FROM GOVERNANCE CRISES TO RESILIENCE: ASSESSING THE ROLE OF PANCHAYATI RAJ INSTITUTIONS IN RESPONDING TO THE COVID-19 PANDEMIC – A CASE STUDY OF BALANGIR DISTRICT, ODISHA

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ABSTRACT
This paper revolves around the significant functions performed by the Panchayati Raj Institutions (PRIs) in the management of COVID-19 pandemic in rural India with special reference to Balangir district in Odisha. In India, gram panchayats and decentralised governance institutions played an effective role in the nation's pandemic response, integrating state-level policies with grassroots execution. The study is primarily driven by secondary sources of data drawn from government reports, institutional records and peer-reviewed literature, highlighting important functions performed by local self-government institutions in mobilising community resources, enabling disease monitoring, handling quarantine facilities and coordinating relief distribution during 2020-2021. The study pointed out that despite limited resources and limited capacity, PRIs in Balangir district were able to influence social capital, community networks and existing institutional structures to strengthen pandemic preparedness and response. The study concluded that institutional capability, Impartial leadership, inter-sectoral partnership and community participation can act as the foundational pillar for better COVID-19 management at the local level. But diverse problems like inadequate finance, ambiguous mission limits, lack of technical expertise and sustainability concerns restrict the PRIs from achieving the goal of effective pandemic governance. The study can assist the government by providing meaningful policy suggestions for democratic decentralisation in public health emergency management, which will optimistically influence future pandemic preparedness. The findings suggest a more robust road for public health governance in resource-limited contexts, i.e., participatory and locally grounded in crisis management, based on democratic accountability and confidence in the community.

Keywords: Panchayati Raj Institutions; COVID-19 pandemic; Democratic decentralisation; Local self-government; public health governance;

INTRODUCTION

1.1 Background of the Study

The initial reporting of the COVID-19 pandemic in Wuhan city of China, in December 2019, was a once-in-a decade public health emergency that pushed all the nations of the world to transform their governance procedures. (Durotoye et al., 2020) India, being the most populous nation of the world with over 1.4 billion population, faced unique hurdles in the containment and management of the epidemic due to its regional diversity. (Nair, 2021) In particular, the eastern state of Odisha became a distinctive case study in pandemic

governance, which adopted one of the world's strictest early lockdowns, leading to relatively lower mortality rates than other Indian states during the first waves of transmission. (Swain et al., 2021).

The national and state-level policy frameworks voted for a broad strategic objective for the response to the pandemic. But, the actual execution of COVID-19 mitigation measures took place at the grassroots level, requiring institutional structures at the local government level. (Vattamparambil & Chatterjee, 2025) The 73rd Amendment Act of India (1992) laid the foundation of the institutional basis of local self-government in rural areas of India. (Rao & Rao, 2026) The institutions of India's commitment to devolution of political power and participatory governance are the village panchayats (gram panchayats), the panchayat samitis at the block level and the zilla Parishad at the district level. (Malik, 2024) Before the COVID-19 pandemic, the participation of these local self-government institutions in public health crises, particularly pandemics, was not properly explored in the academic literature and policy discourse.

The Balangir district of Western Odisha, which has a population of 1,648,997, contributes a lot towards the study of PRI-led COVID-19 pandemic governance. The district population is largely dominated by large tribal and Schedule Caste communities, pervasive rural settlement patterns and few urban centres. (Prusty et al., 2015) The district is burdened with various socio-economic challenges such as poverty, high illiteracy rates and poor healthcare facilities. These problems signify the general developmental issues faced by rural areas in India. (Padhy et al., 2013) This scenario makes Balangir district a perfect case study model for analysing and understanding the response of decentralised governance institutions to health emergencies in resource-poor contexts.

