

Mabelle Arole Fellowship (2008-2009)

Final Report

Jeffrey Holzberg

CRHP, Jamkhed, India

Leaving Jamkhed and this Mabelle Arole Fellowship brings me back to the first day I arrived. I came with no knowledge as to what primary health care was. I came with a belief that rural India was as rapidly modernizing as urban India. I came with excitement and enthusiasm but little experience in community development. And as I look back, I see a fulfilling and life-changing experience. I leave having gained much more than I could have hoped or understood at the time. I have taken a diploma course with health professionals from Africa and Southeast Asia, learning the intricacies and history of primary health care and the Comprehensive Rural Health Project (CRHP). I worked in a hospital that exposed me to diseases and patients I would not see in America, as well as physicians who implement evidence-based medicine in a low-cost secondary hospital in rural Jamkhed. The projects I started provided the base for experiential learning in community development, integrated action and individual empowerment. Then come the aspects which were much less expected – friends made, a new language learned, traveling, reading and learning how an international NGO is run on the administrative level. The fact that the fellowship was as challenging as it was rewarding gave me a true taste for the difficulties in working with the community and affecting behavior as much as disease. I leave Jamkhed amazed that my ten months have passed so quickly while equally unable to remember what life was like before I arrived. I plan to become a medical student and physician who not only practices primary health care but lives the values that has stood CRHP out from other organizations. This report sets to give an overview of my experience as the Mabelle Arole Fellow. I hope to provide some insight as to the projects I worked on, the activities I took part in, and the personal developments made.

Diploma Course

As a first taste of Jamkhed and CRHP, the diploma course was a thali of different exposures. I was joined for two months by four health workers from Liberia, four from Sierra Leone, a health worker from Nepal and two others from India. The diversity was both a benefit and an obstacle, as discussions were lively with varied viewpoints while at other times personalities clashed. Almost all course participants spoke good English, making discussions participatory and interactive. The difficulty of some participants adjusting to Indian village life became the bane of others who did not need as much time to adjust and thus did not mind, for example, the spicier food or the high amount of village walking. The group unified as the course proceeded and we celebrating each other's birthdays and came together to sing, dance and share stories. All of the women in the course had a unique and difficult story to share and I feel fortunate in learning from them. That diversity of experience is rare to come by.

In the diploma course, I learned about primary health care, an approach that identifies the main health problems in a village by working through the community and tackling the needs through integrated services. It is a concept that stresses the role of doctors not as providers of health but rather enablers of it. Misunderstanding of that difference often explains why in India people often become doctors for the money and at the expense of the patient and the country.

The beginning of the course focused on the plight of Indian women, especially rural women. The drastic difference in the status of women compared with men, and even compared with women in the U.S., amazed me. Women face an uphill battle from the moment they appear in the mother's body. The numerous administrative measures that the CRHP hospital has to take to prove it does not condone sex-based abortions by using a sonography machine are evident of the high rate of female feticide in India. I was surprised to learn that up to 500,000 female fetuses are aborted each year in



The diploma course graduates stand with Connie Gates as we show our diplomas

India, leading to the birth of nearly 1 million fewer girls over the past two decades (Lancet, June 2006). From birth all throughout life, females are viewed as a burden and financial liability. Yet the women seem to do everything in and out of the home, as they are responsible for raising the kids, cleaning the house, fetching the water, cooking the meals and working in the farm, while many husbands either work, drink or play cards.

The last month of the course was spent focusing on a local action plan specific for a health problem facing one of the group member's home communities. In our group of four, the topic was to physically and socially rehabilitate disabled people in the Nepalese district of Rautahat. The action plan became a great learning tool as we came to understand that in order to have the community invested in the project and allow for sustainability, an issue cared about by all villagers had to be the starting point. The most trying task of putting together the action plan was working as a team and having productive disagreements rather than ranting arguments. Since we all came from different countries and backgrounds, there were plenty of difficult conversations. The action plan ended up being such a success and effective learning tool that it motivated me to think about my own community and the needs that are faced back home in the States. I used my experience working in social service for a year in the Bronx and growing up in Atlanta to write my own action plan, making the issues discussed in the course relevant to the community I will be returning to in June 2009.

