**Mabelle Arole Fellowship**

**Final Report**

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“The bond that links your true family is not one of blood, but of respect and joy in each other’s life.” -Richard Bach

Joyfully anticipating the now-tangible beginning to medical school, I find goodbyes sticking on my tongue and must admit it is with some reluctance that I must indulge the process of moving on. Serving as the Mabelle Arole Fellow this year I gained not only invaluable exposure and experience in healthcare, public health, and NGO management, but I also gained a sense of family, home, and renewed and inspired passion for community engagement and service. Do not take this to mean the journey was easy or without its bumps, but the journey wouldn’t have been the same or as meaningful without them. I am not nearly eloquent nor concise enough to do justice to a summary of my work and experiences, but I have given my best attempt to put in black and white the accomplishments and experiences of my year as the Mabelle Arole Fellow at CRHP.

 **Fresh Off the Boat**

It isn’t often in life you get the chance to move to a foreign country for a year without ever having visited before, without knowing the language, or without any personal ties. A good, old-fashioned “up and move” because the opportunity presented itself and the goal worth pursuing. For me, this fellowship was such. In the midst of my senior year of college and medical school interviews, I happened to open an email from my pre-medical advising department advertising this fellowship. The opportunity to live in a rural, developing community learning about sustainable, community-based primary healthcare from people who transformed the health of innumerable people in their community and around the world was something I knew I had to do. An application, an interview, and a college diploma later, I was on a plane to India, a place I had never expected I’d go.

Thirty-six hours after boarding my first flight, I groggily wandered out of the Pune airport. Despite being unable to sleep on any of the flights, my eyes were roughly the size of grapefruits as I sat in the front seat and watched the terrifying traffic swivel and peel away in the nick of time before our barreling vehicle. I didn’t know it was possible to say so many things with the honk of a horn or flash of headlights! Crossing the road on foot is like a real-life version of Frogger. Looking back on my first day in India, it is amazing how normal the hectic, unruly traffic has become. The roads were just the start of the adventures India offers. India promotes a sense of adventure and necessitates a willingness to see where things lead, something that has fallen out of vogue in the well-structured West. I have enjoyed releasing my death grip on schedules, supposed-to’s, and intricately detailed planning in favor of adventure and pioneering, attitudes that proved to be a huge asset (if not a necessity) to my time at CRHP.

India is shocking. It is a place of extremes and contradictions. Five star hotels overlook abysmal slums. Here, some cities are the IT hubs of the world, while just a few miles down the road are remote villages that have a standard of living more akin to society hundreds of years ago. At times, it is difficult to process and even more difficult to understand how such extremes coexist so naturally to natives. Colors are bright. Sounds are loud. And smells are strong (for better or worse, it’s just the truth). More than the excitement and bright lights of Bollywood, this sense of fun and liveliness permeates every level of Indian society. While this translates to exciting festivals and high-energy fun, the part of Indian culture that has really struck me is the generosity.

Jamkhed is a rural, agrarian society, and after 3 years of severe drought, it is also quite poor. Regardless of these facts, families and friends of CRHP withhold no invitation, sugar, or bhaji from someone they wish to invite to their home. During my time at CRHP, I don’t think a week went by where someone did not invite me to their home. In Project Villages, the VHW is so committed to caring for her community; she is family, friend, confidante, and doctor to anyone at any time. She withholds no time or resources from those in her community that need her help. CRHP staff support each other through difficult times, not even questioning sending a portion of their week’s vegetables or cooking meals for another staff member.

Availability of resources isn’t even a question; it seems to be act first, think about it later. While this attitude could lead one into trouble if used too liberally, the beauty to me is the value of another over self. Often, this does result in hardship for the family or person giving, but that isn’t enough to get them to stop thinking of and doing for others. That is something I have seen very little of in Western cultures which are more preoccupied with being self-sufficient and successful. Thinking this way, every decision becomes economic: do the pros outweigh the cons? Will the return exceed the cost as it is supposed to? In Jamkhed, these aren’t the questions. The questions are: is there a need? If yes, fill it. You are also not supposed to say thank you, which blew me away. A common saying is, “Thank you is not for friends.” There is an underlying assumption in Indian culture that you take care of others without question, it is a deep bond that is understood and doesn’t need to be acknowledged to exist. It’s fascinating and beautiful.

Indian culture connects people. We had an Indian visitor who works at the UNICEF office in Delhi, and she told a story about an international co-worker. The co-worker wanted to know what the weather would be like in the city they were traveling to for business the next week, and asked our visitor to check online. Our visitor said, “Don’t be silly, I’ll just call my friend who lives there. She knows what the weather is like and will tell us how to pack.” But the co-worker protested, citing that she did not want to disturb or inconvenience her friend, so our visitor should just check Google. Our visitor was flabbergasted. Why wouldn’t she call her friend? Of course it would be no inconvenience to hear from a friend who needs your help.