1.2 STATEMENT OF THE PROBLEM

However, there are significant research and policy gaps regarding the crucial relevance of local government institutions in pandemic response. First, there is limited systematic understanding of how PRIs operationalised pandemic containment efforts. (Pyasi, 2024) Second, minimal documentation of how local institutions generated community engagement and social capital in response to COVID-19. (Monsalve et al., 2026) Third, the specific obstacles facing PRIs in sustaining pandemic governance roles while continuing developmental normal activities are under-analysed. (Faheem, 2023) Fourth, the institutional capacity required for effective PRI-led pandemic management has not been explicitly spelt out. Lastly, policy proposals on increasing the crisis management capacities of PRIs need to be substantiated on an evidence-based foundation.

This study aims to fill these gaps by studying the institutional processes, governance practices, community engagement techniques and organisational issues faced by PRI responses to COVID-19 in the Balangir area.

1.3 RESEARCH OBJECTIVES

1. To study the institutional mechanisms and governance structures of the PRIs in Balangir district in coordination with COVID-19 containment, surveillance and distribution of relief activities.

2. To explore the role of community involvement, social capital mobilisation and inter-sectoral collaboration in promoting PRI-led pandemic governance.

3. To identify constraints in institutional ability, resource limitations and organisational issues faced by PRIs in conducting pandemic response functions in Balangir district.

4. To offer evidence-based policy recommendations on how to enhance the institutional capacity of PRIs for future pandemic preparedness and crisis management in rural India.

2. LITERATURE REVIEW

2.1 Published International Research on Decentralised Governance and Public Health Emergencies

There is global evidence that the right institutional frameworks and resource allocation can act as a catalyst for decentralised health governance in the context of COVID-19 preparedness. (Zarychta et al., 2025) Findings from 3rd world nations that are burdened with poverty and low income suggest that, in comparison to centralised structures, decentralised governance models enable faster local responses due to their proximity to local people, improved adaptation to context-specific epidemiological patterns, and greater community engagement. (Bindeeba et al., 2025) But the success of decentralisation is dependent on fiscal autonomy, technical capacity and intergovernmental coordination. (Bardhan, 2002) International research from Nepal, Bangladesh and Indonesia shows that decentralised institutions run the risk of replicating existing health imbalances without capacity-building investments and clear demarcation of mandates. (Alam et al. 2024)

2.2 National Studies on PRIs and Public Health in India

The Panchayati Raj system in India is being increasingly used for the delivery of health services and disease control programmes. (Rakesh et al., 2022) The National Rural Health Mission (2005) expressly requires decentralised health planning, recognising that participatory approaches enhance the responsiveness of health systems. (Shukla et al., 2014) However, there are reports of continuing disconnects between formal institutional arrangements and real practice. (Scott et al., 2017) Research on Village Health, Sanitation and Nutrition Committees in north India found that while committees were successful in implementing targeted health interventions, they faced challenges like limited resources, gender-based power dynamics and fragmented administrative accountability. Studies reveal that the functioning of different gram panchayats differs in institutional capability, political commitment and community participation. (Shukla & Pankaj, 2023) (Koujageri et al., 2025)

2.3 Research on COVID-19 Management in India

The COVID-19 pandemic has accelerated the pace of policy implementation and governance experimentation among the Indian states. (Dash & Anupama, 2023) Kerala, with its long history of decentralisation, demonstrated that community participation and engagement in local governance could considerably reduce disease transmission and death. (Prajitha et al., 2021) Community volunteers, organised into rapid response teams, frequently through the structures of the panchayat and women-led self-help groups, played a critical role in disease surveillance, contact tracing and community education. (Benny et al., 2023) Similarly, a study in West Bengal records the convergence of multiple schemes and local government entities enabling multifunctional pandemic response. (Guha & Kumari, 2022)

Odisha is the flag bearer of disaster management. (Swain et al., 2021) The study mentioned that the early strict enforcement of lockdown measures in Odisha, backed by a decentralised implementation system through district and local-level administrative institutions, proved to be effective in reducing the number of deaths. (Panda et al., 2024) Human resources were mobilised across different levels of the state, with specific training modules produced for community-level personnel. (Dash, 2025) The integration of women-led Self-Help Groups under Mission Shakti and the PRIs in Odisha has empowered the SHGs to play a crucial role in mask-making, cooking community meals, migrant management, and promoting social awareness campaigns. Odisha government's gender inclusive governance at the grassroots level proved that meeting public health objectives while promoting gender-responsive governance is possible. (Darshan & Kalyani, 2021) The use of social media platforms by the elected women representatives of the panchayat to make people aware about COVID-19 and coordinate community assistance was a great initiative, but the impact of their governance differs greatly depending on local institutional factors and participation of women in the panchayat councils. (Pandey et al. 2023)

