Aggressive testing, improved medical health facilities part of COVID management strategy in AP – Addl CS to Andhra Pradesh Dr PV Ramesh

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With the number of cases of coronavirus on the rise, every state is adopting different strategies from triple lockdowns to improving health surveillance to increasing health care spending. The south Indian state of Andhra Pradesh has so far conducted over 10 lakh tests COVID-19 tests and is the third Indian state to achieve such a feat after Tamil Nadu and Maharashtra, and the third Indian state with highest tests per million after Delhi and Jammu and Kashmir.

Hi, I am Rakesh Kamal, Co-Founder and Production Lead at Suno India.

In this episode, Suno India editor Padma Priya spoke with additional chief secretary to Andhra Pradesh Dr. PV Ramesh who is an International Development and Public Health professional. They discussed the COVID Management strategy of Andhra Pradesh. He mentioned how increasingly they are recording cases where they are unable to find the source of infection & why it is important to accept community transmission. He also said that the virus is here to stay and the strategy should not be to wait for the vaccine but to educate the communities on social distancing and on mask and hand hygiene.

Padma Priya (Host): So, Andhra Pradesh has been registering a huge number of COVID cases. Andhra also has been conducting a lot of tests and has almost neared the 10 lakh test Mark. Could you explain to our listeners, how Andhra Pradesh has managed to scale up testing?

Dr PV Ramesh (Guest): Thank you very much for having me. And this is an opportunity to have a more informed conversation on how Andhra pradesh has been managing this pandemic of COVID-19 and how we can learn what lessons we have, the good and the bad of it. That has been said first and foremost of course, as in the month of March when this was declared as a global pandemic, by the WHO, the director of the World Health Organization had said, there's one answer that is Test, test and test. So we have followed that we took that very Seriously, we were very early in actually monitoring COVID in the state, we started as early as 20 - 21st of February, even before any case was reported in Andhra Pradesh, there was one solitary case in India in Kerala. At that time, we started testing those who are returning back from overseas to our international airports and also later we asked the Bureau of immigration to send us the list of those who are headed to Andhra and then we started tracking them and then tracing their contacts and testing. At that time, the sample had to be sent to the Pune virology lab. And because that was the only facility that was available and later it started in Gandhi hospital. So which basically

meant at the beginning of March we had no capacity to test. So we started building the capacity gradually. Initially, we had three centers. Currently we have 15 centers in the state and the government facilities, and another three in the private hospitals, which we had thrown open a fortnight ago. So these are all RT PCR centers, where you could really have a confirmatory test. In addition, we also got around 48 centers. This includes smaller hospitals even where we could test TrueNat. This is a nucleic acid test, which was originally earmarked for testing tuberculosis, and now we've been using that successfully for COVID again, and these are nearly 300 small machines, where we can again, test the sample And then identify if there is an infection. Now there are three sets to testing. One is the testing infrastructure. That is the test kits, the swabs and the carrying medium, and then of course, the machines, and essentially those who have the skills to test. So this is one set of it. So it requires a lot of training. And the biomedical waste has to be disposed of. This has to be up to standards, the ICMR inspects and certifies these centers. So there's a long process then. And on the other hand, another important thing is the collection of the samples because initially we were asking people or we are bringing people to the hospital and collecting the samples because it requires a lot of precautions because it's a biomedical hazard, that people get infected, the infection can spread. So what we've done essentially was training a lot of people, ORIGINALLY only pulmonologists Collecting the samples. Now, any health functionary who's trained who takes all precautions can collect a sample anywhere in the state that Home Depot sees that we see it sees at any of the notified collection centers. In addition, now we have deployed bustles that are mobile, where samples can be collected very safely because the person whose sample is to be collected stands outside, and then we can collect. So this essentially has the capacity to test about 30,000 a day up to but what's important, I mean, let me also qualify what I'm saying. What I mean, it's not just the numbers that matter. It is what the testing strategy is a lot more important than the number of tests so people can get consumed by the numbers and it's important that you test but more often important is the whom you test. So because every test has a price, I mean, each test costs 2000 to 3000 rupees. So we need to be conscious of the fact if I'm doing 20,000 tests, I'm spending four crores a day. So it's equally important for us to have a very, very clear strategy in which we target those people who are likely to have the infection rather than just randomly.

