Episode 1: Exploring Health and Healthcare in Assam

TRANSCRIPTION

Speakers:

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Vivek Divan:

This is 'Status of States,' where we explore health and healthcare across India's diverse regions, with a particular focus on policy, programmes and ground realities. The Indian Constitution lists ‘public health’ as the responsibility of states.

Join us as we speak with health experts from different states, understanding the unique contexts, challenges and innovations shaping public health.

I'm Vivek Divan, your host for the first episode of Status of States, brought to you by the Centre for Health Equity, Law & Policy at the Indian Law Society, Pune.

Let's dive right in!

We start our series by exploring the situation in Assam. It's a pleasure to have Dr. Sunil Kaul speaking with us today. Dr Kaul is the co-founder of the ANT - The Action North-east Trust, an NGO in the Bodoland region of Assam. To tell you a little bit about his journey and expertise, Sunil qualified as a doctor from the Armed Forces Medical College, Pune in 1983 after which he served in the Army Medical Corps for 10 years. He left to live and work in the rural areas of Assam thereafter, and completed his Master's in Public Health from London University in 1999. He has trained hundreds of community health workers before the National Rural Health Mission (NRHM) set in and later focused his attention on building a sustainable mental illness treatment programme in Assam. For the past 4 years, Sunil has also been teaching at the Indian Institute of Public Health, Shillong, with a focus on the social determinants of health.

I would like to begin this conversation with a broad question- Sunil what in your view, is the status of health in Assam. You can consider this in its broadest sense, which includes the social determinants of health or with a narrower understanding on healthcare. Do begin by describing this to us.

Dr. Sunil Kaul:

Thank you, Vivek and thank you, ILS. I must start with saying that compared to say 20-25 years ago, before the National Rural Health Mission came, I wouldn't have expected this much of health delivery today that is happening all around the country and especially in Assam.

When I first came here, in 1996 and then, set up another NGO in the year 2000, things were really bad and there was very little presence of the government in the rural health sector. Today it's far, far better, yet I think, knowing that India is, and India has been the third largest economy for many years, actually, in between it slipped, compared to that, I mean, I think we should be doing much better. That's

where it rankles. And I must also say that when everybody used to be talking about the BIMARU states, where it was Bihar, Madhya Pradesh, Rajasthan, Odisha. I used to keep arguing that the BIMARU- MA, after Madhya Pradesh should come to Assam, because Assam's health indicators and social indicators were usually far lower than even Bihar, but then it wasn't catching people's imagination. Today, we know that the maternal mortality ratio in Assam is the highest in India. It's probably one of the highest in the world. Still we've not been able to really break out from there. IMR (Infant Mortality Rate) also is one of the worst in India. I must also say that it was much worse earlier. I don't go too much by the figures of NFHS (National Family Health Survey), even the sample registration system by which we get the data. The last MMR (Maternal Mortality Rate) recorded was 205, for MMR, you require a longer period of time and a bigger sample base and what not. So 2017- 19 is the data that the sample registration system has given us and that was 205.

Today, Assam is claiming to have dropped below a hundred. My worry always is that because IMR and MMR both are considered as some of the core indicators or comprehensive indicators. which we see, in measuring health or comparing health. So, for that reason, I'm saying the sample registration system, while Assam is around 90 percent rural, the sample units that they pick up are 89 rural units and 210 urban units.

The sample registration system, which we swear by most of the places in India, is not a very good indicator of health status anyway. So that having been said, I would say that we could be doing much better. We are still one of the laggards in health. It's basically because the social indicators, the social development indicators, as well as the infrastructure development in Assam has been very, very late in coming here because of the insurgency which was there till a few years ago, the economy has been really poor and the state's capability of even matching the 10 percent funds for the centre to implement any scheme of the centre has been very, very poor.

I must also say that we know from the first go in 2005 to 2010, when the current chief minister used to be the health minister, we really jumped up. We were the second highest health expending states in the country. You know, we utilised the NRHM the best and while the neighbouring states of Meghalaya and others were better in health indicators, we managed to cross them and improve upon them. So that's the credit. But I wish that we had continued improving at a good pace.

Vivek Divan:

What would you say are the reasons why that continuation at a good pace didn't happen?

