

The Health Equity Course

Jaipur, Rajasthan

Theme: Building Health Equities to Meet Public Health Challenges Through Community Engagement

Day 1

Oct. 4, 2023,

Prayas organized and commenced a 10-day long health course, starting on Oct. 4, 2023. The session started with the participants singing the songs, to begin the tone for rest of the day. Khushbu and Monica from Uttar Pradesh sang *Tu Zinda Hai*, Yashoda sang *Mai Tumko Vishwas Du, Tum Mujhko Vishwas Do*.

Ms. Chhaya Pacholi, Director and Mr. Vijay Singh from Prayas were the coordinators for the session. Before initiating the session, Pritam ji inaugurated the session by lighting the candle. She also talked about How health and development are interlinked at local and global level- like the WHO, international treaties and health goals and policies and how they influence the workings of healthcare systems and related advocacies of the NGOs. The medicinal and healthcare development are not limited to one community, one area or one community. The diseases and their medicines are global. It is meant for all, across the world and nations.

Ms. Chhaya and Mr. Vijay Singh initiated the session with an introductory activity. The participants were provided with a pink and blue paper. On pink paper, the participants wrote what their expectations were from this workshop in terms of learning. On blue paper, they wrote what would their contribution be to this workshop. Their expectations ranged from learning the Right to Health in the state of Rajasthan, learning from the best health practices, learning new information on various diseases, and enhance and expand their own information and knowledge base when it comes of health services of all people, especially the women. They shared their expectations and potential contributions to this course, with the larger group.

Objectives of the course:

1. To develop Youth leadership in the field of public health
2. To identify how health and development are interlinked at local and global level.
3. Basic principles of Public Health, health equity and health rights
4. Looking at health from the lens of social determiners, and not just medical/disease-based lens. and developing community-based models to tackle the challenges in public health system.

5. To analyse the effect of health policies, laws and mechanisms on the community.
6. To understand the relevance, importance and principles of community-based groups, and to develop effective ways of capacity building of such groups.
7. To develop effective practices to enhance the community participation in local administrative bodies.
8. To understand the importance of effective communication skills and strategies to bring out the social and behavioural changes in public health.
9. To develop the basic understanding of the process of public health related social audit and social research.
10. To develop the skills of participatory approach in public health programs, trainings, and organizational management.
11. To develop one's perspective and values to become a better and effective public and community health and development worker
12. To be able to formulate one's own work plan based on the information, knowledge and skills gained in the curriculum.

Principles of the course:

- Participants will be responsible for self-learning as well as learning of the others.
- Participants will play an active role in developing the course, and will adopt a participatory approach in conducting the session.
- Participants will share their thoughts, and experiences and will learn from each other in groups.
- These processes will enable them to understand the importance of strengthening community and community-based approaches through participatory approach.

How to focus on the 'Do'?

The participants discussed the roles and responsibilities of the group members, and divided these responsibilities amongst themselves. They developed an action plan and identified the sets of responsibilities and roles to be taken up during the course:

1. **Venue/Residence Management:** Sitting arrangement, material (chart paper, board, stationary), ppt, cleanliness, washroom hygiene

2. **Facilitation-** Organization, registration, participation, time limit, consent in group activities, energizers and (cultural) activities
3. **Documentation-** reporting, recap and feedback-challenges and suggestions, processes/models of healthcare systems, photos.
4. **Food and beverages arrangement/Health and medical needs-** 3 times meals, beverages and water

Rules:

The participants decided the rules to be followed for the next 10 days:

1. Abide by the time
2. Developing support and coordination between the participants
3. Shoe management
4. Use your phone only in case of emergencies. Keep it on silent mode.
5. Cleanliness- hall/residence/mess
6. Inform the executive team and Vijay Singh Ji in case they need to go somewhere
7. Do not interrupt the session. Raise your hand before raising your point
8. Do not disturb the environment, students and other staff in Bodh
9. To listen and respect others' opinion
10. No unsolicited/discriminatory comments
11. Do not leave the campus
12. Maintain confidentiality
13. Try and resolve the conflict
14. Do not cause disturbance to your room partner- avoid long calls at night.
15. Maintain the cleanliness in the room
16. Keep the time in mind when tending to personal business.
17. Ensure that everyone feels inclusive through your behaviour, conversations, and language.
18. All decisions should be consensual.

After the lunch break, there was another activity to induct the participants back into the course. They did a quick recap of what they had done since morning. The next task was to decide the sessions that would be conducted and when, for the next 10 days. The participants then shuffled their seating areas. The participants then fixed the schedule unanimously.

