Too Many Cooks and Yet a Tasty Broth!
A Study of Management of SARS- CoV-2 Pandemic in Kerala

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List of Tables

List of Figures

List of Acronyms

CFR- Case Fatality Ratio.

CHC- Community Health Centre.

COVID-19-19- Coronavirus Disease 2019.

FLTC- First Line Treatment Centre.

LSGI- Local Self Governance Institutions.

PHC- Primary Health Centre.

PHFI- Public Health Foundation of India.

RQ- Reverse Quarantine.

RRT- Rapid Response Team.

RTPCR- Reverse Transcription Polymerase Chain Reaction

SARS- Severe Acute Respiratory Syndrome.

WHO- World Health Organisation.

Contents

Abstract

With pandemic becoming the key word buzzing across the globe, academic engagement with it has become more relevant. Rethinking development and re-strategizing developmental goals and policies have become the need of the hour. Pandemic has also surfaced once again the need to have better and efficient governance, especially in developing countries. This research paper presents a case study and how the case presented could become a basic blue-print for developing countries in building a governance structure that can aid in engaging with crises and emergencies, with regulated, collaborative action of people.

Key Words

Crisis management, Decentralisation, Fatality, Governance, Kerala, Pandemic, Peoples' Planning.

Introduction

The Novel Coronavirus induced pandemic has altered human lives profoundly. The past twenty months saw people adapting to newer forms of life which were literally unheard of. Economies across the globe spiralled down into financial crisis, especially in the southern hemisphere. Businesses became remote, education turned online, on site entertainment events collapsed. In a nutshell, social life of people metamorphosed in a way no one has ever imagined.

The manner in which pandemic unfurled across the world was highly contrasting. Some countries did try to control the rampant spread and succeeded in it to a certain extent. While some other countries, saw people succumbing to the virus alarmingly. Therefore, it can be confidently stated that the infections and deaths depended on the management system a country had erected to combat the pathogen.

Having mentioned that, these management systems were an off shoot of the existing institutions, and were influenced by the motivations and aspirations of governments of the respective countries. Resource endowment of the nations also had an influence over their management systems. The systems in a developed country were visibly distinct from that in a developing country. Hence, studying these management systems in close details is much necessary. It is important to discuss these systems and make them a reference for further development of policies and refurbishing the existing ones. With the motive of understanding these management systems and actions, this research aims at studying the management strategies of Kerala, a federal state in India. Kerala received a good amount of attention from media on a global level for effectively containing the spread of the infection. Media did not hesitate to call out the ‘flaks’ within the policies of Kerala in managing the pandemic, when the infections scaled up again.

This ‘judgement’ in the media became the kernel for pursuing this topic academically. An attempt is made to understand what was the aim of the state vis-à-vis the pandemic and what were the core strategies and the reasons to choose those measures. The reason to make Kerala the subject of the study was mainly due to the socio-economic challenges the state already had and how the state managed to resist the pandemic. Secondly, Kerala was the first place in India to report the case and treated the index patient of the infection in the country and treatment protocols were developed in the state. Kerala also happened to be a choice as it was the domicile of the researcher. Thus, selecting Kerala also aided the researcher in gathering relevant information from primary sources, though mostly in a virtual mode.

Picture 1: Map of Kerala.

(https://www.mapsofindia.com/maps/Kerala/Kerala-index-20map.jpg).

Kerala is a federal state located in the southern part of India. Kerala has a population of 35.8 million people as of the census of 2011. Geographically, Kerala is sandwiched between the Arabian Sea of the Indian Ocean and the Western Ghats, an ecologically relevant mountain range as well a globally recognised and studied biodiversity hotspot. Kerala has received global attention for the progress it has achieved in the education and health sector. The state has achieved new zeniths in improving the living standards of people in the state. A Map is given above.

At the same time, Kerala has a weak economy. The state is not adequately industrialised. Authors referred in the literature in the following chapter too have raised this concern. The state for a long time has been dependent on the remittances to the states from expatriates working in middle eastern countries like the United Arab Emirates, Qatar, Saudi Arabia and Oman. These remittances declined significantly as expatriates returned back when the pandemic hit. The state further has a relatively higher population density and a demographic challenge of aged population, as the birth rates are one of the lowest in India. The virus ushered in to these challenges.

Regarding the Covid-19 numbers, Kerala has clocked close to 5 million confirmed cases of SARS CoV-2 viral infections as on November 01.2021 since January 30 2020, through two broad phases of spread. The first phase of the spread is characterised by a high proportion of imported infections where people who moved into the state had infections. Second phase saw a community level transmission. This meant that people who did not have any travel history also had infections. As many as 30,000 people have succumbed to the virus after having combated a severe mode of disease from both the phases combined. Getting deep into a micro level, only 0.6 percent of people have died from the infection till date. The state has maintained this low level of fatality since the pandemic unwound. The 0.6 percent is much below the national average of 1.3 percent. The above data could be used to state that, out of a hundred people who tested positive, only 0.6 people died. The Case Fatality Ratio, CFR is the lowest in Kerala. This feat has been achieved at a time when there were neither any specific medication for the virus nor any preventive vaccination for the first ten months.

1.1) **The Development Theory Selected**

Decentralisation is the development theory that is explored via this research. Development practitioners across the globe have commented on the impact democratic decentralisation can have in a society. Policy makers often debate on the need to decentralise governance for better outcomes. The process is considered to bring more people into the realm of governance who otherwise would have not been a part of it. Decentralising governance effectively would eliminate power being accumulated in the hands of a few and people would effectively make better decisions for themselves. Decentralisation has often been linked to better management of resources in a given area. One set of scholars and policy makers argue that Decentralisation and active local governance deepen democracy and make the people in larger echelons of governance more accountable to their actions.

While the other school critiqued decentralisation as it is seen as another layer of government and added hindrance to the lives of people. Having local governments as agents of the central governments are also critiqued by political scientists and sociologists. Scholars argue for more financial autonomy for the effective operation of local governments. The researcher believes that decentralisation and localising development action are very relevant in a developing country, especially when the population is high and income inequalities are high. Through the involvement of local governments, more people could be positively impacted. When local governments, often in collaboration with people collaborate for actions, the outcomes are more profound. Decentralisation fuels local governance and enhancing democratic decision making

at local levels. In India, Mahatma Gandhi conceptualised the idea of self-sufficient villages from which the idea of local governments took inspiration. However, the idea was not sculpted into a good shape until the later years of twentieth century. Having local level governments was thought to limit the powers of the state governments.

This research uses the theory of decentralisation as it is visibly a form of governance and a set of actions to explore the feasibility of entrusting local governments with the onus of managing disasters and emergencies like a viral pandemic.

The research, sans any bias, would look into the strategies chosen by the state of Kerala, why those were selected and how they influenced the current outcome. The following chapter would present a review of literature that aided in formulating this research. Following would be a chapter on the methodology of the study. A chapter on the excerpts from the interviews done and media reports studied would follow the chapter on methodology. These conversations would stand as an evidence to the arguments made in this paper. An analysis of the pandemic management is provided with observations from the field as evidence to support the argument followed by a conclusion. The document is also provided with a bibliography and questionnaire used to conduct the interview in the appendix.

2) Review of Literature

This chapter would take the reader through some of the thematic areas that fuelled this study. Since the outbreak of the pandemic, academia hardly spared a chance to engage over the nuances of the contagion and its social impact. To further this study, a vast amount of literature, particularly on Covid-19-19 management policies of Kerala, decentralisation movement in Kerala and peoples' planning campaign were read.

Furthermore, literature on governance, public sector, motivating the workers were studied. This chapter would lucidly explicate all themes and various views that emerged out of the review. These literatures were reviewed to understand the development narrative of Kerala and how governance has been happening in the state and how policies were made and the ways in which it evolved over time.

2.1) Kerala Model of Development; An Enigma

Kerala model of development is a highly debated and researched concept in academia. The concept has received immense appreciation as well as backlash. Debates on the 'model' has surface once again post the emergence of the pandemic. Kerala model indicates a trend of low levels of industrialisation accompanied by high levels of human development, especially in the field of literacy and healthcare. Parayil recognises the development narrative to be a demonstrable example from the third world in achieving commendable levels of sustainable development without having a great rise in the scale of industrialisation. (Parayil, 1996). Parayil has identified some of the tenets of the model to be the falling rates of population growth, improved fertility ratio, longer life expectancy and so on. The author celebrates the verity that the achievement in these fields happened through promotion of democratic freedoms and personal liberty.

Some other facts that would add to the enigma of the 'model is the low per capita income of the people of the state and a high level of investment in education and healthcare within the state. The levels of investment in the primary and secondary education was high in Kerala, compared to the national average. The state had a keen focus on the welfare of the financially compromised citizens and established fair price shops and the schools offered free lunch to the students. Another aspect highlighted by the author was the involvement of people in various social movements and social awareness.

Chathukulam and Tharamangalam, further justifies the Kerala model of development by adding the concept of a politically mobilised society that has remained conscious about the political actions of Kerala. Authors argued that the welfare measures enacted by the first elected

communist government in Kerala laid the foundation for high literacy and social consciousness in the state. (Chathukulam and Tharamangalam, 2020). A strong commitment to social welfare and various social movements opposing caste discriminations have helped the marginalised to be active participants in the politics and governance. This resulted in inclusive social development within the state, on which the state could further proceed. A larger commitment to inclusive development has resulted in access to education and healthcare by the marginalised communities. On a deeper contemplation, access to healthcare and education has given the marginalised communities in Kerala relatively higher protection both from pandemic and the deprivation stemming from it (Chathukulam and Tharamangalam, 2020).

Achin Chakraborty has accorded a new validity to the propositions of Parayil by presenting the Kerala model as a new narrative (Chakraborty,2005). Author does approve the commitment of state to a larger welfare-oriented governance. However, Chakraborty does assert that the trajectory of high social development without economic advancement in long term would enter a turbulent phase when there would be demographic transition and the population ages. Author further raises the concern of the continuing the model with a growing ageing population and the increase in welfare provision (Chakraborty,2005).

The Kerala model of development is further critiqued by scholars for being least supportive in fostering economic growth and being less suitable for doing business. KP Kannan has opined against the model where there is least focus on promoting economic growth and the not widening the industrial base in the state (Kannan, 1990). Kannan in his paper has argued that the mismatch between economic growth and social welfare would further hamper the sustainability of social welfare in the state. He rekindles the idea that Kerala needs to promote industrial investments and changes in the labour structure within the state (Kannan,1998). He highlights various dilemmas like demographic transition, higher levels of labour unionisation and so on as threats to the larger economic garb of the state.

2.2) Decentralisation and Governance

Decentralisation was one of the core areas of exploration in this study and it deemed important to undertake a review of decentralised governance, particularly in the developing countries. Decentralisation while being a greater development policy, is often viewed with a shade of doubt of being completely effective. Development and policy scholars often pin point the need to have a viable leadership and institutional support for local level governments to work with commendable efficiency. Fidelx Pius Kulipossa in his paper has opined that decentralisation would lead to development of political consciousness among people and new leadership would

emerge within politics (Kulipossa, 2004). Kulipossa identifies that decentralisation has economic, governance and political aspects. A closer reading of the paper would leave the reader with nuances of decentralisation and its challenges. The paper posits that decentralising has a set of innate challenges as it would take a long time to resonate with national policy interests and decentralisation would add to more layers of government and bureaucracy, which would rather hamper the development of the society due to increased procedures. The author has voiced out that attempts to ensure accountability, especially downward accountability towards people, developing sustainable institutions at local levels and incorporating people in local levels to engage in community actions as methods to have effective decentralisation.

The author finds fiscal autonomy, decision making powers with local levels, active engagement of local level leadership to be the most important aspects of decentralised governance.

