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Covid 19 Pandemic and the Kerala Experience: Necessity for the Securitisation of Human Security Threats for Sustainable Development

SHIBU M. P.
PADMAM. A
NSS College Pandalam

With the worldwide spread of the Covid 19 pandemic, human security resurfaces as a central theme of discussion in the national and international systems. Human security must be prioritised as an influential agenda for policymakers dealing with these pandemics. In this context, the article tries to analyse how securitisation of human security will enable us to deal with threats to human security more effectively, thereby making sustainable development feasible. The article also tries to evaluate the accomplishment of Kerala state in the health sector as a model for sustainable health security in facing further pandemics. During the period of Covid 19, the framework and strategy adopted by the state of Kerala in India were remarkable and have even been compared with the approach adopted by the Western countries in tackling the pandemic. Securitisation is a process by which an issue is prioritised as an essential issue that must be dealt urgently as a primary security threat. Globally, nation-states will have to act as a securitising actor, thereby setting their agenda for the securitisation process. The major research puzzle that the article tries to answer is whether the social and political considerations are essential for the success of the securitisation process in the health sector. Human security needs to be prioritised as a referent object that the state has to address. The states could bring a strong sustainable development agenda by examining 'the human security-centric approach'.

Keywords: human security, securitisation, sustainable development, Kerala model.

COVID-19, as a pandemic, has affected almost all aspects of society, ranging from interconnectedness to human survival. The realist notion of security has yet to examine the pandemic situation in international relations, and therefore, all focus is on the human security paradigm. The question to be answered is whether the state-centric security paradigm's rejection of the human security agenda resulted in the present pandemic. It questioned the 'practical utility of the realist paradigm of security' (Nuruzzaman, 2006, p.289). At the onset, the article tries to understand the importance of the 'human security approach' in managing the health crisis during the pandemic. Secondly, it tries to comprehend to what extent is securitisation of human security important for building a sustainable health. Thirdly, the article analyses the importance of social and political context in the success of the securitisation process by taking the case of Kerala during the COVID-19 pandemic.

The article will also investigate the importance of investment in social capital for the success of human security policymaking.

State-Centric Security Paradigm

The state-centric security paradigm focuses on the state as the referent object to be protected. The state's security is projected as an essential state agenda and reflected in security policymaking and defence budget allocation. For third-world countries striving for economic and social equality, colossal budget allocation for defence affects all other human development activities. The realist security agenda controlled by the military-industrial complex is well supported by academia, think tanks, media and similar agencies that benefit from the liberal capitalist order. The allocation of funds to social security measures is meagre in third-world countries. COVID-19 and its spread clearly show that the state lapses in health security, an essential aspect of human security. As argued by Edward Newman there is a need for transformation in the health security approach by placing the individual as a referent object of security analysis and thereby in policy making (Newman, 2010).

Human Security

The United Nations Development Report, 1994, put forth a new perspective that introduced human security as an agenda for human survival. The report states that,

> Security has been equated with threats to a country's border for too long. For too long, nations have sought arms to protect their security. For most people today, insecurity arises more from worries about daily life than from the dread of a cataclysmic world event. Job security, income security, health security, environmental security and security from crime are the emerging concerns of human security all over the world (UNDP, 1994, p.3).

The seven areas of human security (personal, economic, food, health, political, environmental and community) are interrelated and can be aligned through a comprehensive programme. For example, the COVID-19 pandemic primarily covers health, economic, ecological and community areas. In his speech at the international symposium on human security, Amartya Sen mentioned Japan's Prime Minister Obuchi Keizo's views on human security. According to him, human security is 'the keyword to comprehensively seizing all of the menaces that threaten the survival, daily life, and dignity of human beings and to strengthen the efforts to confront these threats' (Sen, 2000).

Regarding human security, two critical questions need to be addressed. One is why health security is at risk. Second, if there is any menace that threatens health security, to what extent can the state deal with it? While answering the first question, environmental safety needs to be considered, which is in danger due to the over-exploitation of resources with increased production as part of the neoliberal policies. States have been engaged in mere growth without considering the environmental standards for human survival. As a result, a change in the effects of climate and endangering biodiversity can be witnessed. In addition, new viruses that threaten human security and survival will emerge. A sustainable development paradigm is missing in the developmental agenda of states in the globalised liberal order. The insight provided by Mahbub ul Haq is worth mentioning in this regard:

> People must be at the centre of our development debate. What really counts is how they participate in economic growth and how they benefit from it...The developing countries must improve their economic management, liberate their private initiative and invest in the education of their people and in the technological progress of their societies (Haq, 1992).

