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Marginalizing Local Government in COVID-19 Containment: The Case of Kerala, India

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ABSTRACT

Local governments (LGs)have an advantage in fighting pandemics compared to other levels of government. This is evident in the success stories of many local governments worldwide. Because the LGs are closer to the ground, they can act more contextually and flexibly. Pandemic containment measures, such as contact tracing, physical distancing, wearing masks, quarantining, encouraging vaccination, and social support, are more accessible to local governments. They can also forge a certain degree of ownership over such efforts. This study analyzes the role of rural LGs known as panchayats in containing pandemics in Kerala, which has the most empowered village-level panchayats in India and a track record of participatory planning for more than two decades. This paper discusses Kerala's gains in pandemic management and the role played by the local government in implementing goals set at the state level.

Keywords
gram panchayats; health; pandemics; planning; quarantining

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INTRODUCTION

This study seeks to shed light on the efforts of gram panchayats (rural local bodies) in Kerala to contain the COVID-19 pandemic in close cooperation with the state and other actors. They are at the bottom of the rural local government system, with District Panchayat at the apex level and Block Panchayat at the intermediate level. However, the inter-tier relations among these three tiers are not hierarchically organized. This paper is primarily based on secondary data supplemented with selective interviews of experts and people involved in pandemic management. This study is descriptive and analytical, focusing mainly on qualitative data.

Local governments (LGs) constitute sites where the impact of COVID-19 is felt most intensely, where vulnerable groups can be identified and monitored, and where services are provided more effectively. A pandemic such as COVID-19 requires community-wide effort for containment. This can be performed more effectively through the LGs closest to people (Green & Loualiche, 2021a; Gupta et al., 2021). Furthermore, the NGO sector and faith organizations focus most of their work at the community level and will have to do so in partnership with local governments. The U N's 2030 Agenda focuses on the localization of the Sustainable Development Goals (SDGs) at the community level. SDG3 on health or SDG8 on economic growth plays a key role in LSGs (Wright, 2020).

Countries such as the UK, where a centralized approach was initially attempted, have also recognized the importance of local bodies (Ahrens & Ferry, 2020; Resende et al., 2021). Others, such as the US, Finland, and Uganda, have transferred the necessary funds to local bodies either as part of the stimulus package or as special funds. Many sub–Saharan African countries, such as Uganda, have strong local government structures, which have stood them in good stead during past pandemics. Rwanda has robust local governments and a good record of the Ebola threat. The advantage of local governments is that they can do more with limited resources than with other levels of government (Wright, 2020).

Local-level politicians are not particularly known for their preparedness in national emergencies, but are more known to provide services, often after the onset of the emergency. The food supply is one such area. Many local governments worldwide have ensured the availability of food stocks. They also play a role in ensuring local food production and reviving the economy (Gurgel et al., 2020; Mardones et al., 2020; Sukhwani et al., 2020). Local-level functionaries are associated with many African countries. These associations have been directly engaging with national or regional governments on the one hand, and heads of local bodies on the other. However, many local bodies in developing countries do not have a solid health-related legal mandate strong enough to declare lockdowns and impose quarantine measures. Pandemic management also requires the effective coordination of a complex nature within a multilevel governance system. Local, provincial, and central governments are expected to work together as equal partners in a multilevel governance approach to the containment of crises. For example, a South African Local Government Association representative is a member of the High Command

Council (HCC). In London, the Mayor participates in the National Security Committee, known as COBRA (Wright, 2020).

Pandemic management involves testing, tracking, and contact tracing to prevent further infections, protect the most vulnerable, and establish care centers. Managers must quarantine individuals and care for the homeless, migrants, immigrants, and the unemployed. Delays in coordinated response have exposed the fragility of even wealthy countries such as Italy and, to a lesser extent, New York and Miami (Ahmad, 2022). Local governments have an advantage because local communities generally trust them.

Although the 73rd and 74th constitutional amendments in India have brought in the provision of health as one of the functions of local bodies, it is primarily carried out through the health line department. Local bodies have been marginalized in the Disaster Management Act with a passing reference. In India, the police have enforced lockdowns, social distancing, and quarantine. This is a task that they are not trained to perform, except in cases where community policing is prevalent. Many countries, such as Chile, Spain, and Canada, have established intergovernmental coordination mechanisms. India did not have such a mechanism (OECD, 2020).

NATURE OF LOCAL GOVERNMENT

There is also the issue of which type of local government is more effective in containing pandemics, such as COVID-19. While there is no consensus, there is a feeling that directly elected political heads are more effective than indirectly elected ones because they have the mandate of all citizens in the local government area, enabling them to lead from the front (Blair, 2000; Kodiyat MS et al., 2020; Wollmann, 2004). Another issue is the capacity and size of local bodies. Larger local bodies are often seen as more capable of responding to pandemics than smaller ones, due to better resource endowments. However, there is no conclusive evidence to support this hypothesis (Abrori, 2021; Anttiroiko, 2021; Permanasari et al., 2022). The pandemic has emphasized why we must have more powerful and accountable mayors and heads of rural local bodies. Traditional authorities can also play a beneficial role. During the Ebola epidemic in Sierra Leone, paramount chiefs were trusted more than politicians or medical experts, and they addressed the disease as a 'family problem' (Kamara et al., 2022; Parker et al., 2019; Richards, 2019). In sum, experiences everywhere suggest that a bottom-up approach is needed for effective pandemic management and recovery.

