

**Of Culture and the Clinic:
A Study of Culture and Healthcare in Nizamuddin Basti**

By Bradley Iott

Advised by Tom Fricke

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Department of Anthropology, University of Michigan, Ann Arbor

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Towards the One,
the Perfection of Love
Harmony, and Beauty, the Only Being
united with all the illuminated Souls
who form the Embodiment
of the Master
the Spirit of Guidance.

- Hazrat Inayat Khan

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Prologue

I never planned to go to India. It was culture that I always found intriguing, with religions and foods exotic to me in the fullest sense of the word. Hailing from homogenous Monroe, Michigan, my only real interaction with anything Indian – aside from my Bollywood film-obsessed cousin – was a chance to try exceptionally spicy Tandoori chicken at my Indian classmate’s high school graduation party. When a classmate mentioned her trip to conduct research in rural Punjab during the summer of 2011, I was intrigued and took her advice to apply to the University of Michigan Center for South Asia Studies’ Summer in South Asia Fellowship. After weeks of emails and phone calls overseas to find a partnering NGO that would allow me to conduct research under their watch, I was off. However, because of my previous lack of exposure to the culture – along with communication errors with the Indian Consulate in Chicago that transformed my attempt to obtain a visa into a multi-week struggle – I had not had been sufficiently prepared for what I would soon encounter.

Arriving in India was nothing short of a culture shock. Naturally, the Bollywood films I had watched did not adequately prepare me for what I would expect: the hot, bustling megacity known as Mumbai. I normally adapt to new surroundings quickly, but this was

different. On my first day, Bipen, a member of the non-governmental organization (NGO) I had come to work with, took me to have a breakfast of masala dosa, a thin rolled pancake like meal with spiced potatoes and onions inside. Stopping after only a small portion – my stomach's decision, not my own – I realized that this change would be difficult.

Despite the first week being difficult, I fell in love with India. As my project developed, my interest in the nation, its culture, and its people unfolded. In a small way, masala dosa can be a metaphor for my relationship with the South Asian subcontinent: it was hard to stomach at first, but eventually, it became my favorite meal.

I have spent my life learning about healthcare and the lack thereof in various parts of the world. This has led me to the University of Michigan's School of Public Health, where I am jointly enrolled to study Occupational and Environmental Epidemiology. Public health often struggles to meet anthropology when working to resolve issues of health disparities in the developing world. I once watched a TED talk by Dr. Kathleen Sienko, a biomedical engineer at the University of Michigan, regarding the use of Western technology to improve healthcare overseas. She offered an anecdote about undergraduate engineering students who had attempted to streamline the medical record transcription and recording process at a small clinic in India. When Sienko entered the clinic, she found that three workers were tasked to copy medical information recorded on clipboards into three ledger books: one to be saved locally, one to be sent to the district hospital, and one to be sent to the state. To simplify the process, the students sent Palm Pilots loaded with medical record software. Sienko found them collecting dust on a windowsill and inquired about them. She was told that they did not work, and after further prodding, found that the batteries had been removed because the workers feared that the devices would replace their jobs. Despite the incredible effort of the

students to create an efficient process, they had never visited the clinic nor involved the workers in the design of the Palm Pilot recording system, which ultimately led to their failure in implementation. Understanding culture, instead, would be key to the success of the electronic medical record system (Sienko 2011).

Often, medicine that is normalized in the West is perceived in drastically different ways abroad. In my Anthropology 325 course “Childbirth and Culture” with Elisa Renne, a brief study of the introduction of ultrasound technology in rural Botswana and in Hanoi, Vietnam demonstrated this reality. Although healthcare providers found the scans to be useful and safe, some mothers were skeptical and even scared of the technology and its impact on their developing babies. For the first time it became clear to me that health is multidimensional; perceptions of medical treatments and even the notion of being healthy can be seen differently across cultures. The implications of this were nothing less than profound.

Excited to make my own attempt at improving maternal health with modern technology, I arranged a research partnership with Armman India, an NGO based in Mumbai. Armman’s efforts are focused on two projects: Project HERO and mMitra. Project HERO, or Helpline for Emergency Response Operations, is an endeavor to create a 911-like infrastructure in Mumbai via the creation of a system that manages the availability of intensive care unit (ICU) beds and blood bank supplies in real time. mMitra, the project I came to work on, is an attempt to improve maternal and fetal health through updates and reminders delivered to mothers’ mobile phones. Specifically, I came to Armman to conduct ethnographic fieldwork to determine if the level of cell phone usage was sufficient to implement and sustain mMitra in a village outside of Mumbai. I had been warned many

times before leaving the United States that unpredictable troubles would arise while abroad, and indeed they did. When I arrived, I was briefed on a new role I would fill at Armman: managing the NGO's social networking activities. Unable to conduct sufficient research for my thesis project, I made the ultimate Hail Mary: I pitched my plans and drafted a new project overnight. I remembered that Audrey Namtrop, another Summer in South Asia Fellow, was simultaneously traveling to Delhi to conduct ethnographic research in a health clinic operated by an NGO. New opportunity in sight, I bought a plane ticket and was off.

Armed with my academic background in maternal health and medical anthropology, I went to a clinic in one of Delhi's urban villages to understand what providing healthcare looked like: to understand how doctors treated patients and how the process differed from my own concept of medicine in the United States. Tucked away from the opulent India Gate and Connaught Place near the heart of the city, Nizamuddin resides in Southeast Delhi, near a railway station of the same name. A traditionally Muslim, 12th century urban village, the Basti offered a unique opportunity to study health and healthcare. With the Hope Project, the NGO Audrey and I worked with, serving as the primary source of healthcare for the basti's residents, we would have an opportunity to see how doctors respond the community's specific needs, which include female health issues, drug use, and chronic diseases brought about by poor living conditions.

Methodology

My primary method of conducting research was ethnography, specifically via participant observation and interviews. I was inspired by a seminar course I took with Professor Tom Fricke, “Ethnography of Everyday Life”. The class offered an opportunity to study and learn ethnographic methods, which are rarely formally taught at the University of Michigan. Armed with Fricke’s ethnographic weapon of choice, a black Moleskine pocket notebook, I was tasked to document everything in my life ethnographically. Early pages note my perspective of college life, including the interactions between students on buses and the reactions of museum goers in the University’s Museum of Art to a portrait of an early school president. As the pages filled, I became more attentive to the world around me and learned to notice the behaviors and idiosyncracies of my friends and classmates. This period of “training wheels ethnography” was important because it made me aware of the power of the notebook’s presence; heads would turn as I pulled out the Moleskine and recorded what I saw. At first, the glares I received were unnerving. However, just as soon as I learned to ignore the stares did my friends and informants forget about the notebook. Fricke’s lessons did not stop at the notebook; he shared experiences from his own fieldwork to highlight the importance of building rapport, engaging with informants, and holding true to my own values

in the field. Armed with some minimal ethnographic experience, I set out to India to conduct my own research.

Upon arriving at the Hope Project, I gathered data in a variety of ways. Predominantly, I recorded what I observed, both in the clinic and in daily life. I brought my Moleskine with me everywhere, along with my camera, to document my observations in the clinic, Basti, and throughout India. It is important to note that I took on an active role as a volunteer to the NGO, both in the health clinic and in its other functions, such as teaching conversational English classes, helping to translate documents, and assisting with computer classes. This allowed me to build strong rapport with the staff at Hope, who after a few days took Audrey and I in as family.

Audrey and I worked together, both as volunteers and researchers, sometimes conducting interviews together to be efficient with the limited time of the doctors and staff we worked with. We also socialized and traveled throughout Delhi and across Northern India together, guided in large part by her fiery passion to travel, and Lonely Planet guidebook. Audrey's presence was irreplaceable, as she frequently gave me insight into the female experience of the world around us. It is important to note the living arrangements we shared: Audrey and I lived in the Hope Project's guesthouse, an apartment on the top floor of the building. We shared the larger common room to avoid the additional energy costs associated with running the separate air conditioner in the second room. While the arrangements seemed normal by our standards, the conservative Basti community may have seen this situation as scandalous. However, in context, I do not think that this hindered or manipulated our work in any way, as our presence as American volunteers alone caused us to draw stares everywhere we went. In fact, working together was ultimately mutually

benefiting: because it was advised that women not travel alone after dark, my presence allowed Audrey more freedom to move about the city safely.

To gather detailed information outside of what I learned from participant observation, I conducted interviews with most of the Hope Project's English speaking staff. As a result, my sample of individuals was small, with only a handful of doctors to speak with in addition to other staff and administrators. The physicians and staff members varied greatly in terms of willingness and interest to be interviewed, causing much of my data to stem from Dr. Kallol Shah, the Medical Director, and Sami-Ur-Rana, the Executive Director. This, however, is less of a limitation than a reality, as many members of the Basti community are not fluent in English. This is a reminder of the reality of places like Nizamuddin, some of which still linger in a time far less modern and globalized than today.

To gain a perspective not found in the Basti – that of a middle or upper class Indian – I held a small focus group of international students at the University of Michigan. I gathered friends of my classmates in the basement of a local Panera Bread and let the conversation unfold. Steering my three informants with questions about healthcare for the middle class, issues of disparity in medicine, and social stratification. Much to my amazement, our two-hour conversation created a vivid context for the data I had gathered throughout the summer.

All note taking and interview voice recording was done at the discretion of those whom I worked with. As a budding photographer, I took caution with the photos I took. Due to the sensitive nature of the poor living in the Basti, I avoided photos within Nizamuddin, especially of its residents. I made efforts to engage as thoroughly as possible with the community by dressing, eating, and interacting according to local norms. Doing so

was an essential part of the ethnographic experience and helped me to better understand the people and community I was working with.

Introduction

One does not even need to get off of the plane to know that India is different from my native Michigan. When the Air India 747 touched down in Delhi, the nation's capital, the passenger to my right updated the weather on her iPhone. The screen displayed "100°F" at 10 PM local time, with only the airport's lights dotting the darkness outside the window. I looked at her with disbelief. She assured me the phone was correct, as this was the climate she has known in Delhi all her life. While waiting on the tarmac for the shuttle to the terminal, hot wind blew on my face with the intensity of a hair dryer. Of course, my experience with first impressions is one that is too often inaccurate, so I resisted anxiety and headed towards the baggage claim. After struggling to follow my friend's directions to the train that would take me into the heart of the city, I discovered the desk where I could exchange 80 rupees for a blue RFID token that would allow me to board. This interaction was made difficult because I had no understanding of the local language, Hindi, aside from the greeting "Namaste!" The electric train completing the 18-minute journey from the newly built domestic terminal of the Indira Gandhi Airport to the New Delhi Train Station was cool and futuristic, with seats not unlike those of a racecar. As I looked around the car, with

LEDs indicating our progress and frigid air conditioning freezing my improperly dressed body, no other passengers could be seen. My world became even more foreign when I entered Nizamuddin the next day, where everything was completely different.

Because of a generous grant from the University of Michigan International Institute's Center for South Asia Studies (CSAS), I found myself in India with the goal of studying health inequalities through an anthropological lens. My funding, the Summer in South Asia Fellowship offered by CSAS, came with the stipulation that I design a research project with a non-governmental organization (NGO) in India, leading me to work with the Hope Project. Additionally, I lived and worked with a fellow University of Michigan, Audrey Namtrop, who conducted research about child health outcomes of student's in Hope's crèche (a daycare).

The Hope Project is an NGO situated at the heart of Nizamuddin Basti, a district in Southeast Delhi. It was founded in 1975 as a small milk program by Sufi teacher Pir Vilayat Inayat Khan, Hope has expanded to fit the community's needs over the last thirty years. A Sufi organization, Hope offers a variety of services and supports to the community, including a Girl's Formal School, health clinic, crèche, microfinance program, vocational courses, and support groups. Despite their religious affiliation, the Project serves people from all walks of life as part of its larger mission:

“The Hope Project's MISSION is to provide opportunities and resources to people especially the poor and vulnerable to unfold their hidden potentials, so that they can realize their aspirations and become contributing members of the communities” (Annual Report: 2011-2012).

Hope completes its mission with significant international support, both voluntarily and monetarily. Germany is a major contributor, as the government annually sends pairs of volunteers to work on twelve-month rotations. Additionally, the wall of sponsors near the main entrance displays signs from multiple German corporations, who donate money and supplies, including India's first solar powered water filtration machine, to the Hope Project.

My work was in Historical Hazrat Nizamuddin (colloquially known as Nizamuddin Basti, Nizamuddin, or simply, the Basti), is a densely packed, vibrant Muslim community ("Basti" is a Hindi word that is translated as "slum" or "urban village"). Bastis, sometimes spelled in other areas as *bustees*, are common in India's larger cities. When describing bustees in Kolkata, Chakraborty notes, "*bustees* have a reputation within the city of being conservative, and are home to a number of orthodox and ultra-conservative Islamic factions," a description that also holds true in Delhi (2010:271). The Basti is situated next to its more upscale neighbors, Nizamuddin East and Nizamuddin West; the borders separating the districts serve as a permeable membrane rather than a dividing wall. The community is a 12th century Muslim village that formed around the *dargah* (shrine) of Sufi saint Hzt. Nizamuddin Auliya. Due to its small, secluded nature nearly all that is written about the Basti can be found on the Hope Project's website, which reports that this urban village is known for its "congested, narrow lanes, tombstones, pilgrims, cuisine, spiritual music, bustling markets and mosques, houses about 1950 families with approximately 20000 residents" (The Hope Project 2009).

Modernization of this 12th century village has not been without challenges. As the city of Delhi grew and engulfed Nizamuddin, the Basti became incorporated into the nation's capital. However, due to their minority status in India, the Muslims residing in Nizamuddin

have lived in insularity. The Hope Project notes, “they have little exposure to the outside world and lack the contacts and opportunities to improve the quality of their lives” (The Hope Project 2009). The rapid urbanization resulting from Delhi’s growth leaves Basti residents with an inadequate water supply, congestion issues, and insufficient sanitation. Social problems also plague Nizamuddin: minimal access to healthcare, education, and employment opportunities result in most of the population working in the informal economy, often as “daily wage laborers, rag pickers, riksha drivers, maids, vegetable and fruit vendors” (The Hope Project 2009). Because they do not fall under the protection of India’s labor laws, this segment of the population is frequently exploited to work for wages far below the minimum. The remainder of the population fare even worse, as Hope notes, a large number are “Muslim migrants, homeless, deserted women, street children and beggars living in squatter settlements, along the city sewers, under bridges and in the parks” (The Hope Project 2009).