2.4 PRIs Academic Literature by Scholars from Odisha

Different study on Odisha underlines the state's unique governance structure. Research on the functioning of Gram Panchayats in Bhograi block of Balasore district (adjacent to Balangir) revealed substantial unutilized resources in the Panchayat systems due to limited institutional capacity, political bias, and ineffective linking with state and central schemes. (Jena, 2021) Research on decentralised water management projects such as Pani Panchayat in Angul and Dhenkanal districts suggests that successful local governance requires active community participation, technological innovations, enabling policy frameworks and equitable institutional arrangements. (Das et al., 2024) Odisha, due to its geographical location, is vulnerable to different hazards like earthquakes, floods and cyclones, highlighting the necessity for an integrated disaster preparedness plan incorporating the community, government, technology, and environment. (Barik and Ratha, 2024)

2.5 Government Policy Papers and Administrative Structure

The legal basis for disaster governance in India is provided by the Disaster Management Act, 2005, which has created a three-tier structure (national, state, district) and mandates community participation in disaster risk reduction. (Singh, 2023) The National Disaster Management Authority (NDMA) and the State Disaster Management Authorities (SDMAs) are acting as the nodal agencies, with the district and local authorities being responsible for execution. (Lunayach et al., 2025) The Epidemic Diseases Act, 1897 gives state governments the authority to regulate diseases. The National Health Policy, 2017 contribute to enhancing health infrastructure and disaster preparedness. (Pal, 2025) These principles were put into practice during COVID-19 as executive discretion, which brings up significant problems regarding the balance between speedy crisis action and institutional responsibility. (Mohapatra, 2020)

Odisha has its own policy frameworks, including the Odisha Disaster Management Act and resolutions of the State Disaster Management Authority. During COVID-19, the state issued several administrative directives regarding task groups, defined institutional roles, and required inter-departmental communication. According to the Ministry of Health and Family Welfare archives, the state's focus on "community preparedness and complication readiness models" showed an awareness that institutional structures at the local level required targeted operational support to manage pandemics. (Swain et al., 2021)

2.6 Conceptual Models for the Study of Local Governance and Crisis Management

Different theories provide insight into the response of local institutions to public health emergencies.

The concept of social capital differentiates between bonding (within-group), bridging (inter-group) and linking (vertically-integrating) social capital, and explains how communities manage different crisis through mobilization of resources and collective efficacy. (Monsalve et al., 2026) Research shows that social capital functions differently across preparedness, response, recovery, and mitigation phases, with bonding capital being especially important for community cohesion during acute emergencies, and bridging or linking capital being essential for tapping external resources. (Monsalve et al., 2026).

The community resilience framework, operationalised through models such as the emBRACE framework, conceptualises resilience across three basic domains: resources and capacities, actions, and learning. (Kruse et al., 2017) Applied to local governance, this framework helps to explain how enhancing institutional capacity (financial resources, human expertise, infrastructure), promoting proactive governance actions (preparedness planning, community mobilisation) and improving learning mechanisms (monitoring, evaluation, adaptation) contribute to increasing community resilience in reference to health emergencies. (Cimellaro et al., 2016)

The multi-level governance paradigm advocates for partnership across different levels of government to

achieve the target of better crisis management. (Assefa et al., 2022) To achieve a successful pandemic response, the need of the hour is not just a proper institutional framework but a dynamic interplay between governance levels, power-sharing mechanisms, inter-agency coordination, and inclusive decision-making procedures. (Iza Rumesten et al. 2023)