Why Local Governments?

Thus, local governments can play a more valuable role in COVID-19 management. Being closest to the community, they can develop context-specific and people-friendly responses, mobilize local resources, and better monitor compliance. Furthermore, they are more likely to be conscious of the urgent needs of citizens because their ability to respond is intimately linked to their future electoral prospects. The third question pertains to legitimacy. Local governments have higher legitimacy

than authorities representing other levels. This has implications for motivating people to comply with public health directives (Dutta & Fischer, 2021).

Different states in India have developed different pandemic management strategies. In Orissa, heads of village panchayats were given magisterial powers hitherto vested in District Collectors who belonged to a higher civil service. Using Section 51 of the National Disaster Management Act of 2005, the heads of village panchayats were empowered to undertake quarantine measures for migrants and others who returned home and their families and create a community-based monitoring system (Billava, 2021; Pandey et al., 2022; Paul, 2022).

Emergency financial transfers from higher levels of government to local bodies are often necessary. Neither the state governments nor the center has done so (Green & Loualiche, 2021b; Nemec & Špaček, 2020). The Health Ministry in India has developed a micro plan to contain COVID-19, playing a prominent role in community mobilization and surveillance. On April 24, 2020, the Prime Minister addressed the panchayat heads and asked them to play a key role in pandemic management at the local level (Mahapatra, 2020; Saigal, 2020). However, beyond these token jesters, no significant financial transfers have been forthcoming from either the center or the states.

The Kerala Scenario

A solid foundation for medical facilities accessible to all was laid in Kerala even before the state came into existence on November 1, 1956. Since then, all governments that came to power have made health a high priority agenda (Israelsen & Malji, 2021; Kutty, 2000; Ramakumar & Eapen, 2022). Kerala is not an industrialized region. Many Malayalis work outside the state, either within the country or abroad. This state is also known for its high morbidity rate. The overall morbidity rate in Kerala is 30.8%, with a national average of 9.8 percent. The state gains on the social front are well known. This is the result of several years of consistent public policies. Public health is a forte of the state. The state has an elaborate system of primary health centers, most of which have now become family health centers with the posting of additional doctors and the creation of new facilities (Jacob & John, 2016; Rao, 1993). The LDF government developed a new health policy in 2018 to reduce the burden of out-of-pocket expenditures on healthcare. In 2020, the government announced a plan to introduce a statewide screening program for non-communicable diseases, such as hypertension, diabetes, and diabetic retinopathy (Kumar, 2020; Mohanty et al., 2020; Thakur et al., 2020). While hospitals in the private sector outnumber government hospitals in the state, investments in the public sector turned out to be a boon when the COVID-19 pandemic struck. As per the 2016 figures, Kerala's per capita public health expenditure was Rs. 7300 against the national average of Rs. 3800 (Maya, 2016). During the early stages, these government-run hospitals provided care to COVID-19 patients belonging to all classes including tourists.

Participatory Planning

Kerala was selected in this study because the state had a participatory mode of planning for the last 25 years at the local government level right from the 9th Five Year Plan period. This was achieved after a campaign led by approximately 100000 resource persons at the state, district, and local levels. The process started from the village ward-level assembly known as Gram Sabha and went through different stages until the District Planning Committee approved the plans. The government announced the devolution of plan funds to tune 35 to 40 percent of the state plan. This was hailed as a case of extensive decentralization. One of the goals of the participatory plan campaign was to boost the productive sectors of the economy, which were in a state of stagnation, and preserve and improve the gains that the state had made on the social front. Although the promised amount of 35% was never delivered, the state has been devolving around 25% of the plan funds announced in the state budget itself, leaving very little space for discretionary grants (Chathukulam & John, 2002).

During the early stages, the focus of the panchayats was on the productive sectors; gradually, the focus was on the service sector. Initially, local bodies ignored the health sector. There is a standing committee on panchayats that deals with health. Often, it is a woman who heads the committee. The panchayats initially ignored the health sector, and it took time for them to allocate the necessary funds. According to the two commentators (Isaac & Sadanandan, 2020):

> "The lackluster performance of the health sector in the initial years of decentralized planning was partly due to the reluctance of major power holders in the health sector and doctors to engage with local governments. They were also reluctant to shoulder additional duties, such as being implementation officers of local health projects, particularly those involving construction activities. Over time, this attitude changed, and medical personnel began to be actively involved in the local planning process. They realized that it was much easier to get their priorities accepted by the local elected representatives than in the bureaucratic hierarchy."

COVID-19 ONSET IN KERALA

Kerala had the first wave of COVID-19, which ended in February 2020. The second wave started when a family came from Italy, and the third wave came when travelers from all other countries and other states returned to the state. Very few contact cases occurred during the first two stages. The year 2018 saw the onset of the deadly Nipa virus infection in northern Kerala. Within seven weeks, the outbreak was controlled. Therefore, Kerala had some contact-tracing experience and was familiar with the WHO guidelines for similar pandemics. This experience helped the state tackle the first COVID-19 cases. The flood of 2018 was also an eye-opener for the state. As part of the disaster response at the local level, all available all-weather vehicles, earthmovers, and other such assets were identified and documented. From the perspective of COVID-19, "the wisdom of Kerala's planners to keep the network of government hospitals as a counterweight against the private sector's paid off well when it faced the pandemic that left many developed countries petrified" (Krishnakumar, 2020).