Experience in CRHP's Secondary Hospital

Once the course ended, a lot of time was spent in the hospital shadowing Dr. Wout, a Tropical Medicine doctor from Holland also staying the year. Wout's presence allowed Shobha more time to focus on the administrative aspects of CRHP and programs that continue to push the project forward.

At first the hospital was overwhelming and even intimidating. I was struck with the incredible number of patients, the variety of disease, the extent to which diseases disabled the patient before seeking care, and just the overall pain that accompanies the third-world hospital. I had never before seen deformities caused by leprosy (feet curled upward, hands as stumps and a face sagged to the point of pain), the shrunken look of tuberculosis (often accompanied by HIV), the miniature size of a baby born at 1.5 kg's (3.3 pounds), or the ease of peeling off the top layer of skin on a child with third-degree burns. The constant loss of light/electricity during surgery, the

lack of oxygen tanks when they were most needed, and the absence of splints, crutches and wheelchairs made it difficult to keep sane with so much need surrounding you.

Eventually these difficulties began to fade as I got into the flow of the hospital and triumphs & remarkable patients came to the forefront. The patients are tough as hell and live with excruciating pain for months before coming to the hospital. Patients walk on fractured hips and broken legs, sit on huge pus-filled abscesses, deliver babies without anesthesia, and work in the farm with a miserably-smelling completely-necrosed foot remedied only by amputation. The joys of the patients and families become our celebrations as most recover from the problem that brought them there and they feel emotionally recharged as they have been

afforded the care they need and deserve, often regardless of pay. Patients who get better after receiving malaria treatment, having their cataracts corrected, or delivering via cesarean section will graciously thank you and bring happiness and smiles to the hospital and staff.

In addition, it took some time for me to understand how a hospital is run and what the duties of a doctor are. Medical students want to become doctors but, similar to me, seem to know little about the daily life of a doctor and how they work within a hospital, especially in a resource-poor setting. Simply understanding how one doctor manages patients in the OPD, in three different wards, in the operating theater and in the delivery room was as 'medically-revealing' as observing a delivery.

The Hospital as Part of the Primary Health Program

The hospital as the secondary care component of CRHP is essential to the success of its primary health program. CRHP is known for its PHC program and village work, but its ability to provide low-cost, honest hospital care is invaluable. How effective would the VHW be if she referred cesareans to a government hospital where it cost 10-15,000 rupees (\$200-\$300) and placed the family in lifetime debt, rather than to CRHP's hospital for 5000 rupees (\$100)? Or to a private clinician who charged extra for leprosy medications rather than to CRHP where the meds were covered by a leprosy fund? Or to a hospital where the staff treated you like an animal, instead of not only being respected but also being taught?

The secondary care component, in addition to supporting the VHW and her efforts, provides low-cost hospital care, supports a non-intimidating environment, and allows the villager to learn about medicine, thus breaking down unfounded beliefs. Each year about 26,000 outpatients receive treatment, 350 deliveries take place (usually for high-risk patients), and 500 surgical procedures are performed. Family members are allowed into the operating theater during the procedure and family is expected to care for the patient as a nurse would.



Dr. Shobha stands with nurses after a newborn was delivered in the operating theater

On April 5th, 2009, a new 50-bed hospital was opened with a bang at CRHP. Plans have been three years in the making and construction has taken the past year. The



Opening of the new hospital at CRHP

hospital is not only bigger but better built. While the old hospital was built thirty years past with tin roofing and one floor, the new hospital is reinforced with plaster and bricks and has two floors with plenty of space, also permitting a much cooler atmosphere in the hot summer months. The larger wards and consulting rooms will allow for better care of patients and the updated surgery rooms (including one for laparoscopy) will make it easier for doctors to operate. Private rooms will provide safety and comfort to patients with burns and smelly wounds. And the building will provide a long-term hospital solution, as the last hospital (while full of character) was not built to last as long as it did.