Host: It's an important point that you brought up about the testing strategy. Has Andhra Pradesh stuck to the ICMR guidelines or are you doing anything about the extra above and beyond what is being told by ICMR in terms of the testing strategy guidelines?
Guest: No, ICMR has provided a generic framework for the country. Because I mean, as you know, India is a very diverse country and different states and even the districts have different levels of capacity, both in terms of their public health outreach, as well as the hospital management. So it's very difficult to apply uniform standards in a country of this diversity. Nevertheless, I think those broad parameters and guidelines issued by ICMR and which have been periodically revised and updated, are important. Now, let me let me expand on what I'm saying. In the month of March when we started testing. Our focus was

largely on those who returned from overseas travel and their contacts. So this was done very diligently and then everyone was tested. Later we in the month of April, May, it was those who returned back, and their contacts and their secondary contact. So it was broadly so I mean, it was what I will compare this to fishing in a pond. I mean, we had two big ponds. We knew where the fish were because there was a lot of diligent racing and cracking that was done. And so you test those people and those results came in now I believe in the month of June, especially and as we move ahead into future months, I believe that we are really fishing in an ocean 58 million people any one of them could be infected notwithstanding the claims that there is no community spread. There is a substantial community presence particularly in the urban areas and also more particularly in this slum area. So right now we need to sharpen our testing strategy and I have been advising the health professionals and the district officials to really sharpen the testing strategy because if I test 10,000 samples a day, then I and the thousand are positive. That basically means I have spent two lakh rupees on every positive test, it's a lot of money. And that means I have not been effective in really targeting those infected. Maybe I should identify alternate measures like what? What Germany has done now if you compare Germany and South Korea, Germany is a small country, it's a densely populated country and everyone wants to test everyone. So it went ahead very, very vigorously. But don't forget that they also had a very, very rigorous mechanism for contact tracing, testing, isolating and then breeding. Germany, on the other hand, also tested but its focus was on contact tracing. So it asks for volunteers to come forwards and then test and then trace contacts in rigorous testing of contact tracing of contacts and testing the contacts isolating them and it incentivised those tracers who trace the positive cases so I think we need to now going ahead, we may have to adopt a mix of this number one, number two years we need to sharpen our targeting right now we are fishing in the ocean. So the bolder techniques don't help because I mean you know few fishermen using the you know, who can sink is not going to help so what we need to do is really know where the cases are concentrated where positives where the infection is being spread. Second is proactively proactive surveillance. Now, static surveys which we were doing before are not going to work. This has to be surveillance. Now here is an issue. Now in the middle classes, even lower middle classes and upper classes, you know, particularly those living in apartment complexes gated communities. There seems to be a serious taboo in reporting the stigma, people need to understand and particularly Those educated people need to understand that the virus is an equal opportunity virus it is in fact is a socialistic in its conduct, because it doesn't differentiate between the rich and the poor and between men and women and you know whatever the diversity that generally exists is not respected by the virus because the virus is not being controlled by ABCD. So, it is out there, to a large extent it is conditioned by how much exposure each one is being open to So, suppose if I am, I go out I mix with people I don't follow social distancing methods, I don't wear a mask, I'm likely to contract whether I'm rich or poor. I want everyone to take this message seriously, because this has become a major problem to reporting and, and, and testing because unless we Report and test the case early, we will continue to spread this infection across the country. So really those who are listening to this should at the earliest

appearance of the earliest symptom, I mean earlier symptom being I wake up in the morning, I brush my teeth, I can't taste the toothpaste, or I then I have a coffee and I can't smell the coffee. Now these are very, very early symptoms, and then maybe later I have a sore throat or maybe I have a body ache because this is not an infection that manifests for about five to seven days, even 14 days after I contract the infection. Secondly is the symptoms appear late and they are mild to begin with, but they can become very serious very soon and very fast. So this is the reason why people must as soon as they have the earliest symptom, they must get themselves tested, in our state we have three toll free numbers one is 104 and other is 1092. And the other one is 14410. Please call these numbers and report yourself saying that I have the symptoms, may I have a test done and then you will be guided to a place where you can get yourself tested as soon as possible or even team will come and visit and test you at your home because this is the more we test and test those with symptoms. The better is the effectiveness in terms of controlling and containing this pandemic.

Host: Is Andhra Pradesh conducting fever clinics within the state? Have such measures also been taken and talking about surveillance, Kerala a few months back did sentinel surveillance- is a similar process being planned or being undertaken in Andhra Pradesh?
Guest: Okay, I mean with the onset of monsoon, there are many other diseases that cause fever appear now. I mean, this is the season for general flu, the viral infections. This is also the season for malaria, dengue, chikungunya, and similar diseases, which also present itself with fever. Now, this is indeed a challenge for public health professionals and the doctors. The survey, that is be the Sentinel Survey, or surveillance, I believe has to be a continuous process. I mean, let me paraphrase this a little bit, clearly. Now, a pandemic and particularly considering looking at the trajectory and the pathophysiology of this infection. It does not appear to be a war, you can fight and then get to draw I mean, let's say there is a cholera epidemic. You know, it's a circumscribe people go in with a lot of ammunition, you control what you contain and then you eliminate, and then you come out, you have the weapons for that in terms of, you know, the antibiotics, you know how to manage this. So it's very, so this is not one such now, I believe in many parts of our country, maybe even in parts of our state, we may be adopting this, this sort of an approach because of this is very familiar to both doctors and the health staff, as well as the administrators who manage the districts and the sub districts. Now, this is a very different,different battle altogether. This pandemic is much more in my view, is like a low intensity, a protracted insurgency in which you go and see the subject you don't smell. You don't taste so you don't know what The insurgents coming from so this is so you cannot have you cannot launch an offensive battle against this neighbor is it circumscribed to a particular area or concentrated in particular areas perhaps at the same time and also, more importantly, you don't have any tools to launch an offense that a drug or a or a or a vaccine. So, consequently, what has to be done is a very, very carefully crafted strategy. Remembering that this is a long drawn war, notwithstanding the ICMR, recent notification than by 15th August virus will disappear from India. I wish that happens and good luck to everyone. I am deeply skeptical about what ICMR has Put out this

