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Democratic Decentralisation and the Prevention of the Covid-19 Pandemic: An Analysis of Kerala

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Abstract

Democracy guarantees the direct participation of the people in the political process, and the 73rd Constitutional Amendment strengthened administrative federalism by devolving administrative and financial powers from the states to local bodies. During the COVID-19 pandemic, the local governments of Kerala stood on the front line, coordinating health workers, the police, public servants, Kudumbashree workers, drivers and volunteers who delivered food, medicine and sanitiser. This paper analyses how Kerala's decentralised institutions helped to prevent the spread of the disease. The state's prompt response can be attributed to the experience and investment it had built up through earlier emergencies, the floods of 2018 and especially the Nipah outbreak of 2019, and to a strong health system developed over many years. The Chief Minister and the Health Minister led from the front, facilitating inter-sectoral coordination and community participation, while the state focused on a strategy of trace, test and contain, with extensive screening and the quarantine of incoming travellers. The state and district control rooms played a central part in framing advisories and guiding early interventions aimed at saving lives. The paper argues that the decentralised, participatory architecture of Kerala's governance was the decisive factor in its response.

Keywords: - COVID-19, Decentralisation, Lockdown, Panchayat Raj, Quarantine Centre, Social Distancing.

I. INTRODUCTION

Democracy guarantees the direct participation of the people in the political process, and democratic decentralisation is the process of transferring power to popularly elected local governments. To transfer power is to give local governments greater political authority, larger financial resources and wider administrative responsibilities, so that the voice and participation of citizens increase and government becomes more responsive and accountable. Decentralisation is closely linked with democracy, development and good governance: it widens participation in public decision-making and improves efficiency, equity and the management of resources, while enhancing the accountability and effectiveness of the public sector (Vayunandan & Mathew, 2003).

Decentralisation is not unique to India but a global trend (Agrawal, 1993). The Indian Constitution defines the Panchayat Raj Institutions as institutions of local self-government, which presupposes a genuine administrative, fiscal and political devolution (Joshi & Narwani, 2002). In practice, however, devolution has often been minimal, leaving the institutions short of the resources and the decision-making power they need, so that many of their functions remain in effect under the control of the state administration (Siva & Chowdhury, 2002). The 73rd and 74th Amendments to the Constitution were nonetheless a landmark in the evolution of grassroots democracy, transforming representative democracy into participatory democracy and giving local people greater opportunity to take part in the democratic process (The Constitution [Seventy-Fourth Amendment] Act, 1992).

The 73rd Amendment gave constitutional status to village, block and district bodies (The Constitution [Seventy-Third Amendment] Act, 1992). It provided for the Gram Sabha as the foundation of the system, a three-tier structure of elected bodies, direct elections to five-year terms, the reservation of one-third of seats for women and for the backward classes, a State Election Commission to supervise panchayat elections, and a State Finance Commission to review the financial position of

the panchayats every five years. It is within this framework that Kerala mounted its response to COVID-19, the subject of this study.

1.1. Statement of the Problem

In preventing the spread of COVID-19, the decentralised governing institutions faced significant problems and challenges. Yet local responses were often faster than central ones, and the local self-governing institutions proved to be the front-line defence in a global pandemic. The problem this study addresses is how effectively these institutions discharged that role, and what their experience reveals about the strengths and the limits of decentralised governance in a crisis.

1.2. Objectives of the Study

- To understand the concept of decentralisation.
- To recognise the significance of the Panchayat Raj system.
- To identify the various methods used to prevent the COVID-19 pandemic.
- To examine the role of local self-governing institutions in preventing the COVID-19 pandemic.

1.3. Scope and Significance

The study demonstrates the significance of empowering local self-governing institutions, which faced severe tests of their resilience during the crisis, and it shows the importance of fiscal devolution and of disaster preparedness at the local level. Its significance lies in drawing from a single, well-documented case the lessons that decentralised, community-based governance holds for the management of future emergencies.

II. LITERATURE REVIEW

The idea of village self-government has deep roots in Indian political thought. In his Discovery of India (1946), Jawaharlal Nehru drew on the Nitisara, the science of polity attributed to Shukracharya, which described an elected village panchayat holding wide executive and judicial powers, distributing land, collecting taxes and remitting the government's share. Old inscriptions record how its members were elected, how a member could be removed for misconduct or for failing to account for public funds, and even a rule against nepotism that barred the near relatives of members from public office; the Nitisara advised that, in a dispute, the king should take the side of his subjects rather than his officials (Nehru, 1946).