By interviewing the staff and conducting ethnographic research at the Hope Project’s clinic, I sought to explore culture’s influence on healthcare. I wanted to understand the implications of Nizamuddin’s rich cultural and religious heritage on the delivery of medicine. My study intends to answer a simply question: does culture matter in healthcare? Is medicine simply medicine wherever it is prescribed? Does context matter? These questions come about as a view the world from the various lenses of my academic career. As a student in the University of Michigan School of Public Health’s Epidemiology Department, I think about disease in terms of its causes and outcomes. These are quantifiable data points; one can define an exposure scientifically and measure it. Epidemiologists measure the impact of a disease by the number of cases it produces; a simple and practical measure that can

inadvertently quantify a person, turning one's life into a tally mark on a spreadsheet. While I believe that this research is immensely important for improving healthcare, I recognize that public health often avoids personifying epidemiological data. As a result, characteristics such as education status, race, and systolic blood pressure are used to map a person's lived experience. This approach fails to consider culture and its influence on healthcare. In fact, much of public health avoids cultural considerations all together. While interventions and international aid are researched to ensure cultural competency, few actually study the impact of our culture on health.

Before beginning a conversation about health and healthcare, it is important to define what is meant by *health*. In an interview on July 20, 2012 with Dr. Shah, she discussed the notion,

“By WHO definition, the define health as a state of complete social, mental, and physical well-being, not merely the absence of any disease. So I really want to stress on that. Not only, see, the environment plays a major role in everybody's life, starting from your health, to your nature, to your progress, to your attitude towards people. See, so, if we are not able to provide a congenial atmosphere howsoever you hard you may work hard but you cannot achieve that goal.

Before this moment I always associated health with simply “feeling good” or being free of disease. However, Dr. Shah forced me to consider the impact of interpersonal factors on the condition of the human body. Being in India gave me many opportunities to reflect and discover my own understanding of health, as I spent a large proportion of my trip subdued with a variety of illnesses. As I was sick, I became focused on the things I could no longer do, such as working in the Hope Project's health clinic or walk around in Delhi's incredible heat. I also considered the healing process: as I spent days in bed or looking for medications to vanquish my symptoms, I wondered how my difficulties would be different if was a

resident of the basti. Being from the United States, the strength of my native currency meant that I could afford the 2,200 Rs. for a visit with a doctor at a westernized clinic with onsite access to blood, stool, HIV, and malaria testing. These services, although a normal part of the American medical routine, were beyond the means of those from Nizamuddin. Because I found a differential response to the treatment of poor health, however defined, in the United States and in the basti, I began to reflect on the actual meaning of *health*.

The WHO definition provided by Dr. Shah offers an interesting start by focusing not only the physiological condition of the body but also considering its psychosocial state. She is also careful to consider one's *state* of health, not merely being free from certain defined diseases. In essence, Shah considers health as a positive, holistic scalar rather than solely from the focus of the absence of a diagnosable condition. Moreover, as Huber et al. notes, the WHO definition of health "would leave most of us unhealthy most of the time" (2011:1). Creating a universally relevant definition of health is simply not possible, especially due to the differences that make health relative to individual communities. In the ninth edition of his book, *Anthropology: The Exploration of Human Diversity*, Conrad Kottak defines illness as "a condition of poor health perceived or felt by an individual" (2002:590). He explains that various cultural groups recognize diseases and their causes and symptoms differently, as a result of unique traditional practices, access to resources, and pathogenic exposures. One example he cites is of a village community along the Nile River in Egypt, where schistosomiasis, a type of parasitic infection, is spread via snails in water supplies. It was found that the disease affected Muslims more than Christians, which was explained by the Islamic tradition of *wudu*, or traditional bathing, before prayer (Kottak 2002:590).

When I strip away the biomedical indicators of health, I am left with a unique abstraction. As I walked around the basti, it was apparent that its residents had contact with more harmful exposures than most citizens in developed nations, but yet people were still *laughing*. Smiles were found on the faces of children playing in parks and on sidewalks. Friends old and young exchanged conversations and pleasantries, which continued even into the clinic, where Sasha referred to Dr. Shah as *didi*, or sister. Although conditions are not as good here and community health may be quantifiably worse by Western standards, basti residents find value and meaning in their lives. They live to love their children and to make change in their world. The kids I would see playing cricket or soccer did so as a means of connecting and engaging with those around them, as did the men returning from the mosque or women sewing together. Given this, are these people unhealthy? They may exhibit markers of disease, as indicated by a biomedical perspective, but given the circumstances, this is normal in this community.

Considering the difference in health norms is important to establish a context from which we can analyze culture. As a result, I had to acknowledge my own understanding of health and healthcare, which is rooted in the Western notion of biomedicine. As Deborah Lupton notes,

Despite the objectivity implied by the scientific principles underlying western medicine, it is still underpinned by a host of assumptions and beliefs developed through living in western culture. The white coat worn by doctors is a potent symbol of efficiency and hygiene, for instance, and the bleeping medical machines found in the hospital setting convey their own meanings of high technological prowess. (The Conversation 2013)

However, in Nizamuddin, “white coats” and “bleeping medical machines” are not symbols that underpin local assumptions of healthcare. In the basti, where residents are only recently becoming aware of the existence of allopathic medicine, the touch of a doctor’s hand on a

shoulder or an empathetic tone are staples of healthcare. For those not aware of biomedicine, traditional home-based forms of treatment such as unani or yoga are more common.

Ultimately, we see that health is a notion conceptualized by an individual. It can be measured in smiles or beats per minute and can be improved by pills or prayers. The implications of how health is defined will be discussed further in the Epilogue.

In order to understand its importance in healthcare, we must first define what is meant by *culture*. As the specific definition of the word is hotly debated in anthropology circles, I will offer a few definitions that have shaped my understanding of culture throughout my studies stemming both from the Introduction to Anthropology course I took with Dr. Tom Fricke and from Adam Kuper's book *Culture: The Anthropologist's Account*. The first comes from Edward Tylor in 1871, namely, "Culture...is that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Fricke 2011). Clifford Geertz's 1973 definition emphasizes the transmissibility of culture, namely, that culture "denotes an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men [and women] communicate, perpetuate, and develop their knowledge about and attitudes toward life" (Fricke 2011). Richard Shweder's 1996 definition focuses on culture's moral nature, defining it as,

A reality lit up by a morally enforceable conceptual scheme composed of values (desirable goals) and causal beliefs (including ideas about means-ends connections) that is exemplified or instantiated in practice. Members of a culture are members of a moral community who work to construct a shared reality and who act as though they were parties to an agreement to behave rationally within the terms of the realities they share. (Fricke 2011)

Adam Kuper's book *Culture: The Anthropologist's Account*, explores the word's meaning.

In his discussion he notes,

First of all, culture is not a matter of race. It is learned, not carried in our genes. (This point will immediately be conceded, although there is now more interest in some circles about what precisely the genes are up to.) Second, this common human culture has advanced. We are talking here of the very long term, and progress has no doubt been uneven and liable to setbacks, but irreversible technical advances have been logged at an accelerating tempo... Culture is here essentially a matter of ideas and values, a collective cast of mind. (Kuper 1999:227)

Moreover, Kuper argues that culture is made up of different parts. He adds,

However, if the elements of a culture are disaggregated, it is usually not difficult to show that the parts are separately tied to specific administrative arrangements, economic pressures, biological constraints, and so forth. "A 'culture,' Eric Wolf concluded, "is thus better seen as a series of processes that construct, reconstruct, and dismantle cultural materials, in response to identifiable determinants." (Kuper 1999:246)

For practical purposes, I have focused on some of these key "identifiable determinants" as a means of interpreting and discussing one's culture in my research. In Nizamuddin, a relatively homogenous Muslim community, I believe that a few key identities of individuals were important to consider due to their impact on health and access to care, including gender, religion, caste, and socioeconomic status. Thus, in this thesis, culture refers to these identities and the worldviews that result. It is these attitudes and identities that I believe contribute to health and safety.

This study is an attempt to draw attention to culture's importance when considering health and continue to build a bridge between health professionals and anthropology. This is not to say that there is no current research focusing on health culture; notably, Paul Farmer and Jim Yong Kim of Harvard University, and Harris Solomon of Duke University are current health leaders with an interest in culture. Solomon, for example, conducts ethnographic research in Mumbai, where he studies the cooking habits of women and the consumption of *vada pav* – a spicy, hamburger-like snack – to better understand the growing

obesity epidemic (Jarmul 2011). This is an effort to understand the transition from infectious to chronic diseases that occurs as a country becomes developed. In a similar way, my study seeks to understand culture in the clinic, the influence of the environment in which patients live on their health and access to care. Moreover, I worked to discover what healthcare means in the Basti, both as a community necessity and a Western odyssey, as the Hope Project brings allopathic medicine to the community for the first time in its eight-century existence.

This thesis will be divided into four sections. The first will offer background information regarding the current status of healthcare and nongovernmental organizations in India today. This context is important to understand the culture of disparity and its implications of healthcare, especially in areas unassisted by the government, such as the Basti. Here I will discuss current literature regarding NGOs and their function as healthcare providers in India. To understand the impact of health disparities, I will draw upon a focus group I conducted with three Indian students. Our conversation provided context about access to care in regions not supported by government clinics. Additionally, as middle class Indians, they offered their perspective on healthcare in India, providing insight into private care, and the resources available to those with sufficient financial means.

The second section will discuss culture's influence on patient health. Specifically, I will discuss challenges to achieving good health in Nizamuddin as related to residents' identities and cultural affiliations. This chapter will examine issues of health education, religious affiliation and gender norms on health and healthcare in Nizamuddin.

The third section of this thesis will discuss my perspective of the inter-staff culture of the Hope Project and its clinic. This section will elaborate on how the NGO provides

medical care for the community. I will discuss how the clinic operates and overcomes challenges faced through a series of vignettes.

The final section will contrast the motivating forces that drive the members of the Hope Project's staff with some of the negative attitudes that hinder community health. Motivations will be demonstrated via a variety of vignettes that share stories of how many staff members came to serve others through their work at the NGO. A discussion of attitudes will demonstrate some of the unsustainable notions found in the basti that hinder health and healthcare.

Chapter 1

Background: NGOs and Healthcare in India

Non-Governmental Organizations

The Hope Project is a Non-Governmental Organization, or NGO. NGOs play an important role in completing the imperfect healthcare network throughout the Indian subcontinent. Many aim to fill a specific niche, such as offering maternal health services, HIV treatment options, or sheltering the homeless in a certain area. In India, a nation that spends less on public health resources than any other in the world and where rural public health efforts often solely focus on population control via family planning (Amrith 2007), the NGO model becomes essential to provide care to those left without access to care.

Smith et al. offer a distinction that separates NGOs from other organizations in the health sector, namely, that NGOs are where “the concerning people are involved without any desires for the (*sic*) personal gains” (2004). Moreover, the authors offer roles and characteristics of NGOs to demonstrate their importance in healthcare. Primarily, NGOs fill in voids left by government organizations that are lethargic or hindered by internal bureaucracy. NGOs are able to provide basic medical distribution, often more efficiently and

in places where government healthcare is unable to reach. Diversified funding strategies, including patient fees, government support on the national and local levels, income-generating activities, fundraising, and donor support, ensure that NGOs seek fiscal responsibility and sustainability (Smith et al. 2004). Edwards suggests that amongst Indian NGOs, there is a push not only for the organization to be sustainable, but also for its impact to be enduring within its community, especially in terms of improving residents' abilities to do things for themselves (1999).

Perhaps in an effort to best meet the needs of the communities they serve, NGOs differ drastically from each other. Some have very formal written organizational structures while others do not. However, Edwards suggests that this distinction bears no effect on an organization's ability to achieve its goals. Moreover, while some NGOs find their leaders from within their community, others look elsewhere to find leaders immune to "political patronage and other pressures" (Edwards 2004). NGOs continue to differ when considering their relationships with local and national level governments. Sen notes, especially in rural areas, NGOs sometimes have missions that directly oppose "the power nexus and interests of the lower levels of bureaucracy and local elites" which in turn create hostile sentiments towards NGOs (1999). Despite the differences, Patel et al. overarching strengths for NGOs in India, namely, innovation and ability to be flexible, a drive to serve the poor, and their consideration of the needs of those they serve.

The Hope Project can be described by many of the descriptions above. Starting out as a milk dispensary by Pir Vilayat Inayat Khan in 1980, the clinic and Girls' Non-Formal School are now the predominant means by which Hope serves the Nizamuddin community. While many of the seventy staff members come from the Basti, much of the Hope Project's

funding comes from abroad. Names of German corporations adorn plaques on the wall near the main entrance, as do mentions of the German government, which sends aid in the form of currency and pairs of yearlong volunteers. Examining a desk in the computer lab will reveal the random pen or letterhead bearing “KLM” and the distinct blue crown of the airline’s emblem. Airlines, to my surprise, are a major benefactor to the organization and frequently send employees to drop off donations. In fact, I was introduced to a pair of young flight attendants visiting the Basti and the Hope Project on behalf of their carrier. Such connections are partly the result of the NGO’s highly organized structure, which stems largely from an excellent manager, Sami-Ur-Rana. A structural diagram of the Hope Project, shown in Figure 1, demonstrates the roles of individuals within the organization and the meticulous structure that has been established.

