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Local health governance and COVID 19: A study of ground reality in Uttarakhand

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Abstract
Introduction: More than fifty years ago, the United Nations adopted the Universal Declaration of Human Rights (United Nations 1948). The Declaration embraces human rights concerns, which are presented in 30 articles.
Methodology: The research is done scientifically to solve the research problem. The methodology adopted for the present study is descriptive and analytical which is based upon scientific tools such as quantitative and qualitative. The purpose of the present study is to explore and evaluate the status of health governance provided by the public health system and the pattern of utilisation of those services by the community of study areas.
Discussion and Analysis: PRIs or local governance are the constitutional setup in India for grassroots development of the rural areas. Health is one of the subjects assigned to the PRIs in our country. In 1993 the government brought a new PRI Act with more powers and decentralisation to the local bodies.
Conclusion and recommendation: There are enough reasons to suggest that the PRIs engagement in improving the key health indicators will become a reality in India. Decentralisation is a prerequisite for the success of any health-related programme.

Keywords: Governance, vital, sufficient, highlight

Introduction

More than fifty years ago, the United Nations adopted the Universal Declaration of Human Rights (United Nations 1948). The Declaration embraces human rights concerns, which are presented in 30 articles. The first article lays the universal foundation of human rights with the message that every human being is born free and equal in terms of dignity and rights. The other articles cover issues related to political, economic, social and cultural rights and the 25th article says that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care and necessary social services" (United Nations 1948). The declaration did not, however, encompass how these rights were to be fulfilled and who was responsible for their fulfilment. In 1993, during the World Conference on Human Rights, the United Nations adopted the Vienna Declaration and Programme of Action, which identified governments as one of the principal actors in the protection and promotion of human rights, including nations' health and well-being (United Nations 1993).

Amartya Sen, a Nobel Laureate in Economics, claimed that the types of institutions existing in societies and how they function and interact are vital for people's opportunities. He further stated that the provision of sufficient facilities for both education and health care, which he declared are the governments' responsibilities, are essential to fulfil human rights for well-being and good health (Sen 1999). Kofi Annan, former Secretary of the United Nations, pushed a very strong agenda to highlight the importance of governance as fundamental for every society and asserted that governance is "perhaps the single most important factor in eradicating poverty and promoting development" (Annan 2007).

Increasing empirical evidence indicates that better governed countries tend to have healthier populations, suggesting diverse and complicated associations between governance and health systems (Kaufmann, Kraay & Zoido 1999; Gupta, Davoodi). Governance scores in the Nordic countries are above 90% of maximum available scores given by the World Bank and life expectancy at birth in these countries is over 80 years. Countries in Southern Asia score below 50% of maximum available scores and life expectancy in this area is lower than 60 years (World Health Organization 2010).

Good governance is associated with accountability and responsiveness, as authorities are expected to act in the best interests of their populations. They are also supposed to use public resources efficiently and to distribute them in an equitable manner while employing transparent and consensus oriented working procedures, allowing for public participation in policy making and implementation (Sheng 2011). Although politics are not usually included in the definition of governance, they clearly play a role in public health policy making. Countries following social democratic philosophies tend to suffer fewer inequalities and better health outcomes than countries in which liberal ideologies have been followed (Navarro *et al*. 2003; Navarro, Shi 2001; Safaei 2006).

The concepts of "governance" and "health systems" are both somewhat abstract and definitions are not consistent. The World Bank, which annually aggregates data to create an index that ranks countries according to governance quality, refers to governance as the traditional way of managing countries and institutions, involving the process by which policies are executed (World Bank 2010c). The United Nations refer to governance as formal and informal arrangements that determine how public decisions are made (United Nations, Department of Economics and Social Affairs 2007), and the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) simply define governance as "the process of decision making and the process by which decisions are implemented (or not implemented)" (Sheng 2011). No universal definition exists

for health systems, but the World Health Organization refers to the term as a system that includes all participants whose primary purpose is to improve health and a system that delivers quality services to all people, when and where they need them (World Health Organization 2005). A health system therefore requires a robust financing mechanism, well maintained facilities, a well trained workforce and reliable information. How well health systems perform depends on a wide variety of factors, but the World Health Organization has suggested that they should be evaluated on the basis of how well they achieve the goals for which they should be held accountable (World Health Organization 2011).