This is such a different way of thinking compared to the U.S., at least in my experience. We see talking to one another outside of “leisure time” as an inconvenience, asking questions as a bother. We should be self-sufficient; we can figure it out ourselves. Conversely, in India, people are living, breathing networks existing to support one another and always seeking to make more connections. While at times this can be a tad exhausting, it embraces our humanity and encourages us to work together and to engage more with our fellow man. These lessons bring the “human touch” back to my austere, Western philosophy of relationships, something that I think would revive the increasingly mechanical field of medicine in the U.S.

Not only did I get to experience a vast array of new food, culture, and philosophy in India, but I also had an experience of an outsider being welcomed in. Lack of local language skills were an obvious barrier from the beginning, but that is something that I could work to eliminate. No matter how much Marathi I learned, however, was able to erase my obvious foreignness. While I was always treated kindly and with respect, the knowledge of being different and not quite belonging, in other words being an obvious minority, never fully faded. Knowing and experiencing this separation is quite different, and as I go back to work in the U.S., a country with multitudinous minority groups and a current climate of resurgent racial tensions, this empathetic experience will be invaluable as a citizen and even more as a physician.

India and Indian culture are incredibly complex. In many ways, my understanding of this country and the challenges CRHP’s communities face suggest I am still strong in my “fresh off the boat” status. However, as I contemplate my return back to the U.S., I sometimes feel more Indian than American. That is the beauty of India and the CRHP family: they bring you in, accept you, and welcome you to engage with this vibrant, complex society.

**Understanding CRHP and the Jamkhed Model**

Immediately after arriving at CRHP, I joined a 3-week Experiential to learn about CRHP’s history, current work, and the Jamkhed Model. This was the first year the Mabelle Arole Fellow participated in this course instead of the 2-month Diploma Course. The course brought together international students, CRHP visitors, volunteers, and the other interns and fellows; getting to know CRHP together bonded us fellows and interns well as a group, which enhanced our teamwork capacity for the months we worked together at CRHP. The course included teachers that have been at CRHP since its inception and introduced us to staff and programs all around campus. Also as a part of this course, we visited Project Villages, participated in a Women’s Self-Help Group, toured the hospital, made an artificial limb, participated in Village Health Worker (VHW) training, and even learned some Marathi! All of our sessions were geared toward teaching us about how CRHP has put health in the hands of the people through their primary health care philosophy and community-based approach (the Jamkhed Model).

The hands-on nature of this course was complimented by personal stories of CRHP and its staff. One of the most memorable moments of the course was listening to the stories of four Village Health Workers. For an outsider, their stories revealed the depth of how radically different CRHP’s approach and philosophy is from traditional society and made the caste system very real and personal. The reality of being counted something less than human is not real until the person in front of you is explaining how their life is so different after being empowered by CRHP and their work compared to their initial sub-human existence. Through these stories, I was struck by the depth of the impact of CRHP’s philosophy and work in the communities has had and the intensity of the resulting fire of commitment lit in each of the grassroots workers. I have never seen such dedication, passion, and effort bundled in one person’s pursuit of justice and service as with the VHWs and long-time CRHP staff members. It is beyond inspiring.

This course provided an excellent platform to begin to understand CRHP and everything it does and stands for. But it was only just the beginning, something I didn’t realize until many months later. CRHP isn’t something that can be grasped in a few weeks or even a few months. The early foundation provided by this course, however, was key to launching my life-long learning about this organization, these communities, and community-based primary health care. It taught me how to identify extraneous factors to health besides the obvious: how to evaluate a situation with a comprehensive view of the person in need. Factors such as annual income, education level, and lifestyles are not just notes on a page, but they are addressed as barriers to good health by the VHWs.

Not only did the course stimulate my intellectual understanding of comprehensive primary health care in a rural and resource-limited setting, but it also combined the scientific realm with the personal one. One of the most amazing things about how the Aroles’ founded this organization was with compassion as the lens through which all work is based. Meaning that care for a patient or community member is given out of genuine care and concern for the human being of equal worth as any other. This philosophy is fundamentally different than much of Indian society and even Western methods of healthcare. With compassion as the guiding principle, CRHP workers have a deep-seeded passion for providing assistance to community members that cannot be shaken by economic hardships, loss of loved ones, or any other form of discouragement. This became evident to me during the course when we dedicated time to solely learning from the staff. The respect they hold for one another and the community members and willingness to put others’ needs before their own in the midst of challenging circumstances is beyond compare.