Securitisation of Human Security

Constructing threats and formulating ways to tackle them is essential to securitisation. The Covid 19 pandemic as a threat allows us to securitise it and develop efficient policies for sustainable development to defend against these types of threats in future. As Theirry Balzacq (2011) argued on the Copenhagen School perspective on 'how security problems emerge and dissolve', threats like Covid 19 can be prevented by socially constructed agendas through the process of securitisation. The securitisation process needs strategies that have to go through specific interlinked steps. First, the identification of threats or the social construction of threats includes publicising or politicising the threat, aided by the securitising agents like media and civil society in a liberal democratic state. Second, the referent object should be projected, which needs to be protected. In the COVID-19 pandemic, human security must be cast as a referent object to be covered. Third, the securitising agents construct and disseminate the threats to the public through speech acts. If the audience accepts it, the securitisation process succeeds. Certain supporting factors promote securitisation, like human capital, the quality of information and communication technologies, cohesiveness of society, effective healthcare systems, social mobilisation and democratisation (Balzacq, 2011). This article argues that along with the securitisation process, contexts like the socio-institutional environment, mobilisation, and participation help in the success of the securitisation process. As Thierry Balzacq argues, securitisation is context-dependent. The framing of the threat also depends on the context (Balzacq, 2005).

Kerala as a Prototype

Investing in the promise of human securitisation is a much-needed factor for a better world for humanity. The emphasis on a human security-oriented development approach has recently given solid and lasting results (Newman, 2010). The case of Kerala's fight during the COVID-19 pandemic in the primary and secondary stages is an excellent example of the significance of investing in human security. Kerala is a small, coastal state at the southern tip of India with a population of 35 million people. It does not have a GDP to boast about, but it ranks as one of the states with a high Human Development Index (0.84) among the states of India. Kerala's infant mortality rate is 12 per 1000 live births; the sex ratio is 1084 females to 1000 males; the female literacy rate is 92.07 per cent, and the male literacy rate is 96.11 per cent - all these have been considered very progressive. This is where the state of Kerala occupies importance within our perspective of human securitisation (Menon et al., 2020).

Many facts regarding Kerala make it a state susceptible to the entry of new COVID-19 viruses – the geographical location, historical trade, and cultural ties that the land has developed with other nations are prominent among these facts. Kerala's economy is partly dependent upon tourism and its expatriate population; Kerala's

expatriate population has its presence in many countries, including China, Malaysia, Singapore, the Gulf States, the United States, the United Kingdom, Canada and in many more countries. With four international airports, a full-fledged coastal route and a high density of 860 persons per sq. km as per the 2011 census, Kerala had enough reasons to set its barricades anytime to combat the novel coronavirus or any such threat.

The state of Kerala is said to have been ready from the onset. It should not come as a surprise, as, while looking back, the state had prior experience handling two Nipah outbreaks in 2018-2019 and disastrous floods. Also, Kerala had to face weather conditions ranging from cyclone Ockhi in 2017 to floods and mudslides in 2018 and 2019. All these circumstances were much unexpected for Kerala, and it had to rise accordingly to counter such cases. This experience of handling these unforeseen circumstances is said to have aided the state's understanding of arming itself against the COVID-19 rage. During the Nipah outbreaks, the state had to coordinate its organisational and health resources. The essential act during this period was coordination. The fact is that – it is more than this – it is a proactive and cumulative action of a state and its people together in building resilience and walking towards sustainable and progressive tomorrows. Looking at these situations, it is pertinent that, the empirical fact, the securitisation of human resources has always been at the core of the development strategies of the state. The changing policies and politics of the state have always had an uncompromising connection with the needs and wants of the people at its core.

The article aspires to give a picture of why and how this small state managed to handle a global pandemic and, more importantly, why the state was able to adopt such strategies that have kept the state in good stead, fighting the coronavirus with a reasonable rate of success in the early stages. How has Kerala society aided this state in walking through the COVID-19 pandemic without many debilitating effects? In explaining these questions, it is necessary to look at specific areas: the solid social capital of the state, the effective health care system or securitisation of human health, the reach of grassroots democracy, the cooperation and transparency between institutions and social mobilisation.

The COVID-19 pandemic was first detected in Kerala in January 2020 by a medical student who returned from China. The person was traced and quarantined; thus, countering and reducing the risk of spreading began. The state acted per the WHO guidelines of tracing the person, testing and then isolation. The state adopted a similar process during the Nipah outbreak (Sarkar, 2021). The continuation of this course of isolating the suspects and the primary contacts of the suspects and following up with them with the needed support turned out to be the central backbone of Kerala's strategy.