The modern path to decentralisation passed through a long series of commissions and reforms, summarised in Table 1, which runs from the Resolution on Local Self-Government of 1882 to the 73rd and 74th Amendments of 1992 and the extension of self-government to tribal areas in 1996 (Prasad, 1984).

Table 1. Milestones in Indian decentralisation.

Sl. No.	Year	Event related to decentralisation
1	1882	The Resolution on Local Self-Government.
2	1907	The Royal Commission on Decentralisation.
3	1948	Constituent Assembly debates between Gandhi and Ambedkar on Gram Swaraj, or self-rule.
4	1957	Balwant Rai Mehta Committee: an early attempt to build the panchayat structure at district and block levels.
5	1963	K. Santhanam Committee: recommended limited revenue-raising powers for panchayats and state panchayat raj finance corporations.
6	1978	Asok Mehta Committee: identified bureaucratic resistance, weak political will and role ambiguity, and recommended the district as the unit of the panchayat structure.
7	1985	G. V. K. Rao Committee: recommended that the Block Development Office assume broad powers for planning and monitoring rural development.
8	1986	L. M. Singhvi Committee: recommended constitutional status for local self-government, with the Gram Sabha as its basis.
9	1992	73rd and 74th Constitutional Amendments: constitutional status for panchayats and for municipalities and corporations.
10	1996	The PESA Act: extended self-government to tribal communities in Fifth Schedule areas.

Source: compiled by the author.

A substantial scholarly literature has examined these reforms and their effects. Comparative studies place Indian decentralisation within a global movement (Hadenius, 2003), while country studies analyse its bearing on poverty and politics (Johnson, 2003) and on the empowerment of the grassroots (Sivaramakrishnan, 2003; Joseph, 2007). Other studies examine grassroots empowerment and rural development, and the wider question of popular participation in local governance (Ram, 2006; Younis, 2019). A growing body of more recent work considers the role of local government in emergencies, including the financial pressures that the pandemic placed on local bodies (Kasalirwe et al., 2020). The present study contributes to this literature a detailed account of how Kerala's decentralised institutions performed during the COVID-19 pandemic.

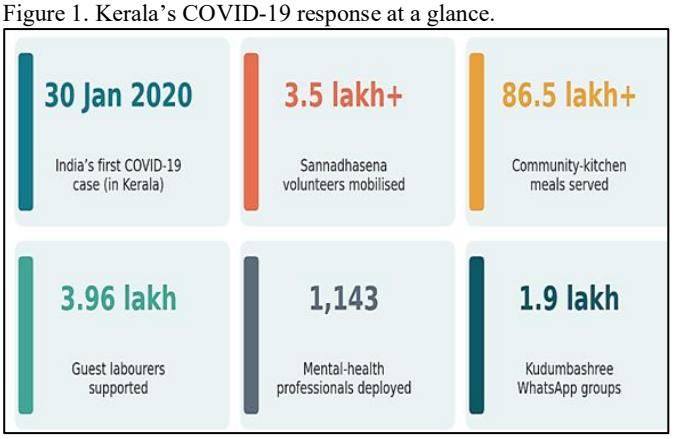
III. RESEARCH METHODOLOGY

The study adopts a mixed-methods design, combining qualitative and quantitative approaches and using descriptive, analytical and historical methods. The descriptive method records the measures taken by Kerala's government and local bodies; the analytical method interprets their coordination and effect; and the historical method situates the response within the longer evolution of decentralisation in India. The study relies on secondary sources, including official government databases and dashboards, the technical guidelines and reports of the Government of Kerala, the publications of the World Health Organization, and newspaper and journal accounts of the response.

IV. FINDINGS: KERALA'S DECENTRALISED RESPONSE TO COVID-19

The scale of Kerala's decentralised response is conveyed by a few headline figures, brought together in Figure 1, before the components of the response are examined in turn.

Figure 1. Kerala's COVID-19 response at a glance.



Source: compiled by the author from Government of Kerala data.

