

**Tackling Social and Economic
Determinants of Health through Women
Empowerment**
The SEWA Case Study

Draft

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**W H O – SEARO
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GLOSSARY

Aagewans	Local leaders
Agarbati	Incensed stick
Awas	Housing
Bharat	India
Bidi	Local cigarette wrapped with leaf
Chipko Movement	Clinging movement
Dais	Midwives
Ghee	Clarified Butta
Grameen	Rural
Gram Haat	Rural Market
Gyan Vigyan Kendras	Knowledge and Science Centers
Jeevan Shala	Home for life
Lok Swasthya	Public Health
Mahila	Women
Mandal	Group
Papad	Spicy Bread
Parivartan	Change
Pratinidhis	Representatives
Pucca Houses	Houses made of brick
Rupee (Rs.)	Indian Currency
Sampoorna Kranti	Total Revolution
Sangini	Companion
Sahkari	Cooperative
Shramshakti	Labour Strength
Shri	Mr.

ACRONYMS

PHCs	Public Health Center
SEWA	Self Employed Women Association
CSWI	Commission on the Status of Women in India
TLA	Textile Labour Association
WWF	World Wild Fund

EXECUTIVE SUMMARY

It has been realized by social scientists, health organizations and other providers of health care that great improvements in health standards of marginalized groups can be realized through improvements in social determinants of health. The present study attempts to document the general and specific contribution of SEWA to improving the social determinants of health through women empowerment. An intensive review of SEWA publications, impact studies of SEWA activities, supplemented by field visits and direct interaction with SEWA members has helped to unravel the linkages between women empowerment and health improvement of a family or community.

The 1970s saw an increase in social activism and action by non governmental agencies in the field of development in India and other parts of the world. SEWA or the Self Employed Women's Association was founded in Ahmadabad in 1971 by a small group of poor and largely illiterate women. SEWA worked to achieve social and economic wellbeing of women through its twin goals of full employment and self reliance. Its founding members like Ela Bhat turned SEWA into a social movement across various states of India. At present, with nearly 800,000 women members, SEWA is the largest trade union in India.

As economic security was crucial to empowerment of women, SEWA sought to offer full employment to produce income security to its members. As a trade union, it organized its members to demand fairness and justice and fight for the right to seek a livelihood. Members were infused with self confidence to fight against harassment at the hands of the police and municipal authorities. By organizing themselves into trade and service based cooperatives, members increased their ability to bargain with middlemen and contractors. Realizing the need for banking services that conventional banks were not able to meet, members started their own cooperative SEWA bank. The Bank now provides micro credit to its members. Loans from the bank are packaged with programmes to train members in skills that enable them to start or expand their businesses. Bank also provides integrated insurance schemes to protect members from property and assets losses resulting from natural calamities and physical illness.

Members' ability to work was found to be impaired by their own ill health or the poor health of family members. Health care services were found to be lacking and SEWA stepped in to provide and strengthen preventive and curative health care. Preventive health care primarily includes health education and awareness, immunization and micronutrient supplements to expectant mothers and health insurance. Curative care includes improved physical and financial access to health care provided by trained health workers (barefoot doctors and other paramedics) and the sale of low cost western and indigenous medicines. VIMOSEWA, a health insurance cooperative, offered health insurance packages to SEWA members and their families at an affordable cost to meet primarily emergency health needs. Likewise, the Mahila Housing Trust offers loans to purchase a house or for expansion and improvement of existing house. It also partners other organizations to improve the quality of life and enhance income generating capacity of slum dwellers through assured provision of drinking water, sanitation and power.

These and several other facilities and services provided by SEWA have played a major role in empowering women. On the economic front they find more regular employment.