2.3) Decoding Decentralisation in Kerala

While India legally mandated local self-governance through the 73rd and 74th amendment act, not all states had proactively implemented this policy. Kerala however has been keen on implementing local governments and granting them their due autonomy. Seema Bhaskaran has argued that decentralisation has aided in marginalised communities, particularly women to enter the realm of administration (Bhaskaran, 2011). Decentralised governance in the state has led to an energised monitoring of rural health and education missions. Significant level of decentralisation and autonomy to the locally elected governments in the state, contributes to the Kerala model development. Therefore, decentralisation as a policy would translate to increased governance and more people in governance.

It is important to understand to how the government implement decentralised local governance. The process is long and has multiple steps to achieve the aim of decentralisation. TM Thomas Isaac has elaborated on multiple ways in which the local governments in Kerala were supported. The most important among them was granting them more financial support. Having financial support helped the local government to devise more development plans. He argued that developmental plans were made in consultation with the local governments and the money to implement them were given to the local governments as grants and aid (Isaac,2011).

Isaac has also added that the planning in LSGs in Kerala had a bottom to top plan where common people actively participated in the planning meetings. This generally happened at the village levels known as the gram sabha. Active participation of people to determine development planning is unique in Kerala and contributes to the development model of Kerala. Incorporation of people into development debates and dialogues concretes the democratic

principles of the state. Policies, therefore were more effective as they were devised to suit the right people with specific needs.

A further agreement to the argument to Isaac comes from Rashmi Sharma, who found that that the active campaign for people's planning and decentralisation has been quite triumphant in Kerala. Sharma finds that the financial autonomy of the local governance bodies has been substantially high in the state and the panchayats and gram sabhas actively pursued the development aspirations of its people. People's campaign also led these local bodies accountable to the flaws in the development (Sharma, 2003).

S Mohanakumar justifies the decentralisation and people's campaign movement as a move to strengthen the democratic stature of the Kerala society (Mohanakumar, 2003). He finds that the commitment the state had to the movement emanated from their active provision of fiscal autonomy to the local governance bodies. The author also asserts that the left leaning government has been more committed to the democratic decentralisation movement.

Another seminal work that was reviewed for this dissertation is the book on people's planning campaign and decentralisation was 'People's Planning'; Kerala, Local Democracy and Development by TM Thomas Isaac and Richard W. Franke. The work elucidates the initiation of people's planning campaign in the state and the trajectory of implementing decentralised governance policies across the state. It was evident from this book that the campaign brought people much close to the governance system and development planning was taken to the lowest level of hierarchy. authors have highlighted how the local level governments were involved in deciding budget and the state budget was initially planned by the local governments. The book has been presented as a historical account of the twenty-five years of commitment to taking development planning to grassroot levels. It was evident from the book that there existed a greater level of fiscal autonomy in deciding the development action plan. Authors opined that planning at the grassroot levels helped in ensuring basic facilities to the people. It can be identified as a customised creation of facilities in the economy. Authors posit that the people's campaign has helped in strengthening governance in rural areas and the making the process of governance inclusive.

Authors through the book have conveyed how there was policy focus on chiselling out able leadership within the local levels and making people leaders in their own spheres. Isaac and Franke have explicated how people led movements and development plans were developed with local people taking initiatives and them being the democratically elected leaders of the respective wards and municipalities.

A closer reading of the book helped to understand the political commitment to democratise the process of decentralisation and ensuring a responsible leadership with commitment towards the bottom level. It was evident that the decentralisation movement in the state happened with according greater fiscal autonomy to local governments and ensuring freedom for them to work.

2.4) Healthcare in Kerala

The pandemic has rekindled the thought to have a robust healthcare system in place. However, over the years, the need to have a strong public health system was neglected by the policymakers and were hardly given any attention. However, in Kerala, a contradiction helped to stage a better fight to the virus. Thomas Isaac and Rajeev Sadanandan has argued that there has been a slow down in the state expenditure in the health sector of the state since the 1970s. this has however been improving since the early 2000s. Isaac mentioned that the communist party led government of Kerala has been keen on improving the health infrastructure in the state and has been allocating funds to the local self government bodies to invest in the development of district levels hospitals and primary health centres. (Isaac and Sadanandan, 2020). The argument also makes it clear that the increased investment in the public health sector has led to more people availing the services from the government health facilities compared to the private sector. The percentage of people availing the government health facilities in the state has scaled up to 48% in 2017 from the 34 percentage in 2014(Isaac and Sadanandan,2020).

It was also found that the local governments were given autonomy in handling the healthcare institutions in the state and funds were distributed to the local governments for operating and maintaining the health facilities. The authors opine that the increased capacities of the local health facilities and the relatively high availability of health care personnel in the state like, doctors, nurses and other paramedical workers has played a pivotal role in management of the viral infection in the state. The local health facilities became the first point of contact for management of pandemic. The medical personnel involved in contact tracing and monitoring the well being of the people quarantined to limit the spread of the virus. Authors find that the public health care system has gained more with effective decentralised governance (Isaac and Sadanandan, 2020).

A closer reading on the healthcare system of the state is extremely important to make further connections within this research. Before stepping into gauging the impact of the pandemic, the state as other healthcare challenges to manage. The persistence of various co-morbid lifestyle

diseases and an ageing population has been a great challenge to the state. Hence a responsive and robust system was necessary for the state. Given these dilemmas, Joy Elamon et.al have argue that the current performance of the state in maintaining high credentials in social development would be a consequence of a highly decentralised healthcare system in the state (Elamon et.al, 2004). Authors have found that the effective people's planning campaign led by the communist government of 1996 helped in the revitalisation of healthcare system and government facilities which were on the verge of dilapidation hitherto. The commitment of the government to ensure financial autonomy and allot additional funds to the panchayats and villages to initiate new ventures helped in strengthening of government facilities.

The paper voices out that the peoples planning campaign had led to a substantial improvement in local public health facilities. The devolution of funds to grama sabhas and panchayats had led to more basic facilities being installed at the primary health care centres. There has been an improvement in sanitation and other facilities. Decentralisation as opined by the authors has helped in improving access to the government facilities for the poor people. (Elamon, et.al 2004).

Adding on to the literature would be the Aardram mission launched by the government of Kerala to metamorphose the healthcare system to a people friendly and accessible one. The mission aimed at strengthening patient services offered at primary health centres and government run hospitals. Boosting basis health infrastructure across all levels of healthcare was conceptualised by this mission. The mission was planned with the involvement of local level governments and the approach was visibly bottom to top (https://Kerala.gov.in/aardram). The government through the promotion of this mission aims to improve accessibility to healthcare for poor people, especially those of rural domains. The movement rather comes up with a motive to make healthcare sector more inclusive, which is central to maintain high levels of social development.

2.5) Motivated Workforce

Having dealt with various aspects of healthcare and localised governance, another sphere of literature reviewed was on to understand motivation of workforce. Reading this topic was essential to understand theoretical notions of the reasons of working in a public sphere. There are ongoing debates on understanding various elements that motivate workers to perform in the public sector or in the private sector. Marc Buelens and Herman Van den Broeck, from their research have found out that the people working in the private sector register a notable

performance in expectation of rewards and emoluments, which are extrinsic motivating factors, while the public sectors workers are least bothered about materialistic compensations (Buelens et.al, 2007). They establish that the public sector employees often demonstrate an innate ethical commitment to the society through their work.

The authors have extended their research by experimenting with various hypotheses on motivation and work situations, to substantially analyse these distinctions. The situations included work life balance, scope for personal development and social responsibility, job stability and so on. Doina Popescu Ljungholm has researched on intrinsic motivation among public sector workers. Their paper showed that public sector employees turned out to be relatively more selfless (Ljungholm, 2014). The paper often adds a justification to the findings of Buelens et.al prima facie. Author adds that the public sector workers have a higher prevalence of intrinsic motivation than their private sector counterparts (Ljungholm,2014).

Ljungholm asserts that the corruption is a demotivating factor for the selfless workers in the public sphere (Ljungholm ,2014). Workers often feel a substantial level of intimidation within a corrupt public sphere. Further, payment of substantial levels of wages to the highly motivated public workers would rather not diminish intrinsic motivation of the workers.

2.6) Online Secondary Data

YouTube was a major source of secondary data in this research. Given the pandemic and various forms of social distancing norms across the globe, YouTube appeased a lot many scholars to collect data and information related to the research. Israel Berger in 2012 has written about YouTube a self publishing sites as major source of data for information. (Berger, 2012). The short essay argues that the site becomes an ethical source of data and it harmonious with the concept of consent and the person publishing is aware of the content published. Various disciplines like anthropology and sociology has acknowledged the use of YouTube for data.

A major challenge in using YouTube for research would veracity of the data collected as too much unrefined information would be available on the site. Hence researcher would have to bear the onus of fine tuning the data to be presented and analysed.

2.7) Gap in the Literature

Pandemic is a new theme that has emerged for social research. Hence academic literature related to the topic is scanty. The available literature was mainly journalistic and they did not venture into examining the underlying factors that enabled a particular mode of action either in Kerala or for any other region. This research would be an addition in to the existing volume where the focus is on a region that has economic challenges and has relatively lower social

privileges. This is also a study focusing on how effective local governance institutions and policies to regulate these institutions would help in achieving social welfare in developing countries. Much has been written about local governance and peoples planning in Kerala. However, the literature connecting governance in Kerala to crisis management has been relatively little. This study is an attempt to connect governance structure crisis management actions.

3) Methodology

In this chapter, the planning of the study is described. This chapter would have a mention on the design of the research, the methods used to collect the relevant for the study and analysis of the same.

3.1) The Research Problem

Pandemic and its social impact in the simplest of the terms is the research problem. Pandemic is certain to cause a serious impact on the lives of people across the globe and it has done so. While the pandemic would affect the population physiologically, it would also affect the society and economy at large. Pandemic therefore is not an issue of healthcare, it is also an intersection of various other politico-economic factors. Given the existing global inequalities, pandemic has affected countries differently. The response of each country to the infection has also been distinct from each other.

Countries with a struggling economy and underdeveloped healthcare sector would encounter struggle in treating people and protecting people from succumbing to the virus. Without effective policies to guide and govern the healthcare sector and the larger economy, most of them had many people facing severe medical and social difficulties.

It is a truth that the effective policies of the government with regard to health and social welfare would help in resisting the controlling the rampant spread of the virus.

3.2) Research Objective

The objective of this study is to observe the Covid-19-19 management action of the state of Kerala in India and academically engage with their plan of action in the approach towards the pandemic. The research aims to study how the state has registered a better performance in limiting the fatalities from the viral infection. The study is interesting as the state is one of the least industrialised and economically deprived one. Hence there is a great policy and governance level intervention that has led the state to limit the deaths from the virus. The motivation for taking up the state to study came from the media coverage the state received on the Covid-19-19 management. It was once celebrated for low counts of infections. Later it was blamed for higher number of infections. Rounds of celebrations and vilifications ignited an interest to study the whole issue better. Kerala was chosen as an area of study as data regarding

the infection and related parameters were accessible and appeared close to the reality. The secondary data for the chosen time period was also available.

3.3) Research Questions

1) What were the strategies adopted by the State of Kerala in India to manage the pandemic?
2) Why did the state use these strategies to achieve the outcomes?

3.4) Relevance of the Study

Any study on the pandemic at the moment is relevant as it is creating new knowledges and motivating more targeted actions. A lot many disciplines have taken up the novel coronavirus induced pandemic as a theme to conceptualise better ways to human lives. This study is relevant as it looks into how developing countries should focus on the welfare of people and how social welfare should always remain a focus for policymakers. The strategy implemented by Kerala in protecting people from deaths at a time when no vaccines and medicines were available had to be studied and the factors that enabled this feat must be engaged at policy levels in the times to come.

3.5) The Research Design

The study is primarily qualitative. The decision to approach the issue qualitatively was primarily to capture the actions of people and experience of a community action at large. Another reason for approaching the study qualitatively was due to the volatility of data and to approach the issue from political and social angles. the research is presented as a case study with primary and secondary data to support the arguments posited. The state of Kerala and its policies were closely observed over a period of time. The time period spans from the first set of infection without a community level transmission in early 2020 till the current period of infections where there are community level infections, fatalities and vaccination drives going on. The official data on Covid-19-19 published by the government of Kerala was the main source in developing arguments. The data on daily infections, deaths recorded, the hospitalisations and the oxygen requirement were the observed parameters.