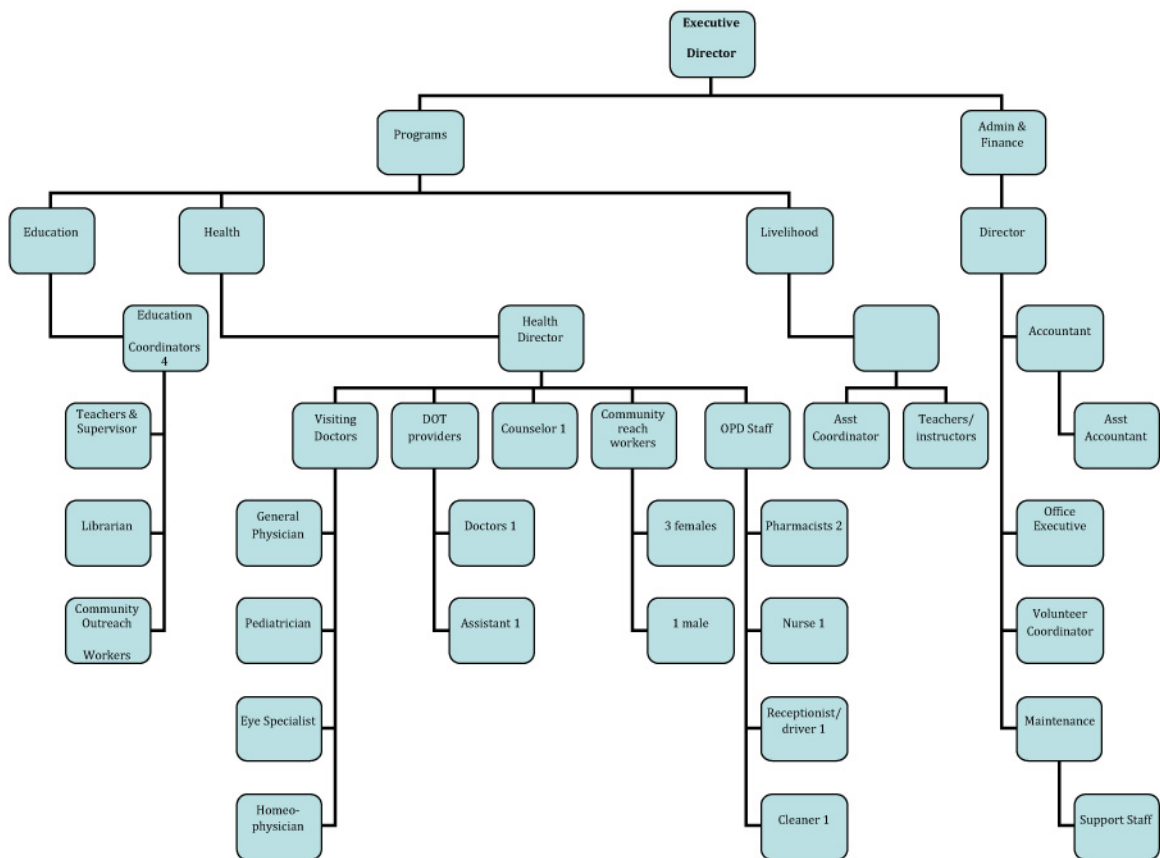


Figure 1: Organizational Structure of the Hope Project (Hope Project website 2009)

The structure of the Hope Project further contributes to its strength as the cornerstone of the Basti community. In agreement with Smith et al., the organization is staffed by a team of individuals dedicated in making a difference in the Basti by empowering those who have never before had the chance to break out of the cycle of poverty. Time has been in the Hope Project's favor; its thirty-three year history has inspired a sense of trust and investment in the organization among Basti residents, which is a challenge in such a small community. As a foreigner who looks vastly different than the average Nizamuddin resident, I can attest to how profoundly alien minor changes can be to the neighborhood and wonder in amazement how difficult it would be to build rapport with the community and establish a successful NGO within its walls.

Walking around the Hope Project, one quickly finds *dargahs* dedicated to Hazrat Inayat Khan and his son, Pir Vilayat Inayat Khan. Situated next to the organization's building and just beneath the window of the guesthouse in which I lived, it is not hard to forget about the Sufi origins of the NGO. During Ramazan, much of the staff adopts alternative working hours to allow for mandatory worship at the nearby mosque, further suggesting religious roots. However, in practice, they are difficult to find. No one tries to lecture me about spirituality or impose beliefs upon visitors of the project; rather, there is a calm disposition that welcomes peoples of all backgrounds. It is only when I see literature about the NGO or walk past the Khan *dargah* that I am reminded of the Hope Project's Sufi origins. The NGO's presence and aura in the basti are a testament to its purpose, that is, to serve *all* people.

Indian Healthcare: An Imperfect System

Healthcare in India is a complex, ever-changing entity spanning multiple fields and types. With a culture whose history spans 4,500 years, medicine has taken a variety of forms across the subcontinent, including ayurveda, yoga, naturopathy, unani, siddha, homeopathy, and allopathy. These various categories of medicine are described in Figure 2 below. Upon achieving independence, India has made it a goal to provide universal healthcare access to all of its massive population. However, the reality of this ideal is not perfect; India's goal of achieving universal healthcare is hindered by inequalities and corruption that frequently funnel resources away from the poor. Caste, gender, wealth, education level, and location all play important roles in determining health outcomes, ultimately creating an environment where those in most need are the one who face the greatest challenges obtaining healthcare (Balarajan et al. 2011).

Figure 2 (Rao et al. 2011):

Panel 1: Ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy (AYUSH)

In March, 1995, the Department of Indian Systems of Medicine and Homoeopathy was created; in November, 2003, this department was renamed AYUSH because of the six recognised systems of medicine under its remit.

- Ayurveda (science of life), like the Greek system of medicine, aims to restore the balance of the three humours or doshas (Vata, Pitta, and Kapha) that govern all the biological and metabolic processes of the human body in health and in disease. It has its own texts, many of which are very old, and its own pharmacopeia. Although Indian in origin and development, the similarity with the ancient Greek system indicates substantial exchange of knowledge between Indians and Greeks in the past.
- Yoga consists of a series of postures and breathing exercises that promote health and prevent disease. It is thought to be especially helpful in chronic, allergic, and stress-related disorders. Naturopathy (not unique to India) is a system of stimulating the body's inherent power to heal itself by restoring the harmony between individuals and nature and the natural elements within.
- Unani is a system of medicine that was introduced in India in the medieval period. Originating as a system of medicine in the Arabic and Persian world under the Arabic renaissance, its name suggests that it came to India from Greece (Ionian) in an earlier period. Like ayurveda, unani is also based on the restoration of the balance of the humours.
- Siddha is also one of the oldest systems of medicine in India and is restricted to the Tamil-speaking areas of the country. It is said to be especially useful for liver diseases, dermatological diseases, rheumatoid arthritis, and allergies.
- Homoeopathy owes its origins to a German doctor Samuel Hahnemann (1755–1843) who postulated treatment with substances (at increasing dilutions) that produce symptoms similar to a disease in a healthy person. It first came to attention in India in 1810 and was widely used in the colonial army.
- In 2009, Amchi or Sowa-Rigpa (the Tibetan system of medicine) was added to the list of existing systems of medicine under AYUSH's remit.

AYUSH's role is to promote and ensure that these systems of medicine are easily accessible to people. The government has established a network of research centres, colleges, hospitals, and dispensaries dedicated to these systems of medicine. Under the National Rural Health Mission, a programme was established to make these services available in the district and subdistrict health facilities, which helped to bring the AYUSH services into mainstream medicine.

Nowadays, an estimated 3371 hospitals and 22 014 dispensaries in the public health system provide only AYUSH services.⁹ Many private facilities also provide these services. How many of the 754 985 registered AYUSH doctors are in active practice is not known.⁹

Quality of care available throughout India is a major concern of healthcare critics, as hospitals and clinics face challenges with staff absenteeism, resource availability, and sanitation limitations. This is not to say that all health centers are bad; India's flagship government hospitals provide excellent allopathic care at affordable costs. However, it is excessive waste, corruption, and poor management at community primary care institutes that result in dismal healthcare (Shiva Kumar et al. 2011:671). Moreover, many claimed "doctors" are actually operating without any medical training, with more than one million rural physicians working under no formal licensure (Balarajan et al. 2011). Often, doctors and staff are not even present in the hospitals and clinics in which they serve, resulting in absenteeism rates of up to 40% (Balarajan et al. 2011). These contributions to lower quality care are found to impact the poor disproportionately, further perpetuating the cycle of poor healthcare.

Geography plays an important role in health outcomes. State by state, there are large variations in the provided healthcare available to citizens. Shiva Kumar et al. offer a comparison of two Indian states, Tamil Nadu and Madhya Pradesh, to demonstrate differences in healthcare spending and health outcomes. Tamil Nadu, which is known for its good state of health, spends more on healthcare costs than Madhya Pradesh, which is known for its poor health. Moreover, by spending proportionally less of its annual expenditure on salaries (72% vs. 83%), Tamil Nadu is able to allocate more financial resources for medicine and supplies. Moreover, Tamil Nadu has higher rates of free surgery (96.5% vs. 61.5%) and drugs (79.7% vs. 7.7%). Finally, the state invests in efforts to improve sanitation, water quality, nutrition, education, and infrastructure (Shiva Kumar et al. 2011:672-673). The result is profound: a comprehensive approach to enhancing community health achieved by

efficient resource allocation and intelligent spending choices. The reality, however, is that most Indian states are not as well organized and committed to providing optimal healthcare as Tamil Nadu, resulting in massive disparities and millions left without access to care.

Healthcare Among Middle and Upper Class Indians: Context for the Basti

Access to healthcare among middle class Indians is a drastically different reality than among the poor. Because my fieldwork in Delhi gave me limited engagement with citizens outside of Nizamuddin, I conducted a focus group of international students from India at the University of Michigan, consisting of Iravati, a first year masters student in Environmental Health Sciences from Chennai; Razak, a masters student in Mechanical Engineering from Agra; and Shravani, a sophomore studying Economics and History from Delhi. All can be considered middle class in India and offered their unique perspective on issues of healthcare, social stratification, and the current women's rights controversy in Delhi.

The conversation began with the issue of healthcare availability for middle class Indians. The current system has similarities to medicine in the United States, with key differences unique to India. First, issues regarding liabilities are more prevalent in American than India, which offers doctors additional freedoms to practice without fear of malpractice. My informants explained that Indian health centers do not have the rigorous legal structure found in the U.S. In practice, this means that doctors are have more freedom to attempt treatments without excessive testing. The notion of conducting medical tests to confirm diagnosis before treatment in America is seen through a lens of mistrust in India, as patients consider excessive medical tests to be a waste of their money, especially in larger hospitals that have the resources for many tests. As Razak explains, they would prefer that the doctor

attempt a treatment and determine its effectiveness by observing if symptoms cease to exist. If not, the doctor would be expected to try another treatment. I believe this mentality is supported by low cost and easily accessible medications at “Chemist” shops, the equivalent of a pharmacy. In my own experience, these shops rarely require a formal prescription even for drugs explicitly marked as such. Iravati mentions that doctors who move to the United States often dislike their experience practicing here due to the regulatory hurdles they face. She suggests that even patient interaction is strained by America’s stringent formalities, noting that one might have to ask, “Can I touch your ear?” When I explain that I have to grade medical students on how well they keep my hospital gown on during my role as a Standardized Patient in clinical exams at the University of Michigan Medical School, my informants are surprised, as such concerns do not seem to be relevant in Indian medicine.

The purchasing of insurance is another point of contrast between Indian and the U.S. My informants offered mixed notions about government care, which is available to all Indians via government hospitals and clinics that charge low fees for treatment. Private insurance can be bought, Razak explained, that covers all healthcare costs at a certain network of hospitals. Having access to privatized care, either through insurance or sufficient wealth to foot the bill, opens the door for care from India’s biggest and best hospitals, which are typically private. The notable exception is the government-operated All India Institute of Medical Sciences, better known as AIIMS, which is commonly considered to be the nation’s best medical center and is located not far from my home in Nizamuddin, Delhi. Shravani explains that private hospitals are much more expensive than their government counterparts, but offer significantly better care. Regarding visiting a private hospital, Razak jokes, “you either have good insurance or are a Bollywood actor.” For those without such means,

government hospitals are sufficient and affordable. Razak continues to explain that his family has just begun to buy health insurance “for some odd reason.” He does not find it necessary, especially for the high cost. For him, government hospitals are good enough, and easily affordable.

Opinions of government care change as one moves up the socioeconomic ladder. When I ask if government hospitals are bad, my informants suggest that the answer depends on one’s economic standing. They suggest that middle or upper class citizens would prefer privatized care, which standards are higher. Iravati notes that she has never been turned away by Fortis, a private hospital in Chennai, which can be a problem at government hospitals in heavily populated cities. This comes at a cost, however, normally at ten times the cost of care at a government facility. For perspective, Iravati paid Rs. 10,000 for a tooth extraction in a private hospital, which she noted was out of reach of many poor Indians.

The issue of social stratification is important when considering disparities and access to healthcare in India. Indian society is unique because it has religious differentiations that can widen or narrow disparity gaps immensely. Understandings of hired help in homes and the treatment of women are old ideas currently seeking translation into the modern world.

Hired help is a common practice throughout India rooted in the Hindu caste system. Middle and upper class families will frequently hire drivers, cooks, and cleaners to assist their needs. These assistants often come from lower castes or socioeconomic statuses than the families they work for. Despite this, there is a mutual respect between servant and master, albeit with limitations. Razak explained this difference, noting, “You won’t feel threatened per se... but you know that you are not the same people definitely” (Interview 2/23/2013). Shravani adds, “Both societies, strata, need each other. There is an accepted

difference between someone who's like an Ambani..." (Interview 2/23/2013). However, respect dominates above all else, notes Iravati. She adds, "we have maids in our house and we have a driver too, but we don't treat them like crap... It's a mutual thing, we need them and they need us for money."

The gaps between castes and social strata become more evident in social gatherings, Razak explains; "When there is a festivity we buy them clothes, you get them sweets, maybe more money but then you wouldn't just ask them to come join you in a party. So they still get the good food but they won't be in that limited space" (Interview 2/23/2013).

The prevalence of the caste system is debated even today. When I first asked my colleague at Armman, Bipen, if Indian society is was still fragmented by the religious tradition, he insisted that it was not. A devout Hindu, I watched the intricacy and dedication he placed on the lighting of incense to depictions of gods on a shelf before the start of work. Bipen suggested that elections were the only real instance of caste divides, stating that candidates of higher castes will sometimes use their identity to their advantage to win votes. This opinion was contrasted when I spoke to three Indian students at the University of Michigan: Iravati, Razak, and Shravani. They suggested instead that the caste system does exist and impacts society, especially in conservative northern states such as Uttar Pradesh and Punjab. It is here that caste continues to serve as a means of stratifying society, creating vast disparities between high and low castes. Often, Indians of lower castes hold other target identities, such as low socioeconomic status or education attainment, that limit the amount of agency they hold in society. Despite social programs that assist members of low castes, access to healthcare is often a challenge, especially if such identities result in limited

economic resources. The caste system's firm roots in much of Indian society perpetuate disparity and limit access to healthcare.

The conversation quickly turned to emergency care, a topic of interest to me because of my previous experience attempting to working with an NGO called Armman in Mumbai. One of Armman's major projects, HERO (Helpline for Emergency Response Operations), is an effort to establish Mumbai's first emergency response services, with a call center designed to constantly monitor bed availability in local hospitals and blood availability in blood banks. Moreover, while in Delhi, it became clear that the concept of an ambulance in India is not the same as the American notion. Simply put, the only agent able to properly interrupt traffic flow is the sacred cow.