Dr. Sunil Kaul:

One of the things is that the economy of the place, the Northeast, usually because of insurgency for many years and then investments are not there. Many people don't even think about the Northeast. So the economy being very poor, the government's ability to take loans for it or spending money on health has been very poor and we know that health doesn't make for a very sexy investment, unfortunately all over the world. When we are asking generally, WHO asks everybody that can we match 5% of the GDP into health? Can we do that? We are only spending 5% of our total annual budgets on health and actually the investment is very, very low.

Two is that, infrastructure itself is poor. Third, governance has been very poor in all the sectors, especially health. So, what we want to get done from your lowest functionary, it doesn't really happen because the governance is poor and militancy has been one of the reasons for it. We should be coming out of it, but then I think plenty of people have got that as a good reason to talk about why they could not manage to go to the field or supervise, or do things.

Similarly, the travel allowances that people are supposed to get to monitor, all those are not really there as the salaries of even doctors and all are much lower compared to Bihar or other places. These all add to the reason why people don't go to the field and perform as well as what they should be performing and giving services to the rural areas and 90 percent of Assam by and large is rural. The indicators for rural areas are far worse than urban indicators.

Vivek Divan:

So, at one point, I do recall you were mentioning this phase of 2005 to 2010 as being a phase where things rapidly improved and the National Rural Health Mission was being actively utilised by Assam, but at that time also It seems that there was a law on a rural health regulation to cover the chronic shortage of trained human resources in rural Assam and encourage a system by which a cadre of rural healthcare workers would then be deployed. My understanding is that this was actually a success. Could you tell us a little bit about this?

Dr. Sunil Kaul:

I wouldn't call it a success in the sense, because it wasn't widespread. The total intake of people was very small every year. So it would have taken 20-25 years for such rural doctors to have penetrated, even if we went to the PHCs (Primary Health Centres), but ultimately because of the pressure from the IMA (Indian Medical Association) and others, I should say, a very Brahminical society, We want it to be the best, but because of that best, nothing really happens.

I'm a person who has trained so many barefoot doctors, in hundreds. I always believe that anybody can deliver even medical services quite efficiently, quite

effectively. But then there was a backlash to it, and so the government, I think, could not continue with that service. I think it was a very good move, wherever they worked, they worked very well. I still feel that now, because in health and wellness centres, they've started putting even GNMs (General Nurse and Midwife) with a certain amount of qualification and Ayurvedic practitioners and what not. So they are managing to deliver services so that's been a good thing. The pressure of the typical allopathic medical lobby which didn't want all this to happen. They've always been arguing in the guise of quality of prescriptions and all. I think if somebody would actually check the prescriptions of people who are MBBS or MD or DM. I mean, we will find big loopholes there also, so let's not blame people who have got lesser qualifications for the mess that we are in.

Vivek Divan:

So that's interesting because one finds that even in Rajasthan, for instance, there has been a pushback against an attempt to legislate the right to health and that came from private interests in the healthcare profession. I'm just curious, does the complaint about this idea of rural health cadre come from the fact that people are not qualified and should not be delivering this healthcare or was it also about the fact that this is a public health cadre and therefore private health care would then be weakened?

Dr. Sunil Kaul:

No, I mean, here, private Assam and even now in the rural areas, there's practically very little private healthcare. It's mostly organised only in the big cities, so that was not the thing, but as I said the puritanism that we have, that how can non MBBS people do it. Still I must give credit to Assam, we were always called an Ayurvedic state because most of the medical officers in the periphery used to be Ayurvedic. When NRHM allowed this thing of having one MBBS, one allopathic and one AYUSH doctor very quickly, most of our PHCs in the field, PHC level dispensaries- they were all manned or womaned by Ayurvedic or AYUSH practitioners. That brought in at least a lot of discipline, a lot of work ethic in the rural areas, because all field workers require motivation. Unlike what people say, we've never had a typical vacancy for doctors anywhere in the government system ever since the British came. So they cleverly called it a medical officer. Part of the work is medical and the rest is officer, that officer work wasn't happening at all earlier, so that started coming in. I think gradually also all the AYUSH doctors were at least being trained and they were sticking to the book, so a lot of lives were also saved by them. Puritanically, many of the IMAs and others have always opposed even AYUSH doctors from practising because let's be frank, they are practising with allopathic medicines. Whether we should ban them or not, I have no stand for it. I would rather that whosoever is practising should be trained well on it and then there will be some monitoring of

whether they're actually following the book or following the guidelines or not. Both don't happen in this country.