Strong Social Capital

The state of Kerala has a long historical foundation of social movements, which has led to a robust social capital base, high human development index, accountable governing bodies, responsible civil societies and an empowered, educated and proactive group of citizens, which is the very power of the state. All these, together with the steady and practical progress of the state in various fields related to education and health, have given rise to the concept of the Kerala Model.

> Kerala had its own model of renaissance, a navodhanam that began in the late 19th century. This 'awakening' and the critical thinking spawned by it played a major role in making the Kerala model. It transformed beliefs, values, ideals and norms in people's conception of and commitment to social and distributive justice and human rights and in people's aspirations for themselves and their children (Chathukulam & Tharamangalam, 2021).

One main component of the state of Kerala is the strength and significance of social capital. The network of people from different streams and levels of institutions is more vital in Kerala than in many other Indian states. This can be connected to the social reforms of the 1920s and the 1930s, the active civil society, the compulsory education given to its population before and after independence and the significant allocation of the state for education and empowerment or rights of the people, especially women. Education and social reforms have played the role of an equaliser and have accelerated inter-networking among sections of Kerala society.

In Kerala, the formation and development of social capital is a process which is still evolving. It is in the hand of many organisations, 'there is consensus among social scientists that the achievements of Kerala were possible due to sustained public action from above and below' (Ramakumar & Nair, 2009). This means that the many organisations include a long list from decades back – the policies adopted by the princely state rulers of Travancore and Cochin in the 19th century, especially in health and education (Arun, 2017), the role of the missionaries' in the same century, the caste related and the social movements which took place in the following century; the formation of the communist party and its activities; the mass literacy movement and the policies adopted by the state after its formation. The erstwhile Travancore state had 31 hospitals during1884-85, according to 'Progress of Travancore' by poet and historian Ulloor S. Parameswara Aiyer. In Cochin, the vaccination was introduced in 1802. The Civil Hospital (present General Hospital Thiruvananthapuram), opened by King Ayilyam Thirunal in 1865, can be considered the first modern hospital in Kerala (Navhind Times, 2022). The spread of education with high literacy rates heightened People's Health Consciousness (Nabae, 2003). The actors' actions in the Kerala scenario came from all sectors. 'What is remarkable in the history of Kerala is that the agents who contributed to enhancing the living conditions of people belong to all the three classifications of social agents that some social scientists have recently identified: the state, political society and civil society' (Ramakumar and Nair, 2009).

When looking at Kerala's historical, cultural and political background, it is evident that the welfare and opportunity of every citizen/community/section of the society, regardless of their background, has been included in the growth process. The foundation of Kerala's development can be seen in the social movements where the old, outdated traditional customs were questioned alike by both the upper castes and the lower castes – the practices of untouchability, the question of temple entry, the denial of education and the outdated practices in legacy – these were given more teeth by the intervention of the state in these matters and many others like land reforms, which in turn gave the movements a sturdy base. Thus, apart from the sense of belonging to an 'aware community', these movements are built upon the power to change legal and institutional frameworks and build accountable political actors. This accountability, in turn, began to reflect in the government's role in developing and deepening the people's social safety net. Gender is also essential in the Kerala

development model (Arun, 2017). Amartya Sen (1992) identifies three factors which led to Kerala's progress in health and education:

> First, the relative autonomy of the government in two of Kerala's three sub-regions (Cochin and Travancore) during the colonial period allowed more appending on health and education. Secondly, women are allowed equal access to these services because of women's social position. Thirdly, a surge of social and religious reform movements influenced the social structure in the nineteenth and twentieth centuries (Arun, 2017, p.39)

