



How We Used AI to hear Health Beyond Hospitals

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Acknowledgments

In addition to the invaluable contributions from the wider Video Volunteers team, deepest thanks are extended to the Community Content Creators, whose insights and personal stories have enriched this report with authenticity and lived experience.

This report is not merely an exercise in data collection; it reflects a collaborative process—co-created alongside the communities themselves. The aim is to ensure that their voices are respectfully represented and central to the narrative. It is hoped that this report honours their experiences and meaningfully contributes to the broader dialogue on social justice and community-driven change.

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Introduction



What does it really mean to ask someone about their health? We often ask how far the hospital is, whether medicines are available, or if an ASHA worker visits. But the real answers are often hidden—in broken roads, caste-based exclusion, lack of clean water, domestic restrictions, or fear of government services. Despite years of funding and data collection, we continue to fall short—not because people aren't speaking, but because we aren't asking the right questions.

The COVID-19 pandemic made visible what many already knew: that India's public health system was never equipped for the most marginalised. But it also raised a bigger question—what if health isn't just a sector, but a symptom of deeper structural inequality?

This study began with that question. We analyzed 472 transcripts of community videos produced by Community Content Creators associated with Video Volunteers across 11 Indian states. While 85 were explicitly tagged under "health and wellbeing," the remaining 387—on education, livelihoods, caste, gender, environment, and governance—kept circling back to health in unexpected ways.

To make sense of this dataset, we deployed an AI-powered research bot to scan transcripts for recurring themes, extract direct quotes, and identify cross-cutting issues. This bot was built pro-bono for us by a tech entrepreneur, Shiva Kommareddi. What would have taken months by hand took just a few days—freeing us to go deeper, not just faster.

What emerged was not just a picture of healthcare gaps—but of everyday lives shaped by power, exclusion, and resilience.

The report weaves a narrative of real-world experiences, drawing heavily on the words of the people most affected by systemic failures. Their quotes—presented here exactly as they were transcribed—serve to ground our analysis in lived experience rather than theoretical abstraction.

Our research findings indicate three key insights:

- Listening to communities is not just ethical, but essential to effective policy
- Health disparities are shaped by power, access, caste, gender, and governance—not merely by medical interventions
- Intersectional, interconnected approaches yield better results—because health isn't just a department. It's a life story

What 85 Health Videos Say About Health



Although every region has its own unique challenges, some truths cut across geography. The 85 videos tagged under “Health” reveal some core insights into how people actually experience the public health system. These stories are not about rare breakdowns. They are about everyday survival in a system where people are often left to navigate around gaps in care, rather than receiving the support they deserve.



We Can't Even Use the Labour Ward

When Infrastructure Becomes the Barrier

The term “broken healthcare” is often thrown around, but what does that look like to someone inside the system? For many, it means delivering babies in unsafe buildings, without hot water, female doctors, or functioning bathrooms.

In Kamdara, situated in Gumla district of Jharkhand, a CC Shanti Kumari Baraik captured the condition of the Community Health Center in the area. The medical professional said, **“There is a shortage of staff and doctors... we can't use the labour ward... we don't have ultrasound and sonography facilities... no caesarean facilities... Even all four geysers are broken.”**



Such conditions forced a pregnant woman in her final month in Barabanki, UP, to avoid the nearby facility and the reason she shared was- **"Because there are no female doctors here."** The doctor responsible for 1 lakh people admitted: **"Women patients don't feel comfortable talking to me... We need at least one more doctor."**



These are not complaints about poor service. They are warnings about a system where basic dignity and safety are absent.



We'll Die of Hunger Before COVID

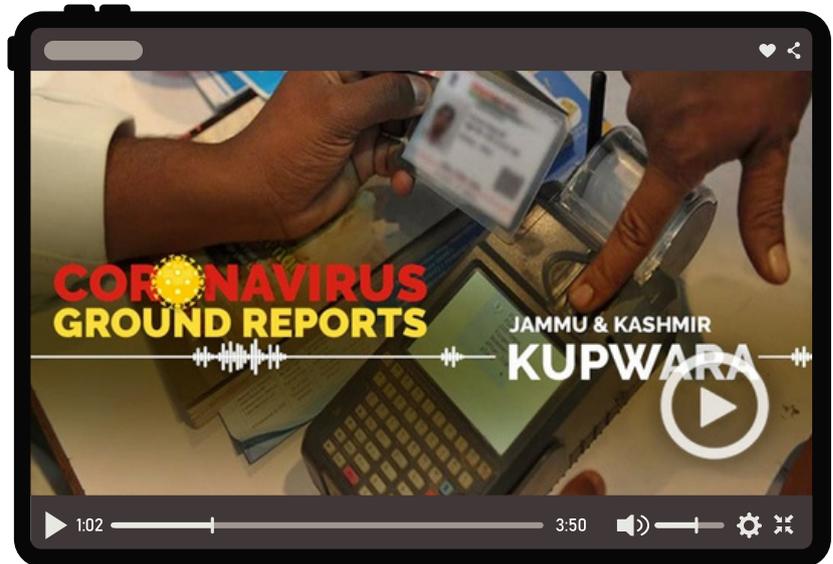
Pandemic Policies That Made Things Worse

COVID-19 didn't create new health challenges—it made the existing cracks impossible to ignore.