3. RESEARCH GAPS IDENTIFIED

Despite a large body of literature on PRIs, decentralized governance, and COVID-19 responses, there are still some important gaps: (1) There is minimal empirical evidence of the specific operational mechanisms through which PRIs have performed pandemic response functions; (2) there is limited focus on institutional resource constraints and capacity gaps in rural local governments in times of public health crisis; (3) there is less emphasis on the questions related to sustainability of crisis-driven institutional innovations within PRIs; (4) there is lack of comparative analysis across districts in Odisha to identify context-specific factors that enable or constrain PRI-led pandemic governance; and (5) there is less number of evidence on how demographic characteristics (gender, caste, education) influence community participation in PRI-coordinated crisis response.

4. THEORETICAL FRAMEWORK

This analysis is complemented by four theoretical frameworks:

4.1 Social Capital and Community Resilience Framework: This framework aims at the necessity of trust, norms of reciprocity, and social networks that advocate collective action in effective crisis response. Communities have social capital such as bonding, enabling mutual support, or bridging, connecting the community to outside resources and expertise. PRIs' access to pandemic response resources and technical support depends on their capacity to influence social capital by bridging local institutions to state agencies and civil society organisations. (Monsalve et al. 2026)

4.2 Multi-Level Governance Framework: This approach implies a vertical merger of central, state and local institutions and horizontal coordination of sector-specific agencies in respect of pandemic governance. For PRIs, this paradigm signifies the binary functions of local self-government as recipients of policy directives from state governments, and at the same time, as being answerable to their constituencies. Effective pandemic response has a defined delineation of mandate, channels for transfer of resources and protocols for cooperation. (Assefa, 2022)

4.3 Institutional Capacity Framework: Institutional performance is a function of availability of organisational resources, human expertise, technological infrastructure and leadership commitment. This framework highlights particular aspects of capacity that are specifically relevant for pandemic response: fiscal resources for crisis response, human resources (health workers, administrative staff), physical infrastructure (isolation facilities, storage), and information systems (disease surveillance, coordination mechanisms). (Khan et al., 2018)

4.4 Participatory Governance Framework: This framework suggests that effective local governance requires significant community engagement in decision-making, mobilisation of resources and implementation. Participatory techniques improve social acceptance of public health measures, dissemination of information, and collaborative efforts for pandemic response. However, participation requires supportive institutional conditions, including clear processes, equitable involvement opportunities, and responsive decision-making. (Grabmaier et al, 2025)

5. RESEARCH METHODOLOGY

The study involves both qualitative and quantitative methods and is primarily based on secondary sources of data. Desk analysis of government reports, institutional records, published research and administrative papers has been used. The time period from January 2020 to December 2021 was designated for data

collection from Balangir district, which represents the earliest phase of the pandemic period. Thematic and content analysis methods were assigned for qualitative data, and for quantitative indicators, descriptive statistical analysis was applied.

5.1 Data Sources: (1) Disaster management authority reports and COVID-19 response task force minutes, Balangir District; (2) Administrative records and community health workers' reports from Gram Panchayat via stratified sampling of 15 gram panchayats from three blocks; (3) COVID-19 management guidelines/circulars from the State Health and Family Welfare Department, Odisha; (4) COVID-19 pandemic response documentation of the Ministry

of Health and Family Welfare India; (5) Published research in Scopus-indexed journals on COVID-19 governance in India; (6) District-level epidemiological data from state surveillance systems; (7) Census data and demographic data on Balangir district population characteristics; and (8) Civil society organizations' reports documenting community-level pandemic response initiatives.

Analytical approach: Data were categorised thematically around major governance functions (monitoring, case management, quarantine, relief distribution), institutional mechanisms (coordination structures, decision-making processes, resource allocation), and enabling/constraining factors. Patterns in the operationalisation of COVID -19 response were revealed through qualitative content analysis. Quantitative analysis included measures of disease burden, resource allocation and coverage indicators for pandemic response services. Data were triangulated from many sources to ensure trustworthiness.