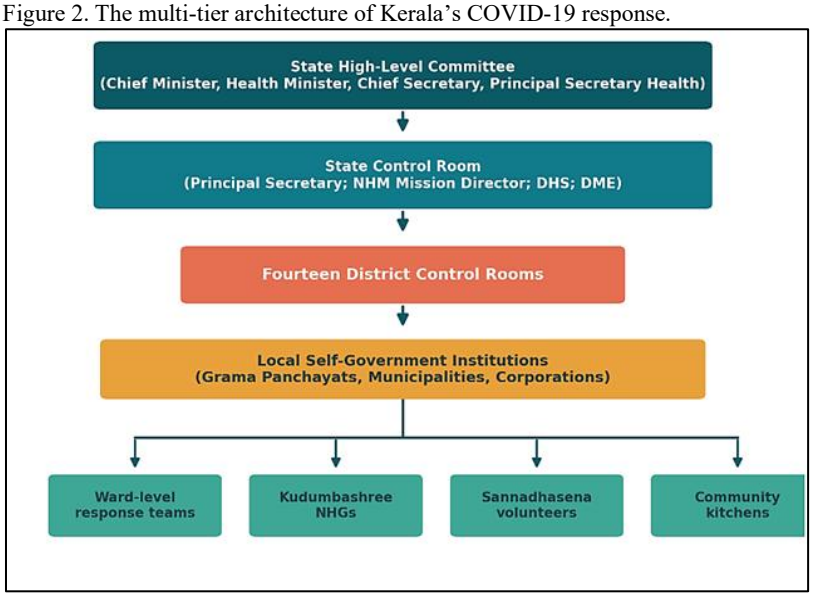
4.1. The Foundations of the Response

Kerala's prompt response can be attributed to the experience and investment it had built up in emergency preparedness, especially during the floods of 2018 and the Nipah outbreak of 2019, and to a strong health system developed over many years. The state drew on its disaster-management experience to deploy resources quickly and to mount a timely and comprehensive response in collaboration with key stakeholders. Active surveillance, district control rooms for monitoring, the capacity-building of frontline health workers, risk communication, strong community engagement and attention to the psychosocial needs of vulnerable people were among the strategic interventions that kept the disease in check.

4.2. The Response Architecture

The response was coordinated through a clear, multi-tier structure, shown in Figure 2. A high-level committee led by the Chief Minister, the Health Minister, the Chief Secretary and the Principal Secretary (Health) monitored and guided action in the field. Below it, a State Control Room led by the Principal Secretary, the Mission Director of the National Health Mission, the Directorate of Health Services and the Directorate of Medical Education, together with its sub-committees, oversaw the various aspects of the response. The early release of technical guidelines on contact tracing, quarantine, isolation, hospitalisation and infection control, together with extensive capacity-building across departments, was crucial to managing the situation (Government of Kerala, 2020).

Figure 2. The multi-tier architecture of Kerala's COVID-19 response.

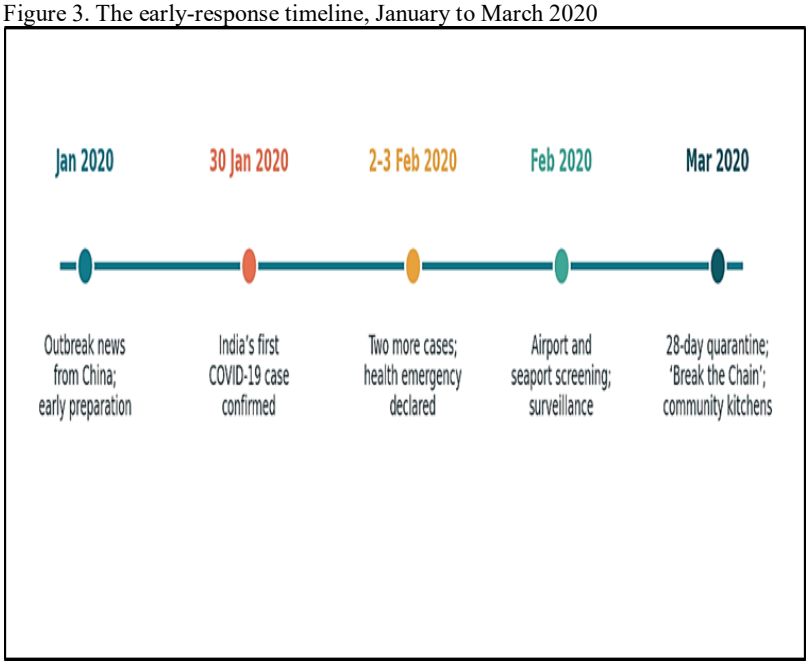


Source: compiled by the author from Government of Kerala guidelines.