While CRHP has in many ways set the mould for an effective primary health program, a major focus now is to become a leader in creating low-cost secondary care. Protocols for patient care, drug therapy and operations will accompany the change in space to streamline and improve access and cost. Villagers with little hospital experience but tons of real life experience will be trained to provide patient care. Doctors will hopefully be attracted to the rural setting to provide services to the neediest of Indians – in eye care, dentistry, surgery and pediatrics. The goal for the new hospital is not an increase in patient numbers but rather an improvement and standardization in patient care, something reiterated throughout the opening. The opening of the new hospital represents the hope that CRHP will continue to be at the forefront of change in the health sector throughout India and other developing countries.

Hypertension Research and Alcohol Deaddiction Program in Indiranagar

In Asha's village, which is more of a rural slum than a typical village due to the many migrant workers, overrun space and lack of community cohesion, an abnormally high rate of alcohol abuse exists. Yet attempts to study these rates have not been conducted due to the stigma associated with high alcohol consumption present throughout the community. Masking the alcohol survey under a hypertension study, Asha (the local VHW) and I went house to house from mid-December to early-March, checking blood pressures and asking questions on exercise, diet, tobacco and alcohol use. The stigma associated with high alcohol consumption was mitigated by directing attention toward causes of hypertension, through trust created by the VHW, and by the collection of data in patient's homes.

Of the 304 men interviewed, 46% had normal blood pressure, 37% were pre-hypertensive, 12% were stage 1 hypertensive, and 5% were stage 2 hypertensive (BP greater than 160/100 mm Hg). 31% of the men were found to drink at least once per week – 42% of whom drank up to seven glasses per week, 13% up to fourteen glasses per week, and 45% fifteen glasses or more. And this isn't beer and whiskey but rather country liquor, as 82% drank an odd mix of distilled brown sugar with battery acid, trash, and other things I don't know about. The more alcohol a man drank, the higher his blood pressure was found to be – of non-drinkers, 52% had normal BP and 10% were hypertensive, whereas of those who drank heavily, 28% had a normal BP and 37% were hypertensive.

77% of the men use a tobacco product, with 85% of these men chewing tobacco (grinded up in their hand) and others using bidi (cheap cigarettes), goa gutka, cigarettes, paan, or marijuana. Of those who drink or use tobacco, 12,045 rupees (\$251) were spent on alcohol and 9991 rupees (\$208) on tobacco per week. Thereby, 22,036 rupees (\$459) are spent in total on both alcohol and tobacco, averaging to 92 rupees per week per drinking and/or chewing man, an astonishing amount considering the average female laborer makes 40-50 rupees per day and male laborer 60-90 rupees per day, five to six days



per week. We also found that 90.5% eat mutton at least once per week (counter-intuitive to the western idea that India is a vegetarian country) and 93.5% eat green vegetables at least once per week.

With the understanding that the data would be used to uplift the health of the village and direct community-inspired interventions, a meeting was held in mid-March for the men and their families to learn about blood pressure, hear the results from the study and discuss solutions. The first meeting was relatively unsuccessful, but the second went much better.

Asha, Lalanbai and I stand with a family after surveying men in Indiranagar

Connections were kept with the Indiranagar village as we identified men in the village who were open to discussing alcohol. A partnership was made with Pune Adventist Hospital's deaddiction program and in May, two counselors came to Jamkhed for a two-day session with our three counselors focusing on both theory and logistics.

In June, the last month before I left, two meetings were held per week between the counselors and myself to discuss the theory behind addiction using Alcohol Anonymous' *The Big Book* as a guide. Simultaneously, one of the counselors (a recovered alcoholic) will begin to meet with men from Indiranagar who want to quit three times per week, eventually taking them through the twelve steps. Once a solid group has formed, an awareness program will be launched and the Pune Adventist group will return to run a five-day detox center. Most importantly, at this point the outlook looks promising and achievable. If the steps as planned are taken, the project has a bright (although difficult) future for CRHP and the men who deserve the opportunity to quit drinking and treat their addiction if they so desire.