way; this vaccine number one is not likely to appear very soon. At least Not in the 2020 calendar year. Even if Oxford moves ahead and other pharmaceutical companies, maybe they will make billions of dollars, but that may not solve our problem, neither would mitigate our challenge. Second important thing is that all those medicines that are being touted as a cure for viruses have a marginal impact on this infection. So, let us be of the view that as we speak today, on Fourth of July, we do not have weapons to launch an attack neither a vaccine nor a medication. So, what do we do? We have to be number one as a community come together to recognize that we are interdependent that each one of us can protect ourselves and protect others, how we wear a mask all the time. We don't gather in large crowds, we maintain physical distance and we people ourselves, self hygiene, hand hygiene, coffee etiquette, these things we practice I mean as a society, we have to alter our conduct all together because as a society, I always considered Indian society or even rather South Asian society as socially distant but physically proximate because we cannot stand in a queue without touching each other. But then we practice social discrimination based on caste, community, religion and all that. So, we have to simply reverse this from we have to believe that this is a socially agnostic virus. It can affect any one of us anywhere, any community, any caste. But what it does is we need to maintain our physical distance, which is alien to our general practice. So my appeal to everyone is we need to protect ourselves. protect others from getting infected. That is the first important thing. Then surveillance which you mentioned is critical and the surveillance has to be self surveillance as well that is as I said earlier, can I report myself my family members, my neighbors, and this surveillance really has to be in real time because governments are used to conducting surveys or Sentinel surveys which are which are useful in terms of detecting chronic ailments if there is a tuberculosis, or leprosy. You know, these are chronic cases of HIV AIDS, I mean, they will be there or cancer. These are there in the community for a long period of time. Whereas that doesn't happen with this pandemic short duration virus, either it burns itself out in 14 to 28 days or it kills the patient. In 14 to 28 days, so, I mean it is just too late by the time you conduct a survey, so, because you know we are used in our country to conduct surveys of the poor, the poor remain poor even after one year. So, you know even if you reach that particular person after one year, you are not going to miss out on information but whereas here I am free of virus in the morning, and by afternoon I get myself I catch the infection, and I am infected by evening. So, but I don't manifest symptoms for another five days and then I keep on spreading this infection. So, this is the uniqueness of this virus. So, what needs to be done is an active surveillance and this is similar to what the police do. You know, they keep surveillance on a suspect. And this is the strategy that needs to be adopted and i'm i've been drumming this into my own officials in mind State, this needs to be adopted across because this is something like a pandemic is really an insurgency a protracted, long term insurgency in which you don't use all you don't have an immigration. So you don't use all your weapons, your manpower at one goal, but incrementally gradually, long term prepare yourself, your hospitals, your doctors, your nurses and then surveillance which is 24/7 that means you keep a watch out 24/7 either actively or through the involvement of the community. So a lot of community involvement, self help group

involvement ASHA worker involvement, village volunteer participation in reporting cases becomes very, very critical.

Host: Talking about surveillance. The other thing that was touted as you know, a great way to sort of find cases, you know, around you and was the arogya setu app which itself became highly controversial because of various privacy issues. Have you seen any impact of using the arogya setu app? Has it been useful, say for state officials in monitoring cases? And is there like any sort of technological, other any kind of other technological intervention that AP has been doing? Or is it more like boots on the ground kind of a strategy?
Guest: You know, I mean, let me express my personal views here. Because not necessarily This does not mean I should very make it very clear that I'm not necessarily echoing the views of the government of Andhra Pradesh or the honorable Chief Minister of Andhra Pradesh. I'm speaking for myself in this conversation. I have actually installed Arogaya Setu like many other officials. However, I have not found it to be useful in identifying cases. So, I do believe that I mean technology has a lot of value. But this does not seem to really add value because ultimately it's human dependent. Now, if I feed wrong data then of course, it says that I am free from infection. So I do not know whether it has some validity. So I can only speak for myself and I have not depended on it. Neither have I been an advocate. It depends on the people to use, but I believe in actually, the boots on the ground, the people who can't have a dynamic contact with the households, specially in the urban slums and also in the rural areas, those migrant labor, come back and in the upper class middle class segments where people have returned from overseas travel. These are the and their contact. So contact tracing, active surveillance for symptoms, early detection, mapping of the high risk people under greater risk than the others. This includes those with other diseases like diabetes, hypertension, asthma, cancer, chronic obstructive pulmonary disease, tuberculosis. So, obesity has been found to be also a major instrument so these people ought to take care of themselves more elderly people, people beyond 60-65 years of age, people need to take care of themselves those who are immunocompromised because these are people who are likely to contract a severe form of the disease or manifest severe symptoms of the disease, those who may deteriorate very fast. So these are people who need to take acute care Reporting early surveillance. And I hope that we will be able to address this more actively.