6. KEY FINDINGS

Balangir District: Institutional Mechanisms for Pandemic Governance
Table 1: Institutional Structure for COVID-19 Response in Balangir District PRIs (2020-2021)

Institutional level	Coordinating body	Key functions	Humanresources mobilized
district level	district disaster management authority + Collector's COVID task force	strategic planning, resource allocation, inter-agency coordination	45 administrative staff, 22 health officers
block level	block development officer + block health officer + Pri representatives	intermediate coordination, resource distribution to gram panchayats	12 block staff per block × 3 blocks = 36 staff
gram panchayat level	gram panchayat secretary + sarpanch + health volunteers	community surveillance, quarantine facility management, relief distribution	8,400+ community health workers, Asha workers, Anganwadi workers

community level	community health volunteers, self-help groups, youth groups	doorstep screening, awareness campaigns, vulnerable population support	25,000+ community members (estimated mobilised)

Source: Based on administrative data of the gram panchayats and the District Disaster Management Authority of Balangir.

Table 2: Balangir District COVID-19 Response Indicators (2020-2021)

Indicator	2020	2021	Remark
confirmed covid-19 cases (district total)	8,450	22,340	secondary wave caused significant increase
mortality rate (per 100,000 population)	1.2	2.8	below state average; early preparedness showed benefits
functional quarantine facilities (PRI-managed)	180	340	gram panchayats converted school buildings, community centres
rapid response team members (community volunteers)	3,200	5,800	ncreasing mobilisation through pris and SHGs
villages with active surveillance systems	385/410 (93.9%)	405/410 (98.8%)	pris mobilised ASHA workers and ANM for monitoring
relief packages distributed (through pris)	52,000	180,000	escalating relief demands due to lockdown impacts

Source: COVID-19 Response Records, Balangir District Administration, and Odisha State Health and Family Welfare Department

Success Factors of the PRI-led Pandemic Response

(Pyasi, 2024) The Madhya Pradesh local governance research identified decentralised decision-making and strong healthcare infrastructure as imperative in managing health emergencies, a trend also supported by the data from Balangir district. Analysis found 4 important enabling factors:

1. **Institutional Leadership and Political Commitment**: District and block-level administrative leadership offered clear directives, support in resource mobilisation, and coordinating monitoring. Turning of school buildings, community centres and Anganwadi facilities into quarantine centres by sarpanch (gram panchayat heads) reflects their proactive leadership approach. However, these efforts demanded political daring, as early-stage resistance of people to quarantine facilities was managed through trust-building and clear communication. (Chatterjee & Vattamparambil, 2025)

2. **Mobilisation of Existing Community Institutions**: Several women's self-help groups especially SHGs) and ASHA-ASA health worker networks, which are recognised as established community structures, were successfully mobilised by PRIs. (Dash, 2025) The creation of masks by SHGs, the facility of community kitchens for the distribution of aid to affected migrants and vulnerable groups, and door-to-door awareness campaigns address the prominence of community participation in the management of the COVID-19 Pandemic. Numerous pandemic related functions were carried out by almost 15,000 SHG members from 380 SHGs in Balangir district during the lockdown period.

3. **Community Trust and Social Capital:** The relational infrastructure that has been maintained between the representatives of the panchayats and the community members, built up over years via developmental activities, helped in ensuring that the community complied with public health standards. (Monsalve et al., 2026) The adoption of quarantine regulations, vaccine campaigns and cleanliness measures in communities was significantly enhanced by local leaders' credibility and trusted standing. The importance of community participation in decentralised health governance is basically dependent on institutional trust, which is globally recognised through various studies.

4. **Inter-Sectoral Coordination**: Efforts were synchronised through formal coordination structures established during the crisis, including weekly meetings with PRIs, health officials, administration, police and NGOs. Block Development Officers presided over block-level coordination committees, which provided a venue for problem-solving, resource sharing, and collaborative action. (Alam et al., 2024) Such collaboration was specifically imperative for managing migrant worker returns, as PRIs cooperated with transport, food, lodging, and health providers.

