STATUS of STATES

Insights on health policy across India

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Episode 4: The Reality of Health and Healthcare in Chhattisgarh

TRANSCRIPTION

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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, programs 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 Diwan, your host for this episode of Status of States, brought to you by the Center for Health Equity Law and Policy at the Indian Law Society in Pune.
Let's dive right in.

In this episode, we explore the state of Chhattisgarh. We are pleased to have Dr. Yogesh Jain, a physician and public health expert who has been working in that state for more than 25 years, speaking with us today.

Yogesh has an MD in Paediatrics from AIIMS, Delhi where he also served as faculty for a few years. He practices as a public health physician and has been mainly involved in primary healthcare through founding and running a community health programme - Jan Swasthya Sahyog in Chhattisgarh - with like-minded health professionals since 1999 and Sangwari in Sarguja in northern Chhattisgarh. JSS served people from over 3000 of the most marginalized villages. Using learnings from the community health programme, Yogesh has been involved in addressing diverse issues that determine health for the rural poor through clinical care, documentation, observational research, developing health-related technology, training, and advocacy. Having observed health and illness through the lens of hunger and extreme poverty, he is a strong believer in the continued role of the State as the primary provider of social services and that unbridled privatization is not the way forward in an unequal world.

So Yogesh I think the best place to start would be to get a sense of the state of health in Chhattisgarh and how you see it. We can look at health in the context of healthcare specifically, and also touch on social determinants of health and how they influence issues of access, equity, et cetera. So could you describe that to us?

Dr. Yogesh Jain:

Chhattisgarh is a central Indian state which has the highest proportion of Adivasis in the country, 33% to be precise in a population of 32 million. As we know that the Adivasis also have a hierarchy of class, even groups that they are, there are particularly vulnerable groups and there are non-vulnerable tribal groups. But also this suggests that there is a lot of diversity in the rest of 67% economic as well as socially. This reflects in the health of the people as much that there are all the problems that are supposed to be more among the poorest people which are the Adivasis in this country are in excess among the people in Chhattisgarh.

So we have a surfeit of, infectious diseases. Whether it's tuberculosis (TB) as determined by hunger, or whether it's malaria and other vector-borne diseases determined by the environment of, you know being in the forest range, and predominantly rural populace or talk about infections that have been persisting for decades like cholera as a cause of

gastroenteritis, or even the newer diseases that seem to have affected the rural people also as much as urban, the small urban population that we have, whether it's the non-communicable diseases like diabetes. Diabetes of a particular type, which is the lean diabetes, is when you're undernourished and get diabetes. Or hypertension and other cancers in large numbers which also happen among the poor. Two problems with that of, persisting problems of nutrition manifesting as anemia or plain simple protein-energy malnutrition. We have it in larger numbers than I would say in almost any other part of the country.

It could not have been otherwise. The fact that we have such a large proportion of the poorest people in the country, I would even go on to say that Chhattisgarh would be the epicenter for marginalization as well as manifestation of this marginalization in the form of poor health could be somewhere in Chhattisgarh. This allows us to have the misery of watching this in this state like no other state in this country. And that has determined whatever I have been doing and our struggles also to sort of set them right.

Vivek Divan:

Okay, that's interesting, Yogesh. Thank you for putting it in such clear terms, especially the inequities and marginalization that you mentioned. So, tell us a little bit about what you have been doing in the last few decades there, and could you also throw some light on how the health systems in the state are responding to these challenges?

Dr. Yogesh Jain:

So I came to Chhattisgarh 25 years ago as a young academic that I was in Delhi for the first part of my professional life. From AIIMS, Delhi, I came here to set up a comprehensive primary health care system in rural Bilaspur in Chhattisgarh where we could not only serve the people of about 3000 villages. But in the process, understand the determinants of illnesses and ill health but also find solutions to the persistently unsolved problems of primary healthcare with which we came up with certain models that have been implemented at the national level. Like the ASHA program that came up from the Mitanin Program of Chhattisgarh, or the entire idea of health and wellness centers where not only illnesses, but also wellness is looked at or the mid-level health professional who now goes around by the name of the community health officer or models for looking after under 3 child nutrition in form of Fulwari program.