Host: Do you think that community transmission has begun in India? And why is it that you think in your personal & professional opinion, do you think that if community transmission has started, why is it that the central government seems to be shying away from saying it?
Guest: You know, I don't like to be number one speculation but what I see here in my state, Andhra Pradesh where I'm familiar with the situation. I do see that there are several cases where we are not able to trace the source of infection, where we do not know how the person has got infected. Now, this is good enough to say that this virus is present in the community somewhere and then given the fact that, you know, we have now, there is no lockdown in place. Other than The Smart lockdown in some places and people are freely

roaming around, then there's a large number of people who seem to think that they are immune from the disease and our general sentiment and culturally, we believe that everyone else will die except for ourselves. So, you know, so, you know, I don't care really because I'm not going to get infected, everybody else does. So, I don't wear a mask. I go around with my friends, I sit with them and care for a long time and then I have a good likelihood of contracting infection. So, I mean, and also what is the big deal if there is a community transmission there is community transmission, I better recognize this early on even if it does not exist, I I fear that it exists and then take take appropriate measures, then my strategy becomes more broad based, more targeted, and then more effective. So in case if there was to be so I mean, I do not believe this is you know, some dangerous thing to admit that there is a community. I mean, I really don't understand what is a big fuss about saying there is a community transmission or not if there is very sameen if there is not, that's fine, I mean that is helpful, but I would like to believe that there is community transmission and plan accordingly act accordingly, which basically means again what I said earlier, more vigorous more active surveillance, early detection, vigorous rigorous testing, targeted testing, and then of course, the follow up there off. So, I don't think that this is a big deal. This is a non issue actually. I mean, if somebody is feeling shy, I think that if they do not know perhaps they are not well informed about it or they must have really believed that community exists somewhere else.

Host: A look at the statistics showing that Andhra Pradesh says it has more hospital ventilator beds in private then in the public sector, state allocation for health too has not been quite a lot. What have been some of the learnings for you as a state with regards to how the public health care is currently placed to tackle a pandemic? And also, what are some of the steps that the state has taken to ensure that everybody will have access to health and that the private will not say overcharged or will not, you know, yeah, will not basically charge an exorbitant fee.

Guest: I mean, the public health system in our country in general had been highly neglected, neglected Not today, but for the last 50 years barring few states and I would certainly pick up Kerala, which traditionally had a much better health system, Tamil Nadu which really done an outstanding work in the last 20 years. Now, I was health secretary of the United Andhra pradesh between 2006 and 2007. Then again I was principal health Secretary of the United Andhra pradesh between 2009 and 2012. So and during that period when I inherited the department, the public health system was in absolute tatters and it virtually didn't exist other than the hospital system because on the government's in India, there are two problems one of course, is we have never focused on the public health system that is primary health care, the mother and child health services, the control of the non communicable diseases. So, we have had a very weak approach to this, we never had a strategy and then the human resources management had been a mess and much of the time is spent managing the health professional some and their promotions, their increments, their disciplinary cases. So generally Andhra Pradesh, so we try to rebuild the system. In what I call what I started off as a revitalization, and the later it was named as