To receive care in the event of an accident, one cannot simply go to the nearest hospital. Iravati explained that it is likely that you will be turned away until a "First Information Report" or FIR. This process was described as "ridiculous," citing that hospitals want to "avoid trouble." Moreover, rejection during an emergency can even take place at a government run hospital, which is unlike America's acceptance of all in emergency rooms. I ask what one might do if involved in an accident and Razak replies that he would try to call 102. Iravati interrupts to correct him, noting that the number is actually 108. Among this group of well-educated, middle class Indians, no one is completely sure of the function of each of the three digit emergency numbers available. Shravani laughs, "You usually rely on the people around you to take you to the hospital." Iravati jokes "Good Samaritans" and the group chuckles nonchalantly. For those who have had a taste of Western life, this "system" seems almost embarrassingly archaic. When the vast disparity between rich and poor is considered, emergency care becomes even more difficult to access. My informants note the

difficulty of simply getting an injured person to a hospital, especially outside of urban areas. Iravati notes, “If there is an accident in a slum, how do you even give directions?,” referring to the general difficulty of navigation due to a culture of informal directions. She explains that cardinal directions are never used in India and are replaced by relative directions, such as “take a left from the spice market” or “across from the masjid.” Moreover, emergency response is simply more difficult in developing nations as “there are too many things happening simultaneously... it’s not just about money, then you have politics. The disparity is too much.”

Health disparities in emergency response can even be geographic. A hierarchy of medical care exists in India, causing the most advanced care to be available in only larger cities. While the clustering of higher-level trauma centers around big cities also happens in the United States, this model becomes very difficult to manage in India, where transportation to hospitals can be difficult to manage, especially for the poor. Razak explained:

“My grandmum stays 85 KM from Agra, and so even... so like I said we have local doctors in Agra. If you have something really severe then you’ll probably go to Delhi. Similarly they have their own local doctors there are well, not as well qualified and who will have like no sense of hygiene around their clinic and people will just loitering around and spitting and whatnot. And then so if they have a slightly major problem they’ll come to Agra and if the thing that... and then this doctor will probably tell them that ‘Okay this is not something I can do’ and then they will go there. So... there is a hierarchy basically.”

To travel between cities to access appropriate health resources can be especially difficult for those living in villages, as Razak explains that arranging a car is necessary to get to a larger city for patients in insufficient shape to take a bus. This creates an additional financial pressure on the poor. Iravati explains that some villages, including her own, have no healthcare at all. In her village, one has to travel to a larger town for treatment, which is an hour’s drive away. This pressure is compounded by the fact that no one in the community

owns a car, requiring additional time and money for a hired car to come. Taking the bus when ill is not a plight reserved only for the poorest villages; Razak tells the story of an IIT Kharagpur who fell sick and had to be taken to Kolkata and died on the way. The connection to the prestigious university caused the story to make national news and serves as a chilling reminder of the often-deadly reality of Indian emergency care.

Much like the hired help a middle or upper class Indians might employ, many families have a designated “family doctor.” Shravani explains that this doctor sees every member of the family and often he will come for home visits. Razak describes this as a “friend-come-doctor.” This is especially useful in case of emergencies or middle-of-the-night concerns. Family doctors typically have connections that can be useful to receive better medical care. This tradition further widens the already massive disparity gap of healthcare in India.

In India, universal healthcare is far from universal; it is instead socially stratified and available to only certain parts of the population. The issue is made much more complex due to the variety of types of social strata, as well as the plethora of healthcare options. Ultimately, it is a system that allocates resources away from the poor, leaving the least fortunate to bear the majority of the struggle.

Chapter 2

Culture and Patient Health

The differences could not be more obvious. Farha, a patient of the Hope Project's clinic, sits with Audrey and I for an interview. Her face is hidden behind her dark burka, her voice masked by her native Hindi. Sharan, a student of a nearby school and of Manu's computer classes at the NGO, translates for us. At forty years of age, she has seen many hardships in her life. After her husband and father passed away, her son sold her home and left her no money. Moreover, she has lost both of her daughters during their teenage years. Having no biological family left in the world, she turns to the Hope Project, which has become her new family. Sharan translates, "The Hope Project is really mine," explaining, "the people that have blood relations left her out but these people are really mine. Familiar with my health" (Interview with Farha 7/30/12). Farha notes that the Health Director prior to Dr. Shah's arrival was like a sister to her. Aside from being her primary healthcare provider, the Hope Project serves as her main social support.

Farha is a typical patient at the Hope Project, much like the approximately 9,000 served annually by the clinic (Annual Report 2011-2012:15). They come from the basti and

the communities nearby to receive free consultations and low cost medication. As I worked alongside of the doctors and staff of the clinic, I realized that these patients were much different than those I had experienced in the United States. Many faced oppression and hardship in their lives and most were devotedly religious. Most were poor and hailed from the basti and its surrounding areas, relying on the Hope Project as their primary care center when no such government clinic existed in their communities. In essence, their culture shaped with clinical experiences. In this section I will discuss how a patient's culture influences their health and access to healthcare, using different personal identities as examples.

Religion is an important component of personal beliefs in Nizamuddin. Despite being a predominantly Muslim community, the basti is home to followers of a variety of faiths. Even the Hope Project's staff is religiously diverse; with Islam, Christianity, Catholicism, and Islam represented. In the clinic, I wondered how different religious traditions and restrictions might influence the delivery of healthcare. When I spoke with different members of staff, I received a variety of responses. Nalini, a volunteer from the basti who has training as a nurse, noted that religion did not influence a patient's health, but it did shape how doctors provided treatment. For example, during Ramazan, Muslims are not prescribed medication to be taken during the day, as this would involve the breaking of the fast. Instead, doctors must determine treatment intervals that allow for nightly intake, when the fast has lifted. Jain patients posed a similar restriction to treatment: as Dr. Dugar, the tuberculosis specialist in the clinic, shows me a packet of government-issued TB medication, he points to a red gel cap amongst a group of white pills, all in various shapes. "This one," he notes, "cannot be taken by Jains. It is non-veg." Because the capsule has animal-based

ingredients, it violates Jainism's vegetarian principles. For Jains with TB, there is simply no other option. Dr. Dugar stresses the importance of taking the entire course of medication for patients, noting that the clinic does not give medication to patients, rather, it requires that they take it on site, with a doctor watching. If a stage of the treatment is missed, resuming is not possible. Instead, the patient must start a longer course of medicine, which is even less likely to be completed in full. Nalini continues to explain that because doctors at the clinic are familiar with their patients' religious practices, such restrictions do not cause issue. Instead, for example, physicians ask Muslim patients if they are observing the fast and adjust treatment accordingly. Because doctors understand the religious lives of their patients, they are better prepared to meet their needs. This flexibility in treatment causes religious traditions to be realities in the clinic rather than issues.

A lack of health education poses significant challenges to community health in Nizamuddin. Sahil Rana, the Hope Project's Executive Director, explains that the biggest impact the NGO has made on the community is raising awareness about the importance of medicine, specifically in allopathic form. Many residents of the basti do not know the importance of doctors, as he notes,

Sahil Rana: Many of the people in India, they are not aware of health. They will go to some spiritual person; they will go somewhere else to get themselves cured. Coming to the doctor, understanding the importance of a doctor...

Bradley Iott: Is huge!

Sahil Rana: In India it is said that all of us are doctors. Each of the Indians is a doctor. If you ask anybody, 'Oh you have fever, you'll do this...' Any child will say so, you know.

Bradley Iott: Okay, okay.

Sahil Rana: Okay, but the point is that always you should look for quality care.

Bradley Iott: Yes.

Sahil Rana: So we also focus on quality care, making people understand our quality care.

Bradley Iott: Okay.

Sahil Rana: No no, so therefore, overall, you know when people come to the clinic and they get cured, they feel better, so the message, it's a snowball effect.

Bradley Iott: Yes.

Sahil Rana: In the community.

Bradley Iott: And they tell their families.

Sahil Rana: Exactly, exactly.

Bradley Iott: 'I had this good experience...'

Sahil Rana: Yeah, yeah, yeah. So, uh, it has an overall impact on the community. That, that way you prevent the diseases, you prevent the infections, you prevent adult death, you prevent maternal death, you prevent mortality, child mortality, mother mortality, so huge range of things.

Bradley Iott: Snowball effect.

Sahil Rana: So overall, the quality of health, improvement of the community.

Health education, Rana explains, is the key to improving health in Nizamuddin. Lifestyle choices are especially important given the resource limitations of the NGO and the community members. Because resources are limited, intelligent decisions to overcome issues such as sanitation and access to medicine allow such obstacles to be mitigated. In an early interview, Dr. Shah explains that a high level of education is correlated with high levels of aspirations, and as a result, Nizamuddin's low levels of educational attainment have

hindered its development. Because of this, people are not empowered to strive and move up the social ladder. Instead, the shortcuts they take to get by only result in community harm. By lacking comprehensive Western health education, as a Western public health official would desire, the basti fails to have optimal health relative to developed nations. However, this considers *health* to be defined as Western biomedicine, rather than the local reality of health. I would argue, however, that basti residents understand impact of the harmful exposures found in Nizamuddin, such as unhealthy food and improper sanitation, on their health. Health education in the basti is adequate when considering health as it has been understood for hundred of years in Delhi, namely, the practice of traditional medicine techniques, such as unani or ayurveda. For example, Nizamuddin residents understand how to use *neem*, the bark of a tree, as an antibiotic, despite this not being a tenet of Western medicine. Rana's challenge discussed above is to bring a more Western ideology of health knowledge to the basti, which demonstrates its current deficiency. My fieldwork demonstrates, however, that knowledge of local health practices exists in Nizamuddin. It is important to not forget the need for traditional medicine to persist in the basti as a local heritage and intrinsic component of local culture. This brings into question where the *authoritative knowledge* of health lies within Nizamuddin. Authoritative knowledge, as defined by anthropologist Brigitte Jordan, is the knowledge that is treated as "legitimate and consequential" and on which the basis of health decisions are made (1989:209). I believe the answer is conflicted: as traditional practices of health are respected, the Hope Project community holds Western biomedicine as the keeper of authoritative knowledge. The NGO seeks to use this as a catalyst to providing residents with new biomedical perspectives that will enable the benefits of both Western and local medicine to be utilized.

Additionally, a lack of sex education as understood in the West plagues the basti. Chakraborty notes that a common belief is that sex education has no place within “the moral fabric of ‘Indian culture’” (2010:269). He explains that it is believed that sex education in schools will lead to exploitation and endangerment of females, as male teachers and students will be made excited by the knowledge spread by “sex education practitioners (or ‘sex gurus’)” (2010:269). This demonstrates the ignorance present regarding the issue of sexuality, especially amongst youth. Because it is believed that education around sexuality will only promote premarital sex, the issue is never discussed. As a result, extramarital sexual relations are a reality in the basti, which was described to me as a negative health attribute locally. In this instance, Western notions of outreach efforts appear to conflict with religious beliefs, resulting in a lack of action.

Drug use is a major problem in the basti. Nalini explains that illicit drugs are commonly used, especially amongst children in Nizamuddin. White Out, a brand of liquid document correction fluid, is most common and is sniffed to achieve a high. Nalini said kids use it because it is cheap and easy to obtain. She explains that drug use is rampant; so much so that an organization called the Butterfly Project has opened to work with users near the basti. I am told that the Hope Project used to offer a nightly program for users but it has subsequently stopped, however, I have not been given an explanation for this. Nalini does explain that a lot of those who spend their nights at the Hope Project’s night shelter are drug users, especially children. Dr. Shah adds that heroine, marijuana, and cocaine are the most commonly used illicit drugs, as she tells me her theory that one day the United States will be free from drug use. In comparison, she speculates that the issue will forever plague India.

Dr. Shah's discussion of drug use prompts questions of motivations and attitudes of basti residents, which will be discussed in Chapter 4.

The issue of women's rights exemplifies the changing of longstanding Indian values and mentalities while remaining an important facet of women's health. A landmark example of this is the national response to the recent rape case of a young student in Delhi. The 23-year-old physiotherapy intern later died after being transported to a hospital in Singapore due to the injuries she received from five males on a bus (Mandhana et al. 2012). The entire nation and world have responded with protests to increase the rights of women and punishment for rapists. This particular case drew a lot of media attention despite the fact that Delhi is notorious for its high number of reported rape cases because the average Indian could easily identify with this girl. Razak explains that the victim was "just a regular girl who had gone to the big city for an internship, was watching a movie coming back at 9 o'clock, it wasn't late. It was just a regular story. It's something that every female in Delhi would do and that is why it resonated so badly with everyone."

My informants were among the outraged. They expressed frustration that the Indian government had only discussed potential punishments for the attackers, rather than starting a dialogue for changes in women's rights. Shravani mentions that even when a woman, Sonia Gandhi, was the president of the Indian National Congress Party, she pardoned four rapists in the government system. As we talk about such atrocities, the notion of change is considered, which they believe will take generations to remove ingrained mindsets of bias and intolerance.

These mindsets exist at every level – even within families. Razak suggests that men are largely at fault, noting, "If I see my dad not treating mom properly, not paying any

attention to any opinion she might have, why would I ever expect to give any importance to any other female?" Shravani adds, "It's seeped to such levels that you do not even notice that, you know, you are performing gender inequalities; you don't notice it anymore." For individuals who wish to break free from the mold of oppression, including my informants, making change will require becoming aware of the problems that exist and then passing along their own new ideas of tolerance and equity to their own children. The group agrees that those aware of the current injustices in place are in the minority, but are committed to making a change. As Iravati notes, "Whatever values we feel are right, whatever we can pass on, you know, to be better humans in general."

Until then, however, Indian women have to take precautions to ensure their health and safety. For some, this is as simple as donning a scarf or walking with friends. While walking through the Basti on our way home after visiting the July 4th celebration at the American Library of Delhi's United States Embassy, Nalini takes a scarf she had been wearing around her neck and wrapped it to form a pseudo-hijab to cover her head and face. Additionally, she is walking with Audrey and I, an additional measure to ensure safety. In the Basti, women must take these safeguards, to counteract the culture of oppression that occasionally leads to mistreatment and violence. When I joined Audrey at the Hope Project, she explained that she had been advised not to travel alone after 7 PM. Moreover, Lucy, a volunteer at the NGO from Poland, had been asked to trade her typical European clothing for more conservative local clothing.