Vivek Divan:

So, obviously, then there was a phase when the act was being implemented effectively. I am imagining, then, that there was obviously a community which was happy to see health reaching its doorstep, as it were, in rural areas. I imagine, therefore, a certain critical mass of support, then, arose for this sort of an idea of a rural health cadre, and then like you said, there were other interests at play.
I think there was also a Guwahati High Court ruling which struck down that law, and then the law got replaced by the Assam Community Health Professionals Act of 2015. So has this new law in any way sort of strengthened the reach to rural parts of Assam?

Dr. Sunil Kaul:

Yes and no. I would say that they just tried to legitimise certain things. To me, it was kind of a negotiation between the lobbies and this has managed at least two or three things which have happened in Assam, which have not really happened successfully elsewhere. One is that the rural postings for the MBBS doctors and freshly passed out post graduates, in many places people get away from serving the rural areas here, at least the government manages to push them and do something. So as I said, part medical and part officer, if at least in many of these peripheral dispensaries, there's somebody who is administering there is a sense of purpose to the health delivery system.

Two is that the ASHAs (Accredited Social Health Activist) in Assam have been far more community oriented than I've seen in many parts of North India, that's another good thing and that also was covered there.

Three is that the AYUSH doctors who at one time were working very well, unfortunately because the rural infrastructure generally, not health only, has been so poor that many of these young doctors who have come in 2005-2007-2010, all of them came and started staying in rural areas. By now, their children have grown up, they want to go to better schools, their salaries are also up there. They're doctors in one sense. They want to have all the amenities of the city. So they now don't stay out there and they just visit the dispensary. So things could have been much, much better if there was governance, people were being paid higher salaries, there were incentives to stay in the field.

But then somewhere they lost steam by 2015 or so they lost steam. To be very frank, I never even expected this level of rural healthcare ever before NRHM came in. We

never thought that we would be able to see the government delivering so much of healthcare.

Vivek Divan:

On the one hand, you are pleasantly surprised on the other, there has been a decline since this period of time where things were actually really showing good results.

Dr. Sunil Kaul:

This stagnation mainly and a bit of slipping. Yeah. It hasn't come down to the previous levels. So that's fortunate.

Vivek Divan:

I see. So then COVID comes along and that probably puts a spanner in the works. Could you describe a little bit about how Assam responded to COVID and how the health system responded to COVID?

Dr. Sunil Kaul:

Ha! You know, COVID was bad everywhere. The only good thing in Assam which happened was that , Assam is very rural and the whole Northeast is rural so, COVID really didn't make a difference in the rural areas anywhere in Assam. Life was more or less normal in the rural areas. The only problem here became that whether it was schools or health, there was a good reason why you wouldn't go to the facility. People from the urban areas would not go to the facility and even rural areas would be scared of urban people coming into their areas. In that sense some of this care did get affected, in many of the bigger hospitals as well, it was only the very junior doctors who were handling all the healthcare. So there was an effect. That's why I think the urban death rates at that time in Assam were quite high because of COVID. As I said because we are 90 percent rural, the spread of, and the density of population is not as high as other places in India. So it didn't spread as much.

So the deaths and the effect was much less but if you look within Assam we could see that there was panic in the urban areas a hell of a lot. And in many hospitals, whether government or private, everything was being dealt with by young doctors who were not very experienced and the older doctors. Initially everybody was worried about them, but then they took it as a right not to really be present and guide the younger ones. I'm saying generally wasn't as a rule, but yeah, generally.

Vivek Divan:

I know your context of work is largely rural, but I'm just curious, for instance, in Guwahati, were there enough hospital beds when Delta came along? We've seen what happened in Delhi, we've seen what happened to other big cities in India, Bangalore, etc. I'm just wondering what the response was like in terms of just the infrastructure that was available to absorb patients?

Dr. Sunil Kaul:

It was bad, but it wasn't as bad as in Delhi one, because there was one lag phase. Anyway, things come late to the Northeast and international travel, national travel, urban travel was much lesser during those days. And in Assam at least the airports and railway stations had continued to be a bit more strict than many others. So it didn't spread as badly, things were bad that it wasn't very easy to quickly get a bed in Guwahati as well, But that was as not as bad as that that you would see people dying on the roads and whatnot, which has happened in many other parts of North India that didn't happen.

Vivek Divan:

So I suppose this is reflective of the malaise in the system in any case vis a vis infrastructure and things and COVID obviously exacerbated or highlighted the malaise. Just on vaccine issues related to COVID, how did that work in terms of reach in rural areas? Was there uptake? I'm also curious about the public health messaging around vaccination in Assam, how did you see that go?

