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SEWA-RURAL: COMMUNITY BASED INTEGRATED RURAL DEVELOPMENT IN SOUTH GUJARAT@

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Abstract

SEWA-Rural (Society for Education Welfare and Action - Rural) is a voluntary development organisation functioning in the tribal area of Jhagadia block in Bharuch district of Gujarat since 1980. The founder members of the organisation, inspired by the life and teachings of Swami Vivekananda and Mahatma Gandhi, were committed to work for the poorest of the poor. SEWA-Rural initiated its programme of community development with health services and gradually expanded the scope of activities to other services. The major activities of SEWA-Rural in the field of health include (i) hospital service, (ii) managing primary health centre under a unique government-nongovernment partnership, (iii) community health project for reducing maternal and neonatal mortality, (iv) comprehensive eye care project and (v) training and resource centre for community health care. The main activities of SEWA-Rural beyond the health field include (i) community based rehabilitation programme for the visually challenged persons, (ii) vocational training of youth and (iii) activities for empowerment of women. In recognition of its admirable service for the rural poor and tribal community, SEWA-Rural has received several awards from different sectors in India and abroad.

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INTRODUCTION

SEWA-Rural (Society for Education Welfare and Action - Rural) is a voluntary development organisation functioning in Jhagadia block of Bharuch district in the state of Gujarat. Starting with the activity of community health, the organisation gradually expanded the scope of its operation to other activities for the development of the rural population. The target of all the programmes of SEWA-Rural has been vulnerable sections of the society, viz. the poor in general, tribals, women, children and elderly. Aiming at the overall development of the rural, poor and tribal population, today the organisation has encompassed various fields of action that include hospital, community based outreach health care, comprehensive eye care, health training centre, vocational training institute for rural youth and women development.

The Beginning

SEWA-Rural came into existence on 26 October 1980. It was the realisation of the vision of a group of young doctors and professionals led by Dr. Anil Desai and Dr. Lata Desai who were trained abroad and returned to India to uplift and empower the rural poor. Their enthusiasm to live and work with the poor in remote tribal villages set the beginning of this organisation. In the process the group visited different areas of Gujarat and selected the rural tribal area of Bharuch district as it was economically very backward and very few voluntary organisations were at work in the area. Many members of the group were medical professionals and they believed that curative services were an integral part of preventive health services and one of the felt needs of the community. Therefore, they decided to begin their activities with a small hospital. This was facilitated with the transfer of the Kasturba Maternity Home run by a local charitable trust at Jhagadia to the newly formed organisation.

As majority of the members of the founding group consisted of medical doctors, SEWA-Rural began with health service as an entry point that has had distinct advantages. However, soon other programmes of

development, such as empowerment of women, education and training of the poor, and income generation programmes were added to the activities of SEWA-Rural. At times the core group members, who were largely medical doctors, found it rather difficult and exacting to conduct some of the non-health programmes. As a result these projects grew rather slowly and experienced greater teething trouble.

The Mission

The professionals, who initiated SEWA-Rural as a voluntary development organisation, were inspired by the life and teachings of Swami Vivekananda and Mahatma Gandhi, and were committed to work for the *last human being,* i.e. the poorest of the poor in society. The founders of the organisation shared a common inspiration and a deep-rooted conviction that one should devote one's life to serving the people and that one's profession would be a good, probably the best, means to that end. As they went through their studies and their subsequent professional work, the shared initial inspiration drew them closer to a common bond. To a generation of Indians born around the time of independence, much of the commitment of the earlier generation to serve the country and its needy people, had become a shared vision. Drawing their inspiration from the life and teachings of Mahatma Gandhi, Swami Vivekananda and Shri Ramakrishna, this group of motivated and sensitive individuals sought to create an institution which would enable them to use their knowledge and skills for the benefit of the rural underprivileged.

The three basic elements of the mission of SEWA-Rural have been (i) serving and working for the poor in society, (ii) value based work and (iii) self development. As the organisation evolved over a period of time, these elements got crystallised and concretised as the core values of the organisation. The entire concept of *daridranarayan* (seeing God in poor), first coined by Swami Vivekananda and later popularised by Gandhiji, is based on the oriental ideal of Vedanta philosophy and the western approach expressed as dignity of human being.