When COVID-19 hit, the local bodies were not altogether off guard. The health institutions at the local level were transferred to panchayats in 1995. The Chief Minister and the Opposition Leader addressed all LG representatives on March 19, 2020. Initially, the chain campaign, physical distancing, targeting slum dwellers, guest workers (internal migrants), and their employers were focused on. Managing guest worker camps was a responsibility entrusted to the panchayats. The guest workers were moved to other buildings where the facilities were not sufficiently good. They were given cooked food, which was discontinued at their request owing to different food habits, and uncooked food items and fuel were later provided to them. The distress calls to supply medicines and hunger calls by senior citizens, even from affluent sections, and the timely disposal of pensions were all attended to by the LGs. COVID-19 care centers and the First-Line Treatment Centers were set up to cope with potentially overwhelming health institutions. Under the scheme *subhiksha*, there was a movement for homestead cultivation, cultivation of fallow lands, and other productive activities such as cattle rearing and fish farming (Muthukumar & Salini, 2021).

Kerala has a statewide network of women's self-help groups known as *Kudumbasree*, created and sustained through state support (Kodoth, 2021; Venugopalan et al., 2021). It is a federated structure and functions at the LG level bringing about 4.4 million women in this network, covering 60% of the families. *Kudumbasree* is the backbone of all welfare-oriented activities at the grass-root level, besides serving as a support structure for the local governments. Most accredited social health activists (ASHAS), who constitute the bottom-most tier of India's public health system, are members of the Kudumabsree network. The *Kudumbasree* units undertook mass production of masks and PPE kits, ensured their distribution, undertook home surveillance, provided counseling, and undertook waste management activities during the early stages of the pandemic. Kerala also has grassroots-level palliative care activities. WhatsApp groups were created at the local level among elected representatives, *Kudumbasree* workers, and ASHAs; thus, the information flow was seamless. *Kudumbasree* units set up community kitchens to provide free food and budget hotels to offer food at affordable rates.

New Health Schemes

In 2005-06 the state government launched *Santhwanam*, an individual micro-enterprise for educated unemployed women aged 18-45 to buy a two-wheeler and necessary medical equipment to measure blood pressure and sugar level (AmritKiran et al., 2018; Swain & Patoju, 2024). This project included approximately one hundred thousand Indian rupees. Two agencies assisted: Health Actions by People and the State Bank of India. Those with 12 years of schooling, graduates in science, completed Auxiliary Nursing and midwifery courses, lab technicians/diploma holders in nursing, etc., were selected as volunteers. They were given seven days of intensive training to check height, body weight, body mass index, body fat, blood pressure, and blood glucose. They visit houses and check immobile patients, aged people, and those living alone with health problems. Where necessary, they advise their clients to

seek assistance from the physicians. The volunteers charged a small fee for the service.

In 2008, Kerala unveiled the pain and palliative care policies. It focuses on community-based care with the family as the primary caregiver supported by projects prepared by local bodies. Palliative care has also become an additional activity of Multipurpose Health Workers and Accredited Social Health Activists (ASHAs). Essential medicines, including oral morphine, were administered to the patient. In 2013, palliative care became a mandatory project for all local bodies, such that they were expected to factor such projects into the annual plan and coordinate the implementation of the project in collaboration with elected members, NGOs, medical officers, ASHAs, *Kudumbasree* SHGs, and teachers (Jayalakshmi & Suhita, 2017). However, beyond providing funds, local bodies were not involved in the governance of pain and palliative care.

In 2016, the Left Front government launched the Aardram mission to transform Public Health Centers and increase the percentage of the population using government hospitals. Under the mission, more than 5,289 posts of hospital workers were added, and health investment doubled from 6290 million Indian rupees in 2014–15 to 1,4190 million in 2018–19. Furthermore, 2,2660 million was raised for improving hospital infrastructure and equipment with the result that the percentage of patients visiting public hospitals went up from 34% in 2014 to 48% in 2017–18 (Isaac & Sadanandan, 2020).

According to Isaac & Sadanandan (2020), after the introduction of the Aadram Mission, there was a significant change in the involvement of panchayats in the health sector in the form of improvement and maintenance of the buildings of PHCs and subcenters, purchase of medicines and medical equipment, employment of doctors, nurses, and paramedical staff, and payment of additional honorarium to the ASHAs. Isaac & Sadanandan (2020) add that Panchayats

> "....provide a bridge between the health department and civil society organizations such as palliative organizations, voluntary food programs, and Kudumbashree health volunteers. They play an important role in geriatric care, support differently abled people, and finance special schools for children with cognitive disabilities. They are responsible for the prevention of vectors and waterborne infections. Given the high level of involvement of local governments in health and related sectors, it was only natural that they play an important role in the fight against COVID-19."