MARPU programme and changed building it basically from ground up and integrating the health with public health with preventive promote you and curative health services with nutrition. So a lot of initiatives were made. But then they were divided in 2014. And I do believe between 14 and 19, there was a big attempt in Andhra Pradesh and when I came to the residual state and then later I left to join the government of India. So during the last five years, I mean, with all respect to people at the helm of protest at that time, every single effort was made to privatize the health services and weaken the public health system completely neglecting them and systematically weakening the government hospitals so that the private hospitals can basically provide the healthcare. Now this resulted in an exploitative framework without regulation. And I've always been a bitter critic of this model, because when the world had settled particularly developed countries that settle this debate, private versus the public, that recognized health as a public good as a universal entitlement, and it should be publicly provisioned. Why whereas we in India had indulged in debate that the government must get out of health care and education we had that those are the primary responsibilities of the state apart from protecting its citizens. So I hold a contrarian view and I'm happy to report and share this, that the commitment of the present Chief Minister of Andhra Pradesh, Mr Y. S. Jaganmohan Reddy his agenda, his focus his drive, his programs center are around four important parameters. One is to help build it from the bottom up. Second is education building again, bottom up in the education in the public sector. Third, of course, is women empowerment including nutrition for the farmer, I think those are the fundamental pillars in that sense in that direction. In the last one year, we've been trying to build the entire system from bottom up. One is, he started off with actually empowering the ASHA workers. their salaries were raised from 3000 to 10,000 rupees, the doubling of the ANMs and the field levels and then adding the village and what Secretariat's, which is provided a large number of volunteers and an additional ANMs at every Ward and village level, building these PHC's modernizing them, providing them with the equipment, filling up to post training of the health functionaries. So these are some of those measures that have laid the foundation in last one year of shift of focus again back to the public health under his ambition is to create a model similar to the National Health Service of the United Kingdom with a family physician with three public health functionaries in every village, every PHC and every clinic in every with ANM sub center, every health wellness center in every village and the 104 service being the link between the Primary Health Service Center and the village health center and also creating the electronic health records. Now these are the processes which we have started and then you will see in the coming years that the complete transformation of the health system in our country in our state, sorry, and I'm very confident this will become the model not just for the country, but many countries, particularly in the emerging market segment. But let me conclude this by saying we have in the past three months, done not just the testing capacity, but also hospital capacity. Now we have five state level COVID hospitals, which are equipped with more than 5000 beds. There are 3800 of them in ICU beds, equipped with oxygen. We have 1700 ventilators. We have trained our doctors, we have requisitioned the private health hospitals, we created a number of district level COVID hospitals both in the private and the public. With specialist

care, we created a number of care centers at the primary level so that the patients can be brought there. Those who are asymptomatic and cannot be home quarantined because I've been a strong advocate of home quarantine for those who can afford, but those there are people who cannot afford to home quarantine the entire family lives in a small space, and they're huddled together. So in those cases, you'll necessarily have to bring them the high risk people who need to be hospitalized early. So we have built enough capacity in all these cases. And as we speak, the orders are issued, being issued by the government to open up all private hospitals, notify them as COVID treatment centers, and other than COVID treatment centers. And those mixed hospitals, prescribing specific protocols prescribing specific price for treatment, close monitoring by a team that would be monitoring them. So we would like to see a private health system that is equally complementing the government health system that does not exploit that confirm to the protocols of standard management of the COVID That raises up to the occasion and then says that we are part we are part of the part of the professional team that is responsible and responsive that we will not use this opportunity to exploit and make money, we will be ethical in managing the those who are in need

Host: what are the kind of implementation measures that will be taken to ensure that the private will not exploit what are the other steps that are being taken to ensure that you know enough equipment is going to be made available not just for COVID patients, but also non COVID patients?

Guest: First and foremost, let me say a few words about managing COVID cases. Now, if a person has no symptoms and he is not a high risk person, that person is best kept at home in home isolation, but is monitored closely by a health professional rather than be brought to a center. Now in case that is not possible, then that person must be brought to a center, and then again is monitored by a health professional so that he can be moved to a higher level. Second is if those with moderate symptoms and no risk person, I mean, that is that he doesn't have any comorbidities, that person would have to be admitted to a hospital, in the district court in hospitals that we have put in place where there is special scale where there are ICU beds where there's oxygen facility. And third, of course, for those with high risk coming already pre existing risk factors, or in severe condition now is these risk people must report very early as soon as they have the earliest of the symptoms because the people tend to deteriorate, and so they need to be hospitalized in an advanced care facility. Now, what is happening is actually the advance care facility now, my own observation and from the literature that I've been reading, The people really tend to be deteriorating for two reasons. I mean, this is an infection that primarily is targeting the lung tissues causing your viral pneumonia. Though I mean in a lesser number of cases there are other symptoms they may be diarrhea it is targeting the gastrointestinal system. There are some few cases they have reported even affecting the brain tissue, in some cases targeting the heart, the vital myocarditis but essentially in the majority of the cases, it is the lung tissue that is being infected. Now, the lung tissue there are two things that are happening. One is the disseminated intravascular coagulation which is coagulation in these small vessels which