Commitment to the Poor

Serving and reaching out to the poor has remained the foremost mission of SEWA-Rural from its inception in 1980. It permeates all programmes and projects of the organisation. Poverty and injustice in larger society motivated the founding group of the organisation to work for the poor. It was this aspect of the mission that prompted the group to select the rural tribal area of Bharuch district as the location for their work. The early period of difficulties of settling down in the interior rural area with the attendant problems did not cause any vacillation in their resolve to serve the poor. The strong emphasis on reaching out to the last of the poorest of the poor and ensuring that he/she is not left out has been stressed again and again in the various activities of SEWA-Rural. Emphasis on reaching the *last human being* (i.e. poorest of the poor) as the mission has been continuously kept alive in the organisation through group and staff meetings, informal discussions, workshops and discourses by eminent personalities.

A necessary complement to SEWA-Rural's community development effort is the attitude of the organisation's persons to the service of the community. The operative tenet underlying all the activities at SEWA-Rural has been that 'individuals develop by serving others.' Taken in that sense, service rewards and elevates not only the served but also the server. It is this convergence of the enlightened self-interest with altruism that provides SEWA-Rural its very special organisational culture.

SEWA-Rural Approach

All the activities of SEWA-Rural have been characterised by (i) social service, (ii) scientific approach and (iii) spiritual outlook. These three are sought to be equitably balanced, so that one of them does not get overemphasised at the cost of the others. All major decisions in relation to the policy, programmes and their implementation are taken in keeping these three *S*s in mind. Every attempt has been made to remain in touch with the advances in medical and health fields, and changes in the field of social development and management, and to incorporate them in the activities of

SEWA-Rural to the extent feasible. Following are some of the features of the approach adopted by SEWA-Rural in its various programmes.

1. Any new programme or additional component of a current activity is undertaken based on availability of competent and reasonably committed *manpower and need of community*, particularly its vulnerable sections. It was almost never begun simply because funds were readily available.

2. For several reasons, it was decided to keep SEWA-Rural *apolitical* and not to get involved in partisan politics. As and when required by a programme, interactions with the government officials have been done and close contact with the elected representatives has been kept at the minimum. SEWA-Rural has taken adequate care right from the beginning to see that it did not get identified with any group in the local political scene. It has been a conscious decision of SEWA-Rural to give prominence to either social workers or spiritual luminaries in the organisation's formal functions of inauguration and annual events.

3. The concept of *collective leadership* has been accepted as an important element of the approach of SEWA-Rural right from the beginning. Over a period of time it has become a critical part of the core value system of the organisation. It helped SEWA-Rural to undertake several programmes at a time. It also provided enough impetus to decentralise the work considerably after the initial policy decision was taken and accordingly delegate responsibility substantially to others. It gave a lot of scope for freedom and innovation in programmes which has been very important for the many young professionals who joined the organisation's original group. And this may be one of important reasons why several of them continued to work in SEWA-Rural for many years.

4. A culture of *participatory management* evolved in SEWA-Rural as almost all involved in the implementation of a programme would be generally included in the decision making process depending upon the nature of the decision and the level at which it has been made. As a result, the individuals concerned would own the decision and come

forward with their own difficulties and suggestions, especially during initial discussion. An interesting example is that of a *dai* (trained birth attendant) who suggested colour thread to tie the umbilical cord in the delivery kit which had been planned and organised by experts. Coloured thread is easily identified in a poorly lit hut during home delivery. The approach of participatory management compelled SEWA-Rural to hold several meetings with persons at varied levels, including sweepers and *ayas* (helpers) working in the hospital. It helped creation of team spirit and informal relationship among staff members, besides the feeling of belonging to the large SEWA-Rural family. As a result, the entire organisation and its functioning have not been affected by the ill effects of hierarchy. It also helped the new comers in SEWA-Rural to settle down recognising and accepting the informal core values of the organisation.

5. SEWA-Rural deliberately decided to *refrain from the attitude of self-righteousness* and collaborated with, in addition to the government, different sections of the civil society like other voluntary organisations, academic institutions and nearby industries. The experience of SEWA-Rural in managing a formal government entrusted PHC (primary health centre) has been an excellent example of collaboration between government and non-government organisation (NGO).