Most of them have experienced an increase in income as a result of being able to devote more time to work, improved skills, better marketing facility and working conditions. They are also able to put aside a small amount of money in their bank account on a regular basis. Loans from the bank have allowed some of them to acquire assets for the first time in their lives. The Housing Trust has helped them to improve the quality of their housing and many of them have access to drinking water, toilets

and electricity. This has had a positive effect on their work efficiency as well as on their health outcome. More children are now able to attend school as their labour is no longer needed to complete domestic chores. The greatest positive impact of empowerment through membership of SEWA is to be seen in the increased confidence and self esteem of its members. They take great pride in being members of SEWA and are no longer afraid to raise their voices against injustice and approach appropriate authorities with their problems. Most of them also report a greater decision making role in affairs at home and confess to being treated with greater respect by their husbands and other members of their families. Leadership quality promoted among many members helps SEWA in spreading the benefits of social movement and it empowers the member as well.

The secret of SEWA's success lies in its organizational structure and its strategy of networking and forging partnerships with other like-minded agencies. Its organizational strength comes not only from its large membership but also from the fact that most of its leadership is derived from among its grassroots members. Its partnership with governmental and non governmental agencies has worked to its own advantage and also to the advantage of its partners and their beneficiaries. It has also networked successfully with other organizations working in similar areas to advocate the cause of its members and lobby for favourable policies and legislation at national and international fora. It has adopted an intersectoral approach to produce synergy among its various wings to benefit the members of its services in an integrated manner.

The SEWA experience has proved that poor self-employed women are bankable and insurable. It has also shown that given the right guidance, poor, illiterate and semi-literate women are perfectly capable of identifying their problems and finding solutions to them. The other lesson that can be learnt from the SEWA experience is that the poor benefit more from health services if these are made available at the doorstep and by the health providers from their own community. Large investment in health care infrastructure are not needed, at least for the poor, as they suffer more from avoidable episodes of water-borne and air-borne diseases. Regular supply of drinking water, adequate housing and proper sanitation can make a substantial difference not only in their health status but also in income generation. Despite its success, there are some challenges that SEWA needs to tackle. While many members have increased their income earning capacity, they continue to remain below or only marginally above the poverty line. SEWA must prepare them for trades and occupations where incomes are substantially higher but where the security net of SEWA may not be available. SEWA needs to prepare its members for globalization challenges that threaten the small enterprises with import of cheap consumer goods.

The study clearly establishes that access to micro finance, secure full employment; improved housing with access to water and sanitation; preventive and low cost curative health care at doorstep can empower the large weaker sections of a society and in turn improve the health of all community members. These emerge the best determinants of health from the SEWA study. Capacity building, partnership, networking and self reliance remain the primary instruments of change.

Tackling Social and Economic Determinants of Health through Women Empowerment

The SEWA Case Study

1.0 : Introduction

There is a growing realization now by social scientists, health organizations and other providers of health care that great improvements in health standards of marginalized groups and general health equity gains can be realized through improvements in social determinants of health. Identification of such determinants, however, remain elusive to define and are primarily contextual. In the present case study, we attempt to document the general and specific contribution of SEWA to improving the social determinants of health through the process of women empowerment.

The study primarily addresses the following four objectives:

- To review the literature associated with women empowerment as it relates to health, economic, education, housing and general welfare;
- To document the historical milestones regarding the establishment of SEWA including major social and political influences and events through review of relevant literature and interviews;
- To identify key features of SEWA empowerment potential and process that allows it to perform in an integrated and intersectoral manner in addressing the health outcomes and welfare of women in order to promote and improve health;
- To disseminate findings to a wider audience that is involved in improving health outcomes of self and others.

Self-Employed Women's Association (SEWA) is an organization of poor women who struggle to support themselves and their families through hard labour and with a great deal of resourcefulness. It is unlike a conventional trade union where all members are already in employment, have the same employer, and a fixed workplace and a well-defined employer-employee relationship. The members of SEWA often have no definite employer and are frequently in competition with one another for the same work. They may work from home, or may be out in the streets, market places or farms and fields to eke out a living. As self-employed women, they need year-round work, fair wages, training to upgrade their skills, maternity protection and childcare, small loans to purchase raw materials and work tools, and legal help to fight against exploitation in the market. By ensuring these, SEWA has become a movement, which works towards the development of the whole human being and not just the worker. This is in keeping with the Gandhian ideology that it has adopted. The guiding principle behind the running of the organization includes self-reliance, sustainability, social justice and social security. The broader vision is participation, integration and interdependence of the various units of SEWA, as it believes in the relevance of local ownership and knowledge.