An abstract about the unique methodology used in collecting alcohol data in an alcohol-stigmatized village was written, submitted and accepted by the American Public Health Association. The poster will be presented at their annual conference in November 2009.

Fundraising Efforts

With the opening of CRHP's new hospital in early April, fundraising has become a high priority. To continue to push CRHP forward, add new programs and sustain current and effective projects, the minimum budget needs to be met during this financial crisis and restructuring in funders and NGOs. While it might not be the most exciting of projects, I have experience in fundraising from my last job in the Bronx, NY, and was particularly interested since funding success correlates with success in project implementation. Two of the projects I focused on were Global Giving and fundraising letters.

Global Giving is a website dedicated to assisting NGOs to find funding for specific projects. It exists as a database for prospective donors to search for different projects depending on the NGO, type of project, country, area of interest (in CRHP's case – health), and timeline. Global Giving is known to be successful in raising the awareness of smaller NGOs doing great work but having difficulty fundraising. For CRHP it is an excellent opportunity to fund an important project while raising awareness of the organization. The project chosen was the water and sanitation program, focused on training villagers to build bathrooms and toilets. The project secures a 24-hour water supply tank to improve hygiene, decreases waterborne disease and encourages community participation in villages. This project is posted on the Global Giving website and has already begun to receive donations.

The fundraising letters will reach out to CRHP contacts and alumni in hopes of then reaching their family and friends. The experience of coming to Jamkhed to learn, visit or work is memorable and at times life-changing. Many visitors come and then use the lessons in their local

setting. These visitors also provide an invaluable resource to help CRHP grow and spread. Fundraising letters will be sent to as many alumni as possible in America, Europe and Australia via email. Attached to the email will be a template letter to personalize and then send out to friends and family. These letters were completed and sent out in April 2009.

English and Computer Classes

In the CRHP spirit of sharing knowledge and using your own skill set to empower and help others, an English class and a computer class was started. Both classes gave me the ability to share what I am good at and have used my entire life to meet the needs and wants of the local staff. Learning both the computer and English is essential for the CRHP staff in the ever-globalizing world and in working with students from other countries. Additionally, most presentations are made using the computer and often made in English. It is essential that the staff learn both these skills.

Teaching has also provided a fantastic opportunity for me. The English class was held twice per week and is directed towards teaching a new batch of nurses who will work in the new hospital, as well as members of the mobile health team. Hearing them try to speak but be fraught with embarrassment and shyness reminds me of my time in learning a new language. Little movements and quirks that all the nurses possess also teach me a new part of Jamkhed culture. I also hold two computer classes, one at CRHP for the librarians and another at a local staff member's house for his children. Both are fun and interesting, as much a time to socialize as it is an opportunity to teach. I have also come to understand again how kids learn so much faster than adults.



In the computer class, Peter, Ramesh and Mr. Pandit were taught in the library

Mabelle Arole Video

Quotes I have heard from staff:

My strengths lie in speeches, acting and drama. But these are not skills I have known my whole life. These skills have been derived from her taking the time to get to know me and understand what I would be good at. She helped me to learn appropriate facial expressions and gestures. She always strived to make me and others as perfect and whole as possible, never leaving things half-finished or incomplete. She made sure that the same person finishes the task whom she assigned it to, correctly. She was fearless.

Even though she is physically not around us anymore, she still guides all of us, so much so that every single morning I cannot start my work until I pay a visit to her memorial site. I have done this every morning for nine years, and my experience is that work goes much smoother with the leadership she still plays in my life.

- Ganpatrao Waibhat (CRHP Worker since 1971)

I remember a story that has since changed my life: Once, we were a little late to Mandli village and there was a leprosy patient sitting under a tree. His fingers were fully deformed and he was not able to break the bread he was trying to eat. She noticed it and went close to him, took his bread, and broke it for him. The patient said “madam, please don’t do this, what if you get leprosy?” She replied “I cannot get leprosy by touching you or your bread. The disease does not spread like that, so you don’t worry about me getting it.” Her love shown for leprosy patients, displayed to the village by cleaning their feet sores, made me very upset that I avoided touching leprosy patients. Yet such a big doctor breaks the bread for him! Slowly, her examples helped me to start to adapt this way. Today, if any leprosy patients come for x-ray, I feel very comfortable to touch them. For the last forty years, I have been working and chatting with them.