Dr. Sunil Kaul:

I would say it was reasonable. Like you look at my district where I used to work earlier and just pre COVID I had moved to look after my mother in Guwahati and I was also getting old and had kind of retired from my organisation, but I would keep going back at least for my mental health camp and for other work also every now and then I would go back to my district.

We lost only one person in the entire district of about 5 lakh. And that also, he was really old and had multiple problems, and he died only when he was referred to Guwahati. People hadn't seen deaths. People were hearing about certain increases in testing rates, but again, that was usually very, very low in terms of numbers. So people weren't convinced that there was COVID. I mean, there was a large population, which I would say. But I think because things were coming out in the media, there was a bit of pressure from everyone also that let's not be foolish. But yes, I can say that in pockets of Assam there were communities, tribal communities, and even the minority communities who felt that we don't need to get this done. Availability wise, I think there wasn't too much of a problem.

Vivek Divan:

It's interesting to see how for instance, I would have thought that with the experience of COVID that society generally has had, that health would become a political issue, have a consequence in terms of at the electoral booth or in terms of what parties are committing, , in their manifestos etc. Is that the case in Assam at all? Because, to me, it doesn't seem to be particularly the case in the rest of India.

Dr. Sunil Kaul:

Oh no , one, there is no secular civil society as such, I would say, compared to any other place. What we have is community based organisations which put pressure. So each community, linguistically or tribal wise, has their own students unions and sometimes other social organisations which group together and claim certain rights. They rarely come to the health sector. So even when we had a public health act in the state which is one of the rare ones, It was top down. It was one great idea by the current chief minister at that time and probably had a very good MD of NRHM who combined and made this, but they never actually affected it because there were no rules which were ever made to how to make it effective.

To date, if I'm not wrong, no rules have been made for that act, and that's why it's never been functional. But it was quite a progressive act, actually, when we looked at it was top down, but there was no demand for it. We don't have a real civil society which will group together and fight, because partly because of the militancy situation, section 144 because of AFSPA the Armed Forces Special Powers Act, there's a permanent 144 for many, many years, till about a few years ago. So it wasn't very easy for rights based groups to collect together and do so. At best, it used to be the general political rights, but not beyond that education rights. So this thing, we tried to start some movements here, but the pressure from the government, the police, the army was quite heavy, and so it wasn't very easy to motivate people to fight for certain, what we call second generation rights.

Vivek Divan:

Yeah. Thank you for mentioning that act, Sunil, because I think as a lawyer, I was enthused to read it some years ago and realised that according to me, it's probably the most progressive health law in the country by far. It has got a vision. It has got an understanding of health as being not simply about healthcare, but a very very clear broad sense of social determinants of health- food safety, potable water, hygiene, etc. Apart from the very rights based sort of equality and equity paradigm within which it rests and the right to health very clearly.

You know, reading it plainly was quite fascinating. I think one of the questions I did have, which you've preempted, is how did this law come about? Like you said, it was top down, but clearly also that it seems to be largely a paper tiger, not implemented at all. I would have thought then that with COVID as a really tragic, but a very clear example of where the right to health can play out in an interesting way, that there would be now momentum around implementing this law, legislating the rules, etc. but that doesn't seem to be the case at all. Has it at all been litigated? Because clearly it's, it's been passed by the legislative assembly there.

Dr. Sunil Kaul:

Yeah. I think the Jan Swasthya Abhiyan JSA , two, three years ago, tried to put in RTIs to ask what happened to it and all, but I don't think they met with any success. As there are no rules, I mean, very clearly you need a set of rules to make any act effective. So in the absence of that there's been nothing and Assam is also a place where, as I said, people are mild here. They don't really try to fight the government unless it happens to be community wise, the state doesn't really want to, unlike many other states, it doesn't really recognize NGOs to come and help it as a state. So not many NGOs can also put an influence on the government.

Thirdly, there are many PILs which have happened in Assam, the Guwahati High Court. I know of many, and I also know that most of the PILs are won by the person who puts in the plaint. But how many times the government actually does what the court tells them to do, It's probably a matter of research. I don't think more than 10 percent of them have ever been effective. But then people, I think, give up out there and after having won that, they don't even go for contempt of court because half the time I'm told that many of the PILs have never really been effective here. So it's this thing that there's not enough civil society to put pressure for rights on the government.

