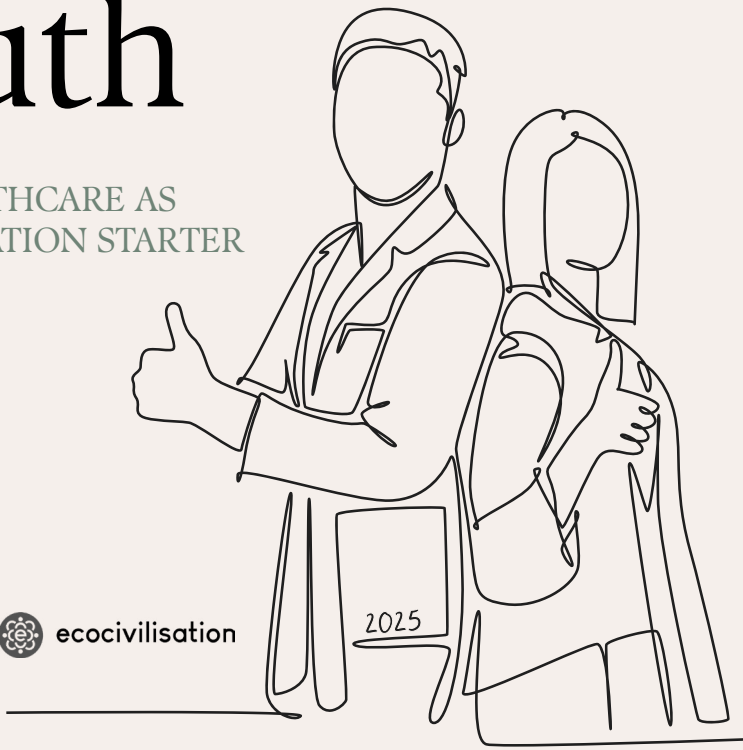
Not so

Random thoughts from India's youth

USING HEALTHCARE AS A CONVERSATION STARTER



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Not so

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USING HEALTHCARE AS A CONVERSATION STARTER

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We thank Alfia Gauri for the wonderful comic strips that she prepared during The F.A.I.R. Project 2025. All rights for these comics remain with her.

We extend our gratitude to all the contributors and supporters of Eight Goals One Foundation for their dedication and commitment to making knowledge freely accessible and adaptable for educational and non-commercial purposes.

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VOICES *that set the stage for us*

Step into the journey of the Changemakers of The F.A.I.R. Project 2025. This book is not a handbook, nor does it offer prescriptions or fixed answers. Instead, it opens a window into their shared inquiry, a space filled with insights, tensions, contradictions, and moments of transformation. Across these pages, thirty young people navigate difficult questions, unfamiliar experiences, and unexpected revelations. We invite you, the reader, to join us with an open mind and an adventurous spirit, not just to see the world as it is, but to imagine alongside us what the world could become.

At the opening session of The F.A.I.R. Project, the Changemakers met with our longtime friends, partners, and guides: Juan Pablo Ramírez Miranda, Deputy Chief of the Executive Office at UNESCO; Violeta Bulc, former European Commissioner and founder of Ecocivilisation; and Ramit Singh Chimni, founder of the Eight Goals One Foundation. The session was a shared moment to pause, reflect, and recognise the weight and privilege of what lay ahead. Their presence was not ceremonial. It was catalytic.

Juan Pablo Ramírez-Miranda

opened the space with a quiet clarity. He reminded the cohort that their presence here wasn't simply a personal milestone, but a shared responsibility to reimagine what is possible, to question what is taken for granted, and to act with humility. He placed the programme within the larger context of our time. He discussed environmental collapse, social fragmentation, and institutional fatigue, and impressed upon the young Changemakers that in this landscape, fairness isn't just a slogan, it's a lifeline. The world, he said, does not change through repetition. It changes through the courage to feel, see, and think differently.

Violeta Bulc

entered the conversation with her characteristic openness and depth. She spoke of public healthcare not as a sector, but as a mirror reflecting the values, priorities, and contradictions of the societies that shape it. She asked the Changemakers to stretch their imaginations, to see healthcare not only through the lens of service delivery, but as a system that either

nurtures or neglects human dignity. She talked of the current age as the age of imbalance, where the natural, human, and technological worlds are colliding without coherence. But in this disruption, there is an opportunity. The opportunity for a new kind of leadership, one built not on hierarchy or control, but on empathy, systems thinking, and care.

Ramit Singh Chimni

brought in an energy shift. He reminded the cohort that all the logos, all the hype, all the language surrounding the programme were nothing more than hooks. What truly mattered was not the name of the Project, but the people who chose to participate in it. He spoke plainly, almost playfully, urging the Changemakers to discard the notion that they had to sound impressive, consistent, or polished. His words were less of a speech and more of a permission slip. Permission to arrive however you were. To contradict yourself. To change your mind. To be human. He spoke of presence, not as performance, but as value. "Just by being here, you are already adding something important," he told them.

He also nudged them to let go of the fear of getting it wrong. He challenged the binary distinction between public and private, as well as personal and professional. Emotions, he said, are facts too. Feelings matter. And if a decision makes sense to your head but not your heart, you owe it to yourself to ask why. His invitation wasn't just to reflect, but to reflect without shame or fear.

The conversation flowed seamlessly, without sounding preachy, yet left a lasting impression. Messages from Juan, Violeta, and Ramit left the Changemakers with a deeper call to integrity, to awareness, to action. What does it truly mean to be a Changemaker? Not someone who acts for the sake of acting, or who speaks the loudest. But someone who listens deeply, thinks critically, and moves with clarity, even when certainty is out of reach.

This was not the kind of opening that fades after a screen goes dark. It lingered, in reflections scribbled into notebooks, in the quiet after the call, in the growing awareness that this journey would not be ordinary. It would ask for something more. The Changemakers were not just beginning a programme, they were stepping into a shared inquiry into what fairness truly demands of us and what kind of world we are willing to co-create.

Prologue

How our Story Began

The F.A.I.R. Project is built on a belief that fairness is not simply an abstract principle but a way of thinking and acting that must be practised, challenged, and refined. It aims to nurture Changemakers who bring courage, curiosity, and compassion to complex social problems.

The F.A.I.R. methodology lies at the heart of this process. Structured into four distinct yet interlinked steps, it encourages a way of learning and acting that is deeply thoughtful and grounded in fairness:

1. **Fact-finding and Familiarising (F):** Changemakers begin by gathering and examining information, ensuring they build a well-rounded understanding of a problem. This stage challenges them to go beyond surface impressions, to see what is visible and what is not, and to ground their ideas in evidence.
2. **Advocate for Alternate Viewpoints (A):** After forming initial positions, Changemakers are asked to advocate for perspectives that may oppose or differ from their own. This exercise is designed to foster empathy, challenge assumptions, and cultivate patience and humility in exploring complex issues.
3. **Introspect (I):** At this point, Changemakers pause and look inward, questioning their own biases and thought processes. By reflecting on whether their positions have shifted, deepened, or remained unchanged, Changemakers learn to embrace uncertainty and recognise where their beliefs may still be incomplete.
4. **Reason and Rationalise (R):** Finally, Changemakers work to synthesise what they have learned. This stage encourages decisions and solutions that remain open to change, acknowledging that new evidence and fresh experiences can and should reshape our conclusions.

The F.A.I.R. Project, through this methodology, creates a safe but challenging space for young people to grow as thoughtful, informed, and fair-minded problem solvers. Since its inception, it has drawn Changemakers from across India, transcending boundaries of faith, gender, language, region, and professional background, fostering a cohort as diverse as the challenges it seeks to address.

Over time, The F.A.I.R. Project has evolved into a living practice of collective exploration. It calls on young adults to imagine how fairness can be applied in real-world settings, while acknowledging that fairness is never finished or perfect, but constantly evolving.

In 2025, the Project continues this journey, focusing on public healthcare as its central theme, and inviting Changemakers to explore questions of equity, access, and dignity in systems that affect millions of lives. The result is a dynamic learning space that balances research with creativity, rigour with empathy, and critical thinking with action.

Story so Far

Since its launch in 2020, The F.A.I.R. Project has grown steadily in ambition, depth, and reach. Its purpose has always been to provide a space where young people could think critically about fairness, challenge their assumptions, and build the skills to act thoughtfully and inclusively in their communities.

In its first five years, the Project has drawn over 4,081 registrations, with 148 Changemakers selected from across 25 states and union territories. They have shared more than 400 hours of conversation with 96 guests from 25 countries, reaching a wider audience of thousands through online sessions and discussions.

The Changemakers have brought together remarkable diversity, spanning different age groups, backgrounds, and ways of seeing the world. They have come from diverse fields like engineering, economics, journalism, social work, public policy, and design. Each one reflected a shared curiosity that transcended any single discipline.

Over the years, the themes of The F.A.I.R. Project have evolved in response to the urgencies of each moment. In 2020, the theme focused on specific sections of existing policies, providing a concrete basis for discussion and analysis. In 2021 we introduced dichotomies, challenging Changemakers to explore and understand contrasting viewpoints. 2022 centred on redefining our eight goals, encouraging a deeper understanding and re-evaluation of our foundational principles. In 2023, we explored the intersectionality of the eight goals, with the Premises based on pairs of goals, highlighting their interconnected nature. By 2024, the theme evolved to choices, prompting Changemakers to consider the impact and implications of decisions within the framework of our eight goals. And in 2025, the collective gaze has turned to public healthcare. It is that universal promise which too often fails those who need it most. This year, we ask how fairness can be re-imagined for public hospitals, clinics, neighbourhoods, and homes.

These conversations and experiences remind us that fairness is not a technical formula or a finished destination. It is a living practice, carried forward by those willing to think, question, and act with empathy and conviction.

Within these Pages

At the heart of this book are the Changemakers, a group of young adults from across India, representing diverse geographies, faiths, gender identities, and lived experiences. Each brings a unique voice and perspective, united by a shared commitment to fairness and social good. Alongside them stand experts and facilitators who guide this journey, offering knowledge, challenge, and encouragement as the cohort engages with some of the country's most urgent questions.

The Indian healthcare system, in all its complexity and contradiction, serves as both the backdrop and the catalyst for this exploration. Through the realities of this system, they understand its possibilities, its vulnerabilities, and its determination. In this journey, the Changemakers examine the critical issues of equity, access, and dignity.

Framing this exploration are the eight goals identified by 8one: Well-being, Gender Equality, Environment, Hygiene, Peace, Nutrition, Education, and Employment. These goals are pursued through the F.A.I.R. methodology, which is built on four deliberate steps: Fact-finding and Familiarising, Advocacy for Alternate Viewpoints, Introspection, and Reasoning and Rationalisation. Together, these elements provide a robust framework for examining fairness in society.

This book does not seek to tell only the story of young adults. Through their narratives, readers will look beyond age or other identities and instead see individuals who, like many, strive for meaningful change. Within these journeys, readers may find reflections of their own questions, doubts, and breakthroughs, and discover different ways to address challenges that affect everyone.

Ultimately, the vision behind this book is to imagine a world where each person learns to question deeply, research thoroughly, consider multiple perspectives, and understand that no decision is ever final. A world built by thoughtful, conscious, passionate individuals dedicated to creating better systems through consistent, honest effort. By shedding light on these journeys, this book aims to foster a culture where fairness is not merely an ideal, but a living value woven into everyday practice.

Purpose of this Book

This book documents and recounts the journey of the Changemakers as they engaged with the F.A.I.R. methodology. Through expert-led sessions and guided activities, each Changemaker was encouraged to research thoroughly, form initial opinions, question those opinions, and test the objectivity of their conclusions. From this critical engagement, they began shaping potential solutions, with the awareness that solutions are never final, but rather part of an ongoing, iterative decision-making process that influences how individuals understand and live their lives.

In this cycle of exploration and reflection, the 2025 cohort moved a step further than in previous years. Equipped with the lessons of their online engagements, the Changemakers entered public healthcare institutions to observe, question, and apply their thinking to lived realities. Most of these Changemakers came from non-medical backgrounds, offering a human-centred view of India's healthcare structures through the eyes of those experiencing and engaging with them from outside the formal health sector. Their observations highlight how public systems are perceived and how new ways of thinking can transform those perceptions.

These accounts do not merely trace progress through the F.A.I.R. methodology but illustrate how each Changemaker internalised and adapted its principles, transforming ideas into personal action and creative expression. In doing so, the book provides an intimate and human perspective on the Indian healthcare system, its challenges, its often-overlooked strengths, and the daily realities it embodies.

Ultimately, this book stands as a record of that manifestation, through reflections, observations, proposed solutions, and even art. It is offered to the world as an opportunity to witness, understand, and adopt these practices of fair thinking and consistent movement toward change.

The Making of these Pages

The Changemakers shape The F.A.I.R. Project as much as the Project shapes them, reflecting a fundamentally collaborative approach. Rather than a one-way dissemination of information, the programme experience has always focused on the co-creation of ideas, perspectives, and action. This book is no different.

Every element of this resource was co-developed by the facilitators, session experts, and the Changemakers. Each insight, case study, and recommendation emerged from shared spaces of dialogue and collective effort. Through field visits, on-ground research, and conversations with health experts and community workers, the cohort explored the realities of health infrastructure beyond theoretical frameworks.

A dedicated digital ecosystem supported this process. Initial engagements took place in a WhatsApp group, known as the "Room of Rambles," which served as a forum for conversation, coordination, and important updates. Alongside this, the Miro Board, designed as "The F.A.I.R. Town", offered interactive spaces to gather and build knowledge collectively. These included personal note-taking corners, a cinema for recordings and session materials, a museum with information on India's healthcare system, an exploration park for offline research, a town hall for debates and discussions, and a parliament area for collaborative decision-making. Over time, these spaces evolved into a rich, living repository of collective and individual thoughts, both structured and unstructured.

A series of audio notes, 'Thinking Out Loud with Aparna', curated by our programme facilitator Aparna Nayyar, provided further guidance, encouraging individual reflection while allowing space to return to group discussions with fresh insights and renewed purpose. In parallel, Changemakers shared photographs, posters, and art to represent their learning journeys. These contributions have been curated here to capture their transformation from passionate young adults into thoughtful Changemakers.

Integral to this unfolding process were the facilitators, the steady presence behind the scenes and beside the Changemakers. They held the space when things felt uncertain, asked the difficult questions when answers came too easily, and gently nudged the group forward when it lingered in pause.

These facilitators mentioned below, shaped this journey in quiet yet defining ways.

Isha Kakkad, the main moderator, became the centre of the sessions not through volume, but through steady presence. She guided conversations with experts, navigated Q&As, explained prompts, homework, and schedules with clarity and patience. When the Changemakers felt unsure, she was the one they turned to for direction, continuity, and the reassurance that they were on the right path.

Sreeshti Sharma brought the Miro board to life. She guided the Changemakers through the lanes of The F.A.I.R. Town, pointing them to resources, reflection spaces, and progress trackers. She took attendance, followed up with absentees, and checked in quietly but consistently, ensuring everyone felt seen and supported.

Karthika Sajeev Changam spoke little during formal sessions, but her presence was unmistakable. She showed up when the scripts ended and conversations began, holding space for stray thoughts, late-night jokes, and the kinds of questions that don't always have answers. During the offline fieldwork, she stayed close not to direct, but to listen, prompt, and reflect.

Aditya Awasthi, with his trademark humour and sharp provocations, kept the Changemakers on their toes. Sometimes a friend, sometimes a challenger, he pushed them to think aloud, argue back, and sharpen their instincts. Whether teasing out contradictions or flipping a question on its head, he brought energy and friction in equal measure turning even the simplest exchanges into moments of insight.

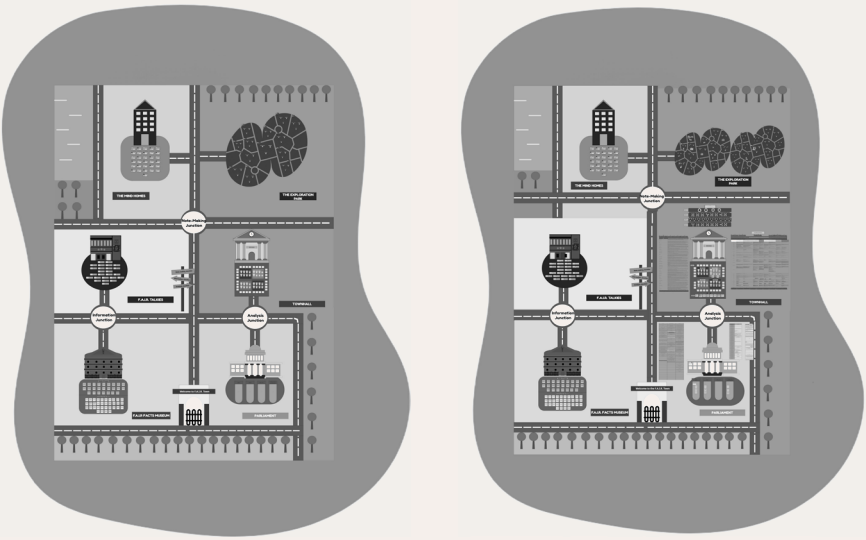
And then, there was the Tech Host. Arguably one of the most mysterious presences in F.A.I.R., they were the unseen orchestrator of the screen. No one knew who they were, not even their name, nor their gender but their impact was everywhere. They created breakout rooms with near-magical timing, managed recordings, dropped unexpected prompts, chimed in with dry humour, sharp wit,

and occasional chaos. Just when a session risked feeling too serious, a perfectly placed comment from the Tech Host would cut through, reminding everyone that learning could be light.

Together, the facilitators ensured that this was not just a programme, but a shared experience. One where people could learn, falter, return, and grow knowing that someone would be there to hold the space, hold them accountable, and hold them gently when needed.

Throughout these pages, the voices and perspectives of youth remain at the core. Their narratives add depth and nuance, presenting an authentic, human-centred account of public healthcare in India. While the book follows a thoughtful structure, its expressions remain open and flexible. Reflections appear in many forms, such as art, comics, personal stories, photographs, and observations, capturing moments that may seem simple yet hold deep meaning. This openness reflects the creative spirit of the Changemakers and The F.A.I.R. Project itself, encouraging authentic storytelling over rigid formats.

Through this process of dialogue and discovery, the Changemakers uncovered systemic barriers, local innovations, and hidden stories that shape the reality of healthcare. These insights, captured here, aim to inspire further conversations and actions for those seeking fair and inclusive solutions.



Beginning and aftermath on the Miro board

Acknowledgement of Contributors

Deep gratitude goes out to our long-standing partners, the UNESCO New Delhi Office for South Asia. We are grateful to have Ecocivilisation as our official partner this year. We thank our dear friends, Juan Pablo Ramírez-Miranda and Violeta Bulc, for lending their support and wisdom throughout all our editions of The F.A.I.R. Project and helping young Changemakers see the world with wider, braver eyes.

A heartfelt thank you to Dr. Lwando Maki, Dr. Flavia Bustreo, Dr. Padmini Murthy, Dr. Revati Phalkey, Dr. Saleyha Ahsan, Dr. Yonette Thomas, and Mr. Rajesh Awasthi for taking the time to share their unique stories and perspectives with the Changemakers. Their generosity in opening up conversations made it possible to gain a better understanding of the healthcare system, the eight goals, and society at large.

Warm thanks are also due to the Asian Medical Students' Association (AMSA) India, whose members, Adarsh Kumar, Eesha Brijesh, Harini Natarajan, Harshini A, Ibrahim Ghouse Mohiuddin, and Vaishnavi Kumar became steady companions, helping the Changemakers navigate local healthcare systems with practical advice, moral support, and honest knowledge.

Finally, our deepest appreciation goes to the countless healthcare workers, along with medical and non-medical staff, who welcomed the Changemakers into their spaces. By sharing their stories, offering their time, and encouraging honest observation, they inspired these young people to believe in change and to imagine new possibilities.

Introduction

The F.A.I.R. Project 2025

The F.A.I.R. Project 2025 turns its focus to one of the most crucial systems in any society, public healthcare. As a system that touches every single life, its quality, accessibility, and fairness have consequences for all people, regardless of their background and or circumstance. Due to its universal relevance, every member of society has a stake in strengthening and making it more equitable.

Yet despite its essential role, some of the most fundamental challenges of public healthcare remain overlooked or unaddressed. With this edition of The F.A.I.R. Project, the effort has been to explore how, as a society, we might support and improve a system meant to serve everyone.

At the heart of this year's journey is a simple hypothesis, i.e., making a difference in healthcare does not require a medical degree. The goal was to test it and understand the limits of our contributions in this ecosystem. It only requires curiosity, commitment, and a belief in fairness. The Changemakers brought their diverse perspectives and a willingness to question, learn, and challenge old assumptions. Together, they set out to see, understand, and reimagine public healthcare in ways that could better serve us all.

Meet the Changemakers

Bound by curiosity and a hunger to build a better world, this diverse community of Changemakers spent three months exploring the F.A.I.R. methodology, examining the intersection of public healthcare with the eight identified goals of 8one. From Delhi to Bengaluru, Kullu to Hyderabad, they have stepped into primary health centres, recorded observations, and turned ideas into action and theory into practice wherever they could.

Each of these remarkable young people brought a unique spark to the collective.

Aishvarya Rajesh

a lawyer based in Bengaluru, showed unwavering focus and a talent for earning trust, guiding the group with clarity and purpose.

Akansh Gandhi

an economics student in Delhi, connected ideas and reality with ease, demonstrating how collaborative work can spark innovative solutions.

Alfia Gauri

exploring social design in Delhi, challenged every assumption through her artistic skills, especially her evocative comics, which helped others see complex issues in new ways.

Ananya Verma

from the peaceful hills of Kullu and the structured grids of Chandigarh, brought deep empathy, warmth and steady listening, ensuring that everyone felt welcome and included in every conversation.

Anika Sahay

a political science student in Delhi, paired curiosity with determination, always ready to contribute and looking for ways to strengthen the foundations of public systems.

Arpita Goenka

a mental health professional in Guwahati, brought calm steadiness, navigating complex conversations with quiet assertiveness and care.

Aryaa Praseed

based in Bengaluru and founder of the Maitri Arha Foundation, showed how community-based work and thoughtful policy debate could go hand in hand.

Devanshee Sharma

in Delhi, drew from a deep understanding of history to keep the group grounded, offering perspective and steady guidance.

Divyanshi Agarwal

in Lucknow, combined her creative streak with environmental awareness, using art to deepen community engagement with public health.

Diya Jain

from Chandigarh, brought sharp technical thinking and a calm approach to problem-solving, helping the group assess gaps in health infrastructure.

Guncha Shandilya

in Delhi, dove into challenges without hesitation, showing what fearless engagement looked like in practice.

Jaya Maheshwari

studying in Kakinada, applied her business analytics skills to look for data-driven ways to strengthen health systems through her quiet reflections and loud actions.

Medha Reddy

based in Noida, with her background in psychology, contributed a thoughtful, balanced voice, listening deeply and adding steady strength to the group's reflections.

Nila Varma

in Mumbai, blended a bright, bubbly spirit with thoughtful storytelling, making connections between social justice and public health.

Prakruthi Kumar

also in Bengaluru, a medical practitioner herself, combined curiosity about medicine and research with a practical sense of community realities, asking how breakthroughs could truly reach those most in need.

Rajshekhar Upadhyay

in Kharagpur, balanced ambitious dreams of social enterprise with a commitment to practical, meaningful impact.

Rupkatha Chakravartty

joining us from Kolkata, anchored our most challenging debates with clarity and poise, consistently probing the depths of an argument and returning with valuable insights.

Samvardhan Tiwari

from Delhi, merged the discipline of law with creative thinking, always ready to question how community systems could be strengthened.

Sana Khan

in Delhi, approached each challenge with quiet determination, applying her engineering mindset to design systems that worked for everyone.

Sanah Dhawan

also based in Delhi, combined a manager's eye with a Changemaker's heart, tackling complexity with thoughtful and inventive solutions.

Saummya Yadav

from Delhi, radiated warmth and openness, always ready to go the extra mile to make others feel seen, heard, and supported.

Shivpriya Dixit

modelled the quiet strength of steady work, showing how change does not always need a spotlight to matter.

Shlok Shah

in Gandhinagar, carried a calm steadiness through his many initiatives, encouraging others to believe that change was possible with persistence.

Shreem Bindal

adventurous and always ready to try something new, fuelled the group with energy and fresh ideas.

Shreya Maheshwary

a clinical psychologist from Noida, centred mental health within the public health conversation, making space for emotional well-being to be valued.

Smriti Banka

working from Hyderabad, blended marketing and WaSH expertise with a practical focus on results, keeping the group grounded in what mattered most.

Smriti Sharma

from Haridwar, brought curiosity and a lively sense of humour, exploring issues from geopolitics to economics while motivating those around her.

Sonal Gramopadhye

a pharmacy student in Hyderabad, is always eager to take initiative and engage with stakeholders firsthand, offering practical reflections on health practices.

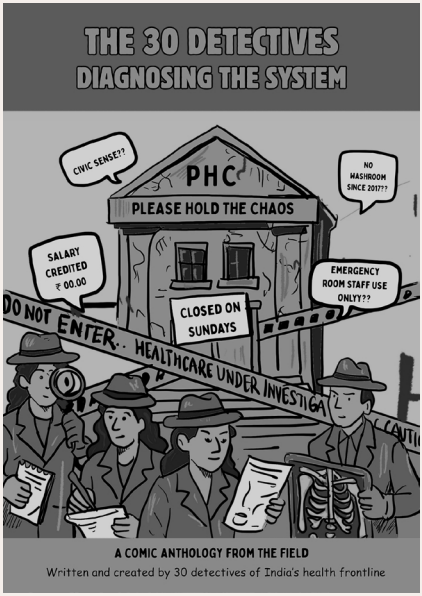
Suhani

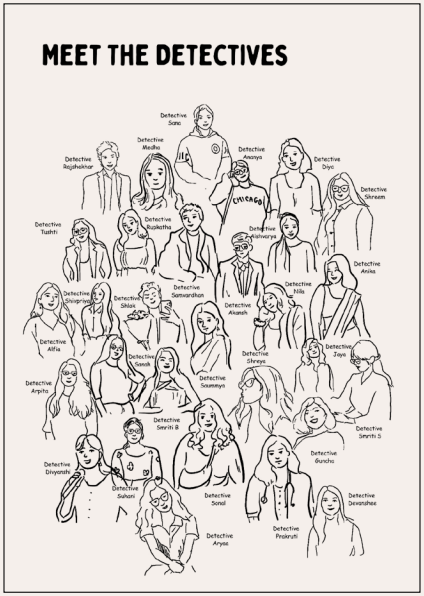
based in Delhi, wove together management skills with empathy, showing how careful strategy and a human heart can push change forward.

Tushti Sharma

also in Delhi, met every opportunity with proactive energy, proving that stepping up can shift the direction of a conversation.

Together, these Changemakers took their ideas beyond screens and notebooks. They walked into clinics, listening to patients, debating policy, and witnessing realities up close. Over the course of three months, they have demonstrated how youthful energy, combined with empathy and courage, can help build a fairer, stronger, and more hopeful public health system for all.





Comic anthology co-created by Changemakers and designed by Alfia

The Map of our Time Together

This year's F.A.I.R. Project unfolded with an intentional design, weaving together community, challenge, and reflection to prepare the Changemakers for the complex realities of public healthcare.

Things began with a series of Open Houses, where free-flowing conversations helped this diverse cohort get to know each other, build trust, and form a foundation of curiosity and openness. These spaces allowed them to share first impressions, fears, and aspirations before stepping deeper into the journey.

The formal opening session brought the group together with two longtime friends of the program, Violeta Bulc and Juan Pablo Ramírez-Miranda, who have supported this Project since its earliest days. Their words reminded everyone of how far F.A.I.R. has come and how much promise lies ahead in this new edition.

Soon after, Dr. Lwando Maki guided the group through an introduction to building blocks of public healthcare, helping frame the path ahead and providing a common ground to begin their explorations.

From there, the cohort entered the first step of F.A.I.R., i.e., the Fact-finding sessions, or F-sessions. These were led by experts and practitioners who opened windows into the deep intersections between healthcare and the eight goals of 8one. The Changemakers listened, questioned, and learned, while also being asked to name the most critical interventions they could imagine in each theme. This exercise pushed them to understand that learning and doing are not separated in silos. Decision-making doesn't pause for the completion of research; it continues, and so does our process of fact-finding. This structure provided them with the opportunity to balance what they had learned with what they still needed to discover while also thinking about actionable steps.

Next, they moved into the 'A' of F.A.I.R., Advocating for the Alternative Viewpoint, where their proposed intervention was flipped on its head. Suddenly, each Changemaker had to defend a position they disagreed with, forcing them to test their own resilience and look beyond long-held beliefs. It was uncomfortable, even frustrating at times, but it provided Changemakers the opportunity to break down the rigid mindset and boxes they had created for themselves.

After that came 'I', i.e., Introspection. In these sessions, they paused to reflect on what they had felt during the F and A stages, digging into why they believed what they did, and how it felt to challenge themselves so directly. This was a chance to look inward with honesty, not to judge, but to truly understand their motivations and values.

Finally, they reached the final step, Reasoning and Rationalising. Here, they stepped back into the role of decision-makers, once again proposing interventions across the eight goals, but now with everything they had learned through F, A, and I. This time, the task was not about defending their side but about collaborating and finding common ground, drawing on research, evidence, and their new understanding of multiple perspectives.