There are many such models in primary healthcare that we have been able to do over these 25 years while serving the people and also understanding the nuances of disease control programs, whether it's in tuberculosis, malaria and other vector-borne diseases, but also, the problems of hunger, as we would say manifesting as in the sanitized world that malnutrition is called. And now I've been also working in the northern part of Chhattisgarh, that is Sarguja, trying to replicate and persist with that. And on the basis of all this work and the learning that we have had, trying to advocate at whatever fora that is available to us, to make a case for the health of the poor.

Vivek Divan:

So in this attempt to advocate for change, some of the more equitable models that you have been able to implement in the state, have those been adopted at a larger scale? Besides, of course, the Mitanin program.

Dr. Yogesh Jain:

So, yes many of these models have been taken on by the state, even at the national level. But with some trivialization that one worries about. So whether it is the Mitanin program that came out of the Chhattisgarh experience that we contributed to, became the ASHA program, the community health officer as the mid-level health professional, in the absence of the physicians going to rural India, as well as the limitations that ASHA programs have in terms of technical skills, so this mid-level professional becoming a community health officer is now implemented across all the health and wellness centers in the at the national level. Or even the entire idea or concept of a health and wellness center for a population of 3000-5000 that has also been implemented has come out of the experience that we have had.

Besides this the idea of having not only 100 days work, but also 150 days of work in NREGA (National Rural Employment Guarantee Act) seem to come out of some of our advocacy efforts, but also the fact that food rations should be available for people who suffer illnesses that are predominantly due to undernutrition like tuberculosis. We could push this and get it implemented at a state level for all patients with tuberculosis to get rations from the state health program. Well, but when it was taken at a national level, they trivialized into a 500 rupee token sum to be paid every month for patients with tuberculosis, which later got even further, I would say, trivialized into, volunteers who would own up, who would sort of *'god lena'* (adopt) in terms of offering, food rations to patients with tuberculosis.

And I would say, there are several other ideas that we've seen. For example, in tuberculosis, we could ensure daily treatment of tuberculosis, when we realized that intermittent treatment, that is, thrice-a-week treatment regimes were not appropriate, and they were causing inadequate cure rates at the national level in tuberculosis. To highlighting aspects of malaria, for example, we realized that malaria continues to be a big issue. And now, once again, there's a resurgence now in recent a couple of years those have been also aspects that have come out from the work. And there are some other aspects of reproductive rights of women who belong to the particularly vulnerable tribal groups that we have sort of fought for and have got the legal rights to contraception as well as, family control that they were being denied. So some of those things have happened, but there's a lot more in progress that we wish to contribute to.

Vivek Divan:

Oh, that was insightful, Yogesh. I think I'll come back to the point you made around framing some of this work in the rights context. But before going forward to look at how national programs have adopted some of the strategies that you have used in Chhattisgarh, I'm wondering how this work over time has had an impact in Chhattisgarh itself. Have some of these innovative ideas made a difference to the state of public health in the state? Can you describe how that has played out?

Dr. Yogesh Jain:

I would say, some of these ideas at the state level have frankly not made much of a change except that as a sort of a trickle-down from the national uptake of some of these efforts. For example, in malaria when we could introduce the fact that there has to be, peripherally available rapid kits for the diagnosis of malaria, as well as the best drugs to be available for the most peripheral health workers, and that could be taken on, thus, we had a major decline in the malaria problem over the last 10 odd years. That was seen nationally also, including in Chhattisgarh, we were the number 2 state in terms of the malaria problem in the country and that situation has resolved and there is now malaria only in some states in the Northeast and to some extent some other districts of Eastern India.