Vivek Divan:

It reminds me of a PIL that I was peripherally involved in years ago in Assam, which was about the HIV AIDS program and its non implementation. And the Guwahati High Court had actually overseen the lack of implementation at past some very good orders, I'm talking about now, probably 22 to 24 years ago, where it had actually given directives saying that you've been allocated these funds, It's not being implemented, ensure that it is, etc. And, it sort of supervised the kind of implementation of the HIV program because Northeast was definitely confronted with many challenges around HIV, including Assam.

I was wondering in the context of what you've just described. Now we have Ayushman Bharat, it's an ambitious program. It is well intended to really make

healthcare accessible to all, but it requires not just central government, but state government also to play a part. How do you see that playing out in terms of a policy push in Assam?

Dr. Sunil Kaul:

I think I must also admit once the prime minister announced that most people with the ration card what we used to call BPL earlier now called the priority household card, that all of them should get Ayushman, because of that, typically the Ayushman card, I think there were just about 30 lakh households were getting benefit out of the PM's Ayushman Bharat, the CM has added another another 27 lakh households to it. So Assam is putting it in its own money to cover many more.

It has definitely brought some kind of healthcare in emergencies to many, many households. In that sense, I'm happy. I'm always for a good public health system doing all this, because it will not be exploitative and it will probably be at much lesser cost. But then when there's nothing to handle medical emergencies in the field, even today I can tell you that most district hospitals also will not be able to handle, I think 80 percent of the emergencies in the state and they will all be sending them to medical colleges or to private medical hospitals in Guwahati or Dibrugarh.

In that sense, I think the benefit to many of the poor people has been very good now that they can afford to go to private healthcare. The sad part is, one is the payment issue- hospitals don't get payments for six months, one year and Northeast anyway is an unmonetized society, there are not many big businessmen and the hospital also don't have too much funds. So every now and then when you reach the hospital, you come to know that they have been dis-empanelled or they have taken themselves out of the empanelment because they can't possibly keep having so much debt.

Two is that the governance has been poor. Very often patients come to me for admissions in the hospital, invariably what happens is the hospital tries to finish most of the investigations even before the person is admitted. He or she manages to spend a lot of money on the investigation even before they're admitted and that actually is a saving for the hospital from the Ayushman scheme because they get a package deal, they get a package from the government for all the things together. So in one sense it doesn't save as much money as it should have saved to each beneficiary.

Yet, as I said, it has given hope to many people that people like us can also push people to go and save some more lives than was possible earlier. And as I said, it was covering only 30 lakh households, but now another 27 lakh have been added by the CM's Ayushman cards, so that most of the beneficiaries who have priority household ration cards get covered. Many are still left out. Unfortunately, we've done

a small sample survey where we found that landless people had the highest category of not having Ayushman cards compared to those who have marginal landholdings or bigger land holdings, that's also very sad that the poorest don't manage to even attract an Ayushman Card.

Vivek Divan:

That's very interesting. I wanted to pick up on something you said earlier in your response. You said most district hospitals aren't able to handle the vast majority, 80 percent of emergency cases. Is this an issue of infrastructure, of human resources, Why is this the case?

Dr. Sunil Kaul:

As a person from outside who has worked in the army earlier, I see it more as a governance issue than anything else. Then when I go and meet many of these doctors and all, I mean, they always are stuck on quality medicines, quality supplies- they all blame it on that and even quality HR, that they are scared of, the kind of staff which has been given to them. Then that's why they are not performing the surgeries and would prefer patients to be transferred instead of risking the lives of the patients in their own hands. It comes to that. And of course , when I look at how people respond in an emergency, it's still very, very late. There's not enough infrastructure for doctors to stay within the hospital compound. Even if it is there, they will probably be staying somewhere else as a governance issue. By the time an emergency comes and if it has to be operated within half an hour-45 minutes, that probably will never happen. Invariably, most of these patients get transferred to a private nearest private hospital or to the medical college nearby.

Vivek Divan:

I'm also trying to think of what could possibly be solutions to this. One solution is to strengthen the district hospital system, obviously, in the various ways in which you've identified.That means more financial commitment, which has to come from the state. The other is this whole thing around moving towards the private sector, diverting patients towards private health. And then of course this amalgam, which is being proposed, which is PPP (Public Private Partnership), and I don't know if you're seeing that also in Assam through this Ayushman Bharat idea, so the PHC level is also becoming potentially privatised or some shape of privatisation. I don't know if you have any thoughts on it.

