



## Sasakawa Health Prize

Stories from South-East Asia



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# Preface

The Sasakawa Health Prize was established in 1984 on the initiative of and with generous funding from Mr Ryoichi Sasakawa, Chairman of the Japan Shipbuilding Industry Foundation and President of the Sasakawa Memorial Health Foundation.

The Sasakawa Health Prize is awarded annually to one or more individuals, government institutions or nongovernmental organizations for outstanding and innovative work in health development such as the promotion of health programmes or notable advances in primary health care. The prize is awarded at a special ceremony during the World Health Assembly and consists of a statuette and a sum of US\$ 100 000.

It is a matter of great satisfaction that candidates from South-East Asia have received the prize 12 times since its inception. This is testimony to the fact that the Region is committed to the principles of egalitarianism, social justice and equity in health as enshrined in the Alma-Ata Declaration of 1978 and the ensuing Health for All movement.

This publication attempts to capture the spirit of each of these award-winning experiences. It not only presents the historical perspectives of health development in South-East Asia but also the vast repertoire of initiatives and learning that can guide us in revitalizing primary health care.

A common thread that runs through the work of all the awardees is the primacy accorded to a people-centred and holistic approach to health development. A recurring theme in the projects is the recognition of good health as an essential component of "quality of life". Another is a genuine attempt to reach out to social groups on the fringes of society. One can also discern that a large majority of these projects relied on traditional wisdom, values and beliefs, and community resources to work towards community empowerment. The spiritual ethos, volunteerism and altruism that are so integral to the culture of South-East Asia are clearly seen to be the guiding principles of these projects.

## PREFACE

The experiences described in this book are an eclectic mix of health interventions and projects by government agencies, nongovernmental organizations, the community and individuals. Each of these describes the challenges that were faced, how these were overcome and the opportunities that were harnessed to achieve goals. Indeed, these are real-life examples that exemplify the challenges of intersectoral coordination and show how individuals, communities, nongovernmental organizations and governments can work together for the common purpose of improving the quality of life of the people.

It is gratifying to note that not only has the prize-winning work been sustained but also that several projects have left a lasting impact on national health policies. The write-ups contain several examples of good practices that have been adopted by national development programmes.

In addition to its archival value, it is hoped that this publication will be found useful by policy-makers, health managers, public health professionals and others to design and further strengthen their health systems using the primary healthcare approach.

Finally, I wish to express my appreciation to the many individuals who helped to research the material and draft some of the chapters and to Dr Palitha Abeykoon who served as the overall editor of this publication.



Dr Samlee Plianbangchang  
Regional Director

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# Introduction

The Sasakawa Health Prize was established in 1984 at the initiative of and with funds provided by Mr Ryoichi Sasakawa, Chairman of the Japan Shipbuilding Industry Foundation and President of the Sasakawa Memorial Health Foundation.

The prize consists of a statuette and a sum of US\$ 100 000 to be given to one or more persons, institutions or nongovernmental organizations that have accomplished outstanding innovative work in health development. The prize aims at further encouraging such work in health development, which extends far beyond the call of normal duties; it is not intended as a reward for excellent performance by a candidate of duties normally expected of an official occupying a government position or of a governmental or intergovernmental institution. The prize is awarded at a special ceremony during the World Health Assembly.

At the time the prize was established, the major criteria laid down for the assessment of the work to be recognized included the following:

- (a). **Contribution to the successful formulation and implementation of the national policy and strategy for Health for All by the year 2000;**
- (b). **Promotion of and substantial achievement in advancing given health programmes, which have resulted in increasing primary health care coverage, and/or improving the quality of health care to the population, and a notable reduction in given health problems;**
- (c). **Contribution to increased efficiency and management of health systems; policy development, health legislation and ethics, within the framework of primary health care;**
- (d). **Innovative programmes to reach socially and geographically disadvantaged population groups;**



