

Mabelle Arole Fellowship Final Report

“This is a beautiful hall and the shining chandeliers are a treat to watch,” Muktabai says, as she points to the glittering chandeliers in the health conference hall, “One has to travel thousands of miles to come to see their beauty. The doctors are like these chandeliers, beautiful and exquisite, but expensive and inaccessible.” She then pulls out two wick lamps from her purse and lights one. “This lamp is inexpensive and simple, but unlike the chandeliers, it can transfer its light to another lamp,” she says as she touches the two together and the other ignites. “I am like this lamp, lighting the lamp of better health. Workers like me can light another and another and thus encircle the whole earth. This is Health For All!”

- Introductory quote to Jamkhed: A Comprehensive Rural Health Project, by Drs. Mabelle and Raj Arole.

My time here as a Mabelle Arole Fellow has given me a different vision of how to achieve good health for the world, a vision that is summed up by the scene at Muktabai’s speech to important figures in global health, including officials from UNICEF and the World Health Organization. In the scene, at the convening of urban, well-educated health professionals and officials from centers of decision-making, an uneducated woman from the deep recesses of rural India tells about her work and argues that people like her, rather than doctors, are best able to achieve better health for all. The scene itself reflects a shift in thinking: to achieve better health, resources need to shift away from their focus on more doctors and hospitals and instead focus on spreading health knowledge to the people themselves in a way that allows them to take collective action for their own health. Yet even more powerfully, the scene captures the fruition of this shift: a woman from rural India has developed her community and herself enough that she has the courage and self-esteem to address the “big” people with absolute confidence that she herself has made a big impact on the health of her community, and all the while the doctors and officials listen with rapt attention and in the end give her a standing ovation. Things have changed. This is not health in the doctor’s hands, but instead health in people’s hands.

My growing understanding of PHC has been the major takeaway from my experience here, and so I will begin this final reflection by discussing how my thoughts about health work have shifted during my time here before moving on to discuss my other work here, including the two month course, my hypertension and diabetes survey, and my mental health training.

Primary Health Care

I spent four years in undergraduate education as a development studies major studying public health and development, yet I never came across primary health care. I came here with a broad perspective of disease causation, feeling that it was important to look beyond the biological at the social and economic to understand people’s illnesses, yet I had never learned ways of intervening at the social and economic level to create better health until I came to CRHP. In short, I left college with a solid academic

background for health, yet this background did not give me the very practical education that my time as a Mabelle Arole Fellow offered. I am therefore very grateful for this opportunity, and saddened that it takes a trip across the world for me to be exposed to the PHC movement. While I know that for a variety of reasons PHC does not lend itself to academic study, I still feel it should be a part of an education for people interested in global health.

My education in primary health care began with the two-month course, extended into my interactions with the mobile health team and village health workers, and really solidified in conversation with a doctor from the UK who lived and breathed PHC. I feel that since it is such a major departure from the typical and hegemonic disease treatment-centered view of health work it took even someone like me who was interested in understanding an alternative approach a long time to fully comprehend. My understanding of PHC reflects these real life experiences and my own academic study, and I hope to interweave the two to help illuminate what I have learned, offer the reader an insight into the shifts in my thinking, and start the process of my figuring out what to do with what I have learned!

The first major shift, I feel, in primary health care is to leave the curative model in which health is achieved through disease treatment. The curative model reflects the biomedical conception of health in which health is merely the absence of disease, a definition which creates a health/illness binary with health being the absence of illness and disease its presence. While such a definition is ubiquitous, it is short-sighted and problematic in that it tends to restrict health work to activities that treat illness and create its absence, thereby marginalizing public health and other health workers.

For developing nations, such a route will not achieve health because medicine and medical care is not actually how the developed nations reached their high life expectancies in the first place! The health of these countries improved *before* the advent of vaccinations and medications and reflects not advancements in medicine but rather raised standards of living. Therefore, in order to create healthier populations it is important to shift from a curative model to a more holistic one that incorporates the centrality of development. Primary health care represents such a shift.

It begins by reaffirming the World Health Organization's definition of health as "full social, mental, and physical well-being, and not merely the absence of disease." In broadening and positively defining health (making it something in itself and not the absence of something), it opened up the term "health work" to include not just curative care, doctors, and hospitals but also clean water, sanitation, adequate nutrition, employment, reduced violence, gender equality, education, and other important elements of well-being and development. In this way, PHC moved beyond the biomedical definition of health and utilized a positive, broader version.

Such a broader definition of health work is widely prevalent in the "comprehensive" part of the Comprehensive Rural Health Project's work, and shows this organization's determination to achieve health through a variety of means. The mobile health team provided curative services in the village yet also focused on organizing farmer's clubs and women's groups to deal with dirty water, poor sanitation, low crop yields, male domination of household finances, and social marginalization. The health team was not restricted to merely curative work but instead aided in overall development and intervened to create health at a variety of levels.