The leaders, Ayyankali, Dr Palpu, Mannathu Padmanabhan, Sree Narayana Guru, Sahodaran Ayyappan, Kumaran Asan, Arattuppuzha Velayudha Panicker, VT Bhattathiripad, Kuriakose Elias Chavara, C. V. Kunhiraman, Sayyid Sanaullah Makti Tangal and Vakkom Moulavi are just some names which helped to pave the way ahead in Kerala. They were social reformers, freedom fighters, thinkers, philosophers, spiritual leaders, educators, lawmakers and prominent social workers who contributed to community development in many ways. In this realm, it is equally important to point out the role of the ideology of communism and its adherents in developing Kerala's social capital. Kerala had the first communist party in power across all of India. However, social capital and social transformation growth cannot be entirely attributed to the left movements because similar advancements in human development indicators are not reflected in West Bengal and Tripura (Oommen, 2009). The followers of the communist ideology actively participated and supported social reform by organising movements against the class domination and feudal system of the land. Later, they were instrumental in ushering in land reforms, building social security for people with low incomes, and investing in the education and health of the people of Kerala. There are three phases of Kerala's socialist path. The first is the communist engagement in class struggle marked by violence before the formation of Kerala state. The second period is from 1957 to the 1970s, when the communists experienced the state's ruling and the transformation of property relations. The third phase was from the 1970s, when there was a total absorption of the communists in electoral politics (Krisnaji, 2007). Though the social and caste movements had their role, it took a bigger picture with the communists entering the scene as political actors. Thus, looking back, the state of Kerala had all the backing of a luxurious and vibrant history that has fostered progress in community and individual growth and support. It would not be erroneous to say that 'the state has managed the crisis by building on legacies of egalitarianism, social rights and public trust' (Heller, 2020). As pointed out by R.K Varghese, a renowned sociologist, social transformation happens not by changing the existing social structure but by realising the power relations and transferring the decision-making power at political and social levels (Varghese, 2016).

Effective Health Care System or Securitisation of Human Health

The health systems in the state have been nurtured and valued since the early 19th century when princely states ruled the region (NavhindTimes, 2022). Even with successive governments and the ushering of private players within the health sector, the health system in Kerala was still nurtured and given its due value. Kerala boasts an excellent doctor-patient ratio of one doctor for four hundred Keralites (Nagarajan, 2018). In Kerala's health care system, several actors and institutions are

involved, like the role and involvement of local governments, local health institutions, civil societies, and the people involved within the health care systems from top to bottom. The healthcare system does not correspond to such inclusion or nurturing in many Indian states (Nagarajan, 2018).

When the cyclone, floods and virus hit the state, this inter-nurturing came out effectively, and there was an efficient response from the health sector while keeping the essential functions intact and going. These can be considered to have trained the state in effectively dealing with the COVID-19 pandemic. This trained the health personnel to detect a threat, plan the threat elimination, identify the resources, make actual use of the resources during a crisis, interconnect with the other necessary institutions efficiently and use many other resources, including data analytics, to contain and manage the spread of the virus.

The health system of any state has to have an interdependent relationship within and without. A synergetic relationship is envisioned, which does exist in the case of Kerala (Sadanandan, 2020). The system has to be nourished with the required physical and organisational infrastructure, training in the field, the needed staff, medicines and other equipment have to be provided, the staff – doctors and others need to be given theoretical and practical training along with a sense of pride and safety net for the work that they deliver. This is not the scenario in many states in India. Most states have a deprived or unproductive health system with little funds or nourishment. The case of Kerala is different, as the state's health system has always been a sector with good interdependent relations within the system. The decentralisation process has also worked well with the state's health system. Another considerable point is that the state has been able to nurture many alternate medicine branches that have progressed with years of support and research.

The health sector's participation with citizens from the lower tier of governance is essential. As the case may be, the grassroots governance system, the Panchayats or the Urban local bodies are in charge of the health system of every place. The primary health centres, or PHCs, are the centres that work at the root of the health system, often called the first contact centres. There are other tiers of health centres above the PHC, and they all come under the charge of the governing bodies, with the members given charge of many sections. These bodies constitute more, bringing ordinary citizens as stakeholders into the health sector fold. These grassroots governance and health systems act as an essential sector where all are under its fold; they invest their resources in many matters related to health, sanitation and nourishment of the people in the area. This interdependent or complementary system of bodies makes practical work possible, with communication and coordination going hand in hand. For example, the circulars and instructions from the bodies above regarding containment and quarantine were circulated and worked upon speedily by the lower-tier bodies in the panchayat and urban levels. This was evident during the Nipah outbreaks, the floods and the COVID pandemic. The only upgradation was that this time, when COVID-19 lashed out, more agencies like the police force, media, self-help groups and other organisations coordinated better. All this was possible not only because of the awareness and alertness of the citizens but also because of the pride and value the people and the health sector staff had been installed within sustainably building a resilient society– these points back again to the securitisation issue.