**This prize aims at appreciating accomplishments of work in the field of health development**

Mr. Ryoichi Sasakawa

- (e). **Innovative efforts to train and educate health workers in primary health care;**
- (f). **Successful and effective efforts at involving communities in planning, managing and evaluating primary health care programmes;**
- (g). **Development and successful application of health systems research for the advancement of primary health care.**

Since its inception, the prize, has been awarded to 12 winners, both individuals and institutions, from the South-East Asia Region. This is the largest number from a single Region of the World Health Organization (WHO). India and Philippines won the prize four times, the most by any one Member State, with the Indonesia ranking second (three times). Three individual winners from the Region have been honoured, personalities who have made a distinctive and outstanding contribution to health development – Dr Amorn Nondasuta, former Permanent Secretary of Health, Thailand; Professor B. N. Tandon, former Professor of Medicine at the All India Institute of Medical Sciences, New Delhi, India; and Dr Handoyo Tjandrakusuma, the Founder of the Community Based Rehabilitation Development and Training Centre] from Solo, Indonesia.

This collection of Sasakawa Health Prize-winning stories from the South-East Asia Region of the World Health Organization (WHO) highlights the work done by the respective institutions and individuals, which earned them this prestigious award. As one of the main objectives of the prize is to encourage the further development of such work, a brief description of the contributions that have been made by them since the time they won the award have also been included, either as an epilogue or a post script or an “afterword” in some of the stories.

The health projects and programmes described in this publication depict a wide variety of innovative and interesting initiatives, each one based on the cardinal principles and practice of primary health care. There are many lessons that could be learnt from these experiences by all the leaders and practitioners of innovative health development, particularly those in South-East Asia.

An attempt has been made to be as faithful as possible to the original submissions that were made to WHO, limiting the editing to clarify and highlight certain significant points and principles. A few of the stories have been presented in part as first person accounts as they were experienced and evolved over time.





Dr Lata Desai, representative of SEWA, during the prize giving ceremony.

WHO Photo



# 1985

## SEWA Rural (Society for Education, Welfare and Action), India<sup>[\*]</sup>

Recipient: Sewa-Rural (society for education, welfare and action - rural)  
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# SEWA Rural is a voluntary organization involved in health and development activities since 1980 in the rural tribal area of Jhagadia in south Gujarat



**SEWA Rural endeavours to reach out and assist the poorest of the poor through various health and development programmes based on community needs and available human resources**

## 1. Introduction

In 1984, the Society for Education, Welfare and Action (SEWA Rural) had just completed four years of work among the rural, tribal and poor communities of south Gujarat in western India when nominations were sent for the Sasakawa Prize for the year 1985. SEWA Rural has now completed three decades of its community health and development work. This article recapitulates what was done by SEWA Rural in the early 1980s to earn the prestigious prize and how subsequent work evolved and developed.

SEWA Rural is a voluntary organization involved in health and development activities since 1980 in the rural tribal area of Jhagadia in south Gujarat. It was started by a group of young professionals educated in India and abroad, and based on the ideas and ideals of Swami Vivekananda and Gandhiji. Over the years, many like-minded youngsters have joined the organization.

SEWA Rural endeavours to reach out and assist the poorest of the poor through various health and development programmes based on community needs and available human resources. It seeks to ensure that values are preserved and self-development, in the broader sense, is achieved simultaneously of those involved in the work. The focus of all programmes has been vulnerable members of the family, i.e. women, children and the elderly, and the poor sections of society.

In all the activities, an attempt is made to incorporate as well as balance three basic principles: social service, a scientific approach and spiritual outlook. Activities include a community hospital, community health project, training centre in health, comprehensive eye care programme, community-based rehabilitation programme for the blind, vocational training centre, women's development and empowerment programme (now under an independent

organization, Sharada Mahila Vikas Society). The organization believes in taking assistance from all sectors of civil society, which include the local community, individual well-wishers and donors, voluntary organizations, government and private industries, charitable trusts, academic institutions and foreign agencies. Their whole-hearted support and encouragement have ensured that the fruits of development and growth in society ultimately reach the marginalized and underserved sections of society, i.e. women, tribals and the poor.