This entire F.A.I.R. structure was meant to get them ready for what comes next: real life, with its messiness, contradictions, and possibilities.

After these sessions, the Changemakers were asked to visit a nearby public healthcare centre. Before heading out, they spent time with AMSA volunteers, who shared some much-needed information about the fundamentals of India's healthcare ecosystem along with some tips and tricks to help the Changemakers navigate the public healthcare system of India. Equipped with this context, they went in not as representatives of The F.A.I.R. Project but simply as people who cared enough to listen and learn.

They observed clinics, engaged with Accredited Social Health Activists (ASHA) workers, doctors, security staff, and patients. They pieced together an intimate, human picture of how healthcare plays out on the ground. Even though they were scattered across cities and states, they stayed connected through shared online spaces, exchanging stories and notes on the Miro board. Through text messages, photographs, a worried question, or an inquisitive voice note, they built a sense of collective learning despite being miles apart.

They returned from the field brimming with stories, insights, and a sense of urgency. Yet no one was sure what to do with all this raw energy. So began the theme mapping sessions, where they attempted to identify concrete ways to intervene through the state, local actors, or their own efforts. This exercise led them to the bigger question of 'how'.

As they designed solutions, they worked hard to stay grounded in practical realities, what was possible, what was sustainable, and what was ethical. They experimented, checked in with each other daily, adjusted their plans, and found creative ways to tailor interventions to the unique needs of their community.

They didn't stop at ideas. Once interventions were tested, they focused on building resilience and sustainability so that any positive change could outlive their brief time there.

In this way, The F.A.I.R. Project 2025 became far more than an experiential program. It became a living rehearsal for the real-world work of changemaking. It became a place to stumble, question, adapt, and ultimately, to stand together in imagining a fairer, healthier future.

Before the Conversation

Before the Beginning Began

Long before the F.A.I.R. methodology was introduced, before research tools were shared and speaker sessions scheduled, the Changemakers met for something quieter, less formal or structured. Two evenings, no agendas, no deliverables, just a screen full of strangers and a virtual room full of questions. These were the Open Houses.

At first glance, they appeared to be simple community-building exercises, the usual icebreakers, perhaps. But beneath their casual appearance was intention. The Open Houses were designed to disarm, not instruct. To create dissonance, not direction. To make space for listening before speaking, and reflection before resolution.

In the first session, the design was deceptively playful. Changemakers were shuffled through Zoom breakout rooms at unpredictable intervals, often mid-conversations and even mid-sentences. The prompts were given to facilitate conversation. They were random and seemingly innocent questions about favourite childhood memories, comfort foods, movies, and dream lives. These prompts provided them glimpses into each other's worlds, while the randomness of movement made those glimpses fleeting. The task wasn't to finish conversations; it was to sit with their incompleteness.

The second Open House mirrored the structure of the first but shifted the intent. This time, the questions turned the lens inward: What words do we throw around without weight? What humour do we mistake for bonding? What do we call "cool" just to be accepted, and what do we call "cringe" because we are afraid to admit we care?

Without explicitly stating it, the Open Houses asked the Changemakers to examine themselves and each other, observing how they filled silences, navigated discomfort, and sought belonging.

In a programme that would later push them into complex debates, ethical contradictions, and policy-level decisions, these two sessions were a prelude. Not to teach what to say but to help them notice how they speak. Not to define who they are but to ask, gently, who they might become.

Open House I:
Broken Conversations, Shared Beginnings

There was no theme. No speaker. No slide deck or grand opening. The simple instruction to each Changemaker was to show up and speak.

The first gathering of the 2025 Changemakers was unlike anything they had expected. Having no context other than the fact that it was an "Open House," the only thing they could count on was that it promised a good time. What they got was a controlled chaos, designed not to test their intellect, but their presence, and their willingness to listen.

The Zoom call began like any other: silent microphones, nervous smiles, polite waves. But once the breakout rooms opened, the structure dissolved. The Changemakers were dropped into random groups of five or six, with no introductions and no agenda. The only guiding thread: a series of prompts that appeared, one after the other, in their shared WhatsApp group.

The prompts were disarming in their simplicity:

1. What is one thing you really love to eat?
2. What's your all-time favourite movie?
3. What's your happiest childhood memory?
4. If you could have any superpower, what would it be?
5. If you could switch lives with anyone, past or present, who would it be?
6. What's something fun you've been doing lately?

On the surface, they were icebreakers. But the design of the session ensured that it achieved something far greater. As the prompts were dropped into rooms full of strangers, the chaos began. Mid-sentence, mid-thought, over and over again, Changemakers started to be shuffled in and out of different Breakout rooms. As the uncertainty in the room rose, so did the rawness of their response. The responses slowly turned into reactions, and reactions gradually became mirrors. Each question asked the Changemakers to show something real, even if briefly, before being reshuffled to a new set of faces and unfinished threads.

> "I am being tossed around like a ball." - *Alfia Gauri*
> "Maybe I am being moved because I said something problematic." - *Sarvardhan Tiwari*

In the rhythm of constant motion, patterns began to emerge. Some tried to anchor the room with humour. Others stayed silent, observing. Some adapted quickly, using each shift as a chance to discover. Some were visibly frustrated. More than one began to wonder aloud whether the timing of their moves was personal.

A few attempted to bring structure to the chaos, eager to make sense of the experience. Others leaned into the unpredictability and allowed themselves to be. As the hours passed, specific dynamics surfaced. Some individuals took up more space, their voices rising quickly in each room. Some began turning their cameras off, retreating. Some kept the energy going by asking questions and drawing others in. Some became quiet, uncertain if there was room to speak.

> "Mein apni favourite hu." (I am my own favourite) - *Smriti Sharma*

There were moments of unexpected resonance. A shared childhood memory sparked a round of nostalgic laughter before the group was pulled apart again. A prompt about food turned into an impromptu recipe exchange. A conversation about switching lives led to reflections on admiration, regret, and parallel dreams. These minor collisions, however fleeting, offered glimpses into who these people really were beyond their bios and accomplishments.

> "I like Maths." - *Divyanshi Agarwal*
> "I do not like Maths." - *Shivpriya Dixit*
> "I really like dal with coffee." - *Sonal Gramopadhye*

But there were fractures, too. Language was used loosely. Sarcasm hovered close to criticism. There were remarks passed without thought for how they might land. Judgment appeared dressed as humour. A few names began to come up more than once, not for what they said, but how they said it. In certain rooms, the energy veered from curious to performative. In others, it softened, carefully held by mutual trust, even if temporarily.

> "I like Turkish movies, but my favourite movie is Nil Batte Sanata." - *Guncha Shandilya*

There was no single story that emerged from Open House I. Instead, it was a patchwork of incomplete conversations, strained introductions, and small shared moments that managed to linger beyond the call. What became clear, however,

was that the exercise had been successful, not because everyone had bonded, but because everyone was disoriented in the same way.

The randomness had done its job. It levelled the playing field. In a room where no one could plan or perform for too long, posturing became hard to maintain. What was left was something more vulnerable, more honest, fragmented first impressions, friendships formed through interruption, trust built, not through polished answers, but through uncertainty shared.

They arrived as strangers. And even if they didn't yet leave as friends, they left knowing a little more about each other than they had when they entered. And for a beginning, that was enough.

As the second Open House drew to a close, a quiet familiarity had begun to settle. The WhatsApp group began to be flooded with photos of their furry friends. Isky, Jason, Simba, Whiskey, Murphy, Pepper, Tutti-Frutty, Kira and Waffle became fan favourites!

Angad's Dojo – The F.A.I.R. Mascot

Rupkatha's Tutti

Guncha's Murphy and Pepper

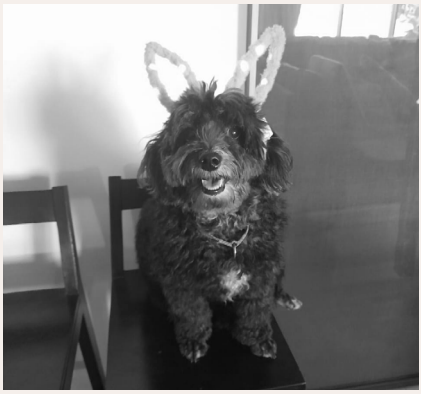
Rupkatha's Frutty

Devanshee's Jason

Smriti Sharma's Simba

Nila's hostel reception cats

Medha's Kira



Smriti Banka's Ishky

Jaya Maheshwari's Whiskey

Names no longer felt like usernames. Silences were less awkward, conversations less tentative. And in that warmth, something small but significant happened. Smriti Banka, Sonal, and Nila decided to meet in person. It wasn't pre-planned or prompted. It simply felt natural.

They spoke of how, despite meeting for the first time, the hours passed effortlessly. There were no icebreakers, no awkward pauses, just an ease that surprised them. Without knowing it, they had marked the beginning of something more. A friendship that hadn't been designed into the programme but found its own way to unfold. The first of many quiet connections that would begin to take root, not through shared tasks, but through shared presence.

Nila, Smriti Banka, and Sonal (L-R) met in Hyderabad

Open House II: Chatter, Shifts, and the Silences in Between

The second Open House, at first, looked just like the first.

Familiar faces on Zoom. Unannounced breakout rooms. Another carousel of seemingly casual prompts. As before, the structure was designed to disorient Changemakers and pull them into unexpected configurations, cutting

conversations mid-sentence, mid-thought, mid-laughter. But behind the now-familiar format, something had changed.

The breakout rooms were more nerve-wracking the last time.

Jaya, after a long session in the breakout rooms

> "Last time Break out rooms were more nerve wrecking. We are chill this time." - *Smriti Banka*

This time, the provocation was intentional.

Where the first Open House had used light questions about childhood memories and comfort foods to build bonds, this one asked Changemakers to sit with discomfort. The prompts weren't explicitly challenging, but they were designed to make them think, not just about the prompts, but what their answers revealed about them:

1. If you had to put ₹10,000 in a swear jar every time you swore, what words would you use instead?
2. Words like "trauma", "triggered", "toxic", or "depressed" are everywhere. Is this normalisation or trivialisation?
3. Is it possible to be funny without being a bully?
4. When do you say something is "cringe" or "cool" even when you don't really feel that way?

Each question invited reflection, not just on opinion, but on habits. And this time, the observation wasn't about who was speaking, but how they were speaking.

Some Changemakers embraced the exercise immediately, diving into conversations about language inflation, mental health, and humour. Discussions touched on the loss of meaning in overused terms, how words like triggered or toxic are used as placeholders for more complex emotions, which are seldom explored, and how difficult it can be to call that out without seeming insensitive. One Changemaker drew on their experience in clinical psychology, observing how jargon is often borrowed from therapy culture without complete understanding.

Another reflected on the way humour can easily blur the line between lightness and cruelty, especially in social settings.

> "Honestly, listening to you guys made me feel like I'm so old. I could not relate to anything that you said." - *Devanshee Sharma*

Others found a different rhythm. In several rooms, conversation veered towards personal experiences, breakups, university gossip, weekend plans, even hair oiling routines and Spotify playlists. Taylor Swift lyrics came up, as did dogs, Delhi's pollution, and favourite professors. At times, the prompt lingered quietly in the background while Changemakers used the space to reconnect and decompress.

> "What is it that you are not telling us?". - *Prakruthi Kumar*

As always, the movement between rooms was randomised. But by now, many Changemakers had grown suspicious of the unpredictability. Some tried to trace patterns; others voiced irritation. There were theories that people were being moved based on how serious their conversations were.

Still, amidst this chaos, change was still afoot.

Some Changemakers who had previously remained quiet began to open up about their reasons for doing so. One said they often found themselves going quiet in louder groups. Another admitted that even when they spoke, they were measuring each sentence, aware of how easily they might be misunderstood, or how much space they might end up taking. There were reflections on tone, how sarcasm could feel like teasing or dismissal, depending on the listener. A few discussed how they sometimes played along with jokes they didn't find funny, just to keep the peace.

> "I want someone to convince my mother to let me dye my hair." - *Shreem Bindal*

There were also contradictions.

Changemakers who, in earlier sessions, had passionately advocated for empathy and safe spaces now found themselves speaking over others or struggling to hold back judgment. A few, as a force of habit, used the very words they were meant to examine, 'toxic', 'cringe', 'depressed', with a casualness that made the original question even more urgent.

Some rooms noticed this. Others didn't.

But patterns started becoming more obvious. Some people consistently held the space in each room, often setting the pace and tone of conversation. Others faded out entirely when the energy grew too fast or performative. In one group, someone asked whether performative language was inevitable in group settings like this. In another, a Changemaker reflected that 'growing out of judgment' wasn't as easy as it sounded when trying to feel included.

Several exchanges stood out, not because of what was said, but because they were remembered. A few Changemakers returned to half-finished ideas from earlier breakout rooms. Some asked quiet Changemakers what they were thinking, without prompting. Others chose to sit in silence and yield space when they could have filled the space.

Open House II didn't produce resolutions. That wasn't the goal. But it did begin to reveal how language when adopted mindlessly can both connect and distance us. That humour isn't always harmless. That agreement isn't always honesty. And that silence doesn't always mean absence.

The prompts may have seemed playful. But their real purpose was to scratch the surface and see what came loose. The goal was not to ruffle feathers or trigger transformation, the goal was simpler, merely to sow a seed. For a start, this was enough.

> "I might end up getting a tattoo with my friends, I do not know how to say 'no'." - *Divyanshi Agarwal*

Laying the Foundation: A Collective First Step into Health

Before stepping into the heart of The F.A.I.R. Project, the Changemakers sat with a fundamental question: What is public healthcare, really? Or what is health? Most of them came from fields far removed from medicine. Our Changemakers came from diverse backgrounds, including law, economics, architecture, education, policy, and the arts. And yet, as Dr. Lwando Maki reminded them, public health is everyone's concern, because it touches every structure that shapes how we live, and who gets to live well.

Dr Lwando Maki, President, Public Health Association of South Africa

Dr. Maki, President of the Public Health Association of South Africa and an expert in climate, health, and systems change, didn't enter the space as a lecturer. He arrived as a listener, a challenger, and a guide. His session opened not with a list of definitions, but with a provocation: What makes a system fair? Who does it serve, and who does it leave behind? What followed was not a presentation, but a conversation rooted in dialogue, stories, and inquiry.

> "Apart from having individual well-being, I think it matters a lot in what sort of environment and what sort of social life you have, because having people around you who accept and validate your world perspectives or life goals is very important because it helps you understand yourself better and actually move forward in life." - *Saurnrya Yadav*

He introduced public healthcare not as a single sector, but as a system of systems, one that intersects with sanitation, housing, employment, gender, education, and the environment. He encouraged the Changemakers to stop looking at issues in isolation and start tracing the threads that connect them. He showed how healthcare reveals a society's values, diving into the depths of who is protected, who is heard, and who is rendered invisible.

> "Indians tend to cure themselves using over-the-counter drugs. So they usually self-medicate before going to a doctor. They usually go to a doctor when it's in a really bad state." - *Prakruthi Kumar*

Importantly, he anchored the conversation in examples that felt close to home. Drawing from his work in South Africa and beyond, he named India as one of the most significant public health stories of the next decade. He praised the plurality and depth of India's health landscape while also calling attention to its inequalities, gaps in access, and deep-rooted mistrust. His message highlighted how local realities are never separate from global dynamics. Health is always contextual and always political.

> "Instead of the wife or the woman speaking up for herself, the husband is so entitled to take decisions on her behalf, 'I believe this treatment is better for her, I believe this medicine should work for her' there lies the problem." - *Sarvardhan Tiwari*

Throughout the session, he reassured the group that expertise was not a barrier. You didn't need a medical degree to care about public health. You didn't need textbook answers to ask good questions. What mattered more was perspective and a willingness to listen, learn, and connect the dots. You already belong in this space, he told them.

Perhaps the most transformative moment came when he named what many thought about but hadn't yet said aloud: impostor syndrome. He spoke candidly about his own early doubts, of being in rooms with UN agencies and ivy league credentials, and wondering whether he belonged. But he urged the Changemakers not to let those doubts shrink their voice. "Your stories, your insights, your questions, they matter," he said. "Don't sit quietly because you think someone else knows more. Your lens is your strength."

By the end of the conversation, something had shifted. The cohort was no longer circling the theme; they were beginning to enter it. Public healthcare was no longer

a distant or intimidating subject. It was a terrain they could now navigate with curiosity, context, and courage.

Dr. Maki did not just give them an introduction. He gave them a way to see. A way to ask better questions. A way to step into this work with both humility and legitimacy.

This was the foundation they didn't know they needed. Dr. Maki provided them with the lens through which every subsequent session could be understood.

Fact-Finding: A Journey to See Clearly

We often make up our minds based on the information that we have received, sought and perceived. It is easier for the mind to choose an option for which the most information is readily visible. This information is better processed when supported by sufficient data, enabling us to assess outcomes with greater confidence.

To make fair decisions, first, the mind must be open to complexity, contradiction, and context. That is why Step 1 of the F.A.I.R. process, Fact-Finding and Familiarising, was designed not to deliver straightforward answers, but to widen the lens. These sessions aimed to expose the Changemakers to as much and as diverse a range of perspectives, data, histories, and lived realities as possible. But exposure was only the beginning. The sessions were designed to spark curiosity, plant the seed for deeper questioning, and encourage each Changemaker to take ownership of their learning journey.

With a fuller understanding or at the very least, an awareness of what remains unseen, they could begin to make decisions that were not only more informed but fairer. For this edition, each Fact-Finding session was curated by combining two goals, their intersectional realities along with their challenges within public healthcare systems. At the end of every session, Changemakers were asked to list what, according to them, is the most pressing issue related to the goal in focus in the context of public healthcare. The session presentations, breakout groups, and discussion time encouraged Changemakers to connect the dots, explore what they thought they knew, and identify where they needed to learn more.

The goals were paired deliberately to highlight the centrality of intersectionality. Each session examined how public healthcare intersects with a combination of goals, such as, Gender Equality and Well-being, Peace and Nutrition, Environment and Hygiene, Education and Employment. This approach allowed Changemakers to trace the ripple effects between issues, revealing how challenges that may seem unrelated often converge within the healthcare system, shaping it in complex and unexpected ways.

To support their exploration, we equipped them with a set of carefully designed tools. The Miro board served as a shared workspace for mapping ideas, collecting observations, and thinking collectively. The F.A.I.R. Talkies provided a hub for revisiting session notes and recordings, allowing learning to continue beyond live discussions. Mind Homes gave Changemakers a personal space to reflect and work through

guided prompts, helping them challenge their own assumptions and stay grounded. Finally, the F.A.I.R. Facts Museum delivered foundational facts about India's healthcare system, giving them a solid base of knowledge from which to build.

Together, these tools and spaces supported a thoughtful, fair, and inquisitive approach, empowering Changemakers to move beyond first impressions and toward a deeper understanding of public healthcare.

Intersecting Paths: Gender, Well-Being, and Health

The first F session brought two deceptively familiar themes to the table, gender equality and well-being, and asked the Changemakers to examine them not in isolation, but as deeply intertwined elements shaping the everyday realities of public healthcare. This wasn't just a conversation about concepts. It was about people, structures, and the invisible forces that determine who gets to live with dignity and who is left to navigate systems never built for them.

Dr. Flavia Bustreo, Former Assistant Director General Family, Women's and Children's Health World Health Organisation

Dr. Padmini Murthy, Professor and Global Health Director at New York Medical College School of Health Sciences and Practice, Physician

To guide this exploration, two global health leaders joined the cohort, each bringing a lifetime of experience across policy, activism, and lived engagement with communities worldwide. Dr. Padmini Murthy, speaking from Macedonia, carried the weight of decades of grassroots advocacy. From distributing menstrual kits in Suriname to working on maternal health in Rajasthan and disaster response in the Bahamas, she brought stories to the room, stories that made the abstract real. Dr. Flavia Bustreo, speaking from Geneva, offered another layer, a systems perspective rooted in global

policy. From algorithmic bias and gendered digital harm to the mental health crisis exacerbated by climate and technological disruption, she widened the scope, reminding everyone that healthcare today isn't only about treatment, it's about ethics, access, and who gets counted in the data that drives decision-making.

The session moved fluidly between facts and feelings, between research and reflection. Health, the speakers insisted, is a right named in constitutions, promised in treaties and yet still unequally distributed, especially for women, children, and adolescents. The conversation laid bare social determinants of health from economic inequality to educational gaps, from gender-based violence to environmental burdens shouldered disproportionately by women. Both speakers echoed that public health isn't neutral. It carries histories. It reflects systems of power.

> "Something that becomes a problem in developing countries is the opportunity cost when it comes to investing specifically towards women or in women's health." - *Rupkatha Chakravartty*

But what made the conversation truly powerful was its openness. The Changemakers didn't simply receive information; their hands shot up almost immediately as the speakers concluded, some ready with their own experiences and others with questions. Shreem, studying in an all-women's college, raised a question that lingered: Even when young women are given a seat at the table, how often are they truly heard? What does it mean to be included but not empowered to be visible but not influential?

> "As much as access to data is a key to empowerment, I believe it's also very poisonous because whenever there's a gender divide, you give access to data manipulation at the same stage." - *Sarvardhan Tiwari*

There were no simple answers. Dr. Bustreo spoke openly about the tokenism she had seen in major global institutions. It was not uncommon, she said, to see young people included for show, not substance. But that was precisely why it mattered to arrive prepared, to speak with clarity, and to hold institutions accountable for the spaces they claimed to offer.

The conversation that unfolded was not just one of diagnosis. It was an invitation to think harder, feel deeper, and respond with both heart and rigour.

Later that day, the Changemakers received a quiet, reflective voice note, marking the first instalment in the "Thinking Aloud with Aparna" series. It reminded the cohort that even in a space as thoughtful as this one, it was easy to fall back on

what felt familiar. During the session, gender had drawn more focus, while Well-being quietly receded into the background. Not because it mattered less, but because it was less visible, less rehearsed. And that, Aparna said, was precisely why this phase of the programme existed.

Fact-Finding and Familiarising was not about drawing conclusions. It was about asking better questions. About noticing not only what was said but also what wasn't. About returning to a moment and asking: Why did that resonate with me? Why did I resist that? What haven't I yet understood?

Indeed, awareness doesn't always arrive fully formed; sometimes it must be gathered, sat on and mulled over. Shivpriya, reflecting on the session days

later, shared how it had altered her approach to fieldwork. She found herself listening more carefully to health workers and volunteers, especially women. The conversation on immunology had given her just enough context to feel equipped not to speak over, but to speak with. What she gained wasn't just information, but the confidence to connect meaningfully, and the humility to do so mindfully.

Later in the session, the Changemakers were divided into breakout rooms and asked to imagine one intervention the Government of India could take in the next five years at the intersection of Gender Equality, Well-being, and public healthcare. The discussions were wide-ranging, from menstrual equity to vaccine access, from gendered assumptions in medical research to cultural narratives of resilience. And slowly, a deeper understanding emerged: gender is not a silo. Well-being is not a personal pursuit. Together, they form the ground on which public healthcare must be reimagined.

This session did not offer a resolution. It was not designed to. What it offered was something far more lasting: a shift in perspective, a deeper lens, and permission, perhaps for the first time, to be uncertain. Because that uncertainty was not a weakness. It was a beginning.

A Climate of Care: Linking Public Health and Environmental Justice

The second F session unfolded like a quiet revelation. It addressed two goals that many believed they understood, environment and hygiene, and placed them squarely within the framework of public health. This wasn't about melting ice caps or distant sea levels. It was about asthma in crowded cities, hunger in rural fields, and the invisible particles we inhale every day. It was about the lives already shaped and, in many cases, shortened by the breakdown of public hygiene and environment.

Dr. Revati Phalkey, Director, International Institute for Global Health, United Nations University

Dr. Revati Phalkey joined the session from Malaysia, where she serves as the Director of International Institute for Global Health at the United Nations University. Drawing on years of global experience, including leading initiatives at Save the Children and UK Health Security Agency, she provided a sharp and urgent account of how climate change is no longer a future crisis. It is an ongoing public health emergency, and deeply unequal in its impact.

> "I wanted to know that through CBDR, has the international community has been able to make strides towards a greener and a better planet, or if it still remains a blame-shifting game?" - *Aishvarya Rajesh*

She highlighted how the worst effects of climate collapse fall hardest on those who already carry the weight of inequality, who are usually people with low incomes, the marginalised, and the geographically vulnerable. Children living in informal settlements. Agricultural workers exposed to extreme heat. Women carrying water over long distances in drought-prone areas. For them, every degree of warming becomes a multiplier of disadvantage.

Even at 1.1°C of warming, the damage is staggering. Undernutrition is rising. Crop failures are becoming routine. Mental stress is escalating. Children today, she warned, will face nearly three times more climate-linked crop failures than the generations before them. And already, 88% of the disease burden caused by climate change falls on those under five. It is not only a failure of systems, but also a betrayal of rights.

> "There are slow-onset events that governments and corporations are pretty much very ignorant about, but it is actually affecting a lot of local communities and the public in general." - *Divyanshi Agarwal*

For Divyanshi, who came into the programme with a background in environmental science, the session opened up something new. She began to see climate not only as a matter of ecosystems and emissions, but also as something intertwined with food, fatigue, finance, and fairness. It shifted her view not away from science, but toward its intersections. She found herself thinking differently about solutions, not only what to propose, but how to imagine alternatives.

Dr. Phalkey spoke about resilience as a virtue that should be urgently woven into systems. She referenced the WHO's 10-point action plan, urging stronger governance, decentralised health infrastructure, data ecosystems that can respond to shocks, and financing models that protect the most vulnerable. She reminded the cohort that climate change isn't just harming crops and polluting the air; it is also costing us economically. In 2023 alone, heat exposure resulted in losses of over $835 billion and 512 billion work hours, primarily among outdoor and informal workers.

> "Disasters like floods lead to displacement of people, and that leads to PTSD… now terms like eco-anxiety and eco-grief are coming up, that talk about how people are living in a lot of fear about climate change." - *Arpita Goenka*

And yet, the response must be dual, both mitigation and adaptation. She made a compelling case for building green health infrastructure, particularly given that the healthcare sector itself accounts for nearly 5% of global greenhouse gas emissions. From energy-efficient clinics to WHO's carbon calculators, the tools exist. What is needed now is a collective will.

The conversation also introduced the One Health framework, a powerful approach that recognises human, animal, and environmental health as interconnected and inseparable. This, Dr. Phalkey explained, is crucial in tackling issues like antimicrobial resistance and the rise of zoonotic diseases. Our bodies, our environments, and our systems are not siloed. Neither should our solutions be.

As the session unfolded, the questions came in waves. Divyanshi asked how we might bridge the technological and financial gaps in the least developed countries where climate impact is rising fastest, but adaptation funding lags far behind. Smriti shared her appreciation for efforts like replacing open-chute toilets on Indian Railways and how such seemingly small infrastructural shifts can radically improve hygiene, dignity, and health. Others raised questions around eco-anxiety, manual scavenging, and caste-based sanitation inequities, reminding the group that climate, like gender, is not experienced equally.

For Medha, the session stirred something personal. The ideas brought her back to a friend's undergraduate thesis on environment and mental wellness, a topic she had once brushed past. Now, inspired by the session's depth and urgency, she was thinking seriously about making it the focus of her own master's dissertation. "There was so much to take in," she reflected. "And even more to return to. I realised how much I hadn't yet understood about how our inner worlds are shaped by the outer ones."

Dr. Phalkey closed the session not with panic, but with possibility. She encouraged the Changemakers to pursue participatory research, utilise community mapping, and leverage platform-based advocacy. She spoke of the importance of credible messengers, cross-sector collaboration, and, perhaps most importantly, strategic patience, the kind of slow, steady resolve that real change demands.

This session didn't just show that climate change affects public health. It showed how deeply public health is the climate crisis, shaped by it, compromised by it, and essential to its solution. It invited the cohort to see pollution not just in the air, but in policies. To see hygiene not just as a practice, but as a right. And to see the environment not as a separate field, but as the ground on which all health stands.

For many, it was a turning point. Not because it gave all the answers, but because it redefined the questions.

Conflict, Care, and Courage: Public Health on the Frontlines of War

The third F-session of the program took the Changemakers into the heart of one of humanity's most wrenching dilemmas: how does healthcare survive in zones of conflict? Dr. Saleyha Ahsan, a doctor, academic, journalist, and veteran of humanitarian medicine, joined from the United Kingdom to share a powerful story woven from decades of lived experience.

Dr. Saleyha Ahsan, Emergency Medicine Doctor, PhD student, co-convenor of the CRASSH, and journalist

Dr. Ahsan opened by describing her unique background, a childhood steeped in stories of partition, a military commission in the UK, and ultimately her deployment to Bosnia, where the brutal reality of war changed her life's direction. Witnessing booby-trapped homes and traumatic injuries, she decided to retrain as a doctor, dedicating herself to humanitarian medicine and conflict-zone healthcare.

> "Conflict doesn't just destroy buildings; it destroys the entire health system. And it's not always immediate, you know, the damage plays out slowly over time, with shortages, with untreated conditions, and of course, the trauma that is beyond physical." - *Sonal Gramopadhye*

Her presentation peeled back the layers of modern conflict, she recounted the tragic reversal of protections for healthcare workers, who are now being directly targeted in contemporary war zones. Red Cross emblems once marked safety; today, they can act as sniper targets. Dr. Ahsan cited WHO data showing more than 6,700 attacks on healthcare between 2017 and 2024, with over 2,000 deaths and 4,200 injuries across conflict regions like Gaza, Sudan, Ukraine, Lebanon, and Yemen.