PRI Pandemic Control: Limitations and Obstacles

Studies on grassroots democracy in rural India have shown that backward regions are the victims of weak governance because of corruption-riddled politics. In the case of Balangir district, several systemic restrictions limit the PRI from achieving its goal, i.e., an effective response to COVID-19: (Faheem, 2023)

1. **Severe Resource Constraints**: Limited financial assistance was allocated to gram panchayats by the state government for pandemic management. While national disaster relief monies trickled down to district and state governments, the flow of resources to gram panchayats was limited. The high cost of quarantine facilities, relief packages and awareness campaigns burdened gram panchayats with exceeding their regular budget. Many panchayats finished their yearly budget by mid-2020 and were dependent on ad-hoc releases from the state or voluntary contributions from the community.

2. **Lack of Institutional Capacity**: Most of the gram panchayat officials (secretaries and assistants) lack capacity in relation to public health emergency management, illness surveillance and data reporting systems. (Mishra, 2024) Many gram panchayats lacked the technical skills to track cases digitally, analyse data or generate situation reports. Manual documentation was the basis of the information system, which increased errors and delayed illness surveillance.

3. **Ambiguous Mandate and Role Clarity**: The Constitution mandates PRIs with the responsibility for development in fields like water, sanitation, agriculture and education but ignores clear demarcation of their role in managing crises. In COVID-19, the demarcation lines between PRIs, health departments and administration lacks clarity. This vagueness resulted in confusion related to accountability, resource management, and decision-making power during crisis management. (Mandalapu, 2025).

4. **Lack of gender inclusiveness**: Despite active participation of Women Panchayat Members' gender biasedness was evident. Participatory role of Women through SHGs was commendable, but gendered hurdles to women panchayat members' (33% of positions are constitutionally reserved) participation in communal governance persisted. Patriarchal home structures restricted the availability of many women delegates for community mobilisation initiatives. (Darshan & Kalyani, 2021) Cultural

conventions kept women out of public view, especially during door-to-door monitoring and community meetings. The existing oppressive social and cultural structures and patriarchal practices led to ignorance of women's views and power during decision-making.

5. **Sustainability and Burnout:** The rapid mobilisation of community volunteers and health workers fostered transient enthusiasm, but limited long-term sustainability. By the end of 2021, pandemic weariness and economic pressures resulted in a reduction in volunteer engagement. Low remuneration complaints by ASHA workers and Anganwadi staff, fatigue problems due to binary duties (regular services and pandemic response) and psychological stress were prominent. (Mishra et al., 2022).

7. DISCUSSION

7.1 Institutional Effectiveness of Pandemic Governance Led by PRI

The response to the pandemic through the mobilisation of PRIs in Balangir district shows that decentralised governance structures, even with severe restrictions, can conduct population-level health interventions successfully with the minimum support needed. The district had lower mortality rates (2.8 per 100,000 in 2021) than the Odisha state average (3.5 per 100,000), indicating that surveillance and strict early containment decisions executed by the panchayats helped reduce mortality. (Bhattacharyya et al., 2022) This success questions the findings, i.e. that resource-poor rural institutions are unable to cope with crises. Instead, there are data-driven findings that locally rooted, trust-based governance can partially make up for resource restrictions in rural areas through active people participation and social mobilisation.

The activation of about 25,000 community members (estimated at 6 per cent of the urban-rural population of the Balangir district) in various functions of the pandemic response such as surveillance, management of quarantine facilities, distribution of relief and awareness creation, indicates that PRIs are important for bridging institutions between state systems and grassroots communities. (De La Poterie & Baudoin, 2015) This is backed up by global research on participatory disaster risk reduction, which implies that community-centred techniques enhance both speed and legitimacy of response.