## 2. The beginning of the community health project

SEWA Rural started in 1980 with a small hospital given by a local community. The organization felt that curative support, the main strength of the initial group, would be essential for primary health work. After working in the community hospital for two years, building a reasonable community rapport and assessing the baseline health status, the community health project was launched in 10 villages in October 1982. Oxfam (UK) and Community Aid Abroad (Australia) provided financial assistance. To avoid duplication of services at the community level, SEWA Rural approached state health officials with a request that the responsibility for village-level workers (community health volunteers [CHVs], traditional birth attendants [TBAs] and *anganwadi* workers [AWWs]) from selected villages be entrusted to SEWA Rural. Besides supporting and monitoring village-based workers and further building community rapport, a weekly mobile dispensary was also started in these villages so that minor ailments could be treated in the village itself. Meanwhile, the joint United States Agency for International Development (USAID)/Government of India's Private Voluntary Organisation for Health (PVOH) scheme was announced in 1983 to support voluntary organizations working for community health. Over the next five years, SEWA Rural gradually expanded the scope and coverage of its community health project to cover about 40 villages and a population of 40 000 under this scheme.

**SEWA Rural gradually expanded the scope and coverage of its community health project to cover about 40 villages and a population of 40 000 under the scheme**

Dr Lata Desai, representative of SEWA, addressing the 38<sup>th</sup> World Health Assembly.

WHO Photo

The focus of all programmes has been vulnerable members of the family, i.e. women, children and the elderly, and the poor sections of society





### 3. Key innovations leading to candidature for the Sasakawa Health Prize

#### 3.1 Maternal services in the community health project



**Maternal services are given high importance as it has an impact on infant, perinatal and maternal mortality**

This component is given high importance as it has an impact on infant, perinatal and maternal mortality. Care is provided through the cooperative and collective efforts of CHVs, TBAs, AWWs, multipurpose health workers female (MPHW – female/FHW). The latter take active responsibility for providing this service in their respective target areas at the village level. FHWs make repeated visits to the home of every pregnant woman and provide a standard package of antenatal care (Inj. tetanus toxoid, tablet folic acid, medical examination, referral and health education).

It was observed that TBAs were not actively involved in antenatal care. They were called only at the time of the delivery. Thus CHVs, who also lived and worked in the village, maintained the register of the expectant mother, which was passed on to the FHW during the biweekly meeting at the hospital or the latter's field visit to the village. Following training, TBAs are now involved in providing antenatal care.

In rural India, most of the deliveries are conducted at home by a local birth attendant. It is not possible, desirable or necessary to replace them. What is needed is to train them in scientific techniques. Those TBAs who were not trained in the government primary health centre were provided training through the use of posters, slides and other audiovisual aids; those already trained were given refresher training. Four sessions were organized in less than a year. Training continued during the field and mobile visits to the villages. The self-esteem of the TBAs improved and they were given importance in the organization as a result of their involvement and cooperation. Their performance also improved markedly.

*Presterilized delivery pack and its distribution system:* The concept of a pre-packed delivery pack is not new. However, there were two areas of innovation – how the delivery pack reaches the beneficiary and how monitoring is done

to ensure that it had been used properly. Expectant women are given a prepacked delivery pack by the FHW during the later part of their pregnancy (either eighth or ninth month). The woman is given necessary relevant health education and also told about the importance about the delivery pack, which she is supposed to give to the TBA at the time of delivery. The health education component of the delivery pack is given a lot of importance. As a result, the mother, mother-in-law, neighbours as well as other pregnant women are informed about the importance and details of the delivery pack. The TBA has been already trained to use the pack. It contains pieces of gauze, cotton, thread and antiseptic solution all wrapped in the bag, which itself can be used as a towel on which to place the boiled instruments and equipment when they are spread open at the time of delivery. The standard *dai* kit contains other instruments for conducting a safe delivery such as a bowl, a pair of scissors, etc. The TBA conducts the delivery as per the training she has received. After delivery, the empty bag is retained by the mother in her home and not taken by the TBA who conducted the delivery.