Arogya Jagratha Samithis at Ward Level

In Kerala, panchayats are in charge of forming and running Arogya *jagrata samithis* (health vigilance councils). They are chaired by the village panchayat president and consist of representatives of *Kudumbashree*, schoolteachers, ASHAs, and Auxiliary Nurses. The committee is responsible for mobilizing volunteers to manage the quarantine facilities, conduct door-to-door surveys, maintain lists of migrants, and run community kitchens. Each village was divided into clusters of 25 households, with three volunteers in charge of each cluster for effective supervision (Interview with an ASHA worker on November 24, 2020).

When a person shows symptoms of COVID-19, the volunteer in charge of the household cluster is first informed of it. The volunteer, in turn, informs the ASHA worker, who will report the matter to a panchayat member representing the electoral ward within which the household falls. The elected member makes necessary arrangements with the local PHC. If a household or person violates the lockdown rules, they are first warned by the ASHA workers. If they persist with the violations, the panchayat reports them to the local police department. The *Kudumbashree* mobilized its large network of female SHGs as a "volunteer army" to register and monitor new entrants to the village (mostly returning migrants), run community kitchens, and make masks, all in close coordination with the panchayat committee. Panchayats perform the dual role of providing social security even as they implement lockdown measures through persuasion rather than enforcement, for which they do not have any power.

Ward-level Arogya Jagratha Samithi acted as the key unit at the ward level to assist those quarantined and monitored their health and compliance with isolation guidelines. The ward-level Samithis comprise the panchayat member representing the ward as the chairperson, ASHA Worker, the Anganwadi worker, the Kudumbashree Area Development Society Member, Scheduled Caste/Scheduled Tribe Promoter (where relevant), Rapid Response Team (RRT) member, a member of Jana Maitry (community) police, an official of the panchayat as Convenor, and other members as required. Every ward had one ASHA worker who worked closely with the elected representative. The responsibility of keeping track of returnees and communicating their whereabouts and welfare rests with the village panchayat secretary. The panchayat should ensure that the person has the necessary facilities for home quarantine, such as an attached toilet, and that elderly persons and children occupy the same home. If the situation is not favorable, then measures for institutional quarantine will have to be adopted. The panchayat secretary has the discretion to create COVID-19 care centers. Medical Officers can transfer people to such centers based on government directions from time to time. COVID-19 care centers house people who have come from outside and are suspected to be infected. When tested and proven to have an infection, but mild, they are housed in first-line treatment centers (FLTCs). Both centers are run under the control of the LGs, although the buildings in which they function are taken possession of by the District Collector.

The LG-level *samithis* are formed in every village panchayat to coordinate and monitor the ward-level *jagratha samithis*. The panchayat president will be the chairperson, the secretary will be the convener and the medical officer of the primary health center, the sub-inspector of the local police station, the village extension officer, the tribal extension officer (where relevant), and one staff member dealing with COVID-19 activities. Social media, such as WhatsApp groups, has been used extensively to communicate with peers and other officials in real-time.

Kudumbashree activities are centered on the panchayats and have a community development society (CDS) at the gram panchayat level. These are arms for the implementation of state and local government schemes. They ensure quorum in

gram sabhas, throw up potential candidates for filling the gender quota in panchayat elections, mobilize volunteers, and provide various other forms of assistance to the panchayat (Dutta & Fischer, 2021).

The community kitchens served more than half a million daily meals during peak times. Food was delivered to people who could not come to the kitchen. It was possible to scale up the operations effectively in such a short time because of the *Kudumbasree*. One commentator claims that Kerala has successfully integrated local governments into the public health system, such that the three-tier panchayat system or urban local governments manage all primary health centers and most secondary hospitals. Ward members head the Village Health, Sanitation, and Nutrition Committees, which have multipurpose health workers as conveners, and ASHA and *Anganwadi* (mother and child center) workers as members (Sadanandan, 2020). However, this integration is still in progress, and local governments are still struggling to achieve an ambiguous role in health governance at the local level.

A massive mapping process was undertaken by local governments during the first wave to identify buildings, such as abandoned hospitals, hostels, and educational institutions in their areas, which could be converted into community quarantine centers should the need arise. Through an online registration process, volunteers were identified, and duties were assigned to them according to the tasks at hand. To ensure that the volunteers did not become carriers of the virus, strict protocols were enforced, particularly on matters related to personal hygiene. There was also a plan to assign adequate volunteers to each cluster of 25 houses within wards to ensure that the information flow regarding government notifications reached the last person. Home quarantine was monitored by local government, police, and health department. All arrangements for institutional quarantine were to be made by the local government (Interview with a village panchayat president, November 25, 2020).

In mid-July 2020, the Chief Minister of Kerala said that plan allocations were released, and the LGs could spend money from the plan fund to set up quarantine and reverse-quarantine facilities. He also suggested that LGs provide additional assistance to COVID-19 hospitals, set up first-line treatment centers, and run community kitchens without prior approval from the District Planning Committee. The treasury decided on the seamless release of funds budgeted to local bodies. Additional funds were promised by the Disaster Relief Fund. In other words, the Chief Minister assured the people that there would not be a shortage of funds for COVID-19 management.