4.3. The Early-Response Timeline

Kerala acted early. Following news of the outbreak in China in January 2020, the leadership mounted a robust response, and when the state recorded India's first COVID-19 case on 30 January 2020 it declared a health emergency after two further cases were confirmed on 2 and 3 February. The initial response centred on the surveillance and screening of incoming passengers from China and their close contacts, supported by the State Emergency Operations Centre and the Kerala State Disaster Management Authority. The high literacy of the population and a strong political and administrative commitment provided the impetus for the fight. Figure 3 sets out the key dates.

Figure 3. The early-response timeline, January to March 2020



Source: compiled by the author from Government of Kerala records.

4.4. Preventive Measures through Decentralised Governance

4.4.1. Systemic investment in health infrastructure.

The government had been investing steadily in its health infrastructure, and during the pandemic it set up at least two dedicated COVID-19 hospitals in each district, staffed by well-trained teams from all specialities. State and district medical boards developed treatment and discharge protocols and assessed each positive case.

4.4.2. Early screening of incoming passengers.

Screening was introduced at all airports and seaports and, as cases rose, at inter-state bus and train terminals. Intense contact tracing and testing became the mainstay of the response, with the state adapting the guidance of the World Health Organization by tracing, testing and isolating as many people as possible.

4.4.3. Isolation of high-risk contacts.

The government instituted a longer quarantine of 28 days and built thousands of shelters for migrant workers stranded by the nationwide shutdown. COVID Care Centres were established in every district for non-residents such as tourists and people in transit, and isolation facilities were provided for residents returning from other states, with adherence monitored by a mix of telephone calls and home visits.

4.4.4. Psychological support.

A telemedicine portal, e-Sanjeevani, and a psychosocial-support initiative, Ottakkalla Oppamundu, were put in place, and 1,143 mental-health professionals, including psychiatrists, social workers, clinical psychologists and counsellors, were deployed to support people in quarantine and the frontline workers themselves. The approach was inclusive, addressing the special needs of the mentally ill, children with special needs, migrant labourers and the elderly living alone.

4.4.5. Risk communication and community participation.

The Break the Chain campaign promoted hand hygiene, physical distancing and cough etiquette, with hand-washing stations installed at railway stations and other key points, while the Arogyam, COVID Jagratha and Directorate of Health Services portals provided comprehensive information. The high literacy of the state and the empowered women of the Kudumbashree network were decisive: Kudumbashree formed close to 1.9 lakh WhatsApp groups across its 22 lakh neighbourhood groups to spread safety messages, and the community-kitchen initiative, run through the Local Self-Government Department with Kudumbashree support, served more than 86.5 lakh free meals to labourers, to those in quarantine or isolation, and to the destitute and needy.

4.5. Quarantine Centres and Community Kitchens

Quarantine was central to controlling community transmission, allowing affected people to be identified early and kept from infecting others, and physical distancing was treated as a key factor. Those arriving from other states or countries, people without adequate facilities at home, and those who broke protocol were quarantined in community centres housed in hostels, educational institutions, lodges, resorts and unused buildings, with the local bodies responsible for providing water, electricity, bedding, food and other basic needs.

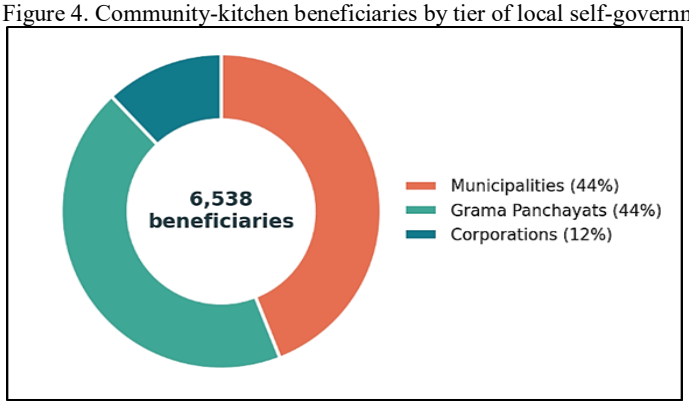
The community-kitchen scheme fed those in quarantine or isolation at home, along with the poor, the destitute and the elderly, at a time when the lockdown had closed most shops and hotels and created great difficulty for guest labourers and essential workers. In each area the Local Self-Government Department took over vacant canteens, catering units, Kudumbashree kitchens and auditoriums to run a kitchen, overseen by a committee that included the local self-government chairperson, standing-committee chairpersons, the Kudumbashree officer, a health inspector and a representative of a non-governmental organisation. Some food was provided free and some on payment. As Table 2 and Figure 4 show, of 6,538 beneficiaries, an equal 44 per cent each were served through municipalities and grama panchayats and 12 per cent through corporations; of these, 3,283 received food free of cost and 2,226 received it by home delivery, with free distribution highest in the municipalities and home delivery strongest in the grama panchayats.