I am thankful that my fellowship term began with this experience. It was a great way to meet staff involved in all levels of work at CRHP and spend time learning about them and their work. I think it is essential to dedicate time to such activities at the beginning of any work in a new community to begin to discover and understand the nuances of the culture and to get to know the people; it is a time to invest. Learning Marathi was an important benefit of this experience, and it is something I am immeasurably thankful to have had early on. Learning and speaking Marathi is a great way to show both staff and community members that you care to know them, their way of life, and understand what challenges they face by putting forth the effort to learn their language and try to gain as deep an understanding as possible. It is a not only a way to show respect, but it also helped me to form deep friendships with staff and enabled richer, more direct work within the community.

**A Day in the Life**

In my opinion, there is no such thing as a typical day at CRHP. Plans seem to be made and broken a hundred times. While this can become frustrating, there is also an element of spontaneity and willingness to “just do” or “see what happens” that is admirable in the dynamism of this organization. I think this pioneering attitude is necessary for an organization as innovative as CRHP. Local communities face severe challenges which demand creative solutions, and that sometimes translates to spur of the moment changes and certainly requires flexibility. The art of the matter is maintaining keenness for such creativity suited to the communities while having enough structure and monitoring to allow for replication of programs and interventions and smooth running of a medium-sized NGO.

Early in my fellowship year, I would spend my morning either making village visits with the Mobile Health Team (MHT) or spending time in the hospital with that staff. On the MHT village visits, we went to Project Villages and made rounds with the VHWs. During the summer, the Team was assisting VHWs to teach their communities about hypertension and detect new patients. In each village, a Team member would offer me the blood pressure cuff and they and the VHWs taught me how to perform blood pressure screenings in the villages. This on-the-ground support is a key element to the Jamkhed Model. The VHWs are the primary healthcare givers for community members, but visits by the MHT serve to support and supplement the VHWs knowledge within the community. The MHT in turn is able to help the VHWs discern when to refer a patient to the hospital, and often they can even offer a ride. This cooperation helps the villagers feel supported and comforted if they must go to the hospital, which is a scary experience for many regardless of where one lives.

These village visits allowed me to see first-hand how the MHT interacts with the community and builds trust between CRHP and village communities. When we would initially arrive in a village, the MHT would make rounds with the VHWs, but often the stops seemed to be no more than friendly chats usually accompanied by a generous cup of tea. Coming with an efficiency-oriented mindset, I was confused about why we were spending such precious time just chatting, especially when the bulk of the conversation wasn’t directly addressing health issues. As we sat at a VHWs house a couple weeks later, I noticed many community members were coming to the VHWs house to chat with the team. Slowly, I realized that these friendly conversations served to build relationships. By chatting with a farmer about his crops or the rainfall, the MHT was building camaraderie, thus creating a relationship where the community member will listen more to what the Team members have to say about health topics. Those extra conversations in the village, or five minutes in an exam room as a physician, to ask a person about their life outside of the science of health creates a world of difference. That is how change happens from the ground up: relationships, respect, and compassion.

In addition to these early village visits, I also accompanied the MHT to conduct health surveys in the village and participate in village clinics. I greatly appreciated the opportunity to do hands-on fieldwork of both a research and clinical variety. It gave me a comprehensive overview of public health fieldwork and research as well as field clinical skills and needs and its accompanying research. This perspective will be invaluable to me as I embark upon my medical education and contemplate career choices. I feel I have a realistic understanding of the practicality of a career in public health, clinical medicine, and a community-based approach to primary healthcare, which empowers people to take their health in their own hands.

I was also able to engage in the training side of CRHP’s work. I spent several days a week working to help plan VHW training each week. Sometimes I would research topics requested by Jayesh or other VHW trainers and give them a lesson plan. Other times I would attend weekly trainings just to observe and assist on an as-needed basis. Regularly attending these sessions allowed me to become friends with many VHWs, something I value greatly, as well as to learn new techniques for training. VHW trainings are by nature incredibly innovative as they consist of teaching women of varying education levels, including some without any formal education and who are illiterate, about complex health issues. The crux is that they must understand the material well enough to teach their communities. I enjoyed learning from the MHT and VHWs how to think creatively in terms of how best to teach information.

More importantly, these trainings taught me how to think on my feet as a health instructor and adapt lessons on the fly in response to the group’s learning needs and mood for the day. CRHP staff makes this look deceptively easy. But over time, I came to see it comes down to practice and knowledge of the community. You cannot teach well if you don’t understand and care for those whom you teach. Even more so, when you understand and care for those whom you are teaching, you actively seek ways to improve information delivery and teaching techniques. My favorite moments in the trainings were when the VHWs created a song to remember the signs and symptoms for schizophrenia, bipolar disorder, and psychosis. They were so proud of their work, and they sang these songs at the beginning of each training session thereafter. Jayesh remarked to me after the songs were written that now they would never forget nor confuse these mental illnesses, an incredibly abstract and entirely novel concept they had just learned. He said this works because this is how they are used to learning and remembering any information, not just health topics. Singing is also a common characteristic of communities here as a way to alleviate the monotony of many day-to-day tasks villagers must labor to complete. It taught me to seek continuous innovation, to try as often as I can to present information in new ways relevant to the community I am working with.