COVID-19 has exposed significant weaknesses in global (health) governance. The World Health Organization (WHO) in particular has come under fire over its deference to China and a lack of rigour in its initial response. While much of the criticism is valid, the pandemic has also revealed a strange disconnect, with states unwilling to invest in strong global health governance structures yet expecting them to deliver quickly in an emergency. Indeed, in many ways, COVID-19 presents not simply a failure of global health governance but, more fundamentally, a failure to recognize health as an inherently global problem, intimately linked to other cross-border challenges.

Although a pandemic is, by definition, a cross-border concern, attention has focused overwhelmingly on national-level impacts and responses. In many ways, COVID-19 has reinforced a trend towards isolationism and nationalist parochialism, with rich countries scrambling over scarce resources such as personal protective equipment, medication, ventilators, or vaccines, while efforts to make access to these tools more equitable are hampered by a US$35 billion funding gap. As lockdowns, border closures, and social distancing measures keep communities physically isolated, "the global" feels more distant than ever before and the onslaught of criticism facing the WHO is making it easier for national governments to dismiss the need for multilateral cooperation.

The UN Secretary-General, has rightly declared the international response to the COVID-19 pandemic a failure. There is a gaping lack of imagination beyond national exit strategies. The WHO, in its current state, is unable to lead a high-level conversation on a truly global strategy to suppress the spread of the virus and national leaders have shown little interest in advancing this discussion. For some observers, the COVID-19 experience is unlikely to galvanize significant change. So far, the pandemic has accelerated rather than halted the trend towards a more fragmented, physically constrained world, characterized by ramped up great power rivalry and vast economic inequality. Yet, as the sweeping scale of the COVID-19 crisis and its long-term implications become more apparent, calls to "build back better" are growing louder. In the past, radical global governance innovations – including the foundation of the UN – have often followed major global shocks.

COVID-19 has certainly been a large enough shock to expose the systemic fragilities of our globalized civilization. Far beyond cross-border infection risks, these include the fallibility of just-in-time supply chains, the interdependence of our economies, the vulnerability of global food systems, and the effect of growing inequality on social cohesion between and within countries. COVID-19 has also served as a reminder that human health is closely linked to the health of the planet, with accelerating levels of deforestation, biodiversity destruction, and climate change driving the spread of zoonotic diseases and other health threats. The pandemic has also exacerbated global inequality, undoing years of progress in a matter of months, plunging millions into poverty, and threatening to unleash socio-economic turmoil which is almost guaranteed to spill across borders.

Addressing these issues will require, first and foremost, a realization of how profoundly interconnected they are and how inadequate our legacy solutions have proven to be. It will also require a recognition that we are certain to face other and more challenging global risks than COVID-19. Pragmatic responses to the current crisis in global governance caution that calls for change must be grounded in political reality. But the very real prospect of global catastrophes worse than COVID-19 compels us to adopt a radical pragmatist position, recognizing that "political reality must be grounded in physical reality," and that building more effective governance solutions is not an option, but an imperative. Neither is it an impossibility. The future is open, change is inevitable, and political leaders – and the global ecumenist at large – have real choices to make as critical climate negotiations in late 2021 loom into view. Such times of opportunity and challenge also invite more searching questions – above all, what exactly is it that we want to rebuild? And what might we want to change or leave behind? In other words, we must ensure that this momentous decade is one of building "forward" rather than "backward".

The aim sat for this thesis was to make a contribution by increasing the knowledge related to the link between health governance and management of COVID 19 in Uttarakhand by applying various research methods. No such study exists in which the relationship between governance and COVID 19 performance is coherently explored both in terms of breadth (different settings) and depth (application of mixed but robust method of analysis). By incrementally increasing the knowledge of this link, this thesis provides additional evidence around the relationship between governance and COVID19. The potential benefit is that policy makers are provided with improved evidence based knowledge which they can apply to develop and improve their working procedures with the aim of allocating public resources more efficiently and equitably.

Methodology

Research methodology is comprehensive and much wider than that of research methods. Methodology is an approach which tries to explore the logic which backs up the methods of investigation. In other words how research is done scientifically to solve the research problem. The methodology adopted for the present study is descriptive and analytical which is based upon scientific tools such as quantitative and qualitative. The purpose of the present study is to explore and evaluate the status of health governance provided by the public health system and the pattern of utilisation of those services by the community of study areas. The logic behind the selection of the study area, sampling design, procedure of data collection and its analysis has explained in the subsequent sections of the study.