Days	Session 1	Session 2	Session 3	Session 4
Day 1	Presentation by the participants	SDGs and Health	Health and its determinants	NA
Day 2	Healthcare processes/mechanisms	Privatization and health insurance	Globalization and Health	Access to Medicines
Day 3	Local Field work			
Day 4	Jaipur Darshan			
Day 5	Community participation	Right to Health	Models of community participation	Need and rights-based approach
Day 6	Gender and reproductive health rights	Mental Health	Occupational Health	Health of Persons with Disabilities and rare diseases
Day 7	Health information and communication/Advocacy and networking	Challenges in accessing health services	Social research and audit	NA
Day 8	Our role in public health leadership	Building leadership for community health	Challenges on the field	Preparing Action Plan
Day 9	Presenting Action Plan			
Day 10	Assessing the course	Convocation ceremony.	NA	NA

After deciding the calendar and agenda to be covered each day of the course, the participants were given a pre-assessment form to fill. The form had four sections: Health, development, community and leadership. The participants filled the form for 30 minutes before dispersing for the tea break.

After the break, the participants assembled. Ms. Chhaya, the coordinator, discussed the questions in the form with the participants to share the perspectives. Due to the time constraint, only first section of the form, i.e., Health, was discussed. The questions were engaging, and all the participants shared their stance.

At the end of the day, Ms. Chhaya shared some tips and pointers for the participants to keep in mind for the presentation next day. After that, Mr. Vijay Singh and Ms. Chhaya informed the participants about their groups for the tasks to be taken up in the upcoming 9 days. As the last activity for the day, the participants shared their feedback and suggestions pertaining to the course, the activities, and rest of the participants, with the Prayas team and with each other as well.

Day 2

Oct. 5, 2023

Today groups commenced with their responsibilities. The day started with the members of Facilitation committee singing a prayer to mark the beginning. They then invited the Documentation committee, who then encapsulated the previous day's activities and learnings. The Facilitation team, before starting the presentations of the participants about their work and organization, set the ground rules and time limits for presentations, and democratically decided the sequence of the ppt presentation alphabetically. Each presentation was 15 minute long, with 15 minutes of presenting and 5 minutes for Q&A session. The participants were also giving feedback. The participants were also asked to identify a short-term goal which they would like to work upon by developing an action plan on the same goal.

Mr. Narendra ji, the speaker for the session, addressed the participants, acknowledging the hard work they have put over the years working in the communities. His session covered the understanding of determinants of health and what comprises of health equity. He said that the marginalized groups live on the fringes socially and economically, and that existence of powerless determines the existence of powerful. And the rich keep the poor under their thumb to maintain the status quo. In the initial few minutes after the session started, Ms. Chhaya and Mr. Vijay Singh conducted an activity where they asked the participants to rate the availability and quality of health services in their area of work. As part of the activity, participants shared their experience and understanding of accessing health services, and why they rated it such. Their reasons ranged from poor infrastructure, lack of cleanliness, mice manifestation, lack of equipment, lack of services and their access, locked hospitals, poor behaviour of staff, lack of hospital staff and specialists in the hospital, etc. Mr. Narendra asked the participants what the determinants of a healthy life were. They all unanimously arrived at clean water, balanced diet and clean environment as the determining factors. The participants were then divided into two groups. They were asked to discuss amongst themselves within their group and identify some aspects where one could observe the differences and discriminations in accessing health services. Health indicators differ from one geographical unit to another, internationally, nationally and at other smaller geographical divisions. These factors could be influenced by the education levels, geographical location, gender/gender preference, financial levels, situations, administrative factors, access to information, employment status, caste, language, sex/sexual orientation, disability, sex work, old age, etc. He ended his session with the words that no matter which of the above categories one may belong to, everyone can cast a vote of an equal value.

The final session was conducted by the resource person Mr. Vikram Singh Raghav, advisor to UNICEF on SDGs. He started his session by providing some population statistics on Rajasthan to put things into perspective. He traced the evolution of 8 MDGs into 17 SDGs. He informed that the Indian government took some critical policy steps and introduced new policies to fulfil its commitment to the MDGs. In 2015, when they sat to reflect on the set targets and coordinated efforts that were made to meet those targets. When the nations of the world

developed SDGs, they also acknowledged that these problems were actually the symptoms of this morbid world. SDGs were aimed at 5 Ps-

1. People,
2. Propriety,
3. Planet,
4. Peace and
5. Partnership.

Panchayati Raj categorized the 17 SDGs into 9 Panchayat level commitments and goals, meant and tailored to fit the local requirements and understanding of people. He said that SDGs can be broadly categorised into 3 aspects, standing on the solid pillars of social, economic and environmental justice. The participants were then divided into 2 groups wherein they discussed the SDGs with the lens of these three pillars, and identify how they influence, or are influenced with health. All the participants looked at the SDGs more like an interconnecting web rather than existing in silos.