7.2 The Role of Community Networks and Social Capital

The integration of formal PRI structures and informal community networks (SHGs, youth groups, religious organisations) is imperative for resilience to pandemic. The PRIs did not enforce state mandates from above but worked to facilitate, using existing social capital. Women-led SHGs in particular have performed multifaceted pandemic functions, concurrently taking up public health, livelihood assistance and social welfare aims. The finding adds to social capital theory by showing that in crises, bonding capital (trust and reciprocity within communities) enables quick collective action and bridging capital (connecting disparate sections of the community) promotes pooling of resources and an inclusive response. (Monsalve et al., 2026)

The pandemic, however, also highlighted the cons of overdependence on social capital. Despite efforts at community mobilisation, marginalised and vulnerable citizens like Scheduled Caste, Scheduled Tribe, migrant and poorest households were often left out. In rural areas, social capital is unequally dispersed along caste and class lines, which might provoke the reproduction of existing social inequalities rather than eliminating them. PRIs are required to deliberately use affirmative strategies to initiate inclusive participation of excluded people. (Beall, 2005)

7.3 Policy Coordination and Federal Governance

The pandemic revealed enduring issues of federal coordination in India’s complicated multilevel governance framework. The Odisha state offered policy instructions, budget allocations and technical support but questions over resource responsibility, decision-making power and accountability persisted

throughout the crisis. (Greer et al., 2022) Where federal leadership fails to deliver adequate national coordination, subnational states and local governments are left to compensate without the necessary resources—a pattern observed in Balangir where gram panchayats stretched resources to meet both routine functions and pandemic response. (Iza Rumesten et al., 2023) Clear institutional mandates, well-resourced federated systems, and pre-crisis agreements on coordinating procedures are essential for effective future pandemic response.

7.4 Gender Dimensions of the Pandemic Governance of PRI

The mobilisation of SHGs was the cornerstone of the pandemic response, but the formal PRI structures, especially the male-dominated decision-making bodies, exposed a gap in gender-responsive crisis governance. The reserved seats for women panchayat members did not immediately translate into effective participation of women in epidemic decision-making. During the crisis, gendered barriers such as time demands of family work, cultural constraints on public involvement, and societal structures that privilege male voices continued to exist. (Darshan & Kalyani, 2021) But there are also examples of women representatives and community activists who can organise complicated collective responses when they find institutional space that is developed and supported. PRI strengthening needs to intentionally address gender dimensions of crisis governance, including capacity-building for women representatives, supportive institutional frameworks that enable women's participation and policies that recognise women's contributions to unpaid care labour in the future.

8. POLICY RECOMMENDATIONS

8.1 Institutionalise and Fund crisis governance roles for PRIs: The constitutional and legislative framework should expressly acknowledge the role of PRIs in coordinated crisis response, including infectious disease emergencies and natural disasters. Separate budget allocations should be made for enhancing capacity-building in response to PRI pandemic preparedness, critical infrastructure (isolation facilities, information systems) and emergency response activities. Crisis-time ad hoc resource mobilisation is not enough.

8.2 Develop PRI Crisis Management Standards and Training Protocols: National and state governments should develop standardised crisis management standards for PRIs that include defined roles and responsibilities, decision-making processes, inter-agency collaboration protocols, and accountability systems. Regular training programmes should be held for gram panchayat staff, elected representatives and community volunteers for coordinated emergency response. Simulation training and disaster response drills should be institutionalised regularly.

8.3 Strengthen Coordination for Federated Governance: well-defined roles, boundaries, resource obligations and decision-making powers at every level of government in pre-crisis agreements are essential. Formal coordination mechanisms, such as frequent collaborative planning meetings, resource pooling agreements and information sharing protocols, should be put in place before emergencies occur. Post-crisis reviews should detect coordination weaknesses and allow for system improvement.

8.4 Advance Gender-Responsive PRI Governance: Health emergency management, public speaking and leadership abilities should be included in specific capacity-building for women panchayat delegates. Institutional reforms should ensure women's meaningful involvement in decision-making forums in a crisis. Recognition and remuneration methods should recognise women's unpaid care labour in the crisis.

8.5 Invest in local health system strengthening: The ability of PRIs to govern in a crisis is primarily based on strong local health systems. Investment priorities should include (a) regular recruitment and retention of health workers in rural areas, (b) development of infrastructure (primary health centres,

sub-centres, isolation facilities), (c) information systems for disease surveillance, and (d) supply chain systems to ensure the availability of essential medication and equipment.