Dr. Sunil Kaul:

Yeah, not much in Assam. We still don't have a private medical college up till now. I'm very happy about that. We're growing in numbers. I'm not very happy with every

district hospital being converted into a medical college because one, the load is not enough for students to train on and two, every doctor cannot become a teacher, so there aren't enough doctors who can be teachers for these medical students. I don't support this, every district becoming a medical college. I'm happy that there are no private medical colleges also because then it's a very quick downslide to the levels of exploitation that happen with private medical care.

Vivek Divan:

So therefore then the solution is the state has to step in and invest more, right?

Dr. Sunil Kaul:

One is investment, but I feel a lot could be done with better governance. A bit of stick and carrot policy with the doctors, they're not bad doctors in one sense. I mean, compared to many other places, you wouldn't find arrogant and renegade doctors kind of a thing. But because it's not expected, their salaries are so low that people expect that okay, they're poor people have to really make money somewhere else also. So they're part timing in the private setup also somewhere in the city. And so, and everybody just expects that, I mean, we can't be expecting too much from such people.

But I think if better salaries were given them better investment there, but then, along with it, better governance that, okay, you are expected to be there in your duty time and at the duty station. So those things both combined together should be able to bring results.

Vivek Divan:

It's quite something to hear you describe this because on the one hand, I, as a lawyer, I'm going back to the Assam Public Health Act, which is such a progressive idea of the right to health, but then the ground reality is being described by you and I think there is obviously a significant gap.

Dr. Sunil Kaul:

I'll just tell you that whenever I've done a bit of in depth study, whether it's maternal mortality, or it's malaria sometimes. Whenever I've done it, it's the best performing districts or the best performing hospitals which have the worst mortality. It's because others are not even catching it. So again, I see it as a governance function. I was looking at simply how many deliveries are taking place in some of my districts in Bodoland. I could see the total number of deliveries, and they're saying that 90 to 95

percent now are happening in the institution, but all those deliveries combined are making up for only 1 percent birth rate, whereas the birthrate of Assam is around 2%. So where are the rest of the 50%? If I see all the deaths which have taken place, except for one death in my entire Bodoland last year. All of them have taken place either in the hospital or in the ambulance.

So I can't believe 50 percent of the deliveries we are not even catching here because the sample registration system has been seeing a decline in the birth rate, but it's not as bad as that in five years time, you would have had from 2 percent to 1 percent birthdate. So nobody in NRHM when these people are uploading all the data, nobody's really questioning that where are the rest of the 50 percent birth rate-women or children. They must be somewhere and some of them must be dying, so what's happening to that? Nobody is really asking questions there in a public health mode. I think that's one of the critical parts of governance. That we need to ask more technical questions than only managerial questions.

Vivek Divan:

That's a great point. I think it gets me to another thing Sunil which is that I know that you're teaching on the social determinants of health at the IIPH (Indian Institute of Public Health) in Shillong, and I'm wondering if institutes like the IIPHs are creating a cadre of people who understand these complexities that you're throwing up around data, around how we analyse data, how then that data affects programming and practice.

Dr. Sunil Kaul:

I hope so. Public health today, we say that health is too important a topic to be left to doctors alone. So many more non doctor people are also coming there and bringing their own ideas into it. But a lot of the teachers have unfortunately been doctors in public health, so sometimes the focus has been narrow. I can see there's a shift now, just saying, not even look at social determinants of health, just look at samples, some simple data, which has been striking that us all, all the time as health people, anything to do with disease, disability, death is a public health domain.

We talk about MMR. I talked about it earlier. You know, we constantly talk about what's happening to MMR and how the public health system works. But when you look at the entire MMR, all the maternal mortality in this country, if you total it up as an amount, I think about three times or four times more women are dying only because of burns and many of them because of dowry deaths. Now, does the health sector ever bother about it? Except that giving care to this thing, but as an issue, is the health system ever bothered about it? No. Should it be bothered? I'm not too sure, but definitely it should be asking somebody to please stop this intake of people. I mean, these are avoidable deaths, right?

The public health people should be bringing this out in front of the other ministries saying that please do something more about gender based violence or domestic violence, it's not happening. I mean, when you look at the amount of people who die every year in the Mumbai suburban trains which is just a narrow track. It's totally avoidable deaths. Do the public health people ever talk about it? No.