Chhattisgarh has, barring the resurgence in 2023-24, shown a major decline in numbers. There were a couple of years where we could also ensure food rations for tuberculosis patients. Actual food being provided to TB patients besides the drugs that they were getting. The augmented regimes that we could also get implemented across the country, but also in Chhattisgarh. But these food ration was stopped there after a few years of work.

I think the NREGA increasing the availability of 150 days of work, plus also the women who delivered, who were enrolled with the NREGA program, for the period of 45 days to 50 days after they delivered their babies, they were also entitled to, their wages, even if they were not able to work, but because they were part of the commitment of the state that they would provide their livelihoods while they were nursing their babies for the next 50 days, was also ensured. And I think that continues to date.

I think the food security bill that came up, the national food security bill, drew largely from the framework of the Food Security Act that we had introduced at the local level in Chhattisgarh. And the right noise is being made about providing hot cooked food for the children below 3 years, which is actually the most difficult age group for managing undernutrition. The only other state that does it very well is Tamil Nadu. But among the other states which were only implementing the Anganwadi program, where only take-home rations were available for children below 3 years. The Anganwadi is remaining largely available only for 3-6 years of age. Chhattisgarh was a pioneer also in this sense in the northern states to launch this creche program equivalent in their Anganwadis, we contributed to that also, but otherwise, I would say the situation may have improved from what was an emergency situation to a serious situation.

We may have jumped a few steps up to becoming from the worst or the second worst state to maybe the fifth worst state, but that is a small consolation for anyone who's living in this part of the world, or the country also. And I must say that the levels of nutrition that I've seen among the people in central Chhattisgarh are among the worst that I've ever seen across the country. Weights of 40 kilos among women or lower as well as, weights of 44 to 48 kilos among men are the average weights that we sort of see among non-sick people. When you turn sick with tuberculosis, then, the weight would go down by another 10 kilos. Then these weights, mind you, are 10 kilos lower than the average people in sub-Saharan Africa average weights. Those countries that one worries about. So we have moved a little bit, but not come out of the woods as it were.

Vivek Divan:

What would you ascribe some of this to? I'm thinking, is it political will, would it be a matter of just resources not being available? Is it about just capacity to deliver that doesn't exist within public health systems? Is it some other factor which doesn't allow for more kind of exponential progress? As you say, it's progress, but not sufficient.

Dr. Yogesh Jain:

You know someone said this very beautifully once. *'Ameer dharti ke gareeb log'* poor people of a rich part of the world, with a lot of resources. I think there is a clear siphoning off of resources, whether it is in the form of coal or power that is generated. And even though Chhattisgarh remains a power surplus state I don't think we are in any way economically better off significantly than in the past. The other thing is that poor people get poor health systems is an adage, I think, which is exemplified here so well. It is not for nothing that states like Chhattisgarh are called part of BIMARU states.

It's a sum total of lack of political commitment, but also in a sense, the lack of cohesive demand for services, people are sort of disempowered even enough to raise their voices. And if a triangle can move…mountains that they say in Thailand, in Chhattisgarh, in spite of our efforts to get universal healthcare implemented in spite of a government that was interested in doing it, the previous government that finished its term was very keen, but there was a lack of demand by the people. So finally, a lack of political commitment also, even though there were some people to champion the cause for it. And we knew what exactly is required to give universal healthcare. We could not move even an inch towards having universal healthcare. And yet what it results at the moment is that some people have some care for some illnesses. It seems that given the crisis that we managed or mismanaged in the last decade, we really haven't learned much. And the system's capacity to even do what one plans, even when there was some sort of political will, it's not even there. And then we top it up by taking some poor decisions.

I remember there were times when there was an attempt to privatize all the laboratories of the public health systems. The insurance program that PMJAY (Pradhan Mantri Jan Arogya Yojana) is, has its own serious limitations. It is not available for a lot of people. It is not available for a lot of illnesses and it is not available for outpatient care. So those issues have prevented this fragmented care that is available for some people. This expresses itself in the form of poor outcomes for many, many conditions, even though maybe, we may be a little better than some other states, like our neighboring Madhya Pradesh, where I think things are even worse than where we are.

