy and procurement policies related to equipment and other commodities.

- An essential drug list will be prepared for primary, secondary, and tertiary hospitals. Procurement policies will be made more transparent and accountability will be given high priority.
- Systems and structures will be created for procurement of drugs, equipment, and commodities to ensure transparency and accountability, and the rational use of drugs will be promoted. Health staff will be trained and an effective logistic system will be put in place.
- High-quality drugs will be made available to patients at affordable costs by examining drug-pricing issues. Unsafe drugs will not be allowed to enter the markets.

### 10.18 Quality Standards for Food and Drugs

Quality standards for food and drugs need to be improved to reach internationally acceptable levels.

This would require a series of measures that include strengthening of the systems and structures at all levels, introduction of new technologies, and rigorous enforcement of laws.

- Uttarakhand will establish laboratory facilities for food and drugs analysis and create a pool of technically qualified personnel to manage labs and develop systems for collection of food and drugs samples. All laws and rules related to food and drugs will be effectively implemented.

### 10.19 Biomedical Waste Management

Biomedical waste is generated in the diagnosis, treatment, prevention, and research of human diseases. Hospitals, medical care establishments, and the general public are being exposed to improperly handled medical waste. Health institutions thus become sources of infection. Biomedical waste management is given low priority in health institutions.

- All health institutions will be asked to identify various components of waste generated and create segregated storage space at various places on the premises.
- Common and intermediate storage areas will be created for different health institutions and safe handling and transportation practices will be introduced.
- Treatment technologies for biomedical waste will be examined and the best technologies available will be installed and used.
- All essential staff of health institutions will be trained in biomedical waste management.

### 10.20 Gender Sensitivity and Empowerment of Women

Gender equality is now universally accepted as beneficial for reducing poverty and increasing all round development. Gender inequalities are still pervasive and much needs to be done to make institutions and societies gender sensitive. Empowerment of women should be central to gender

issues so that women make their own decisions and have control over resources. In Uttarakhand, less than half of women have a right to make decisions regarding health and less than half have access to money. Less than one-third of women go to markets without prior permission. Literacy among women is high, but there are still significant differentials between male and female literacy rates, a reflection of gender inequities in society.

- The Uttarakhand government will play a proactive role in empowering women, addressing issues related to gender inequities in general, identifying gender issues that act as barriers in health service delivery, and sensitizing service providers.
- Differentials in male and female literacy will be reduced and the school curriculum will be revised to inculcate values related to gender equality.
- More women self-help groups will be constituted and these groups will be involved in facilitating utilization of health care services, including emergency obstetric care.

### 10.21 Issues of Equity

At present there is considerable disparity in the health status of population living in different regions of the State as well as between different groups within our society. Lack of adequate health infrastructure and manpower, especially in the hilly regions and rural areas have added to the widening hill-plain and urban-rural differentials. The gaps between the scheduled caste and scheduled tribe (SC/ST) and other sections of the society continue to exist. Gender discrimination is seen in the continuing neglect of the girl child, increase in female foeticide, continuing disparity between male and female mal nutrition, and lower access to health care. Other neglected groups in our society include growing number of the elderly and children, especially those involved in child labour and people with disabilities.

There is therefore an urgent need to address the equity issue by establishing a health system that would focus

attention on regional and geographical disparities and gender and class /caste inequalities.

- The Uttarakhand Government will provide minimum basic health services for all people irrespective of caste, religion, economic class or region.
- Special packages and programmes would be initiated for improving the health care of these vulnerable and disadvantaged groups/regions.
- Women's health rights will be given priority and they will be empowered to make their own health decisions.

### 10.22 Behavioural Change Communication

A positive change in health care seeking behaviour can be achieved through effective behavioural change communication. Successful health programmes invariably have a strong communication component. Information, education, and communication activities in Uttarakhand are unsystematic, aimed more at improving awareness than encouraging behavioural change. As a result, there is a huge gap between awareness levels and desired practices. Behavioural change communication should be an integral part of all health programmes in order to achieve programme objectives on a sustainable basis.

- A state-specific communication strategy will be developed, involving all stakeholders from the public, private, NGO, cooperative, and organized sectors, covering all health, reproductive and child health programmes. Each programme would have a strategic communication package that includes expected behavioural change, segmentation of the audience, development of relevant messages, and media planning.
- An integrated IEC Bureau will be established and it will be given full responsibility to implement IEC strategy for different health programmes.
- Workers at the community level will be trained in inter-personal communication skills, in using the

IEC materials given to them, and in mobilizing community support for health programmes.

- Linkages will be established, in both public and NGO sectors, between mass media campaigns and inter-personal communication so that they mutually reinforce the messages and bring about desired behavioural change.

### 10.23 Marketing of Products

The marketing sector, both social and commercial, has played a major role in promoting the use of spacing methods, particularly for delaying the birth of the first child and for spacing between births. Nearly three-fourths of oral pill and condom users in Uttaranchal depend on market outlets for supplies. Marketing sector presence has significantly increased in recent times for the distribution of ORS packets, disposable delivery kits, Vitamin A solution, and IFA tablets. The marketing sector, therefore, has a significant role to play in promoting spacing methods and maternal and child health.

- Innovative, sustainable marketing strategies will be tried out with the help of marketing agencies, and a basket of products that are relevant to maternal and child health and family planning will be selected.
- NGOs and other agencies will be encouraged to introduce social marketing elements in their projects.

