1. Project Title

The Comprehensive Rural Health Project, Jamkhed (CRHP)

2. Authors (150 characters)

Dr. Raj Arole and his late wife Mabell were among the first global health workers to realize that “the solution is not to build a clinic, but to change the people’s attitudes towards women, children, and the poor.” They trusted in the capacity of poor, illiterate women to provide basic health services, and as a result achieved a miracle: widespread community collaboration across a divided caste system. In 1970 Drs. Raj and Mabelle Arole founded CRHP, an organization that empowers people to eliminate injustices through integrated efforts in health and development.

3. Short description (700 characters)

CRHP works by mobilizing and building the capacity of communities to achieve access to comprehensive development and freedom from stigma, poverty and disease. Pioneering a comprehensive approach to primary community-based healthcare (also known as the Jamkhed Model), CRHP has been a leader in public health and development in rural communities in India and around the world.

4. Full project description (4000 characters)

- **Context/Assessment:** Describe the place and context for this project. What was the assessment of needs (and assets) for the project? Through what institutional arrangements or structures and sectors was the project to be implemented?

CRHP began in 1970 under the leadership of Drs. Rajanikant and Mabelle Arole in a severely impoverished and drought-prone area of central India. These doctors saw the potential that illiterate women had to address the health problems of women and children in their communities when given appropriate training and support. CRHP identified talented and committed women of lower castes to carry out village-level health work. Community Health Worker (CHW) services included health education, diagnosis and treatment of simple conditions, promotion of key messages such as family planning, and referral of patients’ need of higher-level medical care. CRHP also facilitated the formation of Farmer’s Groups that met monthly and supported the CHW with village level problem solving and later Women’s savings and Loan groups. CRHP provided each CHW with training that made it possible for her to earn a livelihood -- usually some kind of income-generating activity unrelated to her work as a CHW.

- **Planning:** Describe the vision, mission, and objectives for the project? Describe participation from relevant sectors and partners from civil society.

**CRHP’s mission**

Health is a fundamental human right. The mission of CRHP is to mobilize and build the capacity of communities in order for them to be able to achieve access to health care and freedom from poverty, hunger and violence.

**CRHP’s vision**

CRHP envision communities where families are healthy and enjoy fulfilling lives. CRHP works to facilitate and empower the poor and marginalized and enable them to achieve their full potential through a value-based approach with equity and justice.
CRHP's objectives

To achieve access to comprehensive development and freedom from stigma, poverty and disease.

Another more specific objective of the project was to integrate mental health into the primary health care setting, with a strong focus on women. By using trained volunteers, the intervention works with groups of women from the community to build competences and self-esteem, and to increase perceptions of personal control.

- **Intervention/Implementation**: What strategies and approaches were implemented? What was the intended scope and level of intervention (e.g., individuals, families, communities)?

The Aroles reached out to donor agencies that funded food-for-work programs. Citizens were employed as daily wage laborers to build dams and were paid one bag of grain per week. Health and wellness lessons, and discussions of home-based, low cost prevention and care programs to enhance children's nutrition, prevent diarrhea, and control pneumonia were provided in conjunction with these construction projects. By providing basic medical care to workers and their children, the Aroles established an initial trust with the residents of Jamkhed. From there, the Aroles were able to start their mission of instituting trained health workers in the villages.

The intended scope included individuals (as citizens play an important role), there was also an emphasis on families (implementing home-based, low cost prevention and care programs) and the community (by training health workers on the different villages).

- **Evaluation**: What were key indicators of success? What methods were used to evaluate progress/improvement? What was the evidence of success and impact? How as information and lessons learned used for adjustment/improvement?

There has been a great number of external evaluations of the CRHP project, with several prominent scientists and organizations such as UNICEF and WHO involved in its evaluation (Kermode et al., 2007, 2008, 2009, 2010; Mann V. et al., 2010; UNICEF, 2008).