In contrast to the many instances I observed women to face oppression, the Delhi metro system reserves the first and sometimes second car of all trains for women. Appropriate areas of the platform are marked with pink signs adorned with flowery shapes

and reading “Women Only.” Compliance is absolute mandatory, lest you want to pay a hefty fine (Rs. 250, approximately \$5). The cars are often shockingly empty, leaving the following cars crammed full of men. Even the moving connector between the cars finds itself full of men, often those carefully bracing themselves as they watch their spouses and significant others sitting gracefully. For a large proportion of my stay I did not appreciate the value of these adorned-in-pink railcars, however, this changed when Audrey found herself inappropriately touched by a stranger on a rush hour “standard” car. Riding together on all other metro trips, we had both come to believe that the train was the optimal means of traveling Delhi, combining efficiently placed stops and incredibly low cost, and, most importantly, air conditioning. However, old habits die hard, leaving Audrey “confined” to a special railcar amongst her female colleagues for all subsequent trips. Reflecting on this now, I wonder if the pink flowers actually mark an entrapment for women, unable to guarantee safety in normal aspects of Indian society. The guarantee of a metro seat (unheard of in any other car) is hardly adequate reparation.

I believe that Nizamuddin’s history and a larger culture of oppression have contributed to these issues. As a religious minority in India, Muslims have retreated to bastis in large cities, where they have established thriving – yet isolated – communities. However, as the larger city of Delhi grew, much of its prosperity failed to permeate into Nizamuddin basti, resulting in a lack of economic and educational opportunities. Over time, the glass ceiling faced by the residents of the basti limited their ability to care for themselves, resulting in sanitation that worsened as the population grew inside the community’s small area. Without access to proper healthcare for a large portion of that history, Nizamuddin has become home to numerous infectious and chronic diseases, including tuberculosis, high

blood sugar, knee and bone problems caused by a lack of calcium in diets, and cough and fever. Nalini explains to me that it is the very densely populated nature of the basti that has fostered the incidence of TB. Today, Nizamuddin is left isolated from the outside world, hindered by unique health challenges that ultimately stem from the oppression found outside of its walls.

Chapter 3

Clinic Culture

Upon first entering the health clinic at the Hope Project, it was clear that the facility was different from those I had visited in the United States. Nestled into the center of the bustling Basti, the clinic had many influences of those found in developed countries, such as a waiting room, German-supplied water purification station, and posters suggesting organ donation (albeit in Hindi, the predominant language spoken in the Basti). Other things I noticed were less usual, such as the animals that could frequently be seen and heard passing by the door, community members peering into examination rooms, and medical record charts resting out in the open atop the clerk's desk. Despite its small size, the Hope clinic serves as the Basti's primary healthcare center and attempt

This chapter is an attempt to provide a window into life in an NGO-run clinic in a developing nation through vignettes and examples observed in the Hope Project's clinic. Observing the "culture" of the clinic provides insights into the priorities and challenges of doctors and staff, who combat resource limitations and structural problems to improve Basti health. This chapter is divided into sections that depict the allopathic clinic (the primary

form of healthcare at the Hope Project), the homeopathic clinic, the mobile medical unit (MMU), and the structural and cultural challenges faced by the NGO to provide care.

Allopathy and its Limitations

I sit on the opposite side of a small wooden desk, not unlike one found in American offices in the 1950's. Across from me is my informant, Dr. Kallol Shah, an allopathic physician and the clinic's obstetrician/gynecologist, and she is very difficult to talk to. This is not a reflection of her demeanor; she is one of the kindest souls I have ever met. Rather, it is the chaos surrounding her and her work. Also at the desk are Rosie, a nurse, and Nalini, a volunteer and basti resident with a nursing background. Importantly, two cell phones sit on the desk, serving as two more characters in the scene due to their frequent ringing and the conversations they connect the doctor to. An evaporative cooler and many fans hustle to push the warm dry air around the crowded room for some semblance of relief from the hot Delhi midday. Together, the cacophony in the room and the stress from the heat would seem to crescendo until a person's breaking point. I am proven wrong; this is just a normal day in the clinic, making it clear to me that delivering medicine in Nizamuddin is a very wild business.

Patients steadily flow from the threshold of room's doorway to the stool nearest Dr. Shah, where most communicate with Hindi very briefly. Their words are often hushed and masked with a recognizable hesitancy; this is a new, uncommon experience. Their descriptions of ailments come with hands pointing, rubbing, and motioning to various parts of their bodies or those of the loved ones they are accompanying. Dr. Shah converses with patients as the cooler's powerful fan continues to unsettle her hijab, requiring constant

rearrangement. This pattern is interrupted, or perhaps complimented, by the comments and bantering of the other people in the room and on the other end of the cell phone connection. In the seconds of pause that occur infrequently, she turns to me and attempts to explain the scene in her high pitched and accented English, developed over a lifetime of training at institutions around the world.

It is her lack of words that is most telling about how the clinic functions and remains fundamentally different than clinics I have seen in America. My inability to speak Hindi allowed me to focus on what I was observing and constructed ethnographic notes. From my vantage, sitting towards the patients and the door to my room, I could not help but focus on the crowding of patients and family members both at the door's threshold and in the tiny hallway connecting the room to the larger waiting room. To my left sat a green medical privacy curtain and wheeled frame, similar to one found in any American hospital room, tucked away in the corner. Throughout my months of work at the clinic I never saw it move, as privacy proved to be a relative construct interpreted differently than in my own experience in the United States. In fact, I was only ever asked to step out of the examination room once, for the treatment of a cyst that required the removal of a woman's burka. This was less of a medical courtesy than an expression of local beliefs about women's bodies; in a place where women are expected to cover themselves, my eyes had no place in a room where the cloth came off.

Information privacy also seemed to be a topic of my own interest, as the Hope clinic contrasts greatly from the University of Michigan hospital where I currently volunteer. With fellow patients and neighbors hovering in and around the door of the examination room, meeting with the doctor is anything but private. In fact, the faces of those watching in are

often expressing intrigue and curiosity. It is also important to note that as much of the world pushes to digitize medical records, including hospitals in India, Hope keeps records of visits, diagnoses, and medicines prescribed on yellow charts made of thick paper. The cards are labeled with numbers and kept in a wooden tray on top of the clerk's desk in the waiting room. I suppose there is a potential for information theft or malice, but I believe that there is a lot of trust amongst the NGO community to do no harm.

Medical records were of particular interest to me, as a friend had been conducting research to determine the potential to initiate electronic medical records in various hospitals in major cities across India. As I watched Howard, a yearlong volunteer from Germany, complete the arduous task of maintaining daily medicine logs, I remembered the many hours I spent assisting Manu with his youth computer class. He works to introduce computers to kids from Nizamuddin and nearby areas who have never before had access to one. To my surprise, I met children who had never heard the term "Facebook" before. If he could accomplish that, I thought, maybe there was hope to getting computers in the clinic to maintain records more efficiently. Later, I realized why this would be impractical: the power cut out almost daily, ruining any potential to have a constantly accessible and reliable computer system.

The many power failures I encountered during the clinic's open hours were only one reminder of the grave reality of resource limitations faced by the staff at Hope. The clinic operates on a small budget, requiring doctors and staff to make due with the supplies and equipment available. The clinic serves many as a medicine dispensary and basic care center, so when patients come in with needs that fall outside of the range of treatment available, they are referred to one of the many hospitals around Delhi. Fortunately, The Hope Project has

good relationships with many local hospitals and medical centers with more resources that can serve patients when Hope cannot. It is important to identify the dispensary nature of the clinic; only very minimal procedures or tests were performed on-site. The most important function the clinic served was providing medicine and medical advice for routine needs. Additionally, the clinic participated in the Indian government's TB treatment program, meaning that it served as a dispensing site for free medicine packs for TB-positive patients. Because the high cost nature of the medicine, as well as the dire consequences of not completing the proper course, patients were required to take each dosage in the clinic. The clinic's TB doctor explained that failure to follow the treatment plan could lead to a longer and more intensive recovery. Here, this synergistic interaction between the NGO and the government allows resources to reach citizens who are not about to access nationally operated clinics. Partnerships like this help the Hope Project reach its goal of improving health in Nizamuddin while filling in areas left without coverage from the government's health program.

The clinic's limited scope of care possibilities stemmed from limitations in medical resources. Of course, resource limitations are relative; the clinic was well established in the basti, but would appear underserved if compared to a similar American clinic. The clinic is staffed by four doctors: one addressing allopathic and obstetrics concerns, a homeopathic doctor, a pediatrician, and one treating TB and working with the Mobile Medical Unit, a mobile dispensary. Each of these doctors has different schedules and positions in other hospitals and clinics, so each type of care is available only on certain days. There are a handful of nurses and dispensers, most without formal medical training. Additionally, the clinic receives help from volunteers, some of which work for up to a year, allowing them to

proficiently dispense medicine unassisted. In an interview with Hope's Director, the lack of formal training is something that is seen as a resource limitation, however, it is understood that employees with more education would demand salaries beyond what the NGO could provide. While this may appear to be a hindrance to healthcare, it is important to note that such jobs employee women from the basti. This opportunity is paramount for women who are kept suppressed by a low "glass ceiling" of economic possibilities. In essence, what would be problematic from a Western perspective is actually opportunistic in Nizamuddin.

Limitations in potential care present themselves frequently because of the lack of a larger health institute's full spectrum of services. Dr. Shah While in the pediatrics clinic, a child from Hope's crèche comes in because of vomiting induced by milk intake. The doctor's solution: limit the child's milk drinking, noting that he could have jaundice. However, the test for jaundice is not one the Hope clinic can perform, it requires a visit to a nearby doctor. For Nizamuddin residents, transportation to outside medical centers is often inaccessible, especially for women, who are bound to the Basti because of stringent social norms. As primary caretakers of their children, this limits the range of healthcare options for youth, which further compounds the challenge Hope faces to provide quality medicine. Here culture hinders healthcare, creating a barrier to treatment that is nearly impossible to overcome.

Most forms of medical testing are not offered at the clinic due to the high cost of machines and equipment. This absence of the capacity to perform formal tests offered me the chance to see the great deal of insight required to practice medicine here. I observed a visit with a patient who was thought to have anemia during my observations in the clinic. The doctor said that the test was expensive and not available to perform, so they had to use

an alternate means to diagnose the disorder. She grabbed a glass of water and placed a drop on one of the patient's fingernails. Together we watched as the drop stayed in place atop the nail as if frozen. The doctor explained that this was an indicator of anemia, because if the patient had a normal amount of iron, her nail would have had greater curvature and the drop would have not been able to sit without sliding off. The patient could be diagnosed and treated at no cost because of a doctor's ingenuity, rather than relying on a test designed for use in more resource-rich settings.

In some regards, the pressure to do more with less makes Hope's clinic very efficient. When speaking about future plans for expansion with the Hope Project's Executive Director, I was told that the current goal is to construct a birthing clinic to allow the Hope Project to provide assistance in childbirth. When I inquired about the cost of such an expansion, I was told that \$2000-3000 would be enough for the entire project. This is easily more affordable than any such center in the United States. One must consider that this birth clinic would be much simpler than its Western counterpart, but it is important to remember that despite the low cost, it would offer a service that would be immensely beneficial to the community. In a similar conversation with the driver and dispenser of the Mobile Medical Unit, I was told that the previous vehicle (a van much too large to squeeze into the narrow passageways of the communities it served) had been sold and a new, smaller Maruti-Suzuki Omni van had been bought for 3.5 lakh rupees, or approximately \$6500. Considering the incredible difference the MMU makes in the communities it serves, the cost seems small. Discussing further plans to broaden the portfolio of healthcare options leads to talk of a new clinic in Kashmir, where a community currently has no access to medical care. Sami-ur is also a businessman, so he is quick to give me numbers and details about the logistics of opening such a facility. More

interesting to me was his commitment to making the resulting center fully sustainable. He spoke of raising initial costs for a doctor and essential supplies while quickly pointing out the importance of demanding that the community have a financial stake in the operation to ensure its sustainability. Admittedly fiscal sustainability was not the first thing I thought of when planning a healthcare facility, but its importance is not to be understated. Sami-ur's plan is ambitious: to build a self-sustaining health care facility in a rural village of a war torn state. However, it is not as impossible as it seems, accustomed to operating on shrinking budgets, he understands both what is needed to make a clinic successful and efficient.

Efficient, innovative medicine extends further into other specialties that Hope outsources to other medical experts to provide. These include pediatrics and optometry, which are provided by a local doctor and doctors from the All Indian Institute for Medical Sciences (AIIMS), respectively. I happened to be in the clinic on a Saturday, which is the weekly time that an eye doctor from AIIMS comes to see patients. The physician, a larger middle age man, notices my large black Ray-Bans and stares with a look of intrigue. He offers to conduct an impromptu eye exam on me, so I oblige him and seat myself next to him at Dr. Shah's consolation desk in the allopathic clinic. He thumbs through the large wooden box of lens, each of a different optical strength used to select the optimal prescription for a patient. I hold each to my eye and attempt to read from the chart on the wall. In less than two minutes, he has accurately determined my prescription. Taking my glasses, he gives me a look of disgust. They are the wrong prescription, and worse, the frames are too wide. I am told to see an eye doctor immediately for an exam.

Remembering the lengthy process of getting an eye appointment in America, this demonstrates the efficiency and innovative practicing I have found among Hope's doctors,

who have to adapt their work to remain relevant in a resource-limited environment. It is important to consider that this is a minimal optometry operation brought to Hope's clinic for a few hours each Saturday. Additionally, there is significantly less paperwork and regulations associated with eye care at the Hope Project relative to developing nations' clinics, but I still find the result impressive. Getting an eye exam in the basti exemplifies that professionalism and compassion can be found in care that is not labored by paperwork, massive regulatory bodies, and cutting edge medical technology.

Homeopathy

Stepping into the homeopathic examination room entails entering a new world, isolated from the rest of the clinic. The stillness is apparent. Focused on the task at hand - interviewing Dr. Jani, the Hope Project's homeopathic physician - I suddenly aware of my breaths. The bustle of the clinic and the basti fall away as my focus locks on this new face. Because of her limited time in the clinic, this is my first chance to speak with Dr. Jani, despite many hours filling the very vials of medicine that she prescribes, separated only by a small pharmacist's window. She is a calm, quiet woman of middle age. Her demeanor seems to speak for her profession; as described to me, homeopathy is a "calmer" form of medicine frequently used for chronic ailments. Still, after hours of watching her work through the narrow window connecting the homeopathic clinic to the adjacent medicine stocking room, on the exterior is hard to see what makes Dr. Jani's work unique.