6. SEWA-Rrural made considerable efforts to *involve community* in the programmes in one way or other. When SEWA-Rural was started in 1980, a local trust handed over its maternity home to the founding group. It saved a lot of efforts and finance in the initial critical stage and enabled SEWA-Rural to make a good beginning without any delay. Since then the local community came forward to provide the helping hand as and when sought. It was truer for the later extension programmes like community health and comprehensive eye care. The founding group of SEWA-Rural was particularly sensitive to the need to involve people in their own development. Its starting premise was that comprehensive development would occur only through community participation and that a participative ethos could be inculcated through the community's

involvement, motivation and consciousness. However, SEWA-Rural feels that more should and could have been done to involve the local community.

ACTIVITIES OF COMMUNITY DEVELOPMENT

SEWA-Rural initiated its programme of community development with health services. As the organisation gained experience in rural development with its health programme, gradually it expanded the scope of activities to programmes of development other than health services. Thus the development activities of SEWA-Rural today can be broadly divided into two categories, viz. health services and programmes other than health.

I. Health Services

The founding group of SEWA-Rural had integrated development as their overall organisational goal. But as most of the original group members were medical doctors, a deliberate decision was taken to start their mission with health services, and health has continued to be the main area of the SEWA-Rural activities even today. The major activities of SEWA-Rural in the field of health include (i) hospital service, (ii) managing PHC under a unique government-NGO partnership, (iii) community health project for reducing maternal and neonatal mortality, (iv) comprehensive eye care project, and (v) training and resource centre for community health care.

(i) Hospital Service

As health professionals the founding members of SEWA-Rural believed that curative health services should precede and form an integral part of preventive health services. When they selected the rural tribal area of Bharuch for their programme of health services after serious deliberation, it was in a way providential that a local charitable trust in Jhagadia (Bharuch district), known as the Kasturba Madical Aid Society, appreciated the ideals and enthusiasm of the young founder members of SEWA-Rural and decided to entrust the management of its Kasturba Maternity Home to the new

organisation. Subsequently, after a couple of decades the trust decided to merge in SEWA-Rural and necessary formalities of getting the approval of the concerned charity commissioner was completed. Ownership of the land was also formally transferred to SEWA-Rural by the government of Gujarat. Both these steps could be easily completed because of SEWA-Rural's credibility in providing effective health care and other development programmes for the poor without compromising on quality and social values.

The maternity home was converted into a fully equipped 40-bed hospital in October 1980. It had four full time doctors, six consulting doctors, and facilities for X-ray, a laboratory and an operation theatre. Resources to fund the facilities were raised through loans, donations from well wishers and personal savings of the founder members. SEWA-Rural decided to render hospital services free to those who were very poor, but to charge others some nominal amount for the care they received. These charges, however, were deliberately kept low (much lower than those at comparable hospitals) so as to reduce the economic burden of an already impoverished rural population.

The impact of the maternity home, restructured as a curative health care centre having linkages with higher urban centres for specialised care, was compelling. As expected, it helped SEWA-Rural to establish its presence and credibility. In a relatively short period the organisation was able to elicit considerable acceptance and support from the community. Earlier, Jhagadia's patients had to trek to distant urban centres for health care, other than the normal deliveries and minor ailments. It meant additional hardship for those who could ill afford the costs of health care in the first place. This major strain on people's time and resources was now averted by SEWA-Rural's hospital that provided diagnostic as well as therapeutic medical care almost at the doorsteps of the rural people. The response of the people to such a well founded medical facility situated in their midst was overwhelming. Utilisation rate of the facilities offered at the Kasturba hospital rose significantly in the months to follow.

Gradually more facilities were added to the hospital and the number of doctors increased. Presently, the hospital with 100 beds offers round the

clock emergency services, special care for women, children and people with eye diseases, and separate clinics for tuberculosis, diabetes and infertility, besides services for eye diseases like glaucoma and squint. These services are strongly supported by well-equipped modern laboratory, X-ray and sonography units along with operation theatres and blood bank. Medicines are available in the hospital premises at low cost without compromising the quality. A well-stocked library offers reference facilities for other staff members and doctors, who keep their knowledge updated through regular academic meetings. Medical students and interns from India and abroad regularly visit the hospital for orientation and training.

However, doctors and modern equipments alone do not enliven a hospital. Dedicated and competent paramedical personnel are equally important. Since it was difficult to get formally qualified paramedical personnel in the remote area, in the early 1980s SEWA-Rural produced a team of local rural tribal girls and boys with extensive practical and demonstration centred training. This brought a new and better change into their lives. These hands doing all sorts of labour began caring for patients and giving new hope of life to them.