So I'm saying there, I think the new public health people who are coming out of the IIPHs, who are coming from various disciplines should be able to integrate all this. And it should be the job of public health people to bring it to the fore that there must be more interdisciplinary talk and pull and push to look at wherever we can avoid more deaths and disability, whichever department it takes to bring public health. We must do it. Anyway, I think a few years ago when, after the Alma Ata conference, when we had the new conference at one of the ex CIS states in 2020 and this new report came out, it clearly showed that most of the indicators which have moved in IMR, it's about 60-70 percent of them or more have not been because of the investment in only the health and family planning department.

It's been because of better education. It's been because of better lifestyles. Many other things. Dealing with health indicators or mortality indicators or medical systems only by health and family welfare is not a very good way to go. I think we need to bring many, many other disciplines, if you really want to be progressive and bring down the mortality rates and many other things.

Vivek Divan:

I'm so glad that you've emphatically described this whole aspect of the larger intersectionalities that we need to look at when we talk about health. I want to turn a little bit to your work presently, Sunil. You're working around issues of mental illness in several locations in Assam. Can you describe a little bit what the nature of that work was and what are the impacts of some of the ways in which you work there on the issue of mental illness?

Dr. Sunil Kaul:

Okay. I'll start with a bit of background. As I said earlier, in my district, which is Chirang, where we used to work, when I joined this part with about 5 lakh population had just three ANMs (Auxiliary Nurse and Midwife) in the field and there was nothing else, except on two edges of the district we had a block PHC with two doctors and two GNMs. That's all the health infrastructure, public health infrastructure, which was there. At one time we were training barefoot doctors, barefoot lab technicians and what not till about 2007-2008 when we started de-inducting, because we didn't want to duplicate the system. So we started training ASHAs, many of my health workers

had become ASHAs. We did that for some time and then we wondered what to really work on without duplicating.

One of the things we realised was the mental health aspect. We also realised that it's something where even if the government will get all the psychiatrists together and everything. It'd be a long while before many of these mental illnesses can be actually handled by the government department, with all its inefficiencies.

The last Lancet report for the government of India was that about 17 percent of India has got mental illness. Those figures are really really fearsome looking at even those who come with very overt, spectacular mental illnesses or one could be epilepsies, and many of them also have a psychiatric overlay, and the others are like schizophrenia or other psychosis like bipolar disorders. These are very spectacular. Anybody can make out that this person is office rocker as people would call it. Who are talking to themselves or many of them, I think about 50-60 percent of them would require medicines without a break. I mean, they would probably require it for life. You know, it's not a good way to say that you are condemned for life, but many of them require it almost full time. How do these people get medicated, especially an illness where one person along with them, I'm talking about the spectacular illnesses kind of thing, one person has to leave their jobs just to look after this person because this person can be destructive when left alone. So for that reason, we decided that we'll focus on the treatment part of mental illnesses. Though we initially tried giving free, because I felt that these people are already in a double jeopardy and we should not charge them, we were doing something right because of which our patients kept increasing. Soon it became very difficult for us to raise funds for so many patients.

Around 2017, we had decided that we would probably make it independent of any funding agency and let's start charging patients. When we went to all the caregivers in 2016, we had rounds of meetings with them and they were all ready to pay about 250-300 rupees for a month's medicine, all the costs together. We started with that, and I'm proud to say that today we've reached a state where we're running about 25 centres, 8 of them ourselves and the rest with small NGOs in their places. For between 300 and 350 rupees a month, we managed to give them every single medication which is required for the patient, apart from the psychiatrist salaries, and this is a camp based approach. It's surviving, many of these centres that we are running have got psychiatrists from various districts. They are also participating in the program. We give them 5-6 thousand rupees a day, or maybe 4 - 5 thousand rupees, depending on how much patient's load there is. Patients seem to be satisfied. There are far more patients that we handle than maybe some of the medical colleges or even the district hospitals where the mental health program is handling. We're obviously doing something right, but I think the good thing about such a thing is that it's dependable, that on that particular day, every month patients get either a psychiatrist or an MBBS or a psychological counsellor, whatever they need will be present on that day. So patients who have left medicine thinking they're

okay and they come back, they don't have to face ridicule. We understand that people will be leaving medicine and then coming back into this problem, and then we'll have to give them the medicine.