In addition to working with the community health workers at all levels of the Jamkhed Model (VHWs, MHT, and the hospital), I spent a considerable amount of time on my computer as well. At first, I resented this. I came to India to submerse myself in the community and get my hands dirty with clinical and fieldwork. I wanted to be in the hospital learning surgical techniques, examinations, and applying this and my hodge-podge collection of public health knowledge in the villages. Over time I realized, however, that being one of two foreigners who stay for a year poised me to be a great help to CRHP in terms of writing grants, establishing electronic monitoring systems, compiling manuals, etc. because of my English and computer skills. I’d even argue this taught me how quickly the perils of hubris can befall someone with good intentions, especially in the medical field where doctors are deferentially treated as leaders of the health hierarchy. I spent countless hours working to compile a mental health curriculum, often getting frustrated with the time I was required to be on my computer to do so. Toward the end of my fellowship, members of the MHT kept asking for copies and thanked me for working on something they can use for years to come. Comprehensive, community-based development needs to follow this pattern: fill a community-identified need using the skill set you can offer to the team.

Throughout the year, with the exception of only a few weeks at a time, many guests came to CRHP to learn about the Jamkhed Model and CRHP’s approach to development through the pursuit of comprehensive solutions to health problems. Such groups included U.S. medical students, U.S. undergraduate students, Australian MPH students, Indian health professionals of all varieties, grassroots healthcare workers from other parts of India, and many more individual international guests in a wide range of careers. In addition to providing much welcome variety to our Jamkhed social circles, this diverse range of visitors educated me on how widely healthcare, and many other aspects of life, can vary. We were welcome to sit in on classes and had countless discussions about healthcare or any other topic over meals in the international mess. Leaving Jamkhed, I feel like I am now part of a global community of people seeking to provide innovative solutions not just to healthcare, but to social justice and development across all sectors of society. My perspective has been healthily broadened, and now I am able to dissect many different approaches to healthcare and development and attempt to optimally reassemble these pieces in future communities where I will work. Not to mention, it has greatly expanded the number of places in the world I can travel and have ready-made friends!

**The FIG Tree**

My greatest legacy at CRHP may be in dubbing the Fellow and Intern Group name as “the FIGs.” This group consisted of a typically two interns at CRHP for 6 months, the Elon Fellow here for one year, and another long-term intern who has been here for 2 years now. The FIGs are responsible for keeping up with CRHP’s social media, writing grants, and helping with program documentation so that CRHP programs can be scaled up and replicated by CRHP as well as other organizations. Whenever I was stumped with a project or coming up with new ideas for projects or work around campus, my fellow FIGs were always there to help me brainstorm or give me tasks to complete.

One of my favorite FIG projects was Family Day. Once a month, all the fellows and interns would plan and sponsor an afternoon for all the staff and their family to come together, play games, have snacks, and reconnect with coworkers in different programs. These provided a great opportunity for inter-staff bonding as well as gave us an opportunity to get out of the intern office and engage with all CRHP staff. At first, we didn’t think any staff would come, and they admitted they were confused and nervous about why everyone was called together. After the first few Family Days, however, staff began approaching us to ask when the next one would be. With the hardships that accompany devoting one’s life to working with poor communities to improve health and development, it was a joy to provide the staff with an afternoon of lighthearted fun and be able to express thanks for the work they do.

In following our 2012-2013 predecessors, this year, the Elon Fellow (Cameron) and I collaborated to develop another round of staff retreats. After the overwhelming success of the Aurangabad retreat Aparna and Annie put on in 2013, Cameron, Ravi, and I sought to establish more routine retreats as a source of motivation for staff. Reminiscent of professional development and continued education used in many professions in the U.S., we hoped to use the retreats as a fun way to teach important skills and values such as responsibility, teamwork, accountability, etc. Due to circumstances surrounding staff and programs this year, our plan was to first conduct a 2-day retreat by program, beginning with the hospital staff and working our way through each program staff. After the initial round of retreats covering topics of responsibility and teamwork, we intended to design follow-up retreats to be conducted every three months or so to keep up morale. The follow-up retreats were also designed to mix staff from different departments in attempt to increase cohesion between departments and cultivate a sense of CRHP in all its parts as one family, one fully united organization.