A glance at the achievements of the hospital, when it has entered the fourth decade of functioning, reveals that the people of the 5000 surrounding interior villages take advantage of the hospital that has now over 20 full time doctors. About 250 patients from these villages receive medical treatment daily in the OPD (out-patient department). In the year 2010-11 the hospital treated 68070 OPD and 12667 indoor patients. In the same year 2284 deliveries with 225 caesarean surgeries and 6201 total operations were carried out in the hospital.

SEWA-Rural hospital has been approved as a service provider by state government for various insurance based schemes like *Chirinjivi*, *Balsakha* and *Rashtriya Swasthya Bima Yojana* (RSBY) to provide free medical care to patients belonging to poor and BPL families. Under Chirinjivi, free delivery services are provided by a gynaecologist. The scheme of Balsakha is for free medical care to young babies by a paediatrician. Under

RSBY, BPL patients with smart card get free medical and various surgical cares. The government or designated insurance company reimburses the cost of such free treatment to SEWA-Rural hospital as per predefined package charges. The number of patients who availed of the free medical services at the hospital of SEWA-Rual in the year 2010-11 was 1566 under Chrinjivi, 1491 under Balsakha and 991 under RSBY. Bed occupancy of the hospital in the year 2010-11 was 90 per cent.

As many as 83 per cent of the indoor patients and 49 per cent of the OPD patients were given free treatment during this year. About Rs.2 crore (20 million) are being spent on hospital services per annum. Less than 50 per cent of this expenditure is met from the government grant. On the whole, only 25 per cent of the expenditure on hospital services is met by the patients who can afford payment. The rest of the deficit is borne by SEWA-Rural largely through raising donations from philanthropic organisations and well wishers year after year, and partly by the funds generated from various schemes like RSBY, Balsakha and Chirinjivi in the recent years.

In 1989 the hospital was recognised as the best managed non-government rural hospital and received the award from the Bombay Management Association and Bajaj Group of industries for achieving excellent operational results, and patient and community satisfaction.

(ii) Managing PHC under NGO-Government Partnership

The decision to work in the villages had been taken at the inception of SEWA-Rural in 1980 and its ultimate goal was not to be confined within the four walls of the hospital. It was also realised that due to a number of complex social and cultural factors, the hospital remained inaccessible to the vast majority of the rural people, and very often they came to the hospital until it was too late. A baseline survey of the surrounding villages conducted in the year 1982 revealed the gross neglect of health services. Children often suffered from measles, diarrhoea, malnutrition, high incidence of anaemia, malaria and tuberculosis, and there was general apathy towards

women's health. As a result, there has been high mortality rate among women and children. Unfortunately many cases of death were related to diseases which were preventable. This rural health scenario prompted SEWA-Rural to formulate and commence a project of health care outside the hospital.

On 2 October 1982 a community health project was initiated in 10 villages covering a population of 11000. The programme was built around a mobile dispensary with a team of medical personnel. The mobile dispensary provided curative health services. In 1984, SEWA-Rural received funds from the government of India and the United States Agency for International Development (USAID) to provide services of both curative and primary health care in 39 villages (gradually to cover a population of about 40000) in the Jhagadia block.

With the responsibility of providing total health care as per the pattern of the PHC of the government, SEWA-Rural was required to undertake all the national health programmes as per the government norms and meet the targets set by them. In an agreement made with the government in 1984, SEWA-Rural was given freedom to devise and implement its programmes, to recruit its staff and provide them additional training. The World Health Organisation (WHO) Geneva awarded SEWA-Rural the inaugural Sasakawa Health Prize 1985 for outstanding innovative community health work.

On completion of five years in 1989, in view of SEWA-Rural's successful management of the programme for providing comprehensive health care to the population of 40000 for five years, the government formally entrusted the management of the PHC in Jhagadia to SEWA-Rural. Under the fresh arrangement the state government would provide 100 per cent grant to SEWA-Rural as per the norms for managing the Jhagadia PHC for the next 10 years. In addition, SEWA-Rural's community health project was recognised for posting government functionaries on deputation whenever such an arrangement would be mutually agreeable. The services provided at the PHC included maternal and child health, immunisation, ICDS

(integrated child development services), family planning, health education, control of tuberculosis and malaria, and school health.