1.1 : Historical Milestones of SEWA

1.1.1 : Socio-Political Conditions at the Time of its Formation

Leslie Calmen believes that in the 1970s there were several factors that favoured the rise and growth of activism and grassroots movements in India (Calmen, 1989). The ruling Congress

party had split and the faction led by the then Prime Minister, Mrs. Indira Gandhi had little connection with the masses. Political unrest was widespread and Jai Prakash Narayan's call for 'sampoorna kranti' was catching the imagination of the people. India had been an independent nation for over two decades but the government had little to show by way of achievement as far improvement in the quality of life of the masses was concerned. The younger generation was disillusioned and ready to take matters in their own hands.

May 1975 saw the release of *towards equality* Report of the Commission on the Status of Women in India (CSWI). The Report documented the sorry state of women in India and called for government action as well as a social movement for their uplift. Other factors too favored the growth of social movements like SEWA. By then, there were many highly educated women who were engaged in political work as members of trade unions and political parties. Women research scholars and institutes dedicated to research on women's issues also highlighted the poor status of women in India. (Calmen, 1989) The press too played its part in publicizing their cause. Ideological inspiration came from women's movements in the west, together with financial and ideological support.

Several women's movements were thus launched in different parts of India at this time. Ela Bhatt started SEWA in Ahmedabad. Jaya Arunachalam, a long time Congress activist started the WWF in Madras (now Chennai) while Prema Puro started the Annapurna Mahila Mandal in Mumbai. Numerous agitations that started in rural Maharashtra and other parts of India also had women in the forefront. The Chipko Movement on forest protection that started in the Garhwal Himalayas under the leadership of Chandi Prasad Bhatt showed how women could be mobilized to confront not only outside forces but even men from their own communities in order to protect their legitimate interests.

On the international level too, the 1970s saw two important realizations. The first, that community organization was a key prerequisite for development. Second, that woman constituted an important part of any community development. As a result, international agencies were looking for non-governmental organizations that were working with women at the grass root level through which to canalize their funds for development work.

1.1.2 : Founding of SEWA

SEWA was founded in Ahmedabad, one of the leading industrial cities of India. In the twentieth century, Ahmedabad emerged as the hub of the textile industry. Its many mills provided direct and indirect employment to thousands of people. One of the first trade unions in India, the Textile Labour Association (TLA) was founded here under the guidance of Mahatma Gandhi and Anasuya Sarabhai. Inspired by the two, Ela Bhat joined the TLA as a lawyer in 1955. By 1968 she was head of TLA's Women's wing and had the responsibility of organizing sewing and typing classes for the wives and daughters of textile workers. These women often worked in the informal sector in order to supplement the family income. Ela Bhat thus came into contact with women who stitched, embroidered, vended vegetables, rolled *bidis* and *agarbatis* and did all sorts of petty work to earn money. They had irregular income, no job security, and lower wages than the organized sector and were subject to exploitation by moneylenders, contractors, policemen and municipal authorities. Such issues were not addressed by other trade unions, government legislation and policies. The worst was

that their work had no recognition. They were ‘invisible’ workers. Ela Bhat realized that this was the fate of 94 per cent of all women workers in India.

In 1971 Ela Bhat and the TLA were approached by a group of head-loaders and cart pullers. These migrant women were living on the footpath and sought help to solve their housing problem. Ela Bhat soon realized that housing was only one of the many problems these women faced. Being illiterate, they were cheated by merchants and deprived of money due to them. Of the cart pullers most did not own carts and a substantial part of their daily earnings were retained by the cart owners as rent. Their plight was highlighted by Ela Bhat in articles written to local newspapers. This initial success inspired several other exploited groups of women from the informal sector to approach the TLA. It was soon apparent that though the nature of their work was different, several problems they faced were common. A meeting of women working in the informal sector was convened and their problems discussed. This was followed by the birth of SEWA in December 1971 (Annexure 1). It could, however, be registered only in April 1972 as Indian labour laws had trouble accommodating a trade union where no formal employer-employee relationship existed.