Table 2. Community-kitchen beneficiaries by tier of local self-government.

Tier of local self-government	Beneficiaries (%)
Municipalities	44
Grama Panchayats	44
Corporations	12
Total (n = 6,538)	100

Source: Local Self-Government Department, Government of Kerala, 18 August 2020.

Figure 4. Community-kitchen beneficiaries by tier of local self-government

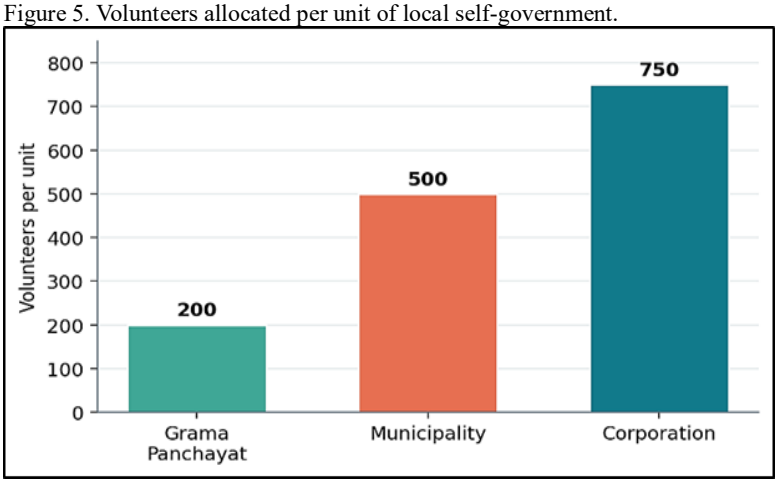


Source: Local Self-Government Department, Government of Kerala, 18 August 2020.

4.6. The Kerala Sannadhasena Volunteer Force

The Kerala Sannadhasena, a volunteer corps, played a major part in the response. Registered online, it drew people of varied skills from inside and outside the state, with the aim of one volunteer for every hundred people, and it allocated volunteers across the tiers of local government: as Figure 5 shows, each grama panchayat identified 200 volunteers, each municipality 500 and each of the six corporations 750. The volunteers cooked and delivered food to families in quarantine or unable to reach shops, supported relief camps, assisted the police and health workers, helped to identify those in need, and answered queries through call centres (Kerala Institute of Local Administration, 2020).

Figure 5. Volunteers allocated per unit of local self-government.



Source: Government of Kerala database, 18 August 2020.

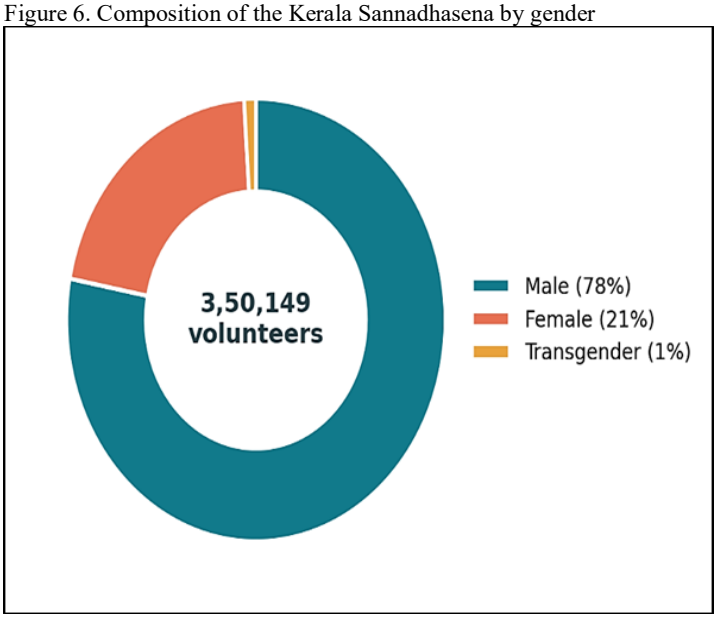
Gender was no barrier to service. The force of 3,50,149 volunteers comprised men, women and transgender persons, and although men made up 78 per cent of the total, the participation of women, who formed 21 per cent, and of transgender persons, who formed 1 per cent, was significant given the social barriers they face. The composition is set out in Table 3 and Figure 6. The volunteers spanned all ages, from 16 to 65: about 47 per cent were aged between 20 and 30, and roughly three-quarters were aged between 20 and 40, a pattern that counters the claim that the young are withdrawing from social responsibility.