Group 1 could identify how health or the lack of it a result of poverty and hunger, and how quality education, gender equality, clean water, clean energy, and economic development stemming out of dignified labour could elevate the living standards of people by means of reducing malnutrition, increasing awareness through means of information, improving mental health, reducing sexual violence, providing employment and dignified wages for dignified work.

Group 2 drew connections how lack of inequality could ensure better medical services for all, how sustainable cities and community development would ensure better employment, which in turn would ensure health. It further drew connections of how fulfilling environment-based goals would facilitate better health- mental, physical and social, and that global peace also ensures individual security and thus, individual peace.

Lastly, the participants shared their feedbacks and learnings for the day. They shared that they now understood better the 17 SDGs, the idea behind them, and their evolution after an elaborate and informative session with Mr. Vikram. Most feedback was about the lack of time management, lack of representation, non-compliance with rules, etc.

Day 3

The third day started with the song “Geet Gaa Rahe Hain Aaj Hum.” The facilitation team asked the documentation team to recap the activities of the previous day. They did it creatively through the set up of a press conference, where one of the members asked the other member questions about the activities that happened. The other participants also shared their experience and learnings about the same.

The first session was on processes of health services, conducted by Dr. Mangal, IIMR University, Jaipur. He said that India has seen a growth in the healthcare and its management, and that being healthy does not imply mere absence of illness, but that health should be looked holistically. It is responsibility of all, the man, the society and the government to ensure the healthy living and outlook of the individual, with the accountability of government, as India is a welfare state. He said healthcare access is threefold Sir Joseph Bhoore Committee in 1946. An international conference in 1978 on primary healthcare presented the proposal for improving health for all in rural and urban areas. They proposed a rural healthcare infrastructure with a lot of specialty and expertise, with proper means at the disposal of hospital. In 1978, the major focus of healthcare was immunization. In 1984, a policy for health and healthcare was written, which had some program- National health program, etc. in 1992, A need for new health policy was felt, and thus came a new policy in 2002, acting as the guiding document for healthcare initiatives in India. Eventually, the focus shifted on population, and it was realised that population is not a bane every time. This directed the kinds of programs that were being run from 2005 onwards, for example, Reproductive and Child Health Program, and National Rural Health Mission, now known as National Health Mission, encompassing both, rural and urban, and handed over the autonomy to the couples about family planning. In 2014, Universal Health Coverage was done under Ayushman Bharat- PM-JAY.

The participants were then divided into groups, where they were expected to identify the inefficiencies and suggestions to overcome them.

Following challenges in PHC and their solutions were identified:

1. Medicines are not stocked/restocked properly, or arrive very late after the requirement is registered.
2. Usage of hospital resources like ambulances for personal usage, so ambulance should be available 24*7, so that any other mechanic issues pertaining to hospital requirements and equipment can be resolved properly.
3. Misbehaviour of staff- rude way of talking creates discomfort and apprehension amongst patients, especially pregnant women.

4. Absence of medical staff from the centre. The solution is to ensure biometric and regular visits from the authority.
5. No treatment available in emergency cases in PHC
6. Behavioural changes are required for better access to emergency services etc.
7. No separate room for adolescent girls to ensure their privacy and comfort.
8. Lack of accountability towards total budgeting and fulfilling the budget needs.
9. Lack availability of blood through blood bank.

The budget is not used properly. But the actions and steps taking in this field to ensure the availability of best medical services, have been taken, and is a positive step. People are often forced to indulge in out-of-pocket expenditure for one's own health, but it is the state's responsibility as it is covered under welfare.

Next session was taken by Ms. Chhaya, who talked about the government and private health mechanisms, and emphasized that around 60-70 percent people are dependent on private healthcare services. She discussed that while corporate hospitals are too expensive for common man to afford, people accessed private clinics, small hospitals, and trust hospitals. Small private health services open up in rural/semi-urban/urban areas to meet the lacuna of demand left by inaccessibility or inefficiency of services of government healthcare systems. Corporate hospitals focus on who can spend, as for them, the return on investment that they make should be high. She talked about PPP model- and gave some examples like Swasthya Bima Yojana and 108 for ambulance.

The participants then reassembled themselves in the old groups and were asked to identify pros and cons of Private hospitals (qualified and unqualified) and PPP.