Vivek Divan:

So you mentioned that there's a level of disempowerment which prevents a demand from emerging, and at the same time you describe the abjectly poor levels of nutrition. You've also spoken about the lack of services in many contexts. I imagine that when elections come, health is really not an issue which people go to the polling booth thinking about, that this is an entitlement and I have the right to it.

Dr. Yogesh Jain:

I think you said it very well. The issue is about all demands for health rights. When you are not sick, you don't feel the need for raising your voice and, and to struggle for your health rights. And when you are sick, you don't have the wherewithal to demand anything. So you are at the mercy of the systems and you just want to get your work done in a way. And that has hemmed us, all our efforts in the state. When we have been demanding things, depending entirely on the largesse of the state, as it were. So the health rights movement has not succeeded here, largely they have not succeeded anywhere. But here with the level of disempowerment that we have it's been even worse than many other places in the country. But we, we sort of don't lose hope and try to sort of still collate ideas together in the civil society. But it doesn't seem very bright.

For example I can tell you that as late as even today the government of Chhattisgarh is now considering to take over the ASHA program, which in most parts of the country has been led by civil society organizations like a health resource center or a ASHA resource center, and now the government is considering to take it over by the health department to run it all entirely. Without any significant participation or control by the civil society.

Vivek Divan:

And what is the motivation for that? Is it because they think that they can deliver better? Is privatization also looming in that context? It's another issue that I'm hoping to kind of discuss a little bit today. You mentioned the privatization of all labs at one point was being considered, which has now not happened. But what are those pressures and where are they coming from?

Dr. Yogesh Jain:

I think in this case of the ASHA program, the Mitanin of Chhattisgarh, is largely to control and not divest power away into community groups. And that is determining, it's not privatization here. But let's see, the PMJAY in Chhattisgarh is largely a program delivered by the private sector. Two-thirds of the money claims are made by the private sector. In fact, more than two-thirds, it's over 70%. As we know that it's not only the fact that the private sector is taking on the bulk of the claims. They would do certain types of surgeries and certain types of surgeries are not done. And medical problems are not looked after by that. And so it's a bad world for you if you fall sick in Chhattisgarh.

So if I may give an example of something like diabetes, which is a common illness and now India is called as a diabetes capital. When you want to get your usual drugs for diabetes or you want to get your special blood test, for these tests may not be available and these drugs are not available from the insurance program unless they're available free from the public system, which is often not the case because outpatient care is not supported by the Ayushman Bharat program. But if you want to get your leg chopped off, if you have bad diabetes, then for that the money will be available from the Ayushman Bharat, amputation for a diabetic foot, which is a complication of neglect of diabetes that would be available. I just mentioned this example to say the insanity of insurance programs to ensure people's health, and how they cannot do what is necessary for the people.

Vivek Divan:

This is quite a…something I'm still trying to grapple with as you describe it. So in a state as poor as you've described. Large delivery through the PMJAY is by the private sector you mentioned, so the amputation of the foot would then happen in the private healthcare setting.

Dr. Yogesh Jain:

Largely, yes. Most NCD (Non-communicable Diseases) care is at the moment with the private sector, even though the public system is supposed to provide care. We have disempowered and even the public sector is not regulated. So, people would farm out the care to the private sector because private practice is also allowed in Chhattisgarh those people would be referring out. And the system gets poorer just to look after those problems that the people don't have a choice to go. So, for example, maternal care may be provided by the public system, but you can go beyond public maternal care, say beyond a cesarean section, beyond a normal delivery, most complex problems that public system doctors should be the best also to manage are now looked after by the private sector and they continue to be looked after. And that's where the moolah is there for the private sector in managing complex problems and particularly surgical issues.