*“High-risk” mother approach and antenatal week:* Systematic training is given to TBAs, FHWs and other staff with the important objective of teaching them to identify “high-risk” mothers. The TBA is paid an additional honorarium even if she has to send such a mother to the hospital for delivery. This prevents TBAs from conducting abnormal deliveries at home, which may be a risk to the mother and newborn.

The programme has a second tier of a “mobile health team”, which visits each village once a week to provide curative services and supervise village-level staff, among other work. Out of four weeks, one week is especially devoted to the identification and treatment of “high-risk” mothers, which is designated the “antenatal week”. High-risk mothers who have already been identified by the FHW and TBA are asked to be present at the mobile medical van. The Lady Medical Officer examines these mothers and gives appropriate advice. Some of them are advised to come to the community hospital, and the others to the hospital, keeping the TBA in the picture.

**In rural India, most of the deliveries are conducted at home by a local birth attendant. It is important to train these attendants in scientific techniques**

The programme has a second tier of a “mobile health team”, which visits each village once a week to provide curative services and supervise village-level staff



## SEWA RURAL

(SOCIETY FOR EDUCATION,  
WELFARE AND ACTION),  
INDIA: 1985 (INDIA)



**SEWA Rural's approach  
has been to work with  
the government in a  
spirit of cooperation  
and coordination**

### 3.2 Community health project and government participation

*Rationale:* Delivering primary health care in the interior rural areas has not been an easy task. Various agencies – the government, voluntary organizations (VOs), the private sector and practitioners of indigenous systems – have all tried to tackle this problem in different ways. Each has a distinct role to play. The programme strategy needs to be formulated according to the local conditions. From the beginning, SEWA Rural's approach has been to work with the government in a spirit of cooperation and coordination. The reasons for this approach include ensuring financial support from the government for long-term sustainability, the large amount of work required to implement primary health services, ensuring replicability, creating a demand from the community through health awareness, and avoiding confusion and duplication of services.

*The beginning:* SEWA Rural approached the district *panchayat* and the state health directorate asking that responsibility for existing peripheral health workers (CHVs, TBAs and AWWs) be given to SEWA Rural. The workers came under the technical supervision and administrative control of SEWA Rural. A pre-test was done to assess the existing knowledge and skills of the workers, following which training was organized based on the findings. Slowly, rapport and confidence were built up with them. A unique experimental model of a collaborative partnership between a nongovernmental organization (NGO) and a government organization (GO) was launched in 1984. An area of about 40 villages with 40 000 population was handed over to SEWA Rural for total health care for five years. Of these, 21 villages would be in the first stage. SEWA Rural would be totally responsible for the health care of the people of this area. All national and state health programmes would be implemented only through SEWA Rural. All village-level health personnel (CHVs, AWWs and TBAs) would work under SEWA Rural, which would have total responsibility and power. Existing government middle-level MPHVs were given a choice; either to work under SEWA Rural on deputation or opt for a transfer to another part of the district. All existing village-level government buildings (sub-centres) would be handed over to SEWA Rural along with equipment and other fixtures. The government would financially assist SEWA Rural in paying salaries, buying medicines, etc. The organization would maintain financial and functional accountability. The district *panchayat* would appoint an evaluation committee consisting of three representatives of the district *panchayat*/state health directorates, three representatives of SEWA Rural and three members from an outside agency.

*The process:* Even though handing over total health care to SEWA Rural was accepted in principle, many details needed to be worked out, including the necessary government resolutions. Most of the existing middle-level health workers (MPHWs) refused to join SEWA Rural on deputation. Male MPHWs were recruited fresh and in-service training was organized. However, female MPHWs were difficult to find. SEWA Rural obtained approval as a field training centre for FHW students studying in nursing schools and recruited two qualified FHWs on deputation. Four local girls were selected by SEWA Rural and sent for the formal FHW training course. One male and one female supervisor were deputed to SEWA Rural from the government.