While the shift towards a broader definition of health is the first major achievement of PHC and CRHP, the operationalization of this broad definition into concrete and practical work represents the second major achievement. To create changes in water, sanitation, nutrition, and social relations that would reflect development, CRHP relied upon techniques that fall under the heading of health promotion. Health promotion is the process by which people understand and take control over the determinants of their own health. Examples of these processes include conscientization, participatory rural appraisal (PRA), and the triple A cycle. CRHP relied upon the latter two to accomplish its work. It used participatory rural appraisal to have the villagers themselves conduct the health survey, collect the data, tabulate it, and then analyze it. In the process, they engaged in the first two parts of the triple A by Assessing their health problems and then Analyzing them. The final part, taking Action, is likely to happen because they collected and analyzed the data themselves, thereby ensuring the validity of the results and having them intimately understand the reasons for the problems.

I can see the results of this process in the keen understanding the VHWs and some villagers have in what the health problems in the villages are and what causes them. They were also the primary motivators in their own health improvement, organizing the villages to install soak pits for wastewater drainage, to reform the landscape to trap water and increase crop yield, or to remove caste prejudice and end dowry. The people understood the root of their ill health, saw the routes towards better health, and took action to achieve that world. In so doing, they took health into their own hands such that they were able to say to the Aroles that they are okay now and the Aroles can move on to the next set of villages!

Although primary health care significantly broadened the definition of health and came up with revolutionary processes to achieve overall development for health, it did recognize the role of curative work, and in its third major achievement altered how such work was conducted. It focused on ensuring that these curative services were universally available, a demand that required deprofessionalizing health work to the lowest educated but competent worker, decentralizing curative work to places where people can access them, and conducting work at a cost the people can afford. CRHP engaged in this work through training its workers in a wide variety of health tasks, by bringing clinics to the villages, and by engaging in empirical doctoring and low-cost secondary care.

The result of these paradigm shifts in thinking about how to achieve health is dramatic: the infant mortality rate, a sensitive indicator of overall health, has dropped from over 150 deaths per thousand infants in 1970 to around 25 in just twenty years. Few other rural parts of the developing world have so successfully eliminated infectious illness and see chronic, non-communicable illnesses as their main problem. To my knowledge, there are only a handful of health organizations dealing with mental health issues like CRHP because many are wrapped up in infectious illnesses. Even more powerfully, malnutrition is nearly absent, there is clean water accessible nearby, crops grow in the field, and major improvements in gender equality and reduced casteism have been made. Seeing that such a world is possible has been moving for me, and motivated me to attempt similar results in my life.

I feel that experiencing this place and understanding how it achieved its success will play an important role in my life trajectory. I see an incredibly important role for the doctor in spreading health knowledge and empowering others to take control of their own

health, a process that requires that doctor to self-efface and go into the background as others take control over their own health. Instead of health being the result of their curative knowledge, their years of study are the wedge that can be used to start larger processes that intervene at higher levels and are more powerfully able to create health. I think the notion of displacing the centrality of curative work can be, rather understandably, a difficult proposition for doctors who have spent years studying and working hard to accept immediately, and I am glad that I had the opportunity to come here before medical school.

On a slightly different yet related note, the role of values in creating this project has made a major impression on me. An important reason why CRHP succeeded, in my opinion, is that it had two very well-educated, intelligent, and dedicated doctors who were incredibly well-developed and interested in equity, empowerment, and the creation of a more just society. They were willing to move to a rural and remote part of India, giving up the comforts and privileges they could easily access, to devote their lives to improving the health of the poor. They focused constantly on improving the abilities of others and were willing to place other people's priorities over theirs even though with their power they would have been able to make their reality the primary reality. Such virtue is uncommon, always inspiring, and yet a difficult state to achieve.

It is clear that I learned quite a bit about primary health care from my time with CRHP, yet I also want to give space to some of the other activities I engaged with during this time, following more or less a chronological order.

Two Month Training Course

The September and October training course is meant to train people who are interested in bringing some elements of CRHP and the training center back to their organization. It functions quite well as the scale squared center in the Taylor Seed Scale model, in which just and lasting development is aided through the creation of centers of excellence in which scale one groups (people interested in engaging in development) can visit for a little while to learn new techniques, practices, and ideas that have been shown to work well so as to be able to stand on the shoulders of giants and not have to recreate the wheel every time someone wants to start a health program. (For closure's sake, the scale cubed group is an enabling environment built by the government, something India has more than other developing countries).

