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Final Report

I. Introduction

My year in Jamkhed has been incredibly transformational in so many ways. My philosophy about healthcare and development, feelings about my own career in global health, and my growth as a person have been dramatic. Throughout my reports, I have made mention about how my preconceived notions have been overturned and that I've been often forced to think outside of my comfort zone. My last days here have been a culmination of that process and I am proud to leave Jamkhed with a much broader perspective.

II. Travel & Conferences

My year has been very heavy on travel and have given me broad exposure of India's development situation and more broadly, the country as a whole. I truly believe my travel experiences have given me an idea of some of the best practices across the country and has helped clarify CRHP's philosophy for me as well. I've provided two examples of my travel experiences below.

In late December, I embarked on what was probably one of my most transformative experiences in my months living in India thus far. Earlier this year, one of my colleagues, Rohan, told me about Jagriti Yatra (www.jagritiyatra.com). JY is fifteen day experience that brings together young people involved in different sectors including agriculture, healthcare, water & sanitation, energy, manufacturing, education, and information technology on a train trip to see some of the best NGO and corporate role models in India. JY was a fantastic way to see the diversity of the country, experience different local cultures, and of course, understand the philosophies and best practices that drive the changemakers of India. Our journey began from Mumbai on Christmas Eve and then headed south—we would eventually end up back in Mumbai after an odyssey of role models scattered throughout Indian cities, towns, and villages including Hubli, Bangalore, Madurai, Chennai, Vijayawada, Berhampur, Patna, Deoria, Delhi, Tilonia, and Ahmedabad. One of the best role models we had a chance to see was Aravind Eye Hospital in Madurai, Tamil Nadu. Aravind has achieved such economies of scale and efficiency, that they are able to perform 60% of their eye surgeries free of cost for people that cannot afford their care. Part of their success has been their streamlining of patient care which has increased the productivity of their physicians. According to Aravind, eye surgeons in the West are able to do twenty cataract surgeries a day — their surgeons average 200 a day. Learning about India's potential to leverage volume as an asset was truly eye opening. Another remarkable role model we had the chance to visit was Gram Vikas in Berhampur, Orissa. A storied NGO, similar to CRHP, Gram Vikas has been implementing running water in villages all over the state and in other

parts of India for forty years. Their efforts have produced dramatic gains in water and sanitation producing impressive reductions in communicable, water-borne diseases. Their approach has empowered the poor and tribals to take control of their health and emerge from poverty. An incredible part of Gram Vikas' model is the fact that 80% of their water projects are now funded by the government— I see this as a roadmap for CRHP's evolution. In order to scale our success across India, we need to work with the government to spread the Jamkhed Model and bring holistic health systems to all parts of the country. Gram Vikas stands as a testament to the success of this kind of thinking.

My final trip until now happened in late January. Dr. Shobha was invited to speak on CRHP at the National Conference for Social Entrepreneurship (NCSE) but was unable to attend and I was given the opportunity to speak in her stead. The topic of the conference was "Rethinking Development: Strengthening the Grassroots" and asked the speakers to comment on how their NGOs/initiatives involved and empowered communities to achieve their own successes. I think one of the key insights I gained from my preparation for this conference was that ultimately CRHP's mandate is one of social justice. By all appearances, health and development are the foci of the Jamkhed Model with relevant benchmarks being proof of our success. However, thinking through the model, spending time with our staff, and explaining our model to others has convinced me that it's our philosophical and moral commitments to radical social change are what drive the organization forward. Health and development are simply vehicles through which we seek to create change in the social order. CRHP's commitment to the marginalized is really what makes this organization different as well as a sustainable enterprise. The dignity and self-esteem the Aroles and CRHP have brought into the lives of Jamkhed's unwanted (HIV+, widows, lepers, low-caste, etc.) is what has really brought about the robust, lasting change in the communities CRHP serves. VHWs have served for decades because their lives have become better as they are seen more and more as social equals to those in power. At its core, CRHP is an artful critique of the power structures that characterize these communities and a call for equality and inclusivity.

III. Grants & Fundraising

A major part of my work at CRHP was grant writing and fundraising. One of my biggest projects at CRHP was pursuing a partnership with the Paul Hamlyn Foundation (PHF), a philanthropic organization based in the UK. After a visit with one of the country representatives and a discussion with Dr. Shobha, it became clear that there was potential to fund a mental health initiative at CRHP. According to the WHO, there are 450 million people worldwide suffering from mental illness. Our research in the last few years has showcased this need in Jamkhed as well. To this end, I sat with Dr. Shobha and fleshed out a program design and then wrote a proposal to PHF for the CRHP Mental Health Program. The program will adapt our successful Village Health Worker model to mental health issues primarily through the "barefoot counselor." This counselor will serve in a similar capacity as a VHW and after intensive training with psychiatrists and psychologists on basic mental health issues such as depression, anxiety, and substance abuse. Leveraging her new training, local knowledge, and trust of her

community, she will become a psychotherapy resource for her fellow villagers as well as a facilitator for the formation of support groups. We aim for the counselor to rally her community to cast off the stigma attached to different types of mental illness and help promote the recognition that mental illness is not a personal failing. My work focused on refining our model, organizing and sending necessary information to PHF for grant funding approval, and developing an implementation timeline for the project. The grant was approved in February and in April we began receiving the funding (nearly $40,000) to run the program for two years. When I was departing CRHP, we had began to undertake the selection process for the "barefoot counselors."