Profile of Selected villages from three blocks

From Upper Himalaya region Bhatwari block has 97 village, Middle Himalaya region Chaukhatia block has 167 and from lower Himalaya Bahadrabad block of Haridwar has 139 village.

Table 1: Description of region wise district, block and Number of villages (Census 2011)

Region	District	Block	Total Number of villages	No selected villages (5% from Total villages)
Upper Himalaya	Uttarkashi	Bhatwari	97	5
Middle Himalaya	Almora	Chaukhatia	167	8
Lower Himalaya	Haridwar	Bahadrabad	139	7

Total 20 villages (5 village from Bhatwari, 8 from Chaukhatia and 7 from Bahadrabad) were selected from the total 403 village of all three regions which is 5% of the total village. The responders also selected based on number of household of villages as per the census 2011. Form Upper Himalaya region 111, Middle Himalaya region 102 while lower Himalaya region 382 responders were selected. The 20% responders was selected from the total of household (census 2011). The highest number of responders were selected from lower Himalaya because the number of householders is just double of both other regions. The villages were selected in a way that out of total villages 50% village is nearest to the selected block head office, and the another 50 % is distant from the block head office but the distant village is identified not only on the basis of distance but also located in the opposite direction from the block head office or any other government institutions. The purpose behind the selection of villages nearer to and far away from block head office was to know the impact of distance factor on the utilisation of services

Table 2: List of villages and Village wise total population and households and selected household

District	Name of block	List of selected village	Total population	No of house hold	Selected householders for as a responders
Uttarkashi	Bhatwari	Sukki	525	101	20
		Nelang	102	48	10
		Mukhawa	680	124	25
		Dharali	583	137	27
		Bagori	567	145	29
	Sub Total		2457	555	111
Almora	Chaukhatia	Agar	224	56	11
		Dhaur	68	16	3
		Ganai	988	232	46
		Jalali	102	31	6
		Laluri	138	41	8
		Malla Tajpur	269	64	13
		Seema	299	71	14
	Sub Total		2078	511	102
Haridwar	Bhadrabad	Rithaura Grunt	634	115	23
		Daluwala Grunt	1779	351	70
		Daluwala Mazbata	1160	230	46
		Hazara Grunt	3359	534	107
		Asafnagar Grunt	609	108	22
		Daluwala Khurd	712	138	28
		Rawan Bans	634	115	23
		Manu Bans Grunt	1962	320	64
	Sub Total		10849	1911	382
Grand Total			15384	2977	595

Selection of Sample Households

The sample size of households for the present study has been fixed at about 20 percent of total number of household from the selected villages. The total house hold selected for study is 2977 (555 population selected from Uttarkashi, 511 from Almora and 1911 from Bahadrabad blocks) according to 2011 census the 20% percent sample size of the household number selected for study approximately is 595. Hence in the present study we have taken 595 sample population. Further this 595 sample households were distributed respectively according to the population of all three districts or regions

= Total Number of household *5/100
=2977X 5/ 100= 595

The selection of households in study area i.e. in the selected villages, systematic random sampling using skipping interval method was adopted. The class interval or what is called interval size indicates the households to be selected at regular interval. In this type of sampling the first house is selected randomly and the remaining houses of the sample are select at fixed interval.

The class interval was calculated on the basis of the following formula.

Class interval = Total Household in the village/ No of household will survey in the village

Class interval =2977/395 = 5

The class interval for all village was 5 for three locations. The very house as entered in the village. Having completed

the survey of that household then selected the next 5 number house on the basis of interval size (class interval).
In each selected household one person was selected as a responders who is elders' in family and should be between 18 to 65 years. If the eligible person was not found adjoining or next family has been selected.