In Kashmir, Community Content Creator Pir Azhar captured one of the most troubling contradictions. While the

government suspended biometric systems for its own staff to prevent virus transmission, poor families were still required to give fingerprints for ration.

“Do you want the whole village to get infected after giving their fingerprints? Or do you want the public to suffer and die without food supplies?”



In Maharashtra, quarantine itself became a risk:

“We had to clean the rooms ourselves, fetch water from communal taps... Santosh, our neighbour, tested positive and was taken away. His small child is now alone.”



COVID showed that when systems break, the poor didn't just face the virus—they faced confusion, neglect, and contradictions that put them in even greater danger.



We Are Called Warriors, But Treated Like Ghosts

The Real Lives of ASHA Workers

ASHA workers (Accredited Social Health Activists) are India's frontline health workers who serve as the crucial link between rural communities and the public health system. Often the first and only point of care in remote areas, they provide essential services like maternal health support, vaccination tracking, and health education. But their testimonies reveal a system built on their unpaid labour, delayed payments, and lack of recognition for their work.

In Kalikapur region of West Bengal, Sourav interviewed some ASHA workers and they said:

"We are working hard but we are not being remunerated accordingly. Our fixed honorarium is 4,500 plus we should get 1,000- 2,000 as incentive. We don't get this money, and then we are also expected to buy our stationary. Our house runs with this money—how do we sustain ourselves for the full month?"



Minara Begum in Howrah reported a similar issue:

"We received nothing from the government except 2 masks... People ask us to go away—they think we carry COVID. But we still go out."

[WATCH VIDEO](#)

In Odisha, one of the ASHA worker, Bina Dei described working without a schedule, pay security, or rest:

"I don't know when I'll return—sometimes it's night... Our remuneration does not match our responsibility."

[WATCH VIDEO](#)

In Morena, Madhya Pradesh, the struggle was not just financial—it was political:

“Is ₹32 a day enough to run a family? One can’t even buy a one time meal with this amount. What will we do with such a small amount? How do we feed our children?”

For two years we have been visiting Bhopal with our demands to the chief minister but none has been heard. If there is such harassment, why should we vote? Why will we elect someone?”

WATCH VIDEO



And yet, these workers keep delivering. In Rajasthan’s Sawai Madhopur, ASHA workers helped convince a vaccine-skeptical community:

“They said, ‘we’ll die if we take the vaccine.’ But we convinced them. Now 90% are vaccinated.”

WATCH VIDEO



These are not stories of volunteerism—they are stories of state dependence on unpaid, overburdened labour.



**The Building
Exists, But
Nothing Else
Does**

Infrastructure Without Accountability

In some places, health centers exist only on paper. In others, they are collapsing around patients.

In Ranchi, Jharkhand, a health worker shared:

“Pieces of the roof keep falling down... We’re working in two cramped rooms with no water supply.”



In West Champaran, Bihar, a ₹4.98 lakh Health Sub-Centre has never opened:

“It has been closed since it was built... We lost our 24-year-old daughter. Had this center been functional, she might have lived.”

WATCH VIDEO 

In Barabanki, UP, an officer described a functioning-but-fragile health facility:

“We have equipment but no staff... A government job is not just a job—it’s a hope for the poor. Strengthen that hope.”

WATCH VIDEO 

When infrastructure exists but is unusable, the result is not just poor service—it is lost lives.



They Asked Me to Leave Because I’m Muslim

Discrimination at the Clinic Door

Health is not just about access—it’s about who you are when you show up for care. Caste, class, and religion too often dictate the quality of treatment.

In Mumbai, Shabana Ansari helped a Hindu woman get to a hospital for delivery:

“When I took her to the hospital, they raised the Hindu-Muslim issue. They said, ‘You are a Muslim and she is a Hindu... How can I take your signature? Call her husband.’ I contacted her husband many times and asked him to come, saying my signature wasn’t being accepted. She was



in extreme pain and crying a lot. I couldn't bear to see her tears. As a human being, it happens in such situations—I'm a woman too, and I understand the pain. I said I was ready to give whatever documents they needed. But they kept saying, 'You are a Muslim, you'll run away.' Why would I run away? If I brought her here, why would I run? It was late in the day, and by then the situation was critical—if the delivery wasn't done in 15–20 minutes, the mother's life would be at risk. Finally, they agreed, and the doctors performed the operation."

In Jharkhand, Rekha Devi, from the Bhuyan community, died after being discharged hours after delivery:

"Rekha was sent home in a leaking vehicle. She died on the way... We paid ₹650 to the nurse."