Country-specific details were harrowing. In Yemen, fewer than half of 5,500 health facilities remain functional, while Sudan's hospitals operate at barely 56% capacity due to repeated attacks. The public health systems in these zones collapse under mass casualties, chronic staff shortages, and the forced flight or death of skilled

workers, leaving only junior and unprepared personnel behind.

The psychological toll, she warned, is profound. 60% of civilians now fear even living near a healthcare facility, worried it will be attacked, while 50% fear seeking treatment altogether. Dr. Ahsan argued for the vital role of humanitarian corridors to keep access open for food, medicines, and surgical supplies, describing how blockades force hospitals in Gaza, for example, to carry out operations without anaesthesia or food for recovering patients.

One of her most compelling themes was 'Peacebuilding Through Health' (PBTH). This meant that viewing healthcare spaces can act as neutral bridges in conflict, sometimes enabling ceasefires to deliver aid or treatment, as seen in parts of South America. However, to achieve this, there must be robust protections and policy frameworks in place to safeguard medical personnel and facilities. These protections, she emphasised, should be enforced by international law.

> "I think, most of us have got such a reality check as to what we see on social media and what happens on ground is, like, vastly different." - *Aryaa Praseed*

Dr. Ahsan reflected on the role of journalism as both a witness and a catalyst, capturing the human cost of war, influencing global policy, and inspiring advocacy. But she also acknowledged the deep trauma that repeated, graphic war coverage can cause, for both viewers and healthcare workers, calling for responsible, trauma-informed reporting.

She challenged the Changemakers to think about their own futures, encouraging them to get involved in legal reforms, diplomacy, media, or policy. We reiterated that there is space for every discipline in these conversations, and protecting and advancing public health in conflict is a human responsibility, not limited to any particular profession. She also described her current research with the WHO and Cambridge University on cancer care access for refugees in Jordan, highlighting how these crises can become increasingly complex.

> "How are we ensuring that no patient gets left behind when we think of clinical interventions and war zones." - *Shlok Shah*

The interactive dialogue was intense. Smriti Sharma reflected on the haunting images Dr. Ahsan showed, including a tank next to a demolished Syrian building, calling them both powerful and disturbing. Shreem and Rupkatha helped analyse

the visuals, correctly identifying military imagery and discussing its symbolism. Samvardhan and Prakruthi explored questions around neutrality in journalism, while Ibrahim, a volunteer from AMSA India, asked about international arbitration and legal recourse to hold perpetrators accountable. Aryaa and Medha raised the mental health effects of constant online war imagery, describing the toll of digital trauma, and Suhani and Shlok considered how information overload might desensitise public advocacy.

These cross-disciplinary reflections influenced by law, journalism, medicine, and public health revealed just how deeply the session had resonated. The questions were not abstract. They came from places of lived conviction and quiet urgency. In response, Dr. Ahsan offered more than analysis; she offered a call to action. Strengthen public policy. Demand legal accountability. Build mental health support for those who work in the shadows of war. And above all, she told the cohort, never stop upholding and advocating for humanitarian principles. Even in the worst of circumstances, healing remains possible if we choose to make it so.

For Aryaa, who had spent most of her time in the education space, the session opened a door she hadn't known was closed. Her work in the social impact sector had brought her close to friends who had lived through crisis and displacement. But she had never seen conflict through the lens of healthcare, never fully understood how violence leaves its mark not just on infrastructure, but on bodies, minds, and systems.

Anika later called it her favourite session, a feeling many echoed in the days that followed. And yet, it wasn't a session that ended on a light note. There was a visible weight in the room, a shared silence that lingered. But beneath that heaviness, something had shifted. There was knowledge now, and with it, a new kind of sensitivity. A sharper awareness. A more profound passion not just to understand the world, but to act within it. The urgency wasn't theoretical. It had become personal.

Rethinking Futures: Education, Employment, and Public Health

The final F session turned its gaze forward, not just toward the future of public healthcare, but toward the systems that shape it from the root: education and employment. It asked the Changemakers to think beyond surface-level reforms and imagine something bolder, more structural, more deeply just. It was not a neat ending to the F phase. It was a threshold.

Dr.Yonette Thomas, founder and CEO of UrbanHealth360

Mr. Rajesh Awasthi, Principal, Choithram School

Even before the session began, they had been invited to reflect on their experiences. In the second voice note from the "Thinking Aloud with Aparna" series, the cohort was offered a quiet provocation. The note described a lone traveller navigating a dense forest. For hours, the traveller walks in a particular direction, relying on a compass, trusting what she knows, until the fog lifts. From this new vantage point, she realises she's been slightly off-course. The destination still exists. However, it now lies in a slightly different direction. What should she do? Keep going in the path she's already committed to, or pivot, not because she was wrong, but because she now sees more clearly?

The story was simple, but the message was piercing: Changing your mind with more insight isn't a contradiction, it's growth.

This voice note wasn't a detour from the learning. It was a cue. A reminder that changemaking doesn't require certainty, but presence — the ability to adapt when new knowledge emerges. It set the tone for what was to come.

Dr. Yonette Thomas, a leading epidemiologist and social scientist whose work has long focused on knowledge justice and cross-sector equity, opened the session with a provocation that lingered: What does forward thinking really mean in public health? For her, it wasn't about futuristic technology or grand policy visions. It was about moral clarity, evidence-based planning, and the courage to challenge whose knowledge gets legitimised and whose is left out.

STAKEHOLDERS

She urged the cohort to look at education not as a neutral space, but as one charged with power: what is taught, who teaches it, and who gets to ask the questions. Learning, she insisted, must be action-oriented and socially rooted, not confined to rigid academic silos, but designed to break them apart. Health, ethics, and empathy must become core to how we teach, not electives to be chosen later. Only then can education become a tool for structural transformation rather than social reproduction.

Later, Mr. Rajesh Awasthi joined the cohort to build on this thread from a different angle. Widely respected for his work with the Choithram Foundation and his commitment to youth-led design and inclusive systems, he brought the conversation back to practice, to institutions, professions, and the decisions that shape what public service looks like. His message was simple but urgent: the question is no longer whether something is good or bad, but whether it is relevant. Are our systems responding to the world we live in or the one we've left behind?

For Shivpriya, that idea landed with particular force. She found herself reflecting on how often we valorise tradition over transformation, especially in health spaces. Mr. Awasthi's call for culturally diverse, technologically adept nursing systems felt especially significant as a reminder that the future must not only be efficient, but inclusive.

Throughout the session, the connections between education, employment, and health began to reveal themselves, not as three separate domains, but as a single, interwoven system. When schools fail to equip young people with tools for participation and care, that failure echoes in employment. When jobs are precarious or exclusionary, health systems absorb the stress. And when we pathologise mental health without addressing poverty, climate anxiety, or discrimination, we mistake symptoms for causes.

The Changemakers responded not just with agreement, but with imagination.

> "Most of us are not doctors by profession, right? But what most of us have is the ability to research, observe, and perhaps interact with people. So, a big part of healthcare is also interacting and doing impact assessments, or just conducting surveys.. I would be happy to do it." - *Devanshee Sharma*

Just like clockwork, the hands rose to ask questions almost immediately after the speakers finished. Rupkatha questioned how law and political science education could be reformed to create a greater social impact. Aishvarya wondered what it might look like for health equity to be taught not at postgraduate levels, but in high school science classes. Shreya spoke about her personal experience of having started in clinical therapy, and she now saw the need to engage in systemic mental health reform. Sana added reflections on justice and trauma, while Ananya, Devanshee, and Prakruthi shifted the conversation toward the decolonisation of knowledge and the bravery it takes to challenge academic conventions.

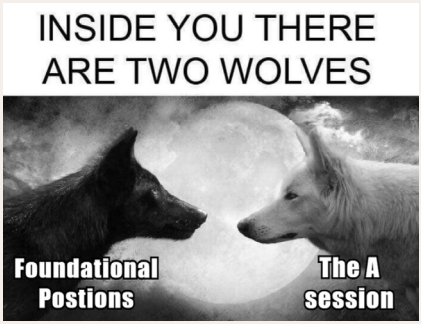
> "As a journalist, I believe the most I could do is report the things that need to be reported....The first stage to any solution is pointing out the problem." - *Nila Varma*

In that space of inquiry, something softened and something deepened. There was recognition that learning must move closer to life, and that public health cannot be delivered by systems that were never built to include the people they serve. Education, employment, and health became less like sectors and more like stories, overlapping, reinforcing, and echoing through one another.

As the F-sessions come to an end, they left the Changemakers with a peek into the healthcare ecosystem from various perspectives. It ignited curiosity, frustration, and hope, inspiring them to challenge what had always been taught. It gave them the motivation to rebuild systems, so they reflect the realities of those within them. And courage to centre not just efficiency, but fairness, in every space where knowledge is created and carried forward.

Advocating for the Alternate: Walking in Another's Shoes

The second step of the F.A.I.R. journey, Advocating for the Alternate Viewpoint, put the Changemakers in an uncomfortable spot, forcing them to test the limits of their beliefs and their ability to adapt. In these A-sessions, Changemakers were challenged to advocate for an initiative or viewpoint related to public healthcare and a goal that went directly against their own beliefs. This did not mean playing devil's advocate, but about building empathy, broadening their thinking, and developing the patience and humility to truly understand how "the other side" makes its case.



Ananya's take on Advocating for the Alternate Viewpoint

Each Changemaker was assigned an initiative connected to a specific goal that they would promote as the only intervention the Government of India should prioritise for the next five years, even if they personally disagreed with it. They were given time to research and prepare, exploring the initiative's logic and the context in which it could be argued as beneficial.

The session took place on Zoom and unfolded across four rounds of breakout rooms; each carefully designed to test and deepen their understanding. In the first round, eight Changemakers gathered in a group, each defending their own goal and its attached initiative. The second round shrank the room to three or four people, all sharing the same broad goal but defending different initiatives within it, giving them a chance to sharpen their arguments even further.

Then, in the third round, Changemakers were mixed into new small groups of three to challenge each other's thinking once more, building on insights from previous

debates. Finally, in the fourth round, yet another fresh group of three or four Changemakers met to put their strongest, most refined arguments forward.

These dynamic, back-to-back conversations pushed everyone beyond the boundaries of their comfort zones. In lively debates full of tension and occasional laughter, they tried to convince peers why their assigned initiative was the best path forward, while simultaneously learning how to respectfully dismantle the initiatives of others.

Between the serious preparation, the group used their shared WhatsApp group to release pressure in anticipation of the upcoming session. A flurry of friendly messages, sticker jokes, worries about fumbling arguments, and a running sense of camaraderie showed how human, vulnerable, and nerve-racking this process was. As one Changemaker described it, it felt like an 'intellectual Bigg Boss task', intense, sometimes even intimidating.

Ultimately, these sessions built not just knowledge but character. By learning to advocate for something they disagreed with, Changemakers exercised critical thinking, empathy, and the power of fair dialogue, essential tools for any leader trying to make sense of a complex, plural world.

Round One: Stepping into Discomfort

They had arrived after a whole weekend of research and learning, taking notes on reports and academic papers, as well as findings from studies that proved their long-held beliefs were, in fact, false. Now, gathered into four distinct groups, the Changemakers faced a more complex challenge than merely observing or reflecting; they had to defend an idea, fiercely and unapologetically, as if it alone could transform public healthcare over the next five years.

It was an uncomfortable ask for many of them, but growth often begins in discomfort.

GROUP 1

Group 1 stepped into the circle with a shared sense of caution. Sonal, Alfia, Shreem, Anika, Diya, Nila, Saummya, and Sanah each held strong positions about centralising nutrition, rethinking mental health delivery, limiting technology in hospitals, and more. Yet they approached their arguments with gentleness, hesitant to interrupt or challenge each other too strongly. Statements were made carefully, one after the other, like stones placed side by side rather than hurled.

Still, small sparks showed their minds working. Shreem raised questions about what was actually practical in the field, nudging the group beyond philosophy. Nila

pushed others to consider whether policies could truly stick without local buy-in. Even when Alfia's rebuttals felt reserved, the group listened generously, yielding space to every voice. A sense of respect ran deep, if anything, too deep to allow a real collision of ideas.

GROUP 2

Group 2 carried a steadier beat, defined by Medha's powerful sense of focus. She argued for prioritising curative healthcare above all else. Around her, Prakruthi, Smriti, Rupkatha, Aishvarya, Divyanshi, Jaya, and Tushti looked for ways to weave in equity, prevention, and systems thinking. Their conversation turned on whether urgent care should consume all resources or whether small investments elsewhere could still be effective.

Prakruthi offered practical stories from the field, encouraging the group to see beyond statistics. Jaya and Divyanshi added thoughtful questions about how to balance fairness with effectiveness. Even when disagreements rose, the group followed an unspoken decorum, taking turns to speak, each question acknowledged. It was a careful balancing act, learning to stand firm while remaining open.

GROUP 3

Group 3 felt like a team of explorers, testing ideas without fear of going off the map. Sana, Shreya, Aryaa, Guncha, Rajshekhar, Akansh, and Devanshee each carried a different lens on public health. Akansh, with an eye for systems that outlast short-term fixes, challenged the group to consider long-term community responsibilities. Shreya highlighted the human dimension of mental health, while Sana anchored the conversation in practical systems design.

Their conversation moved freely, sometimes branching in different directions, sometimes circling back to a central point. Rajshekhar showed flashes of agreement, encouraging others to connect their ideas, while Guncha and Aryaa balanced curiosity with a sense of fairness. Devanshee tried hard to challenge without alienating others, helping them keep the debate grounded. This group had the seeds of a robust dialogue, even if it sometimes wandered off track.

GROUP 4

Group 4 lit up almost immediately with a spark of debate. Shlok invited strong questions from the start, encouraging everyone to speak their mind. Arpita, Samvardhan, Smriti, Shivpriya, Suhani, and Ananya responded with a mix of caution, working through questions of standardisation, local leadership, and public trust.

Samvardhan balanced ideals with reminders of practical gaps, Smriti focused on the power of consistent, nationwide messaging, and Arpita grounded her points in evidence. Ananya, quieter at first, observed carefully before stepping forward, while Shivpriya and Suhani weighed in with their own measured perspectives. There was a sense of motion here, a willingness to dive beneath the surface and test each other's assumptions. The conversation stayed respectful, but no one shied away from asking hard questions.

Round Two: Common Ground, Conflicting Paths

Across every group, a pattern began to emerge: the Changemakers were learning to hold space for disagreement without losing respect. Standing alone, arguing hard, and pushing back felt unnatural. Yet even in their hesitation, you could see something shifting. They were beginning to realise that defending an idea does not mean abandoning compassion, and that disagreement, when rooted in a shared purpose, can be another form of care.

This first crucible of ideas had left its mark. The Changemakers returned to the main room knowing that the next rounds would ask more of them. They prepared themselves for sharper arguments, deeper questions, and bolder challenges. They were ready. Their empathy had carried them this far; now, their rigour and reasoning would lead them further still.

If the first round had been a cautious warm-up, the second was a real trial by fire. Each group now represented the same overarching goal, but within it, they had to defend initiatives that sometimes directly clashed. Each person was expected to make a case for why their version of change deserved to lead the agenda for the next five years.

GROUP 1

Group 1 focused on achieving well-being. Arpita, Medha, Shreya, and Shreem dived straight in, weighing immediate clinical needs against broader ideas of mental and community health. Arpita managed to connect arguments from previous rounds but occasionally circled back on familiar examples. Shreem tried to keep the discussion steady, though her instinct for compromise sometimes weakened her defence. Medha kept a tight grip on curative priorities, reminding the group that resources are finite. Shreya widened the conversation, shifting focus to rural gaps and overall infrastructure. Their exchanges grew sharper as they pushed each other to back up claims, revealing where positions stood strong and where they wobbled.

GROUP 2

Group 2 explored the goal of gender equity, where Ananya, Rupkatha, Saummya, and Aryaa had to thread a difficult needle. Rupkatha shared a deeply personal logic for representation but found it challenging to stay anchored in her assigned position. Saummya leaned into debates around "customised" versus "universal" approaches but occasionally lost sight of her initiative's specifics. Aryaa showed steady confidence but agreed to a counterpoint that weakened her case. Ananya tried to keep the group cohesive while also testing her own assumptions. Their discussion had energy and flashes of boldness, but you could sense the struggle of holding an argument that felt at odds with their natural instincts.

GROUP 3

Group 3 centred on environment, gathered Divyanshi, Devanshee, Suhani, and Anika. Divyanshi drove the conversation with her consistent references to diversity and climate resilience, making others think beyond quick solutions. Suhani stayed firmly grounded in her principles, turning questions back on the group to clarify where their arguments fell short. Devanshee balanced a strong personal conviction with thoughtful challenge. Anika moved through multiple angles, at times moving away from the core focus, yet contributing through insightful and valuable questions. The group's discussion was lively, with tension simmering as they circled around the best way to achieve environmental progress.

GROUP 4

Group 4 focusing on hygiene, consisted of Alfia, Smriti Banka, and Sana. Smriti Banka brought a firm voice about civic duty and personal hygiene, highlighting how the public sector could step back to focus on health delivery. Sana anchored her points around hospitals staying dedicated to medical care rather than non-clinical tasks, even when nerves surfaced. Alfia contributed clearly, keeping the group's focus on hygiene protocols and risk minimisation, though sometimes held back on sharper follow-up. Their group moved briskly, trading perspectives with fewer pauses and a more decisive tone.

GROUP 5

Group 5 took on education as their goal, with Tushti, Smriti Sharma, Diya, and Guncha discussing who should lead health education efforts. Smriti Sharma argued powerfully for national standards and consistency, while Tushti worked to clarify how evidence-based models could prevail, even as she sometimes struggled to hold her position steady. Diya challenged the group to consider qualifications and who gets to teach, although her content sometimes ran thin. Guncha helped steer the group's direction, encouraging others to stay on track. This group showed flashes of healthy disagreement and a more apparent willingness to question each other.

GROUP 6

Group 6 gathered around nutrition, where Sonal, Shlok, Prakruthi, and Akansh debated centralised versus community-led approaches. Sonal showed determination, defending national nutrition schemes with examples from the field, even while visibly under pressure from Shlok's incisive questions. Shlok, confident and precise, tested gaps in everyone's logic, drawing out contradictions. Prakruthi tried to balance empathy with evidence, though at times took leaps that didn't fully land. Akansh initially pushed hard against state-driven programs but conceded ground when challenged on practicality. Their conversation was challenging, and for some, even stressful, but they stayed engaged, trading arguments with real intent.

GROUP 7

Group 7 focused on peace as a goal, represented by Samvardhan, Aishvarya, and Sanah. Samvardhan laid down a framework to weigh each initiative, helping the group keep focus. Aishvarya challenged inconsistencies in the conversation around local involvement, while Sanah brought in the role of education in fostering long-term peace, trying to frame it systemically. Their discussion was strategic, blending idealism with practical realities, and showed a maturing sense of what 'peace' demands in action.

GROUP 8

Group 8 on employment, saw Jaya, Shivpriya, Nila, and Rajshekhar tackling questions of service mandates, upskilling, and incentives. Jaya argued for a mandatory rural service year to correct urban–rural health gaps, appealing to doctors' empathy. Shivpriya started strong, though she wavered as deeper questions came up. Nila raised thoughtful questions about how small enterprises might handle these shifts, keeping things practical. Rajshekhar focused on future-proofing skills and cash transfers, though sometimes felt disconnected from the group's direction. They challenged each other with sharper questions than in Round One, digging into what might truly drive sustainable employment in healthcare.

This second round made one thing clear: defending a position was no longer just an intellectual exercise, but a stress test of clarity, courage, and quick thinking. Some Changemakers wrestled with ideas that clashed with their instincts; others found unexpected confidence when their reasoning fell into place.

By the end, even those who struggled felt a new sense of resolve. In defending these initiatives, even the ones they would never choose themselves, they were developing the ability to break free from their own boxes, strengthening the muscles of argument, empathy, and vision. And they knew the next challenge would demand even more.

Round Three: When Conviction has no Middle Ground

By Round Three, the Changemakers had already carried their positions through two intense trials. But this round was different. Each group had been assigned different goals and even more divergent initiatives within them, amplifying the fundamental contradictions. They were no longer just defending ideas but having to hold the line against concepts that directly collided with their own.

GROUP 1

Group 1's Arpita, Devanshee, and Samvardhan found themselves juggling priorities between social enterprise, public-private partnerships, and state-driven models. Devanshee worked hard to keep her argument grounded, even conceding how she personally struggled with entirely rejecting community perspectives. Samvardhan attempted to anchor the conversation within a broader framework, encouraging the others to weigh practical solutions, although moments of distraction crept in. Arpita started strong but felt adrift when the others edged closer to a middle-ground agreement, leaving her searching for a way to rejoin the conversation. Their conversation revealed how easy it was to slip into compromise and how difficult it was to defend a singular vision when the group leaned toward blended solutions.

GROUP 2

Group 2 had Medha, Saummya, and Suhani. They showed a steadier pace, each holding to their initiative under growing exhaustion. Medha remained firm on resource allocation, though her arguments cycled around the same axis, with a quiet stubbornness. Saummya explored the question of balancing mass solutions against customisation but still found herself testing the edges of her own position. Suhani raised questions that sometimes meandered away from the main challenge but maintained a willingness to probe. Despite their fatigue, they kept at it, pushing each other to stay honest about whose initiative truly deserved priority.

GROUP 3

Group 3 with Shreya, Divyanshi, and Sonal handled mental health, environment, and nutrition with thoughtful exchanges, even if they sometimes felt repetitive. Shreya attempted to expand the conversation to rural healthcare infrastructure, while Sonal offered practical examples to reinforce nutrition priorities, remaining determined despite the heat of the debate. Divyanshi revisited diversity and climate resilience, weaving threads from earlier rounds, but also pushed others to clarify how these goals could coexist. The group's debate showed how deeply these goals intertwined and how separating them felt almost unnatural.

GROUP 4

Group 4's Shreem, Alfia, and Shlok jumped right into challenging one another. Alfia laid out strong hygiene priorities while Shreem tried to keep the discussion on a steady course, even as questions grew sharper. Shlok, calm but confident, pressed for clarity, exposing contradictions and demanding consistency. Their discussion was a reminder that defending bold reforms means being able to weather pointed challenges, and each of them learned to do that, even as the tension rose.

GROUP 5

Group 5 had Ananya, Jaya, and Sana, who moved through peace, rural healthcare, and hospital management with a focus on practical impact. Jaya argued powerfully for mandatory rural service, appealing to a sense of shared duty, while Sana pressed for systems-level thinking around education and peacebuilding. Ananya challenged both to think in terms of equity and broad impact, ensuring that leadership roles remained inclusive. Their exchange was measured but persistent, revealing how difficult it was to rank these priorities when they all felt essential.

GROUP 6

Group 6 with Rupkatha, Anika, and Aishvarya tested the boundaries of leadership, representation, and public health frameworks. Anika, feeling the heat, tried to redirect attention by opening it to other parts of the conversation whenever she was questioned, while Aishvarya called for consistency and fair reasoning. Rupkatha worked to keep representation anchored in merit-based models, even as the group challenged her to explain what that meant in practice. Their discussion was layered, each argument touching a nerve that demanded careful, honest defence.

GROUP 7

Group 7's Tushti, Akansh, and Shivpriya explored education, mid-day meals, and medical standards. Tushti was quieter this round, listening more than speaking, while Akansh tested the state's role in family-led models of nutrition and schooling, conceding at points when the group dug into details. Shivpriya remained thoughtful and steady, even though she held back from pressing the group too hard. Their conversation moved in fits and starts, each person weighing the balance between local and national solutions.

GROUP 8

Group 8 with Smriti Sharma, Rajshekhar, and Aryaa explored public health education, technology, and equitable systems. Smriti worked to anchor consistent messaging across communities, while Aryaa found herself caught up in defending her stance, struggling to step away from tricky questions. Rajshekhar cut straight

to the heart of competing ideas, testing assumptions about scale and fairness. Their debate had flashes of intensity, but also moments of surprising alignment when common threads emerged.

GROUP 9

Group 9 Diya, Nila, and Sanah, engaged on issues related to the health workforce, AI systems, and civic responsibility. Nila raised thoughtful points about how small businesses might respond to major health reforms, although she sometimes shifted away from questions that directly pressed her position. Diya aimed to keep the conversation grounded in education standards, while Sanah raised significant concerns about data quality and risk when AI handles high-stakes decisions. Their group worked hard to keep the conversation on track, managing the friction of fundamentally different starting points.

GROUP 10

Group 10's Guncha, Prakruthi, and Smriti Banka debated civic hygiene, nutrition, and personal responsibility. Prakruthi made bold, even provocative, statements to test Smriti Banka's arguments, while Guncha, more reserved, still managed to point out when certain initiatives felt like luxuries rather than urgent needs. Smriti Banka remained confident and occasionally assertive, emphasising the importance of personal hygiene as a civic duty. Their discussion was energetic, occasionally bordering on fierce, but left the group clearer on how complex public expectations truly are.

By the end of this third round, you could sense a shift. The Changemakers were tired, but they had also learned to hold their ground, even in the face of deeply uncomfortable questions. They had discovered how easy it is to agree on 'change' in the abstract, yet how hard it is to choose a path when resources, values, and social consequences are on the line.

This was no longer a simple debate. It had become an exercise in wrestling with power, trade-offs, and the burden of priority, and it left every Changemaker just a little more prepared for the real-world stakes they had set out to transform.

Round Four: Final Stand, Fractured Grounds

By Round Four, the Changemakers were no strangers to defending their visions. Yet this final grouping placed them with the most fundamentally different positions of all, pushing them to truly confront contradictions head-on. Here, there was no room left for fence-sitting. Each had to persuade the others why their initiative alone should command the state's focus for the next five years.

GROUP 1

Shlok, Samvardhan, and Aryaa, immediately revealed the tension between collaborative public-private models and more state-led or diversity-driven solutions. Shlok stepped in to challenge overly flexible, 'collaborative' approaches, demanding clarity and anchoring everyone to their own positions. Aryaa tried to introduce elements of gender and social diversity, which opened her up to tricky follow-up questions, while Samvardhan carried forward arguments from earlier rounds, again leaning toward public-private partnerships. Their discussion was pointed and searching, as they grappled with competing definitions of fairness and state accountability.

GROUP 2

Group 2 had Smriti Banka, Smriti Sharma, Suhani, and Aishvarya, who found their arguments clashing over how to prioritise civic education, personal responsibility, and peace education. Smriti Banka adopted a more assertive line, ensuring her points held the floor, while Aishvarya navigated a more diplomatic path, suggesting peacebuilding be targeted to conflict-prone geographies rather than applied broadly. Suhani listened but struggled to interject forcefully, and Smriti Sharma posed thoughtful questions that nudged others to stay rigorous. They wrestled with how to define 'essential' education in a society where so many competing needs jostle for attention.

GROUP 3

Group 3 comprising Diya, Sana, Divyanshi, and Rupkatha, entered with a calm yet determined energy. Rupkatha put forward a solid defence of her focus on competence and qualification, while Sana questioned the practicality of some positions, occasionally steering the discussion off its axis. Divyanshi brought the climate and resilience angle back to the table, weaving it into broader priorities, while Diya tried to centre the conversation on the importance of education standards. Their group demonstrated how challenging it can be to maintain a single focus when ideas seem equally important in a rapidly changing society.

GROUP 4

Group 4 with Arpita, Akansh, Anika, and Nila had a debate that felt almost theatrical at times. Arpita connected her initiative to Nila's, only to quickly challenge its priority when tested. Akansh argued for tackling poverty as a root cause rather than prioritising technological interventions, while Nila worked hard to defend the 'why' behind her position, even as questions about 'how' tripped her up. Anika, after moments of hesitation, turned to directly questioning others with renewed sharpness. This group's debate made it clear that structural changes cannot be

separated easily from technological or social reforms, no matter how hard one tries.

GROUP 5

Group 5's Medha, Shivpriya, Alfia, and Sonal explored arguments around resource prioritisation, nutrition, and systemic reforms. Medha held firm on core resource allocation, while Alfia raised thoughtful questions about how policy would be implemented in complex markets. Sonal continued to make points even after the occasional technical glitch, and Shivpriya remained mostly in listening mode, only posing questions when prompted. Their conversation revealed the enormous difficulty of getting systems to work on the ground, beyond slogans and ideals.

GROUP 6

Saummya, Sanah, Prakruthi, and Tushti offered one of the more lively exchanges of the round. Saummya found herself defending the role of consent, though that same argument turned into a vulnerability others quickly explored. Sanah adopted a playful, even sarcastic tone at times, prompting people to consider what feasibility truly meant. Prakruthi tested the boundaries of words and definitions, playing with the line between 'nutritional plans' and 'diet plans' and managing to slip past challenges. Tushti stayed reserved, but watched the others closely, occasionally stepping in with clarifying questions. This group showed how language and framing could make or break a policy's acceptance.

GROUP 7

Group 7 with Jaya, Shreya, and Devanshee tackled rural health, mental health, and animal welfare from vastly different standpoints. Jaya worked to justify mandatory rural service, but opened herself to challenges about how doctors later migrate to the private sector. Shreya explored broader public health infrastructure, while Devanshee tried to stay rooted in her own stance, even acknowledging the personal challenge of entirely opposing community-centred ideas. Their debate had a calm but thoughtful tone, revealing just how intertwined rural development and broader healthcare goals can be.