1.2 : Objectives of SEWA

SEWA **organizes** the individual and voiceless women through various economic activities. SEWA’s approach to organizing is area specific and demand driven. Initially rural workers were organized for providing the minimum wages; later SEWA shifted its focus on livelihood and employment protection and promotion.

The main objective of SEWA is to organize self employed women for their social and economic uplift. They work for the deliverance of **full employment** to its members to help them achieve work security, income security, food security and social security. The other important objective is to organize women for **self reliance** at both individual and community levels to empower them both economically and in terms of decision making abilities. These twin goals of SEWA are achieved through the strategies of struggle and development. The former tries to remove the constraints and limitations emerging due to the poor socio-economic conditions of the targeted population and the latter tool strengthens the women’s economic status, thereby enhancing and achieving social security in the form of better maternal and child health care, educational attainments and improved housing conditions. All these subsequently led to improved health outcomes. Ela Bhatt strongly believed the dictum that “health is wealth”

SEWA as an organization and movement have worked for the empowerment of women through various modes and pathways to protect their livelihood and equity issues. The members themselves have evolved a yardstick to evaluate the success of its programmes (SEWA Annual Report, 2005). This yardstick is in the form of the following 11 questions:

1. Have more members obtained more employment?
2. Has their income increased?
3. Have they obtained food and nutrition?
4. Has their health been safeguarded?
5. Have they obtained childcare?
6. Have they obtained or improved their housing?
7. Have their assets increased? (like their own savings, land, house, work space, tools of work, licenses, identity cards, cattle and shares in cooperatives all in their own names)
8. Has the workers’ organizational strength increased?

9. Has workers' leadership strength increased?
10. Have they become self – reliant both individually and collectively?
11. Has their education increased?

1.3 : Membership and Organizational Structure

Encouraged by its success in Ahmedabad, SEWA spread its activities to other parts of Gujarat and to other states of India. All these centers together form a federation known as SEWA Bharat. The aim of SEWA Bharat is to highlight the issues of women working in the informal sector at the national level. Due to the intense efforts of Ela Bhat and SEWA, the Central Government set up a Commission on Self Employed Women in 1987. With Ela Bhat as Chairwoman, this Commission set up many task forces to study the status of self-employed women in the country. It published a report entitled *Shramshakti: Report of the National Commission on Self-Employed Women and Women in the Informal Sector*. The report succeeded in highlighting the plight of women workers in the informal sector at the national level.

SEWA has now huge membership strength and large spatial reach. The total membership has grown steadily from 1070 in 1972 to 796,755 in 2005, making it the largest single trade union in the country and perhaps in Asia. The membership swelled largely after 1995. The largest membership is from the state of Gujarat (60 percent) followed by Madhya Pradesh. Till 1991 SEWA's membership was confined largely to Gujarat state which later spread to other states. More than 70 % of the membership is from rural areas and is fairly distributed across various religious and caste groups (SEWA Annual Report, 2005).

Its members are organized at various levels based on area, city and trade. They are broadly categorized as

- Home-based workers like weavers, potters, bidi and agarbatti rollers, papad makers, makers of ready-made garments and processors of agricultural products,
- Hawkers and vendors and small businesswomen,
- Manual labourers and service providers like agricultural labourers, construction workers, handcart pullers, head- loaders, domestic workers and laundry workers,
- Producers like artisans.