Despite careful planning and extensive preparation, we unfortunately never got to conduct any of our planned retreats. Things always came up much to our disappointment as well as the staff’s who frequently asked when they would have the retreat and expressed great excitement for them. U.S. President Harry Truman had a plaque on his desk that read, “The buck stops here.” I could have used that sign here. While things do come up and circumstances may be unfavorable, I am a firm believer in the school of “if there is a will, there is a way.” This was my own lesson in responsibility and gumption. It was too easy for me to let recurring disappointment or cancellations negatively impact my pursuit of projects. Recognizing some things are out of my control is a part of life, but that does not give me a license to give up; it is then that I should seek a different way to go about accomplishing a goal.

**Mental Health Program Launch**

Three months prior to my arrival in Jamkhed, the 2013-2014 Mabelle Arole Fellow, Ani, had just received a grant from the Paul Hamlyn Foundation to start a Mental Health Program at CRHP. After completing the Experiential Course, I was approached by Jayesh and other CRHP staff to ask about the Mental Health Program (MHP). As a brand new program with a brand new donor, this program posed a great challenge. For the first month I worked on the project, I spent most of my time scouring the Internet for pictures that represented signs and symptoms of mental illnesses to create instructional flashcards. I was simultaneously working on compiling a comprehensive mental health training of trainers manual to use for VHW mental health trainings. I provided instructional support to Jayesh, the main trainer for the MHP, for VHW trainings by providing flashcards and some basic outlines about the mental illnesses our program covered.

After a few weeks of using flashcards from outside sources, members of the MHT asked me if it was possible to get pictures that the VHWs could relate to. Something that reflected life here rather than some generic picture that doesn’t make sense to the villagers. We were able to get in touch with a local artist in Jamkhed to whom I explained various signs and symptoms of mental illnesses and he created illustrations that the VHWs could immediately identify. This served as a great test of communication. Not only was there a communication barrier, but mental illness is a new concept in the area, and therefore the signs and symptoms are that much harder to properly explain. This along with VHW trainings stretched my communicative capacity, requiring me to think quickly and find the best way to describe entirely foreign health information to new populations, a skill I think I will use often throughout my career as a medical professional.

Another keystone to beginning this project was conducting baseline surveys in the village. With the help of Ravi and Jayesh, I created questionnaires for the MHT to use to gather baseline data from 10 Project Villages. One part of this baseline data collection was a focus group that asked about current beliefs about mental health to gauge the level of superstition versus scientific, medical understanding of mental health and mental illness. In addition to understanding the current climate concerning mental health in the villages, we also gathered baseline prevalence data through house-to-house surveys and village-wide focus group discussions. I accompanied the MHT to the villages to conduct each of these surveys; it was exciting to be able to participate from start to finish in community-level research using participatory methods. Having conducted laboratory medical research in college, it was nice to be able to get hands-on experience in public health research. This aspect of the MHP combined with the determination of survey timeline in accordance with training from the schedule Ravi and Ani gave me the opportunity to be responsible for a large-scale, community-based public health intervention.

In addition to helping to design, schedule, and conduct research and training sessions, I was also responsible for the administrative aspects of the Paul Hamlyn grant. I was responsible for writing our 6- and 12-month follow-up reports and worked with Ravi to create the corresponding budget reports to submit to Paul Hamlyn. After I had been working on the MHP for about one month, we had our first visit from a Paul Hamlyn representative. To my surprise, and hers, she declared the program in disarray at the conclusion of her visit. We did not have any registers to track vehicle trips, attendance at mental health training sessions, she couldn’t understand our financial tracking, and we were behind schedule on many proposed activities. Much of what she enumerated as a problem I was not aware there were parameters for. As a result of her findings from her visit, we were assigned an early audit date in December. Therefore, from September until early December, we engaged in a massive program overhaul.

 While exhausting and frustrating at times, this overhaul provided me with valuable insight to the administrative workings of an NGO and an on-the-ground public health intervention program. Ravi and I spent many hours brainstorming how to create registers, how they should look, how to categorize expenses, tracked vouchers, created manuals to govern CRHP purchasing policies and other administrative documents. I had no prior experience with this type of administrative and financial work, but it has given me a fuller understanding of the practical side to running a health NGO, something I have considered at times. It was a privilege to be entrusted with so much responsibility regarding the oversight of this program, something I am grateful for Ravi giving to me.

Even though we did not perform perfectly and there are still ongoing discussions with Paul Hamlyn as to their rules and how that affects our MHP, it was good experience to problem-solve administrative and financial issues and be involved in all aspects of this public health program: from administrative guidelines to finances to the field work. This grounded my idealistic goals of empowering communities to seize their health through community healthcare as a physician, a public health worker, and a representative of an organization. As I begin medical school and try to decide in what capacity I want to be involved in clinical medicine, research, public health, and health NGOs, this experience makes me feel like I can make a fully informed decision as to what type of healthcare path I want to embark upon.

**Hospital Experience**

Beginning my fellowship, I had the idea that a good portion of my time would be spent in the hospital seeing patients and learning clinical skills. While I was able to spend time in the hospital, it was much less than I initially anticipated, something that has a cohort of causes behind it.