GROUP 8

Group 8 had Guncha, Rajshekhar, Shreem, and Ananya, and they brought the final heat of Round Four. Rajshekhar wasted no time in pressing Shreem about whether her policy was essentially maintaining the status quo. Guncha listened carefully and expressed surprise at certain statements, while Ananya tried to jump in but

found herself occasionally agreeing too soon, exposing herself to counterpoints. Shreem pushed back with conviction, trying to reframe her policy as transformative rather than repetitive. Their group's conversation showed just how difficult it is to distinguish a truly new approach from incremental improvements.

Across the round, Changemakers were sharper, bolder, and less willing to leave contradictions unchallenged. They began to break through politeness and test each other's logic in earnest, though some still looked for ways to collaborate or hedge their positions. Fatigue was setting in, but so was a deeper recognition: ideas alone do not win, only ideas that survive intense questioning and reflect genuine priorities have a chance to move forward.

By the end of this round, the Changemakers had pushed their arguments to the breaking point. If in the first rounds they found themselves expressing values and sharing pleasantries, this final round was about seeing whether those values could withstand the reality of disagreement and competing claims. It was a hard lesson, but an important one. The goal was not to lean on arbitrary contradictions in the name of discourse, but to acknowledge the complexity in everything, and hopefully we will be a bit kinder while engaging with people with differing opinions.

In Conclusion

Across the four rounds, the Changemakers' journey revealed far more than their ability to argue. The A-sessions were not simply about debating policies. They were about stepping into dissonance, inhabiting unfamiliar positions, defending what they didn't believe, and learning how discomfort shapes insight. These were not just intellectual exercises. They were psychological stretches. Emotional recalibrations. And, for many, the most disorienting and revealing part of the journey so far.

The rules were deceptively simple: argue a case that may not be your own. But what followed was far more complex. The positions they were asked to defend were never the point. They were tools designed to expose gaps in understanding, test conviction, and challenge the instinct to cling to certainty. Many entered the sessions assuming the task was to present a view clearly and wait politely for questions. But as the ideas clashed more fundamentally, that surface confidence began to shift. Some hesitated. Some resisted. Some began distancing themselves from the views they had been assigned. Others leaned in, treating the role not as a burden, but as a portal, a way to understand why someone else might believe what they did.

The reactions to discomfort were telling. Some became nervous. Some became combative. Others went quiet. A few slipped into performance, presenting well-

crafted arguments or using semantics or statistics as crutches without truly sitting with the position they were defending. And some, in the name of balance, tried to find safety in the middle ground. "Both sides have some truth," they said, and often, they were right. But at other times, that middle space became a hiding place, a way to avoid taking a stand altogether.

These differences mattered. Because they revealed how each person thinks when they're under pressure, what they protect, and what they're willing to re-examine, and hopefully triggered an essential question in the mind of the Changemakers, i.e., why weren't they willing to re-examine their thoughts?

Samvardhan found the sessions especially transformative. Moving through both the F and A phases, he began to notice the quiet gaps in his everyday life, places where he had stayed silent, where questions had never made it out of his head. He started asking uncomfortable things, for instance, about the social security provisions for staff at his own law school. The sessions had pushed him beyond theory. They had pulled the questions out of his head and into the room.

Rajshekhar appreciated the methodology itself. For him, the A-sessions weren't about proving a point. They were about testing the limits of others and of himself. Watching fellow Changemakers wrestle with unfamiliar views gave him a deeper respect for the internal work it takes to stay open. It reminded him that openness isn't passive. It's active, vulnerable, and brave.

Anika on the other hand, wished for more structure, especially when conversations were becoming confusing or veered off course. As the session kept getting chaotic, her inclination for clarity and reasoning increased, reflecting a need shared by many others in the group as well. The lack of clarity forced her and others to dig deeper. To go the extra mile. In trying to locate the centre, they had to define it for themselves first.

Aishvarya, usually calm and composed, found herself unexpectedly anxious. The smaller breakout rooms were more intimate, less predictable, and unsettled her at first. But within that tighter space, she discovered it was actually easier to defend her position. The proximity allowed her to articulate herself better, making connections that often don't get a chance to emerge in a crowd.

And then there was Rupkatha, who listened to a post-session voice note and said, without hesitation, that it felt like she had been called out for six straight minutes. Aparna's voice note was a reflective message shared with the group. The note didn't name names. But it named tendencies. The ease with which some slipped into new views without thinking. The temptation to perform rather than probe. The

instinct to agree with everything to avoid friction. The fear of standing alone. It was a mirror, not always flattering, but deeply honest.

In many ways, that voice note became a pivot. It reminded the cohort that the A-sessions weren't just a stage for ideas to be presented. They were a rehearsal for the real world, where arguments don't come with warning, and discomfort rarely offers disclaimers. It asked them not just what they thought, but why they thought it. Not whether they could argue, but whether they could sit with contradiction and still remain open.

No two Changemakers experienced these sessions in the same way. And they weren't meant to. The discomforts were individual. The learnings, collective.

By the final round, something had shifted. They began to see disagreement not as disruption, but as discipline. They saw how conviction grows stronger when tested, how clarity arrives through friction, and how the pursuit of justice is rarely tidy. The strongest ideas, they now knew, are the ones that can hold their shape under pressure or be reshaped without breaking.

And so, they turned toward the next phase: Introspection.

But this was no retreat. It was not a soft pause after the heat of debate. If anything, it was the deeper challenge to gather everything the A-sessions had surfaced and sit with it, fully. Not to solve it. Not yet. But to see it clearly.

It was time to look inward, but through the reflections of what had just been shared, questioned, and broken open. Because sometimes, the clearest mirror is not our own but someone else's.

And sometimes, the real debate begins only when the talking stops.

Introspection

After a well-deserved break, the Changemakers came back to the Zoom session, hoping for answers to the chaos they had experienced the last time. But the I-sessions were never designed to resolve anything. They existed to create a pause.

There were no new positions to adopt. No initiatives to defend. No closing arguments to prepare. The Changemakers were simply placed back into the same breakout rooms, with the same people and the same unresolved conversations from before.

Tension resurfaced. The frustration and unease from the last session reappeared, but now, time had shifted something. The emotions weren't gone, but they were more visible, more observable, no longer all-consuming.

Previously, many of these groups had ended mid-conflict, in silence, in rebuttal, or in the exhaustion that follows disagreement. Returning to that space recreated the exact conditions under which judgment had formed. But this time, there was no agenda to advance.

Instead, they were asked to notice, not just the room, but themselves. What had shifted? What remained? And what could now be seen that wasn't visible before?

The session unfolded in three parts.

In the first round, they were asked to avoid "I" statements altogether. They were given prompts that asked them to observe others, how someone else had felt, what someone else had said, what stuck, and what didn't. The idea was simple: to reflect on what they had witnessed, without inserting themselves into it.

This shift was subtle but unfamiliar. Without using "I", there was no room for defence. No justification. No qualification of tone or intention. The only task was to hold space for the other.

The second round flipped the mirror. Now, only "I" statements are allowed. Each sentence had to begin from the self: "I felt...", "I missed...", "I could have...". The structure forced specificity. It became increasingly challenging to blur discomfort into politeness or to obscure clarity in the pursuit of group consensus. In earlier rounds, silence could pass unnoticed. Here, silence became its own answer.

Then came the third round.

Ten cognitive biases were laid out in front of them, each explained in clear, behavioural terms. They were asked to scan their experiences from the Open Houses, the F-sessions, the A-session, and the two rounds they had just completed. The goal for them was to just sit with themselves and give themselves the space to answer the questions posed to them:

Did I change my words to seem more agreeable?

Did I trust someone more just because they seemed like me?

Did I ignore ideas that didn't fit what I already believed?

Did I think about how I sounded more than what I meant?

The list was long. The answers didn't have to be. The point was not confession. It was pattern recognition.

Some Changemakers discovered they had stuck to positions not because they were strong, but because they had spent time building them. Others realised they had dismissed a person's idea before fully hearing it, because of who they thought that person was. A few had defaulted to the safest position in the room, not the one they believed in most, just because it was easier to defend.

None of these were admissions of failure. They were just recognitions.

The F.A.I.R. process never asked for perfection; it demanded something even more tedious to achieve: precision. Not just in thinking, but in self-awareness. Not just in logic, but in the quiet honesty of noticing when, how, and why a belief began to shift.

By the end of the session, no one had changed sides. That wasn't the goal. But they had, each in their own way, begun to see that fairness is not just about what we argue for. It is also about how we listen. What we notice. And what we choose not to ignore.

Round One: What we Noticed in Each Other

In the first round of the I-sessions, the Changemakers were asked to step away from themselves to reflect not through their own emotions or performance, but through the lens of observation. It was a conscious departure from the structure they had gotten used to: no defending, no clarifying, no "I think" or "I felt." Instead, they were invited to consider how the others around them had shown up the day before.

Naturally, this wasn't easy. Most conversations began with compliments, moments of reassurance, encouragement, or gentle appreciation. The tone was warm,

sometimes tentative. There was a shared understanding that everyone had been under pressure in the previous rounds, and now, given space to breathe, many were ready to acknowledge the effort it had taken.

Some Changemakers observed how others had managed to present their points with clarity, even in situations where it may not have aligned with their usual way of thinking. Arpita, for instance, was noted for her steady articulation, with Nila and Akansh both mentioning how she maintained an agreeable, composed presence in the room. Anika added that Arpita's background may have made the argument feel more accessible, which in turn added weight to her delivery.

Others commented on the choices their peers made in framing their positions. Samvardhan, in particular, was recognised for the structured way he engaged with the group, often beginning his contributions with thoughtful framing, such as "As a law student..." or "As someone on this call..." It became a familiar rhythm, one that reflected his instinct to ground arguments within a specific context or identity.

The reflections also created space for conversation about the subtle dynamics that had emerged in the earlier sessions. Aishvarya noted that some arguments, while well-delivered, seemed to lack conviction. Smriti Sharma, whose stance had been under discussion, openly agreed. There was no sense of confrontation in the exchange; instead, it suggested a shared understanding that adopting unfamiliar positions, especially those that contrasted sharply with one's values, was not just an exercise in debate, but in emotional labour.

Across rooms, Changemakers began to offer observations that were not just about performance, but about growth. Banka reflected on Aishvarya's approach to combining strategies, noting that she had found the insight valuable even though she hadn't said so at the time. Similarly, Shlok's interaction with Aryaa showed how mutual respect and light humour could create space for both reflection and learning. His suggestion that a little rhetorical misdirection could have made her argument even stronger came with a smile, not as a critique, but as a sharing of secret tips and tricks.

Some reflections blurred the prompt, shifting from outward observation into gentle self-awareness. Sana, for instance, began speaking from her own experience, and the group stayed with her, not correcting but listening. Sanah revisited her arguments from the previous session for the benefit of someone who hadn't heard them and then wondered aloud whether the group might be repeating itself or straying from the task at hand. Moments like these revealed how naturally the self weaves into our perceptions of others, and how difficult it can be to keep the two apart.

The conversations were slow, searching, and sometimes circular. But these conversations made one thing quite clear: that there was an early acknowledgement that everyone had seen each other at their most convincing, their most uncertain, and often somewhere in between.

By the end of the round, what had emerged was not a consensus, nor verdicts about each other's performance, but a quiet map of memory. A map of who stood out, and why. Of what stayed with them. And of the simple fact that introspection, even when directed outward, inevitably finds its way back home.

Round Two: Noticing Ourselves

If the first round had asked the Changemakers to observe others, the second brought them face-to-face with themselves. This time, they were explicitly instructed to stay within the boundaries of "I." No analysis of others, no evaluations of arguments. Just honest reflection: "I felt… I struggled… I was unsure…" In theory, it was a simple linguistic shift. In practice, it required a kind of vulnerability that few were accustomed to, especially after days of preparing to debate, defend, or deconstruct their arguments.

Some found the words quickly. Arpita shared that her internal compass had stayed fixed throughout; she simply wanted to win. For Samvardhan, the strategy was different. He said he was searching for a middle path throughout, a way to maintain the integrity of his argument without sacrificing nuance.

Others spoke of fatigue and how it had shaped their decisions in ways they hadn't noticed at the time. Anika acknowledged that by the time she reached the later rounds, she was too tired to argue and instead focused on asking questions. Shreya reflected on how her difficulty aligning with the position she was assigned made the whole experience harder, but also more revealing. Even in disagreement, she said, she found new ways to gain a deeper understanding of the topic.

Sonal recalled moments of hesitation; she had to sit through silence while trying to decide just how far to push her argument. By the end, though, she found herself surprisingly on board with the very position she had struggled with at first. Aryaa simply stated that she agreed with both her assigned and initial positions, a statement that captured the quiet contradictions many were still working through.

Not all reflections were tidy. Alfia, with characteristic frankness, admitted she had grown restless toward the end of the session, frustrated that others didn't agree, and eager to move on. Ananya, more softly, noted that as the session progressed, the camera in the call was turned off, and the absence of faces on the screen left her feeling unsettled. "I like to see people," she said. "It makes it easier to connect."

For Medha, the shift was almost self-affirming. She began her reflection with a line that surprised even her: "I used to think everyone here was brilliant, but I've realised I am smart too." That moment, half-spoken and half-realised in the saying, echoed the kind of confidence this step was meant to nurture.

Some voices revealed discomfort not with others, but with themselves. Rupkatha acknowledged, without hesitation and quiet honesty, that she could have owned her position better. Suhani, in turn, reflected that she could have spoken more and asked more questions. Shreem admitted she hadn't prepared as much as she wanted to, while Smriti Sharma shared that one question from a peer had unsettled her more than she expected.

Even Rajshekhar, who believed that his assigned position was not far from his own, found himself revisiting it, defending it not to convince others, but perhaps to understand why he held it so firmly. And Shlok, even as he drifted toward "you" instead of "I," revealed more than he realised when he said he had deliberately masked parts of his argument to steer the conversation his way.

This wasn't a round for clarity or closure. Many spoke in fragments. Some began in "I" and drifted toward "we," as if still unsure how to locate their own voice in the collective. But the discomfort itself was telling. These were not polished reflections; they were unfiltered, sometimes messy efforts to name the choices they had made and the emotions they had held back.

It didn't matter that not everyone followed the format perfectly. What mattered was that they, in their own way, tried to look inward, to speak without deflection, and to sit for a moment with the possibility that their loudest moments weren't always their most honest ones.

Round Three: Naming What Shapes Us

By Round 3, the room had grown quieter as the Changemakers prepared for what was to come. The prompt this time wasn't just to speak about oneself, but to look for what had gone unseen. Ten questions. Each one is blunt. Each one traces the contours of common cognitive biases. The invitation wasn't to confess. It was to notice and acknowledge: Did this happen to me? Did I let it? Did I even know it was happening at the time?

Some Changemakers met the questions head-on. Others held them at a distance, answering briskly and moving on. A few toggled between sincerity and self-protection. But everyone, whether overtly or not, was pulled into a new kind of reflection.

Aryaa admitted she often agreed with others not because she believed in what they said, but because it felt polite. Jaya echoed the same, "I was agreeing with more than I actually agreed to," she said. The recognition came with clarity and an opportunity to dig deeper and ask, 'why.' She also identified with sunk cost fallacy, the tendency to keep defending something just because one had already invested time or effort. "I'm still working on it," she added. Medha said it differently but pointed to the same place: "I was defensive. I wasn't open to other people's opinions."

Nila's response came with quiet depth. She acknowledged she might have been "subconsciously nice and polite" because she was trying to understand the other person's stance. But when asked how she was answering these questions, she paused. "I'm not thinking only about The F.A.I.R Project," she said. "I'm answering this from how I am in life." Around her, the group stilled. It wasn't just the prompt she had taken seriously; it was the act of reflection itself.

Across breakout rooms, similar moments flickered.

Shreya opened up, too. She had struggled, she said, to fully engage with a position she didn't believe in. "It made the breakout rooms hard," she admitted. "But the research showed me there's another side to things." The fundamental insight came after. "I kept thinking," she said, "how could I have disagreed better? In a way that was clear, but also respectful."

Some chose humour. Others went quiet. A few resisted the structure of the exercise altogether. Rajshekhar said, without flinching, that he wasn't interested in being polite. "I've dealt with the sunk cost fallacy," he recounted. "That was in college." But peers weren't so convinced. The dynamic shifted. Some disengaged. Others withdrew. "If I don't like someone," one person later said, "I just stop listening."

These weren't isolated moments; they were the very biases the prompt had named.

Confirmation bias. Spotlight effect. In-group bias. Compromise effect.

Some read the terms. Others lived them.

In one breakout room, the conversation turned soft, almost vulnerable. Diya shared how, even when no one was watching, she felt judged. "Even writing in the chat makes me nervous," she said. Smriti Sharma said she often feared sounding rude. Aryaa, nodding, said she'd been overly agreeable just to avoid conflict. The breakout room gently became a space of shared recognition. A fear of being seen too much, or not at all.

Meanwhile, Smriti Banka stood on the other end of the spectrum. "I don't feel judged," she said confidently. "I have high self-esteem." And while her tone carried her usual conviction, she also named a bias she saw in herself: "I place more value on people who are older and working. I don't take students seriously. I hate that, but I can justify it." The in-group bias, spoken aloud.

Some rooms drifted into light-hearted chatter. Others circled the prompt without sitting with it. In some cases, the answers were safe and politically correct. "Conversation for the sake of talking," someone called it. But elsewhere, something fundamental was taking root.

The truth is, no room captured everything. And no one claimed a clean slate. But that wasn't the point. This round wasn't designed to produce neat reflections. It was intended to leave behind a trace —a small, sharp awareness — that the ways we form opinions, defend them, or discard them are often shaped by forces we barely notice.

And so, when the ten questions were done, when they had named what had been invisible, the session closed not with conclusions, but with new uncertainties. The kind that makes you pause before a sentence. The kind that makes you ask, next time: What's really shaping what I believe?

In Conclusion

The I-session did not end in revelation. It ended in recognition.

No positions were reversed. No final arguments were made. There was no agreement to be won, no resolution to claim. And yet, something had undeniably shifted, not in the facts at hand but in the way they were being held.

The session had asked for no performance. Only presence. It asked the Changemakers not to rethink their stances, but to notice how those stances had been formed. Not to rehearse empathy, but to reflect on where it had faltered. Not to challenge others, but to confront the less visible forces of fatigue, fear, ego, and habit that shape what we believe and how we behave.

And in doing so, it revealed something uncomfortable and straightforward: that fairness is not a destination, but a discipline. It is not just about the evidence we find or the points we make. It is about what we choose to hear. What we ignore. What we justify, or excuse. What we cling to because we built it. What we let go of because we must.

The I-session, in many ways, was the quietest of all. But it was also the most personal. It was where bias became visible. Where silence became a signal. Where vulnerability, even in passing, became an act of clarity.

No charts were filled. No reports were submitted. But in the quiet tension between a question and a pause, between an instinct and a decision, the Changemakers met the one voice they had not yet debated, their own.

And from that meeting, they did not emerge with new arguments. They emerged with better questions.

Reason and Rationalise

After weeks of exploring facts, arguing alternatives, and pausing for personal reflection, the final step of the F.A.I.R. process asked something of Changemakers, not a new opinion, or a louder position, but a decision. Not as individuals, but as a group. And not in theory, but in practice.

The R-session, Reason and Rationalise, was never meant to deliver a neat conclusion. If anything, it was designed to resist one. This final phase of the methodology asked the cohort to step into a kind of discomfort they had not yet encountered. The discomfort of having to decide, together, in full awareness of contradiction, limitation, and trade-off. It was the point at which the ideal and the implementable were expected to meet.

The process unfolded over four carefully structured rounds. In the first, Changemakers returned to the eight goals they had gotten at the beginning of the journey. These were now reimagined as Ministries, small collectives anchored around a shared theme: Gender, Environment, Peace, Nutrition, Hygiene, Employment, Education, and Well-being. During the first round, these groups were not meant to reach consensus, not yet. They were asked instead to revisit the ground they had already covered and begin testing whether their ideas could withstand policy pressure.

In the second round, everything changed. Each Changemaker was assigned to a deliberately diverse Working Group, with one representative from each goal. There were no designated spokespersons. Everyone carried equal responsibility. In these rooms, they were expected to present their Ministry's ideas and negotiate how those ideas might intersect, overlap, or contradict with others. The task was to produce a shared set of policy directions that India could take, not a wish list, but a real, reasoned proposal that accounted for complexity, contradiction, and consequence.

The third round brought them back to where they started, to their Ministries, only now with a broader lens. Each group had to integrate what they had learned in the Working Groups and decide what they would take forward. They had to revise, strengthen, or even abandon parts of their own proposals to account for broader realities. If earlier rounds had been about expression, this was about evaluation. Every decision made here would be made with full knowledge of what it costs.

And finally, the fourth round: the collective Town Hall. One by one, each Ministry would present its final direction to the entire cohort. Each Changemaker could still

agree, dissent, or express questions about the proposed direction. The aim was not to make a value judgment regarding the proposed direction but to understand it as a potential option. Each direction carried the memory of the journey that had shaped it and the awareness that to decide something, even provisionally, is to become accountable for it.

Throughout the R-session, the goal was not to reach a permanent consensus. It was to practice what it means to reason in public. To speak in a way that acknowledges not only what must be done but what must be weighed, what must be let go of, and what must still be held on to. This final step was not about resolution. It was about readiness. The readiness to act with clarity, practicality, and care.

Round One: The Meet of the Ministries

The first round of the R-session brought the Changemakers back to the goals they had worked on since the early days of the programme, but now they returned to them not as individuals, but as collectives. Each Ministry, one for each of the eight goals, came together to begin re-examining their initiatives. The task at this stage wasn't to arrive at consensus, but to explore: how does this goal intersect with public healthcare? What questions does it raise? What tensions need to be acknowledged in order to design effective solutions?

The conversations unfolded differently across the eight groups.

In the **Employment Ministry**, Changemakers focused on the concept of entering the job market. Rajshekhar took on the role of summarising the discussion, while Shivpriya brought in references to IIT and MBA graduates. Her comment prompted a visible reaction from Rajshekhar, a moment that marked the undercurrent of unspoken scepticism surfacing. Jaya, meanwhile, raised the issue of reservations as the first thing that came to mind when she thought about unemployment, noting that she wasn't entirely against it. The group stayed on track, collecting ideas without forcing them to align.

In the **Peace Ministry**, the focus remained on outlining various factors to consider while connecting peace and healthcare. Sanah and Aishvarya were noted to be struggling to avoid slipping into intersectional analysis, a familiar instinct, but one that was intentionally held back at this stage to maintain focus on their specific goal. But during the conversation, they wondered out loud if this conversation could even be had without addressing the obvious intersectionality.

The **Education Ministry**, comprising Tushti, Smriti Sharma, Diya, and Guncha, anchored their conversation around ways to increase awareness of substance

abuse through the school curriculum, particularly in rural areas. As the dialogue progressed, Tushti steered the group toward a more philosophical line of questioning, broadening the frame beyond implementation and into values.

In the **Hygiene Ministry**, Alfia, Smriti Banka, and Sana found themselves navigating the overlap between waste management, sustainability, and public health. Their discussion circled around a pressing dilemma: how to promote better hygiene practices without contributing to plastic overuse. As the dialogue deepened, Smriti Banka emphasised the need for stronger civic responsibility, a point Alfia supported, while Sana raised questions about how feasible such ideals would be in practice.

The **Environment Ministry**, Divyanshi, Devanshee, Suhani, and Anika talking along similar lines of waste management and segregation seem to be taking another route altogether of giving institutions greater power to manage issues. Devanshee highlight the fundamental contradiction in promoting waste segregation and environment. Divyanshi, Suhani and Anika found themselves quietly reflecting at the challenge ahead.

In the **Nutrition Ministry**, Sonal, Shlok, Prakruthi, and Akansh focused on Mid-day meal programmes, but took a step further to address the challenges of people with dietary preferences or restrictions. All four found themselves revisiting the research they had done so far, so see what could be done to cater to everything while keeping in mind the limitations of resources.

In the **Gender Equality Ministry**, Ananya, Rupkatha, Saummya, and Aryaa, who were no longer limited by the positions they were given to defend, could finally approach the intersectionality between Gender and Healthcare with a balanced lens. Rupkatha found herself revisiting the lessons she had learned so far, with Aryaa, Ananya and Saummya working together to reconcile the extreme sides of advocacy.

Across these eight breakout rooms, the tone of the session remained exploratory. Rather than pushing for resolution, the Ministries focused on identifying connections and surfacing useful frames of reference they could carry into the next round. Some groups stayed tightly within the parameters of the task. Others drifted briefly into familiar patterns, bringing up intersectionality or slipping into abstract reasoning, but the broader intention held: to prepare the ground for policy thinking by first laying out the full map of ideas.

It was the beginning of a process that would demand even more critical thinking and adaptability from them. However, the point was not to agree. It was to see.

Round Two: The Working Groups

By Round 2, the air had shifted. Ideological explorations had given way to logistical deliberations. Changemakers entered this round with a singular purpose: to chart out concrete policy directions for how their assigned goals, now embedded within their Ministries, intersected with public healthcare. Unlike previous sessions, where disagreement could linger unresolved, this round required alignment. Every Changemaker was a spokesperson. Every voice needed to be heard. And every group had to deliver not just conversation, but consensus.

Each Working Group brought together one representative from each Ministry. In theory, it was a simulation of real-world negotiation. In practice, it was a test of endurance, listening, and clarity. There was no single model of progress, just a shared canvas, a ticking clock, and the quiet pressure of accountability.

In one of the Working Groups, a thematic clarity began to emerge early on. The group moved quickly from scattered ideas to layered integration. Peace was positioned as a matter of information equity, calling for patients to be actively informed and medically neutral spaces to be protected, especially in areas of conflict. This, in turn, connected easily with Education, which was framed as a mechanism to equip both students and healthcare workers to navigate crisis, through structured curricula, local awareness drives, and community inclusion. Health education, they proposed, needed to be embedded in daily civic life: in city panels, classroom discussions, public toilets, and even street plays. From menstrual hygiene to heatwave protocols, the group wove together goals that might otherwise have stood in isolation, each finding reinforcement in another. It wasn't always seamless, but there was a sense of cohesion. Even when intersections weren't immediately obvious, for instance, between hygiene and employment, they searched for common ground. Translators. Local trainers. Adaptive learning modules. Nothing was off the table, as long as it moved the discussion forward.

Elsewhere, a more granular approach emerged. Redefining Well-being was the starting point, pushing beyond the absence of illness into a broader ecosystem of mental health support, crisis preparedness, and technological access. The Peace policy was especially detailed, listing five distinct strategies for protecting healthcare systems and workers in moments of conflict. Environment was framed not only through the lens of medical waste and climate threats, but also early warning systems and resilient information networks. On Gender Equality, the emphasis fell on representation and reform, mandating inclusive clinical trials, embedding gender sensitivity into medical education, and ensuring that women and LGBTQIA+ communities weren't just passive recipients of care, but active Changemakers in designing it.

One group proposed a youth panel framework, a model that spanned the country's four geographic zones, enabling student-led health inquiries from high

school through early adulthood. Their thinking was bottom-up: let the curiosity of young people surface hidden challenges, then activate community media nukkad nataks, visual tools to drive literacy from the ground up.

Other directions were more technical. For Nutrition, they moved beyond conventional responses and broke the issue down across classes, from starvation and malnourishment in under-served regions to dietary ignorance in affluent ones. In each case, the challenge was not only what to eat, but also who educates and enables those decisions, including rural healthcare workers, public distribution mechanisms, and regulatory systems. Hygiene was also addressed through tiered strategies, waste segregation plans, cost-effective and eco-friendly products, and urban-rural differentiation in community awareness.

In another room, the conversation moved from systems to structures. Reframing Well-being became the anchor, not just as a health condition but as a living reality. There were calls for mandatory therapy check-ins for high-stress professions, integration of mental health into primary care, and a complete overhaul of how public health infrastructure supports mind-body integration. At the same time, policy drafts for Peace focused on preparedness and protection, early-warning systems in conflict zones, community first-aid programs, and civilian trauma response education.

Environment, in that same space, was tackled with urgency and precision. Clean energy infrastructure in hospitals, low-emission zones around health facilities, mandatory AQI monitors, and resilient hospital design were all considered essential, not add-ons, but core to healthcare delivery in the face of rising climate volatility.

As these layers were built, contradictions surfaced, too. In multiple groups, the old friction between Environment and Hygiene reappeared. The medical push for sterility and disposability often clashed with the environmental push for sustainability. But this time, those contradictions weren't dismissed, they were logged. Discussed. Kept visible. It became clear that policy doesn't eliminate trade-offs, it manages them.

And still, there were moments of pause. Shlok joked about not knowing what to do and feeling lost in the process. Some groups momentarily lost sight of their ministry roots, slipping into personal opinions rather than organisational priorities. Others leaned too heavily on dominant voices before quieter members pulled them back into balance. There were saves, missteps, and pivots. One Changemaker typed out their points because the discussion was moving too fast. Another began summarising for the group, not to take over, but to create space for others to catch up.

Across all rooms, one thing stood out. Policy wasn't being drafted in silos. Changemakers were no longer just representatives of their individual positions. They were now conduits for multiple lenses, carrying the responsibility of their Ministry while holding space for intersectionality. No one person made the decision. Every direction emerged from a mesh of lived experience, prior research, and that particular mix of voices in the virtual room that day.

By the end of the session, the whiteboards weren't perfect. Some were dense, others patchy. A few ideas overlapped; others stood alone. However, each reflected a genuine attempt to envision policy not as a siloed script, but as a collaborative process, shaped by expertise, tempered by negotiation, and grounded in reality.