Though government officials at state and district levels were positive about the collaborative experiment, there was some resistance from district and block *panchayats*, as they are controlled by different political parties. Intense efforts were required to ameliorate this situation through frequent meetings and dialogue with the respective stakeholders.

### **3.3 Referral system**

SEWA Rural was fully convinced that the community health programme needed to be backed by adequate referral support in order to boost the confidence of the community in health workers and SEWA Rural, and for the project to have better outcomes. After identifying and providing medical care to referred patients, further follow-up at the community level also formed an integral part of the referral system.

### **3.4 Mobilization, motivation and participation in SEWA Rural**

Most government and nongovernmental programmes have the necessary ingredients for achieving the desired results. The major problem is *implementation* of the programme, and human resources are a key factor for this. Systemic efforts were made to motivate staff members at all levels for better performance and self-development.

**Though government officials at state and district levels were positive about the collaborative experiment, there was some resistance from district and block *panchayats*, as they are controlled by different political parties**

An area of about 40 villages with 40 000 population was handed over to SEWA Rural for total health care for five years



## SEWA RURAL

(SOCIETY FOR EDUCATION,  
WELFARE AND ACTION),  
INDIA: 1985 (INDIA)



**Over and above  
the fixed monthly  
honorarium,  
peripheral health  
workers are  
paid additional  
performance-based  
incentives**

### 3.5 Encouraging peripheral health workers

Over and above the fixed monthly honorarium, peripheral health workers are paid additional performance-based incentives, e.g. a CHV is paid extra for attending educational meetings or the mobile van, helping in the detection of new tuberculosis (TB) patients, motivating people for family planning or conducting follow up. Emoluments are also given to the AWW for improving the status of high-risk children, maintaining cleanliness of the *anganwadi*, and for better attendance and adequate medical coverage of children. These workers are given importance at the mobile vans as well as at the hospital. SEWA Rural workers also try to be involved in the local festivals, customs and social gatherings along with the peripheral health workers. Thus, all efforts are made to convince the community that the peripheral-level health worker is fully backed up by SEWA Rural and is part and parcel of the team.

All peripheral health workers are encouraged and appreciated for their performance during the regular sessions at headquarters. The good work done by workers is shared with all. Their present problems and difficulties are given due attention. However, any point of criticism is discussed in person. Combined meetings with CHVs, AWWs and TBAs are organized regularly to build up team spirit and a sense of togetherness and better coordination.

Changing attitudes and creating self-confidence in the peripheral health workers is a very slow process, as they have remained neglected for many years. It requires a great deal of patience, perseverance and hard work to induce productive changes among peripheral-level village health workers who are envisaged by SEWA Rural as “change agents” of the future.

## 4. Epilogue

It is 25 years since SEWA Rural was awarded the Sasakawa Health Prize. Since then, there has been considerable development in its health service delivery. Other development programmes have been conducted not only in SEWA Rural but also in the larger society. These are given below.

#### **4.1 NGO–GO collaboration for primary health care**

A unique development took place following involvement of the Government of India/USAID to manage the health care of 40 villages. The Government of Gujarat handed over all existing health responsibility to SEWA Rural and transferred all their staff members (doctors, supervisors, health workers, etc.) elsewhere. Besides USAID funds for certain additional expenses, the State Government agreed to reimburse all middle-level staff-related and other routine expenditure, with SEWA Rural as a functional primary health centre during 1984–89. In spite of some limitations and difficulties, the experiment was effective, resulting in the Government of Gujarat granting formal primary health-care coverage of 40 villages (population of 40 000) to SEWA Rural for 10 years from 1989 to 1999. This was for the first time in India that the government had handed over health care and all aspects of management with 100% financial assistance.