Another major project I had a chance to work on was a concept paper outlining the need to expand our training facilities and capacity as well as what our vision for the future is with respect to the role training will play in the Jamkhed Model. We see the most effective way of scaling up the Jamkhed Model is through replication by training. Individuals from all over the world come to CRHP to learn the Jamkhed Model and then can go back to their own contexts and apply the philosophy of Jamkhed while also accounting for unique local circumstances. Right now, a major roadblock in our training program is housing & staff. We are not equipped to accommodate large groups of health workers from many Indian states interested in training. Furthermore, we believe that if we have the means to tailor the Jamkhed Model to changing circumstances (i.e. dealing effectively with non-communicable disease or mental health), the training program will change in tandem and stay relevant while still containing the philosophy the Aroles pioneered in their success with creating social change. Dr. Shobha made a trip to Delhi to speak with representatives of many major funding agencies (Ford Foundation, Gates Foundation, etc.) to pitch our ideas and possibly secure some funding for a training expansion.

Finally, the Adolescent Boys Campaign was another major funding project I worked on. The purpose of the Adolescent Boys Program (ABP) is to build the capacity of rural males to advocate for gender equity and decrease the risk of violence and discrimination against women and girls. Using the www.indiegogo.com website, my colleague Irene and I (as well as many others who helped), constructed a campaign to raise funds to restart the Adolescent Boys Program. In the end, we raised about $7,000 and will be able to run ABP with the boys of two villages for the duration of the ten week program. ABP has and will improve the lives of women in Jamkhed and make our boys leaders in the community.

IV. Keystone Project

A project I mentioned in my first Quarterly Report was my gender-based violence curriculum. Thankfully, this project came to fruition and produced some amazing results. The first part of this initiative was extensive planning. I spent the spring planning out lessons, generating protocols for activities, and creating actual materials to be used in my lessons. These had to be modified based on feedback from local trainers regarding content, oftentimes because of difficult cultural idioms that didn't seem difficult to understand or explain from a Western vantage point but were actually very foreign to

our VHWs. I also had to make sure my curriculum was designed for the level of education possessed by our health workers (middle to high school) and used lots of visual and tactile activities with very little lecture or writing assignments. During this process, I also conducted a focus group with the VHWs to assess knowledge and opinions concerning the subject. The next step after all of this was to implement. Over the course of eight sessions (two each week) local trainers, another American colleague, and I implemented a comprehensive educational program on gender-based violence with our health workers. Topics included identifying violence, understanding the social causes for violence, a discussion on rape (especially marital rape), identifying such abuse happening with patients, mobilizing the community to stop gender-based violence, and finally elucidating sexual rights and responsibilities. Oftentimes modules were modified to accommodate for open-ended discussion or to allot more time to an activity.

One of my most vivid memories from this program was an incident in one of our earlier trainings. The concept of marital rape was introduced and we were met with laughter and scorn. The women proceeded to explain that there was no such thing and even though rape by definition was non-consensual forcible sex (they agreed with this), the definition did not apply in the context of marriage. My colleague and I were dumbfounded and began to ask how and why this was the case. We were then explained the economic, social, and cultural circumstances under which one is married. Women are seen as economic burdens, inferior individuals, and simply vessels for childbirth in many of these communities and this translates to subhuman treatment in their marriages. Sex is an expectation in such arrangements given that the man is saddled with responsibility and upholding reputation in the community. These women acknowledged the marginal position they occupied but many of them couldn't see it any other way given the circumstances and constraints of the contexts they were from. My colleague and I began to realize that fighting inequality and violence was about understanding people’s assumptions and context rather than jumping to conclusions about right and wrong based on our own frameworks and context.

V. Clinical Experience

My clinical experience varied greatly in my time at Jamkhed. Some weeks I was at the hospital quite a few times and other weeks, my work would take place primarily outside of the hospital. Nevertheless, I had some very memorable clinical experiences. This has included surgeries, outpatient clinic, inpatient rounds, ultrasounds, and some clinical instruction from Dr. Shobha. I was allowed to scrub for surgery many times and found it exhilarating and interesting. I think the highlight of my clinical experience were my lessons with Dr. Shobha. Her clinical reasoning is incredible to witness and her teaching style has really pushed me to think like a doctor and make judgments based off of the observations one makes in an exam. The range of her abilities and intimate knowledge of the human body has truly impressed upon me what a real general practitioner ought to be like. The trend towards ever-more specialization in the US is a troubling one and I fear fewer and fewer doctors (myself included) will have such versatility.

VI. Challenges & Reflection

CRHP presented an array of challenges that were both opportunities to learn and grow as well as points of frustration (sometimes). I was often frustrated with timeframes of many of the projects we were working on along with our very ad hoc system to get important things done. My time at Jamkhed has definitely made me far more patient and practical in the way I see things. Finally, I want to add that one of my biggest takeaways from CRHP has been a new sense of humility. Everything I saw and experienced deeply humbled me. Over the last year, I gained a deep respect for the hardships that individuals in Jamkhed and rural communities around the world go through. Despite this, the staff at CRHP persist on, enmeshed in the work of making human lives better, no matter the odds or obstacles. CRHP is the epitome of unfailing optimism and universal respect; I hope to epitomize these traits in my practice as a physician.