The pros and cons identified based on the service type are as follows:

Hospital/Service	Pros	Cons
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Qualified Private Practitioner	1. Better health services available 2. Better public relations while the treatment is on 3. High-tech ambulance and other services available 4. Cleanliness 5. Services are available 24*7 6. Online counselling and home counselling are available 7. Lesser time	1. Expensive services impacting patients economically 2. More than required medicines 3. No regulation and monitoring 4. Misleading medical practices to mint money 5. Extra charge for private services like ambulance 6. Less respect for patient's rights 7. Unavailable in rural/remote areas.
Unqualified Private Practitioner	1. Ease of access 2. Economical 3. Option to pay later due to informal/personal structure 4. Primary treatment 5. Home consultation	1. May misdiagnose 2. Unscientific treatment without proper check-up 3. Misleading/misinformative 4. Unclean surroundings 5. Dissemination of redundant drugs.

PPP	1. Availability of medical staff 2. Quick treatment 3. Cleanliness 4. Free treatment (Health insurance) 5. Grievance redressal mechanisms	1. Only some hospitals have been marked 2. Unethical use of insurance by hospitals 3. Limited scope of health insurance in terms of coverage 4. Hiring untrained staff 5. Complicated paper work for patients 6. Overdependence by government may crash the system in terms of conflict
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After the break, participants Deepak and Swapnil presented the status of healthcare system in Maharashtra. They covered issues like overpricing, especially during Covid-19, the status of execution of policies and acts like Maharashtra Nursing Act, and challenges in their implementation.

Next session was conducted by Mr. Narendra. on access to medicines by all citizens. He clarified the difference between vaccination and medication, working on the principle of prevention and cure respectively. He informed about the clinical trials that medicines and vaccines go through, about the patent, universal name of the vaccine, and generic versions of the vaccines available in the market. He also informed that while most medicines available in the market are fake and old, the medicines available in the hospitals, specially government hospitals, have the best quality of medicine stock available, which is generic in nature. He then asked the participants to think of the ways they could promote the use of medicine and increase awareness about it in the community.

Ms. Chhaya conducted a session on globalisation of medicines. India is 3rd largest exporter of medicines across the world, and 1st in generic medicines. She pointed out that if medical healthcare was free for people, like it is in the state of Rajasthan, it would take away a lot of burden out of a common man's pocket in terms of out-of-pocket expenses, reducing them significantly by 70 percent, with all the medicines, tests, and processes like chemotherapy, available to the citizens for free. All the participants shared their understanding of globalisation. After that, Ms. Chhaya delved deeper into what globalization meant, and what did it mean in health and medicinal aspects. After that, Ms. Chhaya, and Ms. Yayoi facilitated a debate on globalisation between the participants. The team in favour of globalisation gave

arguments that globalisation supporting export, increased value of border, increase foreign funding to NGOs to work better on nutrition and health, better access to medicines, increased access to technology, saving time, increased tourism, increased economy/GDP, access to arms and ammunitions, abroad studies, better options to do things online, for example in COVID, sharing the inventions etc. The side against globalisation gave their arguments in context of privatisation, increasing unemployment and poverty, diseases, differences, increased gap between the rich and the poor- country and its people, loss of culture, increased cybercrime, increased migration, harm to wildlife and environment, brain drain, harm to small businesses, increased pollution, trafficking, bad health practices like substance abuse, junk food etc. After a lot of to and fro, questions and answers, the teams were asked whether they were still in disagreement with the opposition team, prepared their conclusions on the basis of their discussion and reflections. The activity ended with a focus on effect of globalisation on medicine and health, with discussions around female body, surrogacy, and right to choose.

Day 4

Session 1: Visit from Brick Kiln Workers, Balwadi teachers (CLRA)

The day commenced with an energetic song led by Ms. Khushbu and Ms. Varsha, setting a positive tone for the day. Following the song, the recap team initiated a reflective session, recapturing the essential learnings and activities conducted on the previous day. This recap session was centered on self-reflection, goals, and potential solutions.