Table 3: Calculation of Class Interval

District	Name of block	List of selected village	Total population	No of house hold	No of responders	Class interval
Uttarkashi	Bhatwari	Sukki	525	101	20	5
		Nelang	102	48	10	5
		Mukhawa	680	124	25	5
		Dharali	583	137	27	5
		Bagori	567	145	29	5
	Sub Total		2457	555	111	
Almora	Chaukhatia	Agar	102	22	4	5
		Bamangwali	112	34	7	5
		Dhaur	68	16	3	5
		Ganai	988	232	46	5
		Jalali	102	31	6	5
		Laluri	138	41	8	5
		Malla Tajpur	269	64	13	5
		Seema	299	71	14	5
	Sub Total		2078	511	102	
Haridwar	Bhadrabad	Rithaura Grunt	634	115	23	5
		Daluwala Grunt	1779	351	70	5
		Daluwala Mazbata	1160	230	46	5
		Hazara Grunt	3359	534	107	5
		Asafnagar Grunt	609	108	22	5
		Daluwala Khurd	712	138	28	5
		Rawan Bans	634	115	23	5
		Manu Bans Grunt	1962	320	64	5
	Sub Total		10849	1911	382	5

Collection of Data

Both primary and secondary data were used in the study. The study is mainly dependent on primary data. Hence relevant data was collected from field survey. Interview schedules were designed separately for selected households and personnel of households of the study area. Informal chat with village leaders, social workers, and local representatives was done to access the necessary information.

The secondary source of data relating to the health governance status of the people of the villages, health governance welfare programmes provided by public health system and other government health institutions were collected form published materials, books, journals, relevant libraries and government publication such as annual reports, statistics were also used to make the study more informative.

Interview Schedule

Interview schedules were designed to collect the necessary data from the households as well as from personnel of local governance members. The questions were prepared in such a way to examine the objectives related to the study. It consists of structured statements, open ended questions and multiple choice questions. The questions were grouped in to different sections.

Interview Schedule for Households

The first two sections of the schedule had a list of questions dealing with the identification particulars and general household information. The third section probed the family particulars like names, sex, education, marital status, occupation income and morbidities found in the family. The fourth section consisting of those questions which enquire about the risk factors influencing health governance at local level. The fifth section consists a big list of questions investigating the reasons for utilisation or non-utilisation of health care and family welfare services offered by the public health system. The last two sections of the schedule consisted, questions relating to the perceptions, opinions of respondents about local governance and their suggestions in improving the quality of health care services provided by the public health system.

Data Processing and Analysis

All data checked for inconsistencies, missing values, and incompleteness, then entered into SPSS- 20 for further analysis. Descriptive statistics, including frequencies and proportions, will be computed and presented in the form of text and tables. The binary logistic regression analysis will be performed to identify factors associated with health care utilization for the meaningful interpretation of results. Enter method will be used to select candidate variables having a P-value of <0.2 in the bi-variable analysis and entered to the multi variable analysis for controlling the possible co-founders. Adjusted odds ratio (AOR) with 95% CI will be estimated to show the strength of association. Data analysis and case descriptions would include description, statistics, cross tabulation, frequency, correlation etc.

Study Finding or Result

The present study "Health Governance and COVID 19: A Study of ground reality in Uttarakhand" has also tried to inculcate the scientific method, tools and techniques to maintain the objectivity in the process of research. In the contextual of the review of the literature presented in the previous chapter, the study is designed to explore and evaluate the objectives laid down for study of provision of

health and governance by the public health system by the people in the study area during COVID 19 period.

The study was conducted in three districts of Uttarakhand selected from three distinct zones of the state as per the altitude. Uttarkashi was selected from upper; Almora from middle Himalaya and Haridwar was selected from plane area. In Uttarkashi district, Bhatwari, Almora district Chaukhatia and in Haridwar district Bahadrabad block were selected.

Table 4: List of villages and Village wise total population and households and selected household

District	Name of block	No villages	Total population	No of household	Selected household for as a responders
Uttarkashi	Bhatwari	5	2457	555	111
Almora	Chaukhatia	7	2078	511	102
Haridwar	Bahadrabad	8	10849	1911	382
Grand Total		20	15384	2977	595

The study was conducted in 20 villages of selected blocks of the Uttarkashi, Almora and Haridwar districts. The total population of selected villages were 15384 in 2977 households in which 595 responders were selected randomly in interval 5 households at village level. 64% responders from the Haridwar, 19% from Uttarkashi while only 17% responders were from Almora.