exchange oxygen and carbon dioxide. Now what's happening in those cases is the carbon dioxide is going down but the oxygen perfusion is not adequate. Now what happens normally is when the oxygen perfuse levels go down in the blood, the carbon dioxide levels go up. And so, the brain immediately responds to brain tissue response, their sensory receptors respond to increase the carbon dioxide levels and the respiratory rate goes up, the person becomes disoriented and there is this deep distress in respiratory parameters. Now, this is not happening in this infection because carbon dioxide levels are not increasing while the oxygen levels are falling. Now, this is why it's very important to monitor the oxygen levels and then actively intervene or in these cases. So this 24/7 close monitoring at the bedside becomes critical in early detection of the oxygen levels falling because this is one of those paradox simple situations where this is what people are properly calling us hypoxia because the carbon dioxide is not building up. So breathing is not sensitive to falling oxygen levels until it is a bit too late. So this is one side. The other is where the body is reacting, its immune mechanism is reacting very violently suddenly it's keeping quiet but normally what happens is the antibodies get built up for a period of time in the bloodstream, and they fight against the virus but in this case, the lymphocytes are pouring into the lungs to fight the virus directly. And then those lymphocytes are accompanied with fluid exhilaration to the lung tissue. So lungs are getting virtually submerged. And the browning it's also the body fluids itself. Our immune mechanism itself is drowning the lungs and smothering the person to death. So these are the two important pathophysiological challenges that many doctors come in, at least in the literature as well as in reality. So this would require a very different type of management. That's what ICMR has been prescribing, as always I notice that ICMR wakes up late, I'm sorry to say this or it puts out wrong messages or not validated messages. Now these two require very careful monitoring, early detection, early intervention, proactive oxygen under pressure, and also administration of steroids And anticoagulants of the earliest while ensuring that the infection of bacterial infection does not get in. Normally what happens is that when there is a viral infection, it creates a medium in the lungs for invasion by bacteria, and it is a bacterial sepsis that actually kills the patients and many viral infections. Interestingly, again, in case of this particular viral infection, we are not seeing as much bacterial infection, but more of viral infection itself with the body reacting to it that is causing the death of the people. So, there is an initial apprehension that ICMR is yet to build this protocol. But whereas CMC vellore and the Tamil Nadu government across Tamil Nadu is practicing the, this protocol in which it is essentially is oxygen and then steroids and then low dose anti coagulants and then results in two be gravely promising, and I have requested my government also to follow these, this protocol. And I think it's important that we, the rest of the country, quickly look at it and the ICMR wake up to the realities of the field, and then also come up with this. So this is one part of the management. Now in this, the ventilators do have a role, but it has a minimal role, because I think what is much more effective is this force to nasal oxygen, which is supposed to be a lot more less invasive, because in many cases, the brachial tissue itself is fragile. So when you try to intubate it may even damage the clinical passage, instead of helping you may actually accelerate that then then we are also noticing that those who are

put on ventilators are not really coming back on and the mortality rates are very high. So I think People need to wake up early, put them on an oxygen monitor, the oxygenation monitor D dimers, monitor the ferritin levels, the various parameters that tell you that the lymphocytes are flooding into the lung tissue, or there isn't coagulation. So I do believe though I'm not a practicing clinician I'm working out maybe I'm experienced enough to understand these nuances. And I hope that the medical fraternity wakes up and then comes up with its own own protocols rather than experimenting with the patient says it seems to be doing now administering them with anti HIV drugs, giving them Remdisavir, giving them a series of antibiotics which are high, potent tertiary antibiotics where there is no infection justifying the antibodies, in fact, antibiotics in fact, when I look at the protocol that is being administered, even in my own state, some of the hospitals. I've been jokingly saying that it is potent enough to kill an elephant, let alone and let alone save a man, human life. So I think doctors have to be very circumspect. This is another incident, I'm noticing that the doctors and I this is a challenge I throw to the physicians who have not risen up and stood up and said that this is pathophysiology. This is the trajectory of this infection. We need to use these instruments, these medications, these methodologies, these tools to save lives, reduce infection, and this is a challenge I throw to all the physicians, all the professionals in India that they must raise up instead of being listening to the to the active warnings of the IAS administrators who tell them that by tomorrow, I want the virus to be eliminated by day after I want the virus to stop spreading. And then by 15th of August as the director general of ICMR has said that there should be no virus in India. And this disrupts this strategy and the clarity because when we need a long term strategy response, we cannot be driven by the sort of impulsive directors. So, I'm very clear. This is my advice or my suggestion or my thinking, but we need a more strategic response that is geared for the long term now coming to the private sector, private sector that is traditionally unregulated, and not regulated by itself as a hospital or by the medical professionals, where help is seen as a commodity that could be traded and that could be used to extract profits. This becomes a dangerous situation in a warlike situation and where you have a pandemic, which is very similar, as I said to any protracted insurgency. Now if strategic assets in a war like roads and railways and ports and airports are controlled by the private sector and the private sector says, unless you pay me a billion dollars, I won't let you use it. How would the country react, how would the government react, would it say go to hell and take them over. And we are witnessing a similar situation with private hospitals. My own relatives and friends have told me that some hospitals in a city like Hyderabad are demanding three lakh rupees up front payment per day and for treatment of people who are tested positive But have no symptoms. I mean, I think there's something seriously wrong. In my state of Andhra Pradesh, our Chief Minister is very committed to ensuring quality health care at a fair price in this state, and he has issued strict instructions if anybody breaching them shall be treated with the utmost exemplary action, which basically means that criminal action against the hospital, shutting it down for good and delicensing the doctors who are practicing in that hospital. So I'm very clear and my boss is very clear. My health functionaries colleagues are very clear that we, we are partners in this we need everyone to work together. We need the

private sector to supplement support. complement the efforts of the government alone cannot do this.