In spite of certain constraints in working with government, the project achieved most of the goals set by the government of India under "Health for All by 2000 AD" much earlier and sustained them over a period of time. This included significant reduction in infant and maternal mortality, birth rate, malnutrition, and vaccine preventable and communicable diseases, and increase in the coverage of maternal care and immunisation. Another important achievement was raising the level of health awareness in the community. All these achievements were made possible by forming cadres of village level volunteers (*anganwadi* workers, *dais* and community health volunteers), and middle level male and female multipurpose paramedical workers. On successful completion of the project after 15 years, the PHC was returned to the government in 2000.

(iii) Community Health Project: Safe Motherhood and New Born Care

After the return of the PHC to the government, SEWA-Rural continued its community health service with the project of *Family Centred Safe Motherhood and New Born Care*. The project, started in 2003, covers 168 villages in Jhagadia block (a population of 172000) and is managed in partnership with the district and block level government health department. The main objective of the project is to develop an evidence based model to reduce maternal and neonatal mortality and morbidity in resource poor settings.

Over 3000 pregnancies are registered and followed up every year so as to ensure appropriate care at all levels. Community level and family centred interventions are introduced for ensuring proper antenatal care (including birth preparedness to ensure safe delivery and complication readiness to handle any complications during delivery), intranatal and postpartum care. This has been made possible by building up a cadre of frontline volunteers who included village level women (about 165 *arogya sakhis*) and trained birth attendants (TBAs) - the *dais*. About 100 of them

are active at present in certain pockets, while the rest have been gradually weaned out. For referral of complicated cases from periphery to the base hospital, a sound communication and transportation network has been established.

During the year 2010-11 the number new antenatal registrations was 3459, and 1869 mothers were referred to the hospital for treatment. Hospital delivery accounted for 65 per cent of the cases in the same period. The number of women who were provided treatment by the *arogya sakhis* was 23529 during 2010-11. In the same year 14 gynaecological camps attended by 794 women, and 63 mobile medical van visits attended by 1505 patients were organised under the community health project. The frontline volunteers are confident as they have the assurance of SEWA-Rural's base hospital, which provides round the clock comprehensive emergency obstetric and newborn care, and is also recognised as a first referral unit by the government of Gujarat and the UNICEF.

It is encouraging to note that more and more complicated high risk maternal and neonatal cases are now reaching the base hospital. The micro level interventions have resulted in significant reduction in maternal and neonatal mortality over the past few years. As per the data of the year 2010-11, there has been reduction of about 70 per cent (from 19 to 5) in cases of maternal deaths and of 38 per cent (from 47 to 29) in neonatal mortality rate as compared to the baseline data of 2002-03. There has been significant improvement and expansion in the various services. Coverage of prenatal care and birth preparedness increased from 68 to 83 per cent, and complication readiness, from 67 to 88 per cent. Institutional delivery rate has increased from 22 to 65 per cent, use of pre-sterilised delivery pack at home delivery increased from 10 to 72 per cent. In postpartum care more than 80 per cent of the mothers and new born babies were followed up and given appropriate home based care. SEWA-Rural was conferred the international "Mac Arthur Award in the Category of Creative and Effective Institutions: 2007" for its pioneering work in saving the lives of mothers and their babies in India.

(iv) Comprehensive Eye Care Programme

The unique comprehensive eye care programme, initiated by SEWA-Rural in the year 1988, was born out of the need of the rural community as well as availability of competent committed manpower. The programme, for which young friends well versed in eye care were drawn to the ideals of SEWA-Rural, encompasses all components of eye care (prevention, promotion and rehabilitation). The eye programme has modern facilities like operating microscopes, diode and yag lasers, auto refractor, phaco-emulsification and automated perimeter. The programme provides modern treatment of eye diseases with advanced equipments in hospital as well as in *netra raksha kendra* for tertiary eye care. Arrangements have been made for operations by microsurgery like keratoplasty and intraocular lens (IOL) placement for cataract. Spectacles are made available in the hospital premises as well as at camp sites at low cost through optical shops.

Diagnostic eye camps are regularly organised in the interior villages of the districts of Bharuch, and adjoining parts of Narmada, Surat and Vadodara in the state of Gujarat. The number of camps held during the year 2010-11 was 96. The local community generally does the necessary publicity in the surrounding area of the proposed camp site. As a result, people get treatment and spectacles (if necessary) near their homes. Patients with cataract are identified and brought to the hospital at Jhagadia on the same day. Similarly they return home the next day following the operation. Hundreds of old persons who used to live a dependent life are now living a new life following the restoration of their vision. SEWA-Rural is also an eye ball collection centre registered with the Eye Bank Association of India.