The highest number of BPL responders for Haridwar (23) while equal number of percentage were participated from Uttarkashi and Almora (3). The highest percentage illiterate and above then graduate in Almora while lowest percentage of illiterate and postgraduate responders from Haridwar. More 60% of responders were the between 19- 50 years in which 60% from Haridwar district. The largest number of responders below the age group of <18 years from Haridwar while Haridwar contributed lowest number of people age group >51 years. Across the districts only 20% responders were in government and private jobs while more 60% have involved in agricultural activities and own business while 20% are not doing anything. Interesting was that Individuals were in jobs in which less than 10% are in government department while rest 90 percent were in private sectors.

Utilization of Health services

The finding suggested that both mountain districts were more dependent on health services on government system while plane district was more dependent on private health system while across three districts or three regions (upper Himalaya, lower Himalaya and plan area) majority of population access private health care services during the COVID time. The findings also indicated 20% population also access health services from other stream in which more than 90% utilizing AYUSH services both formal and informal. The findings also indicated that local panchayat motivated people in early stage of disease for screening, isolation and treatment across the three districts. The study also revealed that AYUSH professionals are easily accessible at community level especially in upper and middle Himalaya regions while allopathic or modern facility is easily accessible lower Himalaya or plane regions. The local panchayat members also have very effective coordination with ASHA, ANM and Anganwadi workers which actually served at household across the three districts. During the discussion it also became very clear that large numbers of NGOs, Individuals and other organizations not only mobilized community for screening, isolation and treatment but also distributed humanitarian aids during the COVID time.

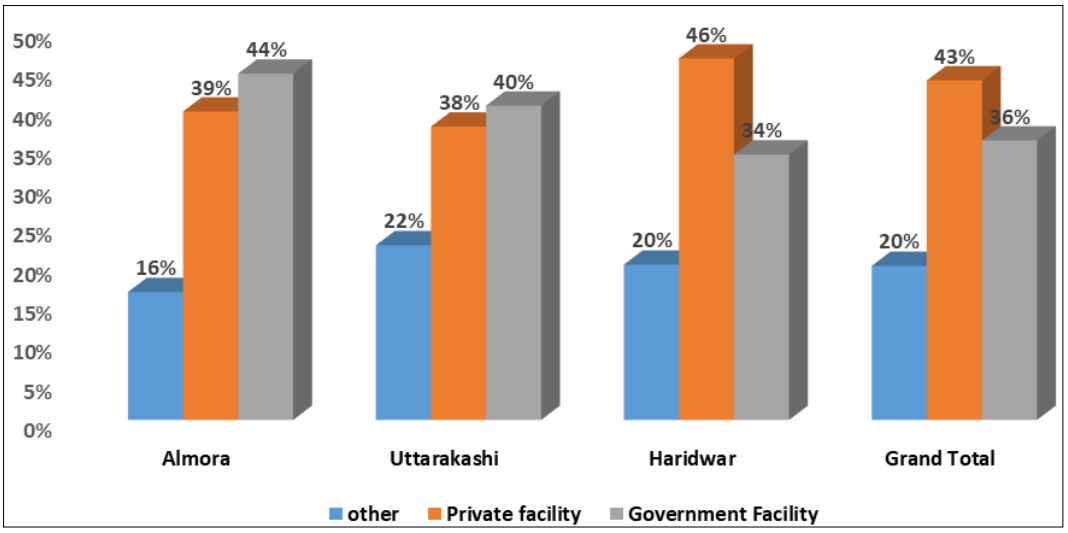

Fig 1: % of Accesssing Health Services from Different Facilities During the COVID Time

The findings also suggested that the members of local governance also play significant role to motivate people coming from outside the area/ district/ state for screening and isolation. Large number of village panchayat made their own role and regulation so that appropriate COVID behaviour can be ensured properly. Local governance also manage effectively the coordination between health system and community across the three districts.