Vivek Divan:

So like you said earlier, the Pradhan Mantri Jan Arogya Yojana, the PMJAY in itself as a program has a lot of exceptions. There's a limit on who can use and to what extent and for what procedures and services, nothing outpatient, only inpatient, etc. There are all these variables involved, along with the private sector, of course, So at the end of the day, is it still a program which is not delivering on inclusivity?

Dr. Yogesh Jain:

So, PMJAY suffers from several problems. One of which is that it does not look at primary care, it does not look at preventive care, it does not look at outpatient care, or curative care, and it only is available for certain people who are classified as officially poor per the 2011 census. It is more focused on surgical care and it has problems of…operational problems because of which a lot of private sector also, people don't like to get themselves enrolled or empanelled for the PMJAY because there are delays in getting the money from the state insurance agent. But also the fact that it is poorly regulated also that there are hospitals who would charge people in spite of being enrolled, enrolling their patients under the PMJAY smart card system. They would take money from them and also would make an insurance claim to the state.

So it's in a way, almost like, as we call it, liquid oxygen. Oxygen will not allow people to die, but liquid will sort of, not allow people to survive. So it's a very partial and it's a band-aid-like thing that I would label the entire PMJAY. Per se, outpatient care is not amenable to insurance programs, and that excuse is used by the state to sort of not make it available to people. So we are far away from what other care that we would want for our people. And we

have a completely broken system, for most of us, for all of us, I think, but much more broken for the poorer.

Vivek Divan:

So what is the state of primary healthcare in the state? You mentioned that Chhattisgarh was a model, which the health and wellness centers tried to emulate at a national level, which means that obviously, it was something worth emulating. But is it all across the state that primary healthcare has never worked and that it's not been strengthened at all? And in that context, I'm wondering what sort of a budget does the state government allocate to health?

Dr. Yogesh Jain:

Primary health care, there have been some good initiatives that are at some civil society level in certain districts. But overall, I think it's a poor situation even for primary care. I don't think that primary care could be better than secondary care in a relative sense, and that sort of a thing does not happen here. We are really doing poorly, in spite of the fact that there are studies. I remember one study that they did, the 6 states done by Jean Drèze's group when they compared Rajasthan and Chhattisgarh and many other states to ask about how is the situation of primary care? And they came up with the idea that Chhattisgarh was doing better than Rajasthan, which frankly may be the case, but it does not make it good enough. Just merely having doctors open a health and wellness center or a primary health center, Does not make healthcare available to people. And I would say from the point of view of the outputs that these primary healthcare systems do, this would not pass muster. And I think there has to be a different way of judging the effectiveness of primary healthcare systems. That probably economists and some other developmental professionals may not understand.

It's not that you do something, it is better than nothing in healthcare. It has to be a certain level of… to pass muster for even the minimum amount of care that should be available from a system. And overall, I think we don't pass muster even at the basic level of primary care.

Vivek Divan:

And what is the government budget to support all of this?

Dr. Yogesh Jain:

So I would say for universal healthcare, what is necessary is about 8% of the state SDP (State Domestic Product) as they call it should be available for health. I think in Chhattisgarh, it's still about 5% or 6%. So there is very little money. Drug shortages still happen. There are also obviously operational issues. Even though we have a medical services corporation, drug stockouts are not uncommon and partly it's because of the little amount of funding that goes in. But at the same time, the entire idea of a contractual program running, national health mission is almost like a contracted program. So all the employees, 50% of doctors or whoever are in a sense, on contractual employment of this NHM which is centrally funded. They don't feel that they're a part of the larger so called horizontal health system, a health program that is funded from the treasury. These compound the problems of a feeling of a public system that one has.

Vivek Divan:

So I want to go back to for a second, you mentioned tuberculosis a few times, and I want to understand the context within which it's playing out in Chhattisgarh. It is one of the programs at the national level, that we want to eliminate TB from India by 2025.