3.6) Data Collection

The study was initially thought of collecting more primary data from people who were involved in Covid-19-19 management and the people who recovered from the virus in the state. However, the existing protocols prevented any form of physical visits to participants. Hence

the study depended on more secondary data. Primary data was only obtained from a few participants. The participants mainly included the locally elected ward members of Thrissur city corporation who were in charge of the pandemic control in the city and the officials from the government who were assigned additional duties in managing the pandemic control activities. The healthcare assistants both in the private and government facilities were participants. Medical students involved in the treating the patients and assisting senior doctors were included in the research. Data was collected following the existing pandemic protocols on social distancing. The patients recovered from the infection were contacted via telephone. The conversations were semi structured and more responses were provided by the participants. The excerpts from the conversation were recorded in the journal. All the participants were assured of anonymity and the recording of the information was done with due consent from the participants. Population of the study was local leaders, infection survivors, volunteers and business people. the sample size was fixed at 10. Most of the participants for the study was obtained using personal contacts

A total of 7 people was contacted over telephone and some excerpts from those conversations are provided in the following chapter.

Apart from the data collected via personal contacts, newspaper reports were referred periodically. One of the major sources of data regarding the pandemic was the small column on the cumulative number of infections, recoveries and deaths was the Hindu newspaper. Another newspaper that was referred to was the Malayalam daily Malayala Manorama which had information on the pandemic. The numeric information published in a concise manner helped in conceptualising a research on the theme.

Established news channels helped too had special debates with health experts and politicians who presented various views on Covid-19-19 management and the kind of policies the state and the central governments should pursue with respect to public health and governance of people.

YouTube was another source of information for gathering the information. Expert level interviews were a major source of information to this research. Though none of them directly engaged with decentralisation, debates on what the further plan of action should be and the governance action were discussed in these interviews. Hence discussions at the background level helped to develop an analysis highlighting the need of decentralised governance.

Location of the Study

The study was based in the city of Thrissur, in the state of Kerala. Owing to the pandemic induced travel restrictions data was only collected from the city. Thrissur was relevant to the study as it was the first city in India to report the SARS CoV-2 infection and the local leaders and the health officials created the first treatment protocol for the index patient in the country.

3.7) The Research Timeline

The theme for the research was initiated during the month of March and the research problem was finalised by the end of April. To arrive at a relevant research problem, a brief review of literature on pandemic, socio-economic challenges erected by the pandemic in various countries were analysed. Media reports and government data were observed to formulate a research problem. The thesis was approved for further research in April and initial work began in the month of May. An extensive review of academic literature was done from the May till June. Data to support the study was conducted in the months of July and August. The Analysis of the collected data was done in September and various drafts of the dissertation was done in September and October, aiming a final submission in November. The research analysis was presented to the supervisory panel in the last week of September to seek review of the work done hitherto.

3.8) Limitations in the Study

The researcher feels that the study could have been more elaborate had the pandemic related restrictions been lowered in the state of Kerala. Sample size was small and the primary data collected was limited. More subjective leadership and management experiences could have been gathered had in person meetings happened. These experiences could have led to insights on innovations implemented by the local leaders.

4) Excerpts of Conversations

In this chapter a brief transcript of some of the people interviewed and some of the YouTube interviews referred to are given. The participant did not have any hesitation in researcher using their real names. However, upon their request, their contact details are not provided.

4.1) Primary Interviews

Name of the participant	Designation	Mode of interview	Date dd/mm/yyyy
Ms Radhika N V	Division Councillor Thrissur Corporation	In person at the house of the researcher	15.06.2021
Mr Suresh AK	Division Councillor Thrissur Corporation	Telephonic	08.07.2021
Ms Jaine Shiny MJ	Senior Ophthalmic Assistant, Thrissur	Telephonic	22.09.2021
Mr Vivekanandan	Student TISS, Covid-19 Patient	Telephonic	10.09.2021
Mr Prabakaran AK	Covid-19 Patient, Young Policy Professional, Karnataka Government	Telephonic	22.10.2021
Mr Rahul Krishnan	House Surgeon PK Das Medical College, Kerala	Telephonic	21.09.2021
Mr Sukumaran Nair	Business Owner	Telephonic	02. 09.2021

a) Interview with Ms. Radhika NV

In this in person conversation that happened with the councillor, She asserted that the when the Covid-19 cases started increasing and cases, the panchayat and the corporation took all major

decisions regarding the management. She said that the local self-governments would manage the pandemic. The state government was only looking into channelizing the procurement and distribution of resources. The councillors were involved in contact tracing and during the initial days when the infections were imported we also had prepared elaborate route map of the patients to find further contact. The councillors made it a point to call and warn primary contacts who had higher chances of an infection and forced them into quarantine to prevent further infection in the ward.

"We did all actions. the management was taken to ward level. The corporation decided that every ward would have their councillor in the leadership positions and recruit their volunteers from their respective wards".

In the frequent meetings held with the health officials, local management by councillors was considered to be the better measure. She said, rather than a few government officials handling the cases of the entire district, ward level management helped in preventing overburdening of the hospital. She said that councillors were given the task of effective contact tracing and finding primary contacts of patients infected with the virus. She said that contact tracing was one of the tedious jobs, yet the most important in controlling the infections.

Ms Radhika said, she was completely aware of the people who got infected with the virus as patients itself called them.

"positive aayavar enne thane vilikkum, njan pinne avare aduthulla cooperative hospital allenkil jilla hospitalekk kond pokum. Ente volunteers athinulla sahayam okke cheyth kodukkum. Positive aaya patients nte aduth thamasikkkunna aalkkare vivaram vilich parayum. Angane oru community awareness undakkiyittund. (Meaning that, people would call her if anyone tested positive and she would call her volunteers to take her to the cooperative/ district hospital/ FLTC, she also said that she would alert about the positive confirmations to the neighbours. Hence a community awareness about the situation was created in Malayalam).

When asked about why local governments involved she said that, the state government was sure of more infections and more severe patients. The state government therefore entrusted us with the duty of testing symptomatic patients, enforcing quarantine contact tracing and hospitalisations. She further said that over years councillors were so involved in the daily lives of people and they naturally became first point of contact whenever in need.

When asked about whether they had any authority to make decisions, she said <u>YES.</u> We councillors took the decisions to lock down and inform the District Collector to formally announce the lockdown. We had periodic meetings held with Covid-19 protocols in place to

take crucial decisions. She said that she along with her team monitored the development in her ward and all councillors did the same. She had the details of the all the people above 65 with her which was used to enforce reverse quarantine in the state of Kerala.

b) Conversation with Mr A K Suresh, the division councillor:

Talking with Mr Suresh helped to understand the strategy of the state more clearly. He said that the collector and the government gave complete authority to the respective councillor to plan and implement the action. The councillors just had to ensure that all people who could be saved was done and maximum people received adequate medical care. Councillors recruited volunteers to help in action. The state government just wanted the death rate to be less than one percent.

Suresh said that councillors were given training at collectorate on the pandemic by doctors. Training to handle the cases and initiate work on ground was given to councillors. The SOP to handle the case was developed by the district hospital in Thrissur. Volunteers once selected were also given all training by the health officials. Police also cooperated with the councillor and the team.

Suresh mentioned that people had some confidence in their councillors and the state government was keen on using this confidence in preventing high rates of infections.

During the floods of 2018, councillors were involved in managing relief camps and getting people out of their flooded homes with the help of volunteers. we applied the same technique even during Covid-19.

"*Njangal eppzhum ready aan, enth sambhavichalum. Ippo gulf returnees und, interstate pokunnavar und. Avare onnum pokanda veranda enn parayan pattilla. Appo njangal test cheyyanum, hospitalil kond pokanum okke 24/7 ready aayitt und. Our ambulance unit thanne ready aakki vechittund. 2020 april thott njangalde life thanne ingane aan. Pakshe ath oru vailya lakhsyathinu vendi aayath kond njangalkk parathiyilla*"(We were ever ready for anything 24/7. We get people tested and take them to FLTCs and so on. We even have an ambulance unknit set up for quick action. Our lives have been like this since 2020. We don't complain as it is for a larger good; in Malayalam)

When asked about why local governments were involved, Suresh mentioned that local governments were a part and parcel of lives in the people in Kerala. For every problem in their lives, people immediately depended on the councillors and the problem was solved. It was

understood that the local governments had a role to play when an emergency of the size of pandemic hit.

When asked about his involvement in contact tracing, he said that it was not even a question to be asked. All councillors were mandated to trace maximum contacts. In his ward, there were two volunteers who used to call primary contacts of people who tested positive in the area and ask them to enter into quarantine. This was done with no compromises. He further stated that councillors could not be lethargic as it mattered lives and livelihoods of many.

c) What Vivekanandan had to Say

Vivekanandan Satyamoorthy is a student of Tata Institute of Social Sciences Hyderabad and is a native of Salem. His family was infected with the virus in August of 2020. His father developed serious complications and he was admitted to Apollo hospital for further treatment. Vivek mentioned that he had to run a crowd funding campaign to pay the hospital fee of 4.72.000 Indian rupees. Vivek mentioned that he had no idea and no information on what to do. The local panchayat member said that he had no idea on what to do as it was decided by the 'officer'.

"Yes PP (as the researcher is addressed by the participant, informally). Councillors are involving but most of them are just for political gains. Elections are coming. They don't know which hospital had a free bed or if a government hospital is having beds. Even during second wave, they were very passive in their actions. People who had contacts got a bed and some were saved from dying. The other had to suffer. When my family got infected, I had to depend on my friends with a car to get my dad to the hospital. The management system was so confused".

The system needs to be much more organised in TN (Tamil Nadu). He said that the local governments are just agents of the ruling party in the state. They have no real power to make any valid decisions. He further said that the charitable organisations formed by various religious group were involved in helping people. *"I personally disagree with charitable organisations by religious groups and they have their own communalised agenda. However, something was better than nothing at a time of emergency*." He mentioned that Tamil Nadu must relook into the local governance in the state of Kerala and learn some lessons from it.

d) Conversation with Prabakaran AK

Prabakaran was another participant in the study. He was admitted at the Manipal Hospital in Bengaluru. He too had to shell out 4,50,000 Indian rupees in treating the viral infection. He

said that he was not willing to get treated at Manipal, he had no other option as he developed serious hypoxia. He mentioned it was very difficult to find a government hospital in the city of Bengaluru. The management in the state was again improper as they did not rise up to the size of the event. For the poor people the struggle would be much higher. The RTPCR test are as high as 2500 Indian rupees.

Prabakaran was also insightful in giving academic insights as he was a graduate in public policy. He mentioned that the India should focus on strengthening its local governments and given them training. He mentioned that the Panchayati raj system in India must also focus on making better leaders amongst local people. A native of Tamil Nadu, Prabakaran had a greater penchant for the local governments in Kerala and he mentioned that India should imbibe lessons from Kerala on strengthening their local governments for better development outcomes.

Prabakaran mentioned that in India where a huge fraction of people is poor and have no sufficient education, it is important for making policies that would change their lives. The best route to it would be through making local governments strong enough to make policies and fund development action.