People always said good things about those who have passed away, but I genuinely, from the bottom of heart, thank her for what she has taught me professionally and personally.

- Moses Gurram (CRHP Worker since 1972)

One of the most impressive people I met since I arrived in Jamkhed has been Mabelle Arole. However, Mabelle died in 1999. Throughout the first four months, I was told stories about her impact on them and CRHP and how she continues to be felt today. Therefore, the last five months of my stay in Jamkhed were dedicated to working with a social worker to interview and collect the stories and memories of Mabelle from those who knew her best - thirty seven village health workers, villagers and staff members.



Mabelle Arole stands with her husband Raj and her son Ravi outside her house in Jamkhed

One of the challenges that CRHP seems to face in the future is to continue to push the organization forward, be innovative and exemplify a sustainable, equitable and integrated mission. This is still done well but it will become more difficult when the original staff, those who knew the initial struggles faced by CRHP and the dependence on a vision and values, begin to retire. To help keep Mabelle’s stories alive, to keep her endurance and spirit active in the new staff, the video hopes to capture the original struggle and soul behind CRHP.

When I left Jamkhed, Ratna Kamble had completed all the interviews, giving us twelve and a half hours of tape. All the interviews were done in Marathi, so Rinku Desai and I sat for three weeks translating all the tapes into English subtitles. The video is not completed, however, and the project will now be left for the next MAF fellow to complete. The hope is the final product will be a 20-30 minute video where every interviewer is included and qualities are told through stories of Mabelle Arole.

The Experience of Working on the Projects

The projects were not just a way to assist CRHP and the local community but also helped me to learn about development work and community integration. Many lessons were learned through the projects but I want to highlight just a couple.

One was the importance of starting at the level of the community with needs identified by them. The importance is felt in their trust in you as a health worker and in their involvement throughout the length of the program. This was a lesson learned both the easy and hard way. The English and computer classes were started because the staff expressed their desire to learn the material. Thereby, it was not difficult to get them involved and participating. For me, it was an honor to teach English to them, yet at the end of the class it was them who thanked me. The alcohol project was different in that the health effects of alcoholism and heavy drinking were not a priority to the community. Even after many years of working in the village and with a village health worker, there were still many other problems with a higher priority. Health was not one of them until it became too serious to ignore. Thereby, when we held our first hypertension meeting to raise awareness as to the effects of hypertension and to give the study results, very few people showed. People seemed to not care so much and the relationship was flipped. Now, I was thanking them for their participation as they were hesitant to come take part. It was a lesson first learned in the diploma course but reinforced throughout my proceeding work.

The project work also taught me the importance in speaking the local language. I spent the whole ten months attempting to learn the local language of Marathi. What I came to find was that learning a language is more than just acquiring an ability to speak but additionally explains community and tradition that translation cannot convey. How villagers communicate and what words they use to describe situations say a great deal about the values held by that person and in that community. For example, Marathi allowed me to learn about the aggressiveness with which Indians speak to each other. There is little politeness in conversations, as questions are screamed at the men and answers are yelled back. Without understanding what is being said, every conversation seems to be an argument when really they may be talking about the effects of high blood pressure. There is also little use of *thank you, please, excuse me* or *I'm sorry* in the language. In fact, I almost never heard anyone say *please* in a sentence since I arrived and an American friend has been told that she should not say *thank you* so often because "it makes you look weird when no one else says it." Being able to speak Marathi allowed me to ask follow up questions to patients and helped me to remember villagers and conversations. Finally, learning to speak the language seemed to show respect to a community where I lived for nearly one year.

The projects, while supported by CRHP, were incredibly self-directed and initiated. This provided for good moments and bad. Because there were many additional projects happening at CRHP while I was there with an already limited staff, it was often my decision as to the next step of the project. With my limited experience in community development, I at times felt lost and frustrated. The next step was hard to come by and it forced me to go beyond my expectations and really research into the community and development work. While difficult at the time, the success of many of the projects are an attribute to how much I have gained in knowledge and practice. It also peaked my interest in being a person who listens and is able to respond in addition to being an initiator.