[WATCH VIDEO](#) 

And in Odisha, Deepak Mallick, a Dalit youth, was brutally assaulted:

They made me kneel down and beat me... Shopkeepers refuse to sell us anything. We're not allowed in the temple."

[WATCH VIDEO](#) 

These stories make clear: systemic discrimination does not pause for emergencies. It decides who lives with dignity—and who doesn't.

Across all five themes, one truth is constant: the people are adjusting to a system that no longer adjusts for them. From unsafe buildings to exhausted health workers, from social stigma to absent infrastructure, these stories expose a reality that public health data often fails to capture.

What 387 ‘Non- Health’ Videos Say About Health

The most revealing insights often came from where we didn't expect them. Of the 472 videos we analyzed, 387 were not tagged under "health." They focused on education, livelihoods, caste, governance, gender, and environment. But health kept showing up—quietly, repeatedly, and unmistakably.

In videos about school closures, we heard how vaccine myths spread when children were out of classrooms. In stories about daily wage workers, people skipped treatment because missing work meant losing income. Where women couldn't travel alone, reproductive care—even when available—remained out of reach.

Caste discrimination appeared in the form of families barred from public water sources, leading to disease. Poor roads delayed pregnant women from reaching hospitals. These videos weren't labelled as health issues in the VV database—but they were about health.

AI helped surface these connections. A human researcher might not have reviewed 387 non-health videos for health clues. But the machine did, and what it found was clear: health isn't confined to hospitals. It lives inside every structural barrier, every social injustice.

We cannot fix what we don't see. And if we continue treating health as a standalone issue, we'll continue missing the realities most people live with every day.

10 Tips to Listen Better in the Field



In the age of qualitative data, a growing number of people, like NGOs, journalists, researchers including CCs associated with VV are out on the field, gathering stories and asking questions. . But how we ask, listen, and connect the dots can shape what we learn. Illness is not just a medical issue—it's shaped by caste, gender, livelihood, governance, and daily dignity. Whether you're designing a programme, reporting a story, or conducting a community interview, here are 10 practical shifts that can help uncover the deeper realities behind health challenges.

01 **Ask Bigger, Deeper Questions**

Move beyond symptoms. Ask about what keeps people from seeking care—be it distance, cost, discrimination, or fear. Instead of “How often do you visit the clinic?” Ask: “What stops you from going?”

02 **Apply an Intersectional Lens**

People live at the intersection of caste, class, gender, religion, and age. These shape both access to care and how care is delivered. Ask: “How does being a Dalit woman migrant affect access to reproductive care?”

03 **3. Listen Like It Matters**

Don't just collect responses—listen for what's unsaid. Be non-judgmental, create safe spaces, and validate people's experiences.

- 04 Go Beyond the Surface**
Follow up on every answer. Dig into causes—financial pressure, stigma, bad past experiences. Real insight lives beneath the first layer.
- 05 See Systems, Not Just Individuals**
If someone doesn't follow medical advice, ask why. Don't blame—understand. Look for structural barriers like unavailable doctors or lack of transport.
- 06 Redefine What Counts as Health**
A broken road is a health issue if it blocks access to a hospital. Domestic violence is a health issue with both physical and mental effects.
- 07 Equip Field Teams for Reality**
Train teams to navigate social hierarchies, ask sensitive questions, and build long-term community trust—not just extract data.
- 08 Make Communities Co-Problem Solvers**
Ask people what they need and what they think will work. Support local innovations like mobile clinics or self-help groups.
- 09 Track Failures and Demand Accountability**
Support communities to monitor local health services, document failures, and follow up with authorities.
- 10 Connect Health to All Your Work**
If you're working on education, livelihoods, housing—integrate health. Everything is connected. Your programs should reflect that.

Conclusion: How We Understand What's Broken Must Change

This study began as an inquiry into health. But what emerged was not just a health report—it was a deeper recognition of how all social issues are connected, and how we've been looking at them in fragments.

By analysing 472 community videos—only 85 of which were tagged as “health”—we uncovered what communities have always known: that health is shaped by caste, income, mobility, gender, corruption, and infrastructure. The remaining 387 videos, seemingly unrelated to health, showed us that a broken road, a missed wage, or a lack of clean water is often where the real health crisis begins.

This is more than a new data method—it's a shift in perspective. What if we studied education, housing, or livelihoods the same way? What would we learn if we listened across labels, and trusted people's lived experience as the primary evidence?

We invite all stakeholders to deeply engage with these unfiltered accounts—not just to validate programs, but to reimagine how we define problems in the first place. Because the people closest to the issue are also closest to the answer. And they've already started telling us how to see things differently.

We just have to listen.



Video Volunteers is a global organization dedicated to advancing the right to voice. VV amplifies marginalized voices to ensure social change and policymaking are grounded in community-led, participatory insights from the ground up.