4.2) YouTube Interviews

Two major individuals' online interview was critically studied. One was of Dr TM Thomas Isaac, the former finance minister of Kerala and the second one was Dr Sarada Muraleedahran IAS, the additional chief secretary of department of local self government.

e) The Interview with Dr T M Thomas Isaac with the Harvard Club of India

In this YouTube interview, Dr Thomas Isaac mentioned at the very beginning that Kerala had a strong public health system and a fairly autonomous local governments to tackle the crisis. Dr Isaac who had worked academically on the issue of decentralisation describes the local governments as 'fantastic'. He also stressed on the need to localise the control, sustain the economy and limit the spread. He said Kerala needs healthy people to go out and work as it has a fragile economy. He mentioned the role of volunteers in providing support measures and psychosocial support. Further in the interview he mentioned that the state economy was going to contract and the challenges would be severe. He said that exert level committees were made to give opinion on how the financial policies should be. However local government took the final decision and implemented the action. He said that local governance is the backbone of governance in the state of Kerala. He too mentioned that past experiences of disasters and viral

outbreaks in the state and managing them by the cautious action of local governments has helped in fighting this pandemic as well.

https://www.youtube.com/watch?v=TVQwDFzLxfo

f) The Interview with Dr Sarada Muraleedharan on YouTube

Dr Sarada Muraleedharan on her YouTube interview with newsclick, have also reiterated the critical role of local governments in controlling the pandemic. She asserted that the local governments played a vital role in enforcing quarantine, contact tracing and getting people to test. She believed that the outcome of the state vis-a-cis the pandemic would have been worse if it had failed to do contact tracing and enforcing reverse quarantine and providing necessary care for the elderly and people with comorbidities. She mentioned that the Kerala was one state that adopted devolution of power post the panchayati raj amendment and that had paid off during Nipah outbreak, the 2018 floods and the Covid-19 pandemic. She said the role played by the local governments of Kozhikode in finding the patients in the first Nipah outbreak of 2018 was so vital, so that a second cluster of infections and further community level spread did not happen.

She further added that Kerala government had always focused on strengthening the local governments. In the budget of the state more funds were allotted to the local governments for developing institutions in their regions.

“Their intervention has been a game changer for Kerala” she said. Their community kitchen and the grocery and the medicine supply also was a major activity of the local governments across the state. She said that Kerala could not have even thought about an alternative without local governments.

https://www.youtube.com/watch?v=3KTFzJa-720

g) Conversation with a health official

Ms Jaine Shiny, who was a senior ophthalmic assistant was another participant with whom a telephonic conversation was possible. she was posted on non Covid-19 emergency duty for four days a week and for the rest two days, she worked at the panchayat Covid-19 control room. She mentioned that the Covid-19 management conducted in a manner where panchayat members were the leaders and the health officials just provided them with expert opinions.

Whenever a patient with complications were reported by the member to the nearest CHC/ FLTC or the general hospital, necessary preparations were made. Panchayat member really took a great lead in contact tracing and making route map of any patient with the help of assistants from the health department. Panchayat members really helped the health departments through contact tracing, getting primary contacts tested and managing quarantine centres.

She said that the health department could not have handled the crisis alone and more people and brains were required to handle the crisis. the involvement of the panchayat and their leadership has helped in reducing stress and workload for doctors and nurses. Their management of the FLTC and support given to patients in home isolation and FLTC had helped patients with severity to get treatment.

h) Interview with a Medical Student

Rahul Krishnan, was a house surgeon in a private hospital of Palakkad district in Kerala. He mentioned that medical students were also involved in non Covid-19 wards of hospitals and were added to the workforce as interns. Students considered this as an option to do their part for the good od the society. Some students went in as volunteers to FLTCc where most of the patients were asymptomatic. Students were deployed in monitoring the vitals of the admitted patients and assist them whenever required.

Rahul had volunteered at one of the FLTCs in Palakkad and mentioned that they were completely organised by the panchayats. Councillors were present their throughout and a set of volunteers were present at the centre. Volunteers worked on the instruction of the councillor.

Conversation with Mr Sukumaran Nair, a small business owner.

Sukumaran Nair, informed that the total lockdown was a loss for businesses. Despite the lockdown cases did not decline. When asked about localised lockdown, he mentioned that it did help him to open the shop for some time in a week and it was also an indication of coming down of infections in the area. Sukumaran mentioned that during total lockdown area wise information was missing.

When containment zones became active, councillors kept on providing information about the infections and that really helped. Councillors came and checked the visitors entry register regularly. Councillors also requested shop owners of the area to make online orders from people and in that way both customer and the business people were satisfied.

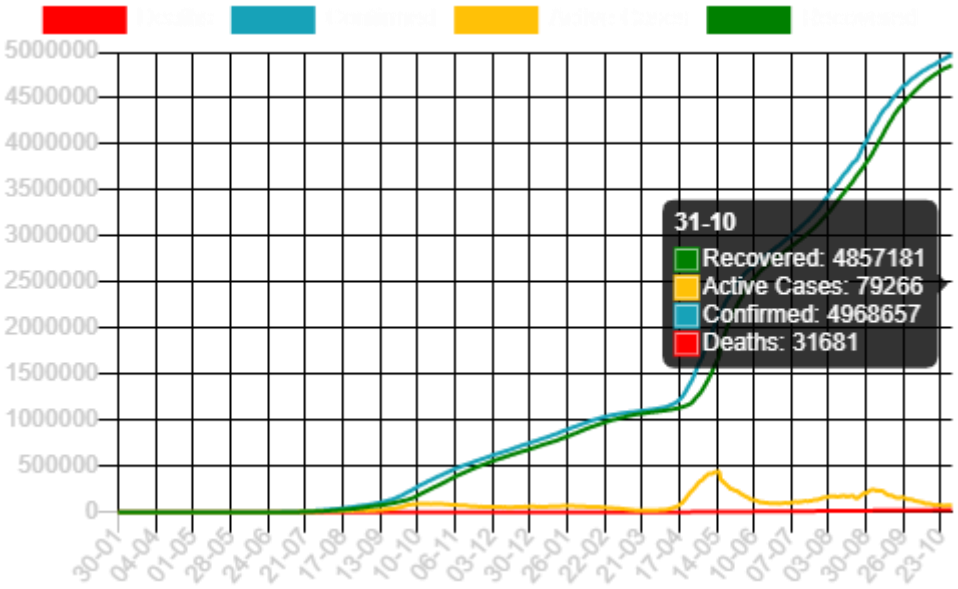
Councillors during pandemic became more approachable. Even before they were helpful, but when the pandemic hit, they became more visible. Volunteers often were quick in delivering supplies to the customers.

Even when the lockdown rules were relaxed, only young people came into the shops, as elders were provided with supplies at their homes. Elections to the panchayats happened during the pandemic, and despite the change in the councillor, the activities a councillor should constitutionally do did not change.

5) Analysis

In this chapter, answers to the broad research questions are developed. The answers are developed by collating the observations from the field and the literature reviewed. Firstly, a description of 'what' would be done followed by an attempt to engage with the 'why' part. Towards the end of this chapter an attempt to link the outcome and the actions would be made. This analysis was made developed by referring to the conversations presented in the previous chapter and the major arguments in the literature. All the excerpts mentioned there had mentioned the indispensable nature of local governments and their autonomy in the state of Kerala. Before proceeding into the details, the official Covid-19-19 data of the state is provided below. The review of literature above has helped to understand the history of governance and development practice in the state.

Below is the graph of Covid-19-19 in Kerala.



Picture 2: The Covid-19-19 Graph of Kerala.

A link to the dynamic dashboard with latest the complete data is provided: https://dashboard.Kerala.gov.in/Covid-19-19/index.php

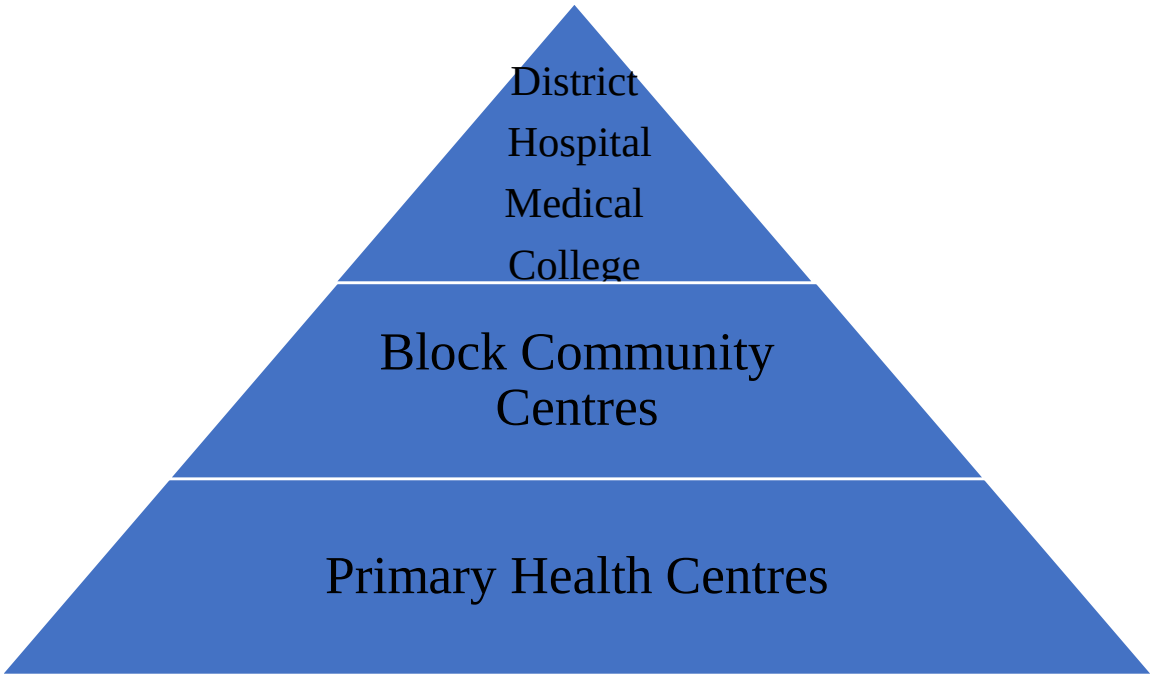
5.1) Strategy 1: Localised Approach

From the responses from the interviews, it was understood that the main feature of the pandemic management strategy of Kerala was controlling the infection and other socio-

economic concerns at the local level. The state made the control protocol highly local. The state followed a strict bottom to top approach in managing both medical and social aspects of the pandemic. The focus of the state was to 'limit' the number of the deaths and delay the peak to the maximum possible extent. From the above two sentences it is understood that the state was sure of consistent spread of infections among the larger population and the deaths that would happen. The strategy of Kerala was also different from the zero Covid-19-19 strategy adopted by some nations as the virus had already entered into the larger community.

From the responses in the previous chapter, it was also clear that the local leaders were extensively involved in contact tracing of people of their wards and enforcing quarantine and reverse quarantine in their wards. Volunteers and the councillors themselves supervised these actions. The focus was on each ward. Data published was also at the local levels.

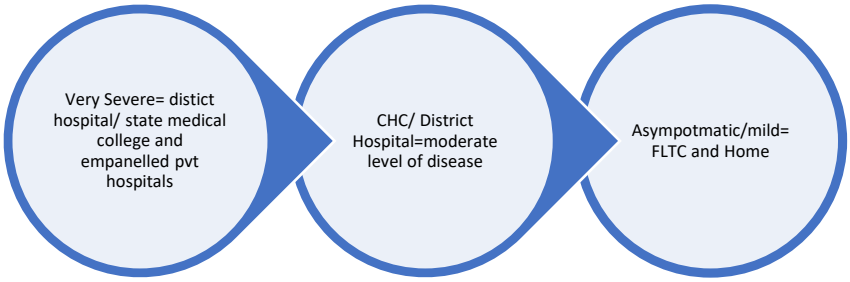
Decentralisation of the public health care sector and their classification of patients based on severity too, helped in a better management of the situation. The public health care system in the state is organised into the primary health centres (PHC) in at the ward levels and the community health centres CHCs at the block levels and the district hospital at the top of the organisation. PHC occupies the lowest level in the hierarchy, while CHCs occupied the intermediate level and the district hospital occupied the highest spot in the hierarchy.



Picture 3: The public health sector in Kerala.