The *Kudumbasree* was entrusted with setting up 1000 community kitchens and providing meals at Rs. 20 in the context of COVID-19. In this regard, Rs. 230.64 million was used for preliminary expenses. On 26 March, an order was issued asking the local governments to pass their budget before March 31, 2020. The LGs were also expected to provide groceries to quarantined persons in collaboration with the Food and Civil Supplies Department. Those entitled to free cooked food identified by the LG could procure it from the community kitchen or pay a nominal price if they had the means to do so (Interview with a *Kudumbasree* leader on November 30, 2020). The LG president would monitor each community kitchen. The president will be assisted by

the standing committee chairperson, a *Kudumbasreee* official, a ward member, the CDS chairperson (the highest functionary of the *Kudumbasree* at the LG level), the health inspector, a voluntary worker, and a representative of grassroots organizations selected by the LSG. Eleven templates were prepared for the data reporting. Barring the report relating to infrastructure, all other reports were submitted daily (Interview with a village panchayat member, December 4, 2020).

Kudumbasree as the Anchor

Kudumbasree served as the primary mechanism for covid-related welfare measures. Four hundred and sixty-five persons were trained to undertake disinfection activities, and 68 such enterprises were established covering all 14 districts. The *Kudumbasree* is a multitasking group whose members can be switched into a range of services under the overall leadership of the panchayat with monetary, supervisory, and training support from the state government. One allegation was that *Kudumbasree* members were used as cheap labor. As the state patronizes them, what they do cannot be described as an agential voluntary action. On the frontline, they were most exposed to infection.

Kerala had been unable to prevent the virus's spread despite all these measures. Its main success was to ensure that the infected were provided with care, enabling them to restore a reasonable level of health before being discharged. Kerala's main goal was to keep the death rate low at 0.37% until late November 2020 and to ensure that no one went hungry or suffered from a desire for medicine and care. To provide this, the intermediation of elected members plays a crucial role. However, the bureaucracy assisted by *Kudumbasree* women constituted the anchor even at the grassroots level. At the District level, collectors play a central role. The district panchayat president was just one of the district level coordinating team members (Interview with a District Panchayat member, October 27, 2020).

Kerala has been busy providing vaccines since March 2021. While there was not much initial enthusiasm for vaccination, it picked up quickly, with the elected members playing a key role in removing vaccine hesitancy. The distribution of vaccines elicited criticism of political patronage by the ruling Communist Party in some northern districts. During this stage, lockdowns were imposed from above, with panchayats being declared as containment zones instead of specific wards where high incidence was found (Interview with a village panchayat member, December 1, 2020).

The Situation in Selected Countries

One can see scenarios worldwide where local governments took the initiative with the community and various local organizations when the central government was seen as far removed from the ground. Such community-based mobilization has promoted the spread of the virus. Indonesia is an example of a community-based containment measure that did not suddenly spring up but resulted from existing background conditions. One commentator says (Meckelburg, 2021):

> "The first thing to acknowledge is that these local-level mobilizations have not been "spontaneous." Rather, they have emerged from existing networks of social solidarity and community organization, which typically take the form of local community groups: everything from skaters, musicians, and artists to pensioners, religious associations, and nature lovers, to name a few. The self-initiated organization of sections of society across rural and urban societies during this time of crisis has shed light on the presence of significant spaces that operate beyond state governance structures. Such spaces are typically neglected by the state in normal times but become visible in times of crisis or natural disasters."

Similar insights also come from Brazil, where the state abdicated its responsibility to address the spread of the virus, leaving local bodies to fend for themselves. This happened in the Favela municipality, where residents engaged in collective self-care, building on historical pre-existing social networks and political capital to protect themselves from violence and state neglect. In other words, the self-organizing capacity of communities plays a crucial role in ensuring collective action (Ortega & Béhague, 2022). In Thailand, the "local government's ability to make decisions unfettered by the requirement for those decisions to be approved by higher levels of government" facilitated effective local action (Laochankham et al., 2021)

The Distinctiveness of the Kerala Experience

What made the Kerala situation different from the above-cited cases is that the local bodies did not have leeway to take initiatives, which the provincial government monopolized. A hierarchical governance system is more visible in Kerala. This is due to the legacy of the state-directed participatory plan campaign, the over-dependence of the local governments on provincial grants, and the bifurcation of developmental functions from the regulatory functions at the local level, with the latter entrusted primarily to the line departments staffed by the general and sectoral bureaucrats. The dual control system in the line departments' local units transferred to the village panchayats is also a hurdle. There was also a lag and discontinuity in community-level containment measures when a new team of elected representatives came to power in January 2021 (Chathukulam & Joseph, 2022).

Despite a quarter century of participatory planning, NGOs are yet to be actively involved in collaborative projects with the local governments, largely because of the tendency of the political class not to recognize them as key actors at the grassroots level and not share credit for successful ventures. Such a high degree of overt or subtle politicization or political capture of all new organizations does not provide space for persons without prior partisan political connections to engage in voluntary work or effectively motivate civil society actors (Chathukulam & Tharamangalam, 2021). However, the pandemic has brought out the potential for high-level cooperation with the different agencies of government, private, and the voluntary sector in emergencies, which was also witnessed during two devastating floods that Kerala had seen two years before the onset of the pandemic.