- 1. Rekha:** She highlighted that female workers are often unaware of their rights, face challenges such as the absence of bathing facilities, washrooms, and fixed work hours. They have access to PDS ration and the "One Nation, One Ration Card" scheme, but accessing government schemes without proper identification like Aadhar remains a challenge.
- 2. Suraj:** As an activist working for brick kiln workers, he shed light on the bonded labor-like conditions they face, being unable to leave and having to leave family members behind for insurance purposes. Suraj emphasized the poor living conditions, extensive work hours (14-15 hours per day), and the challenges faced by their children in accessing education, clean water, and healthcare. He noted that they have to arrange their own medical treatment, and during pregnancy, female workers often prefer returning to their native villages for deliveries. Discrimination and challenges persist when accessing the healthcare system, and they advocate for better wages. Suraj Ji further elaborated on the challenges faced by brick kiln workers, including violence, lack of access to education, clean water, and healthcare. Discrimination and challenges during pregnancy and accessing healthcare services persist. He pointed out that brick kiln owners have a union and often threaten workers and their families when they demand their rights. Owners do not engage with unions, viewing them as a source of potential demands. Owners also resist engagement with social workers, and violence from owners is a significant obstacle to addressing labor issues. Activists often have to reach out to laborers in their native villages. The labor rates remain exceedingly low.
- 3. Sarvesh:** A former brick kiln laborer, Sarvesh shared his experiences, emphasizing that wages are at the mercy of the contractor, who modifies rates according to convenience. He also mentioned the difficulty his children face in accessing education due to constant migration.
- 4. Rameshwar:** A brick kiln worker for over a decade, Rameshwar expressed concern that his children struggle to access education due to frequent moves. He echoed the sentiment that wages are arbitrarily determined by contractors.
- 5. Ms. Indra:** She discussed the challenging conditions in brick kiln settlements, where most sites are on rented land with no infrastructure, electricity, washrooms, and are located away from main villages near alcohol shops. Medical facilities and nutritional support are largely absent. CLRA has established Balwadi centers in Ajmer and Bhilwara.

They conducted surveys in these settlements, collecting data on pregnant women, children aged 0-6 years, and those aged 6-14 years. For the latter, they attempt to enroll them in schools and encourage their association with the Balwadi through school rather than the brick kiln. Owners are wary of such surveys and often threaten Balwadi workers.

Due to the lack of documentation, children in these settlements face challenges in accessing nutrition, education, and other facilities. In response, Balwadi workers initiated kitchen gardens to tackle the nutrition issue. The efforts of Balwadi workers have led to free check-ups and vaccinations for females at brick kilns, even in the absence of identification documents like Janadhaar. On their own, ANM only come for vaccination for polio and Mission Indradhanush, as they are the central schemes.

Discussions:

Participants raised several queries during the session:

- Clarifications on "janaadhar" and vaccination by ASHA or ANM.
- Impact of the presence or absence of Balwadis on different brick kiln sites.
- Challenges in securing government schemes for kiln workers.
- The role of ANM in vaccination programs.
- Compensation for workers' losses not provided by brick kiln owner unions.

The participants asked whether the Balwadi workers follow-up about the admission/enrolment in the school, and what do they do in off season. The Balwadi workers responded that during the off season, they hold up meetings with school department, aanganwadis, and other departments. They said their goal is to develop aanganwadis locally. On being enquired about how do they tie up pregnant women with government schemes, they said that they are able to get them in some locations. These success stories are limited to only one-two locations, the problem is still systemic. They are not eligible for any state scheme.

The session shed light on the dire conditions faced by brick kiln workers and the vital role played by Balwadi teachers in addressing the educational and healthcare needs of their children. The challenges and discrimination faced by these marginalized communities were discussed, and potential solutions were explored. It was evident that there is a need for comprehensive efforts to address the systemic issues affecting these communities and to ensure their access to basic rights and services.

The session concluded with a commitment to continued advocacy and support for these communities and a call for greater awareness and action to improve their living and working conditions.

Session 2: Visit to Homeless Shelter Aarogya Ashray Sthal in Jaipur

Homelessness is a complex issue that persists in many urban areas across the world, and Jaipur, the capital of Rajasthan, is no exception. In recent years, the city has witnessed a significant increase in its homeless population due to various factors, including rural-to-urban migration and displacement in the name of urban development. Despite this growing crisis, there is a pervasive blindness in society towards the plight of homeless individuals, and they continue to face numerous challenges in their quest for basic rights and accommodations. This sheds light on the current state of homelessness in Jaipur, focusing on the lack of initiatives to integrate homeless individuals into mainstream society and the challenges they face in accessing healthcare services.

The issue of homelessness in Jaipur has reached alarming proportions. According to a recent survey conducted by the Institute of Development Studies, Jaipur, in December 2022, there were approximately 34,000 homeless people in the city. This number represents a staggering increase from 17,000 in 2017. These homeless individuals include both internal and external migrants who come to Jaipur in search of work and a better life.

Who is homeless?

People come from different states, as migrants, for work. There are both, internal and external migrants that come to Jaipur for work. A lot of them are also DNTs. 9 percent of Rajasthan population is DNTs. They come in search of work.

How to spot homeless?