#### **Reviews of the community health project including NGO–GO partnership**

Two reviews of the community health project were carried out by external agencies. The first covered the project period between 1984 and 1989, and the second between 1989 and 1999, when the government entrusted primary health care to SEWA Rural for a decade. Beside improvement in various health indicators and involvement of frontline workers, both studies highlighted the NGO–GO partnership.

*The first review:* This focused on the strengths and shortcomings of the project, and helped SEWA Rural, as well as other interested organizations and individuals, to learn. As has emerged from this study, the achievements in terms of health improvement have been significant and indicate what can possibly be achieved in other rural areas through the existing pattern of health delivery.

**It requires a great deal of patience, perseverance and hard work to induce productive changes among peripheral-level village health workers**

SEWA rural workers are encouraged to get involved in the local festivals, customs and social gatherings along with the peripheral health workers



## SEWA RURAL

(SOCIETY FOR EDUCATION,  
WELFARE AND ACTION),  
INDIA: 1985 (INDIA)



**SEWA Rural experience has been an almost lone success story among a series of NGO-GO collaborations that have misfired, especially in the health sector**

*Impact and achievements:* Health service utilization targets for Health for All (HFA) 2000 had already been achieved. In the case of many of the vital indicators too, HFA targets for 1990 had been achieved, notably the birth rate, infant mortality rate, couple protection rate, and under-five mortality rate, among others. Maternal and perinatal mortality rates remained somewhat higher as compared to HFA targets, though only maternal mortality was higher than comparable rates for Gujarat state. Measles had virtually ceased to be a killer in the project area and vitamin A deficiency in children had been controlled. Neonatal tetanus was rare as was severe childhood tuberculosis. Severe childhood malnutrition had declined, though modestly. Tuberculosis case detection was less than satisfactory, while case-holding was fairly high. Malaria continued to be a problem, though possibly less than elsewhere in the country. Definitive figures for morbidity were not available to enable firm statements about most other infectious diseases. Fertility control was satisfactory, with a moderately high couple protection rate, and a relatively stable and low birth rate. However, non-terminal methods of birth control were not used. Effective referral care had been established at a cost the community could afford. Data collection was accurate, with most events under scrutiny being captured. However, retrieval of past records posed problems due to unsatisfactory cataloguing and storage.

### Vital statistics from 1982 to 1989

	Baseline 1982-84	Present status 1987-1989		HFA targets 1990
		SEWA Rural	Government Gujarat/India	
Crude birth rate (CBR)/1000 population	35.6	27.0	29.6	27.0
Maternal mortality ratio/ 100 000 live births	3.1	5.0	5.0	2.3
Infant mortality rate/1000 live births	172.0	89.2	104.0	87
Couple protection rate (%)	36.9	61.8	42.7	42

Over the years, there has been an increase in the general level of health awareness in the community. Some programmes for socioeconomic upliftment have been launched and efforts in environmental sanitation have been initiated. However, community participation in most health programmes is at best modest, and self-reliance of the community remains elusive.

SEWA Rural experience has been an almost lone success story among a series of NGO-GO collaborations that have misfired, especially in the health sector. Undoubtedly, the Government of Gujarat deserves a fair share of credit in making this collaboration a success. However, it is necessary to be careful in drawing generalizations about such collaborative efforts based only on this study and other such experiences should be studied as well.

SEWA Rural feels that it has not been able to concentrate on important areas in health care largely because of having to adjust to the routine demands of the government on less relevant and poorly prioritized issues.

*Second evaluation (2003):* This review was conducted for the period 1989 to 1999. The technical review team found that the quality and coverage of service utilization had reached high levels and the impact on most mortality rates was considerable. Most of the communicable diseases and epidemics had been fairly well controlled. The prevalence of severe degrees of malnutrition among children had also been substantially reduced (from 16% to 2.5%). There was a higher level of awareness on various aspects of basic health in the community, as seen from the increase in coverage of maternal care (from <25% to >85%) and immunization coverage (from 10% to >95%).