Table 3. Composition of the Kerala Sannadhasena by gender.

Gender	Share of volunteers (%)
Male	78
Female	21
Transgender	1
Total (n = 3,50,149)	100

Source: Government of Kerala database, 18 August 2020.

Figure 6. Composition of the Kerala Sannadhasena by gender



Source: Government of Kerala database, 18 August 2020.

4.7. The Guest Labour Force

Kerala is home to a large number of migrant workers from other parts of the country, affectionately called guest labourers, who form an indispensable part of its economy, and during the lockdown approximately 3.96 lakh of them were stranded in the state. The local police identified every dwelling and camp where they were staying, and each camp was given a Home Guard who could speak Hindi, Odia or Bengali so as to communicate with the workers and address their grievances. Camp management committees, supported by corporate social responsibility funds, the Local Self-Government Department and philanthropic organisations, arranged food and essentials, while televisions, carrom boards and sports equipment were provided to the larger camps, and videos featuring the State Police Chief in several languages urged the workers to stay calm.

To counter the fake messages circulating on social media, the police ran an active campaign to disseminate correct information, and round-the-clock control rooms with helplines were opened in every district. Medical screening and health check-ups were conducted with the Labour and Health Departments, tele-counselling was arranged for highly stressed workers by more than a hundred counsellors, mostly alumni of the Tata Institute of Social Sciences, and Camp Cards were issued to ensure that welfare measures reached every labourer.

V. DISCUSSION

Kerala's experience shows that decentralised, participatory governance can be a powerful instrument of crisis management. The response succeeded because it combined firm direction from the top with dense organisation at the bottom: the high-level committee and the state and district control rooms set strategy and issued guidance, while the local self-government institutions, the Kudumbashree network and the Sannadhasena volunteers carried that strategy into every ward. This pairing of central coordination with local delivery, visible in the response architecture, allowed the state to trace, test and contain at scale while still attending to the particular needs of the quarantined, the migrant and the vulnerable.

Three factors stand out. First, prior investment mattered: the health system built over decades and the lessons of the 2018 floods and the 2019 Nipah outbreak gave the state both the infrastructure and the practised routines on which it could draw. Second, community participation was decisive, for the Kudumbashree groups, the volunteer force and the community kitchens turned a state policy into a social mobilisation, reaching millions with information, food and care. Third, the breadth of participation, across genders and age groups and including transgender volunteers, gave the effort both legitimacy and reach.

At the same time, the local self-governing institutions faced real financial strain during the pandemic, a reminder that the devolution of responsibility was not always matched by the devolution of resources.

5.1. Suggestions

- Greater financial resources should be devolved to local self-government institutions.
- Community participation should be further strengthened for disaster management.
- Health centres and ASHA workers should be strengthened.
- Global cooperation in public health should be deepened.

VI. CONCLUSION

The COVID-19 pandemic was a real-time stress test of India's governance, and in Kerala the local self-governing institutions emerged as the most critical line of defence. Community participation and the effective work of these institutions helped to slow the spread of the disease, with the ASHA workers serving as the vanguard of prevention. The strength of Kerala's response lay in the marriage of a capable, centrally coordinated health system with a deeply organised and participatory local government, a combination whose value was recognised internationally. The case suggests that empowering local institutions, matching their responsibilities with adequate resources, and sustaining a culture of community participation are the surest foundations for meeting the emergencies to come.

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