How the Experience Impacted Me

While in Jamkhed, I had the opportunity to do some things which really helped me take time to examine myself. In addition to what I learned at CRHP, I gained friendships that I hope will last

far past my time in India. Friends and staff offer a different perspective on many of my beliefs and thoughts, and I would often sit listening to them speak and learn about myself as much as



Jamkhed culture. Some of these conversations simply confused me and made me feel as if my friend was trapped in something that he needs to get out of, but often I felt enlightened to a type of life I do not live in the United States. It is friendships with people both young and old. I was friends with kids as young as 14-years-old to men who had already retired from CRHP. Everyone treated me like an equal and respected my thoughts. The countless dinners I had at staff houses or the tea that was bought for me will not be forgotten. Instead, it is this ongoing giving to friends that I hope to emulate in the U.S. Their ability to host me

in their houses so caringly will be an example I hope to follow in the states. It is these friendships and these conversations that affected me as much as the work that I did.

Traveling also gave me the opportunity to see new places and explore in and around India. I was able to travel to Kathmandu (Nepal), Gadchiroli, Sevagram (Gandhi's ashram) and Delhi to visit other NGOs doing great work. I hiked along the mountains in Dhadingbesi, Nepal. I slept on a single bed with another man I had never met on a bumpy twelve-hour bus ride to Nagpur. I rode elephants to stalk tigers in the jungles of Kanha, Madhya Pradesh. I partied in Goa, Pune and Mumbai with friends. Traveling helped me to understand that when visiting a foreign culture and a new type of people, the tendency to judge differences as strange, incorrect and unhealthy is easy and it serves to justify the decisions behind our own life. However, adjusting to the differences and forcing yourself out of your comfort zone is difficult but essential to learn about others and yourself. Stepping outside your comfort zone is a fantastic way to open your mind to new ideas, new ways of life and different forms of happiness and suffering. Without placing western and personal judgment on them, it encourages you to reanalyze yourself. This challenge very much brought about by traveling has pushed me to be accepting of others and appreciate differences rather than judge them.



Dr. Shobha and I visiting the slums in Delhi while evaluating the NGO named Asha

My time in Jamkhed made me think about my future. The legacy of the Arole's and the life they lived inspired me to think about what drives me? What is the issue that I am willing to fight for until my last breath? How do I find the needy communities in my own city and country and work to implement a program of equity, integration and empowerment? And then it leaves me both excited and anxious to think about hopefully meeting the person who complements me the way Dr. Raj and Mabelle complemented each other.

The experience in Jamkhed has challenged me to think bigger and more seriously about the role of the doctor. The role of a physician in a developing community is one of education, communication, and cultural understanding as much as disease and root causes. The role of a

rural physician mandates the necessity to understand agriculture, villagers' work schedule, and when market day is held. Will the role of a physician be the same in an urban and developed community? I also find it hard to dismiss things that I find wrong as simply being a part of the culture, thus letting it stand as is. Universal rights are innate no matter where the country or hospital and dismissing poor health as a cultural characteristic is a great disservice. The movement towards human rights involves behavior change as much as socioeconomic and environmental ones, yet how much of the local culture and mystic belief should be utilized to adequately create change? And who are the ones enabling this behavior change — NGOs, the government, or the people themselves?

One thing I will take with me as I become a physician is the importance of service and the giving to others in my work. Regardless of what is done for the community, I have found that I always acquire a personal gain and that mixture of personal satisfaction with community service will always have to be present throughout my work, with neither lost nor sacrificed.