First, Dr. Shobha has retired from most of her clinical work, only going to the hospital for special teaching occasions and complicated cases that require her attention. CRHP is in a transition phase where she and Ravi are working to pass on responsibilities to the next generation of leaders, and this applies greatly to the hospital. During the experiential course, there were a couple medical students from Belgium who had come to learn at CRHP. While they were here, Dr. Shobha conducted morning rounds which I was able to attend. She would introduce us to each patient, tell a little about them, their family, and their condition, then she would teach us the examination that patient required. I was able to see and/or participate in an abdominal exam, a neurological evaluation, evaluation of the lungs of a tuberculosis patient, in addition to a few others. After the summer, though, I would sparingly see patients with Dr. Shobha in the hospital as she was busy with other endeavors and my time was largely consumed with developing the Mental Health Program.

Another reason the clinical aspect of the fellowship was in slight decline from previous years is due to the transition CRHP is currently undergoing. In recent years, patient flow in the hospital has slowed to a trickle for many reasons. Because of the shift of the burden of disease from communicable to non-communicable in villages and the approach of CRHP to supporting these communities, the Mabelle Arole Fellow now works more closely with Ravi on public health oriented projects as the main focus and opportunity to engage in other activities per the fellow’s interests. Even though I was not in the hospital eight hours a day and patient flow was low, I still was able to do a considerable amount of hands-on clinical care and gained valuable experience and skills prior to medical school. Some procedures I was able to do include: C-section assistant, hernia repair surgical assistant, tubal ligations, natural deliveries, and IV placements.

After the summer course, if there were no village visits in the mornings for me to go on with the MHT, I would often spend that time in the hospital. Immediately following the course, there were two U.S. nurses who had come to CRHP as medical volunteers for the summer that came with me to the hospital. It was great to have two medically trained people to accompany me because they could help explain what the doctors were discussing or what tests or monitoring procedures each patient needed. They were also just as eager as me to get to know the hospital staff and learn Marathi. Consequently, many of my early days in the hospital were spent getting to know staff by sitting and talking and by learning various procedures around the hospital, such as dressings. In my time at the hospital, I was able to dress leprosy wounds, amputations, severe burns, abscesses, and even put in a couple necessary stitches to name a few.

These early days were critical to establishing a rapport with the hospital staff which opened the door to being involved in surgeries, in-patient monitoring, and led to some of my deepest relationships with CRHP staff. I enjoyed many mornings of jokes and Marathi lessons from Sameer, Shahabai, Uma, Moses, Dr. Pravin, Dr. Pattekar, and Dr. Prashant to name just a few. Sometimes they were teaching me how to draw blood from a patient, take an x-ray, perform a prenatal exam, or do a dressing, but many times we would discuss our families, how a girl that was 22 could possible be unmarried without any plans for marriage, and their history at CRHP.

These impromptu lessons are the nature of medicine and taught me an important lesson: how to learn medicine and how that is fundamentally different from the book learning I have performed to this point. I remember scrubbing into my first surgery ever: a C-section with Dr. Pravin. He let me be second assistant, meaning I held the Doin’s retractor to keep the bladder safe while he opened the uterus to deliver the infant. After he closed the inner layer of tissue and put in the anchoring stitches to the skin, he turned to me, offered his suturing tools, and asked if I wanted to finish the stitches. I was flabbergasted. I had no idea what to do, and my hands shook like leaves. I was able to put in one stitch with his verbal and a little hands-on guidance.

A few days later in the OPD, a patient with an abscess came in and Dr. Pravin asked if I wanted to assist with the debridement. I excitedly agreed, and I was unexpectedly handed a needle and told to insert it in attempt to relieve the pressure and provide avenues for infected tissue to come out through. With a person lying in front of me in both cases, I was suddenly hesitant and had a hundred questions: Where do I poke the needle? How deep? What angle? How many times? Slow or fast? While it is important to ask questions in medicine, it is also important to act decisively. These and many other clinical learning situations taught me that in medicine, I have to be able to listen, ask, and act practically simultaneously. I am a type of person that wants to be certain before I do anything, but there are medical situations where there is no certainty and you have to take your best stab at it. I am thankful to have had so many clinical experiences prior to medical school so I am not left standing jaw agape, hands frozen in midair in my first rotation third year.

**Quality Control**

Serving as the Mabelle Arole Fellow allowed me to be involved with work at all levels of the three-tiered Jamkhed Model: the VHW, the MHT, and the low-cost, secondary care hospital. First-hand exposure to both the work and the workers at each level taught me that there is a difference between a healthcare provider and a healthcare practitioner. As the WHO states in their definition of health, “health is not merely the absence of disease or infirmary,” but rather it is a comprehensive state of well-being.[[1]](#footnote-1) It’s about quality of life, not just quantity or health statistics. It’s about the person within the patient.