This wasn't about idealism. Not anymore. It was about finding a language that could hold contradiction and still move forward.

Round Three: The (not so) Final Decision

The third round of the R-session marked a return to familiar circles. Each Changemaker re-entered their original ministry group, this time carrying not just their own understanding of public healthcare but fragments of everyone else's. They had seen how gender intersected with education, how employment complicated hygiene, and how peacebuilding depended on information equity. Now, it was time to gather what had been scattered and shape it into something coherent.

The task was straightforward in principle; each ministry was to arrive at a final policy direction. But the path to consensus was anything but linear. Over the course of the next hour, these conversations unfolded in fits and starts marked by insight, contradiction, fatigue, and a growing awareness of what it meant to decide together.

Some ministries moved briskly. They revisited earlier points, merged notes from the Working Groups, and translated that collective input into unified recommendations. Others lingered longer, caught in the tangle of diverging perspectives. But slowly, across all eight ministries, the shape of something final began to emerge.

The Ministry of Well-being focused on redefining health itself, not just the absence of disease, but a combination of prevention, research, digital outreach, and curative care. They placed mental health at the centre of both primary and tertiary care, pushing for student-led research, safe spaces, and tech-enabled support systems for vulnerable populations.

The Ministry of Gender Equality leaned into representation and implementation. They called for a gendered lens in medical research, personalised representation in health decision-making, and the use of simulations to better understand body-based experiences with equity, not just equality, as their end goal.

The Ministry of Peace assembled a multi-layered framework. They demanded protection for healthcare professionals during conflict, public access to information in moments of disruption, and widespread education on medical neutrality and patient rights. Training, alternative practices, and collaboration with local agencies became cornerstones of their proposal.

The Ministry of Environment put forward a vision of Green Health, integrating sustainable infrastructure, mandatory waste segregation, climate resilience, and low-emission zones in and around public health spaces. They also prioritised inclusive research, especially into biodegradable medical products, and expanded sectoral employment linked to environmental care.

The Ministry of Hygiene reframed its role from service provision to accountability. Their core recommendation was the creation of an Impact Measurement Framework, built into the National Hygiene and Public Sanitation Policy, to ensure transparency and consistent assessment of hygiene-related interventions.

The Ministry of Nutrition presented a detailed proposal under the title Ghar Ghar Ka Paet Bhar (Fill the stomach in every home). Their direction included strengthening the Public Distribution System (PDS) through condition-specific food allocation, promoting regionally appropriate sourcing, and improving nutrition literacy through schools and community outreach. A major emphasis was also placed on research, health kits for vulnerable groups, and inter-ministerial collaboration.

The Ministry of Education framed their approach as layered and local. They proposed student-led awareness campaigns, school-based panels, and a phased curriculum adaptable to regional needs. Their model integrated health education into the National Education Policy and utilised storytelling, animations, and expert-led sessions to make complex topics more accessible.

The Ministry of Employment focused on three fronts: expanding employment by creating more specialisations within healthcare, improving work conditions through inspection and policy, and setting up government-monitored portals for job discovery. Special attention was paid to anganwadi workers and others in grassroots roles, suggesting targeted training to integrate them more closely into public health delivery.

Across these rooms, not everything clicked. Some groups moved quickly; others struggled to synthesise what had been discussed. There were edits, hesitations, moments of silence, and threads of fatigue. However, over the course of three hours, the work was completed. Each Ministry returned with a direction that wasn't perfect but was real. Backed by lived experience, collective thought, and the persistent awareness that this wasn't just an exercise. It was a window into how decisions are made and who gets to shape them.

What came next was the final step: presentation, scrutiny, and agreement. But that was still to come.

For now, the work of consensus was complete.

In Conclusion

What had started as a thought experiment, a test of empathy, evidence, and expression, had now become something else entirely. The R session didn't ask for opinions. It asked for ownership. It didn't reward loudness or cleverness. It rewarded listening, rethinking, and letting go.

Across four rounds, the Changemakers had confronted not only opposing ideas but also uncomfortable overlaps. They had seen how a solution for one goal could complicate another. They had felt the limits of consensus. They had negotiated in real time with incomplete information, shifting attention spans, and very human emotions. And through it all, they had chosen to stay in the room.

Not because they were certain. But because they were accountable.

The goal had never been to settle for majority opinion. This was not a vote. It was a conversation in which even a single dissenting view was expected to be heard, recorded, and held. Consensus here did not mean uniformity. It meant arriving at a direction with full awareness of what voices stood behind it and which ones did not. That awareness mattered just as much as the final conclusion.

The directions they presented were not perfect. They were, in many cases, provisional, uneven, or ambitious beyond immediate reach. But they were also specific. Thoughtful. Unafraid to name contradiction. And perhaps most importantly, they belonged to everyone in the room. No decision was made alone. No voice was irrelevant. The final outputs bore the imprint of multiple hands, a shared draft of what policy could look like when written in public, by peers, with care.

The R-session was not a culmination. It was a calibration. A reminder that reasoning isn't the absence of disagreement it's what happens after. That action isn't clarity; it's courage with accountability. That policy, if it is to matter, must make space for both ambition and humility.

In closing this session, the cohort didn't arrive at final answers. They arrived at something better: a deeper understanding of how answers are formed, re-formed, and given meaning.

And with that, the F.A.I.R. process stood complete. Not closed, but complete enough to begin again.

Visits to the Healthcare Centres

After weeks of intense discussions, policy debates, and moments of genuine introspection, the Changemakers were finally asked to do something radically simple yet profoundly impactful: step outside.

This next step would not be taken together. There were no Zoom rooms to log into, no Miro boards to fill, and no sessions to attend. Each Changemaker would walk into a healthcare centre in their own city or town, not as a researcher, not as a representative of 8one or The F.A.I.R. Project, but just as themselves. As someone who belongs to the community they were seeking to understand.

To make this experience more grounded, an immersion preparation session was arranged in collaboration with AMSA volunteers. They came in and laid down the bare basics of how a Primary Healthcare Centre functions within India. They set the expectations for the Changemakers for what they were about to witness.

They knew public healthcare not through theory but through practice. The session was light and honest. There were stories about broken fans, missing records, and the quiet improvisations that make overstretched systems work. There were tips on how to ask questions without intruding, how to recognise when a centre is overwhelmed, and how to carry oneself with awareness and respect.

Beneath the anecdotes was a deeper reminder. This was not a survey. This was not an audit. It was not even a formal visit. It was an exercise in observation, in careful attention, and in humility.

In Bengaluru, the anticipation of the upcoming visits sparked its own momentum. Prakruthi and Aishvarya met with Isha, one of the facilitators, and Ibrahim, a volunteer from AMSA. It was an informal meeting, but filled with purpose, a chance to ground their excitement, clarify doubts, and share the quiet nervousness that often precedes doing something unfamiliar. It wasn't a strategy session. It was simply a pause before the plunge. A moment to remind each other that they weren't entering these spaces alone.

AMSA volunteers met Isha to plan for the immersion preparation session

Prakruthi, Aishvarya, Ibrahim, and Isha met in Bengaluru

In the WhatsApp group, a voice note followed soon after, echoing the same spirit. Everything you have done so far has reminded them; it has been a rehearsal. The real work begins now.

This was no longer about theory. This was fieldwork.

They would walk into hospitals and clinics that carried the weight of lived realities. There would be corridors with peeling paint and registration desks that never stop buzzing. But there would also be systems that held together. A nurse who remembers everyone's name. A helpline that works. A solution hidden in plain sight.

They were asked to carry forward the qualities they had developed through the programme. Curiosity from the Fact-Finding sessions. Flexibility from Advocacy. Self-awareness from Introspection. Reflection from the Rationale rounds. But to hold all these not as conclusions, but as working drafts.

This phase was not about proving a policy idea. It was about testing it. Could it stand up to the messiness of a real waiting room, the silence of a tired patient, or the quiet resignation of a staff member who has seen too much?

They were reminded to notice not only what was being said, but also what was being left unsaid. To gather patterns, observe carefully, and withhold judgment. To remember that freedom does not always feel like ease. With no checklist or rubric, they would have to ask themselves in real time: What am I noticing? What am I avoiding? What am I assuming, and why?

So, one by one, they stepped out. Into centres tucked between bus stops, behind markets, near schools and shrines. Some went with hesitation. Some with quiet excitement. Some stayed fifteen minutes. Others went back again the next day.

What they found was never meant to be uniform. That was not the point. The point was to see. And to see, this time, with nothing but the eyes of someone who belongs. Not as an expert. Not as a reformer. But as part of the very system, they hoped to understand.

These were not just visits. They were encounters. With people, with places, and with perceptions that do not always make it into policy documents. Encounters that would shape the following chapters of their journey, not in abstraction but in lived experience.

As the voice note had said, this is where The F.A.I.R. Project actually begins. Not in the conclusions, but in the fieldwork. In seeing for yourself.

Aishvarya

Aishvarya approached her visit with the care of someone eager to look beyond what was visible, not just to assess what functioned, but to understand what was quietly missing. She spent time at a smaller Primary Health Centre, one that appeared orderly on the surface: colourful posters about government schemes, waste segregation, and maternal and child health painted the walls; vaccination schedules and lists of staff and available medicines were clearly displayed. At first glance, the structure appeared to be intact.

But it was a weekend, and the silence felt telling. There were no patients in sight, and only a single nurse was on duty. Curious, Aishvarya struck up a conversation, and what unfolded was a glimpse into the layered workings of the centre. The nurse explained that most people in the area simply assumed the PHC was closed on weekends. As a result, patient footfall was almost non-existent on Saturdays and Sundays, not due to policy, but rather due to perception.

Their conversation soon turned to what weekdays looked like. The nurse spoke of patient queues stretching far beyond the centre's gates, of long hours, and limited hands. She also said, candidly, of the resource gaps, how equipment shortages were not uncommon, and how the centre's ability to function smoothly often depended not on protocol, but on personal connections. Their Medical Officer, she said, had good relationships with key officials, which helped them manage better than most. Without that network, operating the centre would have been far more difficult.

THE GREAT EQUIPMENT HUNT!

What stayed with Aishvarya, however, wasn't just the operational insight. It was the emotional texture of the space, the quiet coexistence of pride and fatigue, of resilience and fragility. She noticed how easily patients were expected to rely on verbal directions, how little there was in terms of navigational signage or systems designed to make the experience less daunting.

Even in this brief interaction, she could feel how hesitation and gratitude often lived side by side, how learned helplessness, shaped by years of systemic neglect, sometimes muted the demand for better.

After the visit, Aishvarya discussed with the fellow Changemakers how something as simple as public awareness, such as a signboard or local announcement, could shift perceptions and bring more patients in on weekends.

She plans to return on a weekday not just to see the centre in action, but to continue a conversation that had only just begun.

Akansh and Anika

Healthcare Centre Visited by Akansh and Anika

For Anika and Akansh, the PHC visits were not just exercises in observation; they were layered experiences that raised more questions than answers. Their journey began at the Mother and Child Welfare Centre in Hauz Khas, a smaller Panchkarma hospital that, at first glance, appeared warm and well-functioning. The walls were alive with posters on ORS, contraception, and maternal health. ASHA workers were present, responsive, and structured, each keeping detailed records of pregnant women in their area to ensure consistent visits for check-ups.

The physical environment seemed to match the administrative one: the centre was clean, well-lit, and, despite what Google Maps had incorrectly stated, very much open on weekends. That last detail wasn't lost on them; they made sure to inform the staff about the discrepancy.

Their conversation with the Medical Officer started with hesitation but gradually opened up. He spoke about how changing environmental conditions, rising air and water pollution had led to year-round respiratory issues in children. She noted, too, a subtle but powerful shift: the average age of pregnancy had risen, with most

women now over twenty, signalling greater autonomy and decision-making. Literacy, awareness, and hygiene, she said, were all improving. And yet, as Anika later noted, one topic remained conspicuously absent from the maternal health space: mental health.

For Akansh, the Hauz Khas visit was also a reminder of how information systems shape perception. He and Anika had arrived at the centre with incomplete online data, and this lack of updated digital visibility made them wonder: How many others never make it to such facilities simply because Google Maps says they're shut?

The next day, their path led to a far larger site: the Urban PHC in Mehrauli. Here, the narrative changed.

Spread across multiple floors, the facility was airy and well-staffed, yet it carried a noticeable dissonance. Certain areas were barely used, and the smell, in places, was unbearable. Two lifts existed for access, but neither worked, rendering the OPD spaces inaccessible to persons with disabilities. The Homoeopathy department was deserted. The Unani wing is locked.

Despite this, the centre saw a staggering 500 patients a day. Posters again lined the walls, this time created, they learned, by medical interns. Services were functioning, systems in place. But the air was heavier here, not because of the space, but the people.

The Medical Officer they met shared his views with sharp candour. His words weren't angry, but they were edged with frustration. "There isn't a gap," he said quietly. "There's a valley, a canyon even." His reflections touched on a deep structural grievance that healthcare professionals, despite being at the core of the system, were rarely seen as stakeholders in its design. Bureaucracy, he argued, dictated too much. Expertise too little. "If medical professionals were allowed to lead policy," he suggested, "the system might finally begin to heal itself."

Anika and Akansh left with a long list of observations and an even longer list of questions. Why is mental health missing from even maternal healthcare spaces? What does it do to a system when those holding it up feel excluded from decisions? Are doctors across the public system quietly burned out?

But they also left with glimmers of possibility. A toll-free helpline listed on a faded wall turned out to be functional. Within seconds, they were speaking to a real person. That moment of efficiency also stayed with them.

Together, their visits traced two distinct arcs of the healthcare story: one of slow, hopeful progress, and the other of structural fatigue. But both revealed the same truth: the system is not just bricks, medicines, and protocols. It is people. Their presence, their frustration, their commitment, and their quiet endurance.

Alfia

Alfia didn't just visit a healthcare centre; she returned to a place she already knew. A wholesale market she had studied before, where daily-wage labourers formed the backbone of the local economy. But this time, she wasn't looking through the lens of economics. She was looking for health. And what she found wasn't just the absence of infrastructure, it was the absence of imagination.

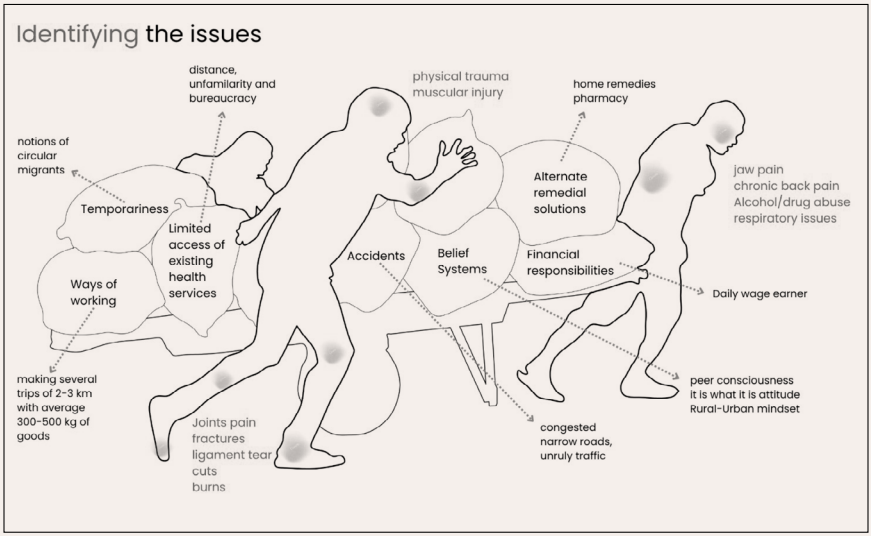
She had never examined this field with a public health perspective before, and doing so felt like peeling back layers she hadn't known were there. The market, dense and pulsating with human movement, revealed itself as a space riddled with risks: sharp turns, informal pathways, lack of emergency signage, and no visible health protocols. Accidents, she noted, usually happened at narrow junctions or unmarked intersection areas so familiar they had almost disappeared into the background of daily life.

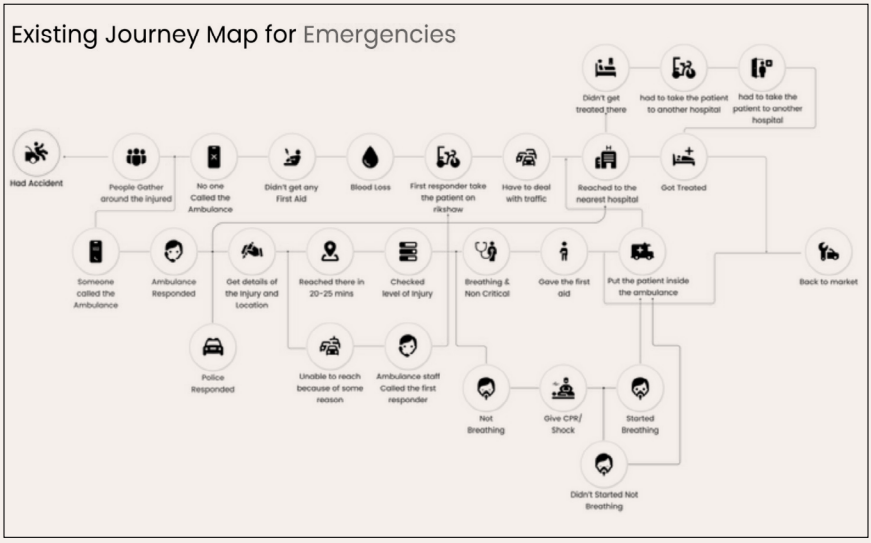
What set her process apart was not just observation, but mapping. Drawing from past research, she began sketching out the physical and procedural journeys that workers undertake during emergencies or, more often, fail to undertake. Her diagrams revealed a chaotic, broken pipeline of care: injuries that went unreported, intersections where labourers collapsed only to be carried away by coworkers, first responders who didn't know where to send them, and doctors who weren't informed in time.

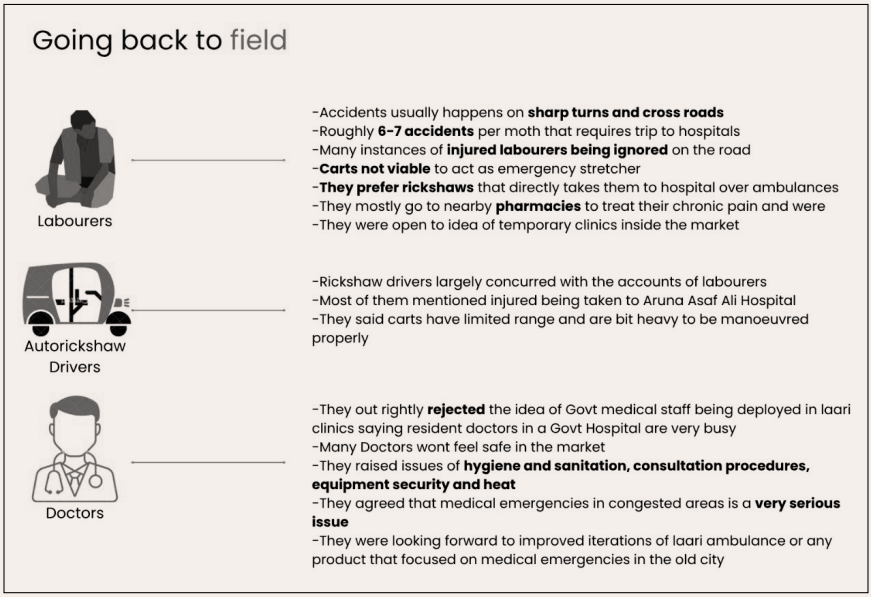
In one of her notes, she captured a simple, cutting truth: "They participate only at the end, when the case reaches the hospital." Health interventions were not just delayed. They were entirely missing from the first half of the journey.

Her visit revealed critical blind spots not just in the system, but also within herself. Why hadn't she seen this before? Why had her earlier research not asked these questions? She couldn't stop thinking about the invisibility of care in spaces of labour, how waste disposal was ad hoc, how hygiene tools were scarce, and how civic responsibility was treated as an afterthought.

But instead of retreating from the discomfort, Alfia turned it into design. She built a journey map for emergencies, overlaying it with pain points, gaps, and possibilities. Her goal was not just critique. It was clarity.


Identifying the issues
distance, unfamilarity and bureaucracy
physical trauma muscular injury
home remedies pharmacy
notions of circular migrants
Temporariness
Limited access of existing health services
Ways of working
Accidents
Belief Systems
Alternate remedial solutions
Financial responsibilities
jaw pain
chronic back pain
Alcohol/drug abuse
respiratory issues
Daily wage earner
making several trips of 2-3 km with average 300-500 kg of goods
Joints pain
fractures
ligament tear
cuts
burns
congested narrow roads, unruly traffic
peer consciousness
It is what it is attitude
Rural-Urban mindset


Existing Journey Map for Emergencies
Had Accident
People Gather around the injured
No one Called the Ambulance
Didn't get any First Aid
Blood Loss
First responder take the patient on rikshow
Have to deal with traffic
Reached to the nearest hospital
Got Treated
Didn't get treated there
had to take the patient to another hospital
had to take the patient to another hospital
Someone called the Ambulance
Ambulance Responded
Get details of the injury and Location
Reached there in 20-25 mins
Checked level of injury
Breathing & Non Critical
Gave the first aid
Put the patient inside the ambulance
Back to market
Police Responded
Unable to reach because of some reason
Ambulance staff Called the first responder
Not Breathing
Give CPR/ Shock
Started Breathing
Didn't Started Not Breathing



Designs created by Alfia after her visits

By the end of her reflection, one insight stood out most clearly: you can't fix what you haven't seen. And sometimes, seeing differently isn't about going somewhere new, it's about returning to the same place, with a different question.

Ananya

Ananya chose to go alone. She didn't coordinate with her peer, Diya, not because of scheduling conflicts, but because she needed to face the space on her own. The idea of navigating a clinical environment solo had felt daunting. But once inside, the anxiety dissipated with the rush and hustle of the centre.

Her visit was to a Health and Wellness Centre (HWC) in Chandigarh, a city that, unlike others in the cohort, operates through HWCs rather than traditional Primary Healthcare Centres (PHC). The morning began slowly. Though work officially started at 9, activity didn't pick up until 10. By noon, the crowd had thinned, which staff attributed to the nearby civil dispensary.

Still, what the centre lacked in patient footfall, it made up for in glimpses, small, telling moments that left their own mark. A nurse with a warm, easy laugh helped calm a pregnant woman who was nervous about her tetanus shot, distracting her

with gentle humour. It was a brief interaction, but it stood out, not because it was extraordinary, but because it was deeply human.

Ananya moved through the space with quiet curiosity. She saw a pharmacy, a labour room, a dressing area, even a designated breastfeeding section, which she hadn't seen in her earlier visits. And she noted what was missing: fire safety equipment, which PHCs are mandated to have; a designated health educator; and staff who seemed aware of those gaps.

At the entrance, she noticed something unusual: a long desk with multiple boxes, each labelled with different contraceptive options. An ASHA worker explained that the layout was intentional: a quiet, non-verbal way for people to pick what they needed without the discomfort of asking aloud. For Ananya, it felt like a small but meaningful intervention, a way of honouring dignity while expanding access.

There were pamphlets on mental health, too, early signs of anxiety and depression, quietly pinned to a bulletin board. The posters elsewhere felt more obligatory, as if they had been placed because they had to be. Few used visuals, and the language lacked clarity or engagement. But the breastfeeding section, the contraceptive desk, the rain-drenched ASHA worker returning from a home visit, those felt real.

She struck up a conversation with that ASHA worker, who shared how her training had evolved, beginning with maternal care, expanding into neonatal support, and eventually into wider field visits. That morning, her umbrella had broken mid-round. She was soaked, tired, but still moving.

Ananya didn't walk into the HWC to fix anything. She walked in to notice. And that act, deliberate, quiet, and fully present, became its own form of contribution.

What she saw wasn't perfect. It wasn't broken either. It was something far more complex, a space held together by systems, people, and improvisations. And in choosing to witness it on her own terms, Ananya left with more than observations. She went with insight that would stay with her long after the visit was over.

Arpita

In Guwahati, Arpita had always known of the two Community Health Centres near her home. However, it wasn't until this visit, sparked by earlier conversations during the Project, that she finally stepped in. She didn't need a grand reason. Curiosity was enough. That realisation stayed with her as she moved through both the public facility and the local mental health NGO, which she had long wanted to understand better.

The Urban Health Centre, on the surface, appeared clean. But not cared for. Overgrown grass crept around its borders, and while the registration line was short, the waiting time stretched disproportionately long. Inside, the walls were cluttered with posters and slogans, most of which were faded, some unreadable, and nearly all in Hindi or English. In a region where Assamese is widely spoken, the inaccessibility felt like more than a linguistic oversight; it felt like a metaphor.

She was noticed immediately. The person at the registration desk, initially confused, grew visibly cautious after Arpita explained her presence. "Don't linger too long," they said, eyes flicking over her shoulder every few minutes. It set a tone: observation was welcome only within a tight boundary.

Still, Arpita noticed plenty. A single patient, a mother of two daughters, had come in for routine vaccinations. She found the helpful centre, she said, for things like fever, cuts, and immunisations. But the long wait times were a strain, and while nurses and doctors were usually present, she often left feeling exhausted.

A conversation with the cleaning staff revealed more. Overworked and filling in for colleagues on leave for Ambubachi Mela, the staff spoke of vague rules, stretched responsibilities, and a sense of being overlooked, not just during festivals, but always.

But it was Arpita's visit to Ashadeep, a mental health and rehabilitation NGO, that lingered with her the longest. Unlike the health centre, Ashadeep wasn't cold or formal. The people there, from the co-founder to the special educator, welcomed her, not just as a visitor but as someone who might one day return to help.

Her first visit introduced her to the head psychologist, who oversaw community outreach, child therapy, and the rehabilitation of the homeless. She spoke with calm assurance about her work, which, she said, was fulfilling but often emotionally exhausting. The special educator, newer to the organisation, echoed that sentiment more vulnerably. Some days, she said, were challenging, days when multiple children broke down, and it felt like too much to carry alone.

On her second visit, Arpita met the co-founder, a woman who spoke openly about the personal journey that led her to build Ashadeep. The NGO had struggled for ten years before securing stable funding. Now, with four branches, it offered services ranging from therapy to education to rehabilitation. But the challenges remained. One, in particular, struck Arpita, the parents of children with mental disabilities, who were unable to find consistent professional care, were now acting as therapists themselves. It was admirable, but also alarming. Shouldn't the system be stepping in where families were being stretched too thin?

Ashadeep was resourceful, resilient, and driven by a deep commitment. But it also made visible just how much of the mental health system rested on individuals, their will, their improvisation, and their unpaid hours.

By the end of her visits, what stayed with Arpita wasn't just what she heard. It was what she felt in the spaces in between. In the government centre, it was the guarded glances, the unspoken resignation. At Ashadeep, it was the quiet fatigue of those holding up a system with too little help.

Arpita's reflection, in the end, centred around silence, not as absence, but as presence. The silence of neglected wards. The silence of children navigating invisible pain. The silence of a healthcare system that still doesn't know what to do

with minds that hurt.

But she had shown up. She had listened. And for a world that too often turns away from quiet, that itself was a start.

Aryaa

Aryaa arrived at her healthcare visit in Bengaluru without the benefit of the tips and tricks shared by the AMSA volunteers. And in a way, that absence worked in her favour. She walked in without frames or expectations, guided by observation, not outcome.

What she encountered, however, was a quiet rupture. The outpatient centre was functioning; people were being seen, records were maintained, and tasks were completed. But the space itself felt frayed at the edges. Cracked benches lined the waiting area, offering no comfort at all. Faded posters peeled away from the walls, their messages nearly unreadable. Patients sat in silence, waiting without engagement, without acknowledgement.

It wasn't chaos that struck Aryaa. It was the stillness. A stillness that didn't feel peaceful, it felt resigned.

What lingered most for her was the body language of the staff. The nurse she observed moved briskly, carrying out her duties with mechanical precision. There was no visible frustration, no cruelty. But there was also no softness. No eye contact. No pause. No gestures that said, "You are more than a name on a file." The system, Aryaa realised, was running. But it wasn't feeling.

And that, she understood, was not a minor gap.

It reframed her understanding of public health — not just as a question of coverage or capacity, but of atmosphere. The way a place feels. The way a person is received. The subtle, often invisible cues that determine whether someone feels safe, respected, and worthy of care.

The visit was short. But what it revealed to Aryaa was lasting. Health, she now knew, is not built solely on efficiency. Dignity cannot be an afterthought. And empathy, though unmeasurable, may be one of the most essential indicators of care.

She returned not with questions. What would it take to restore feeling to a system that has learned to function without it? Who teaches compassion in a structure that rewards only speed? And how might she or anyone begin to rebuild what's been slowly numbed?

Devanshee

In the days leading up to her visit, Devanshee was riddled with hesitation. The idea of walking into a government health centre unannounced, alone, without any institutional identity or authority to shield her, felt unsettling. But when she finally went in, something shifted. She realised that the discomfort was precisely the point of the exercise. It was in letting go of the impulse to prove, intervene, or fix that she began to see.