During the year 20010-11 the total number of the OPD patients was 51688 (24909 in the hospital at Jhagadia, 21270 in the diagnostic camps and 5689 in the satellite centres). There were 11514 cases of auto-refraction, 5367 eye sonography, 5627 operations and 4629 IOL implants during 2010-11. As a result of the financial assistance provided by different philanthropic trusts, well wishers and local community organisations, about 75 per cent of the patients get free treatment.

SEWA-Rural is a member of the Vision 2020 Right to Sight India Programme which is an advocacy group for realising the goal of the national programme for control of blindness. The eye care programme of SEWA-Rural is contributing to the realisation of the WHO goal of vision 2020 in the area of its operation. Under the eye care programme of SEWA-Rural, Jhagadia and Valia blocks were made cataract free as per the guidelines of the WHO in 2000. However, it has been a struggle to sustain the cataract free status during succeeding years. In the year 2008 SEWA-Rural received the award for outstanding work in the field of community ophthalmology from the Community Ophthalmology Society of India.

(v) Training Centre for Community Health

Many organisations and individuals have been looking forward to learn the lessons from the SEWA Rural's experiences mixed with stories of success and setback. In order to facilitate this, a training centre was established in 1990 with financial assistance from the USA based Share and Care Foundation which was initiated by Indians settled in America. A new state of the art resource and training centre was built at Gumandev, 4 km from Jhagadia with financial assistance of MacArthur Foundation (USA) and National Rural Health Mission of Government of India. It was inaugurated on 18 February 2010.

The centre offers training and orientation programmes in the area of community health. It is also a resource centre for students and professionals engaged in community health, and functions as a site for field placement of students of public health, medicine, social work and community development. Students from various institutions in India and abroad, workers from voluntary organisations (including the grassroots level workers of the health projects of SEWA-Rural) and intern doctors from medical colleges of Gujarat avail of the resources and programmes of the training centre.

Every year over 1000 trainees from more than 50 varied organisations benefit from the programmes conducted at the training centre of SEWA-Rural. Various training programmes and workshops are also

organised for the workers of SEWA-Rural so as to enhance their competence and knowledge, and strengthen their involvement with the core values of the organisation. During 2010-11 the training centre conducted 51 formal training programmes attended by 1389 trainees from 44 organisations. In the same period there were 24 orientation programmes attended by 100 participants from 20 organisations, while 394 students from 17 educational institutions benefited from 25 field placement programmes at the centre.

II. Other Activities and Programmes

In addition to health activities, SEWA-Rural has been involved in many other activities. The main activities of SEWA-Rural beyond the health field include (i) community based rehabilitation programme for the visually challenged, (ii) Vivekananda Gramin Tekniki Kendra for vocational training of youth and (iii) programmes for empowerment of women including the formation of Sharada Mahila Vikas Society.

(i) Community Based Rehabilitation of Visually Challenged

The project for rehabilitation of the visually challenged was added to the comprehensive eye care programme of SEWA-Rural in 1997. A survey was undertaken for the project in order to identify curable cases of visual disability for treatment at the hospital and for rehabilitation of the other cases. The SEWA-Rural experiment of adding primary eye care to traditional community based rehabilitation has been unique. This includes school screening, identification of cataract cases, distribution of vitamin-A capsules, vaccination, health education and primary treatment. Visually challenged elderly persons have been given training for mobility and youth have been trained for economic rehabilitation in different vocations, like petty shop and animal husbandry. They have also been assisted in availing of the benefits of the government schemes, like certificate of visual disability, free bus pass and pension.

Several persons with incurable visual disability have been rehabilitated economically under this programme. Many of them have been

provided with interest free loans by SEWA-Rural. Some of the young beneficiaries of the programme have been sent to Tatawadi Fansa - a semi-government agricultural training centre for rehabilitation of the visually challenged - for a two year free training in agricultural activities. Nineteen of the youth who completed this training were supported financially by Tatawadi Fansa to purchase land or agricultural equipments or start a flour mill. Children with permanent visual disability are being educated in their village schools or in special schools with the help of Braille teachers under integrated education programme. Financial assistance from the Sight Savers International and government of India is made available for this programme.