"I get satisfaction when I give the patient mental relief," Dr. Jani explains, when asked about her favorite aspect of the job. It is obvious that she cares a lot, which is an important foundation in homeopathy. She explains that homeopathic philosophy is often the

reverse of its allopathic counterpart, as she says, “We treat a man, not a disease.” Mental status instead plays a dominant role in diagnoses, as members of her field maintain that the brain is the most important organ in the body. This is determined by asking what seems to be a barrage of questions, including:

“How is your mood?”

“How is your thirst?”

“Do you feel dullness? Energy?”

“How do you sleep?”

It is only after asking many of these questions to determine one’s physical and mental status that a medication can be considered. It is important to note the seemingly endless variety of options surrounding me in the supply room, as hundreds of tiny bottles lined fragile shelves, with spills seemingly eminent. Only an experienced eye could find a desired one with any haste, as they all shared the same manufacturer and thus the same label. Jani considers every possible aspect of a patient before selecting the perfect medicine. Essentially, she delivers bespoke medicine: much as a buyer might scrutinize every wood inlay and shade of leather available on a Bentley, Jani considers every detail of each of her patients, including personality traits, hopes, desires, body shape, eating habits, sleeping habits, and energy level. The result is that no two cases of disease receive the same treatment. She explains that my colleague Audrey and I could have the same ailment and receive completely different medications due to our different needs and identities. Remembering my work filling tiny plastic tubes with tiny balls of sugar, surrounded by hundreds of bottles of chemicals with names not normally found outside of a laboratory, I realize the incredible magnitude of homeopathy’s ability to tailor treatments to an individual’s needs.

One medicine does stand above all the other: SL or “saccharum lactis” (ABC Homeopathy 2012). SL is the most prescribed medicine in Hope’s homeopathic clinic. SL serves as a placebo, meaning that it does not offer any healing effects. After making a diagnosis, Dr. Jani determines that appropriate medicine for the patient’s needs and prescribes it. The patient typically receives three doses of medicine (one tiny vial containing approximately 20 small sugar “pills,” split over three doses), of which a few drops are allowed to soak into the sugar pills to create a chewable, easy to handle form of the medicine. This is followed by three weeks during which SL secretly replaces the prescribed medicine, for placebo effect. Because the pills keep the same appearance and taste, the patient fails to notice any change. Dr. Jani even continues the act on the patient’s yellow medical chart, where “repeat” written simply means, “give SL.”

The patient is never allowed to know that they are actually being treated with placebo pills for the majority of their treatment period, as they serve to treat the mind. Dr. Jani suggests that the minimal medication given is far less important than the mental satisfaction provided by the entire treatment. She explains that homeopathic doctors treat diseases “from the root,” implying that all aspects of a person’s health must be fit, including mental health. In homeopathy, organs are considered and treated by level of importance, with the brain being of highest priority. Because of this, emphasis is placed on positive lifestyle behaviors and mental health, rather than intensive drug or clinical therapies. Jani notes that the most common disease she treats is gastric trouble, as her patients eat fatty and spicy foods for taste rather than for health. For chronic patients or people frustrated with negative side effects of allopathic medicine, homeopathy seems to be an excellent option.

In the middle of July I find my condition worsening after many days of being ill. Having only slept between two and four hours, I struggle to breathe from congestion and have a cold, despite the enormous heat. Desperate, I step foot into Dr. Jani's clinic, where she is sitting with Dr. Dugar, a physician trained in allopathic and unani medicine and assigned to Hope's Mobile Medical Unit (MMU) and Tuberculosis clinic. The barrage of questions begins, as she explains that homeopathy asks many questions, sometimes even situational. Some questions I later noted:

“How much water did you drink this morning?”

“Do you drink a little or a lot?” (referring to size of sips).

“Do you want the windows open or closed?”

“Have you been warm or cold?”

“Is your nose stuffy or runny?”

“Is the discharge thick or thin?”

I quickly realized that the interview would be much more interrogative than a typical visit to my American doctor. The incredible detail of the questions asked often felt unnecessary, but I trusted the process and remained patient both for my own understanding of homeopathy and to alleviate my symptoms. I can understand that homeopathic physicians have to pay attention both to their patients' answers to these questions and their attitude answering them, as the nature of being bombarded with questions can be frustrating. I was given a vial of medicine to take that day, but was spared the SL because I had already been told “the secret.”

Hope's homeopathic clinic treats a unique subset of the total patient population. Nearly all women, many of Dr. Jani's patients suffer from chronic ailments. For them, homeopathy is seen as a good option because it is safe and yields no side effects. However,

for more acute trauma care, treatment is best found in the allopathic clinic. It was explained to me that many people in Nizamuddin do not understand what allopathic medicine is or do not trust it, instead choosing more traditional types of medicine, including homeopathic and unani.

Education and Cultural Practices

In a later interview with Sahil Rana, the NGO's Executive Director, education and trust were revealed to be incredibly important factors in maintaining and improving the health of the community. He explained that the biggest problem he faced was informing the community on the availability of the clinic's effective allopathic medicine, as so many people in Nizamuddin simply do not understand what it means. He struggles to find the appropriate word to describe the types of healthcare that people otherwise use, and I suggest "voodoo" and "witchcraft," notions with negative connotation in the west but unintended as such in this instance. He agrees, providing examples including the use of *neem*, the bark from a certain tree with antibiotic effects, and prayers for healing. He is quick to state his opinion that these are insufficient means of meeting the community's needs, dismissing them as relics of a previous time. You can see the struggle he has had over the course of his entire career working to improve health in various regions in India.

In the eyes of Rana and the doctors I encountered, the clinic's presence brings healing resources to a community underserved by the Indian government. The physicians take medical knowledge and innovations from other parts of the world, including India, and bring them to the basti as a means to caring for its residents. Because of this, an interesting cultural and ethical juxtaposition presents itself. Allopathic medicine is used around the world in

societies with different moral standards that Islam, opening the door to controversial treatments such as embryonic stem cell research and abortions that would never before be present in the basti.

Abortion is an issue of particular interest, as attitudes towards it are frequently bound directly to one's religious beliefs. Sami-ur explains to me that Islam is against abortion, causing a struggle to determine how to best educate women about maternal health. He shares the following anecdote:

[You] cannot give money for family planning. It is difficult to promote. Can be done in Jarkhand and Bihar but not in Nizamuddin. Islam prohibits contraception. Quran says you cannot stop permanently Allah's will. The prophet once said, now I'll tell you what happened (not a story). When Islam was spreading in Saudi Arabia and all these regions, people used to go for Jihad, means struggle, and also if the fame of Allah is in trouble, you can fight. There is another rule, unless the other party attacks you, you are not going to attack the other person. Jihad is different prayers. You are waiting for all akhbar, and don't want to go to the mosque, but somehow you defeat the devil, get up and go to prayer. That is Jihad. At that point of time, there was a fellow going for jihad. "If I died and my wife gets pregnant, who is going to look over her? He practiced the withdraw method, 1400 years ago." She was full of guilt. He went to the prophet Muhamed, and confessed. "Have I done something wrong, is it a sin?" Prophet said, "Oh it also happens like this?" He did not say it is wrong. Al-Asl: coitus interruptus. At that time the prophet approved this, considering the situation. That means considering the situation, but not permanently lock the reproductive system. No matter how much money you give. We look at the community, and we need individual donors, who care for the community.

Rana makes it clear that often moral conflicts challenge the optimal delivery of health care, an issue faced daily by the doctors I met. Dr. Dugar, when showing me the TB drugs provided by the government, pointed to a red pill amongst five white counterparts, noting that it was "non-veg" and that Jains could not take it. Ramazan's occurrence during my stay also raised issues, as Muslim patients could not take medicine until after the fast broke. Additionally, the delayed arrival of the monsoon in Delhi left many Muslims struggling to stay healthy in the abnormally immense heat, requiring modified work schedules to take

effect. It became very clear than strong beliefs held in the community shaped not only life, but also health.

A Perspective on Mental Health: a visit to the Institute of Human Behaviour and Allied Sciences in Delhi

Even health policy shows signs of influence from Indian values and culture. I was given the chance to tour Delhi's Institute of Human Behaviour and Allied Sciences (IHBAS) and meet with its director, Dr. Nimesh Desai, thanks to my colleague and fellow Summer in South Asia Fellowship recipient Marisa, who had met Dr. Desai at a national conference on mental health in Chennai. Despite being renowned in India as a top mental health facility, IHBAS was difficult to find, in large part because no one we asked knew about it. I found this strange, but shook of the feeling and kept an open mind. As we walked around the grounds, surrounded by tropical trees and the calls of birds not found in Michigan, I wondered what I would find. As it turns out, I would be very surprised.

Touring the facilities demonstrated both the advancement and antiquity of the institute: new ideas and forward-thinking care were housed in a visually outdated campus. Unflattering, basic concrete and steel construction contributed to a strange aura about the place. We sit under an awning, whose fan provides a cool breeze that causes me to not even notice the rain that has begun falling, and are served chai as we talk about IHBAS. Dr. Desai discusses the institute's dedication to serving the mentally ill population that lives on Delhi's streets by bringing them in, providing care, and working to find their families. These patients, he explains, are considered INK, or *Identity Not Known*, a term that originates with

the British, as he believes that everyone is known by someone in their life. Dr. Desai explains that although IHBAS has capacity for patients to stay long term, he seeks to prevent this, as he feels that remaining at the facility violates a person's right to be in the community. I am intrigued to learn that Indian psychiatrists have just come to a decision on the custody of the children of single mothers with mental illness. Unlike the United States, which mandates the separation of children from their disabled parents, India has determined that it is important that the family remain together, even in an imperfect environment for childcare. To realize this new practice, patients with children receive their own nurse to ensure that sufficient care is provided for both mother and kin. This decision reveals the importance of the family unit in Indian culture, as well as the nation's ability to adapt foreign concepts of care to best fit South Asian needs. Moreover, the 1,500 patients that IHBAS has reincorporated into back into family and community life are a testament to Dr. Desai's strong belief in the social nature of humans and the importance of one's kinship. This fundamental distinction from psychiatric thinking in the United States demonstrates the enduring presence of Indian culture in healthcare.

Chapter 4

Attitudes and Motivations: How our thoughts determine health outcomes

On Attitudes

The power cuts out during an interview with Dr. Shah. The interview continues as the daylight struggles to pass through the tiny window's aperture to illuminate the room. Despite the shade of the roof, the room begins to swelter. I am reminded that Delhi's daytime temperature can run from 100-115°F as sweat permeates my shirt. "It is a problem of attitude," she notes. The building's generator has failed, cutting power to the lights and fans. "It's not that we do not have, it is that we are not maintaining. I would like my fan to work, I don't care about yours."

This conversation arises when Dr. Shah considers the merit of volunteers (such as myself) in India. She surprises me with her perspective on the contrast between my own experience and that of locals, noting the tremendous disparity. She says that she struggles with her work because Nizamuddin is home to so many troubled people; noting that "The delinquents, the drunk people, the beggars, are maximum in this area." She is not the first to mention the basti's struggle with drug use; Nalini mentioned that even kids are using drugs, as she had seen them sniffing white out for a cheap high. Again I am reminded of the

contrast: Nalini is very traditional in her beliefs and covers herself in our travels after dark, yet kids growing up in the same environment a generation later don kurtas while inhaling white out – the corrective tool of choice in office work.

In an early expedition through the basti after sunset I first notice the sea of white kurtas – sleeves elevated supporting cigarettes dangling from lips young and old. Their users are all men. I am shock to see so many sitting around one of Nizamuddin’s hidden alcoves – similar to kids on a Brooklyn stoop – as darkness consumes the sky. Without an informant among them I decide it is best to observe rather than disturb. I think about what Dr. Shah says: an “empty mind is the devil’s workshop,” referring to the idleness of the lives of some husbands that drives them to do bad things. Men have a strange role in this community, supporting families in the financial and patriarchal sense, but often seeming to lead independent – and perhaps inappropriate- existences both after dark and behind closed doors.

Dr. Shah notes that is these men who belong to the group of “empty mind/unemployed people” who “go about unscrupulous methods to get food for their family.” Naturally, my mind makes a comparison to my own family. As a Catholic from the United States, the notion of a father is that of a leader of a family unit. Simply put, dads are expected to meet the needs of their families, rather than running away from them for selfish pursuits. This might be possible because of the patriarchal design of basti society. As I look at my parents’ marriage, I see a partnership, a union. I see two best friends deciding to live their lives side by side. When I think about the relationships I have with my best friends, they cause me to feel remorse at the idea of hiding secrets or taking advantage of their commitment to my life. This is something I believe to be lost in some of India’s less successful arranged marriages.

The trouble with some of the bad attitudes found in India is their cyclic, seemingly endless nature. As parents struggle, their children also become stuck. Dr. Shah, a successful doctor who lives outside of the basti community, finds herself stratified from those she struggles to help. She has a personal driver. She notes that she does not make her own chai. As she sees a worker at the NGO, she notes: “She has two kids. Take a case of a worker’s kids: How do you think my kids and their kids can compete?” Struggle becomes generational, not unlike the western world.

Worse still, Shah notes that as husbands are off doing malice, their wives fill in to do the work. As I walk through the basti, the power dynamic between genders is tense. Well, actually, at first I noticed nothing abnormal about the relationship between genders in Nizamuddin. It was not until my friend Audrey, another student from The University of Michigan, pointed out the near lack of women in the basti’s causeways after about 7 PM. I looked around in awe. My eyes were not deceiving me; there were simply no women around. Audrey explained that had I not been living and traveling with her, she was advised to remain inside the NGO’s building after about 7 PM. Suddenly I found my attention heightened, constantly aware of the struggles a women might face. I noticed Audrey and other foreign female volunteers at the NGO struggle to learn the proper method of securing one’s headscarf to ensure modesty. I was especially surprised when Manu asked me to “encourage” (read: warn) Lucy to dress more modestly around the basti. (Interestingly, this warning was only pertinent to Nizamuddin, not the generally less conservative city of Delhi.)