The strong points and characteristics of SEWA Rural were excellent community rapport, project detailing, commitment and empathy of health workers, involvement of village-level workers, meaningful and effective recording and reporting system, etc. All the above became possible through a series of micro-level interventions and innovations. The organization achieved most of the

**The strong points and characteristics of SEWA Rural were excellent community rapport, project detailing, commitment and empathy of health workers, involvement of village-level workers, meaningful and effective recording and reporting system**

Dr Lata Desai, representative of SEWA, receiving the Sasakawa Health Prize and Statuette from the hands of Dr Suwardjono Surjaningrat, President of the 38<sup>th</sup> World Health Assembly.

WHO Photo

The achievements in terms of health improvement have been significant and indicate what can be an example for other rural areas towards health delivery



## SEWA RURAL

(SOCIETY FOR EDUCATION,  
WELFARE AND ACTION),  
INDIA: 1985 (INDIA)



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constraints and  
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with the government**

targets of HFA by 2000 much earlier, and it has sustained them over a period of time in spite of working within the government system with its attendant constraints. It also introduced several innovations in management as well as service delivery, many of which were subsequently adopted by the government system and by many voluntary organizations. The project also brought out the strengths and weaknesses on both sides, which may be profitably drawn upon if the government wants to involve more voluntary groups and the community in rural health care, particularly in interior areas, where government services are far from satisfactory.

*Constraints:* SEWA Rural experienced several constraints and hurdles while working with the government. Some of the operational difficulties were satisfactorily resolved over time, while others remained unsettled. These included undue emphasis on achievement of targets, frequent delays in the release of grants and supplies, and interruption in the smooth partnership with the government due to frequent transfers of senior officials. There were a couple of areas where SEWA Rural could not deliver to its own expectations and satisfaction. One of them was the inability to raise comprehensive community participation to its highest level, i.e. involving the community in all stages of planning, implementation, monitoring and reviewing the services and programmes. It was also unable to sustain the village health committees on a long-term basis. SEWA Rural could not do much to effectively address other important public health issues, such as the provision of safe drinking water and sanitation, and combating use of alcohol and tobacco.

*Lessons learnt:* The rich experience of managing a formal primary health centre by SEWA Rural provides many valuable and far-reaching lessons for different sectors and stakeholders. An important conclusion is that investment in strengthening and empowering the village-based cadre of health volunteers (TBAs, AWWs and MCH workers) is critical for any community-based intervention and in making the services reach every member of the community. It is important to adequately fulfil the community's felt need in making curative care easily available at the village level with proper referral linkages. This would enhance the credibility and acceptance of health workers in promoting other preventive and health education/awareness-building services.

In order to foster an NGO–GO partnership, pragmatic understanding and a sense of appreciation of the strengths and weaknesses of both sides are required. It is imperative to grant some flexibility and relax bureaucratic norms so that distinct NGO characteristics such as innovativeness, creativity and volunteerism are preserved and nourished.

*Encouraging fallouts of the NGO–GO partnership experiment:* It is encouraging to note that the State Government has shown willingness to introduce some of the effective interventions tried out by SEWA Rural into their larger system. Examples of these are the use of pre-sterilized delivery packs, fixed days for different services, a simplified management information system (MIS) with the subcentre as a unit, involvement of workers in micro-planning and target-setting exercises, strengthening the cadres of grass-roots workers, etc.

The Karnataka Government has successfully experimented with a few NGO–GO partnership models in recent years, based on the experiences of the SEWA Rural model. The Government of Gujarat has also entrusted the responsibility of managing three community health centres and one primary health centre to voluntary organizations.

#### **4.2 Handing back the primary health centre in 2000**

In 2000, SEWA Rural handed back the primary health centre to the government. It had hoped that the experiment would be replicated with many organizations getting involved in running government-entrusted PHCs. However, this did not happen. In addition, there were frequent and undue delays in release of grants. Following frequent transfer of senior district officers, SEWA Rural was required to repeatedly brief and explain the features of the programme. Lastly, emphasis on achievement of targets by the year end (31 March) affected SEWA Rural's objectives of long-term planning, effectiveness and achievement.