### 10.24 Role of the Private Sector

In India, nearly 85 percent of health expenditure is out of pocket expenses, and Uttaranchal is no exception to this. The poor spend a higher proportion of their household income on health than the rich. Nearly two-thirds of health care seekers depend on private health institutions. The private health sector is very diverse and complex, consisting of formal and informal sectors and qualified and unqualified providers practicing different systems of medicine. The private sector is growing at a rapid pace, but no information is available on the number of private practitioners, private clinics, and hospitals.

- The Uttaranchal government will create a comprehensive information base on private sector practitioners, clinics, and hospitals.
- Registration of private hospitals/clinics will be compulsory and updated at regular intervals.
- Regulatory mechanisms, in collaboration with private and public sector professionals and professional bodies, will be established to encourage improvement in quality standards of private medical units and to promote ethical medical practices.
- Private and public sector partnership will be built to achieve synergy. In addition, private sector participation in the support services of public hospitals will be encouraged as has already been done in the case of diet, laundry, and diagnostic services in selected major hospitals.
- Private sector will be encouraged to establish hospitals in the secondary and tertiary sectors.

### 10.25 Role of Other Departments

Health and population policy objectives can't be achieved without involvement of other departments that deal with direct and indirect health determinants. For instance, drinking water, sanitation, pollution, food, education, and other development activities have direct relationships with the health status of people, health practices, and prevalence of diseases. Yet all the government departments work for the achievement of the objectives of their own departments not realizing the inter-relationships.

- School health programmes, a collaborative effort between health and education departments, will be revitalized not only to provide health services to school-going children but also to inculcate the values related to hygienic practices.
- School and college curricula will be revised to introduce family life education and health topics appropriate at each level.
- Safe drinking water and sanitation will be given high priority taking into account the successful experiences of the Swajal Project in the state and involving community and women's self-help

groups in implementation and maintenance of the schemes.

- Coordination linkages will be established with other departments dealing with education, rural development, social welfare, environment, and forests to introduce health and family welfare elements in programme implementation.

### 10.26 Involvement of Civil Societies

Uttaranchal has a long legacy of voluntary action that goes back to the Gandhian era and the quest of working for self-reliant villages and ecological conservation. There are about 100 voluntary agencies that are active in the state working in different development sectors. NGOs play many critical roles, such as provision of clinic-based services, development and testing of innovations, application of community-based distribution models, use of social mobilization to create an enabling environment, and experimentation with creative education and information methods. To realize their full potential, NGOs need to be treated as strategic partners in development activities in health service delivery.

- The Health Department will create a directory of all NGOs who could be actively involved in health service delivery in the state.

- A NGO cell will be created in the Directorate of Health to specifically deal with NGO issues and build partnerships with them.
- Capacity building of NGOs will be given priority and all projects granted to NGOs will emphasize sustainability of activities over a long period of time.

### 10.27 Legislative Measures

Uttaranchal will largely rely on persuasive methods to change the behaviour of people. However, a few legislative measures are required to supplement the persuasive approach. These include passing legislative acts relating to:

- Compulsory registration of marriages
- Registration and regulation of private clinics and hospitals
- Prohibition of smoking in public places

### 10.28 Implementation of GOI Acts

The Uttaranchal government will effectively implement all the Acts passed by the Government of India dealing with relevant issues, such as The Pre-Natal Diagnostic Techniques (Regulation and Prevention of misuse) Act 1994, Drugs and Cosmetics Act, Prevention of Food Adulteration Act etc.



# 11 Policy Implementation

Policy is often considered as a statement of intent. However, the present health and population policy goes beyond intentions and suggests action to be taken, particularly in regard to providing quality services; encouraging the convergence of services with other departments such as women empowerment and child development and the Ayurveda, Unani, and Homeopathic systems of medicine; and coordinating linkages with departments dealing with water, sanitation, rural development, social welfare; and involving all stakeholders in programme implementation.

## 11.1 Operational Plan for Policy Implementation

An operational plan will be prepared to facilitate implementation of the various activities identified in the policy document. The strategies proposed will be translated into action and the operational plan will succinctly specify the major activities, the persons or agencies responsible, and the likely time of initiation and completion of the activities. The implementation of the operational plan will be periodically reviewed.

## 11.2 Implementation Mechanism

### 11.2.1 State Health and Population Policy Coordination Committee (SHPPCC)

The Uttaranchal government will constitute a committee at the state level to coordinate the activities of different departments in regard to health and population policy implementation, to monitor progress, and to provide guidance to various departments. The Chief Secretary of Uttaranchal will be the chairperson of this committee with secretaries

drawn from education, water supply, sanitation, environment, rural development, social welfare, and finance sectors as members. The Secretary, Medical, Health, and Family Welfare will act as Member Secretary to the Committee.

### 11.2.2 State Health and Population Policy Implementation Committee (SHPPIC)

Another committee will be created to look into the operational aspects of implementation. This committee will consist of the Secretary, Medical, Health, and Family Welfare as its Chairperson; the Additional Secretary, Medical, Health, and Family Welfare as Vice Chairperson; the Director General of Medical, Health, and Family Welfare as its Member Secretary; concerned state programme officers of the national health programmes as members; representatives from the selected development departments as required; and NGOs. This committee will be responsible for ensuring implementation of the operational plan for the health and family welfare and ICDS programmes. This committee will provide technical direction, and monitor and review policy implementation at regular intervals.

## 11.3 Monitoring and Evaluation Mechanisms

Considering the importance of implementing the state health and population policy, an appropriate monitoring and evaluation system will be put in place. A monthly monitoring report will be prepared by the SHPPIC for each of the districts to ensure that the operational plans are being implemented in accordance with the time-line.