I imagine that this timeframe is obviously not going to be met, and I don't think anyone realistically expected it. Also with COVID coming along, I'm sure there have been setbacks. From what you've described, it sounds like TB in Chhattisgarh is unfortunately thriving. So, what strategies or commitment are you seeing on the ground in terms of government efforts to curb the spread of TB, to ensure treatment is available. You mentioned nutrition is so closely linked to TB, and how that is a huge problem. So are there any hopeful signs around curbing TB in the Chhattisgarh context

Dr. Yogesh Jain:

Unfortunately not. I don't see any major signs of hope. Tuberculosis as it is largely determined, over 55% is determined by undernutrition per se, as well as some other bits about from tobacco use, as well as diabetes and HIV and some amount of alcohol problem and silicosis also. I don't see major changes in the numbers of new patients declining unless we handle the entire problem of people's nutrition, for which we are not doing very much. Whatever efforts are made in nutrition care, it is mainly for children through either the ICDS (Integrated Child Development Services Scheme) or some other midday meal programs. We don't really have any model in this country for adult nutrition. Till we handle that, we are not going to get any decline in the risk of getting tuberculosis, and that is borne out by persistent numbers.

On top of this, the program itself is very poor. Once you get symptoms of tuberculosis, the ability to diagnose them in time and then offer them treatment, this system was not running very well earlier also, but it got completely demolished by the COVID pandemic, but also at the same time the numbers of tuberculosis patients increased in the country, but also in Chhattisgarh. And thereafter, it has not been able to pick up. The tuberculosis program was not in great shape even earlier, before the COVID-19 pandemic. We were doing poorly. The situation of severe undernutrition that we had, which we have been living with for decades now and a program that was at best a poor form of the program that we had that you have at the national level. The COVID pandemic certainly destroyed a large part of the program. The drug shortages started happening. We could not diagnose people who were having tuberculosis in time and not being able to complete the treatment and the numbers of patients actually increased over time in the first two years of the pandemic. And that we have not been able to get back to even the pre-COVID pandemic baseline of the number of patients that we had. And now with the other problems that the national program has done, we know for the last year, we have been having major shortages of drugs, because of which, I fear that we will have an explosive outbreak of tuberculosis in the next few years with a larger number of people with resistant tuberculosis.

At a personal level, it is such a challenging thing to face these patients who come to the public system asking for drugs, then we have to tell them no, no, we don't have the drugs, please, you'll have to buy the drugs from outside or resign to your fate. It's a national

problem. But because people here are poorer than most of the parts of the country, the consequences of a broken program and the shortage of drugs and diagnostics. is going to harm us far more than most of the parts of the country.

Vivek Divan:

Thanks, Yogesh, again for that eye-opener, because one knows that it's been difficult actually to access TB medication across India, but it seems in Chhattisgarh the problem has certainly been exacerbated.

I want to move to the issue of law and policy now. As a lawyer and as someone who's worked on rights-based approaches to health, I see the need to articulate health as a right. At the same time, I completely understand that the ability of civil society and of disempowered communities to articulate and seek this right is obviously a challenge and it is a challenge anywhere.

Earlier you spoke about reproductive rights and an instance where women from tribal groups sought legal rights related to contraception, could you describe what that issue was and its outcome?

Dr. Yogesh Jain:

The women from particularly vulnerable tribal groups Baigas are one of them. These women were not being allowed to undergo terminal contraception that is in the form of sterilization procedures that they had a right to in other parts of the country on the species grounds that their populations were decreasing. And a government order was issued about 20 years ago, which disallowed their right to have terminal procedures, and sterilization procedures that they should increase their numbers. So we… The country sort of took on this paradigm of high fertility and high mortality because they had certainly more number of deaths that happened in their children and that's why their population was falling. And these women said that we are not going to be machines who are going to be producing babies. So they would often go to some other places in Madhya Pradesh to get their procedures done, by even changing their surnames and preventing them from being called PVTG (Particularly Vulnerable Tribal Group) women. But this was, I think, completely inhuman and we sort of supported their right to the control over their fertility and including the right to getting procedures for themselves.