She chose a small dispensary nestled between a school, residential buildings, and a busy construction site. Though unassuming from the outside, the centre revealed itself to be far more dynamic than it first appeared. The inside was clean and functional, but she arrived late in the day, just as the place was beginning to wind down. The doctor, visibly tired and in a rush, offered no time for conversation. But the caretaker did. He spoke about how mornings often saw the centre overflowing, especially in the summer, with lines that sometimes ended in shouting matches over who would be treated first. The staff, he said, had grown skilled at diffusing such tensions and restoring order.

The dispensary was mainly used for vaccinations, minor injuries, and basic tests, services that, as the caretaker noted, would otherwise be unaffordable elsewhere. Many of their walk-in patients were construction workers who often came in with metal scrapes and wounds. Devanshee was particularly struck by the fact that some patients even brought their own vaccines, unsure whether the dispensary would have the right stock. It was a poignant reminder of the many subtle ways in which trust in the system had been eroded.

On her way back, she overheard two women in the metro: an ASHA worker and an Anganwadi worker. True to her instinct for observation, she struck up a conversation. They were initially wary but warmed up quickly once she explained her interest in them. The ASHA worker described her team's involvement in the Anaemia Mukt Bharat programme, their collaboration with NGOs, and the role of community volunteers in bridging resource gaps. Her words painted a picture of a system held up by invisible scaffolding, relationships, improvisations, and a shared determination to keep things moving, however imperfectly.

The Anganwadi worker spoke about her role in early childhood development, from spotting birth defects to holding difficult conversations with families in denial. Nutritional support was central to her work, but she noted how a lack of respect, understanding, and manpower often wore down even the most committed staff. What stayed with Devanshee was the quiet resilience in both women's voices, a blend of exhaustion and conviction, rarely captured in reports, but everywhere in practice.

As she shared her reflections with the rest of the cohort, she joked about cracking jokes with strangers to make them talk, but beneath the humour was something more profound: an awareness that listening itself was a form of engagement. Her visit became a reminder that observation is not passive and that sometimes, the smallest conversations open up the most enormous windows into how public systems really function.

Divyanshi

Divyanshi made her way to a government combined hospital, a place that once stood at the frontlines of the COVID-19 response and has since been repurposed into a multi-speciality facility. She had expected bureaucracy, maybe even neglect, but what she found was more layered. The hospital was a study in contrasts: signs of order held together by an undercurrent of strain.

At first glance, the hospital appeared relatively well-maintained. Key government schemes, such as Ayushman Bharat and Jan Aushadhi Kendra, were visible and functioning, and many of the core services, from emergency care to CT scans, were either free or heavily subsidised. The wards were clean, beds were made up, and nurses were equipped with proper kits for patient transfer. Ambulance services ran efficiently. Yet, it was clear that cleanliness was a continuous battle. The restrooms told a different story: clogged drains, cockroaches, and a glaring absence of accessible washrooms. Despite colour-coded bins, there was no visible segregation of waste. Improper food disposal added to the disarray.

And yet, it was the presence of the often-invisible that held the system together. The cleaning staff, rotating across four shifts, played a crucial role in maintaining the hospital's internal order. The security guards, stationed on every floor in the absence of surveillance cameras, lent a quiet sense of vigilance. There were no dramatic scenes, just a palpable rhythm of people doing what they could with what they had.

Divyanshi noticed how the OPD bore the weight of understaffing. The Medical Officer seemed to be everywhere at once, attending to patients, managing staff queries, and updating records. Medical interns working in staggered shifts provided some relief, but the pressure was evident. Biomedical waste was treated in-house, a sign of infrastructural progress, though the lack of consistent enforcement in daily hygiene practices remained a concern.

What struck Divyanshi most wasn't the absence of systems, but the way people adapted around their limitations. In a space often criticised for its inefficiencies, there were glimpses of quiet diligence: a nurse adjusting an IV drip, a cleaner

sweeping a corridor long after the crowd had dispersed, a patient waiting patiently for test results under a ceiling fan that flickered on and off.

On her way out, she thought about civic duty, not as a lofty ideal, but as something as simple as not discarding a packet on the hospital floor. She left with more questions than answers, but also with a clearer understanding that even in a system stretched thin, it is often the smallest efforts that keep the whole from falling apart.

Diya

PHC visited by Diya in Chandigarh

Diya's visit to a community healthcare centre in Chandigarh unfolded slowly, less as a tour and more as a process of noticing. What stood out to her wasn't just the facility or the services on offer, but what remained unclear, unsaid, or unused. She didn't enter expecting grand dysfunction or a perfectly oiled system. Instead, she arrived with questions and left with even more layered ones.

The centre she visited wasn't crowded. In fact, the low footfall surprised her at first until she realised it had less to do with the quality of care and more with how the city's infrastructure was designed. In Chandigarh, primary health centres are often located within close proximity of residential areas. But patients, she noticed, frequently bypassed them in favour of tertiary hospitals, even for concerns that could have been resolved at the primary level. It wasn't about convenience; it was about trust, habit, and awareness, or lack thereof.

Inside the centre, Diya observed that while posters and visual materials were informative, they were often overlooked. Partly because people were in a hurry, but also because the design made them easy to ignore. Too much text. Too little clarity. She imagined how much more helpful they could be if they included flowcharts, pictorial guides, larger fonts, or were grouped under clear headings. Visual tools, she felt, should speak to the patient before the staff does.

She noticed there was no visible signage at the entrance to inform people about what services the centre actually offered. This absence of basic information seemed symbolic of how underutilised these spaces were, and how little the

public knew about them unless they were regular visitors. She wondered if a city-wide database or app could help people identify which hospital to visit for specific types of care. But she also recognised that even the best-designed system needs trust and awareness to function.

What stayed with her most was the missed potential. These community centres could serve as the first line of care and as crucial nodes in the public health network, but only if people knew how to use them. Diya wasn't frustrated, just curious. She left thinking about how a slight shift in information flow could ease the burden on overcrowded tertiary centres, improve patient experience, and offer dignity to both care seekers and providers.

For her, the visit wasn't just about health infrastructure. It was about how people move through systems guided not just by logic or availability, but by perception, confidence, and the quiet hope that someone, somewhere, will know how to help.

Guncha

Guncha walked into her city's Central Government Health Scheme dispensary expecting efficiency, and in many ways, that's what she found. There was structure, even polish. Nurses worked from designated rooms with clear routines displayed on the wall. A small television looped health advertisements at the entrance, replacing paper posters. Patients wore masks. Syringes were unwrapped in front of them for approval. It felt reassuring, almost quietly impressive.

But even in that sense of order, something gnawed at her. A menstrual hygiene poster carried a glaring factual error. The weighing machines were outdated, offering inaccurate readings. Patients had to fill out multiple forms before seeing a doctor, an unnecessary burden, especially for the elderly. The most jarring detail, however, was a broken toilet room, missing an entire wall. It was still in use, including for collecting urine samples. When Guncha asked why it hadn't been repaired, she was told the government hadn't initially wanted a dispensary in that area. The land had been donated by a private trustee. The infrastructure, like the toilet itself, felt exposed, fragile, provisional, and always just one step away from being forgotten.

As she witnessed the gaps, she probed deeper. She stayed. She noticed. She asked questions. She corrected what she could. An ASHA worker listened carefully to her feedback about the menstrual poster and promised to act. It was a small, meaningful exchange. And yet, the heaviness lingered.

In contrast, the nearby PHC she visited later was a quieter space with fewer visible structures, but it told a deeper story. Women from surrounding slum clusters spoke to her candidly. They had heard of menstrual health schemes on TV or in political

announcements but had never attended a single sanitary pad workshop. She was surprised to learn that many women were unaware of how to use a sanitary pad.

Guncha's unease wasn't with individuals. It was with what systems fail to notice, what they overlook in plain sight. She found herself wondering: Had people simply stopped expecting change? Had the cracks grown so wide that they'd been normalised?

Still, she wasn't one to romanticise despair. Instead, she turned her reflections into quiet strategy. What if we created better health posters, more accurate and more local? What if we raised funds for basic infrastructure, such as dustbins, when state promises failed to materialise? What if we formed health clubs on campuses to carry forward public conversations, beyond the walls of government centres?

For Guncha, knowledge had no value unless it was in motion. It had to be translated, mobilised, and passed on, not just as information, but as shared responsibility. The broken wall in the toilet wasn't just a structural flaw. It was a symbol. And symbols, she believed, deserve to be taken seriously.

Jaya

Jaya hadn't planned to be in Kakinada that week. Her field visit was supposed to happen in Ranchi, her hometown, familiar terrain, where the surroundings, language, and even the rhythm of her days made her feel more grounded. But plans shifted. A schedule change brought her to a new city, just as she was juggling interview preparation classes and trying to recalibrate her time. That unfamiliarity made observation difficult. But Jaya was not deterred.

She located the nearest primary health centre and made her way there. There was no dramatic encounter. No moment of confrontation. What she found instead was a kind of stillness. The infrastructure was modest, with a foot traffic light, and the staff were thinly spread. Patients came and went quietly. There were no posters announcing government schemes, no bright visuals drawing people in. No chaos. But also, no signal, visual or otherwise, that this place was designed to serve a broader public.

It didn't feel dysfunctional. It felt forgotten.

That subtle absence stayed with her. In a country where health infrastructure is often measured by what's broken, what Jaya encountered was something more challenging to name: a lack of presence. Not of walls or medicines, but of outreach, of care extended visibly and deliberately into the community it was meant to serve.

She returned with a shifted gaze, from what is visibly wrong to what is quietly missing. Jaya did not walk away with a list of demands or a fixed set of solutions. What she carried instead was something quieter, and more enduring, the awareness that exclusion does not always shout. Sometimes, it barely whispers. And in that whisper lies a call to notice.

Medha

Medha had always known that a PHC was tucked behind her home in Delhi. She often heard the muffled sounds of activity each morning, patients arriving, staff calling out names, the hum of a place just waking up to its duties. But until now, she had never stepped inside. When she finally did, what she encountered wasn't startling, but it stayed with her.

Her first visit was quiet. It was almost closing time, and the OPD hours had come to an end. The centre was being cleaned, and the air felt subdued. She noticed something unusual: walls lined with posters on almost every imaginable health issue, and signposts that were unusually abundant. The space was trying very hard to be informative, to reach out, to make itself known.

She introduced herself and requested permission to simply observe. The medical officer, who was polite, was puzzled and gently redirected her to the Chief Medical Officer's office, where she was told that permission required a letter. The bureaucracy was familiar. Still, it was a strange feeling to be so close to a system and yet not quite a part of it.

The necessary papers were prepared, and the next day, she returned, this time during OPD hours. The scene was different. Patients came and went. Conversations unfolded in corners. She spoke to several people, including two pregnant women who said they used to visit another PHC but now preferred this one. She learnt that their trust wasn't blind; it had been built over time through routine check-ups, home visits, and the quiet reliability of ASHA workers.

One ASHA worker who had seen her the day before remembered her. She smiled, offered help, and even invited Medha to join her on a home visit. "Everything here is perfect," she said with a kind of practised certainty. It was hard to tell whether the perfection lay in the system or in people's capacity to make the best of what they had.

What struck Medha wasn't a dramatic failure or a heartening success. It was the soft, invisible labour of care that threaded through everything. The centre worked, not without flaws, but without collapse. Its quiet efficiency hid the effort it took to keep it all going.

And perhaps what stayed with her most was the realisation that closeness doesn't always equal access. The PHC was just behind her home, but she had needed intention and permission to truly see it. Ultimately, the visit was not just about observing healthcare. It was about recognising how easily we can live next to systems without ever entering them and how entering them when we do asks us to listen more than speak.

Nila

Throughout several quiet visits to Nair Hospital in Mumbai, Nila began to notice things that aren't always listed in reports. Some of them were obvious: the construction dust that clung to the air, the chipped murals meant to inspire

awareness, the scattered materials that made navigating the hospital feel less like moving through a care facility and more like walking a maze. But other observations required a different kind of noticing, one that came not from assessing, but from lingering, watching, and listening.

What struck her first was language. Most signs were in Marathi, a few in Hindi, and even fewer in English. For a city like Mumbai, often held up as a cosmopolitan symbol, this raised questions about accessibility. How do you find your way when the system speaks a language you don't fully understand?

As she moved through the sprawling campus, shared with a medical college, the scale of the place became both impressive and overwhelming. The distances between departments were vast, posing a quiet challenge to patients already

strained by illness. The corridors, though technically clean, felt heavy with disrepair. Seating was scarce, especially near the X-ray unit, where Nila saw patients with bandaged feet and splints standing simply because there were no other options. In some corners, empty spaces that could have held benches instead held people lying down, resting, waiting, or perhaps simply with nowhere else to go.

And yet, amidst the fatigue of infrastructure, there was an undeniable pulse of order and humanity. The guards, far from indifferent, were helpful and watchful. She spoke with one who explained that while the hospital's metal detectors were sometimes turned off for the sake of ease of movement, high-definition CCTV systems and internal coordination ensured security. His comment that "people do listen to us" stayed with her, not as a boast, but as a quiet assurance in a place often associated with chaos.

HALDI FROM THE HILLS

The hospital was not just a place of treatment, she realised, but a site where civic life unfolded in ways both visible and hidden. Students ran awareness programmes and health check-ups. Professionals, though rushed, often returned her gaze with a smile. And then some moments hinted at the hospital's broader role in society. On her way out one day, she saw a van filled with women, all of whom were covering their faces. She was told they were being brought in for pre-court medical checks, a reminder that hospitals also serve as institutions of justice, verification, and state procedure.

For Nila, the takeaway was neither glowing praise nor blanket criticism. It was complexity. A recognition that public hospitals, especially one as layered as Nair, are not just about walls and wards, but about how people move through them, make sense of them, and hold them up, sometimes in ways we fail to see.

Prakruthi

For Prakruthi, the visit to the PHC and Jan Aushadhi outlet wasn't a step into the unknown. As a medical professional, she walked in already fluent in the language of protocols, prescriptions, and public health logistics. What the visit offered instead was a confrontation with the quiet compromises that often go unnoticed when seen only from the outside.

She reached the PHC around 3 PM. The medical officer had already left for the day, though the centre was meant to be operational 24/7. Nurses and ASHA workers were still on site, wrapping up the day's remaining tasks. They explained how the doctor typically stayed longer only when there was a high patient load, for instance, on Thursdays, when child immunisations and antenatal care converged. Specialist consultations were scheduled on designated days, such as Tuesdays, which were for ENT specialists, creating a rotation-based rhythm for care.

It wasn't chaotic. In fact, the place was clean, organised, and visibly maintained. There were posters on everything from waste disposal to dog bites. A list of stocked medicines was pinned clearly to a board. Basic laboratory facilities for standard tests, including CBC and malaria parasite detection, were available. But what Prakruthi noticed wasn't just what was present; it was what that presence masked. Systems seemed to function, but often only within the bounds of minimal expectations. Nurses handled most minor ailments themselves; escalation was rare unless truly unavoidable.

At the nearby Jan Aushadhi outlet, she struck up a conversation with the pharmacist. He was candid in talking to someone who understood the workings behind the counter. The outlet stocked medicines for chronic conditions, including antihypertensive medications, diabetes treatments, and multivitamins. All highly

subsidised. And yet, the footfall had declined. Many patients, he said, now preferred to collect their medicines for free at government hospitals.

The real tension surfaced when they began discussing the medicines themselves. That pharmacist admitted what few say out loud: the efficacy of some generics isn't always on par with branded alternatives. Government doctors, aware of this discrepancy, sometimes compensate by prescribing slightly higher doses. Prakruthi observed how the system was working, but not optimally. Care was being delivered, but not always with equity or precision.

In group discussions, these observations stuck with her. She wasn't disillusioned; she had seen enough of the system to know how it bends and holds. However, the visit made the gaps feel sharper and more personal. The rationing of care, the subtle downgrades in quality, and the reliance on workaround solutions all sat uncomfortably against her training.

For Prakruthi, this wasn't just a field visit. It was a layered reckoning with a system she knew well, one that demands both compassion and clarity. Her insights weren't just medical; they were structural. And her takeaway wasn't just about what must change, but about how much we miss when we don't look closely enough.

Rajshekhar

Rajshekhar's visit didn't take him to a PHC or CHC. Instead, he found himself at a municipality-run health centre, a facility with different roots, a different logic, and a noticeably different pace. It wasn't rural, understaffed, or struggling for visibility. It was a five-storey building, situated right in the heart of the city, with departments that extended well beyond primary care, including nephrology, diagnostics, a maternity ward, and a pharmacy, all under one roof.

It wasn't just the scale that stood out. It was the structure. Nurses were present in full strength, with no staffing gaps. The pharmacy stocked both generics and branded medicines. There were no ASHA workers per se, but program-specific equivalents staffed the maternity and immunisation services. And while the medical officer wasn't available that day, something Rajshekhar planned to revisit the system didn't feel suspended in their absence. Things moved on.

What struck him most was the contrast. Compared to PHCs he'd read about, where staffing shortages and infrastructure gaps are common, this municipal facility had the advantage of geography and governance. Municipal corporations, he learned, often have bigger health budgets than state-run primary care systems. Doctors and nurses, drawn to the city for its opportunities and lifestyle, stayed. The churn was lower. The environment is more stable.

But it wasn't seamless. Despite its resources, the centre lacked clear signage. The absence of colour-coded bins, a basic hygiene protocol, stood out, especially in a space that otherwise seemed so well-resourced. There were plenty of posters, but little direction was provided. Construction was underway for more advanced diagnostic services, but the foundations of patient navigation and sanitation still needed attention.

The visit left Rajshekhar with a quiet question: If this was what well-funded looked like, what was the baseline across the country? How wide was the gap between municipal centres in cities and PHCs in rural areas? And how often did the conversation about health equity overlook the structural and geographical contexts that shape it?

For him, the visit was not about finding faults or celebrating success; it was about finding a way forward. It was about recognising the layered ways in which systems work or don't. And how proximity to power, funding, and infrastructure can shift not just access to care, but the very expectations we carry into the waiting room.

Rupkatha

Rupkatha wasn't sure how to behave at a public health centre, how to observe without interrupting, or how to ask without overstepping. So, she started with presence. Over three days, she visited two urban primary health centres, one in Baghajatin and another in Bansdroni. What she encountered was not dramatic failure, but quiet, persistent strain.

At both centres, staffing was the first thing that stood out. Several personnel worked only half-day shifts, supplementing their income with other jobs to make ends meet. Operational hours seemed shaped less by policy and more by practicality. The correlation was stark: fewer staff, fewer hours, fewer services.

The facilities themselves offered the basics, including vaccinations, outpatient care, and a pharmacy, but availability was a gamble. Supplies didn't always match demand. Patients sometimes returned home without medicines, simply because the lone pharmacist couldn't restock in time.

In Baghajatin, the irony was more visible. The UPHC was located beside a community pond, a breeding ground for mosquitoes. Dengue awareness posters lined the walls, but the air was still thick with bites. Nursing and security staff showed her the repellents they used, small 'All Out' machines, but even they admitted their efforts barely made a dent. In a space meant to prevent illness, exposure felt inevitable.

PHCs visited by Rupkatha were closed on weekends

Patients she spoke to were largely satisfied with the preliminary care, but their satisfaction often felt tempered by low expectations. There were no beds, few doctors, and long wait times. Yet they came, and waited, and adapted.

Weekends revealed another quiet contradiction. Though both facilities were labelled as primary health centres, their doors remained shut on Sundays. Baghajatin stayed open till noon on Saturdays; Bansdroni barely functioned. What puzzled Rupkatha most was the information gap. Online portals listed full schedules. On the ground, there were no doctors, no patients, and no contact numbers to clarify the situation. Even the act of knowing when to go felt inaccessible.

But Rupkatha didn't rush to conclusions. She carried her questions with her. Why were dengue precautions left to household devices in a public facility? Why were staff overworked and underpaid in the country's most basic tier of care? Why was

knowing about opening hours, stock levels, and services such a complicated act?

She didn't leave with answers. But she left with clarity. The discomfort she felt was not a deterrent; it was direction. Because sometimes, observation isn't about what you see, but about what you start to ask.

Samvardhan

Samvardhan visited three PHCs across Delhi and Noida, along with a private hospital's dispensary, aiming to understand not only how systems function but also how they are maintained or quietly compromised.

In Greater Noida, awareness posters for malaria and dengue were being displayed in preparation for the upcoming monsoon season. In contrast, the PHCs in Rohini stood out for their coordination with MCD operations and active participation in Indian Medical Association (IMA) conferences. These quarterly events, which offered everything from food to discussions on oncology and innovation in Parkinson's treatment, seemed to indicate a more engaged, better-networked public health ecosystem.

But what lingered for Samvardhan wasn't the structures that appeared functional; it was what slipped through the cracks. At one PHC, he found that the individual dispensing medicines wasn't a qualified pharmacist. Nor was the man who replaced him midway through the shift. They were known to the community, and that familiarity, Samvardhan realised, had begun to replace formal accountability. When asked for ID, they hesitated. None was produced.

At the private hospital's dispensary, he found a different but equally troubling pattern. A wide array of branded and generic medicines was on offer, but the pharmacist seemed unsure which to recommend or why. Sponsorships appeared to dictate distribution. Samvardhan, who lives with asthma, paid close attention when strong medications like Rotacaps were handed out to young teens for common colds. The mismatch between diagnosis and dosage wasn't just inefficient, it was dangerous.

What emerged for him wasn't a comparison between public and private, but a more profound unease about how decisions are made, and by whom. "Familiarity," he noted, "should never replace qualification." And yet, at more than one centre, it had.

Samvardhan didn't come away with easy takeaways. Instead, he left with a sense of disquiet, a recognition that some of the most persistent gaps in public health don't stem from absence, but from erosion: of oversight, of rigour, of accountability. His visits became less about comparing systems and more about tracing the quiet ways in which they bend under pressure.

In the end, it wasn't just about what worked or what didn't, it was about what was quietly allowed. And for Samvardhan, the work going forward was clear: to keep asking the questions that too often go unasked, and to notice the fault lines that familiarity makes invisible.

Sana

Sana's visit to a Mahila Mohalla Clinic in Delhi was marked by contrasts: clean, digital, and women-led, yet quietly uncertain beneath the surface.

The clinic was a dedicated space for women and children under 12, staffed entirely by women and run with a degree of efficiency that stood out. From registration to prescription, everything was digitised. The pharmacist received prescriptions

directly on her tablet, and medicines were dispensed without the usual paper trail. It felt modern, accessible, and largely well-maintained. Patients echoed this satisfaction, citing cleanliness, the availability of medications, and the staff's politeness as reasons for returning.

But not everything aligned so seamlessly. Despite posters about waste segregation, Sana noticed the absence of colour-coded bins, an example of how implementation often lags behind messaging. A conversation with the pharmacist confirmed that stock was managed through regular procurement every three months, and there were no significant shortages.

What left a lasting impression, however, was a single moment: a doctor, mid-consultation, speaking to a patient with her feet up on the desk. It was not loud

or abusive, but it was still bothersome. To Sana, it reflected how even the smallest gestures could signal disregard in spaces meant to restore dignity.

She also picked up on another undercurrent of uncertainty. With many Mohalla Clinics expected to transition into Arogya Clinics, the staff expressed quiet concern about their future employment. The system looked stable from the outside, but the people within it weren't so sure.

Sana walked away with an insight that was easy to miss: that strong institutions don't run solely on infrastructure and policy; they rely, quietly yet entirely, on how secure and valued their workers feel. And that perhaps, in a clinic built for care, care must also extend to those who provide it.

Sanah

Sanah approached her first visit with hesitation. The thought of entering a public health centre without formal authorisation made her uneasy. She waited, hoping to go with someone else, but eventually, she went alone. That initial discomfort stayed with her, not as a barrier, but as a quiet reminder that public systems may be open in theory, but they are not always welcoming in practice.

Her first stop was Acharya Shree Bhikshu Hospital. Operationally, the centre seemed efficient, patients received tokens, the OPD ran on schedule, and emergency services remained open beyond regular hours. But the infrastructure told a different story. Walls with cracks, exposed bins, rusting grills, and an ever-present caution about what surfaces to touch made her question what "functioning" really meant. Doctors were overworked, juggling patient care with bureaucratic demands like data uploads and government reporting. Medicines were often unavailable. Patients with even minor injuries had to be redirected elsewhere, and what looked like minor inconveniences were, in reality, steep deterrents for those with limited means.

Her second visit was to a seed PHC in Uttam Nagar. Here, the human link to the community felt stronger. ASHA workers were actively helping people access Ayushman Bharat cards, and there was evidence of engagement, including skits on No Tobacco Day, separate days for elderly and pregnant patients, and a sense of familiarity between staff and community members. But Sanah also noticed the strain: medical officers taking on tasks unrelated to patient care, like scripting awareness programmes; ASHA workers underpaid and overstretched, receiving just ₹2 for a household survey and ₹50 for registering a pregnant woman. Systems were functioning, but only because people were bending themselves to make it so.

On her third day, at yet another PHC, the contradictions sharpened. There were rooms available, but they were locked and unused due to staff shortages. Basic tests could be conducted, but no further action was taken. Again, no dressing supplies. A medical officer brushed it off as "a long story," blaming years of state-centred politics. What stood out most was the mention of a polio clean-up drive, despite India being declared polio-free. Staff explained that poor water quality had led to the detection of traces of the virus again. Sanah also learned that the staff had pooled their own money to buy a cooler for the waiting room because the Delhi summer was too brutal for a single fan to handle.

Through all this, Sanah's reflections sharpened. She had entered the field with fear, of asking questions, of seeming out of place, but walked away knowing that the more profound fear lies elsewhere, in systems that demand everything of their workers and offer little in return; in institutions that function just enough to not fall apart, but never enough to be fully trusted. Her insight was clear: the burden of care in public health often rests not on policies, but on people, and even their generosity has limits.

Tushti and Saummya

Tushti Sharma and Saummya Yadav visited their local PHC and met with an ASHA worker

Tushti and Saummya visited a PHC tucked behind the ruins of a collapsed structure that once housed the older facility. Locals said the building had long been slated for demolition, but no action had been taken. In its place, a new PHC was set up in 2016, standing quietly behind the derelict shell. It was a jarring contrast: to reach the centre, one had to pass through crumbling remains, waterlogged in the monsoon, posing serious safety and dignity concerns, especially for women who may need to visit during emergencies or after dark.

The newer building, while structurally sound, wasn't immune to decay. Torn posters clung to walls, hand-drawn health instructions about pregnancy, and a past quiz competition hinted at efforts to engage the community, but also at a system that couldn't afford proper signage. Inside, things were no cleaner,

used and unused gloves, discarded masks, and dust heaps collected along the stairs. Medical waste lay unmanaged. If the medicines were indeed stocked as claimed, there was no guarantee they were being stored in safe or hygienic conditions.

Yet amid this, what stood out most was the ASHA worker, a woman juggling digital reporting on her phone while patiently answering every question. She spoke openly about unpaid salaries for the past 4 – 5 months, explaining how administrative delays following a change in Delhi's government had paralysed disbursal. Still, she and her colleagues continued showing up, committed to their work despite the strain. There was a sense of structured rotational duties, scheduled health drives with refreshments for patients, and timely medicine deliveries, but it all rested on the will of underpaid staff.

Some workers were hesitant to speak, and Tushti and Saummya respected their boundaries. But what they did see was enough to linger. In this PHC, infrastructure and medical supplies were not the primary issues; trust and maintenance were. If the facility was there, why was it so hard to access? Why was there no certainty that care delivered here would be safe, sterile, or sustained?

Just a day earlier, they had visited a PUHC with functioning buildings and active staff, albeit overstretched. There was order, even within crisis. And the day after, they encountered a locked PHC disguised as a house, no signboard, no explanation, just absence.

The contrast wasn't just in infrastructure. It was in visibility, in consistency, in the sheer unpredictability of what healthcare meant depending on where one stood. For Tushti and Saummya, the visit became less about observing "healthcare delivery" and more about reckoning with how invisibly fragile access truly is and how often, care survives not because of the system, but despite it.

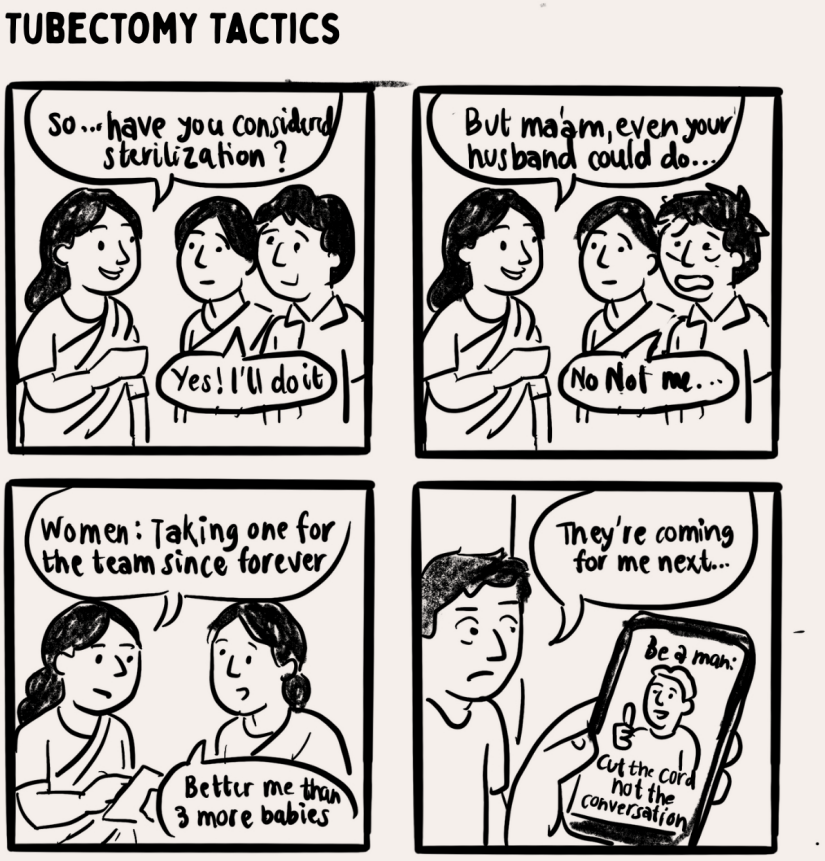
Shivpriya

In Faridabad, Shivpriya found that the online portal lacked proper details of the nearest PHC, and she wasn't even sure if it counted as a PHC. It turned out to be an Employees' State Insurance (ESI) Dispensary, quietly operating under the Ministry of Labour and Employment. While technically public, it didn't feel widely known or accessible unless one already belonged; most services were available only to ESI cardholders, a distinction that blurred the lines between public access and targeted coverage.