Local Governance and health outcomes

The study also assessed the choice of health facility selected by people during the COVID time and also try to understand the reason of selection. Around only one third of population received primary health and investigation services within 5 kilometre range while rest 75% of population have to travel more than 5 kilometre distance to reach public health facility. The local governance play a crucial role not only

motivating health workers and professional but also provide other support to their families and facilitate better coordination with higher authorities. The study indicated that dissemination of health education was also the only effective tool which can saved life of people. Accredited Social Health Activist educate community various level and make sure all villagers would follow COVID instruction strictly. The study findings suggested that in Uttarkashi more than half education program were organized by local panchayat members by the help of community health workers

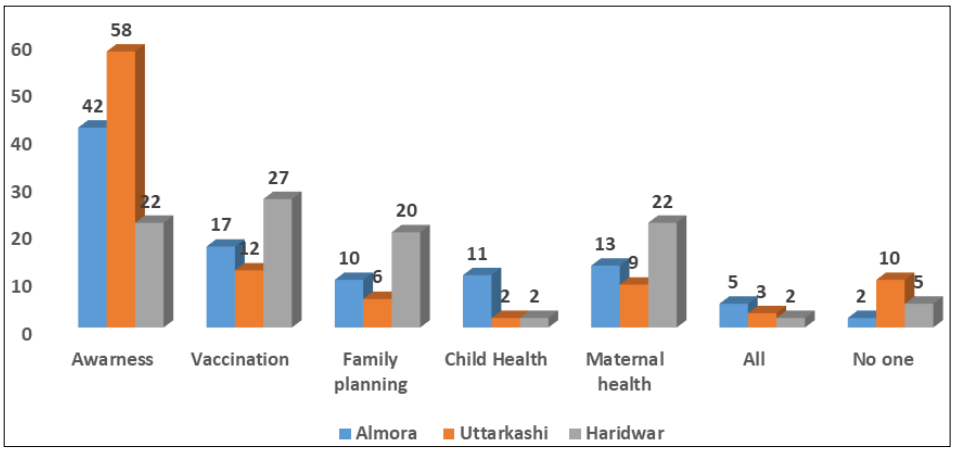

Fig 2: % of types of Health Services providing by local governance at community level

Legal, functional and financial strength of Local Governance

Local governance not only help to COVID related health activities but they also help to existing health restart the vaccination, family planning, maternal child health intervention at community levels. Across the three districts specially vaccination (27%), family planning (20%) and maternal child health (22%) intervention start and sustain by the help of local panchayat members.

Total 595 responders graded the performance of local panchayat based on their performance in respective areas. It clearly indicated that panchayat members basic life skills such as coordination, negotiation, financial management, planning and monitoring was below the 50% which also limited their performance certain extent. The finding also suggested that specific training and exposure on health program and interventions also totally negligible. The finding also revealed that the local panchayat members of Haridwar district was much better position to understand various aspects health as compare to Uttarkashi and Almora. The study also shown that clarity on role and responsibility always have significant impact on individual performance. The finding suggested that only one forth responders were agree that that local panchayat has sufficient clarity on their role and responsibilities as well as capability and capacity to handle their task effectively. The findings clearly indicated that more than 50% were insufficient or did not know, what sorts of clarity and capacity actually required to achieve the desire outcomes.

Discussion and Analysis

PRIs or local governance are the constitutional setup in India for grassroots development of the rural areas. Health is one of the subjects assigned to the PRIs in our country. In 1993 the government brought a new PRI Act with more powers and decentralisation to the local bodies. The linking of the health sector to the Panchayati Raj system is a multifaceted chain procedure involving various stakeholders at different stages. The PRIs have often been dominated by the local elite, obstructed by politicians at the state level, and are mostly seen as advisory rather than decision-making bodies. The financial resources allocated to them are often inadequate, usually governed by the tied budget lines, leaving little flexibility at the local level to meet the precise needs of local people. However, based on the recent Union health budget, a new budget line has been introduced. This provides elasticity to the PRIs in using a part of the total health budget according to the local needs and new guidelines.

Although PRI officials take their own decisions on planning and budgeting of programmes, it seems that they are not in tune with the local requirements. PRI officials do not even consult GPs. According to them GP members are illiterates and they don't have any capacity to handle any health issue or crisis. Local politics in rural areas affects Government health officials in the decision-making process. The field survey shows that some or the other forms of conflict exist between the health department and PRIs. Hence dual responsibilities and controls upset and severely affect the quality of the public healthcare delivery system in rural areas. Health officials should not be under the obligations of the elected representatives of PRIs at any cost while preparing the health plans. The responsibility of PRIs, especially in human resources management, financial management, planning and problem-solving is very vital. PRIs have some sort of control on the lower level health staff only. In some cases, some health officials have a nexus with PRI representatives for various personal reasons. It is found that in a few cases the capacity of the health officials in monitoring and appraisal of various health programmes are continuously connected with the added official responsibility and are over-burdened. The health administrators must be given some extra discretionary powers for timely decisions (Bossert *et al*., 2010).