When the World Health Organisation called Corona a Public Health Emergency, Kerala adhered to it (World Health Organisation, 2020). Health is also a vote bank politics as it is counted as necessary in Kerala. The decision-making in government regarding the allocation of resources in the health sector is the outcome of a bargaining process by a few persons in the socio-economic and political context (Sadanandan, 2001). Government initiatives, recently and in the past, have put efforts into upgrading the facilities, equipment, and other resources in the health infrastructure. Kerala has government and private healthcare institutions running parallelly and with a good amount of credibility. During the corona crisis, the medical facilities worked in tandem and were upgraded – online consultation with prescription was made available to the people; psychological needs of the people who were quarantined were also looked after (Sarkar, 2021); in government hospitals, the corona treatment was given free of cost, the government started separate buildings for covid treatment (Covid First Line Treatment Centres) where medicines and food for the inmates were also accessible – taken up by the government, and in private hospital's specific number of beds were made available with the government fixing the charge for treating covid so that the patient would not be overcharged. Apart from the treatment point, the frontline medical staffs have been instrumental in many areas during the COVID-19 crisis, like monitoring the quarantine of positive patients and spreading awareness.

> Kerala's early investment in the health sector is one of the important factors that helped the state deal with the pandemic without overwhelming the hospitals and overburdening the medical community. Although the Kerala model of managing the COVID-19 outbreak failed to bring the pandemic under control, one needs to accept that the health sector in the state did not collapse despite the alarming increase in infections (Chathukulam & Tharamangalam, 2021).

Kerala could sum up its resources effectively only because of the earlier investment that the state had in its health sector and because of its prior experience of handling sudden health emergencies like Nipah and floods. The early investment in the health sector is due to considering human health as a matter of primary importance; as securitisation theory postulates, Kerala society accepts human health as a referent object that needs to be protected. According to the Securitisation theory proposed by the Copenhagen School of Security Studies, the State is often projected as a referent object that needs protection (Balzacq, 2011). Kerala's government's investment in health is an ongoing process, just as before COVID-19 and after COVID-19. During the times of COVID, the state was able to summon more capacities in terms of staff who were working for longer hours uninterrupted, added more facilities like laboratories, ICU beds, and medical oxygen supply, and added more infrastructure by turning buildings into COVID treatment centres; and free shelter and covid treatment for its citizens and guest workers. A significant capacity that the state has shown is the un-delayed action during emergencies and accessibility of preventive and curative health services to its citizens. As part of its ongoing progress in the health sector, under the Aardram scheme of the government, the Primary Health Centres are being converted into Family Health centres, which would have an increased number of doctor services and more medical facilities would be made available at the lowest level so that its citizen's access to these capacities would be seamless. In addition, the Community Health Centres are being converted to Block Family Health Centres; the infrastructure

in Taluk and district hospitals is being upgraded, and the facilities are being made people-friendly (Kerala Development Report, 2021).

A simple Google search about why Kerala performs well in health care systems results in the state boasting of high social indicators like literacy rates – of both men and women; healthcare accessibility in the state, low rates of infant mortality. One of the lessons learnt from the COVID-19 pandemic is that the states that have not been effectively nourishing their healthcare systems have had to compromise. Kerala has successfully developed and sustained a robust, alert community that values health and healthcare systems. The case differs from the country's outlook on the health sector. This is because of voters' and politicians' low political prioritisation of health (Tillin, 2021).

Grassroots Democracy and Social Mobilisation

Effective decentralisation and social mobilisation helped the Kerala state set the stage for prioritising the health sector in the development agenda. The democracy at the grassroots level, the many organisations included, and the people or society including every citizen - all these sections complimented each other through their respective work. In actuality, grassroots democracy, cooperation, transparency and social mobilisation can be seen explicitly in the state's social solid capital, the effective healthcare system and the state's social securitisation of human health. They all work in tandem in situations and reach.

In Kerala, the most vulnerable people were the elderly citizens, the poor and the migrants. Kerala has a high life expectancy rate, which is more in the case of women than men. The Economic Review 2020 has stated that the elderly population of Kerala's life expectancy is expected to grow more (The Indian Express, 2021). During the coronavirus crisis and the lockdown that followed, a list of older adults above sixty years of age was compiled, and their health complications, if any, were noted; later, the primary levels frontline health workers like the ASHA (Accredited Social Health Activist) workers and others were given the task to spread awareness among these elderly citizens and their families. Apart from the ASHA workers, the section of the society that spread awareness among the people included panchayat members, the self-help groups of women, neighbourhood groups among women and primary health centre workers.

The role of government has various hues, and one most prominent in a welfare state is to take care of its people. Kerala was the first state in India to announce a revival package by adopting a firm stance, 'health first' or 'health above all', as its vision for development (The Times of India, 2021). The government came ahead with its economic packages. Welfare pensions for its people: those not part of any welfare schemes were given relief packages; the guest workers were given relief packages; the self-help groups were given loans. Moreover, there was the free distribution of food grains and kits through the public distribution system so that nobody in the state would go hungry – regardless of their financial status (Mohammed; Azad; Muhammed &Maya 2021). These were some of the strategies that the government of Kerala adopted to help its people mitigate the perils of the COVID crisis. While speaking of these, the guest workers' case needs to be mentioned here.