8.6 Formalise agreements for community health workers: ASHA workers, Anganwadi workers and other community health professionals are crucial during health emergencies. But their positions, pay and support systems are generally informal. There should be formal agreements for employment, suitable pay, protection at work for health and safety, and transparent career paths.

8.7 Build inclusive pandemic response protocols: Ensure special focus on vulnerable people – Scheduled Castes, Scheduled Tribes, migrant workers, elderly, those with disabilities. Protocols should enable equal access to monitoring, health care, quarantine facilities and relief provisions. Community-specific engagement techniques and accessible formats of communication need to be established.

9. CONTRIBUTION TO THE BODY OF KNOWLEDGE

This research is relevant to various fields of knowledge:

9.1 Decentralised Governance and Public Health: The study offers empirical evidence that decentralised governance organisations can effectively provide large-scale population health interventions when they are suitably supported. This challenges the premise that public health emergencies primarily require centralised command and control responses, demonstrating that participative, locally embedded systems are feasible and may be more legitimate.

9.2 PRIs under a development paradigm: The literature has mostly analysed PRIs from a development perspective (infrastructure, livelihood, service supply). The findings reflect the importance of PRIs in decentralised crisis governance and security duties, and advance theoretical knowledge of decentralised governance beyond the ordinary development context.

9.3 Social Capital in Crisis Response: The study identifies particular ways in which bonding and bridging social capital is imperative for crisis response. It goes beyond abstract debate to tangible proof of the instrumental role of social capital. The fact that social capital deposits before crises enable rapid mobilisation in times of crisis has crucial implications for proactive social capital investment as a pandemic preparedness strategy.

9.4 Gender, Decentralisation and Crisis Government: Very little research has explored the gender aspect of decentralised crisis government. This research adds wisdom and knowledge towards feminist political ecology literature by documenting the opportunities (mobilisation of SHGs, community organising of women) and demerits (gendered domestic responsibilities, lack of formal representation) for women's engagement in COVID-19 Management.

9.5 Federal Systems and Health Emergency Response: The research adds to the literature on comparative public administration that accounts for coordination of crisis response in federal systems when the leadership of the central government is ineffective or inconsistent.

10. CONCLUSION AND FUTURE DIRECTIONS

The COVID-19 pandemic offered a unique chance to explain the performance of India's decentralised governance mechanisms under great stress. The findings from Balangir district mentioned that Panchayati Raj Institutions united communities, coordinated multi-sectoral activities and helped restrict disease transmission and preserve social welfare functions despite severe limitations of resources and capacity. PRIs uniquely combined governmental authority with community trust through community-based illness surveillance, volunteers managing quarantine facilities, trusted local leaders distributing aid, and awareness campaigns. But the pandemic also highlighted fundamental vulnerabilities, i.e. limited financial allocations,

blurred mandates, lack of capacity for technical skills and crisis management, and gender biased governance. Sincere efforts for enhancing institutional capacity, well-defined policies and proper allocation of financial resources are a must in order to make Panchayati Raj institutions resilient towards decentralised crisis governance. These investments are not short-term investments for better pandemic preparedness; rather, they are long-term investments in democratic resilience – increasing the capacity of local democratic institutions to protect their communities in emergencies, while ensuring accountability and participation.

Future research should focus on: (1) comparative analysis of PRI pandemic response across different districts of Odisha to identify context specific factors; (2) longitudinal studies to explore the post-pandemic sustainability of crisis driven institutional innovations; (3) mechanisms to measure social capital and community resilience in decentralized governance frameworks; and (4) possibilities of integrating technology like digital disease surveillance, telemedicine and real-time coordination systems that could enhance the PRI crisis governance capacity.

India's efforts for democratic decentralisation through PRIs are an original governance concept which addresses that sustainable development and resistance to crises is primarily based on empowered local institutions anchored in their communities. The COVID-19 experience teaches that with the right support and improved capacity-building, PRIs can deliver on this promise not only for ordinary development but as basic custodians of community security despite public health emergencies.

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