At the Gram Panchayat level also there must be a stipulation for sufficient independence to reallocate funds and change activities and programmes according to the local needs of the concerned villages/blocks. As per the current plan of action, the health plan restricts the preparation of suitable village level health schemes by GPs. However, the district level plans by the ZP that approves the nature of grants and programmes are fixed at the GP level. Hence, the health

programe is often described as a partially decentralised system whereas a more real devolution of power at the ground level is necessary today. Although the health scheme allows better elasticity in implementing a variety of required public health programmes, increasing significant and appropriate interventions of GPs in a more meaningful manner are the need of the hour. It is generally opined that more discretionary power should be given to Gram Sabhas/Panchayats with respect to the planning of a variety of local health programmes including monetary issues.

Further, locating health schemes functions within the GP and implementing essential health programmes by the village health committee will make the health-for-all scheme an achievable reality. Effective coordination between the concerned PRI members and Government health officials may be helpful in breaking social and cultural hurdles in implementing health sub-programmes. Health policy experts say that the health programme privileges the ZP as the key implementing body without providing the necessary discretion and autonomy at the GP level to reallocate resources and change activities according to its needs. Although health mandates the development of the village level health plans, they only form one component of district-level schemes, which in turn determine the quantum and nature of funding that is allocated for the GP level (NRHM, 2012, 2013 reports).

The major problem is that different political parties have control over the state health administration, PRIs and health officials for various reasons. Thus, some amount of caution is needed in devolving requisite powers to PRIs within the health department. Moreover, one more serious and vital issue is related to the financial powers accorded to PRIs under the health programme. The PRIs have very limited financial resources of their own, and hence, are hugely dependent on Government grants. Until and unless PRIs are empowered with financial resources, their involvement in strengthening the rural health service delivery will remain only supplementary rather than decisive (Gupta, 2010).

PRIs are jointly responsible for the implementation of public healthcare schemes in rural India. The PRIs are responsible for providing infrastructure for the PHCs/CHCs. The study found that the PRIs don't have the required technical skills in handling some of the health issues. In most cases, local politicians are not interested in public healthcare issues. However, the up gradation of the PHCs/CHCs largely depends on a political decision. PRIs need more capacity-building measures without which they are unable to provide any professional support to the health programme. The majority of the health system staff accuse PRIs of unnecessary intervention in their work. Even today most PHCs/CHCs are working without any fundamental facilities in the rural parts of Uttarakhand. Manpower shortage is also a big issue. Doctors are not ready to serve in rural areas because of their remoteness and other issues. The private practice of government doctors is also causing a major problem. The Government is ready to pay more than 125,000 monthly salary to a doctor. But doctors are not ready to serve in the rural parts of the state. Uttarakhand, the situation is very pathetic. Here, many Block/District hospitals are running without required doctors, equipment and other fundamental facilities and the PRIs are not really decisive.

The transfer of health system staff to administrative control under the PRIs gives a good result when elected representatives and health service provider's officer's work in good coordination. Understanding and sharing of information between these two segments is very vital. In the majority of cases, PRIs have played a good role in improving the functions of health facility in the state. The quality of service and the supply of medicines have also increased now. Moreover, absenteeism among medical staff has also decreased today because of the PRI role. The service of health providers and the paramedical staff also needs to be improved soon. However, the study found that better quality service has increased in many public health facility that are close to the urban areas of Uttarakhand.

Public Health Institutions (PHIs) also play an important role in preparing village health plans. Village health/Block health plans are being prepared at the various levels of PRIs with the help of PHIs. Gram Sabhas, working groups and the standing committee on health are playing an active role in preparing village health plans. However, Gram Sabhas need more training and power on health issues. Health providers also advise PRIs during planning. PRIs take the final decision about funds to be allocated for PHIs. Village-level health plans are prepared by the respective Panchayats that are scrutinised by the technical committee and the district planning committee finally. The major problem is that Uttarakhand has no unified public health law.