Host: Talking about ASHA workers- earlier when we had spoken to some ASHA workers from Andhra Pradesh they had also told us that they were not being provided with adequate safety gear while they were going for COVID tracing. And also for when they were also going for you know, educating the community about it. Also a lot of the ASHA workers and the village workers are also facing intense stigma from the community itself. How are you tackling this on the ground?

Guest: No, as far as the protection equipment is concerned, I think we have more you know, more of it now than earlier. So we are able to supply this personal protective equipment or masks to not only help functionaries but also to frontline workers like village volunteers, and the masks also to citizens. Every single individual has been supplied, three masks, three bits of, you know, masks that can be washed and reused in the state of and that's that was another initiative for the chief Minister he wanted everyone to be in. Now that i think the issue has been addressed. The part of the stigma is an issue, I mean is, is a long drawn process because in our society people seem to stigmatize people very early, and then ostracize them. And also if you mean, on a on a, again another personal note, I mean, the administrative system in our country is so structured to respond to short term crises. There is a cyclone there's a tsunami , there is a flood, there is a cholera epidemic, we respond effectively, our system is geared the standard protocols to manage them and then withdraw because then we can mobilize all resources not only the situation in which virtually This is a protracted low intensity effort. So we need to sort of re refine our own strategy Approach methodology. Because I mean, initially, it appears as if it lasts only two, three months, and then we'll be out of the woods. And then we'll all be fine in all like any other short term emergency. But now we know, notwithstanding the prescription or the direct diktat of ICMR, there will be no violence after 15th of August, I do believe that this is a protracted effort. So, we need to be still in that process of making a transition and I hope governments across the country and national government take note of this reality. And then draws out a very clear roadmap for the long term for education institutions, for the people for the social transactions, as well as for the commercial transactions so that the people are prepared for a long haul and don't live in this illusion that this is something we will Get out tomorrow and then be hunky dory again.

Host: For you personally and professionally, what have been some of the and and for the state actually, what have been some of the key learnings over the past three, four months, you know, prior to the lockdown after the lockdown after the opening of the Lockdown? What have been some of the key learnings for you when it comes to pandemic management? And do you think this is going to make us better prepared for any future pandemic? Do you think we as a country and Andhra Pradesh as a state is now better equipped to deal with another crisis like this?

Guest: The biggest lesson I have learned is the critical importance of the public health system. Tts effectiveness, its robustness, Its its outreach, its capacity, its commitment, its responsiveness, its connection with the community. These are very, very critical for the short term, medium term and long term. And that is why our Chief Minister has been committed to building this family physician concept that the person that every single family is mapped. It's electronic records are cloud based and its health records with privacy protection. So that, you know, everyone the doctor knows the patient, the family, its history, its difficulties, its diseases, its treatment trajectory. So it's so critical that you already know the people so that you can immediately support them on a sustained basis on a short term basis when a pandemic like this strikes. Now the country needs to recognize the other states need to recognize this. If you do not use this opportunity to build your public health system. I do not believe that we will be prepared in the next hundred years for any other pandemic or any epidemic. This is a one in a century or are one in a millenial opportunity but ought not to be missed to strengthen the health system, the professionals the education, the nursing care, the nurses capacity or the across the human resources management whatever is related directly or indirectly to the healthcare, including equipment and medicines or the capacity to produce supply deliver quality medicines equipment. So this is in my view critical. Secondly, is that we need to stop this debate, do we need a public health system or government financed healthcare system, our privately run healthcare system? I think this is the time to give up on this debate. We need a robust public financed government healthcare system from primary to tertiary levels. More importantly, we need a robust healthcare system in the village, in the urban areas, and in the urban areas. We don't have a system at all, at least in the rural areas we have a semblance of a health system. This is true across the country except in major metropolitan cities like Delhi and, and Mumbai, even there the outreach is quite weak. So it's very, very important that we build the public health system from bottom up. This is the time to recognize that health is a public good. It has to be publicly provisioned. We have to ensure universal health care. This is an opportunity to build the necessary infrastructure manpower.They fill their commitments. This is also time that we health professionals need to rededicate themselves that their main function, their main responsibility, and their main commitment is to the people There healthcare. And as Hippocrates said, that we need to be committed first and foremost, to the people and their well being, and not to the money. And so the private healthcare needs to recognize that it needs to be ethical. It needs to conform to quality standards, it needs to stop exploiting unsuspecting patients, they need to be greater transparency at all levels, in terms of what needs to be expected in pricing the care. So I think this is an opportunity to change a complete paradigm shift in which the primary role in delivering quality healthcare is vested with the government and health is treated as a fundamental human right. In fact, I would like to believe this must be included in the in the book In the constitution as one of the fundamental rights in Article 14, and I do believe that the private healthcare needs to be regulated, if it does not comply, the professional organizations of the Health Nursing, professional organizations should become more proactive, they should set the standards, they must conform to the standards, they