Picture (1-3): SEWA members engaged in Income Generating Activities (Agarbatti, Bidi making, Embroidery)



These women workers are vulnerable due to their poor socio-economic conditions, no assets or working capital and little social security. They can become a member of SEWA by paying a membership fee of Rs.5 per year. The number of women in the manual labourers and service providers categories are the highest (70 percent) followed by home based workers. This reflects the nature of work these poor women are required to do with little income at their disposal for their survival. SEWA has worked more towards the issues of such rural women (68 percent) who are living below the poverty lines and are facing economic

constraints.

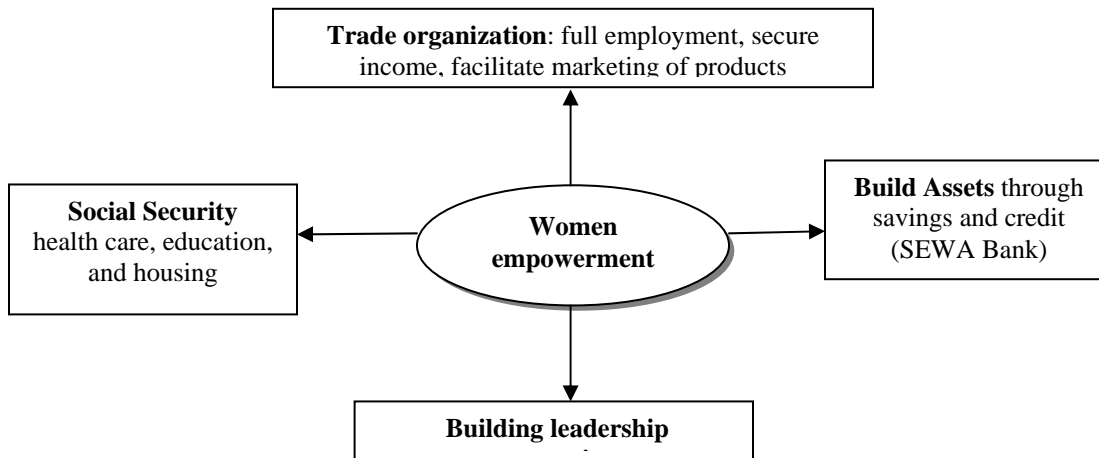
SEWA has a dedicated team of elected leaders (executive members, trade council members, aagewans) to discuss policy and business matters, performance of various cooperatives and trade organization and other management issues. In addition to Ela Bhatt, committed and professional leaders like Renana Jhabwala looks after its organizational activities. Mirai Chatterjee, who has a degree in public health from Johns Hopkins University, looks after its health related activities. Jayashree Vyas, who has experience of banking in the public sector, heads the SEWA Bank. SEWA Mahila Housing Trust is headed by Bijalben. Martha Stewart initiated the creation of Video SEWA which ideographs SEWA activities and helps with educational and publicity work.

1.4 : SEWA as a Social Movement

SEWA has worked at all levels and hierarchies. The monthly meetings of the SEWA workers helped them to know the issues and problems associated at all the levels concerned. This strategy of organizing community with a blueprint makes SEWA more transparent and result-oriented. It has identified and organized the primary organizations at local level. Organized Campaigns for recognition of Dais, child care as a basic service (FORCES-Forum for child care and services), forest workers and agricultural labourers at the national level. At international level it has organized workers movement in African countries, south East Asia, Turkey, Yemen and SAARC countries. SEWA has contributed in the labour movement, cooperative movement, women's movement, self-employed movement, and health movement within India and abroad.

SEWA has placed emphasis on consensus, and attempts to build a movement that would achieve sustainable and improved economic status for women within the unorganized sector. SEWA recognizes that struggle without collective strength or development without infrastructure support is ineffective and has facilitated the means to build up both collective and individual strength. Almost two-third of its members are not protected by any form of work legislation and continues to organize them through unionizing. SEWA thus came together as a composite union of self-employed women. There are three major aspects of SEWA that are shown in the figure (1) below:

Fig.1: Role of SEWA as an Organization



Source: Author

The various SEWA organizations operate at village, district, state, national and international levels. These are registered as cooperatives, societies, producer's association, or remain unregistered. All the SEWA organizations are owned, managed and run by them with only necessary assistance from professionals. All these organizations are independent entities in themselves (Annexure II).