Having focused on a diverse range of issues such as the environment, sanitation, social and cultural practices, economic and political conditions in addition to health, CRHP has been able to observe a significant and readily measurable impact that is both quantitative and qualitative. CRHP takes an interdisciplinary approach to everyday barriers that are at intersections of multiple issue areas.

From the initial 30 villages in 1970, the project had expanded to a region of over 250,000 people for the first 25 years. Infant mortality fell from over 176 per 1,000 births to 23 per 1,000 (and at its lowest to 17 per 1,000 for some villages).

The impact of the project on mental health has also been evaluated by Kermode et al., 2007. This evaluation of the project indicated that the intervention had a positive impact on mental health. Many women acknowledged how the opportunity to engage independently in the labour market had benefited them and their families. Furthermore, the women felt they had a greater participation in decision making and freedom of movement, which gave them a sense of competence and control and improved their domestic relationships. These changes in lifestyle and circumstance improved their mental health.

- **Sustainability**: Were the critical components of the project maintained? Through what approaches were they sustained?
During the early 1980s, the government of India failed in its attempt to scale up the Jamkhed CHW model. Beginning in the 1990s, the Jamkhed CHWs began training visitors from throughout India and around the world on the approach they had pioneered. The CHWs and staff continue to train CHWs from tribal areas in Maharashtra and neighbouring states. The work of the CHWs has become renowned internationally and has been featured in *National Geographic* and as a video on their website. (Johnson, 2008; Rosenberg, 2008).

CRHP also facilitated the formation of Farmer’s Groups that met monthly and supported the CHW with village level problem solving and later Women’s savings and Loan groups. CRHP provided each CHW with training that made it possible for her to earn a livelihood—usually some kind of income—generating activity unrelated to her work as a CHW.

- Options to upload documents (pdf):
  - Read more [http://www.jamkhed.org/node](http://www.jamkhed.org/node)
  - References:


7. Indicate which thematic area the case study most closely relates to:

   - Students; transforming health workforce education for the future
   - Social determinants of health
   - eLearning/ICT for Health
   - Interprofessional education
   - Community based and health systems education
   - Social accountability

8. Indicate which transformative education recommendation it most closely relates to (see [http://whoeducationguidelines.org/content/recommendations-glance](http://whoeducationguidelines.org/content/recommendations-glance))
• Faculty development
• Governance and planning
• Curriculum Development
• Simulation methods
• Direct entry of graduates
• Admission procedures
• Streamlined educational pathways and ladder programmes
• Interprofessional education
• **Continuous professional development (CPD) for health professionals**
• Accreditation

9. Indicate key policy area (see [http://whoeducationguidelines.org/content/key-policy-issues](http://whoeducationguidelines.org/content/key-policy-issues))

• Education and training institutions
• Accreditation and regulation
• **Financing and sustainability**
• **Monitoring, implementation and evaluation**
• Governance and planning

10. Quality *

Quality refers to the qualifications of health professionals and the adequacy of these qualifications to address the health needs of a specific population

Indicate: No / Yes

11. Quantity *

Quantity refers to the number of health professionals and the adequacy of that number to address the health needs of a specific population

Indicate: No / Yes

Since the opening of the Training Centre in 1994, over 22,000 local and 2,700 international representatives from NGOs, governments and healthcare professionals have been trained in the CRHP approach

12. Relevance *

Relevance refers to the relevance of health professionals’ education to meet the current and future health needs of specific populations, including skill mix, availability and equitable distribution of health professionals to the local context

Indicate: No / Yes

**Education of the community in health related issues, not only health care providers**
13. Sustainability *

Sustainability refers to the commitment by the government to support investment in health education institutions and students

Indicate: No / Yes

14. Is your project integrated or likely to be integrated into mainstream / national planning *

Indicate: No / Yes

15. Has your project been evaluated? *

Indicate: No / Yes

There was an attempt to be integrated that failed, but it is currently well known, and it has expanded in and beyond India.

16. Evaluation type *

Self evaluation

Or

External/independent evaluation