Kerala was the first state in India to have social security schemes for migrant workers. Kerala has a sizeable population of migrant workers in many job sectors.

They form a vast unorganised workforce in Kerala. When the COVID-19 crisis hit and the lockdown proceeded, many were stranded in the state without money, food and shelter. The government ushered in a safety net for them by arranging food, shelter with entertainment, COVID testing centres and medicines. Trains to take them back to their native places were arranged; even a helpline for guest workers in their languages was initiated.

Moreover, the state has had welfare schemes for the guest workers since 2008, inclusive education has been introduced for their children; there are literary schemes to teach Hindi and Malayalam to these guest workers; increased access to health-related matters and insurance schemes for the guest workers are in place (Peter; Sanghvi & Narendran 2020). In addition, 65 per cent of the migrant workers' camps and 47 per cent of migrant workers in India were given shelter in Kerala (Issac & Rajeev, 2020). In all these efforts, the intervention and group actions of the local government bodies – the panchayats and the urban bodies, the civil supplies department, the labour department, the health and welfare department, the revenue department, and NGOs and self-help groups – were relevant.

Local governments started community kitchens as part of the strategy to prevent everyone from being hungry. The self-help group Kudumbasree also actively participated in packing food for people in need. The police force also did its role of surveillance and protection, bringing awareness programmes in 'break the chain' and taking part in many duties and not theirs by a rule like arranging for medical aid. Modern digital technology also goes hand in hand – an example is the use of geo-fencing applications by the police force to counter quarantine offenders (Sarkar, 2021). In all these efforts, the influential role of the decentralised governing system, the cooperation and transparency of all actors and their actions and the social mobilisation in countering the COVID-19 pandemic can be seen, which has been possible only because of the initial investment done decades before as part of human securitisation.

During the covid 19 pandemic, one significant risk for the state emanated from Kerala's considerable expatriate population. The issue of this population returning home during the pandemic raised significant concerns as the risk accompanying it was not simple. It spiked the cases of COVID during the third phase. It had cascading effects on employment and the economy, too. Though the risk was high, though there were criticisms, the state did manage to tackle it with its high management skills in tracing and tracking the cases and later initiating packages for returnees.

There could always be a counter that there is a negative tie between investment in health infrastructure and COVID management because even the best of the state could not prevent the destruction, which ensured COVID-19 (Pandey; Prakash; Agur & Maruvada 2021). True, but the debatable point here is that one, humans have not understood the whole encompass of our physical self, its weaknesses, nor the possibilities of medicine; research is still going on these spheres, and it would not be wrong to say that people in authority have put the best resources to the best use during a health crisis which could have wiped humanity off the face of the earth. Secondly, the states with better health investment and services have had a better grip in handling the circumstances; the devastation could have been total, but then most of us are still here to talk about it, thus proving the survival and sustainability of human securitisation.

The cases of some states prove that better health infrastructure has led to better management of the consequences (Seethalakshmi & Nandan, 2020). When the coronavirus wave raged nationwide, many states were unprepared for such a crisis. Some states in India had difficulty delivering health services and oxygen supply. On the other hand, there are states like Kerala and Odisha that have been able to manage the wave – at least in the initial phases- and have sustained through the crisis. The political participation, the availability and investment in the health sector, the balancing socio-economic factors, the inclusivity of all sections of people and the scope and space for discussion on issues have a positive contribution. State intervention, support and sustainability were necessary during the COVID crisis. The government of Kerala was very responsive to the sudden emergency. It took the necessary measures to detect and trace, provide emergency medical aid to all, and deliver food and financial security to its people (Sarkar, 2021).

In a social democracy like Kerala society, the transparency between the governing and the governed holds a vast space (Sandbrook; Edelman; Heller &Teichman 2007). The transparency between these factors holds the capacity to take the movement forward. 'Malayalees have extremely high levels of trust in their institutions and locally elected local representatives. More than anything, this points to the robust nature of Kerala's social compact' (Heller, 2020). Kerala kept its communication channels with the people transparent, and there was a give and take of information and transparency between the systems – governing bodies, health and the media – which brings out the earnestness that the system gives to the core factor of human securitisation. The role of information and making a community a partner in the process went long way in containing the pandemic. One medium through which transparency and trust were kept going was the daily media telecast of the state's Chief Minister to the people. The media telecasted the Chief Minister's speech at the end of each day to instil trust and transparency within the people. The information and subsequent decisions were spoken straight to the people.