In the *Jamkhed* book, the Aroles recount their realization of a need for a comprehensive consideration of all factors that affect health in order for lasting change in people’s health to come about. They cite confusion as to why people refused to bathe and use soap; that is until they tried to live on the income that most people in the Jamkhed area made. Quickly, they realized that they did not have enough money to both eat and buy soap. What is more important: filling your belly or going hungry in order to prevent a sickness you don’t even have yet? This question may seem simple, but many of the health and public health challenges we face both in the west and globally boil down to similar choices. Do I spend the extra $15 at the grocery store to buy more fresh foods when I’m struggling to make a car payment to help prevent diabetes, a disease I may or may not get?

How many physicians in the U.S. know if their patients are struggling to make car payments? Or have a history of medical debt, and so they stop coming to appointments because it is beyond their capability to keep up with the payments? Here, patients are known as people. The VHWs can tell you the full medical history of anyone in their village from memory. The MHT knows every VHW, how many people are in her village, and what are the most pressing needs in each community. The hospital staff take care to gather information on the current state of affairs for each patient before beginning treatment courses, careful to judiciously order tests or medication so as not to bury patients in medical debt. Medicine is personal here, and that is how I believe it should be.

I have had many conversations with Ravi and Shobha about how doctors in the west increasingly rely on tests and machines to make the diagnosis or decision for them, turning the role of a physician more into one of a technician. While I value modern technology and believe advances in medicine and medical technology truly save lives, there is more to life than the number of years and that is something doctors must be mindful of. Not just in palliative care, but in everyday treatment of patients who walk in with a cold, a broken arm, or anything else. What technology cannot do is provide explanations that provide the patient with a full understanding of their condition that allows them to feel a little more in control of their situation, even if it is only in the decision-making process. Technology cannot make a person feel supported or heard. It cannot make exceptions or try something based on intuition just like a pilot will argue a man in the cockpit in a dogfight is infinitely better than a computer because it’s the little moments that define the outcome.

I want to be a physician. I want to be involved in my community in such a way that allows me to be more connected to my patients in order to provide them the best clinical care possible and enables us to collaborate to empower people to take health in their own hands like CRHP and the VHWs have done here.

 **Home Away from Home**

CRHP has truly become a home and a family to me beyond any hope or expectation. I remember my first full day here, I went to the preschool with a girl who had been at CRHP for 11 months. She knew the preschoolers by name and was speaking Marathi to them. Later that day, she gave her farewell presentation and was talking to several staff members in Marathi. I remember thinking, “I don’t know how I’ll ever get to the level with this language that I could speak even semi-coherently to people. I’m not sure I can make such deep relationships here.” That could not have been farther from the truth. Every staff member has become my unofficial Marathi teacher. I frequently stop on my way to the hospital or Old Training Center to chat with staff members and their family. Shockingly, I’ve even served as an unofficial translator on village overnights or trips to the farm with other fellows and interns.

Every member of the CRHP community has been incredibly welcoming to me and treated me as family. My last month at CRHP, I had to have a minor surgery that took a few weeks to recover from. After the surgery, any time I saw a staff member the first thing they would ask me is if I was ok and how my recovery was going. Ravi, Shobha, Chris, Shahabai, Sultana, and the interns and fellows took tireless care of me without any question. I love that about CRHP: there is never a question of does a person have the time or the means, they just immediately take care of others, no questions asked.

Throughout the year, friends and family in the States would ask about my day-to-day life and always ask if things were weird or very different. I had a hard time answering, because my life at CRHP and in India seemed so normal. I have tea twice a day, just like most of the people here. I love samosas, wadapav, and wearing bright colors. I would be askef I got homesick. Some evenings, I would go visit Meena on campus, and one time she told me, “Don’t be lonely. Come here; I am your family here if you want.” I have formed some of the deepest friendships with international guests, students, and interns.

Perhaps the most influential part of this experience has been my personal spiritual life. India is quite a spiritual place with many religions. As a Christian, I was excited to find out that there was an on-campus church I could attend. Although I did not end up going regularly, the situations I experienced through the year, the lessons I learned from the passion and generosity of everyone at CRHP, and the time I had to pursue books and spend time reading the Bible resulted in significant growth of my faith and spiritual growth. Unlike any other place I’ve worked, here I’ve learned what it means to live out faith and be a servant first. I have been challenged here, undoubtedly. For months, I was the only foreign Christian; that was the first time in my life I have been without any Christian community. However, there were people who came to CRHP throughout the year who bolstered my faith and provided much welcome community. Regardless of personal religion, being in Jamkhed so long allows time for extensive personal reflection, and it will stretch you as a person.