This petition was filed by 15 Baiga women whom we supported and the High Court annulled the order of 20 years ago of the government of Chhattisgarh. But I must say, this happened about 3 years ago, even till 6 months ago, or even till date, I would say these women are still facing problems in getting their procedures done in India in the local health centers for whatever trivial reasons, the public health system physicians are denying them their new-found right to get sterilizations done, but this struggle is on.

This has been a matter of much sadness, if I may say, disappointment that even the civil society partners are not able to sort out even get their legal rights that now have been given into practice.

Vivek Divan:

That sounds like a dismal situation, getting the right but not being able to enforce it or have it implemented. I also appreciate that the law and the legal system can be extremely intimidating for most people to even contemplate using, but it's wonderful that at least some relief was obtained through the courts.

I'm sure you've given it a lot of thought. What do you see as key solutions to deal with the state of health and health systems in Chhattisgarh more effectively and equitably, so as to actually change the course of how things are?

Dr. Yogesh Jain:

So I would say that at the state (level) we are trying to advocate with the present government if they can take on the large political step of ensuring universal healthcare, as we know the nuts and bolts of how to get that done, but to put in the money for that, as well as to take a decision that they would like to implement it through a strengthened public health system is what would be the right way to get to that. And that would mean looking at the determinants of health, but also providing free care for all common and important problems that people face in this state and it is doable with the money that can be raised plus some other additional resources that innovative financing can do.

At the same time, regulating the private sector which at the moment the state does not seem so inclined to do, would be able to strengthen the public system And I would say, added to this, if we continue to work also, we need to work especially on some of the determinants of health especially food availability. I think our food basket that we get as a part of the public distribution system needs to be augmented with more protein containing either pulses or even for people with certain illnesses who would be better with higher protein content, things like milk products or even eggs. I would say that would be the way to go. But I would say that it's almost essential that this state, which is suffering such a poor health state with a system that easily can be gamed, we need a sort of a justiciable right to health, something that can ensure right to healthcare as the barest minimum thing besides the determinants from the public system when they need it whether it is for routine problems or for emergency needs as well as for other aspects like rehab and other palliative level care. So we really need a legally enforced Right to Healthcare Act, about which I'm not so hopeful, but we need to sort of, start that sometimes and which will require mobilization at the civil society level, but also some political will to sort of, get that first passed and then implemented.

Vivek Divan:

That's a lovely encapsulation of what a holistic and useful approach would be. Let me conclude by asking you about that last point you mentioned that it will require some work to really get this going, an act or legislation or some kind of articulation of the right to health. You also mentioned throughout this conversation that civil society has actually been delivering on various fronts vis a vis health in Chhattisgarh. I'm wondering if there is that sort of conversation happening in larger civil society, or is that something that still needs to take place in the context of bringing it then to the government as a pressure group or something like that?

Dr. Yogesh Jain:

I must say that the civil society formations and their, and the processes of networking have suffered a major hit in the last few years. The enthusiasm and the energy levels that one once saw around in the early part of this century are missing at the moment. Protest against some attempts to privatize public health systems are much fewer now. Voices against non-delivery of the insurance programs, denial of care are not being raised as much as we have done in the past. Not to lose hope, but I think there's only one way, but that is to go forward. And we need to learn from both the right strategies as well as the mistakes that have been committed by partners in Rajasthan when they got this limp Right to Health Act passed or whether the efforts which sort of have got aborted in Tamil Nadu when they came up with a draft bill. We need to learn from that and move on.

There have been efforts in the past where the civil society formations were stronger, But as of now, I think there's a large need to regroup and also network. Network not only within the state, (but with) similar thinking members from across the country.

Vivek Divan:

Well on that forward-looking note Yogesh, I want to thank you very much for the time you've given and more so for the incredible work you're doing in a context, which is clearly very, very challenging. We wish you the best and hopefully, we can learn from the experiences that you have to share and through this conversation.

Thanks, Yogesh.

Dr. Yogesh Jain:

My pleasure.

Vivek Divan:

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.