The course functioned brilliantly as a scale squared center. The 14 participants spent two months learning the condensed wisdom of 40 years of experience as the Dr. Raj Arole, his daughter Shobha, the facilitator Connie, the mobile health team, and many village health workers took us systematically through the history of CRHP, its engagements with certain problems and illnesses, the role of the different components, and some theoretical considerations. We learned how leprosy, TB, diarrheal infections, and other illnesses were handled in different means. We learned how the community created most of the change themselves through triple A cycles and participatory rural appraisal, a class that had us challenge and consider the meaning of "community" and "participation". We discussed the low status of women, the caste hierarchy, and the special situation of tribals to gain a better understanding of the social and economic milieu in which CRHP has worked and then discussed just how they were able to create

change. We also discussed different theories of management organization based on either hierarchy and teamwork and the advantage of one over another. In group discussions we analyzed different approaches to development that either see the people as passive beneficiaries of charity or participatory agents of justice. Perhaps most illuminating for a fresh undergraduate were the classes on how to operate in the world of non-governmental organizations in which you are beholden to tight funding schedules for donors yet seek to engage in long-term change that affects your real stakeholders: those with and for whom you work. My favorite classes, however, were the personal development classes in which we discussed our how we ended up at CRHP, our value systems, and what our utopias might look like.

We spent the last few weeks preparing an action plan to take back to the organizations to enact some ideas from primary health care. At this point I worked with Dr. Moses Karat to discuss how his organization, SAHARA, could morph to reflect community needs and utilize village health workers. It was a difficult project, reflecting how hard it is to bring change to an organization, and certainly a learning experience for me.

I think this course was an excellent introduction to primary health care filled with a lot of great wisdom for people interested in recreating the success of this place and learning from their experience. I highly recommend it to anyone in the field.

Village Visits

Following the training course I spent the majority of my time heading out to the village with the mobile health team. I enjoyed working with them, understanding how different water, sanitation, and toilet schemes have worked over the years and gaining an appreciation for the fruit of their work. A particularly powerful part of visiting the villages was that it opened my eyes to an entirely different world. It was also after repeated visits that I started to really feel and notice the vast differences in the society for myself. At every village we collect from the preschool the numbers of boys and girls under five, and after some time I decided to quickly compute the sex ratio. To my dismay, the ratio would typically amount to about 750 girls for every 1000 boys, a marked decrease from the overall sex ratio of about 850:1000, driving home the truth of the effect of increasing sex-determining ultrasounds and abortions in the past couple of years. During an overnight stay in the village, I spent the evening walking through the village noticing that most everyone was outside sitting together and enjoying each other's company instead of inside in their nuclear families minding their own private time. Finally, it was always interesting to see how people used indoor and outdoor space, with the inside used mostly for storage, sleeping, and entertaining important visitors like us. Most of life occurred outside in the sun and not in the house, unlike my life back in America.

In this way, spending time in rural India was a cross-cultural experience for me, showing me a completely different way of organizing society. Women marry and move to the husband's house where their labor is directly controlled by their husband and mother-in-law. All marriages are arranged, and dowry and caste are important factors in life. There is no such thing as divorce and a widowed or unwanted woman is in a terrible place. Sons are viewed as gifts from god and daughters are sometimes cursed, an unfortunate economically logical consequence born out of the serious problems of

investing in a daughter through her dependent years and then losing her labor during her productive years as well as having to pay a large amount of money to marry her away! All of these social factors are important to understand in order to fit health work into the societal reality, and village visits offered me a precious opportunity to gain early knowledge about these realities.

Mental Health Training

In December I began a 6 month training program with the village health workers in which I taught them about depression, anxiety, and counseling. Next to learning about primary health care, this was my favorite and most meaningful experience here. I considered every minute I spent with the village health workers to be a treat and I fell in love with their spirit, their heart, and their generosity. I deeply valued building a relationship with them. They are the backbone of this organization, and I feel much of the other work exists to back them up.

I caught a glimpse into the difficult reality the Aroles faced in the beginning when I tried to teach the older VHWs. The younger VHWs have attended at least 8 years of school and have learned how to learn: they sit in one position, keep notes, are familiar with how teaching works, and understand how to learn what is being taught. The older ones, in sad contrast, have not had any education and so sitting in one position for a long time is difficult, cues for transition or emphasis by a teacher are missing, and abstract or conceptual thinking is difficult as they are used to relying on real life instances not hypothetical examples. To respond to this difficulty I began to severely limit the amount of time I spent “lecturing” but instead to rely solely on pictures, role plays, and skits. In the end, I was planning out my lesson a day in advance, giving it a break for a while, and then returning to the written content to turn it into pictures that would form the basis of my lesson. The switch from text or mere auditory learning to only drawings, skits, and role plays helped the older ones quite a bit and taught me a completely different method of teaching.