The success of local organizations depends upon their link to all other administrative units in the hierarchy and through accessibility to markets, to training and to technical inputs. Hence the policymaking is crucially linked to these primary organizations. The above organizations are democratic, self-managed and sustainable in terms of their functioning. These organizations by working on the principle of self-reliance produce individual and collective empowerment.

2.0 : Views on Women Empowerment

Women, although they constitute half of humanity, are socially, economically and politically marginalized. They are seen primarily as wives, mothers and home-makers rather than as workers, because their reproductive role is given prominence over their productive role. This has kept them away from playing a significant role in the public domain in almost every part of the world. The large amount of work they do in looking after the home and family is unpaid, unnoticed and unrecognized. Not only this, but a large amount of income-generating work that they do in and around the house also goes unnoticed and is not computed in national income statistics. When they do step out of their homes to seek work in public spaces, they are discriminated against, exploited and become vulnerable to harassment and violence. In some society's right from her birth till death, the female receive an unfair deal in comparison to her male counterpart. The situation is worse in the less developed world, where poverty, malnutrition and certain social customs worsen her plight

2.1 : Process of Empowerment

For the past several decades, national governments, non-governmental organizations and international agencies have been aware and concerned about the status of women. Efforts

have been made by these bodies to improve women's literacy, nutritional and health levels and enhance their income-earning capacity. Various strategies have been adopted to achieve these ends, with varying degrees of success. Initially it was believed that economic growth would automatically lead to improvement in the status of women. When it was realized that such improvement was not forthcoming, women were made the recipients of numerous schemes specially designed for their welfare. Even these schemes failed to bring about substantial change in the position of women as they did nothing to change the economic, political, social and cultural forces that contributed to their marginalization. In the 1980s and 1990s it was realized that improvement in the status of women (and other marginalized groups) would only be achieved through structural changes in power structures which gives them greater control over their own lives and also the world around them. This could only be achieved through empowerment.

The World Bank's 2002 Empowerment Sourcebook identifies empowerment as "the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives." Empowerment is the means by which a relatively powerless individual or a group of individuals attain power. Rappaport defines empowerment as an attempt to "enhance the possibilities for people to control their own lives" (Rappaport, 1981, 15). Vanderslice (1984) includes within the concept of empowerment of individuals, the ability to influence those people and organizations that affect their lives and the lives of those they care about. Empowerment is both a process as well as an outcome. As a process empowerment helps relatively powerless people. They work together to increase control over events that determine their lives. It gives them freedom of choice and action. Power or control is not granted to them by other agencies, rather they themselves must obtain it. The process of redistribution of power is not always smooth but often involves resistance from and conflict with the structures, systems and institutions that are disempowered. External agencies can provide guidance and create conditions conducive to the shift in power relations between different individuals and social groups in favor of those seeking to be empowered. As an outcome, empowerment is the product of redistribution of resources and decision-making authority. It is reflected in the increased sense of self-esteem in the empowered individual or group of individuals.

UNICEF's empowerment framework involves five hierarchical levels. The first level of empowerment is the *welfare level*. At this level, women are passive recipients of schemes designed to remove gender gaps in material well-being. At the level of access, women's access to resources, such as land and credit, is improved. At the third level of *conscientization* women become aware of discrimination against them and identify and remove obstacles that work against them. This leads to the level of *participation* when women begin to take part in resource and power allocation. The final stage of *control* is achieved when women begin to control and direct events that affect their interests. Empowerment can be considered complete only when women gain control over themselves as well as over resources and factors of production and participate in decision making at home and in the public arena.