Different standing committees on health are a vital and integral part of the PRI system. The Village Health and Sanitation Committee (VHSC) and the Arogya Raksha Samithi (ARS) are also playing both advisory and executive roles in improving government health programmes. The Committee work also includes sanitation, nutrition and funds allocation. The creation of new PHCs and the monitoring of disease mapping will be based on the recommendations of the standing committee on health. These committees are very well placed in the preparation of village health plans. Some of the industrialists and the individuals are also now donating money to the PRIs. The Health Management Service (HMS) is getting revenue from patients in the form of the 'user fee'.

The service norms of the health officials come under the jurisdiction of PRIs. However, they are continuing as state government employees and only their salaries are being distributed through the ZP. The State Health/District society is responsible for the recruitment, postings and promotion of health personnel within Uttarakhand. PRIs have limited control over health officials regarding the service norms. Only certain disciplinary actions can be initiated by PRIs against the PHI staff. These steps also need some modifications.

Given the mixed pattern of utilisation of healthcare facilities of both the private and public sectors, as reported by the respondents, an inquiry was made into the reasons behind the utilisation of private facilities. These reasons serve as clues towards understanding the gap in public health facilities. The prominent reasons cited are the unavailability of doctors in public facilities and the better treatment and related issues in private hospitals. Apart from these prominent reasons, the other reasons cited were convenience, time-saving, immediate attention and behaviour of the staff. This indirectly hints at the limitations of public health facilities. To bring about a change in the grassroots health system, different health providers need to be very responsive in terms of designing specific programmes to cater to the needs of the local community.

One of the major roles of the PRI is to implement various Government health schemes according to the local needs. The VHSC can play a key role in the effective implementation of the JSY scheme. The system should try to bring in an institutional framework and empower Panchayats for a sustainable movement. There is a need to educate elected local government functionaries on the need to support and encourage the movement with local NGOs. The State government should allocate more funds in the budgets. The funds should mainly be used to train doctors, nurses and volunteers and Panchayat functionaries to hold an health awareness programme for people and establish a network of facilities to promote institutional deliveries.

The roles and capacities of PRIs are crucial to the kind of contribution that they can make towards improving the grassroots health system (Pahwa & Daniel, 2013). Such roles and capacities involve the awareness of PRIs regarding their operational jurisdiction for intervening in the health system as well as ensuring better health for people. In either case, PRIs need to have an environment that enables them to serve the cause of better and efficient healthcare provisioning.

Conclusion and recommendation

There are enough reasons to suggest that the PRIs engagement in improving the key health indicators will become a reality in India. Decentralisation is a prerequisite for the success of any health-related programme. However, absenteeism, low quality in healthcare, low satisfaction levels and unbridled corruption have hit public health services in India. This has led to mistrust of the system and the rapid growth of private service. Quality PRI engagement is the only way to realise the Government's large-scale community health programmes impacting the marginalised and vulnerable sections of society. This necessitates capacity building to have skilled manpower and an administrative system that can address many complex issues pertaining to the local health care system. During the COVID time three tier panchayat system has received global attention through their remarkable performance in rural arrears of Uttarakhand.

Finally, study concluded that local governance (three tier panchayat) is only one tool which can improve individual, family, community, society and governance as well as government effectiveness, efficiency, transparency and accountability in the health outcomes. COVID 19 made very clear that local panchayat make significant difference in health outcomes at community level. World Health Organization also recognized the efforts made by millions of ASHAs (Accredited social health activist) – Community Health workers - in rural areas of India. The all ASHAs are the part of local governance and their selection, appointment, capacity building and health delivery supervise directly by Gram Panchayat. The multi nodal and multi modal health system also manage at community level through the Village Health Nutrition and Sanitation committee which is a subcommittee of Gram Panchayat.

Limitation of study

There are several limitations related to this conceptual framework. Firstly, as no universally accepted way exists to measure neither quality of governance nor health systems performance, interpretations of the association between these two complex concepts, as set up in this conceptual framework, might be affected. Secondly, the perception of local governance quality differs depending on the context within which health systems operate, which could cause some important governance qualities affecting health systems performance to be overseen. Thirdly, as the focus of the thesis is on national and local governance, important governance factors within the health sector, having an influence on health systems performance and health outcomes, might be neglected.

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