Either the shelter people are tipped, or they go scouring the city looking for homeless, and orient them to come to the shelter. They are given a primary health check, and are taken to the SMS hospital if the need be so. The shelter staff ensures that there is a proper follow-up of the patient's medical requirements with the hospital. There are challenges that the shelter faces with respect to de-addict the patients. They sometimes hatch the escape plan because of their addiction to substance abuse. Sometimes, the homeless are in such vulnerable situations, that even the doctor refuses to touch them. So, it is the staff that ensures the cleanliness and hygiene of the patients.

Challenges Faced by Homeless Individuals:

- 1. Lack of Accommodation:** There is a glaring absence of initiatives aimed at integrating homeless individuals into mainstream society. This lack of accommodation and support systems perpetuates their marginalization.
- 2. Access to Healthcare:** Homeless individuals often suffer from various health issues, including paralysis, orthopedic problems, and mental health conditions. Accessing healthcare services is a significant challenge due to the lack of identification, making it difficult for them to receive timely medical care.

3. **Addiction and Rehabilitation:** Substance abuse is a prevalent issue among the homeless population. Rehabilitation programs face challenges in helping individuals overcome addiction, with some resorting to escape plans due to their dependency on substances.
4. **Social and Economic Rehabilitation:** After receiving medical treatment, efforts are made to rehabilitate homeless individuals socially and economically. This includes reuniting them with their families, helping them find employment, and providing support to reintegrate them into society. However, some individuals continue to live on the streets.
5. **Vulnerable Women:** Homeless women, particularly pregnant women, face especially dire conditions. A majority of them suffer from mental health issues, and they are often exploited, forced into drug peddling, and even prostitution to survive.

Addressing Homelessness:

Efforts to address homelessness in Jaipur include street medicine programs that provide medical care to homeless individuals in slum areas. Those in need of ongoing medical and social care are brought to shelters for rehabilitation. However, challenges remain, including the lack of identification for homeless individuals and the need for better-trained staff to care for homeless women.

The participants asked questions to Ms. Komal and other staff of the shelter. She said that the issue of homelessness in Jaipur is a complex and pressing challenge that demands urgent attention. It is essential for society, policymakers, and civil organizations to acknowledge the existence of homelessness and work together to develop comprehensive solutions. The pervasive blindness towards homeless individuals must be replaced with empathy and proactive measures to integrate them into mainstream society. This includes providing shelter, access to healthcare, rehabilitation, and support for vulnerable groups such as homeless women.

The following questions were asked:

1. How many shelters are there in Rajasthan?
 - Homeless policy calls for a shelter in each district, but due to elections, progress is on hold.
2. What is the age group of homeless individuals?
 - Homeless individuals in Jaipur typically range from 18 to 80 years old.
3. What happens after homeless individuals receive medical treatment?
 - Efforts are made to rehabilitate them socially and economically, including reuniting them with family, finding employment, or providing continued support.
4. How do homeless individuals without identification receive medical treatment?

- They rely on interpersonal associations with doctors who provide care out of goodwill.

5. What challenges do homeless shelters face regarding addiction and cleanliness?

- Shelters face challenges in de-addicting patients, and sometimes, patients with addiction issues hatch escape plans. Staff also ensure cleanliness and hygiene for vulnerable patients.

6. How can society better address the homelessness issue?

- Society must recognize the issue, provide shelter, healthcare, rehabilitation, and support for vulnerable groups, and replace blindness with empathy and proactive solutions.

The bustling streets of Jaipur, known for their vibrant culture and historical significance, are also home to a hidden crisis - a growing population of homeless individuals. As the city undergoes development in the name of becoming a "smart city," thousands of people have been displaced from their homes, left to fend for themselves on the unforgiving streets. This report sheds light on the Street Medicine program in Jaipur, an initiative aimed at providing crucial healthcare services to the city's homeless population.

Street Medicine Program:

The Street Medicine program in Jaipur serves as a lifeline for the city's homeless population. In the face of daunting challenges, it offers hope and essential healthcare services to individuals who have been marginalized and displaced. A significant number of people, both internal and external migrants, have come to Jaipur in search of work opportunities. However, due to various economic and social factors, they find themselves without shelter or support structures. Many of them belong to the Denotified Tribes (DNTs), a marginalized group, constituting approximately 9 percent of Rajasthan's population. These individuals come to Jaipur hoping for a better life but often end up living on the streets.

The Street Medicine program in Jaipur operates five days a week, addressing the healthcare needs of homeless individuals who lack identification. Identifying these individuals is a significant challenge, as they often do not possess any form of identification. The program focuses on reaching out to those who are extremely ill and in need of ongoing medical and social care.