Inside, the dispensary was quiet. A few people waited for OPD consultations. A printout on the gate, A4-sized, advised TB and malaria patients to wear masks. Still,

beyond that, there was little to suggest an active public health presence, no colourful health posters, no awareness materials, and a visibly locked storeroom with what appeared to be empty cartons of medicine. There were few chairs, limited signage, and almost no outreach materials, just function, stripped of flourish.

But what the place lacked in visibility, it made up for through its people. Shivpriya spoke to the lab technician, who expressed satisfaction with the centre's basic functioning. The medical officer, although overwhelmed with paperwork, took the time to talk to her. She shared that the dispensary catered to around a thousand workers and their families, primarily treating common illnesses and referring any severe cases to the Civil Hospital. Regular immunisation drives were conducted through Auxiliary Nurse Midwives (ANMs), sometimes with the support of ASHAs.



It was in the ANM room that the story took a deeper turn. Shivpriya met four women who were busy updating their health registers. They spoke of their outreach work, especially in nearby slums and rural areas, often undertaking it alone, occasionally with support from ASHAs. One of them worked in a zone with no ASHA presence, which made her job harder. Yet, the women in the communities were responsive, eager to learn, asking about new schemes, calling directly for vaccine schedules or test details.

Still, not everything came easily. Conversations around family planning remained lopsided. When ANMs encouraged vasectomy as a safer alternative for families with multiple children or miscarriages, women often rejected the idea for their husbands. Often uncomfortable with asking their husbands to have the operation, they often volunteer to take on the burden. The burden of choice, once again, fell on women.

DIGITAL DISASTER

Inspired by Jaya

Digitisation posed another silent challenge. ANMs were expected to maintain both physical and digital records, but few were equipped for the latter. The medical officer helped bridge this gap, but the system's expectations often outpaced its support.

What struck Shivpriya most was the dispensary's quiet invisibility. Not just its physical stillness, but its institutional silence, no online clarity, no loud posters, no civic buzz. It existed, but just barely. Her checklist of questions quickly gave way to a more difficult realisation: how do you assess the quality of care in a space that the system itself seems to overlook?

Her visit highlighted a critical tension: when public care is contingent on documentation and visibility is tied to entitlement, who is left outside the gate?

Shlok

Shlok approached his field visits in Vadodara with the mindset of someone looking beyond the obvious. To him, these weren't just healthcare centres, they were case studies in how public trust is built or broken. Even before stepping in, he noticed

PHC visited by Shlok in Vadodara

something unusual: the walls of the Urban Primary Health Centres were freshly painted, the posters neatly arranged, and the entrances clean and dignified. It didn't feel like the kind of neglect people often associate with government spaces. There was colour, there was order, and, at least at first glance, there was care.

Yet the question that surfaced almost immediately was: Why here? Why this standard, in this neighbourhood? Shlok began to wonder whether these visible efforts reflected genuine investment or were the result of political favour, a performance of functionality in places deemed electorally or symbolically necessary. The idea that service quality could be uneven, not due to capacity, but because of political calculus, made him pause.

Still, what he found inside was promising. At one centre, a security guard briefed him on the daily footfall, which mainly consisted of residents of local slum

communities, and described the range of services provided, from TB screening to maternity care. At another, Shlok met with the Medical Officer, who took the time to answer his questions on immunisation hesitancy, sexually transmitted infections, and vector-borne diseases during the monsoon. They discussed "Mamta Diwas" community outreach programmes, adolescent wellness centres, and the use of colour-coded treatment kits. Functional RO water tanks and waste segregation bins reinforced a sense of structured care.

But for Shlok, the deeper insight came from noticing not just what was present, but what it signified. The consistency in infrastructure design, logos, paint, and layout seemed part of a larger push under national schemes. But he couldn't shake the thought: Why was this done in other PHCs as well? What factors influence the general state of affairs in these institutions?

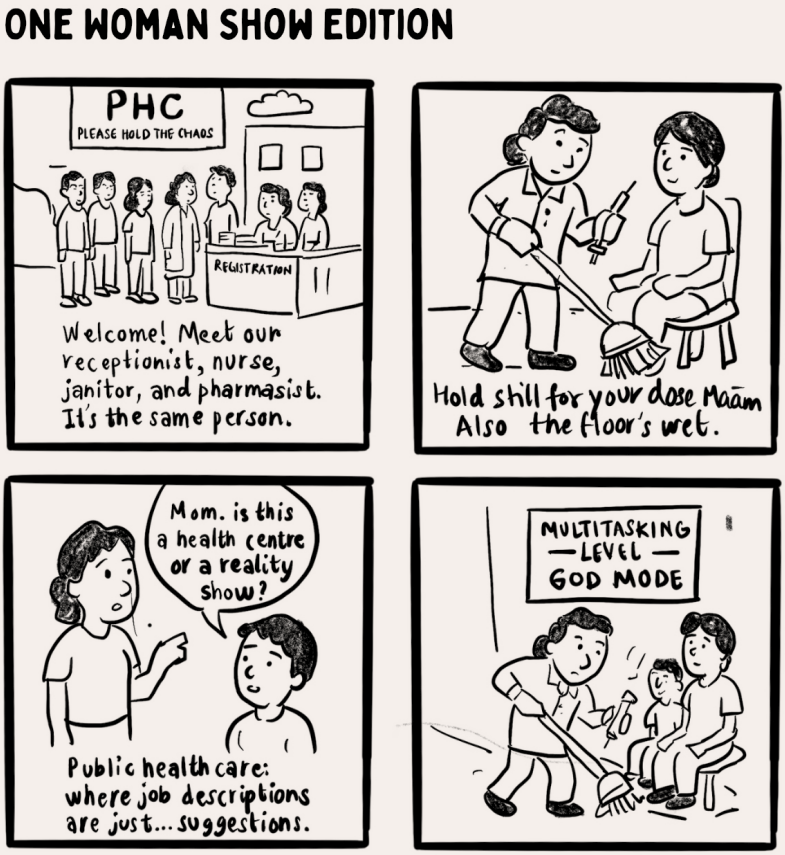
In later conversations with peers, he consistently returned to the refrain that perception shapes participation. That sometimes, what invites people into a space isn't just the promise of treatment, but the feeling that someone cared enough to make it feel welcoming. Still, he remained cautious, holding space for both appreciation and critique, and continuing to ask what, and who, determines where care looks this good.

Shreem

Shreem didn't confine herself to a single visit or a single kind of facility. Over a week, she made her way through four healthcare centres, including two primary health centres in Mussoorie and Modinagar, and two institutional hospitals in North Delhi, one of which was affiliated with her college. Each space held a different rhythm. Each left her with questions that no single site could answer.

The PHC in Mussoorie was tucked into a hilly curve, quiet and functional but far from equipped. It was small, too small to hold the complexity of what public healthcare was meant to do. There was no full-time specialist, and one Medical Officer managed most of the patients. The infrastructure was minimal but intact, featuring a labour room, outpatient rooms, and a pharmacy that provided the basics. Digitisation had begun, the nurse explained, but network issues frequently stalled the process. Most patients, she added, came for routine needs, such as wounds, immunisations, and basic medicines, and trusted the centre for those alone. Anything beyond that was referred out to Dehradun. The PHC didn't feel abandoned, but it also didn't feel alive. It was running but not breathing.

The PHC in Modinagar told a different story. Crowded, chaotic, and cramped, it was surrounded by narrow lanes and unhygienic surroundings that felt at odds with its purpose. Inside, the space was brimming with posters, some helpful, others



cluttered. The waiting area was overcrowded, the staff visibly strained, and sanitation standards fell short of even the most basic requirements. Still, the work went on. A Medical Officer, two nurses, and a pharmacist juggled the needs of mothers with infants, the elderly, and a steady stream of patients who had nowhere else to go. There were signs of effort, including vaccine cartons and educational messages, as well as blue dustbins, but few signs of maintenance or follow-through.

Her visit to Bara Hindu Rao Hospital, a super-speciality teaching hospital in Delhi, was a shock of scale. The building was larger, the staff more numerous, the facilities broader and yet, it was perhaps the most overwhelming of all. Patients spilled into corridors, sat on floors, and waited in endless queues with no visible signage to guide them. Long lines blurred into more extended silences. OPD blocks, diagnostics, blood banks, and emergency services were operational, but barely containing the

pressure. Critical areas were kept clean, but waiting rooms and public toilets were visibly neglected. Shreem noticed the irony of hand hygiene posters above sinks that hadn't been scrubbed in days. What troubled her wasn't just the overcrowding. It was the question it left behind: If even the most established public hospitals struggle to manage, where does that leave everything else?

In contrast, her visit to the WUS Health Centre felt almost surreal. It was quiet, clean, and largely empty. Most rooms were unoccupied, and only one nurse was on shift when she arrived. Doctors were present but unhurried. Everything was in order, sterile, efficient, still. There was nothing visibly wrong, but the space lacked the urgency, even the anxiety, which had characterised her earlier visits. And that, too, raised a question: when healthcare becomes too quiet, is it because it's working well or because people aren't coming?

Through it all, Shreem kept returning to one realisation: how a healthcare facility looks, feels, and functions matters far beyond its walls. Patients may not articulate it as such, but they know when a space welcomes them and when it merely tolerates them. Between missing signage, overburdened staff, and unclean toilets, it became clear to her that trust in public healthcare isn't just about medicine. It's about dignity.

What Shreem walked away with wasn't just a set of comparisons. It was a sense of how space itself can heal or harm. And in that realisation, her questions about access and equity only deepened.

Shreya

For Shreya, the field visit to the Urban Primary Health Centre in Fazilpur was not just an exploration of public infrastructure; it became an intimate lesson in how presence doesn't always translate to access. The centre was nestled inside a rented apartment complex, its modest exterior belying the essential services within. It was, by every account, a stop-gap solution, and everyone inside seemed aware of its impermanence. The nurse she met was patient and welcoming, walking Shreya through the daily workings of the space, record-keeping, staff responsibilities, and the basic layout of services.

But the challenges began where the walls ended. The nurse described how limited space forced compromises, most notably, the lack of privacy for female patients during vaccinations or intimate check-ups. The workaround? Asking male doctors to step out during sensitive procedures. Shreya listened as the nurse spoke candidly about working without pay for the past two months. Salaries were delayed. Promises of resolution hung in the air, but nothing had arrived. Still, she came to work. Still, she served.

The healthcare centre Shreya visited was tucked away in the middle of a residential colony

The conversation moved beyond the clinic. The nurse shared how ASHA workers covered neighbouring localities, including one that Shreya immediately recognised as the area where her house help lived. When Shreya returned home, she asked her if she had ever visited the UPHC. The response was revealing but straightforward: "I didn't know about it." She and her neighbours had been relying on private hospitals, unaware of the free services just a short distance away. Shreya sent the location to her daughter and encouraged her to share it with others.

This small act felt heavier than it seemed. It revealed a quiet, often unspoken truth: awareness is not automatic, even when the service exists nearby. The encounter left Shreya in a state of reflection, not just about what governments fail to provide, but about what doesn't get communicated. A system's proximity means little when its presence is invisible. And invisibility, she realised, doesn't begin with walls. It starts with the absence of trust, clarity, and a welcoming atmosphere.

In the days after her visit, Shreya remained in that reflective space, committed not just to documenting observations, but to asking the more complex question: What is access, really, if the people most in need never even know where to knock?

Smriti Banka and Sonal

Smriti Banka and Sonal, both in Hyderabad, had been hesitant at first. The idea of entering a government healthcare centre without an official role felt uncomfortable, even intrusive. But they reminded themselves that discomfort was not an excuse to disengage; it was a signal to pay closer attention. And so, they went.

Their visit took them to a primary health centre tucked into the everyday rhythms of its community. From the outside, the building seemed calm and quiet. Inside, however, a different story unfolded. There were a few patients, mostly elderly, seated on wooden benches near a front desk managed by a single nurse juggling multiple responsibilities. The infrastructure was minimal, the posters sparse and difficult to interpret, and although colour-coded bins had been placed, their intended purpose wasn't being followed.

The nurse, grateful to speak to someone in Hindi, shared candidly about the challenges. The PHC had been operating without a Medical Officer for weeks. Resources were scarce. Even something as basic as a cabinet door for storing medicine was missing. When Smriti raised the safety concern, the nurse acknowledged it with a resigned shrug, "There's no budget right now," she said. The team tried to keep an eye on things.

They encountered an ASHA worker, too, who was buried in paperwork and promised to speak on a quieter day. "Try Sunday," she offered. "People think the PHC is closed, then."

What stayed with Smriti wasn't just the infrastructure or its gaps; it was the politics that dictated them. She began to trace connections between governance and resource allocation, realising how political dynamics between central and state authorities could stall or skew even basic service delivery. For her, this wasn't just a logistical failure. It was a systemic failure to prioritise public health as a right, not a favour.

PHC visited by Sonal

Sonal, meanwhile, was struck by the emotional contradictions of the space. Machines were broken, staff were unpaid, yet the centre remained open. The patients came anyway. Some waited quietly. Others navigated the disarray with practised resignation. It wasn't just inefficiency that caught her eye; it was endurance. The resilience of the system's people, not its paperwork.

Together, Smriti and Sonal returned from their visit with more than just notes. They returned with a changed frame of reference. Public healthcare, they realised, is not measured only by what exists, but by what persists.

Smriti Sharma

Smriti Sharma at her nearby PHC with ASHA workers.

Smriti's visits to Chinray Zila Women's Hospital were like peeling layers off a complicated system that resists being understood at a single glance. Her previous impression had pointed to strained hierarchies between doctors and community health workers. But this time, the narrative shifted. Contrary to what she had initially heard, doctors and the Chief Medical Officer were reportedly supportive of ASHA workers. The friction, she learned, often came from elsewhere; nurses, many of whom were already stretched thin and underappreciated, tended to redirect their frustration toward those lower in the pecking order. ASHA workers, caught between patients and practitioners, bore the brunt of this displacement.

It was a sobering discovery, how even in institutions meant for care, empathy could be eroded by exhaustion.

The CMO was unavailable that day, overwhelmed with ultrasound duties and long queues of expectant mothers. But through informal conversations, Smriti learned that the position itself wasn't always earned purely on professional merit. The role allegedly came with an unofficial cost, a price that, once paid, positioned the officer more as a manager of funds than as a steward of medical ethics. It made her question the quiet mechanics of how healthcare leadership is installed and incentivised.

Her conversations moved between infrastructure, systems, and stories that didn't quite fit in spreadsheets. Iron and calcium supplements were provided free of cost, but women often abandoned them due to side effects like diarrhoea, nausea, and dizziness. Yet, investing in nutritious food was rarely an option for their families. In these rural households, where husbands often worked as daily-wage labourers and resources were scarce, the logic of trust leaned toward free medication over expensive dietary changes. That medication-induced discomfort led to more complications in pregnancies and postpartum recoveries. It was a quiet cycle of good intent, insufficient support, and predictable fallout.

At the AYUSH clinic, Smriti witnessed a different dynamic, one fueled less by public health planning and more by digital virality. With Haridwar nearby, patients, including tourists, often walked in drawn not by prescriptions but by Instagram reels and WhatsApp forwards touting the benefits of Ayurveda. The doctor spoke of how many now sought "natural" alternatives, hoping to avoid the side effects of "English medicines." It felt like a modern form of belief-making, part clinical, part cultural, wholly mediated by the digital.

But not all systems were faltering. Smriti found a quiet success story in the free cab service offered to pregnant women, available both for pick-up when labour began and for postnatal drop-offs. It wasn't glamorous, but it was working. Each block had a designated vehicle. It was a detail that could easily be missed, but to the women, it made all the difference.

Still, larger cracks ran through the hospital's foundation, including irregular and delayed payments to staff, not just for ASHA workers but even for doctors. In one particularly jarring moment, Smriti learned that some had gone unpaid for months. The strain wasn't always visible, but it was palpable.

And then came a conversation that changed the tone entirely. Speaking with a friend interning at a psychiatric facility in Ranchi, Smriti heard stories that didn't just shock, they disturbed. Patients, mostly from low-income households, were often admitted under pressure, especially for addiction issues. Doctors prescribed medicines far beyond what the patients could afford. Some families viewed admission as less a matter of care and more a matter of access to government

benefits. The most chilling detail? In the women's ward, physical mistreatment was common. A guard dragging a patient by her hair was not an isolated act; it was described as routine. Female patients, her friend said, were far more likely to be abandoned than male patients. The hospital had recently introduced stricter policies to curb this, but the damage revealed a gendered cruelty that ran deep.

Yet Smriti didn't let the weight of it all stop her. She channelled her observations into a simple idea: install digital screens in hospital waiting rooms, not for advertisements, but for real-time health education. Replace the peeling posters and fading murals with videos that people can absorb passively, at their own pace. If private hospitals used LCD screens to flaunt services, why couldn't public ones use the same format to inform and empower?

She knew it wouldn't fix everything. But it could be a start, a slight nudge toward dignity, design, and better awareness.

Smriti walked away not just with notes and reflections, but with a sharpened clarity that reform wasn't only about grand policy shifts. Sometimes, it began with the decision to see things fully, to name what was broken, and to ask how even one part of it might be rebuilt.

Suhani

Suhani walked into the ESI dispensary in Kundli with a quiet sense of uncertainty. Like many of her peers, she had wondered whether a solo visit would be dismissed, whether her questions would seem misplaced. She eventually coordinated with two fellow changemakers and made her way to the centre. What greeted her wasn't disorder, but a facility that, on the surface, seemed tidy and relatively well-run. There was a noticeable effort toward maintenance, walls were clean, posters promoting health awareness were visible, and the staff seemed composed.

She struck up a conversation with a staff member from the medicine department. He spoke candidly about the facility's rhythms and constraints. The dispensary, he explained, conducted health drives twice a month and was decently equipped in terms of beds and basic machines. Salaries, he noted, were paid on time, a rare affirmation in a public healthcare setting. If someone went on leave, replacements could usually be arranged, though not always.

Yet beneath the operational calm lay inefficiencies that weren't visible at first glance. The dispensary lacked basic diagnostic equipment; for example, there was no machine to test lipid levels, and patients had to be referred elsewhere. Suhani was especially struck by the rigidity around pharmaceutical prescriptions. The medicine brands stocked were not chosen by the doctors based on patient response

but dictated by higher officials through centrally determined tenders. Even if a particular brand didn't suit a patient, frontline staff had no authority to change it.

One question led to another. How were machines allocated? The answer was not very clear; the government sent them "as per process," but no one really knew what that process entailed. It was a telling moment, care was being delivered, but decision-making power was distant and opaque.

What surprised her most was her own realisation. Until that visit, she hadn't fully understood what ESI even stood for. The staff member explained that the dispensary was part of the Employees' State Insurance scheme, administered by the Ministry of Labour and Employment. The centre existed to serve insured workers and their families, those within the formal employment sector. It wasn't a space open to all, and its rules followed a different logic from the primary health centres many others were visiting.

Suhani didn't walk away with a long list of interventions. What she carried instead was perspective. A deeper understanding of how bureaucratic layers shaped patient experiences. A sense of how neatly a facility could appear to function, even while deferring core decisions to distant actors. And the quiet realisation that knowing how a system works, who it's for, how it's funded, where its discretion lies, isn't just an academic detail. It's the difference between observation and comprehension.

In Conclusion

By the end of their field visit week, the Changemakers found themselves in an emotional and intellectual space that was difficult to define. They had walked into health centres across the country, some welcoming, some chaotic, and others shut without notice, returning with observations, discomforts, and questions that refused to fade. And after all the listening and all the learning, one question rose to the surface: "Is this enough?"

It was a sincere question, posed not from indifference but from a deep yearning to make things better. The stories they had heard about dustbins being sanctioned, staff showing up despite months of unpaid work, small wins, and patient interventions were hopeful. And yet, many were haunted by the scale of what remained broken: the systemic gaps, the indifference of authorities, the unevenness of care, the erasure of those most vulnerable. "Good intent alone," one Changemaker wrote, "doesn't shift broken systems."

But perhaps that was never the task. Or at least, not the whole of it.

As one of the facilitators reminded them, the history of change has never belonged to one person or one moment. It is carried forward by those who came before, those who walk beside us, and those who will carry the baton after we are gone. Sometimes the results of our efforts won't be visible in our lifetimes. That doesn't make them any less meaningful.

It is easy to be paralysed by the magnitude of problems. But change rarely begins at scale. It begins, like most things, in quiet, determined acts: a nurse explaining a prescription with patience; a young woman making posters to help patients navigate the building; a Changemaker asking a staff member, "How can I help you feel seen?"

One Changemaker recalled the story of the little girl who threw stranded starfish back into the sea, one by one. When told it wouldn't make a difference, she replied, "It made a difference for that one."

That story stayed with them, not because it offered a neat solution, but because it honoured the value of doing. At the beginning, even when overwhelmed. Of trying, even when unsure. Of showing up, even when outcomes feel out of reach.

Another Changemaker remembered Princess Diana shaking hands with AIDS patients at a time when fear and stigma were rampant. She didn't do it because she knew it would reshape global awareness. She did it because it was the right thing to do. Sometimes, action precedes clarity. Sometimes, trying is the point.

And so, the Changemakers did not leave this week with a sense of closure. They left with more profound questions, sharpened awareness, and a feeling that they were part of something much bigger than themselves. That they were not alone. And that was enough, for now.

Because systems change may not begin with intention. But it never begins without it.

Theme Mapping and Solution Building

They had entered the field with questions, clipboards, and open minds. They returned with something heavier: stories they couldn't unsee, emotions they hadn't prepared for, and a quiet but persistent discomfort they were still trying to name.

In the aftermath of their visits to primary health centres and state-run hospitals, the Changemakers found themselves suspended in a strange in-between. They had observed, documented, and reflected on their experiences. They had noticed the obvious, crumbling infrastructure, overworked staff, long queues, and locked rooms. And they had caught the subtler details too, a nurse's quiet fatigue, a patient's dignity in waiting, a torn poster that had once tried to inform.

But observation alone was not the goal.

The field visits were never meant to end with realisations. They were meant to unsettle something deeper. And now, that unsettling had to be channelled into something else, something forward-facing, something real.

In the days after their visits, a voice note landed in their shared WhatsApp group, unfiltered and direct. It wasn't a pep talk. It was a call to clarity. "Are you doing this to make a difference," it asked, "or to be seen making a difference?" It reminded them that change isn't always big or dramatic. It isn't always photogenic. It doesn't ask for applause. It asks for humility, consistency, and follow-through, especially when things don't go according to plan.

The message landed hard. It asked for honesty, not just about the system they had seen, but about themselves. About how much time they truly had, how much risk they could take, how flexible they were willing to be. It didn't glorify ambition, it honoured adaptability. It framed shrinking the plan not as a failure, but as a sign of strategic maturity.

This next phase, they were told, wasn't about grand proposals. It wasn't about crafting perfect solutions or reaching final answers. It was about stepping into responsibility. It was about asking difficult, layered questions:

What should the system be doing that it isn't?

What can healthcare staff do, even within the limits they face?

And what can they do, not as a policymaker or a professional, but simply as a person who now knows more than they did before?

The Changemakers were not expected to know the answers. They weren't even expected to agree. The first step, they were told, was to feel. To sit with the emotions that their visits had brought up frustration, guilt, admiration, and confusion while allowing those feelings to shape how they think about change. The next was to dream freely, to think of all that could be done if systems listened, if resources flowed, if political will aligned. And finally, they'd be asked to pare it all back, to anchor their hopes and commit to actions they could actually sustain.

The transition from witness to actor is never clean. But change begins when observation leads to responsibility. When discomfort turns into questioning. And when those questions are asked out loud, together.

Alfia's response to our Miro board obsession

This was not the phase where all answers would be found. This was the phase where the courage to keep asking would be tested, and where the ability to build something honest, grounded, and responsive would be demanded. Not for the sake of spectacle. But for the sake of showing up, when it counts.

Policy Changes

They had seen enough to know that something was broken.

After a week of visiting Primary Health Centres, district hospitals, abandoned AYUSH rooms, and overwhelmed urban clinics, they returned to the room with a new kind of quiet. The Zoom calls, instead of starting with the usual characteristic nervousness and anticipation, had an uneasy stillness of people who now understood what needed to change and weren't sure how to begin.

They were instructed to think about policy. To zoom out. To imagine structural change. But what happens when you've just spent hours in rooms with peeling paint and staff who haven't been paid in months? What happens when "policy" feels like a word you were never meant to use?

There was resistance. Apathy. Fatigue. Some admitted they didn't believe the state was listening. Others confessed that they didn't know enough about policy frameworks to make 'real' suggestions.

And yet, they tried.

Because, despite their frustration, they couldn't look away. Not now. Not after seeing firsthand the overworked nurses, the exhausted doctors, the long queues, the empty rooms. Not after hearing how one medicine brand was trusted, and another wasn't. Not after meeting people who were doing their best and still falling short because the system itself was set up to fail. So, they began to think, not with confidence, but with care.

Some things felt obvious, for instance, the salaries. They spoke about ASHA workers, emphasising their vital role and how easily they are overlooked. One

proposed a simple fix: make them salaried employees. Another added that this should ensure timely disbursal, offer pensions, and reduce dependency on incentive-based wages.

The problem of overcrowding led them upstream: to the need for a stronger referral system. Could patients be directed back from tertiary care centres to PHCs for follow-ups? Could the state decentralise care and reduce the burden on city hospitals?

They had seen too many patients return empty-handed, with medicines out of stock, and staff unavailable. They envisioned real-time stock tracking, transparent fund allocation, and routine audits. Not just a bigger budget, but a smarter one.

Posters and murals had come up in nearly every visit, either peeling, irrelevant, or entirely absent. The Changemakers proposed digital screens in waiting areas, playing multilingual health videos and awareness clips about the scheme. Why should information be dull when it could be dignified?

Smriti Sharma noticed these weathered murals at her nearby PHC

They thought about mobility. If workers can't reach the clinic, why can't the clinic come to them? Mobile healthcare vans in industrial belts, construction sites, and markets, offering basic checkups, maternal care, and even mental health support.

And if posters are unreadable or missing, let there be multilingual signage. Let health communication be inclusive in language, in tone, and in design. One group suggested standardising pictorial posters that were accessible to people with different literacy levels.

They remembered the disillusioned doctor who said he didn't feel like a stakeholder in the system. So, they proposed something radical: create space for healthcare professionals to participate in policy design. Train them in public policy. Make them part of the committees. Reduce the bureaucratic gap.

They looked at systemic gaps through the lens of lived experience. Integrate occupational health checks for sanitation workers. Mandate first aid and mental health literacy across training programs. Improve infrastructure by setting minimum standards for space and accessibility. Others turned to longer arcs. Reform the research ecosystem, align postgraduate research with grassroots health needs. Offer grants for real problems. Build a national repository of findings. Connect knowledge to the ground.

They had seen young mothers not knowing what to expect. They had seen old men confused by language on a pillbox. They had seen doctors choosing brands not because of bribes, but because they knew one worked better than another.

So, they proposed better data collection and increased reach. A national health app. Maps. Helplines. Human dignity, backed by policy.

And behind every proposal, there was a shift, subtle, slow, but real. From apathy to responsibility. From disillusionment to shared authorship. Once they were put in a position to actually consider the policy changes each one of them had so passionately demanded, they understood the true complexity of the task at hand.

The ideas weren't labelled. No names attached. What began as individual field visits had turned into collective accountability. They didn't just want change; they had begun to take ownership of imagining it.

The work had just begun.

Health Staff Interventions

If the previous day had been about zooming out, this one was about zooming all the way in.

Not to the state, the policy tables, or the health ministry, but to the corridor of a PHC at 10 AM, to the look in the eyes of an exhausted nurse, to the pharmacy

counter where one person juggles six jobs at once.

This day was about the people who were already inside the system.

They were asked to propose interventions that healthcare staff could lead, not because it was their responsibility alone, but because they understood the centre best. The very people who wake before sunrise report in without fail and answer the same questions hundreds of times a day. The very people who don't have the luxury to think of 'systems', because they are the system.

This was a harder prompt than expected.

How do you suggest a change to someone whose life you've only seen from the outside? What right do you have to offer solutions to someone who is clearly already doing too much?

The Changemakers wrestled with these questions. And as they did, a shift occurred.

They stopped seeing the staff as distant actors and started seeing them as co-navigators. As people trying to stay afloat. They began to notice not just what wasn't being done, but what was already being done, often without acknowledgement, and always without enough resources.