Creating several task-oriented committees and institutions at the local level to tackle problems is, to some extent, a legacy of local government-level participatory planning (Chathukulam & John, 2002). A substantial part of COVID-19 containment

measures was made possible through voluntary and private contributions. However, whether this will lead to the institutionalization of such synergies is debatable given the highly political nature of managing disasters and calamities in the state. Although the local government functionaries were not consulted during the framing of decisions relating to pandemic management, the local capacity and health infrastructure, for which the state is widely known, were used by the state government to the hilt.

CONCLUSION

Local bodies in Kerala, especially village panchayats, played a crucial role in COVID-19 containment matters, focusing mainly on the social rather than the epidemiological front and helping to prevent a humanitarian crisis. The pandemic governance of village panchayats was primarily focused on mobilizing resources and volunteers and creating a people-friendly and persuasion-oriented form of surveillance, as opposed to the punitive form undertaken by the police during the initial stages. The Block and District Panchayats, constituting the next two tiers in the rural local government system, hardly played any role in pandemic management. This is a drawback of the Kerala model. Most initiatives by local governments were uniform since they were part of statewide measures mandated from above rather than innovative practices evolved from below.

In other words, the village panchayats played a key role at the grassroots level where most containment and relief measures took place. However, this role was performed with the active support of the *Kudumbasree*, a unique statewide movement initiated by the state government that functioned as a dedicated support structure at the village panchayat level. Over four million *Kudumbasree* members bore the brunt of the welfare measures needed for pandemic management in collaboration with the health staff and the ASHA workers, most of whom were also *Kudumbasree* members. On one hand, they were patronized by the state government and deployed at the grassroots level. However, they are often asked to underpay, unattractive, or burdensome tasks. It cannot be said that their actions are voluntary. Instead, there was a certain degree of compulsion. This kind of instrumentalization of *Kudumbasree* women for pandemic efforts may be looked upon by gender specialists. The fact that most *Kudumbasree* women are supporters of the Marxist party, the dominant actor in the state's ruling Leftist coalition, is an alternative channel that facilitates coordinated action.

The Kerala experience shows that despite a quarter-century of participatory planning and extensive decentralization, the initiative for pandemic containment and relief always rested with the provincial government, with the local governments serving as the implementing agencies, constantly looking up to the state government and the District Collector for guidance. This is comparable to disaster management governance in states with similar structures. The pro-government volunteers, pro-government and state-supported *Kudumbasree* workers, and frontal organizations of the ruling party figured prominently in the pandemic amelioration efforts, leaving little

space for civil society actors. When local governments are merely asked to follow instructions from above and do not have the freedom to take the initiative independently, very few good practices are likely to emerge. In such situations, the efficiency level of local governments can be assessed purely in terms of their implementation ability, rather than the agency for taking initiatives.

REFERENCES

Abrori, F. (2021). The role of local governments in regional financial management for the handling of the COVID-19 pandemic. *Yurispruden*: *Jurnal Fakultas Hukum Universitas Islam Malang*, *4*(2), 208–222. https://doi.org/10.33474/yur.v4i2.10250

Ahmad, E. (2022). Multilevel responses to risks, shocks and pandemics: Lessons from the evolving Chinese governance model. *Journal of Chinese Governance*, *7*(2), 291–319. https://doi.org/10.1080/23812346.2020.1813395

Ahrens, T., & Ferry, L. (2020). Financial resilience of English local government in the aftermath of COVID-19. *Journal of Public Budgeting, Accounting & Financial Management*, *32*(5), 813–823. https://doi.org/10.1108/JPBAFM-07-2020-0098

AmritKiran, M., Suresh, A., & Jayashree, S. (2018). A study on Kudumbashree in Kerala. *International Journal of Pure and Applied Mathematics*, *118*, 4195–4201. https://www.researchgate.net/publication/333164090_A_Study_on_Kudumbashree_in_Kerala

Anttiroiko, A.-V. (2021). Successful government responses to the pandemic: Contextualizing national and urban responses to the COVID-19 outbreak in East and West. *International Journal of E-Planning Research*, *10*(2), 1–17. https://doi.org/10.4018/IJEPR.20210401.oa1

Billava, N. (2021). Role of Gram Panchayats in tackling COVID-19: A case study from Karnataka. *Journal of Rural Development*, *40*(1), 80–93. https://doi.org/10.25175/jrd/2021/v40/i1/166504

Blair, H. (2000). Participation and accountability at the periphery: Democratic local governance in six countries. *World Development*, *28*(1), 21–39. https://doi.org/10.1016/S0305-750X(99)00109-6

Chathukulam, J., & John, M. S. (2002). Five years of participatory planning in Kerala: Rhetoric and reality. *Economic and Political Weekly*, *37*(49), 4917–4926. https://www.jstor.org/stable/4412934

Chathukulam, J., & Joseph, M. (2022). *Management of the COVID-19 pandemic in Kerala through the lens of state capacity and clientelism* (WIDER Working Paper 2022; WIDER Working Paper, Vol. 2022). UNU-WIDER. https://doi.org/10.35188/UNU-WIDER/2022/191-4

Chathukulam, J., & Tharamangalam, J. (2021). The Kerala model in the time of COVID19: Rethinking state, society and democracy. *World Development*, *137*, 105207. https://doi.org/10.1016/j.worlddev.2020.105207