Take Home Messages of CRHP Jamkhed

There are a couple key lessons that CRHP has taught me that I will take home with me:

- 1) It doesn't matter how smart you are, or how much money you have, but what matters when it comes to success is a die-hard commitment to the community, especially those who are most vulnerable and needy. In fact, I have come to find that money and intellect are at times barriers to really being able to work with the community.
- 2) The work that you do with the community needs to be based not on finances, not on theory or formulas that have been shown to work, not on great ideas, but on values. Values like love, equity, trust, humility and confidence are the pillars of a successful organization and project. Without them, struggles and uphill battles cannot be overcome.
- 3) The true caretakers of the community and the family are women, and that very often they get little of the respect they deserve. Even in America, I have come to realize that women are often mistreated and not allotted their full status. The women are the ones who are constantly there for their family, who work their butts off to make their family safe and healthy, and yet who rarely share many of the luxuries that us men share.

The most inspirational people I met in Jamkhed were the Village Health Workers - illiterate women who rose to meet challenges greater than they could imagine with a determination and grit unfound in most educated people. These women taught me how to create change in a community and country by changing myself, always being proud yet humble. CRHP has taught me much more than this and I surely won't be able to give credit to how much I have learned.

Thanks

The fellowship has provided me with new friendships that have made CRHP a home away from home. The staff has been warm and welcoming and their varied personalities have given a sense of family to this campus. In addition, the foreign visitors have provided a nice respite at times from Indian culture and the opportunity for conversation that can range from Australia's method for improving the health of the aboriginal population to America's best baseball team. David Pyle and the John Snow, Inc. team deserve great thanks, especially David who was always in contact and never at an end for good ideas and contacts. Dr. Wout was a constant friend and a fantastic person to bounce off thoughts and ideas. His ideals and his desire for knowledge and service are truly inspirational. Finally, I must be very grateful to the Arole family. Their hospitality has been exceptional, especially at times of personal hardship with the numerous illnesses they faced and the many programs that needed planning at CRHP. Shobha was supportive of the projects I took on and provided excellent direction and advice on how to make

them successful. Ravi has gone, as is typical for him, out of his way to make me feel comfortable and have more than my basic needs met. Dr. Raj Arole continues to inspire me daily and inspire the whole CRHP staff to always think about the community first and be graciously humble with success.

Finally, I thank Mabelle Arole for teaching us to strive to greatness and see it in ourselves. It is not difficult to still feel Mabelle on campus. Every village health worker continues to speak of her. Her memorial site on campus is visited daily by staff. People live their lives based on the teachings she gave them. Through the interviews of her video, I was amazed at how many little things about Mabelle people remember. It is those small things that really seem to touch people, that people remember the most. Mabelle never wore jewelry, her sarees rarely matched, she at times wore her shoes on the wrong feet, she laughed loudly and openly, she would rush out of bed if a patient came or VHW called, and she lived a simple life. She brought life to villages upon arrival and every visit used to be a community event. People would sit and listen to her speak, believing not only in her intellect but in the fact that she was one of them. And that seems to be one of her biggest contributions – she made each person not only feel empowered, but made them believe that others are equally good. She truly believed in the power, goodness and strength in each person and people feel alive by having known and spoken with her.

A common theme to the interviews was the feeling of one large family. “She cared for her family just as she cared for us. The world community seemed to be her family,” Yamunabai said, a VHW in Ghodegaon for 30 years. And she worked to spread primary health care and women’s rights around the world, working with the local, state, and national government. She was regional director to UNICEF for Southeast Asia, working in Kathmandu, Nepal, and she was a member of the Christian Medical Commission and World Council of Churches. Her greatest legacy, however, lives in those she continues to touch and the leadership she continues to play at CRHP, nine years after her death. “She taught us how to care for the problems of others. How to love others. How to participate in the sorrows of others. She guided us throughout our path. She taught us how to struggle in order to achieve something bigger. She gave us the gift of a lifetime-courage. This will help us as long as we live.” Said by Sofia Bee Shaikh, VHW in Patoda for 32 years. I feel so proud to have completed a fellowship in her name.

The experience of living and learning in Jamkhed is based in what cannot as easily be measured; value-based learning. The things I have learned in my fellowship go far beyond the projects I have started and the difference I have made. It is that difference in me that is most difficult to measure yet it is that education that I am (and will be) most thankful for.