Kerala is an excellent example of a promise of human security when the Human Development Index is taken as an approach to measure human security (King & Christopher, 2001-02). However, human security needs to be prioritised to manage issues like the pandemic effectively in the future. Even with all these, the interrogation of how well the state fared with these efforts is a matter that needs analysis. The answer to this lies in the fact that – any policy or programme initiated is always bound to bring in criticism, but the crux of the matter is to let the good work go on. In the third phase of the pandemic, the state did not perform as well as before, but this cannot discredit the past efforts that the state has advanced in the health sector. The only apt reply would be to retell that 'Kerala's biggest advantage was its robust healthcare system and participatory mode of governance or social democracy when handling the pandemic' (Chathukulam & Tharamangalam, 2021).

The government of Kerala's practices during the initial phases of COVID-19 aided the state in managing or controlling the crisis without becoming out of control. However, by the third phase, this was not the case. Studies blame it on little caution as, when the state rode high on the success of the first two phases, people had become less careful and neglectful with wearing masks and using hygiene practices; secondly, the cause for the laxity has been pointed at the adversarial politics that the state got embroiled into (Chathukulam & Tharamangalam, 2021). Criticism has also been raised at how the state held its testing of COVID suspect cases – that enough tests

were not conducted. 'In Kerala, the unhealthy face of adversarial and competitive politics took the front seat while mitigating the spread of the Covid-19 pandemic took the back seat' (Chathukulam & Tharamangalam, 2021). Nevertheless, it is proven that the state has managed the initial phases.

Conclusion

To conclude, during any crisis, one significant matter that should exist for effective mitigation is consensus. The consensus between all the parties involved – all the tiers of the government, the people, the civil society, the health sector, the other government and non-governmental organisations involved – in a democratic manner. In the initial phases, there was consensus between all the actors, but later, that was lost. Though this is the case, it is undoubtedly clear that the major strengths of the state are that it is an interventionist state with a people-friendly approach, a diverse population aware of its rights and a well-mobilised socially. Better said in the words of Patrick Heller, 'Social democracies are built on an encompassing social pact with a political commitment to providing basic welfare and broad-based opportunity to all citizens' (Heller, 2020). Kerala needs to continue its securitisation process in human security with the help of favourable social and political contexts. This would strengthen human security-oriented policymaking. The other political systems can comply with similar securitisation processes only after strengthening their social and political context, as the securitisation process is context-dependent.

References

Arun, S. (2017). *Development and Gender Capital in India: Change, Continuity and Conflict in Kerala*. Routledge.

Balzacq, T. (2005). The Three faces of Securitisation: the Political Agency, Audience and the Context. *European Journal of International Relations*, 11(2).pp.171-201.

Balzacq, T. (2011). *Securitisation Theory: How Security Problems Emerge, and dissolve* (Eds.), London-New York: Routledge.

Chathukulam, J.& Tharamangalam, J. (2021, September). The Kerala Model in the Time of COVID19: Rethinking state, society and democracy. *World Dev*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7510531/.

Haq, M. ul. (1992). *Human Development in a Changing World*. United Nations Development Program. https://hdr.undp.org.

Heller, P. (2020, April 18). A Virus, Social Democracy, and Dividends for Kerala. *The Hindu*. https://www.thehindu.com/opinion/lead/a-virus-social-democracy-and-dividends-for-kerala/article31370554.ece.

Issac, T. M.Thomas & Rajeev, S. (2020, May). COVID-19, Public Health System and Local Governance in Kerala. *Economic and Political Weekly*, 55 (21).pp. 35-40.

Kerala Development Report (2021). Kerala State Planning Board. February 2021. https://spb.kerala.gov.in/sites/default/files/inline-files/Kerala-Development-Report-2021.pdf.

King, G. & Christopher J. L. Murray (2001-02). Rethinking Human Security. *Political Science Quarterly*,116(4).pp.585-610.

Krishnaji, N. (2007). Kerala Milestones on the Parliamentary Road to Socialism, *Economic and Political Weekly*, 42(23). htpp://www.epw.in/journal/2007/23/special articles/kerala-milestones.html.

Menon, J.C., Rakesh, P.S., John, D., Thachathodiyl, R., Banerjee, A. (2020, July 27).

What was Right about Kerala's Response to the COVID-19 Pandemic? *BMJ Global Health*. https://discovery.ucl.ac.uk/id/eprint/10106889/.

Mohammed, K. C; Azad, P;Muhammed, R. E & Maya, K. (2021, November 18). Effectiveness of Public Policy in Reviving the COVID 19 Hit Economy: Evidences from Kerala. *India. J Public Aff*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8646417/.