2.2 : Empowerment and Health Disparities Reduction

Inequalities in health in a society are the outcome of unfair distribution of power between different groups within that society. Power relations within a society influence the

distribution of resources and the development of policy. This is why economic development and changes in the health care system by themselves have not been able to enhance the health status of marginalized groups to the extent desired. A case is now being made for using empowerment, together with economic development and health sector reforms, as a strategy for reducing persistent disparities in health and quality of life across gender and ethnic groups (Kar et.al). It is believed that in the process of empowering itself, a group or community would tackle the underlying social, structural and economic conditions that impact on its health. As a result, it would gain more control over the social determinants of health.

Kar et. al justify the empowerment of women for better health for all on the following grounds :

- (i) In spite of longer lifespan, women suffer a greater burden of health risks and abuses;
- (ii) Women are the primary caregivers in almost all families;
- (iii) Women spend their discretionary money and time differently (from men), with priorities on better health and quality of life for children and family; and
- (iv) Compared to men, targeted education of women regarding health results in greater health benefits to children and families.

Thus empowerment of women leads to better health for women and also to children, families and communities. There are many examples of empowerment strategies initiated by various agencies. Sometimes the marginalized group itself has taken the initiative while at other times governments, civil society groups and international agencies have played the lead role. **Reprosalud** works towards the empowerment of economically disadvantaged women in rural and peri-urban areas in Peru. The project adopts a participatory approach to address the fundamental issues of gender inequity that affect the reproductive health of women. It sees income generation as a factor that would enable women to overcome economic obstacles to improving their health. The **Grameen Bank** has assisted a large number of poor people in Bangladesh in improving their standard of living by providing them micro credit to start their own small business. Its experience shows that with six to ten successive loans, an utterly destitute person can break free of the shackles of poverty. Poor housing and chronic ill-health are seen as the major deterrents to freedom from poverty. The Bank, therefore, also provides housing loans at low interest, together with low cost housing technology. It has also started a health programme that includes health insurance. In addition to credit, Grameen Bank also offers guidelines to members with the aim of improving their social and living conditions. Many of these guidelines are related to health. The impact of the programme is evident in better literacy levels (especially among children), better toilet and drinking water facilities and increased use of contraceptives among its members. The **Small Farmers' Development Programme (SFDP)** in Indonesia has helped women engaged in agriculture, fishing and home-based industry to improve their level of well-being. This has been done by skill enhancement, leadership training, marketing and business management in addition to provision of micro credit. Women report greater participation in decision – making, lower fertility and improved nutrition (Rosintan, 1999). In India, the **Annapurna Mahila Mandal** in Mumbai works for the empowerment of women through programmes related to literacy, health and nutrition, mother and child care, family planning and environmental sanitation. It trains women in decision-making and group leadership. It provides education, training in

self-employment, micro credit and legal and medical aid. More than 200,000 women have benefited from it so far.

Attempts at empowerment often run into trouble when a clash of interests takes place. Fonjong's study examines the role of non-governmental agencies in empowering women in Cameroon (Fonjong, 2001). It was found that while NGOs had reached a large number of women, their impact had been mixed. While they had been fairly successful in meeting the Practical Gender Needs of water, safety, income and health, their success in meeting Strategic Gender Needs (education, self-confidence and decision-making) was relatively unsatisfactory. NGOs had been successful in providing women access to resources but not in real empowerment in terms of reversing discrimination against and subordination of women. This was because Strategic Gender Needs could be met only after fundamental cultural and institutional changes. Such changes were resisted by the state and by men who had vested interest in the subordination of women.

Arti Sawhny's study of the Women's Development Programme (WDP) also found a similar clash of interest in the implementation of the programme. In 1984, Rajasthan became the first state in India to initiate a programme for women's empowerment. Sathins (grassroots level workers) were selected and trained under the WDP. In 1986, a health programme was launched as part of WDP. To begin with, WDP worked very well. Women organized themselves to fight against domestic and sexual violence and also to demand employment, minimum wages and basic needs like water, education and health care. In 1987 a year-long health project, with focus on reproductive health problems of women, was initiated in Ajmer district. The project elicited tremendous response from women. For the first time women found space to discuss openly issues like fertility and sexuality. New found knowledge gave them a sense of control over their lives. But within six months, the authorities were rattled by the growing sense of power in the women. Rajasthan experienced severe drought in the 1980s and situation came to a boil when government officials tried to use drought relief to achieve family planning targets by making the adoption of birth control measures as a precondition to receiving relief. The grassroot interest of women and community needs came into open conflict with government policies. Empowerment of women was now perceived as a threat rather than a goal. As the author concludes, "no form of collective strength will be tolerated by the state if existing power relations are challenged." (Sawhney, 1994)