The programme of community based rehabilitation for the visually challenged, that began with Jhagadia block in 1997, was gradually expanded to other six blocks (of tribal majority population) in the next decade covering a population of about 700000. During the fourteen years of this programme, 820 visually challenged persons of all ages have been rehabilitated in different ways based on their age, physical condition and family requirements. Out of these, 44 children are attending regular school in their own villages at present and are largely supported by Braille teachers of SEWA-Rural. In addition 49 children from the area have been placed in various special schools for visually challenged in Gujarat and are continuing their study with the active support of SEWA-Rural. During these years, 55 visually challenged youths in their productive life were given special training in different vocations along with continuing support and guidance for economic rehabilitation, and they are gainfully earning in their village setup at present.

(ii) Vivekananda Gramin Tekniki Kendra

Youth of poor families in rural India are trapped in a vicious cycle of poverty, ignorance and lack of opportunity. To bring about some change in this situation and to provide opportunities to the deprived youth, a vocational training centre - *Vivekananda Gramin Tekniki Kendra* (VGTK) - was started by SEWA-Rural in 1987. With significant financial assistance from the tribal development department of Gujarat government under the scheme of *vanbandhu kalyan yojana* and USA based well wishers, the VGTK

was expanded and revitalised since April 2009. This assistance brought about the long felt renovation of the VGTK which included replacement of old fabricated buildings constructed with low cost housing technology, and machinery. With these grants new constructions of workshops, hostels and classrooms are being undertaken, new facilities like computer lab, modern machinery and audiovisual aids are added, course modules are updated and being formally certified, and the student strength is also increased.

The centre offers training in skills like turner, fitter, welder, gardener, electrician, and environment plant operator. The centre also provides training in skills for self-employment such as masonry, carpentry and motor mechanism. Besides technical competence, the centre holds other activities such as group prayers, sports and library reading. There are also activities for inculcating the values of discipline, punctuality, self introspection and hard work for value based life. Since 2009-10 duration of the present courses has been extended to two years, in which the second year is devoted to on the job training in collaboration with industries for the students already employed in industries and getting salaries. In addition, the centre has recently added a few new short-duration courses of 3-6 months, like basic computer skills, garment making, vision technician, and one year courses for nursing assistant and laboratory assistant.

It is an arduous task to enable the children from poor families to come out of grinding poverty through vocational training and subsequent gainful employment. As they hail from interior rural and tribal areas, the young trainees of the VGTK naturally face some difficulties at the training centre as well as in industries. But they overcome them, and more and more young people are satisfactorily completing their training. This has been possible due to the support from various sectors of the larger society, including the government, and the committed efforts of the teachers. The trainees who complete the programme at the VGTK are earning reasonably well, and thereby contribute to the betterment of their families. Over the years, the reputation of the students of the VGTK has grown, and now almost all of them get absorbed in industries. The close collaboration of SEWA-Rural with government and industry is a unique feature of this venture. At present about 200 youth are trained in the VGTK every year.

(iii) Empowerment of Women

From the outset, women have been at the centre of most of the activities of SEWA-Rural. Several specific programmes for women have been started over the years. They include the income generating activities of *papad* making and garment making, and saving and credit group.

(a) Papad Making

Begun in 1985, *papad* making was the first formal venture of SEWA-Rural in non-health area. It was started with the understanding that women from disadvantaged sections of the society needed to be empowered and made aware of their rights and potentials through a multi-pronged approach, which included income generating activities. In the absence of any local traditional crafts or skills, groups of tribal and rural women were trained in *papad* making skill. After the initial struggle, a number of women now earn Rs.80-100 a day, all at or near their homes. In 2010-11, 59490 kg *papad* was produced and the total earning of about 100 women engaged in *papad* making was Rs.13.03 lakh (1.3 million). Some of the older groups of women now show remarkable understanding and courage in facing adverse social situations, and it is planned to devolve as much power as possible to the groups.

(b) Garment Making

Another initiative for the economic betterment of women - garment making - was started in the year 1998. Introduction of this activity followed informal surveys and focus group discussions among women about their needs, skills and potentialities. The garment making activity has considerable potential for growth and expansion in view of the large industrial units nearby requiring uniforms for their workers. Garment making has succeeded in helping women earn Rs.60-80 a day and about Rs.5 lakh in total by about 25 women during the year 2010-11.