It's a paper free program, now it's totally app based. Sitting out here, I can track the treatment protocol for every single centre and every single patient. We, of course, believe in generic medicines and only essential medicines which are required by the book are given to them. So, that's about 5,000 patients on our rolls at this moment.

Vivek Divan:

This is just really remarkable to listen to and learn from. There's two questions which occur to me, and I think I'll kind of try and conclude the conversation after this. One question was, so you are doing this, is it possible for then the ownership of this to be moved to the government, for instance? Because this seems to be at scale, 25 locations, like you said. Clearly something that can be scaled up if the right people are trained to do that and where ownership actually rests in public health instead of an NGO or individuals who are taking initiative.

Dr. Sunil Kaul:

It can be, but we've gone quite a few times to the government, but they've not taken it up. I mean, beyond the point we can't push them.

Vivek Divan:

I see the attempt has been made, but there's been no uptake or enthusiasm. The other question related to this is, have you worked with people in other contexts who want to do similar work in other parts of the country? And the reason I ask this is because I find there's so many interesting projects of this kind, which are successful in their geographical location, and of course, geographical locations and contexts vary so much, so it's not easy to necessarily replicate. But I'm wondering if there is that sort of exchange of ideas because there's so much to be learned from examples like this, and then frankly, to emulate,

Dr. Sunil Kaul:

We've been hoping I think all the doctors who are with the program- nobody's full time, and unfortunately in a medical program, the doctor becomes a leader. So we don't have enough people to go everywhere and do the job. But for the first time, we've started a centre in Bihar also where a local NGO is doing it. It's only been three months, this has started. Knowing that every single centre requires about one lakh rupees of investment to start with, and in six months time, it runs on its own

without any losses, you don't have to really put in money and there's some amount of surplus always made for even cross subsidising a patient who doesn't have the money on a particular day. I'm hopeful that this will progress there as well. Some people do not believe that patients should ever pay any money. So then this program is not made for such NGOs.

As I said, the government response has not been very great because maybe I think they're scared that how do you run only a camp based program or how do you force the doctors to only give a certain amount of medicine and not anything else. So for whatever reasons I think the response from the government has not been very great in Assam. But we are open to this because it's an app now and the app can be tailored for any other requirements, which some other party has, we're doing quite well with it. At least patients are voting for it with their money and their free time.

Vivek Divan:

Okay, absolutely wonderful to hear this. Last question Sunil, so what would you say is a difficult question like pick the three top things that you would do to really change the direction of people's ability to have better health in Assam, whether it be the broader understanding of health or health care in a more narrow sense. What would you do as a policymaker to kind of change the direction of that? Because clearly the trajectory was very positive some time ago. And that is like you said, stagnated.

Dr. Sunil Kaul:

One is, of course, I'm a votary of a public health cadre, but then everything good has to have a good governance system, a good motivation and a governance system that people do what they're expected to do. So these two together and earlier I talked about investment. A better investment for all leadership, for health definitely, but along with governance, public health people with public health training who understand the nuances. I mean, just like picking up that, where are the rest of the 50 percent deliveries happening in the, in Assam? If we are catching only 50 percent for somebody to point that out in the system. Better infrastructure surely, but then all that I keep feeling that without a good governance system, most of this infrastructure or even good HR goes waste. So I'm a big votary of putting governance at the first point.

I'm also a big votary of government public health systems, a district kind of accommodation for all the doctors and peripheral people so that they can comfortably go there and even in an insurgency situation or whatever, I hope it never comes back again. You're fairly assured about the security of your family. You're assured about the education level, maybe the central school in the district and if we do that, then more doctors will be seen in the field.

Last but not the least, if we can't do anything, if we can't even think that we'll ever be able to achieve good governance in the government system, then, may be a universal insurance for everybody.

Vivek Divan:

Okay, thank you so much Dr. Sunil Kaul. I think that was deeply insightful. I think sitting afar from Assam, I feel that I have got a little window into what happens in a context which is much more complex than I'm sure we've been able to lend it in the last last 45 minutes or so, but certainly the conversation for me has opened eyes to the various possibilities of how success can be achieved and what we need to probably emphasise in improving health in Assam, so thanks a lot for your time and more strength to your efforts.

Dr. Sunil Kaul:

Thank you so much Vivek. It's been a pleasure talking. Every time the mind is asked a few questions it always makes one analyse a bit more and do a bit more again.
Thank you so much.

Thanks for joining us for this episode of status of states, stay tuned for more such conversations. This is your host Vivek Divan signing off.