Dutta, A., & Fischer, H. W. (2021). The local governance of COVID-19: Disease prevention and social security in rural India. *World Development*, *138*, 105234. https://doi.org/10.1016/j.worlddev.2020.105234

Green, D., & Loualiche, E. (2021a). State and local government employment in the COVID-19 crisis. *Journal of Public Economics*, *193*, 104321. https://doi.org/10.1016/j.jpubeco.2020.104321

Green, D., & Loualiche, E. (2021b). State and local government employment in the COVID-19 crisis. *Journal of Public Economics*, *193*, 104321. https://doi.org/10.1016/j.jpubeco.2020.104321

Gupta, S., Nguyen, T., Raman, S., Lee, B., Lozano-Rojas, F., Bento, A., Simon, K., & Wing, C. (2021). Tracking public and private responses to the COVID-19 epidemic: Evidence from state and local government actions. *American Journal of Health Economics*, *7*(4), 361–404. https://doi.org/10.1086/716197

Gurgel, A. do M., Santos, C. C. S. dos, Alves, K. P. de S., Araujo, J. M. de, & Leal, V. S. (2020). Government strategies to ensure the human right to adequate and healthy food facing the Covid-19 pandemic in Brazil. *Ciência & Saúde Coletiva*, *25*, 4945–4956. https://doi.org/10.1590/1413-812320202512.33912020

Isaac, T., & Sadanandan, R. (2020). COVID-19, public health system and local governance in Kerala. *Economic and Political Weekly*, *55*(21), 35–40. https://www.epw.in/journal/2020/21/perspectives/covid-19-public-health-system-and-local-governance.html

Israelsen, S., & Malji, A. (2021). COVID-19 in India: A comparative analysis of the Kerala and Gujarat development models' initial responses. *Progress in Development Studies*, *21*(4), 397–418. https://doi.org/10.1177/14649934211030462

Jacob, M., & John, J. (2016). *Local governments and the public health delivery system in Kerala: Lessons of collaborative governance*. Cambridge Scholars Publishing.

Jayalakshmi, R., & Suhita, C. (2017). Home-based palliative services under two local self-government institutions of Kerala, India: An assessment of compliance with policy and guidelines to local self-government institutions. *Indian Journal of Palliative Care*, *23*(1), 65. https://doi.org/10.4103/0973-1075.197947

Kamara, F., Mokuwa, G. A., & Richards, P. (2022). Keeping Ebola at bay: Public authority and ceremonial competence in rural Sierra Leone. *The Journal of Modern African Studies*, *60*(1), 65–84. https://doi.org/10.1017/S0022278X21000422

Kodiyat MS, B. A., Siagian, A. H., & Andryan, A. (2020). The effect of centralistic political party policies in selection of regional heads in Medan City. *Indonesian Journal of Education, Social Sciences and Research (IJESSR)*, *1*(1), 59–70. https://doi.org/10.30596/ijessr.v1i1.4899

Kodoth, P. (2021). *How Kudumbasree forged a massive network of neighbourhood groups: Micro politics and the strategies of women in Kerala*. Center for Development Studies. http://192.168.2.12:8080/xmlui/handle/123456789/593

Krishnakumar, R. (2020, March 22). *Kerala model* [HTML]. Frontline. https://frontline.thehindu.com/cover-story/article31130309.ece

Kumar, D. V. (2020, February 2). Fight against non-communicable diseases gets a fillip in Kerala [HTML]. *The New Indian Express*. https://www.newindianexpress.com/cities/thiruvananthapuram/2020/Feb/02/fight-against-non-communicable-diseases-gets-a-fillip-in-kerala-2097872.html

Kutty, V. R. (2000). Historical analysis of the development of health care facilities in Kerala State, India. *Health Policy and Planning*, *15*(1), 103–109. https://doi.org/10.1093/heapol/15.1.103

Laochankham, S., Kamnuansilpa, P., & Lowatcharin, G. (2021). Locally driven action in pandemic control: The case of Khon Kaen Province, Thailand. *Contemporary Southeast Asia: A Journal of International and Strategic Affairs*, *43*(1), 8–14. https://muse.jhu.edu/pub/70/article/796889

Mahapatra, R. (2020, April 24). Panchayati Raj Day: Pandemic and the panchayats [HTML]. *Down To Earth*. https://www.downtoearth.org.in/governance/panchayati-raj-day-pandemic-and-the-panchayats-70674

Mardones, F. O., Rich, K. M., Boden, L. A., Moreno-Switt, A. I., Caipo, M. L., Zimin-Veselkoff, N., Alateeqi, A. M., & Baltenweck, I. (2020). The COVID-19 pandemic and global food security. *Frontiers in Veterinary Science*, *7*. https://doi.org/10.3389/fvets.2020.578508

Maya, C. (2016, May 11). Public health expenditure high in State [HTML]. *The Hindu*. https://www.thehindu.com/news/cities/Thiruvananthapuram/public-health-expenditure-high-in-state/article8588010.ece

Meckelburg, R. (2021). Indonesia's COVID-19 emergency: Where the local is central. *Contemporary Southeast Asia: A Journal of International and Strategic Affairs*, *43*(1), 31–37. https://muse.jhu.edu/pub/70/article/796892