Key Benefits of Street Medicine:

- 1. Identification of Vulnerable Individuals:** The Street Medicine program operates in the slums of Jaipur, where healthcare providers search for homeless individuals who require medical attention. This targeted approach helps identify the most vulnerable among the homeless population.
- 2. Rehabilitation for Complex Cases:** Patients suffering from severe conditions such as paralysis, orthopedic issues, fractures, and mental health disorders are brought to

shelters for rehabilitation. These individuals require persistent medical and social care to recover.

- 3. Overcoming Identification Barriers:** Lack of identification cards is a significant obstacle to accessing healthcare services for homeless individuals. Street Medicine helps bridge this gap by offering medical care to those without official identification.

Challenges Faced by Street Medicine:

The Street Medicine program faces several challenges in its mission to provide healthcare to the homeless population of Jaipur:

- 1. Substance Abuse:** Many homeless individuals struggle with addiction issues, making it challenging to provide the necessary care and rehabilitation.
- 2. Escape Plans:** Due to their dependency on substances, some homeless individuals resort to escape plans to avoid treatment and rehabilitation.
- 3. Stigma and Vulnerability:** In some cases, the homeless are in such dire situations that even doctors are reluctant to provide care. The program's staff plays a crucial role in maintaining cleanliness and hygiene for these vulnerable patients.

At the end, the participants talked to the patients.

As the day approached its end, the participants reflected on the sessions of the day- visit from the brick kiln workers and activists, and visit to the homeless shelter. They identified the issues that they could identify today, and what their potential reasons could be. They needed some clarity about the difference how lack of education is not the same as lack of awareness, and being aware does not mean they have the means to put a fight against the systemic challenges and issues that suppress them.

At the end, announcements were made about the next day's schedule of Jaipur sightseeing. Participants were told to be mindful about the whereabouts of each other while roaming, and sticking together as a group. Mr. Vijay Pal ji identified the coordinators for the sightseeing who would be responsible for smooth communication with the other group members with respect to information and plans. Some ground rules were set- like carrying water bottles etc. The participants were told to stick to the schedule.

Day 5

The day started with the facilitation teams facilitating and participants singing Jeena Isi Ka Naam Hai. The recap team then recaptured the previous day's learnings through the means of a Theatre act.

Session 1: Right to Health

For the first session, Ms. Chhaya distributed a list of questions to the participants and asked them to mark the answers based on their understanding and experiences. After they were done, Ms. Pritam Pal took over and sang 'Le Mashaalein Chal Pade Hain' along with the participants. After the song, the session started with Ms. Pritam asking about the rights of people and punishments during the times of kings and kingdoms. The religions institutions have always protected the interests of these kings and rulers and assigning them such unreachable and untouchable pedestals.

Who questions the king? What relates arguments/reason/question to information, and in turn links information to rights. She said that how can we question and argue with someone who is said to be the king, and ultimately, how do you access and exercise your rights. She said that it is our values and beliefs that influence all these aspects. If one believes that the king is supreme, what reasons do they have to argue/reason/question the ultimate and ask for our rights?

She also said that if for a long term, one does not ask/demand for their rights, they become comfortable in their roles as a victim. It is different than adjusting and compromising as per the need of the hour. She asked the participants what potentially could motivate people to seek their rights. The participants shared the factors that may motivate people which are- the dreams of your heart, Faith in yourself, collaborative solutions of the problems, exemplary stories of struggles in life, life after rights, new possibilities, introduction to better and blessed life, open your heart, open your mind, right selection of simple lexicon for better communication with people who need the solution, and if need be, re-assess the issues/problems to keep updating the solutions, etc.

She then asked the participants to think and express what right do they think they have or have exercised, that has changed their lives for better. After participants shared their experience, Ms. Pritam said that struggle never sees an end, and fights keep on coming. But then, so does solutions and learnings while you are in the process.

The session then moved forward to understand how constitution facilitates and promotes exercising the rights. She asked the participants to read the following: what constitution is, its clauses and the rights associated. She posed some questions as food for thought for the participants to chew on, such as-

1. What are the processes which push people towards poverty and are forced to bear through the oppression?
2. What are the mechanisms/processes that centralize information and knowledge?

Session 1 contd.: Right to Health (Rights – based approach)

This session was conducted by Ms. Chhaya. She asked the participants what it means when we say we are asking for our rights. Participants shared that we ask for compulsory needs of life, not seeking favours, freedom (from fear), responsibility, equality, equity, accountability, and justice. She said that rights are universal and unaffected by external factors. Dr. Pritam chipped in to add that certain aspects of life have intrinsic value. They add value by merely existing, not just achieving.