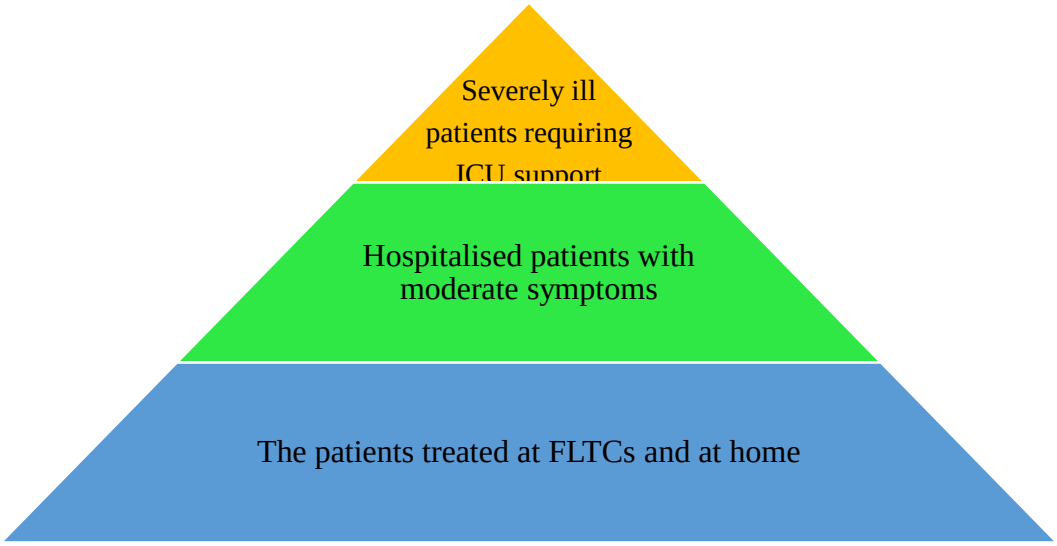
The operations of these hospitals are managed by the respective local governance institutions. When the pandemic hit, these government facilities were utilised in a graded manner. The

primary health centres did not have large in-patient capacity. Hence PHCs along with the panchayat/ ward of the area were given the charge of running the First Line Treatment Centres the FLTCs which were temporary arrangements made for treating asymptomatic and mild cases of the viral infections. People with mild to moderate cases were handled both at the CHCs and the district hospital. These hospitals had intensive care units and ventilators. Those with severe infection directly went to the district hospital or the nearest state medical college which were all state-run facility. The empanelled private hospitals were directed to serve patients with moderate to severe infection.



Picture 4: Progression chain of patients in hospitals in Kerala.

The above diagrammatically shows the admission of Covid-19-19 patients into medical system. Grading patients according to the severity of disease helped in providing required medical attention to every patient.



Picture 5: The Percentage of patients across levels of Covid-19-19 healthcare.

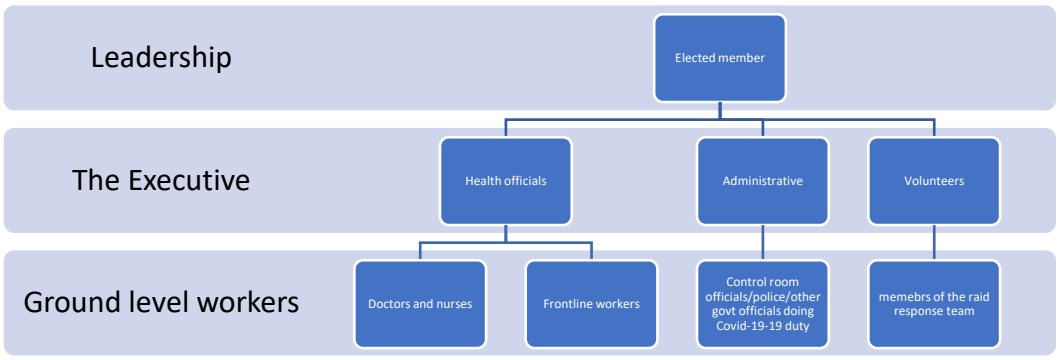
The above diagram shows the share of people who were infected and the manner in which they were treated. the diagram needs to be looked from bottom to top as it indicates the number of patients who ended up in the critical care. More people were put into the FLTCs wherein the antibiotics were started and further infections could be stopped. This prevented hospitals from being overcrowded with all patients. This has helped doctors not being exhausted and facilities like oxygen beds and ICUs being misused.

Picture 6: A First Line Treatment Centre FLTC in Kerala.

https://www.thenewsminute.com/sites/default/files/First-line-treatment-centre-Kerala-1200-compressed.jpg

These facilities especially the FLTCs were directly managed by the local governments and at every level there were volunteers of the rapid response team deployed and it had helped in better actions.

The Management Hierarchy



Picture 7: The hierarchy of personnel managing Covid-19-19 in Kerala.

The above is the diagrammatic representation of a Covid-19-19 management team of a ward in a panchayat/municipality or corporation. There were multiple such units where the local

leaders led the whole team comprising of police, doctors, frontline staff and the volunteers. This system did help in extremely coordinated management action. People may not be well aware of government officers. Officers too would be unaware of many people of their area. Having a familiar person in leadership position helped people to adhere to the norms and protocols. Ability of people to connect more to familiar people, was exploited to the greatest extent in Kerala.

From the conversation with Ms Radhika, it was understood there was great level of coordination with the health officials and the panchayat members to develop an action plan. Panchayat member/ward member of the area was at the leadership position and coordinated all actions.

5.2) Strategy 2: Free Treatment

Kerala was one of the first states in India to announce free treatment to all people irrespective of their financial status for the viral infections. It was only after a while government allowed private hospitals to accept patients and a payment for the treatment. However, the treatment costs were fixed by the state. Treatment for Covid-19-19 is still free in any government facility for anyone in the state of Kerala. This has helped more people to access hospitals for treatment. Similarly, the molecular tests were done free of cost at government facilities and the state had regulated the costs that could be levied by the private labs 500 INR which was a sum affordable for a wider section of people, while in other states testing charges were high. https://www.YouTube.com/watch?v=FfE1V59IFMY

The above is a link to a video where it is mentioned how Kerala has regulated the rates to be charged from Covid-19-19 patients in private hospitals in Kerala. Secondly from the primary interview conducted with the patients who recovered from virus in Kerala, two of them opted for private hospital, wherein they paid rupees 3000 per day for food treatment and monitoring tests. The patients commented that private hospital was in a much closer location to their residence and they thought it to be the better option. Participants further commented that the costs were also affordable as they had a well paying job and they had insurance for their treatment.

Affordability of the treatment has helped in more people receiving adequate medical care to recover from the viral infection. The hesitation of people to visit hospital due to high costs was substantially eliminated. More people therefore were tested and treated for the infection, which had substantially reduced unnoticed infection and deaths that could occur from not acknowledging tests. Ms Jaine who was another participant in the telephonic interview

mentioned that the treatment was completely free at the Covid-19-19 wing of the government hospital in which she worked. People who were below poverty line were given special attention to get admitted in the hospital.

https://www.YouTube.com/watch?v=AQywJ3nx_84. This is a link to the interview with the former health minister of Kerala, Ms. KK Shailaja, who mentioned how improving affordability of treatment had been prioritised by the state government through various progressive policies.

The patients admitted at FLTCs were also given free treatment and care. Ms Radhika, who was the ward member of division 3 of Thrissur municipal corporation mentioned that food was provided free of cost by the Kudumbashree wing of the area and no patient was charged for their admission at the FLTC.

The decision to provide free treatment to Covid-19-19 at government hospitals and regulate the charges at private facilities were made by the state government. However the implementation and sustained operation of the decision happened under the supervision of panchayat and municipal bodies in the state. The ward member had all details of the poor families in their area. The availability of data was the confidence that state government had. Local governments ensured no one misused the free treatment option at any point of time.

5.3) Strategy 3: Social Protection

When discussing about the pandemic management strategy of Kerala it is important to look into the commitment the state had on social welfare of the people, especially the poor and the destitute.

Government of Kerala had already recognised the need to minimise adverse socio-economic impact of the pandemic in the state and it was the first state to formally announce compensation package of 20,000 crores INR. This package included funds for scaling up health infrastructure, providing welfare pensions to all beneficiaries in advance for two months and provide loans without interest and with longer repayment for merchants and small businesses. This package is more important as it came at a time when the economy of the state was extremely pressurised and low performing. The government distributed free food kits to all ration card holders above the allotted monthly quota. The government also provided free food kits to students of government schools who were beneficiaries of the midday meal scheme to their homes as schools were shut. Mr Jose Martin, teacher at a government school, who was in charge of the mid day meals at his school mentioned that the midday meals kit was provided

from the school every two months to the child. Parents were so excited to collect the kits as it helped to feed the children who came from poor backgrounds.

These were the policy measures formulated by the state government, however the implementation of it was done by the local government like the Panchayat or the corporation. The councillor regularly informed people of her/his ward when food kits had reached their area. The welfare funds like old age and widow pensions were delivered by the Panchayat only and the councillors guided people to avail those funds.

5.4) Strategy 4: Informed Volunteers

Another key strategy of the state was to recruit volunteers to assist the officials in crisis management. A reference to the previous chapter would be recommended to know about the opinion on volunteers. Rapid response teams (RRT) were formed in every panchayat or wards. The volunteers were chosen by the elected member of the panchayat/ corporation ward. These volunteers assisted in aid distribution, helping in getting infected people to hospitals, aid people in home quarantine and help the families with supply and delivery of essentials to ensure sufficient social distancing. Volunteers were given training before the commencement of the work. The volunteers were mostly graduate students, members of various political organisations. Volunteers were deployed for various tasks like, data collection, managing helplines, monitoring in patient admission details, swab collection details, oxygen monitoring as well. Volunteers were also in charge of conducting awareness campaigns for people on need for social hygiene and need for scientifically encountering the infection and pandemic. Volunteers included students, people who were working part time, entrepreneurs to name a few. As the government of Kerala website shows (link in the beginning of this chapter), there were 3,80,000 volunteers recruited to assist the councillor.

Mr John Daniel the former councillor of division 3 of Thrissur mentioned that the management would have been difficult without volunteers. At the same time too managing the volunteers were also a difficulty. Hence the volunteers were recruited gradually in relation with the growth of infections in the area and they were given all necessary training on necessary protocols and were completely managed by the councillor. He said that volunteers he chose were from the ward primarily as it helped to provide services faster.

The following is the link to the official module developed by the government of Kerala for the volunteers. https://www.YouTube.com/watch?v=6OgjLhwGnSU. As mentioned in the video and by the participants, volunteers were mainly deployed in prevention activities and raising awareness among the larger population.

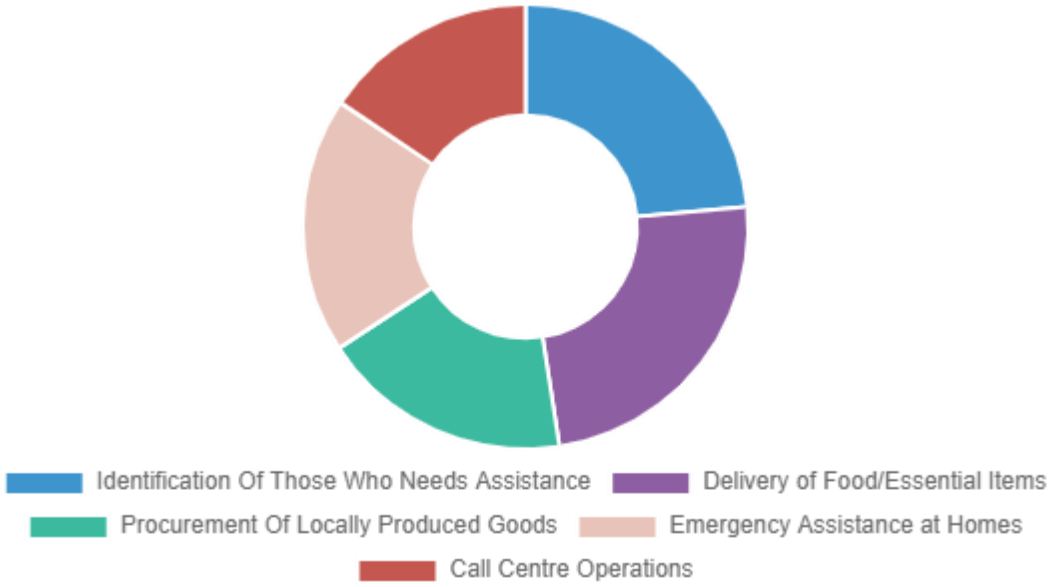
https://www.YouTube.com/watch?v=DAXTZfjpehk. This video shows how two volunteers took a Covid-19-19 patient to the nearby hospital on a two-wheeler. The volunteers are seen carrying the patient donning a protective gear. The volunteers are seen following the necessary protocol rather than acting up rapidly without caution. Though this is never recommended, this video how they are altruistic in serving the society, yet following all possible protocols.