And so, their interventions became subtler. More grounded. Less about disruption, and more about support.

They spoke of rotation schedules, of 10-minute breaks, of rest areas for staff tucked behind the OPD rooms. A few suggested wellness circles, not mental health counselling in the clinical sense, but a weekly gathering where staff could talk honestly about the frustrations and fears that came with caregiving.

They recognised that burnout wasn't a personal failure, but a systemic outcome. So, they envisioned mechanisms for support, including peer clubs, grievance boxes, support groups for junior doctors, and regular check-ins led by senior staff.

They suggested that ASHAs, ANMs, and nurses could use checklists for follow-ups and conduct health education talks in waiting areas during peak hours, not as extra work, but as a way to use waiting time meaningfully, turning chaos into conversation.

To reduce confusion, they proposed a 'patient buddy' system, where a nurse or attendant reinforces the doctor's instructions after a consultation. One person

even floated the idea of assigning a guide per shift, someone who could help patients navigate the maze of rooms and corridors.

They envisioned elderly-first tokens, health posters designed by local interns, and digital screens showing how to wash hands properly or what symptoms to watch for during the monsoon.

And still, they were cautious.

They knew that asking more from a tired staff might feel insensitive. So, they turned inward, in the attempt to come up with better interventions, they asked themselves, what can be reallocated, streamlined, lightened?

They suggested digital logbooks to reduce paperwork. Digitised registration desks to cut queues. Turning unused rooms into counselling spaces or storage areas. Rotating legal duties among a medico-legal team so that not every OPD doctor is pulled away when the court calls.

And then there were the seemingly small but impactful suggestions.

Disposable glasses next to water coolers.

Suggestion boards listing the centre's needs, so passersby could contribute without being asked.

Cleanliness drives hosted with the local community.

Peer-led storytelling circles for adolescent girls or caregivers.

Local champions sharing their health journeys in workshops coordinated by ASHAs.

The more they thought, the more they realised that meaningful change didn't always require massive reform. Sometimes, it just meant making space. Sometimes, it meant asking the right person the right question at the right time.

And through this process, the Changemakers began to feel something unexpected, a closeness.

Not just to the system, but to the people within it. Their interventions no longer came from a place of critique, but from a place of care. They weren't outside observers anymore. They were co-authors in a shared story of service.

Still, they knew this closeness brought its own blindness. When you care too much, it's harder to see clearly. That's why they challenged one another, gently, to think critically even while thinking kindly.

They didn't want to romanticise the staff, or burden them further. They wanted to support them. To lighten the load. To remind them, and themselves, that the ecosystem could hold everyone, if it were designed with empathy at its core.

This was no longer about what they would do for them. It was about what we could do for each other. And that was the beginning of something much deeper, a community bond, which would prove to be invaluable for the coming week.

Interventions by Self

Until now, the Changemakers had been looking outward, toward the state, toward the system, toward the staff. They had questioned policies, drafted reforms, and brainstormed fixes. It was a process of pointing to what was broken and then figuring out how someone else might mend it.

But on the third day, the spotlight shifted. There were no more 'they' or 'them.' The question was simple: What can you do?

At first, it felt disorienting. Some sat back in silence. Others looked around, waiting for a prompt, a model, a rulebook. But there was none. This wasn't a policy document or a theoretical debate. It was a mirror. And it demanded something much harder than intellect, it required self-belief.

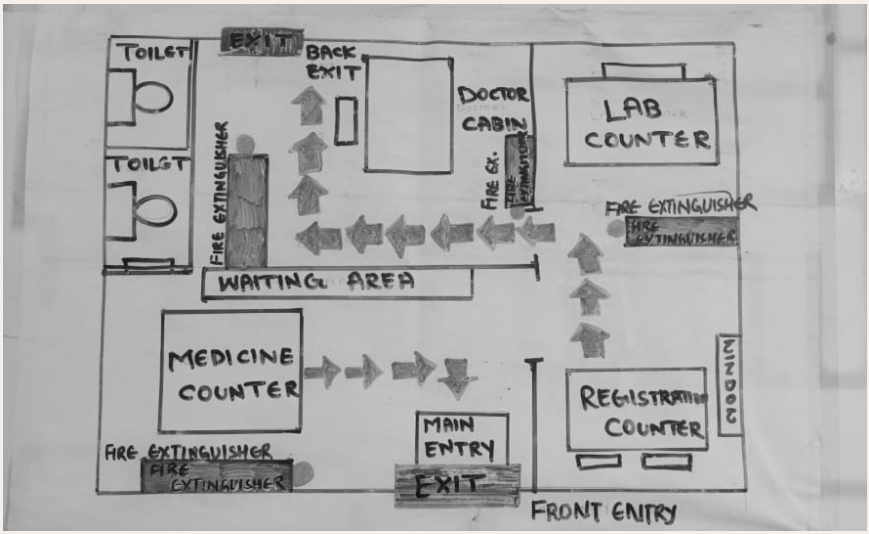
Not belief in being heroic. But belief that even the smallest gesture could matter.

They had spent days immersed in the dysfunctions of the system. Many had begun to internalise a kind of helplessness; the problems were too deep, the power too far. But now, the framing shifted. The idea was not to solve everything; it was to act on something.

That changed the way they approach these interventions. Slowly, the ideas began to surface.

Some were grounded in the deeply practical, such as volunteering at PHCs during rush hours, helping elderly patients navigate long queues, translating posters into local languages, and even updating incorrect information online.

Others wanted to work alongside the system, creating better signage, designing walk-throughs for first-time visitors, running awareness drives in their communities,



The hand-drawn floor map Sana found at the Mohalla Clinic

and helping staff with inventory checks or noticeboard updates.

Someone quietly added, why not just give every PHC a physical map at the entrance? Let people know where they're going. They had already seen hand-made posters of floor maps; it was just a matter of replication, something they could do themselves.

A few found themselves drawn to the invisible work, sitting with patients, asking how they were feeling, listening without judgment. They began to understand that public health wasn't just about service delivery; it was also about dignity, about trust, about making someone feel seen.

They proposed wall posters with QR codes linking to audio guides. They envisioned pictorial comics explaining how to use a PHC.

They offered to accompany ASHA workers on field visits and record learnings to help build better tools.

Some even imagined social media collectives that mapped volunteer needs across PHCs.

There were moments of hesitation. Some still asked: Will this even matter? But that question, too, was slowly losing its power.

They weren't waiting to be empowered anymore; they were stepping into it. Because they had seen something significant over the past few weeks: Change doesn't arrive fully formed. It's made. Bit by bit. Choice by choice.

It wasn't about scale anymore. It was about showing up. It wasn't about systems theory. It was about fixing a leaking tap, moving a bench into the shade, and helping one person understand where to go.

And somewhere along the way, the mental wall that had once separated activists from citizens began to dissolve.

The Changemakers weren't waiting for permission. They were becoming Changemakers, not in theory, but in action. Because in the end, the power to create change wasn't something they had to earn. It was something they already had.

Ready for Action

By the end of the week, something had shifted.

After days of imagining policy reforms, mapping structural improvements, and drafting suggestions for staff, the Changemakers found themselves standing at a quieter, more intimate threshold. It was no longer about the possibilities and potential of action. The question had become more direct and more difficult: What would they do?

This was the day that required them to turn inward. Not just toward their feelings, but toward their realities. The task was simple in words, but complex in spirit. From a growing list of proposed interventions, they were now asked to choose, not based on what sounded good, but on what they could actually commit to. The shift from possibility to practicality was not just logistical; it was emotional.

It forced them to hold their dreams up to the light of their actual lives, which included busy class schedules, family responsibilities, limited mental energy, and the challenges of location and access. And that honesty, while humbling, became its own form of power.

They revisited their notes, recalled conversations from the field, and listened to each other with renewed clarity. There was less performance now, and more purpose. The change in tone was palpable. It was no longer about offering the best idea in the room; it was about finding the most doable one. And in that act of grounding, something subtle and beautiful began to happen.

Each Changemaker began to articulate their personal interventions.

Ananya decided to enhance the digital footprint of the PHCs in Chandigarh by updating their timings on Google Maps, uploading photos, and adding contact details in both Hindi and Punjabi. She decided to go down and volunteer her time as well. Arpita made similar plans in her own city and added that she would visit the local NGO working on women's health to see if deeper collaborations were possible.

Devanshee wanted to help ASHA and anganwadi workers during their community surveys, and she had already begun thinking about sourcing essential supplies, such as ORS and masks, for nearby PHCs. Diya was designing a simple feedback form, hoping to offer it as a prototype to one of the centres she had visited. She also committed to translating her online reviews into local languages to make them more accessible.

Divyanshi mentioned her past work with menstrual health and hoped to continue pad donation drives in vulnerable areas. She also planned to channel her ongoing academic writing into a policy paper, one that could make a meaningful contribution to the knowledge base on public healthcare.

Guncha, ever brimming with enthusiasm, suggested starting a F.A.I.R. alumni network across platforms, a space for sharing volunteer opportunities, on-the-ground updates, donation drives, and impact stories. She spoke of harnessing this momentum into a collective engine, one that could continue to move forward long after the sessions ended. She was also already working on poster translation and had identified a few PHCs in her region that needed minor but urgent repairs.

A few others were making plans to co-write white papers. Some were designing illustrated posters, comic strips, or language-neutral visual aids for patients. Others were figuring out how to build relationships with nearby PHCs not as outsiders, but as consistent, trusted volunteers. Several committed to supporting ASHA workers with administrative assistance or simply being present on days of high foot traffic to help manage queues and explain forms.

Akansh and Anika had taken it upon themselves to look into getting the lift at one of the PHCs fixed, a seemingly small detail, but one that carried enormous meaning for the patients who had to climb those stairs. Alfia planned to use art to tell stories of healthcare, translating data into something that would speak to communities, not just academics.

Shreya had offered her phone number to the PHC staff and committed to visiting regularly. She was developing audio descriptions for key posters, hoping it would

make the information more accessible to patients who were visually impaired or had difficulty reading. She also proposed monthly cleanliness drives and mental health sessions for staff, to be planned with peers like Medha and Arpita.

Prakruthi, drawing from her professional background in healthcare, focused her efforts on digital access. She proposed a QR code-based system that could lead patients to all relevant information in one place, a portal offering multilingual content on entitlements, services, and preventive care.

Smriti Banka wanted to start an Instagram page to map and share volunteering opportunities at PHCs. She also planned to organise small food and beverage drives, update Google Maps entries, and donate clothes. Her vision was quiet,

consistent, and deeply personal. Shlok decided to get in touch with local NGOs and social organisations to get there support and establish collaboration between local actors and PHCs to ensure a sustainable impact.

The ideas were as varied as the people proposing them, but what bound them together was a shared refusal to wait. They had each reached a point where they no longer needed permission to act. They no longer saw themselves as merely 'students' or 'Changemakers'. They were not waiting for a grant, a letter, or a policy. They were simply beginning.

Some planned to visit their PHCs weekly. Some planned to write. Some chose art. Some chose advocacy. Others chose to listen. But each of them had moved beyond ideas. They had chosen action, shaped not just by empathy, but by accountability to their own values and capacities.

They also reminded each other that this wasn't about perfection. The interventions did not have to be revolutionary or significant. They simply had to be real. And once that bar was set, not high, but grounded, the weight lifted. Action became a natural next step, not a distant aspiration.

As the session ended, a new energy filled the room, accompanied by renewed passion and excitement to follow through. Helplessness and scepticism had given way to agency and quiet hope; without saying it out loud, everyone knew that something had shifted for good. What began as a week of observation had now become a personal practice. And what once felt like a distant, broken system was now understood as a living ecosystem, one they were already a part of.

They were not its saviours. They were its stewards. And they were just getting started.

Interventions Implemented

As we reached the second-to-last week of The F.A.I.R. Project, the Changemakers didn't need a prompt.

The structure of the week had been clear. Sessions were scheduled every day. They were asked to check in, show up, and track their progress. But there were no more instructions, no guiding questions, and no facilitators to steer them forward. This was deliberate. The work of The F.A.I.R. Project, after all, was never to handhold. It was to bring them into the room and then step back.

What followed was not chaos. It was cohesion, and from a group of individuals who were strangers, not so long ago, we witnessed collaboration.

What they built was not a flurry of isolated tasks; it was a community. Some of them returned to PHCs. Others worked from home. But wherever they were, they showed up not just for their Projects, but for one another. This wasn't just about execution, it was about solidarity.

And so, the WhatsApp Community was born, as a quiet necessity to keep track of all the different initiatives that had taken root. They created separate groups within it, each one designed for a purpose, each formed organically. It was never explicitly stated, but the intention was clear: they were done talking about change. Now, they were making it.

There was a group called "Poster Prep", where Changemakers gathered to design visual material for PHCs. Many of them, like Alfia, had taken on the responsibility of turning public health data into accessible comics. Others were creating bright, illustrated visuals to demystify access to contraception, safe motherhood practices, and hygiene tips. Some worked with local languages, others experimented with pictorial formats. Their focus wasn't on aesthetics; it was on clarity, usefulness, and dignity.

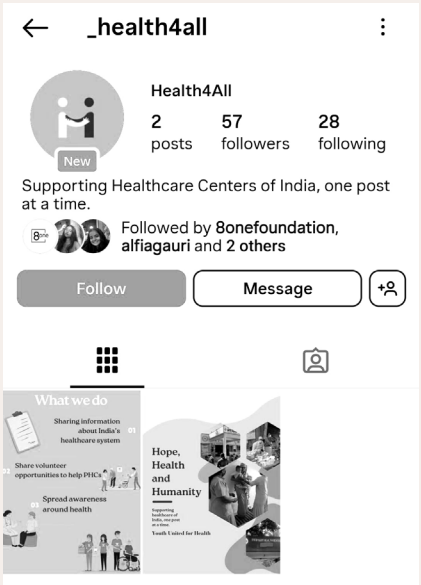
Another group, called "The QR Gang", focused on a very specific idea: installing QR codes at PHCs. These QR codes, once scanned, would direct patients to a simple, multilingual, and visually appealing page, providing key information such as available services, timings, phone numbers, and basic health literacy content. It was a small intervention with an outsized impact, especially for first-time visitors to the centres.

Then there was the "White Paper/Policy Paper" group that took it upon themselves to consolidate all policy suggestions, collate research, and start drafting letters to relevant state and central departments. They weren't content with just imagining systems change; they wanted to articulate it and send it somewhere it might be read. The paper wasn't authored by one or two people; it was stitched together by many, and no one was trying to take credit. Ownership here was collective.

Meanwhile, "Comicccccccss" became a quiet collaboration space where volunteers shared stories and dialogues they had encountered during their PHC visits, some humorous, some painful, many real. These would be developed into visual narratives, thanks to Alfia and others who shared their personal experiences, conversations and visits.

Another group, "Instagram Things", was quietly building a public-facing platform. Their aim was simple: to map PHCs across India, share real-time updates, highlight volunteer efforts, and raise awareness about what people can do to support their local centres. The idea wasn't to sensationalise the system's shortcomings, it was to honour the work already being done, while showing where support was still needed.

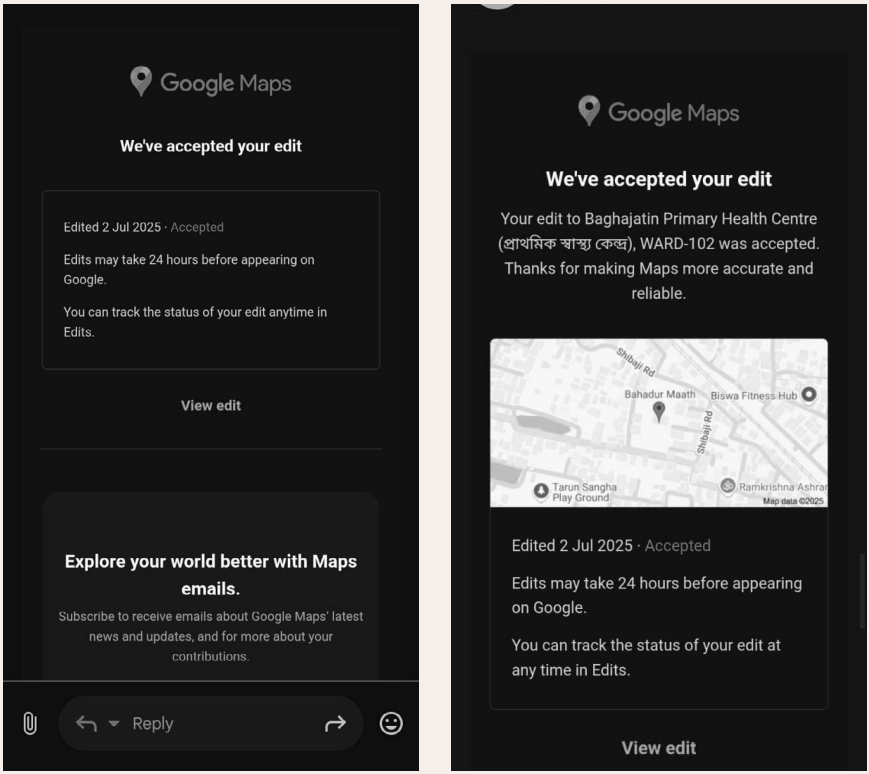
From ideas to action: posters made by Changemakers now in PHCs



The Instagram page made by the Changemakers to spread awareness about the Indian public healthcare system

The mental health professionals created a group called "Mental Health for All". The Changemakers focused on the medical professionals. In a society where burnout among healthcare workers is seen as just part of the job, they chose to challenge that narrative. Their early discussions focused on three tangible goals: conducting surveys to understand emotional burnout, creating peer-support systems, and launching social media campaigns that normalise mental health check-ins for medical staff. They weren't trying to solve everything; they were just trying to begin a conversation that too often went unspoken.

Across all these groups, work had quietly begun. Some volunteered to geotag PHCs and update their timings, photos, and contact details online. Others helped design floor maps that would make it easier for patients to navigate inside the buildings. Some created visuals for WhatsApp awareness chains, while others visited their local PHCs to ask staff what they actually needed. And when someone felt stuck, or unsure, or simply overwhelmed, they turned to each other for help.



The Changemakers helped make PHC information accurate and accessible on Google Maps

There were no performance charts, no awards, no applause. But the shift was real.

This wasn't about good intentions anymore. This was about implementation made possible not by one influential leader, but by a collective of young people who had spent weeks listening, watching, learning, and unlearning. They were not waiting for systems to open up. They were opening up the system from within, quietly, consistently, and together.

The interventions may have started as individual ideas. But by the end of the week, they belonged to everyone.

And perhaps that was the real success of The F.A.I.R. Project. Not that it gave these Changemakers a plan, but that it gave them to each other.

The White Paper

The Changemakers got together and drafted a white paper, an articulation of care, clarity, and commitment. It brought together proposals across all eight goals of the F.A.I.R. framework, anchored not in abstraction but in lived experience. This was not a theoretical exercise. It was shaped by what they saw, heard, and often felt during their visits to Primary Health Centres, and the long, layered conversations that followed. Each section emerged from questions asked in real places, in real time, with people who rarely participate in policy discussions, but whose realities shape the very foundation of public healthcare. The white paper is a collective offering, grounded in the belief that transformation begins not in grand declarations, but in noticing what is broken, imagining what could be, and asking, together, what we are willing to do about it.

The focus on Well-being was led by Smriti Sharma, Saummya, and Shreya, while Prakruthi, Aishvarya, Alfia, and Samvardhan shaped the section on Gender Equality. Guncha and Devanshee reflected on climate and environment, and nutrition was explored through the lens of Prakruthi and Smriti Sharma. Hygiene, often the most visible sign of neglect, was closely examined by Sonal, Suhani, and Diya. Aishvarya, Shreem, and Shreya brought nuance to the section on Peace, and Aryaa, Guncha, and Nila contributed to the vision for Education. Employment challenges, particularly around frontline health workers, were captured by Nila, Saummya, and Devanshee. The paper was carefully proofread, edited, and formatted by Sanah, whose quiet attention gave form to many messy drafts. Throughout, it was held together by the steady coordination of Aishvarya, who gently ensured that no voice was left unrepresented.

Summary of the White Paper

Despite well-intentioned policies and national frameworks, India's Primary Health Centres (PHCs) continue to fall short of delivering equitable, reliable, and dignified care. Drawing on field visits to over 50 PHCs across diverse regions, this white paper captures the lived realities of patients and frontline health workers. It highlights critical gaps in infrastructure, delivery, accountability, and legal protection and offers grounded, community-driven policy proposals under eight intersecting goals.

Key Observations & Proposals by Goal

- **Well-being**: Infrastructure remains inconsistent, staff morale is eroded by delayed payments, and care is often compromised by administrative burdens. Proposals include timely incentives for ASHA workers, medical-legal liaison systems to reduce court-related disruptions, and decentralised governance models, such as Kerala's People's Plan, to improve ownership and service delivery.
- **Nutrition**: Iron and protein deficiencies persist in maternal and child health. Supplements are often rejected due to side effects, and meals are irregular. Proposals include nutrition murals in PHCs, recipe-based pamphlets, promotion of traditional foods, redirection of surplus PDS grains, and structured training for ASHA workers in nutrition counselling.
- **Hygiene**: Despite numerous sanitation schemes, PHCs remain unhygienic, with broken toilets, poor waste disposal, and absent cleaning staff. Recommendations include regular hygiene audits, QR-code-based feedback systems, integration of menstrual hygiene, training on biomedical waste management, and clear accountability protocols for housekeeping.
- **Peace**: Healthcare workers are vulnerable to violence, especially in conflict-prone or understaffed PHCs. The paper urges the effective implementation of the MoHFW's anti-violence guidelines, improved security infrastructure, enhanced emergency response mechanisms, and improved staffing and legal protection systems to ensure safety and trust in care settings.
- **Gender Equality**: Deep-rooted gender disparities affect access, decision-making, and health outcomes. Reforms should focus on equitable representation, inclusive health communication, dismantling of gender norms that discourage care-seeking (especially among men), and stronger integration of gender equity in healthcare policy.
- **Environment**: PHCs face growing challenges from climate change and unsustainable practices. Proposals include establishing green zones in PHCs, enforcing waste segregation, promoting local hygiene education, and investing

in research at the intersection of health and climate resilience.

- **Employment**: Delays in wages, lack of recognition, and discriminatory work environments affect frontline workers. Key proposals include real-time wage tracking, grievance redressal mechanisms, legal safeguards, and investments in fair, dignified, and inclusive employment within the health ecosystem.
- **Education**: Low health literacy weakens public health outcomes. The paper recommends integrating health education into school curricula, promoting community outreach on maternal health, disease prevention, and hygiene, and positioning PHCs as learning hubs for lifelong public health awareness.

Medico-Legal Concerns

PHCs regularly encounter medico-legal cases but often lack the training and systems to handle them safely. Recommendations include mandatory training in documentation and consent, legally-informed SOPs for MLCs, audits to ensure compliance, and improved coordination between health and legal authorities.

Conclusion

PHCs are the foundation of India's public health infrastructure, but without accountability, investment, and intersectoral collaboration, they cannot fulfil their constitutional promise. This white paper calls for a pragmatic shift from policy to practice, rooted in dignity, decentralisation, community partnership, and systemic reform to truly realise health for all.

The Journey Continues

Such interventions are still unfolding. In homes, communities, campuses, and quiet moments of self-reflection, the Changemakers continue to learn, grow, evolve, and push for change in ways both visible and invisible. This book was launched during the closing session on 18th July 2025 to mark this pause in their journey, a moment to look back before moving forward. They met Violeta, Dr. Flavia, Elle Hepburn, Dr. Yonette, and Dr. Lwando once again, sharing with them the transformation they had undergone and the experiences that had shaped them throughout the Project. Each Changemakers spoke, echoing a shared sentiment: that changemaking is not a destination, but a never-ending journey. This book does not mark the end of that journey; it is only a point of pause, a trace of where they have been. Their stories are not bound by the timelines of The F.A.I.R. Project but carried forward in the choices they make every day. If there is one enduring lesson we hope stays with them, it is not what to learn, but how to learn with humility, curiosity, and the courage to remain open. Because the real work of change is not a single intervention, it is a lifelong practice.

Beyond the Conversation

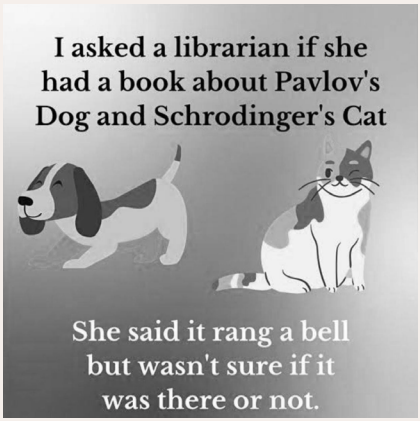
This section is secret. Just like the session it's about.

You won't find it on the programme. It's not on the Miro board, not scribbled in anyone's notes, and definitely not in the index. There was no announcement. No warning. No breakout rooms or closing slides. It just... happened. The recording stopped. People lingered. And a new kind of session began.

At first, it was just a few of them sticking around. Out of habit, maybe. Or curiosity. Then silence gave way to questions. Questions gave way to laughter. Laughter gave way to stories. And before anyone realised it, they had stumbled into a space with no agenda, no timer, no facilitator waving them back to the task.

There were no titles here. No one was "leading" anything. No one needed permission to speak. You could arrive in a thoughtful mood or a silly one, ramble your way through a memory or listen from the sidelines. Some ate dinner, while others braved the angry looks of their family members who were waiting for their call to end. Meanwhile, others had their video off, tired but unwilling to leave for fear of missing out.

It was open to everyone, but stayed alive only because some chose to stay.



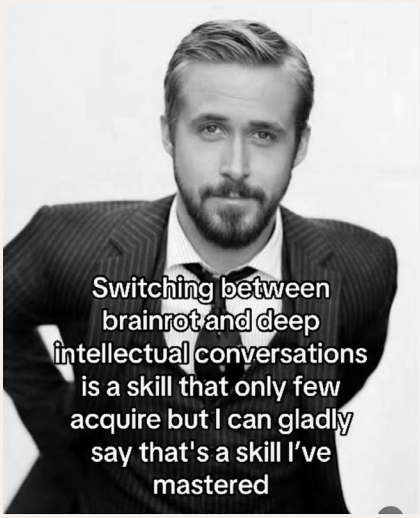
Aishvarya's #NoContext banter

There was total privacy. Even other Changemakers didn't really know what was going on unless they were there. The only clues were the memes and stickers that appeared in the group chat, always captioned with the mysterious but familiar tag: #NoContext.

And it's going to stay that way.

We won't tell you what was said. Or who said it. Because those moments belong to the people who showed up. That space wasn't meant for the archive. It was meant to be lived in.

In that room, there was no line between personal and professional, no such thing as appropriate or inappropriate, no worry about saying the right thing. It was just people being people. Some thinking out loud. Some talking in circles or maybe spiralling. Some talking about their childhood love for chomping chalk. Some asking if free will even exists. Some just… being.



Prakruthi's take on our post session conversations

It was the kind of space where nobody needed to be certain or polished or impressive. Where you didn't have to bring a solution, or a closing statement, or even a point. You could just arrive as you were. And that was more than enough.

It didn't change anyone's life overnight. But it did something subtler. It made space. Real space. To spiral without shame. To say things that didn't need to go anywhere. To admit confusion. To be seen. To be held.

And in doing that, it reminded everyone that the most powerful parts of this Project weren't built by a framework. They were built by each other. This wasn't The F.A.I.R. Project holding space for the Changemakers. This was the Changemakers holding space for one another.

It didn't look like a session. It looked like friendship. Like trust. Like humanity, at its quiet best.

And, of course, there are no notes from that night. But if you know, you know. #NoContext.

This book captures the journey of the 2025 cohort of The F.A.I.R. Project, as they explored the many facets of decision-making, with healthcare as their guiding lens and the following partners as trusted companions along the way.

unesco
Partnership

The United Nations Educational, Scientific and WORLD Cultural Organisation (UNESCO) was born on 16 November 1945. UNESCO has 193 Members and 11 Associate Members and is governed by the General Conference and the Executive Board. The Secretariat, headed by the Director-General, implements the decisions of these two bodies. The Organisation has more than 50 field offices around the world and its headquarters are located in Paris.

8one Eight Goals One Foundation

Eight Goals One Foundation (8one) is an India headquartered civil society organisation with projects across the globe. In addition to grassroots programmes, the Foundation engages with governments, inter-governmental organisations as well as various civil service organisations, universities, and development agencies in India and across the world, for policy and social sector initiatives. 8one actively seeks and builds panoptic collaborations across demographics and geographies to create synergies for meaningful dialogue and action.

ecocivilisation

Ecocivilisation is a movement which represents a holistic approach to societal development that places the well-being of the planet at the core of human endeavours. It envisions a harmonious coexistence between humanity and the planet, recognising that the health and prosperity of both are intertwined. It is a purpose-driven disruptive cluster with the aim to safeguard the planet as an ecological haven by embracing inclusion, empathy, and diversity at its core, nurturing universal knowledge and wisdom.

AMSA INDIA
2025 Thematic Partner

The Asian Medical Students Association (AMSA) India is a network of medical students and alumni, dedicated to empowering and supporting the next generation of physicians. We exist to inspire, educate, and inform medical students committed to making a positive impact in the world through healthcare. Our mission is to provide resources, leadership opportunities, and a platform for fostering compassionate and responsible future healthcare professionals dedicated to advancing medical work ethic and advocacy of better healthcare practices.

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