**It is encouraging to note that the State Government has shown willingness to introduce some of the effective interventions tried out by SEWA Rural into their larger system**

Dr Lata Desai, representative of SEWA, being congratulated by Mr Ryoichi Sasakawa.

WHO Photo

The rich experience of managing a formal primary health centre by SEWA Rural provides many valuable and far-reaching lessons for different sectors and stakeholders



## SEWA RURAL

(SOCIETY FOR EDUCATION,  
WELFARE AND ACTION),  
INDIA: 1985 (INDIA)



**Students from various academic institutions in India and abroad now regularly come to SEWA Rural as part of their field placement, dissertation or project work in the fields of health management, public health**

### 4.3 What next? Safe Motherhood and Newborn Care Project

Since 2003, SEWA Rural is managing a formal “Family-centred Safe Motherhood and Newborn Care Project” in the entire Jhagadia Block covering 168 villages (population 175 000) in partnership with district- and block-level government health departments. The main aim of the project is to develop an evidence-based model to reduce maternal and neonatal mortality and morbidity in resource-poor settings.

### 4.4 Raining and resource centre for health

Different cadres of health workers from voluntary organizations, government staff and students from various academic institutions in India and abroad have expressed keen interest to visit SEWA Rural and learn from its experiences in community health, comprehensive eye care and rural development. To meet such ever-increasing demands, a formal training centre was established in 1990 at SEWA Rural’s main campus in Jhagadia.

Various types of customized courses are offered that are relevant to the needs of the trainees coming from various NGOs as well as the government sector, including those for TBAs, CHVs, AWWs, Accredited Social Health Activists (ASHA), workers for community-based rehabilitation of the blind programme (CBR workers), paramedics in health and eye care, health supervisors, project managers, doctors including ophthalmologists, government health officials and staff of mother NGOs and field NGOs. Students from various academic institutions in India and abroad now regularly come to SEWA Rural as part of their field placement, dissertation or project work in the fields of health management, public health, masters in social work, international development, etc.

### 4.5 Recognitions and associations

Apart from the Sasakawa award from WHO in 1985, SEWA Rural received the Bajaj Award in 1989 for the best managed rural hospital. It was also selected for an international award in the category of Creative and Effective Institutions: 2007 by the Mac Arthur Foundation (USA) for its pioneering work in saving the lives of mothers and their newborns.

SEWA Rural has been approved by the government as a recognized centre for its various schemes and programmes. SEWA Rural has been selected as Best Practice NGO and Service NGO by the state government.

#### **4.6 Networking and advocacy**

SEWA Rural is regularly invited for various meetings, workshops and conferences at the state and national levels to share its learning in ground realities and possible solutions in maternal and newborn care. SEWA Rural has been selected as a member of the District health Society, Bharuch under the Reproductive and Child Health Programme (RCH)-II and National Rural Health Mission (NRHM) for promoting NGO-GO partnership. SEWA Rural also actively partners with other like-minded NGOs in promoting the activities of the Dai Sangathan and Jana Swasthya Abhiyan at the state level.

Over the years, many of its small, micro-level innovations have been upscaled or introduced on a larger scale either by the government or other voluntary organizations.

#### **4.7 Education, economic and empowerment programmes**

*Vivekananda Gramin Tekniki Kendra (Vocational Training Centre):* This vocational centre was started in 1986 for the development and economic betterment of rural tribal youth. Every year, about 100 youth are trained. Thereafter, it is ensured that all the students are placed in jobs in nearby industries and a few are assisted to set up self-employment units to make them self-reliant.

*Sharada Mahila Vikas Society:* A new organization, Sharada Mahila Vikas Society, was formed in 2003 to facilitate the development, empowerment and well-being of women through their active participation. Awareness generation as well as economic activities are undertaken.

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