Volunteers here are referred to as informed volunteers. It is done so highlight the aspect of training and educating the volunteers. these volunteers were often given honour and consideration by the society. They were also disciplined as they worked under the ambit of the councillor/ward member. The work of the volunteers was highly disciplined. Their presence in the system added more value and helped in precise interventions rather than their presence being redundant and unproductive and chaotic.

Picture 8: Former health minister Ms KK Shailaja addressing the volunteers.

https://images.indianexpress.com/2020/09/Covid-19-19-Brigade-Kerala.jpg

Below is a pie chart describing the utilisation of the volunteers in the state.



Picture 9: The categorisation of volunteers and their activities

In essence in a sentence the strategy of Kerala could be described as an extensively localised control of the infection, with too many people at varying capacities involved in the action with requisite decisions made rapidly by the local governance body and medication provided locally but in a graded manner.

From the paragraphs above, the ability of local governments to lead an action during emergency and manage multiple stakeholders and impact people have become evident. These paragraphs do give a sense that the local governments were not passive spectators during the crises.

5.5) Why did the State Adopt these Strategies?

In simplest terms, poor economy, huge and dense population and a rapidly spreading virus. The strategy adopted by the state was an intersection of localised control, social protection and local volunteerism. While the state government was a supervisory authority, it did not shoulder the burden on getting on ground to control the spread. Autonomous intervention of various local governments undertook the activity on ground. The reason to adopt such policy was fuelled by three main motives. Limit the death rates and secondly, sustain the economy and protect the poor and vulnerable.

Adopting a localised lockdown and management by local government had certain benefits that helped the state in maintaining the death rate much below the national average and keeping the economy afloat. Centralised management would not have yielded better result in the state. There were too many people to manage and to aid maximum people, more human resources were needed and intervention was required at the grassroots. Hence the only option left behind was a localised targeted approach. At the local level, contact tracing was easier, identifying primary contacts were done rapidly and more infections were picked up whereas in a centralised lockdown these same processes took more time.

Taking a detour at this juncture, centralised management of the pandemic without involving people and local governments also exist. There are countries that have adopted a centralised approach. China, Singapore and New Zealand are some of them. They have a visible zero Covid-19-19 policy in place.

A zero Covid-19 policy is utopian. While there is a serious dearth of credible data from China, New Zealand and Singapore are small nation states with small yet affluent populace and a strong national economy. Yet they had some substantial number of Covid-19 cases. Governments of these nation states were capable of providing welfare measures even with a non-performing economy. On the other hand, there are countries where the pandemic was handled with indiscipline at institutional levels. Brazil would fit as a perfect example.

Kerala did not have the liberty of keeping the economy closed for a prolonged period. The state had to desperately strike a balance between economy and the pandemic. The resources were scarce and the economy had to function in the state for revenues. At the same time, deaths from virus should also be limited. Hence the only option the state had was to have localised lockdown. Implementation of localised lockdown proved to be effective due to a strong local governance system in place. Mr Suresh said, a total lockdown did not help as targeting of infections could not be made. When containment zones were made there was more knowledge on where infections were growing and where it was declining. Containment zones were made at ward levels and when a ward became a containment zone, more focus was installed there. Councillors became more alerted and volunteers were deployed for rapid actions.

5.6) A ‘Fantastic’ Local Governance System

Taking lead from the words of Dr Isaac and Dr Muraleedharan, Kerala is a state where local governments hold decisive role. The local government also have substantial autonomy in managing the daily affairs of the city or the village. People were dependent on their local governments for various needs. Literatures reviewed have also mentioned its indispensable

presence. Local governments own and operate various institutions ranging from schools, hospitals and spaces for recreation to name a few. It is involved in planning activities and developing local infrastructure. The state government capitalised on these LSGIs.

Looking back into the political history, Kerala was a state that pioneered the concept of peoples planning in development of the society. Isaac, Franke and many others have contributed to the development of strong local governance in the state. People were involved in planning for development. Hence the local governance in the state was more inclusive and consultative. There were schools and clinics in place of malls and expressways. Development planning with people resulted in ensuring basic facilities instead of developing artistic landscapes. Local governance has also ensured in development of the rural areas the ensuring all necessary amenities in a village.

The above paragraphs indicate the indispensable nature of local governments from the lives of people. At a time when there is an unprecedented crisis, marginalising local governments that were closer to people was considered inappropriate. The state by according the LSGIs with the responsibility to manage the pandemic in fact took an ethically correct and the most accurate decision. From the interviews in the previous chapters, in those states where the local governments took a lackadaisical stance, the scale of adversities was high.

The State government since the beginning of the pandemic had been firm on its 'people first' approach. Saving lives of people became the utmost priority. Creating social awareness about the virus and its effects and social etiquette had to be taken to people. Taking cue from the responses, sans the involvement of local governments, the process would have been tedious. Ms Jaine Shiny a health official who was one of the participants in the research, mentioned that the government was keen on ensuring that people are protected and they are informed about the disease and the protocols to be followed. She said that awareness creation campaign like 'Break the Chain' became effective as it was led by the councillors and volunteers. She said local governments were efficient in taking break the chain campaign to people, even to small children in their respective wards.

Above paragraphs reflect the operational acumen local governments in the state possessed. Efficient operation of local governments resonates with the training LSGIs have received over years, especially in collectivising and mobilising people for a larger good.

5.7) Social Justice Perspective

There is a social justice angle to the localised approach of the pandemic. Managing the crisis at the local level has helped in poor people getting more attention. The councillors were keen

on helping the poor sections of their respective wards to get tested and treated. The councillors ensured that the deserving people who were poor got admission to hospital in case they had severe infection. Ms Radhika, mentioned that the she had a list of people who were below the poverty line in her ward and had helped three such people to get a bed in the district hospital when they developed moderate level symptoms for the infection.

Reverse Quarantine was another pioneering policy adopted by the state of Kerala and it was formulated and implemented by the local governments. Reverse Quarantine referred to the prioritised home quarantining of senior citizens and those people with other comorbid diseases and protecting them from the viral infections. Every councillor had the list of senior citizens and comorbid people in their wards and they were provided with all necessary services so that they did not have to step out of their homes at all. Be it medicines or groceries, the volunteers of the RRT were available for their services. Protecting the senior citizens is another manifestation of social justice and giving priority to less privileged people. Councillors also ensured that these people could also get RTPCR tests from their home through the help of volunteers.

The role of community kitchens cannot be excluded when mentioning about social justice during pandemic. The local governments actively operated community kitchens in their wards and hot meals were provided to those people who could not cook food due to hospitalisation of some of their family members. Food was also distributed to the poor families and elders. Community kitchens were funded by the local governments and Kudumbashree members prepared the food and volunteers distributed it. Community kitchens too stand as an evidence of local level management of the pandemic. Dr Muraleedharan too have mentioned about community kitchens and its operation by the local governments.

Picture 10: A community kitchen in Kerala.

(https://www.thenewsminute.com/sites/all/var/www/images/ulloor_community_kitchen_650.jpg)

Indian society is known for having 'influential contacts' and people frequently exploit those contacts to pace up their transactions. Kerala effectively prevented this practice during the time of pandemic by disciplining hospital admissions. The councillor intervened in admitting people to hospitals and the FLTCs. This has helped in right people getting the right treatment. Had the process been centralised, and had the local member not involved in the managing hospitalisation, poor people would have had a lesser chance of gaining access to healthcare and more deaths would have happened.

The above paragraphs have explained in detail how the local governments prioritised the poor, aged and comorbid individuals and protected them through this strenuous period. The ability to pursue social justice and implement action reflects the learning local leaders have on the issue.

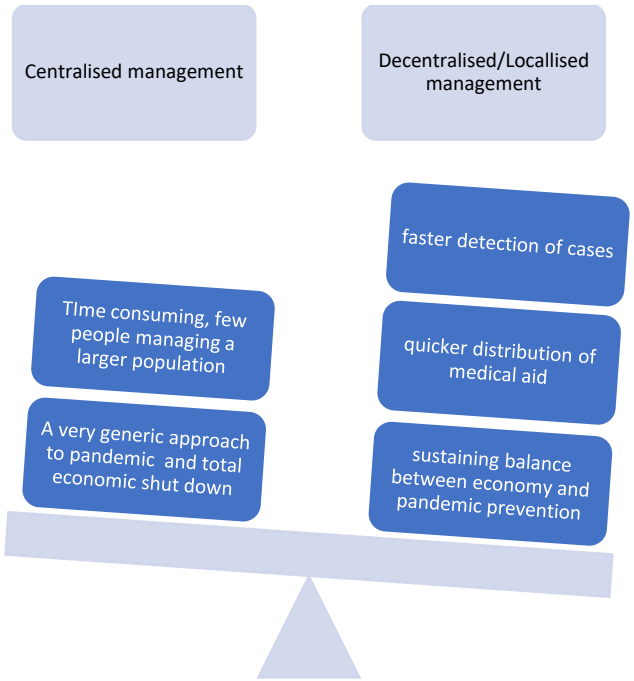
5.8) The Economic Side

The way a pandemic would unfurl itself in an impoverished society would be very different. Apart from infecting and causing deaths of people, it would further drain the economy and there would be paucity of essential resources. The same has happened in India and particularly in Kerala. Kerala being a resource scarce state has been dependent state has relied on remittance from the middle east for its development. In the literature, Parayil has argued about the vitality of remittances in the development of the state (Parayil, 1996). There has been a decline in remittances as expatriates returned to the state after loss of livelihood. Hence the state has to depend on the domestic economy to operate to generate income for funding various pandemic related policies. As argued by Dr Issac (refer to the link in the chapter titled excerpts) healthy people had to go out and work and the economy needed to run for the state to generate at least the minimum of income to move ahead.

Centralised total shut down did not prove to be an effective method to control the pandemic. Rather, it did throw the economy and local business into a bad shape. Mr Sukumar who owned a supermarket in the city of Thrissur mentioned that the first lockdown did cost a huge amount as the shop had to close down for two full months. After localising the lockdown through containment zones, there were twenty to thirty customers on an average daily purchasing from the shop. Some income could be generated from such an arrangement. Localisation of pandemic helped in ensuring the business to operate with necessary protocols in areas where infections were subsiding. Localised management further aided in close monitoring of the

situation, which helped people to run their businesses with precaution as it has helped in close monitoring of the infections and movement of people. This has helped in easing lockdown rules as and when cases dropped. Some economic activities ensured livelihoods to a large group of people.

Councillors had a latest information with which they decided what further actions would be implemented in their ward vis-à-vis the pandemic. When the infections rose, they imposed closures of shops except for the essential ones and when the infections waned, more shops were allowed to open. Their involvement helped in quick action as officials orders came up instantaneously upon the decision of the concerned councillor. This further is a reflection of their ability to manage risks and initiate actions for the larger good.



. Picture 11: Benefits of localised management over centralised management.

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Picture 12: The key methods of Covid-19-19 control in Kerala.

5.9) A Different Decentralisation?