Armed with a new perception of gender dynamics, I began to question everything I saw around me. Those men smoking together after prayers in the dusty, dim basti alcove; the posh, contemporary young couples frequently late night restaurants and malls. Space defines

social interaction in Delhi. The men donning Sufism's traditional white kurtas and conversing in the basti's narrow passageways are different from the men I find taking their families to movies at the cinema. Contrast again makes an appearance; people of completely different worldviews can live isolated lives in Delhi, separated by nothing more than a road and different universal perspectives.

Nizamuddin provided an excellent opportunity to understand just how much disparity can be found in the world. As I walked the 15 minute walk from the Jangpura Metro station back to the Hope Project one evening, the wail of an engine revving caught the ear of the petrol head inside of me. With motorcycles literally everywhere I had yet to see a high-performance racing model. A streak of red blasted along Mathura Road, the road that serves as the southwest edge of the basti. As it came back in the opposite direction, I noticed that the red streak was not a sport bike, but rather, a new Ferrari 458 Italia. Aside from my interest in cars, this intrigued me for a few reasons. First, it provided another striking contrast to witness, namely, a person flaunting his wealth by launching his exuberantly expensive sports car along side a poverty-stricken district in far too low of a gear. Additionally, I began to think of the sheer lack of practicality of the exercise: after riding in many cars and rickshaws, I can safely say that keeping any car scratch free in New Delhi traffic would be a challenge for any driver. The presence of the Ferrari confirmed what I had hoped would not be a reality: the disparity between rich and poor in India is immense on a scale that is difficult to even grasp. An important question arises: if one can have so much, how can another have so little?

In our interview, Dr. Shah expressed frustration with her fellow countrymen regarding this issue of disparity and the role of attitude in contributing to it. Enthralled with

the concept of American students coming for research and volunteering, she asks “How about my country’s people?” She answers herself, stating, “They are not willing to.” I remember my current location, Nizamuddin Basti, a few minutes’ walk from Nizamuddin West, a posh district of ornate flats and townhouses for the wealthy. The differences are obvious: the car-lined boulevards of West are home to those who pay for the services of the residents of the basti. For context, many basti men are taxi and rickshaw drivers. On my departure to the airport, I ask the rickshaw driver offering me a ride (after befriending my group of friends) what type of car he would have. In response he laughs at the absurdity of the question because of his limited funds. I am reminded that in India, there is no physical or cultural divide between the rich and poor. She caught me off guard, noting: “I might not have ever made a cup of tea for myself and you guys might be cooking for yourselves. You might be much more healthier.” contributing to the idea that ultra-low cost service industries drive India, and the vicious cycle of poverty.

Competing attitudes also appear to be to blame. Initially frustrated with the Ferrari driver for flaunting a car worth so much, I struggled to rationalize such excessive spending in the light of so much nearby poverty. My disgust was harder to vanquish when I remember that the new birth clinic Hope is looking to build will cost approximately two thousand dollars, an insignificant fraction of the price of the car. Dr. Shah cited poor attitudes as the cause of the broken generator, noting, “It’s not that we do not have [a generator], it is that we are not maintaining. I would like my fan to work, I don’t care about yours. It is a problem of attitude. Every single person is fighting to make both ends meet.” I cannot speak personally to negative attitudes amongst workers at Hope, I did note a few examples of “me first” attitudes shaping social interactions. Boarding a metro car on a busy day takes a sufficient

amount of skill, or perhaps selfishness. As soon as the automated doors open, a panic occurs as the packed station crowd tries to push onto the train, directly into passengers trying to exit the train. Trying to board while allowing women or children first is futile, as you will be pushed forward regardless by the throngs of people behind you, a metaphor for all affairs in India.

On Motivations

Attitudes of Nizamuddin residents are not all amiss; one must also consider the stories of the clinic's staff and their motivations for doing the benevolent work that they do. An appropriate starting point would be Dr. Kallol Shah, an allopathic physician and the Medical Director of the Hop Project. Her motivations to do this work are simple: her grandfather dreamed that one of his children would become a doctor. However, because most members of Sikh families become businessmen or join the army or police force, only Dr. Shah was left to take on the abnormal role of physician. Although her explanation is simple, watching her practice tells an even deeper story of what drives her. With every new patient to enter the examination room, a connection is almost instantly made, establishing a sense of community. It is important to consider her entire story to best understand her engagement with patients.

Born in Tanzania, Dr. Shah's father was a transporter who died shortly before her birth while her mother was a teacher. After a brief return to the United Kingdom with her mother, the pair traveled to Northern India. In Himachal Pradesh she did her schooling and prepared for medical school. Her medical training took her to Delhi, Florence, and Philadelphia for training in gynecology, obstetrics, anesthesia, and echocardiography. In our

conversation, she rattles off the many nations in which she has worked, which includes nearly all of the countries in Europe. Without siblings or remaining parents and an extended family literally spread around the world, I realize that much of Shah's life has been along, which might explain the electric connection she makes when surrounded by others. While working as the CEO of Bansal Hospital in nearby New Friends Colony, a nasty tuberculosis infection picked up from a baby with streptococcal pneumonia resulted in a collapsed lung, which led Dr. Shah to pursue work at the out patient departments of NGOs in the surrounding area. Here she discovered her passion for engaging patients rather than being isolated from them as an administrator. Moreover, as we talk about Shah's passions, she notes,

I am more of a doctor than an administrator. That is why I enjoy greeting my patients than doing this work [*referring to her role as Hope's Medical Director*]. I hate it and because I always used to have an assistant or something, he took care of us, that is why I you might have hardly seem me with a computer... It is sometimes so difficult because what I feel is my purpose is to treat people. By WHO definition, they define health as a state of complete social, mental, and physical well-being, not merely the absence of disease or infection, so I really want to stress on that. Not only... See the environment plays a major role in everybody's life, starting from your health to your nature, to your progress to your attitude towards people. See, so if we are not able to provide a congenial atmosphere of people, howsoever hard you may work, but you cannot achieve that goal. I'll give you medicine, but I cannot give you a bacteria-free environment, so what is the point of giving you the medicine?

For others, working at Hope stems from more practical explanations. Faria, the homeopathic medicine dispenser, came to work at the clinic after attending the Girl's Non-Formal School and living in the Basti. After tenth class, she completed a six-month training, volunteered at the clinic for five years, and has been working at Hope's clinic for eight years. For Faria, the Hope Project has been a ladder of upward mobility towards a new life. Being

the oldest daughter, however, means that she has increased responsibilities caring for her sick mother at home. Marlen, a volunteer from Germany, tells me that Faria has already made her family lunch before starting her daily work in the clinic. Nalini, a Basti resident and volunteer, tells a story of overcoming repression insinuated by her father to attain an education. When she was in the 10th grade at the nearby government school, her family faced financial and personal hardships, causing her to fail out. As a result, her father prohibited her from going back and insisted that she wear the burka. With support from her mother, Nalini took it upon herself to study at home and prepare for further education. Despite a family life that was not conducive to her academic success, she was able to participate in an international exchange program in which she studied nursing at Gasdon State Community College in Gasdon, Alabama for one and a half years. Having previously worked at the clinic, Nalini has since returned to volunteer her time and abilities. Faria and Nalini's accounts are significant as they embody the struggle women face in the Basti to overcome oppression and become independent. Each breaks free from the mold of societal expectations in an effort to achieve their fullest potential. I am impressed that the Hope Project is able to foster life long personal and career development, rather than simply offering elementary school or focus groups.

To understand the background of Sahil Rana, the Executive Director of the Hope Project, Audrey and I join him in his office, where a large *MICHIGAN* banner hangs from the wall, autographed by a study abroad program that had come to work at the NGO in the previous two years. He is quiet and soft-spoken, yet demands a certain level of respect because of his portfolio of incredible work. Much like the banner of my alma mater, Rana comes from outside of Nizamuddin, bringing with him a literal world of experience. Born

into a Muslim family in West Bengal, Rana attended school at a Christian missionary school before attending Visva-Bharati University¹. He explains that Rabindranath Tagore, India's first Nobel Laureate, founded the University in an effort to get people from around the world to study in Santiniketan, West Bengal. This goal is even reflected in the school's motto, "Yatra visvam bhavatyekanidam," which translates to "Where the world makes a home in a single nest" (Visva-Bharati University Website: http://www.visva-bharati.ac.in/at_a_glance/at_a_glance.htm). After college, Rana arrived at Delhi University to study for his Master of Social Work, where he found "total acculturation." Rana's arrival in Nizamuddin is an effort to make a home for the world in the Basti through the incorporation of new leadership and its ensuing values and goals.

Rana's journey to the Basti began after his college career, but Nizamuddin was never intended to be his destination. Starting out as a researcher at Delhi University, he studied destitution amongst children in the city. Various position changes sent Rana across India, working on projects to improve literacy and expand contraceptive options for women. In our conversation he notes, "Wherever I had been, I had always tried to do something new, different and things like that. I never bothered about my salary or my work or whatever it is." He worked as the coordinator of ARC: Advocating Reproductive Choices, a coalition funded by Hewlett-Packard. He did advocacy work to expand reproductive choices so that contraceptives could be used for people's convenience according to cultural norms. He noted in our interview that he was the only Muslim at the time working with the group.

Faith remained an important influence on Rana's life. After a long career working with ARC, Rana applied for his family to go on Hajj, the Islamic pilgrimage to Mecca. The

¹ *Visva* means "the world" and *Bharati* refers to India.

experience proved transformative, inspiring Rana to give up his work and focus on the community, as he notes,

When I came back, you know, when I was there I felt “what is this life? Everybody has to perish one day... I told my daughter “Look, when I go back I’m going to give up this job and I’m going to do something for the community if I can go back.” And my daughter said “Are you going to give back to the community and this?” And I said “Yes.” And my wife said “Okay.”

Upon hearing about an opening for the Executive Director position at the Hope Project, Rana applied. However, a waiting game began and it after a long time there had not been a call for an interview. After inquiring about why he had not been offered an interview, Rana explained that the NGO had seen his large salary and decided that he would not be interested in the minuscule pay that they could offer. He explains,

I am not applying for money. Okay, I have applied; I prefer to do this job. They called me for an interview and Mr. Fabians said come in, come in. All of them are there, twice. And Mr. Fabians repeatedly asked ‘Why do you want to come back here? Are you crazy?’ and then ‘Will you like this place? I mean, what about your salary? You come from such a high profile. I hope you bring advocacy from the government of India and the State government and politician and this and that. We can’t give you AC in your room and things like that.’ And I said ‘No.’ Then I told them ‘Frankly I am telling you I come from Hajj and something had happened, maybe an inner something, something like that.’

He continues to explain that a previous employer called offering a high salaried position to bring him back, to which Rana refused, explaining, “Maybe God wants something done from me differently.” Happily seated in his office, which is a bit too hot from a lack of AC and too loud because of the noisy evaporative cooler, watching Rana work makes it apparent that he had made the right decision.

From pragmatic to profound, the spark that motivates the Hope Project's staff comes from different points in each member's life. These biographies tell stories of obstacles and oppression overcome as well as dedication to one's community and faith. All are important, as they fuel the Hope Project's mission and provide a unique character at the NGO that is not found in other institutions.

I have shared motivating experiences to contrast the disruptive attitudes that harm the Basti community intentionally, as it is these people who work to make life better for all residents. They are literal agents of change and must be celebrated, not only for the work they do but also for the inspiring experiences that drive them. These motivations must be contrasted with the antagonistic attitudes that continue to erode values and impose glass ceilings on certain members of society.

Conclusion and Recommendations

Conclusion

The goal of this study was to learn about culture's importance in the delivery of healthcare and to better understand how nongovernmental organizations provide healthcare to Indian communities without access. Using the Hope Project in Nizamuddin Basti as a case study, we can learn about how such clinics operate and serve the unique needs of their communities. In this way the Basti is a prime example, as its healthcare needs are special due to the nature of the community.

As a result of my fieldwork, I believe that culture is an important determinant of health. In Nizamuddin, health is disrupted by a culture that tolerates drug use, oppression of women, and dismal sanitation conditions. These are only a few examples of social determinates of health, but they exemplify the importance of our worldview on the condition of our bodies. Moreover, it is important to remember that culture is an inseparable component of a patient's life. This study does not seek to isolate culture nor focus on it with excruciating detail; rather, it aims to guide healthcare providers to consider its influence on a patient's life. While allopathic physicians would undoubtedly consider a patient's blood pressure or heart rate when assessing health, I would like to encourage them to also be

attentive to the backgrounds of their clients. This study also questions the notion of health, prompting physicians and policy makers to consider what it means to be healthy in different parts of the world. For example, in a society largely without access to biomedicine, the use of biomedical parameters to measure health may not be appropriate.

In the Hope Project's clinic, having an understanding of a patient's back story allows doctors to establish a sense of trust with patients who are largely unfamiliar with allopathic medicine. As they literally bring new technology into an older community for the first time, this trust is vital to make patients feel safe and to ultimately provide benefits for them.

Recommendations

My ethnographic data can be used to offer suggestions for the improvement of healthcare to the Indian government, NGOs providing healthcare, and current and future doctors. From the perspective of a Western practitioner, who many consider health to be derived from a patient's biomedical markers, such as blood pressure or BMI, coverage gaps that exclude India's poor from healthcare access are unacceptable and must be addressed on the national level. This is a difficult challenge that will require collaborations and accountability from all branches of government. I believe that it is unrealistic to expect the national government to be able to complete this task independently and instead believe that leaders must support NGOs and private healthcare providers that currently fill in coverage gaps. Until the Indian government is able to provide satisfactory healthcare for all of its citizens, NGOs will retain an important role in national health.

Nongovernmental organizations must continue to remain innovative in their approaches to ensure sustainability and effectiveness. The Hope Project provided me with an

ideal model of how such a group should go about serving its community while maintaining accountability for its actions and resources. A solid structure and well-defined mission are excellent tools to guide a staff dedicated to assisting those in need. Here, the Sufi philosophy of helping the poorest among you directs the Hope Project to avoid conflicts of interest that would cause it to deviate from its objective. Moreover, by working to cause real, tangible change in the Basti, the NGO has cultivated some of its current employees, which I believe exemplifies its effectiveness. In this way the Hope Project is investing in Nizamuddin and in its people, a lesson other NGOs can learn from. For those that come from outside of the Basti, a strong sense of motivation partnered with the cultural competency to understand the implications of one's actions is a means of ensuing success.