A particularly powerful session occurred when the idea of depression as an imbalance in the juices of the brain that causes prolonged sadness finally clicked and all of a sudden there were dozens of examples and stories about their friends’ or their own struggles with depression. They each shared their stressful life experience, talked about how the depression affected their lives, and enacted the symptoms they recalled (depression manifests itself with physical symptoms very often here). In a very difficult moment for me, they looked at me for help. I knew that in the short-run there was little I could do except for referring them to Dr. Shobha for counseling and medication, yet I did say that I hoped to begin teaching them counseling soon so that they could help their neighbors in similar situations.

From that point on our classes gained a new energy as we felt a little more push to learn as much as possible. In the next few months we covered anxiety and counseling, learning to distinguish between temporary sadness and worry and more prolonged versions, how to reassure someone who has depression or anxiety, to explain to them what they are experiencing, to teach them relaxation techniques, to give them advice for tiredness or sleeping problems, and to engage in problem solving work. We created flashcards to use in the villages to raise mental health awareness and to use in personal counseling sessions. We prepared the village health workers to be mental health

counselors in the villages, always available and accessible. There is a bit more work - the flashcards need a bit of tweaking and some training in Interpersonal Therapy would help - but by and large the VHWs are ready. It's been quite an honor and pleasure to have been involved in this work, and I sincerely thank CRHP for this opportunity.

Hypertension and Diabetes Survey

As a part of CRHP's attempt to innovate once again in the field of non-communicable, chronic illnesses – an increasing problem in the villages and hospital – in April and May I went out with the mobile health team to conduct a hypertension and diabetes survey. The whole exercise piqued my interest in the academic, knowledge-producing side of public health and solidified my desire to go to public health grad school. I came to more deeply appreciate the amount of work involved in the studies I read and the need for good study design and equipment. I also became really interested in understanding how risk factors work to create disease and how to intervene for a healthier population.

In the course of the survey I went out every day with Monica, a mobile health team member, to the villages and surveyed individuals about their economic background, lifestyle factors, eating habits, exercise habits, and caste and then took their blood pressures and, if they passed criteria, their urine sugar levels. I hope to have this survey be the basis for other surveys and to build up a library of useful information on this topic, including a baseline study to compare interventions against. My preliminary results showed 4% prevalence of diabetes, agreeing with other studies in rural India, and a 40% prevalence of hypertension. It's difficult to know how to interpret the results, but I know this will help later surveys.

Social Life

I really appreciated the warmth and generosity of the staff here. They welcomed me into their lives with open hearts and really helped me to feel comfortable and at home here. I wish that I had been better able to master Marathi so as to have built deeper relationships with other staff members but I guess that will have to wait until next time. Amazingly, during my ten months I was only here without a foreign visitor for two and half weeks. I really appreciated the opportunity to spend time with people from many different countries and backgrounds, and conversations with them proved to be fertile land for new ideas and thoughts.

Conclusion

It has been quite an intense past ten months. I feel very much at home with this culture and this organization. I am very grateful to have had an opportunity to return to this country that has taught me so much and to have had such a unique and incredible experience here at CRHP. I don't know if there is any one specific intention behind the Mabelle Arole Fellowship, but in my mind and experience it was to give a medical student an opportunity to see how he or she can create health through seeing health not as found just inside the body as medical school will teach, but instead as a complicated result of social, economic, environmental, and behavioral factors interacting with each other. This is exactly the experience I had: I can actually articulate based on my experiences at CRHP how to facilitate health promoting change in this complicated

network of factors. I am incredibly grateful for this opportunity, and I will try my best to make the most of it in my future career as a global physician.

Coming to CRHP offered me an opportunity to spend a year in a rural part of the developing world, a useful experience for making longer term life decisions. I am not quite certain what exactly I will want to do when I finally finish school, but I know that being closer to my family and having access to the exciting cosmopolitan atmosphere and the similarly educated social circle are important to me, a realization that, at least at this stage of my life, pushes me towards urban life. While my prior fondness for India remains deep, my roots in Latin America and its proximity to my family may play an important role in decisions about my future. Nevertheless, regardless of where I go, I know that I will bring an orientation towards health promotion, medical care deprofessionalization, and a positive, broader definition of health with me, and I can thank my time at CRHP for developing these ideas.

In closing, I would like to thank those people who created such a wonderful opportunity and gave me an incredible experience. I am incredibly grateful to Dr. Raj Arole, Dr. Shobha Arole, Ravi Arole, Pandit, Jayesh, Kooldeep, the rest of the mobile health team, each of the village health workers, and all of the staff for their role in a wonderful year. I would also like to thank David Pyle, the John Snow Institute, and the American Medical Students' Association for creating the Mabelle Arole Fellowship. In my mind it has served its purpose: for me, it has been a life-altering, paradigm-shifting experience, and I hope to take the lessons of CRHP with me in my career.