Decentralisation as mandated by the 73rd and 74th amendment act of 1992 has given rise to a uniform pattern of local governance in India. All states follow a regular pattern of three tier governance system. All of them are elected for a tenure of five years. However, local governments in Kerala stands out in the crowd due the autonomy it has garnered in the society. Referring to the interview of Dr Muraleedharan once again, consistent capacity building and training the local leaders was largely done in Kerala and that made a big difference.

Firstly, local governments were never seen as facilitators in implementing a policy or of social welfare in Kerala. They were very much the government. They had the power to make crucial decisions pertaining to their area. People and media to a large extent have accorded greater relevance to local governments and its elected members. Elections to local governments are politically as well as socially a highly revered process. Local governments resulted in a larger political awareness in the state. Due to a proactive presence of local governments in the lives of people, people understood it as a valid form of government itself.

While in other states, as participants responded, local governments were seen as just agents of the larger governments. None of the participants mentioned that local governments were inactive. However, most of them failed to take a lead to initiate critical actions on time.

Vivekanandan from Tamil Nadu whose excerpt is shared in the previous chapter was infected with the virus mentioned that the ward member supported in getting bed and a test done, but he was assistant to the health officer of the ward and the process took a long time. They did not have a power to command. In Kerala local governments managed quarantine centres, contact activities which were the most crucial. Local governments over time had acquired enough capacity to manage crisis. The state government as mentioned by experts like Dr Isaac and Franke had invested in developing local governments since the end of twentieth century. Various research institutions like he Kerala Institute of Local Administration (KILA) had helped in upskilling the local leaders in battering governance and management of the state.

The result that the state has achieved today also needs to be historicised to its commitment to localised planning and promoting the autonomy of local governments. Despite the limitations of the federal system in India, Kerala has devolved power to local governments and the autonomy to plan and develop public facilities. Local governments have built hospitals, diagnosis centres and dispensaries in their wards and panchayats. Local governments also demand funds and have limited authority to collect taxes from its citizens to keep many of the facilities operational.

The world health organisation during the pre-vaccination phase of the pandemic mentioned that Kerala had made early preparations and had invested consistently on improving public health facilities, which has resulted a relatively better outcome in the state (https://www.who.int/india/news/feature-stories/detail/responding-to-Covid-19-19-19---learnings-from-Kerala).

These preparations were made at the local levels and was monitored by the local members. The preparation was not building big facilities but strengthening and repurposing the smaller hospitals and ensuring presence of adequate tools to manage any surge in patients.

WHO in the same report has mentioned a key factor that had influenced the Covid-19-19 management in Kerala was communicating the risk of the virus to people. “Break the Chain” campaign became effective as local leaders could connect to people of their ward without any inhibitions. Personal yet official communications influenced the behaviour of people in the state. Local leaders were listened to and that did have an influence on the people following the protocols. Dr Muraleedharan too had made a similar comment and it is mentioned in the previous chapter.

In essence, it is the larger ‘practice’ of decentralisation that has resulted in the outcome of the pandemic, not the structure. What is evident in the case of Kerala is a craft of building and

maintaining vital institutions and operating them frugally. Local governance is relatively better in the state of Kerala. Kerala with its existing financial troubles, has devolved funds and responsibilities to the local governing bodies. As mentioned by the ward councillor again, there were difficulties in getting funds for general infrastructure. There were long procedures too. However, the council could decide to set aside funds for Covid-19-19 hospitals and FLTCs without any further permissions from the state government.

K Srinath Reddy the chairman of Public Health Foundation of India, in his interview to the Newsclick, an online news platform had mentioned how real time management of the pandemic should be done at the district level. He was critiquing the Covid-19-19 management of India where only a few resources were handling majority of cases (https://www.newsclick.in/There-is-No-Alternative-Decentralised-Covid-19-19-Response-Dr-K-Srinath-Reddy).

During a disaster or calamity, 'actions' are undeniably more important than a set of social development indicators. Having high levels of literacy or high life expectancy would not have prevented viral infections. Proactive interventions made all the change on ground. Leadership of the local members and ability to lead actions by taking risks by staying committed to social justice and economic operation and yet committing to achieving lowered death rates had been impactful.

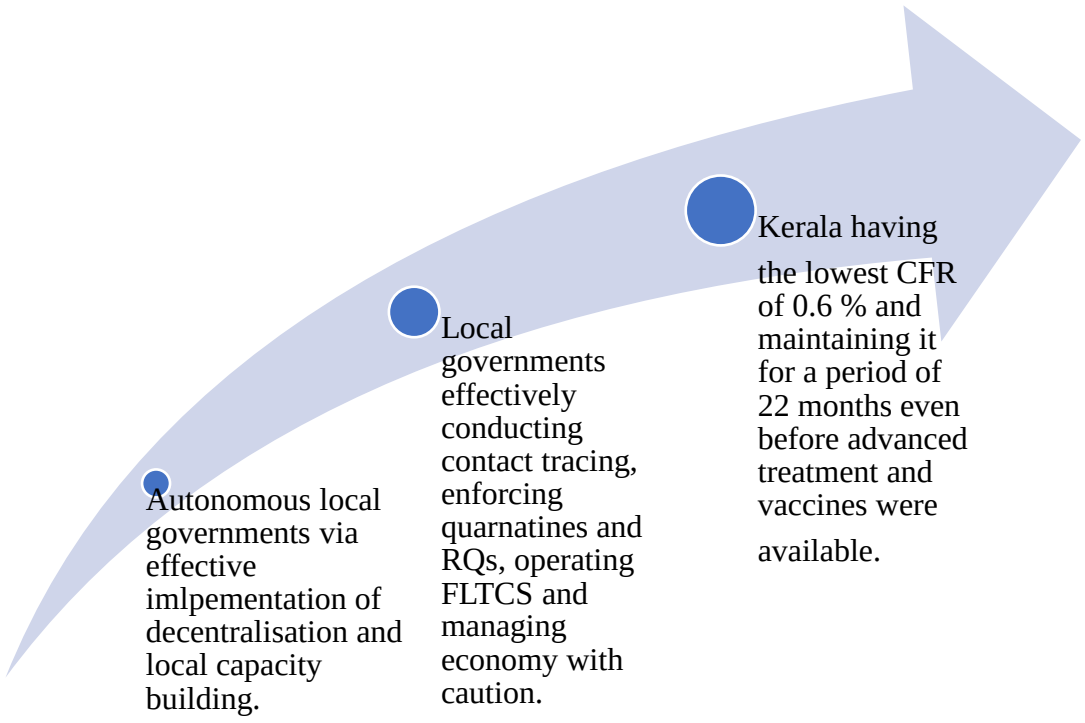
5.10) Linking Outcome to the Action

The outcome in a pandemic is the number of the people died. The outcome is better if lesser number of people lost their lives and vice versa if the deaths are more. The input action here are the management strategies.

The literature reviewed here echoes the better conceptualisation and implementation of decentralised governance in Kerala, like training and financial powers. Literature further presents the idea of a better functioning public health care system in the state again with local governments having a role to play in its operations. The participants in this study too have mentioned the inseparable role local governments have played in the management of the pandemic by leading and coordinating various actions in their wards. The numerical figures show that the CFR has been remaining at 0.6 percent. Therefore, tracing back, the only factor that can be found to have created some impact is 'Decentralisation in the state of Kerala'.

It is plausible that decentralisation in Kerala has had an impact on the pandemic outcome of the state. Had the decentralisation not been effective in the state of Kerala, local governments would not have been autonomous and trained enough to take crucial decisions and initiate timely actions. If that was the case, then the management approach could not have been made extremely localised. Had the process not been localised, effective contact tracing, enforcing quarantine and reverse quarantine, running FLTCs and operating community kitchens would not have happened. Had the localised strategy been absent, the hospitals would have overburdened and the deserving people would have missed a chance to get adequate treatment. Had this happened, the death rates would have gone beyond the 0.6% which meant more people who could have been saved would have succumbed to the virus. Therefore, it is largely the localised management by the local government that delivered the existing outcome.

A comparison can be made to a tree and a storm. The tree in a garden here represents the society. Wind is the pandemic. Fruits on the trees are people. It is inevitable that some fruits would fall off in the storm. However, it is still better than the tree falling off and complete loss of all fruits. For the tree not to fall, the roots should be strong. In the case of Kerala, decentralisation was the root that held the trunk which represented the management system like contact tracing, quarantine and RQ. The depth of the root added strength to the trunk which could hold the branches with fruits from falling down. Roots got the strength here because it was continuously manured and the manure here is more decision-making power, more financial autonomy, training the leaders for better community interventions.



Picture 13: linking the outcome to the action.

Conclusion

In a nutshell, the action plan of Kerala to combat the virus came stemmed from the intersection of progressive social welfare policies of the state and decentralised people centred approach. A highly localised decision making and quick execution of those decision combined with a low level of centralised supervision did work in the state hitherto. Kerala has further demonstrated that local governments can diligently handle any serious crises. Revisiting the literature, social welfare, localisation and so on have influenced the crisis management. Kerala consistently nourished its local governance system through effective devolution of power and capacity building, which is necessary in any attempt of decentralising governance. The consistent capacity building, as argued in the literature, became the root of the management system Kerala installed to fight the pandemic. It would not be fallacious to mention that the consistent institution building Kerala did towards its local governments paid off in the long run.

The research with all its limitations helped to understand how localised actions could help in resolving crisis when they are empowered cautiously. The numerical figures presented may not be the most accurate. It is understood that in developing countries the chances of non-reporting and underreporting of cases would exist and the data would be tampered and manipulated for various political gains. However, looking into the official data available, Kerala still has a staged performance that is not scary.

A revisit to the review of literature after looking into the responses of councillors and people would give an idea of how evolved local governments in the state has become and the impact the policy had on ability of the local leaders to positively impact people at large.

What developing countries can refer from the case of Kerala is how development and crisis management could be more planned and implemented at local levels and incorporate people as responsible actors. The conceptualisation of development needs a paradigmatic change. It can be a long marathon rather than a sprint.

Other states in India too have to learn certain lessons from the pandemic action of Kerala. The important of it would be need to strengthen local governments and prepare them to initiate actions during emergencies. This would need consistent training and devolution of more power and ability to make financial decisions. Local governance institutions are yet to evolve in many

other states in India in terms of decision-making capacity. More policy level focus and action are required to strengthen local governance in states of India and consistently build capacity and train the local leaders to deliver better outcomes. Decentralisation without capacity building amongst local leaders and without devolution of power is meaningless.

The pandemic is not over yet. With anticipation of more waves and more variants, the only thing that could be done is to vaccinate more people and medicate as many people and protect them from dying. This case study of Kerala has demonstrated that local governments, without too much of money or technological sophistications can save lives of people by preventing them from dying early. What led Kerala to this stage was its local governments which were consistently strengthened and developed over years. This case study shows that decentralisation is a better development and governance policy for low income and highly populated regions if implemented paying attention to vital nuances. Kerala has shown that getting on to ‘ground’ can in fact take to greater heights. Kerala also proved wrong the famous proverb “Too many cooks spoil the broth”. Kerala had too many cooks in the form of local governments and its volunteers who knew what to cook and how to cook. The too ‘many’ of Kerala has made the broth tastier or as the Dutch says ‘Lekker’.