Nabae, K. (2003). The Health Care System in Keral: Its Past Accomplishments and New Challenges, J. Natl. Inst. Public Health, 52(2).pp.140-145. https://www.niph.go.jp/journal/data/52-2/200352020010.pdf.

Nagarajan, R. (2018). 6 States have More Doctors than WHO's 1:1,000 Guideline. *The Times of India*. https://timesofindia.indiatimes.com/india/6-states-have-more-doctors-than-whos-11000-guideline/articleshow/65640694.cms.

Navhind Times (2022). The Erstwhile Healthcare Model of Kerala, https://www.navhindtimes.in/2022/10/09/magzines/panoram/the-erstwhile-healthcare-model-of-kerala/.

Newman, E. (2010). Critical Human Security Studies. *Review of International Studies,*36(1).pp.77-94.

Nuruzzaman, M. (2006). Paradigms in Conflict: The Contested Claims of Human Security, Critical Theory and Feminism. *Cooperation and Conflict*, 41(3).pp. 285-303.

Oommen, T.K. (2009), Development Policy and the Nature of Society: Understanding the Kerala Model. *Economic and Political Weekly*, 44(13).pp.25-31.

Pandey, P., Prakash, A., Agur, R., & Maruvada, G. (2021, May 7). Determinants of COVID-19 Pandemic in India: An Exploratory Study of Indian States and Districts. *J Soc Econ Dev*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8104459/.

Peter, B., Sanghvi, S., & Narendran, V. (2020, November 12). Inclusion of Interstate Migrant Workers in Kerala and Lessons for India. *Indian J Labour Econ*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7659401/.

Ramakumar, R. & Nair, K. N. (2009). State, Politics and Civil Society: A Note on the Experience of Kerala. In U G Rist (Ed.), *Decentralisation Meets Local Complexity: Local Struggles, State Decentralisation and Access to Natural Resources in South Asia and Latin America* (pp. 275-310). Bern: Centre of Competence in Research (NCCR) North-South, University of Bern.

Sadanandan, R. (2001). Government Health Services in Kerala who Benefits? *Economic and Political Weekly*,36(32).pp. 3071-77.

Sadanandan, R. (2020, June). Kerala's Response to COVID-19, *Indian J of Public Health 2020*, 64. S99-101.

Sandbrook, R; Edelman,M; Heller,P. & Teichman,J. (2007). *Social Democracy in the Global Periphery: Origin, Challenges and Prospects*. Cambridge University Press.

Sarkar, S. (2021). Breaking the Chain: Governmental Frugal Innovation in Kerala to combat the COVID-19 pandemic. *Government Information Quarterly*. https://www.sciencedirect.com/science/article/pii/S0740624X20303282.

Seethalakshmi, S. & Nandan, R. (2020, April 24). Why Some States do Better than Others in the COVID-19 Fight. *Live Mint*. https://www.livemint.com/news/india/why-some-states-do-better-than-others-in-the-COVID-19-fight-11587732917794.html.

Sen, A. (1992). Missing Women. *BMJ: British Medical Journal*, 304 .pp. 587-588.

Sen, A. (2000, July 28). Why Human Security?. [Presentation]. *The International Symposium on Human Security*, Tokyo.

The Indian Express (2021, January 15). *Life Expectancy to Increase in Kerala, Every Fifth*

Person to be a Senior Citizen by 2036. https://www.newindianexpress.com/states/kerala/2021/jan/15/life-expectancy-to-increase-in-keralaevery-fifth-person-to-be-a-senior-citizen-by-2036-2250277.html.

The Times of India (2021). *Covid Revival Package of Rs 20,000 Crores, No Fresh Taxes in Kerala LDF Govt's Budget*. https://timesofindia.indiatimes.com/covid-revival-package-of-rs-20000-crore-no-fresh-taxes-in-kerala-ldf-govts-budget/articleshow/83235002.cms.

Tillin, L. (2021). A Democratic Health Check: Why India Shows the Need for Democracies to Prioritise Healthcare. In *Build Back Better Together: A Blue Print for a Better World. School of Global Affairs*. Kings College London. https://www.kcl.ac.uk/global-affairs/assets/buildbackbettertogether-g7report-final.pdf.

Varghese, R.K. (2016), Local Governance, Civil Society and Social Mobilisation. *Kerala Sociologist*,44(1).pp.1-8.

World Health Organisation. (2020, January 30). *Emergency Committee Regarding the outbreak of novel coronavirus*. https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meetingof-the-international-health-regulations.