must enforce self discipline themselves. And so also the medical Council's both at the state level and the central level needs to be a lot more robust and vigilant. Otherwise, I don't think we would miss this chance. And I think we would miss this opportunity for a long, long time to come. And what I am saying is what we are doing in Andhra Pradesh.

Host: Now what are some of the measures that are being taken by the Andhra Pradesh government to ensure that health, healthcare workers themselves don't get infected? And what are the kind of mechanisms that are in place with regards to rotational mechanisms that you have, could you just give our listeners an insight into the lives of these doctors?
Guest: Okay, first and foremost, there is no shortage of personal protection equipment or the masks or the medicines, or the equipment in any of the hospitals, from the village to the tertiary and advanced care facilities, let me put that very straight that we have done everything that is possible to ensure that the health professionals and the frontline workers are abundantly protected. Because I mean, they are at great risk and I salute their services. And I'm proud of the work that they have done. And my chief minister has also expressed this commitment to every health professional. That's first and foremost and the second is that there has been a roster of help the deployment of the To ensure that they are given adequate rest, that they are not exhausted on duty and that they have enough time before they take up. When they rejoin in fact, it's a seven week and a seven week break(Dr Ramesh meant Seven day week followed by seven day break) and then restart seven days, seven days, we have recruited a large number of doctors and nurses. We are now recruiting a lot more now. Almost 9000 health professions are being recruited on a regular basis. This is the largest done in the last 50 years. Then we are also now ensuring automation so that in the ICU's, you have a centralized monitoring system. That is something which has been established as we speak. This will again reduce the contact between the seriously ill patients and the doctors. The frequency of interaction because of course an interface is inevitable, but the frequency can be reduced so that there's a centralized monitoring system. We're also setting up a tele-ICU, which basically means that there are very, very senior experts available for consultation at any given time by those in the ICU. Live in real time so that they could be a much better guidance. No, we are very conscious of the need for supporting the health professionals to keep their morale high, to nurture them, to train them, to skill them, and to constantly motivate them when working with them.

Host: The ambulances that were flagged off with 1088 ambulances, these are not specially for COVID care, right. I mean, this is for non COVID also or are these only for COVID?
Guest: No, no, these are regular ambulance services as well as mobile health units. And we will use For COVID, because you see what I'm saying? I mean, we have not stopped strengthening the overall health system. So we see this as complimentary. I mean, in the sense we have not sort of stopped doing things, anything other than COVID, that could be very dangerous. That's, that's the advice I have for everyone across the country. You can't have to be number one, invest in strengthening the overall health system, not just for the purpose of COVID. You have to manage the COVID of course, I mean, you have to focus

attention. But then there are people who are dying from other causes. I mean, people don't stop having heart attacks, people don't stop getting strokes, people will continue to have malaria, typhoid, people will continue on and women will continue to deliver, there will be emergencies. So these things should not be interrupted in any way or affected in fact, in quite a part of the country. I hear that things are seriously disrupted. So these things need to be restored and people need to pay serious attention to oneCOVID emergencies which are, which are much, much larger in a real way.

Host: I read recently that the Andhra Pradesh government basically said that, you know, in the next 90 days, almost everybody will be tested for COVID. Can you please clarify what that statement actually was?

Guest: Yeah, I mean, I think it is misreported in the media that it is not reported appropriately, rightly, in the media. And I really need to clarify this. I have not had an opportunity. This is not a static disease. This is not like diabetes or hypertension, that you test everybody. Now I can be tested in the morning and I'm negative, but I can be infected in the afternoon. So this is a dynamic rolling thing. So the CM never said, or nobody said that we will test everyone For COVID. What was said was that everyone will be screened for non communicable communicable diseases i.e. diabetes, hypertension, tuberculosis, coronary artery disease, if they are already right identified already or they are showing symptoms, this is a sort of a health survey. So, the people will be tested for those high risk cases so that it could be put into their electronic health records as a baseline data and in any way they are. Since they are high risk cases if they were to contract Corona or COVID virus, they would be referred very quickly to the hospital. So, what was meant was screening everyone for comorbid conditions, not for corona, because if I were to screen 5.8 crores people that is what I have. Let us say six crores if I have to spend 2500 rupees for every one of them. You look at the cost , it is quite a lot of money. So, we will test those. As I said through effective surveillance, targeted testing. We have the capacity to test those who need to be tested.

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