Ms. Chhaya said, that during COVID, the government ensured that the people did not go to sleep with a gurgling empty stomach. It was because of all citizen's entitlement to Right to Life. Thus, no matter what the external factors are, the government must preserve the rights of its citizens. Health is also a right. She talked about what sections of the Indian constitution cull out health as its core driver. The Articles were Article 14,15,16,17, 21, 32, 38, 39 (e)(f), 42 and 47. As per the Directive Principles of State Policy (DPSP), ranging from Ar 36-51, it is the state's obligation to ensure and fulfil the requirements, services and facilities required to ensure the Right to Health. She also clarified why the citizens were entitled to ask the state for their fundamental rights, and the states were obliged to fulfil them by the virtue of DSDP.

To translate the rights into reality rather than rhetoric, the state brings schemes, programs, laws, policies, campaigns. Ms. Chhaya elaborated on the difference between fundamental rights and DPSP by drawing the line between right holders, and duty bearers towards those rights.

Then Ms. Chhaya gave some background on Right to Health, how the advocacy for it started, which led to it being part of the election manifesto of some parties, and how it came to be developed. When the final draft bill was tabled, it was different from the bill that civil society had submitted. It alerted the private hospitals and doctors because they perceived that it was pro-poor at the cost of being anti-hospital in terms of economic benefit, regulations and accountability. After accommodating the suggestions, the bill was then tabled in constituent assembly. The bill also faced a lot of pressure from the doctors and the private sectors, that the Lok Sabha Speaker asked to put the bill on hold, and re-assess it to incorporate the demands of the private sector. Private sector was still apprehensive about the bill and refused to accept it. It spread misinformation about the bill, and the act, calling it anti-patient and draconian. There was a protest in Rajasthan where the doctors from private hospitals went on a strike. Eventually after incorporating the demands, the bill was modified and passed. Now it an Act. The government made a settlement with the private sector outside the act, that the act would not be implementable on all the private hospitals, only on those that avail the concession or any other support or association with the government.

The act had support from the common people, and resistance from private sector and doctors. Civil Society played a critical role in ensuring that the RTH Act sees light of the day.

After the session, the participants were divided into three groups. They were told to read the RTH bill, and identify what the bill has as its strengths and weaknesses. Ms. Chhaya facilitated this activity.

Session 2: Community Participation

Ms. Chhaya conducted this session on community participation. The participants were divided into 3 groups, and each group was provided with a community-based challenge. They were then asked to come up with a solution for the same.

Group 1 presented on the topic that mothers in Pal village were not getting their children vaccinated. They brainstormed about what they could do in the community as community-based initiatives, and how they would do it. It was identified that understanding the underlying reason of the problem will change the approaches toward the solution. Also, the group lacked the community representation. Mostly, the tasks identified by the group were only required to be taken up by the NGO, with no agency or participation by the community. Thus, Ms. Chhaya took it up as a point of discussion to ensure that there is ample participation of community when it comes to identification of issue, seeking solution and implementing it. It may be a long drawn and cumbersome process, but it develops the accountability and responsibility in the community, and any project becomes community project in the real sense of the word.

Dr. Pritam said that even something as initial and basic as identification of problem and the planning thereafter needs to have the involvement of community. If the community is not involved, what an NGO considers as the problem in the community may actually not be the problem, or is not even considered a problem by the community, to begin with.

Group 2 started their presentation in the form of a story. Their issue was lack of water in their village. They used community participation as a tool for resolving the community-based issues and challenges.

In Group 3, the challenge was that there was shortage of medicines and check-up facilities in the village. This group's POA was also community based and led. They, however, missed out on identification of stakeholders from the community to participate. Dr. Pritam chipped in and said that it is important to expand and simplify the problem, and identify the impact it may have.

The key Cs are- Community, Communication, Connection

Based on that, Ms. Chhaya showed some tips to be employed in community work, which may make the workings in the community more nuanced, and the approach more

participatory. She also informed about the need-based and right-based community participation.

Ms. Yayoi pitched in and linked the participation with empowerment, thus creating a loop of the two. For the feedback session, she also provided with a different feedback format, with a focus on communication behaviour and skills for learning from one another, along with participatory training. Participants were divided in 3 groups, and were given chart papers to note down the characteristics that their group members need to start, stop and continue. The participants themselves identified the purposes of exchanging feedbacks within a group, along with the tips to give feedback effectively. Two most important tips were to make sure that feedback was given in softer and constructive words, along with the examples. The day ended with announcements and responsibility declaration for the next day.