(c) Savings and Credit

The savings and credit programme for women began in 1987 with the objective of reducing their dependence on money lenders and preventing them from getting into perpetual debt. Special training sessions were conducted for the members and group leaders for their capacity building in previous years. It is encouraging to note that the group members have now become independent since 2006 in managing their affairs. There are 7 women groups formed so far having 101 women members in total. The saving of all the groups was Rs.1.23 lakh during the year 2011–12, while cumulatively it amounted to Rs.10.76 lakh by March 2011 since 2006. The main purposes, for which loan is provided to the members, are children's education, house repair, family functions, and agriculture and other economic activities. The total amount of the loan disbursed to 74 women members during 2010-11 was Rs.2.84 lakh. The regularity rate of loan recovery has been 94 per cent.

Sharada Mahila Vikas Society

Involvement of women in the above mentioned programmes for women's development led to the formation of an independent women's organisation, named as the Sharada Mahila Vikas Society. It was promoted by SEWA-Rural in July 2002. Since then all women related activities are carried out under the aegis of the newly formed women's organisation. It functions independent of SEWA-Rural and women groups have all the say in its affairs.

Economic activities involving women - *papad* making and garment making - have been the main focus of the organisation. But gradually educational activities for children and awareness programmes for adolescents and women are being held by the organisation. Different activities, like excursion, games and discourses to increase general knowledge have been increasingly undertaken for children during the time of school vacation. Adolescents are provided interactive sessions on various topics, such as bodily changes and associated questions, substance abuse, environment awareness and practical

knowledge about public services through visit to post office, bank, panchayat office etc. The women groups as well as adolescent girls serve as nodal points for initiating discussions on broader women's issues, like atrocities on women, alcohol abuse, unwed pregnancies, and reproductive health disorders in camps conducted in villages as well as nearby schools.

CONCLUSION

There are 182 full time employees engaged in different programmes and activities at SEWA-Rural. About 75 per cent of them have completed more than 10 years. It is the environment of team spirit, group leadership, delegation and decentralisation of authority and power with the focus on building a second line cadre that has built the sense of owning the organisation among staff members. The founding members have purposefully relinquished the position of the managing trusteeship in course of time and handed over the reins to two young members from within the staff. The organisation has adhered to the values and norms evolved and nourished during the last three decades in its creditable alliance with the other voluntary organisations and the government. They have ensured transparency and accountability at all the levels of the organisation, and thereby the credibility of the organisation all these years.

SEWA-Rural has remained indebted to several individuals, philanthropic organisations and the government for the continuous support and encouragement they have given for its different activities. First and foremost their support to SEWA-Rural has come in their function as the financial sources. Secondly, the social recognition of the work of SEWA-Rural in the form of awards from different sectors of the society has been encouraging it in the endeavour of service to the poor.

SEWA-Rural believes in taking assistance from all sectors of civil society including the government. The major sources of SEWA-Rural's funds have been Gujarat state government grants, international funding agencies, and donations from the varied Indian sources, such as charitable trusts and industries, and well wishers from India and abroad. In addition, some income is generated from the nominal hospital charges and income generation activities of women.

SEWA-Rural spends about Rs.4.75 crore for its recurring expenditure at present. Dependence on government grant has steadily been reduced. During the years of 1985-1990 it was about 56 per cent of the total funds of SEWA-Rural. The share of government grants declined to just 20 per cent during 2005-2010. It is a healthy sign for any voluntary organisation. Similarly receipts from indigenous resources have steadily increased over a period of time and which now stand around 25 per cent of the revenue expenditure. Likewise the support from larger civil society including well wishers, and foundations from India as well as abroad have continued to support SEWA-Rural for the ongoing expansion beside the continuing activities for the poor and marginalised sections of the society. The whole hearted support and encouragement of the government and different sections of the civil society have ensured that the fruits of development ultimately reach the marginalised and underserved sections of society.

The work, rendered by SEWA-Rural in the field of health, education and other social services for the rural poor and tribal community, has been widely acclaimed as pioneering. In recognition of this admirable service, SEWA-Rural has received several awards from different sectors, including the international agencies, the WHO and the Mac Arthur Foundation. Awards within India have come from various national, state and local level agencies. These gestures from the larger society have been a great source of encouragement to SEWA-Rural in its relentless pursuit of service to the poor – to uplift the last person of the poorest of poor - through its community based rural and tribal development activities.

NOTES

@ The website of the Society for Education Welfare and Action – Rural is: www.sewarural.org.

*The authors have extensively used the available annual reports published by SEWA-Rural and the in-house documents prepared on its different activities and programmes.