From the perspective of a basti physician, who may consider a patient's mental and social health of equal or greater importance than biomedical indicators when defining health, understanding culture's influence on medicine is extremely important. Nizamuddin demonstrates that a patient's background – including religion, ethnic group, socioeconomic status, or geographic location – has profound implications on health outcomes and access to care. Even details such as the treatment of women in the community influence access to healthcare, employment opportunities, and safety. Doctors must work to understand their patients' specific cultural and religious needs to ensure optimal care. Doing so will allow them to direct treatment that will be culturally competent and more effective for patients. This is especially important as doctors and NGOs bring allopathic medicine to new communities, where establishing trust and rapport will be key to success.

From the perspective of a resident of Nizamuddin, health may simply be considered to be a state of minimal physical discomfort considering healthcare resource limitations.

Moreover, social relationships and happiness derived from kinship and spirituality may play a more important role in perceived health. As a result, and in light of recent events, I would like to offer encouragement to Indians to stand up and fight for justice in the wake of the nation's current proliferation of rape and violence towards women. My informants from the University of Michigan have shown me that a small group of people acknowledges the culture of oppression that has been reinforced by many generations of ignorance. They will rise up and work to make change in the government through protests and civic action.

Epilogue

I would like to take an opportunity to reflect on the fieldwork process and the things that I have learned. Coming to know another culture as intimately as one does when doing ethnographic research causes you gain perspective beyond what is possible to know when existing only in one society. I found that in learning to be attentive to the world around me, I was changed. I have learned to see the world differently, which has shaped me in my current life and in my future professional life.

Ethnographic research is not without its uncertainties. In the field, I found myself constantly in question, nervous about my progress and its outcome. Living in an unfamiliar environment fosters an initial sense of hesitation, especially in the basti, where life can often be informal and constantly in flux. For anthropologist Harry West, uncertainty is a reality even until the end of this work, as he details in his book *Ethnographic Sorcery*. Sitting with Chombo, he is advised to receive a “vaccination,” consisting of the “splitting of the skin with a razor blade and the insertion in the incision of *mitela*, generally mixed with the acid of a disposable battery” (2007:89). Obviously uncomfortable with the idea, he must resolve the problem in a sensitive manner. Fortunately, I was not offered battery acid as a form of medication, but unexpected things did happen during my fieldwork, and learning to deal with them has helped me grow and become more adaptive to my environment.

Ernestine McHugh describes dealing with uncertainty and frustration in a wonderful vignette from her book *Love and Honor in the Himalaya: Coming to Know Another Culture*. On a trek, Apa asks Ernestine to carry a large pack of “stinking deer meat” (2001:114). Frustrated, she expects him to do so, as customary in the United States. After a while, she becomes frustrated and runs off, and it is only when Ama explains that the local tradition for an elder daughter to carry a father’s pack does Ernestine understand the situation fully. My project also presented frustrations that I at times did not understand: for example, while gathering data for this project, informants would randomly be absent from the clinic without explanation, despite being during working hours. This made planning interviews difficult and often frustrating, but ultimately learning to resolve such issues caused me to learn in the progress. Fortunately, confidence grows once one’s footing is found. In my own work, once I was able to embrace the uncertainty, ethnography became natural.

As an aspiring physician, I would like to reflect on my own motivations and offer my colleagues suggestions. Working alongside doctors in resource limited environments like Nizamuddin and the communities served by the Mobile Medical Unit shows the difficulty of practicing medicine and the level of intuition that doctors need to constantly function at. In a sense, it seems as though the ability to work here would ensure that one could practice medicine anywhere. Stripping away the electronic gadgetry found in American hospitals has a purifying effect on the care Drs. Shah, Dugar, and Jani provide; by watching them work with minimal resources, one observes the most basic doctor-patient interaction. The result is profound; these doctors focus more energy on relating to their patients, some of who do not fully understand allopathic medicine and require care sensitive to their needs. I watched

touch and small talk drive the conversations between doctor and patient, which built rapport and trust, essential for the interview to be successful.

From this we can learn a plethora of lessons about the trade we soon wish to practice. First, patients are not simply blood oxygen or creatinine levels on a chart, they are summation of their lived experiences. They come to the clinic at a time of need, bringing with them certain obligations, whether familial, cultural, or religious, that will influence how they wish us to care for them. We will have to consider these cultural covariates with equal attention as conventional biomarkers when assessing, diagnosing, and treating our future cases. If we ignore these important data points about our patients, we risk treating them without respect for the people they truly are. Moreover, we may offer treatment that conflicts beliefs or lies beyond a patient's wishes. By ignoring culture, we may quantify a qualifiable being, thus reducing a summation of lived experiences, beliefs, emotions, and relations to a series of numerals provided by a scanner or laboratory. By embracing culture, we can move beyond becoming simply a cog in the biomedical machine, instead becoming practitioners focused on the notion of the good.

How strange it is that the profession of caring for and repairing people has recently forgotten about *people*. In the Basti, where there is minimal biomedical technology for a doctor to hide behind, the full gamut of the doctor-patient relationship is exposed. Abraham Verghese, an American physician at Stanford University, provides an anecdote in a recent TED talk:

Now I've been influenced in this thinking by two anecdotes that I want to share with you. One had to do with a friend of mine who had a breast cancer, had a small breast cancer detected -- had her lumpectomy in the town in which I lived. This is when I was in Texas. And she then spent a lot of time researching to find the best cancer center in the world to get her subsequent care. And she found the place and decided to go there, went there. Which is

why I was surprised a few months later to see her back in our own town, getting her subsequent care with her private oncologist.

And I pressed her, and I asked her, "Why did you come back and get your care here?" And she was reluctant to tell me. She said, "The cancer center was wonderful. It had a beautiful facility, giant atrium, valet parking, a piano that played itself, a concierge that took you around from here to there. But," she said, "but they did not touch my breasts." Now you and I could argue that they probably did not need to touch her breasts. They had her scanned inside out. They understood her breast cancer at the molecular level; they had no need to touch her breasts.

But to her, it mattered deeply. It was enough for her to make the decision to get her subsequent care with her private oncologist who, every time she went, examined both breasts including the axillary tail, examined her axilla carefully, examined her cervical region, her inguinal region, did a thorough exam. And to her, that spoke of a kind of attentiveness that she needed.

For this patient, even the best medical technology currently available was not nearly as important as establishing a connection with the people treating her. As much as doctors are caretakers, they also embody a bridge that spans from the biomedical world to the realities of patients, who rely on their physicians to translate the medical science of diagnoses and treatments into more applicable language. Failing to recognize a patient's understanding and sentiments towards a treatment or diagnosis are similar to a writer who fails to consider the knowledge of his subject that a reader may not have. Hemingway writes about this phenomenon in his book, *Death in the Afternoon*,

If a writer of prose knows enough of what he is writing about he may omit things that he knows and the reader, if the writer is writing truly enough, will have a feeling of those things as strongly as though the writer had stated them. The dignity of movement of an ice-berg is due to only one-eighth of it being above water. A writer who omits things because he does not know them only makes hollow places in his writing. (Hemingway 1932:192)

The "hollow points" that may occur in the clinic, where a patient with limited knowledge of the inner workings of his or her body fails to fully understand a doctor's explanation of a

treatment or of what is going wrong with their body. Making a connection rooted in trust with a patient can help mitigate this problem and fill in “hollow points.” This lesson was reinforced daily at the Hope Project clinic, where the touch of Dr. Shah’s hand on a patient’s shoulder silently said *it will be okay*.

I offer these recommendations as a first step to improving healthcare systems in India and around the world. However, based only on my limited fieldwork experience, I advise that they are taken with caution and in stride. I believe that in doing so, healthcare providers can better connect with their patients in order to provide optimal care. By making one’s culture a biomarker measurable during an examination, one can not only better understand a patient, but also the underlying disease.

Returning to the definition of health, my fieldwork has presented the notion that health cannot be uniformly defined. From spanning from simply “feeling well” to quantified measure of beats per minute and pounds, health means different things in different realms. How it should be defined in individual contexts must be considered based on local environments, practices, and beliefs. I would, however, like to consider Aristotle’s interpretation of the good life, that is, “the idea that the morally good life is also the life that is best for the individual” (Allmark 2005:3). In the basti, I feel like this definition is very close to optimal, as residents work to do good in their lives, despite medical problems. Religion, relationships, and happiness take priority to the limps, aches, and pains that might present themselves after years of lacking adequate medical care. This does not make medicine irrelevant, rather, it simply explains the world of the basti, where people learn to live with discomfort and embrace the positive parts of their lives.

In defining health, my research creates more questions than answers. What makes up one's perspective of health? Are mental and social health as important as biomedical notions of health? Who can make these decisions? What role do doctors have in improving these aspects of health? Such questions are culturally defined and must be interpreted in the context of a specific community. Seeking their answers is a first step in improving health and celebrating life.

Ultimately, I believe that Hope is something more than the name: it is a reality. On one of my final evenings in Nizamuddin, I walk to find an ATM. The night is crisp; vendors tempt me with all sorts of grilled and fried street foods that I have learned not to eat. Again, the basti is full of men; pulsating with vivacity and illuminated with small light bulbs and gas-fueled lamps. Two modernly dressed men in their twenties notice my wandering and realize that I am lost after rounding so many turns and corners of the basti's causeways. We converse and they offer to lead me to the ATM, as it will bring them closer to a shop to purchase cigarettes. As we walk, we trade stories. I share my experience working with the Hope Project as they tell me about their own organization, the Delhi Bravehearts. They explain that the group is designed to be an NGO that is immune from corruption by never dealing in cash, only in donated clothing and time. The Bravehearts are made up of a group of Delhi teenagers who are tired of social problems and determined to make a tangible difference in their world. I agree to follow their activity on Facebook and see that I am joined by more than nine hundred other followers. After two months of looking at major social problems head on, I feel relief knowing that kids are taking a stand and working to bring change to Nizamuddin and its surround area.

The Bravehearts, along with the diligent staff at the Hope Project, bring hope to the basti. They are tasked with a difficult challenge: walking the fine line between providing modern, allopathic healthcare while respecting and celebrating the traditions of a seven hundred year old community. It is their cultural competency that fuels success, and it s a model that many should adopt. In doing so, it will bring hope to many.

Works Cited

- Political Culture of Health in India: A Historical Perspective. 2007 *Economic and Political Weekly* 42(2):114.
- ABC Homeopathy
2012 What is SL in Homeopathy. Electronic document, <http://abchomeopathy.com/forum2.php/358165>, accessed 01/15, 2013.
- ALLMARK, PETER
2005 Health, Happiness and Health Promotion. *Journal of Applied Philosophy* 22(1):1.
- Balarajan, Y., S. Selvaraj, and S. V. Subramanian
2011 Health Care and Equity in India. *Lancet* 377(9764):505.
- Chakraborty, Kabita
2010 Unmarried Muslim Youth and Sex Education in the Bustees of Kolkata. *South Asian History and Culture* 1(2):268.
- Edwards, Michael
1999 NGO Performance – what Breeds Success? New Evidence from South Asia. *World Development* 27(2):361.
- Fricke, Tom
2010 Anthropology 101: Introduction to Anthropology Lecture 5 (January 20, 2010).
- Hemingway, Ernest
1932 *Death in the Afternoon*. New York: Scribner.
- Huber, Machteld, J. André Knottnerus, Lawrence Green, Henriëtte van der Horst, Alejandro R. Jadad, Daan Kromhout, Brian Leonard, Kate Lorig, Maria Isabel Loureiro, van der Meer, Jos W M., Paul Schnabel, Richard Smith, Chris van Weel, and Henk Smid
2011 How should we Define Health? *BMJ (Clinical Research Ed.)* 343(jul26 2):d4163.
- Jarmul, David
2011 Harris Solomon: Studying Obesity in India. *Duke Today*.
- Jordan, Brigitte, and Robbie Davis-Floyd
1993 *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Prospect Heights, Ill.: Waveland Press.
- Kottak, Conrad Phillip
2002 *Anthropology: The Exploration of Human Diversity*. Boston: McGraw-Hill.
- Kumar, A. K. Shiva, Lincoln C. Chen, Mita Choudhury, Shiban Ganju, Vijay Mahajan, Amarjeet Sinha, and Abhijit Sen
2011 Financing Health Care for all: Challenges and Opportunities. *Lancet* 377(9766):668.
- Kuper, Adam
1999 *Culture: The Anthropologists' Account*. Cambridge, Mass: Harvard University Press.
- Lupton, Deborah
2013 The Cultural Assumptions Behind Western Medicine. Electronic document, <http://theconversation.com/the-cultural-assumptions-behind-western-medicine-7533>, accessed April 19, 2013.
- Mandhana, Niharika, and Anjani Trivedi
2012 Indians Outraged Over Rape on Moving Bus in New Delhi. Electronic

- document, <http://india.blogs.nytimes.com/2012/12/18/outrage-in-delhi-after-latest-gang-rape-case/>, accessed 02/05, 2013.
- McHugh, Ernestine Louise
2001 *Love and Honor in the Himalayas: Coming to Know another Culture*.
Philadelphia: University of Pennsylvania Press.
- O'Brien, Charmaine
2007 *Recipes from an Urban Village: A Cookbook from Basti Hazrat Nizamuddin*.
- Rao, Mohan, Krishna D. Rao, AK Shiva Kumar, Mirai Chatterjee, and Thiagarajan Sundararaman
2011 Human Resources for Health in India. *The Lancet* 377(9765):587.
- Sen, Siddhartha
1999 Some Aspects of State–NGO Relationships in India in the Post- Independence Era. *Development and Change* 30(2):327.
- Sienko, Kathleen
2011 93%. Electronic document, <http://www.youtube.com/watch?v=xxB-vAVYd7o>, accessed 04/02, 2013.
- Smith, Elizabeth, Ruairi Brugha, and Anthony Zwi
2004 *Working with Private Sector Providers for Better Health Care: An Introductory Guide*. *The ICFAI Journal of Infrastructure*:85-92.
- The Hope Project
2013 *Annual Report: 2011-2012*.
- The Hope Project
2009 *The Hope Project*. Electronic document, <http://www.hopeprojectindia.org/>, accessed 02/03, 2013.
- Treiman, Donald J.
1970 Industrialization and Social Stratification. *Sociological Inquiry* 40(2):207.
- Vergheese, Abraham
2011 *A Doctor's Touch*. Electronic document, http://www.ted.com/talks/abraham_verghese_a_doctor_s_touch.html, accessed 4/9, 2013.
- West, Harry G., and Inc ebrary
2007 *Ethnographic Sorcery*. Chicago: University of Chicago Press.