Mohanty, S., Venkatarao, E., & Yasobant, S. (2020). Non-communicable disease care and physical activity promotion in India: Analysis of recent policies, guidelines and workplans. *Family Medicine and Community Health*, *8*(2), e000206. https://doi.org/10.1136/fmch-2019-000206

Muthukumar, P., & Salini, R. (2021). Impact of COVID 19 on production and productivity of Kerala agriculture sector. *IJISET - International Journal of Innovative Science, Engineering & Technology*, *8*(6), 155–162. https://ijiset.com/vol8/v8s6/IJISET_V8_I06_16.pdf

Nemec, J., & Špaček, D. (2020). The Covid-19 pandemic and local government finance: Czechia and Slovakia. *Journal of Public Budgeting, Accounting & Financial Management*, *32*(5), 837–846. https://doi.org/10.1108/JPBAFM-07-2020-0109

OECD. (2020). *COVID-19 and fiscal relations across levels of government* (OECD Policy Responses to Coronavirus (COVID-19)) [OECD Policy Responses to Coronavirus (COVID-19)]. https://doi.org/10.1787/ab438b9f-en

Ortega, F., & Béhague, D. (2022). Contested leadership and the governance of COVID-19 in Brazil: The role of local government and community activism. *Global Public Health*, *17*(4), 483–495. https://doi.org/10.1080/17441692.2022.2028304

Pandey, V., Singh, S., & Kumar, D. (2022). COVID-19, information management by local governments, and food consumption. *Food Policy*, *110*, 102278. https://doi.org/10.1016/j.foodpol.2022.102278

Parker, M., Hanson, T. M., Vandi, A., Babawo, L. S., & Allen, T. (2019). Ebola and public authority: Saving loved ones in Sierra Leone. *Medical Anthropology*, *38*(5), 440–454. https://doi.org/10.1080/01459740.2019.1609472

Paul, S. K. (2022). Consequences of Covid–19 and role of Gram Panchayats in tackling the pandemic situation: Some highlights from West Bengal. *NAVEIÑ REET: Nordic Journal of Law and Social Research*, *12*, 63–74. https://tidsskrift.dk/nnjlsr/article/view/135352

Permanasari, V. Y., Nadjib, M., Sjaaf, A. C., Besral, & Anjani, A. A. (2022). The response of local governments in financing related to the COVID-19 pandemic: A literature review. *Journal of Public Health Research*, *11*(2), jphr.2021.2620. https://doi.org/10.4081/jphr.2021.2620

Ramakumar, R., & Eapen, M. (2022). The legacy of public action and gender-sensitivity of the pandemic response in Kerala State, India. *Economia Politica*, *39*(1), 271–301. https://doi.org/10.1007/s40888-021-00249-1

Rao, S. P. R. (1993). *Administration of primary health centres in India: A study from the three southern states*. Mittal Publications.

Resende, T. C., Paschoalotto, M. A. C., Peckham, S., Passador, C. S., & Passador, J. L. (2021). How did the UK government face the global COVID-19 pandemic? *Revista de Administração Pública*, *55*, 72–83. https://doi.org/10.1590/0034-761220200418

Richards, P. (2019, June 28). Ebola and chiefs in Sierra Leone [HTML]. *Africa at LSE*. https://blogs.lse.ac.uk/africaatlse/2019/06/28/ebola-chiefs-sierra-leone-research/

Sadanandan, R. (2020). Kerala's response to COVID-19. *Indian Journal of Public Health*, *64*(6), 99. https://doi.org/10.4103/ijph.IJPH_459_20

Saigal, K. (2020, April 24). PM Modi inaugurates key rural schemes on National Panchayati Raj Day [HTML]. *Invest India*. https://www.investindia.gov.in/team-india-blogs/pm-modi-inaugurates-key-rural-schemes-national-panchayati-raj-day

Sukhwani, V., Deshkar, S., & Shaw, R. (2020). COVID-19 lockdown, food systems and urban–rural partnership: Case of Nagpur, India. *International Journal of Environmental Research and Public Health*, *17*(16), 5710. https://doi.org/10.3390/ijerph17165710

Swain, S., & Patoju, S. K. S. (2024). Role of social enterprises in bridging healthcare sector gap: A case of 'Santhwanam.' *Journal of Entrepreneurship and Innovation in Emerging Economies*, *10*(1), 13–25. https://doi.org/10.1177/23939575231210185

Thakur, J. S., Paika, R., & Singh, S. (2020). Burden of noncommunicable diseases and implementation challenges of National NCD Programmes in India. *Medical Journal Armed Forces India*, *76*(3), 261–267. https://doi.org/10.1016/j.mjafi.2020.03.002

Venugopalan, M., Bastian, B. L., & Viswanathan, P. K. (2021). The role of multi-actor engagement for women's empowerment and entrepreneurship in Kerala, India. *Administrative Sciences*, *11*(1), 31. https://doi.org/10.3390/admsci11010031

Wollmann, H. (2004). Urban leadership in German local politics: The rise, role and performance of the directly elected (chief executive) mayor. *International Journal of Urban and Regional Research*, *28*(1), 150–165. https://doi.org/10.1111/j.0309-1317.2004.00508.x

Wright, C. (2020). Local government fighting Covid-19. *The Round Table*, *109*(3), 338–339. https://doi.org/10.1080/00358533.2020.1763017

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