**Just Away from Home**

A happy by-product of being a foreigner in India for a year is that you have to exit the country before 180 days. While I knew this since my visa was returned to me, for some reason I did not give traveling outside of India much thought prior to my arrival. During my time here, I was able to travel to Nepal, Thailand, and throughout Rajasthan and to Agra within India. The Himalayas are astounding. Thai beaches are even more idyllic than the pictures. I never imagined I would ever visit any of these countries, but I am already itching to return.

As a fellow and intern group, we took a trip in September to Goa. Pune and Ahmednagar are cities near enough for a weekend getaway, which many fellows and interns chose to do when the insular environment Jamkhed became too much. Such getaways were great for refreshing the mind and perspective when frustrations with work mounted or a change of pace was desired. There is also a nearby “waterfall” (depends on if there is actually rain whether or not you get to see the waterfall), and it was a lovely place for a hike. These trips were helpful for clearing the mind and also adding to the perspective on Jamkhed and just how different it is from any project elsewhere in the world. Or at least the parts of the world I have been able to see so far.

**Gratitude**

Thank you may not be for friends according to Marathi proverbs, but I very much want to convey my deepest gratitude to everyone who made this experience possible. Thank you to David Pyle, John Snow Research & Training and AMSA for the time, resources and effort to make this fellowship a reality. It is truly a life-altering experience and provides unique learning and perspective on healthcare and development work and philosophy. The nature of the fellowship and CRHP allows in-depth, hands-on exposure nearly impossible to get elsewhere without years of experience. Monthly Skypes with David made me feel supported and secure, especially when I felt a little lost in my Fellow endeavors. I greatly appreciate his mentorship and continuous engagement in seeking new partnerships in pursuing better global healthcare through establishing partnerships for CRHP within in India and for me personally globally. In one of our chats, he told me about Health Houses in Mississippi, an innovative healthcare model similar to CRHP modeled from Iran’s healthcare system, and he put me in touch with the leading doctor. We now have plans to meet when I’m back in the States to discuss his model and my ideas for adaptations to the U.S. healthcare system based on observations and lessons from CRHP.

 I wish I knew more words to express my thanks to Ravi and Dr. Shobha for their generosity, openness, and willingness to teach me about their work and experiences throughout their lives. We spent many hours laboring over report documents, brainstorming new ideas, and enjoying a good dinner and movie. I have to say a special thanks for all the cooking lessons! I appreciated all the life chats and learning more about Drs. Raj and Mabelle Arole through their stories. I truly feel like they welcomed me into their family and to join the movement that is CRHP, and that is something I will cherish. The mentorship provided is invaluable to me, and I look forward to continuing it for many years to come.

I would also like to thank all the members of CRHP’s staff. They kindly and patiently put up with my endless questions, poor attempts at putting together a proper Marathi sentence, and teaching me about their work, letting me try anything I wanted for myself. This openness combined with their friendly, positive attitude made me feel right at home and like I was a valued member of the CRHP team in achieving the organization’s mission and vision. I hope to emulate their work ethic and exhibit the same level of dedication and effort in my work as they do theirs. I deeply appreciate many staff members welcoming me into their homes. Several had standing invitations, and I would go in the evenings to chat and share a cup of tea and snacks while swapping stories. These moments and conversations I will remember and cherish, and I hope that others to follow will develop similar relationships, because the staff truly are phenomenal.

This year would not have been the same without my comrades in arms: the fellows and interns. So many hours in the intern office on our computers, walks to the lake, and sometimes general confusion created a great air of camaraderie and cultivated genuine friendship. While I enjoy being at CRHP and in the surrounding communities, it can be a difficult environment at times. This group of people made those times better. We shared many laughs, and the occasional tear. Cameron, the other one-year fellow, in particular was a special friend and incredibly caring. She took immaculate care of me when I was ill, after surgery, or even just what I was having a bad day. Her work ethic and compassion are inspiring, and I am so thankful she was my partner in crime throughout our year in Jamkhed.

I am honored and humbled to have been able to serve as this year’s Mabelle Arole Fellow. For all the ups and downs of the year, it truly was an opportunity to engage in my dream job, integrating social justice with healthcare, with people who have made a significant impact on the lives of people locally and around the world. Throughout the year, I have constantly been inspired and amazed at the legacy of Drs. Raj and Mabelle and everything they, the CRHP staff, and the village communities have accomplished and sustained. As I return to the States and begin medical school, I bring back these relationships, experiences, and perspective on community involvement and healthcare. Like the Aroles, I want to immerse myself in community, serve the people, and empower people to radically change their lives. Seeing it accomplished firsthand provides me with renewed confidence that progress, equality, and justice are possible. I will never forget these people or these experiences. This has been a defining experience, one I wouldn’t trade for the world. Thank you!

1. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. [↑](#footnote-ref-1)