Appendix 1

The Questionnaire

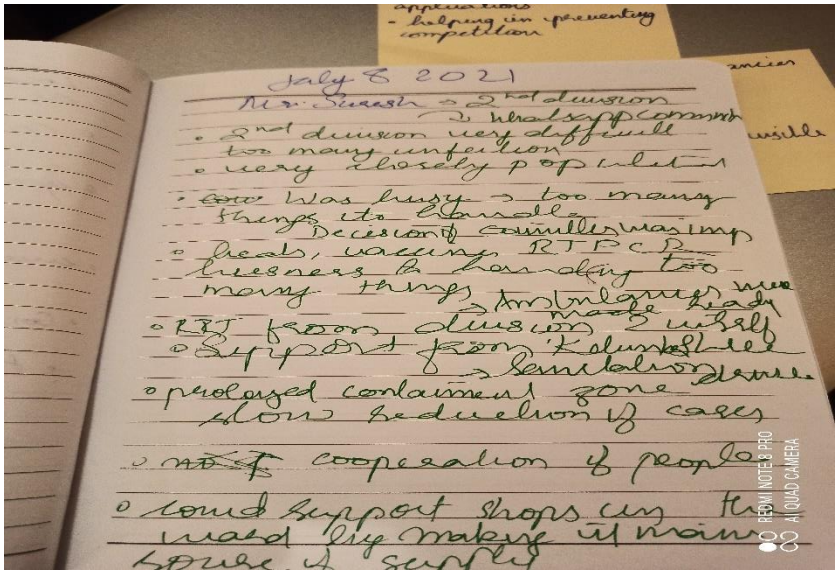
Name:

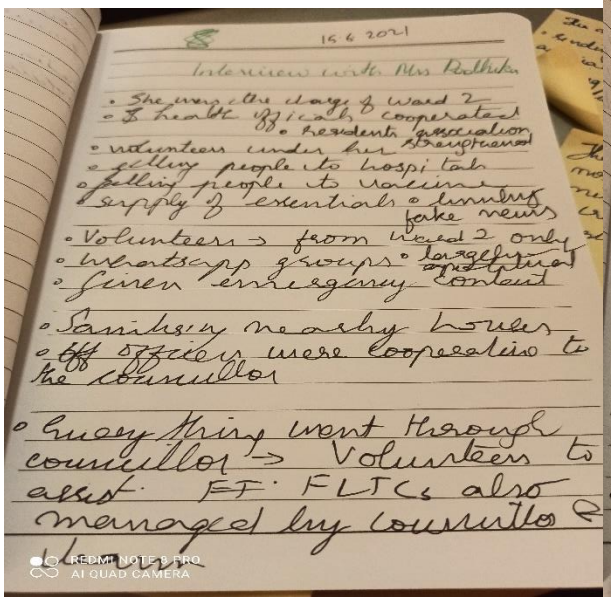
Designation:

Date of Interview:

1) Could you please explain your role/what do you feel about managing the pandemic?
2) What do you think of the role of the local governments in controlling the virus?

Appendix 2: Responses from the Participants


July 8 2021
REDMI NOTE 8 PRO
AI QUAD CAMERA


15.6.2021
Interview with Miss Radhika
REDMI NOTE 8 PRO
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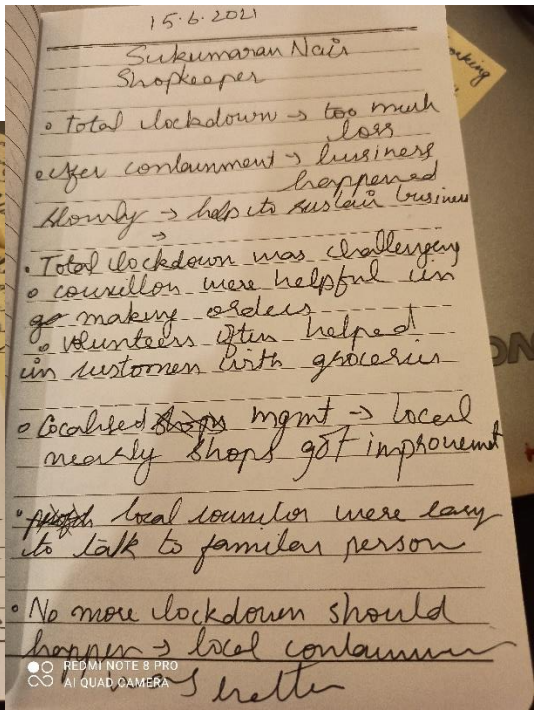
15.6.2021
Sukumaran Nair
Shopkeeper
REDMI NOTE 8 PRO
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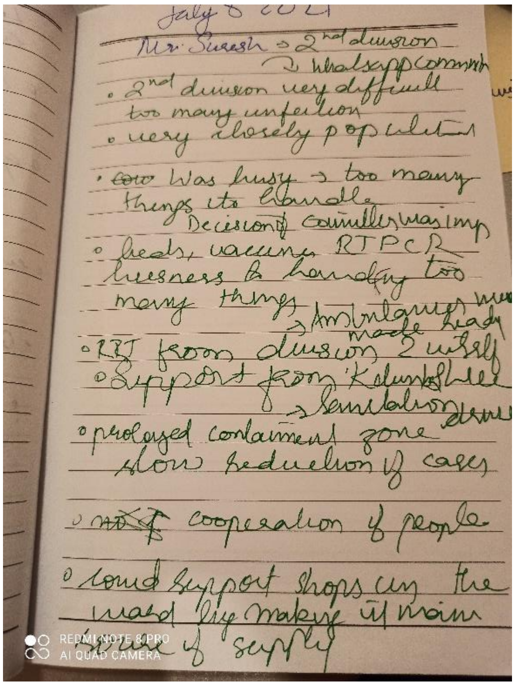
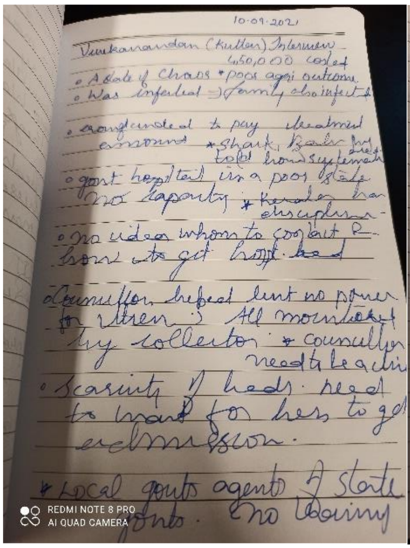


July 8 2021

Mr. Suresh → 2nd division
→ whatsapp communication

- 2nd division very difficult too many infection
- very closely population
- Was busy → too many things to handle
  Decision of Councillor was imp
- beds, vaccine, RTPCR business & handling too many things
  → Ambulances were made ready
- RRT from division 2 itself
- Support from Kalunkotthalee
  → Sanitation drive
- prolonged containment zone slow reduction of cases
- cooperation of people
- Local support shops in the ward by making it main source of supply

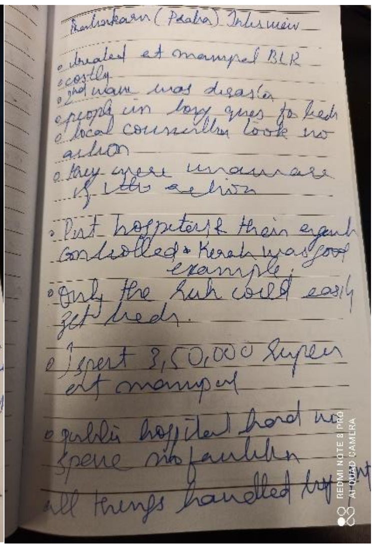


10-09-2021

Vivekanandan (Kuttan) Interview

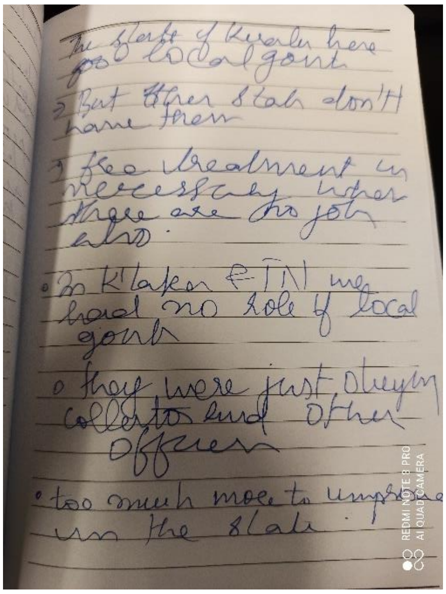
6,50,000 costed

- A State of Chaos * poor agri outcome
- Was infected → family also infected
- compelled to pay treatment amount * shark, Bala treat total houses systematic
- govt hospital in a poor state
- no capacity * Kerala ... discipline
- no idea whom to contact & how to get hospt. bed
- Counsellor helped but no power for them; All monitored by collector * counsellor needs to be active
- Scarcity of beds. need to wait for hrs to get admission.
- * Local govts agents of State govts. no ...



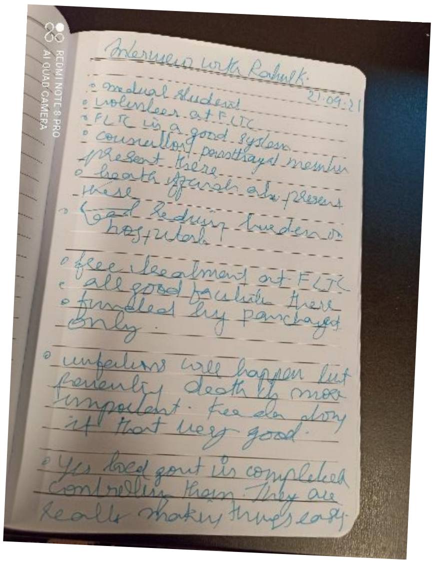
Rathinkaran (Peelra) Interview

- treated at manipal BLR
- costly
- 2nd wave was disaster
- people in long ques for beds
- local counsellor took no action
- they were unaware of the action
- Pvt hospitals & their equip controlled * Kerala was good example.
- Only the rich could easily get beds.
- spent 3,50,000 super at manipal
- public hospital had no space no facilities
- All things handled by ...



The state of Kerala have good local govts.

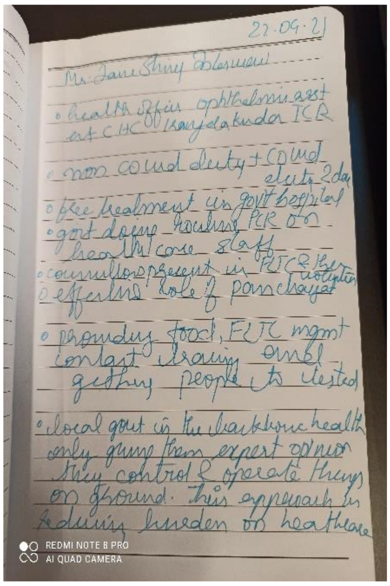
- But other state don't have them
- free treatment is necessary when there are no jobs also.
- In K'taka & TN we had no role of local govts
- they were just obeying collector and other officers
- too much more to improve in the state.



Interview with Rahul

21.09.21

- medical student
- volunteer at FLTC
- FLTC is a good system.
- counsellor, panchayat member present there
- health officials also present there
- lead reducing burden on hospitals.
- free treatment at FLTC
- all good facilities there
- funded by panchayat only
- infections will happen but severity, death is more important. Kerala doing it that very good.
- Yes, local govt is completely controlling them. They are really making things easy.



22.09.21

Mr. Jane Shiny Interview

- health officer ophthalmic asst at CHC Kaydabuda ICR
- non covid duty + covid duty 2 days
- free treatment in govt hospital
- govt doing routine PCR on health care staff
- counsellor present in FLTC & ... activities
- effective role of panchayat
- providing food, FLTC mgmt contact tracing and getting people to tested
- local govt is the backbone health only giving them expert opinion. They control & operate things on ground. This approach is reducing burden on healthcare

Glossary

Community Kitchen: It is a makeshift large cooking arrangement made during the pandemic to feed people in quarantine, first line treatment centres and senior citizens in old age homes and living alone. They were run by the local governments.

First Line Treatment Centre: They are the mass treatment facilities developed to treat patients with no symptoms or serious illness from Covid-19-19. They are set up in schools and colleges where classes do not happen or in large auditoriums. They are operated by the local governments. They are set up close proximities of every wards. It had in house doctors and volunteers to manage any kind of emergency.

Panchayat: Panchayat is formed by the union of wards of a given area. The ward members elect the Panchayat president.

Ward: Ward is the basic unit in a local governance system of Kerala/India. It is constituted by a stipulated number of neighbourhoods. Ward is represented by an elected member.

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