3.0 : Women Empowerment by Major Activities of SEWA

Organizing women for collective bargaining and improving their capacity to receive essential basic services (education, health, training, etc.) is one of the strategies adopted for empowering women in India (Ila Patel, 1998). SEWA has provided poor, self-employed women a forum to canalize their individual strengths. It believes that "self-employed women must organize themselves into sustainable organizations so that they can collectively promote their own development" (SEWA Annual Report, 2005). Some of these organizations are trade based while others provide social security. Some operate at village level, others at district, state and national levels. There are 96 cooperatives with a total strength of 78,000 members, 3,200 producer's groups, and 6,000 savings and Credit groups. Other organizations provide social security through services like health care, child care and insurance. These organizations serve to link members to the larger economic structures of the

national and regional economy (SEWA Annual Report, 2005). SEWA's sisterhood of institutions consists of the following:

SEWA Union (Swashree Mahila SEWA Sangh): Recruits and organizes SEWA's urban and rural membership around issues of concern to its membership.

SEWA Bank (Shri Mahila SEWA Sahakari bank Ltd.) : Provides financial services.

SEWA Cooperative Federation (Gujarat Mahila SEWA Cooperative Federation):Responsible for organizing and supporting women's cooperatives.

SEWA District Associations: Provide services to SEWA-organized village groups and link SEWA members for other services.

SEWA Social Security: Provides health care, child care and insurance services.

SEWA Academy: Provides research, training and communication services.

SEWA Marketing (Gram Haat and Trade Facilitation Centre): Helps women producers, through their cooperatives, associations and groups to directly reach local, domestic or international markets.

SEWA Housing (Gujarat Mahila Housing SEWA Trust): Provides housing and infrastructure services.

Experiences....

“ For SEWA, women's empowerment is full employment and self reliance. When there is an increase in her income, security of work and assets in her name, she starts feeling economically strong, independent and autonomous. Without economic strength they will never be able to exercise their political rights in the local government. A woman has to have more work on their hands, such work that ensure her income as well as food and social security that ensures at least health care, child care, insurance and shelter...” Ela Bhatt, Founder of SEWA

Keynote address at the 1st meeting of South Asian Association for Women's Studies, Nepal (2002)

We discuss below the empowerment of women (economic and social securities) at SEWA through three SEWA entities of Shri Mahila SEWA Sahkari Bank, SEWA Social Security and Gujarat Mahila Housing Trust.

3.1: Empowerment through Shri Mahila SEWA Sahakari Bank

At about the same time as the birth of SEWA, the then Prime Minister, Mrs. Gandhi, launched a poverty eradication programme. As part of this programme nationalized banks were forced to allocate a small percentage of the loans disbursed by them to people falling below poverty line. Some banks sought the assistance of SEWA for identification of beneficiaries and disbursal of loans. Despite the best efforts of SEWA, its members faced great trouble in interacting with the banks. Some were unable to provide definite addresses and sometimes even their own names while opening accounts. Being illiterate, they were unable to fill in bank slips. They would stand in wrong queues. The bank timings too were unsuitable to them as they coincided with their working hours and a trip to the bank meant loss of the day's earnings. The bank staff, with its middle class attitude, had neither the patience nor the ability to help these women. It was then felt that SEWA members needed a bank that would be sensitive to their needs and one that would make them feel welcome and comfortable. Thus, 4000 women who contributed share capital of Rs. 10 each started the Mahila SEWA Sahakari Bank in May 1974. It now has around 275,000 depositors and has

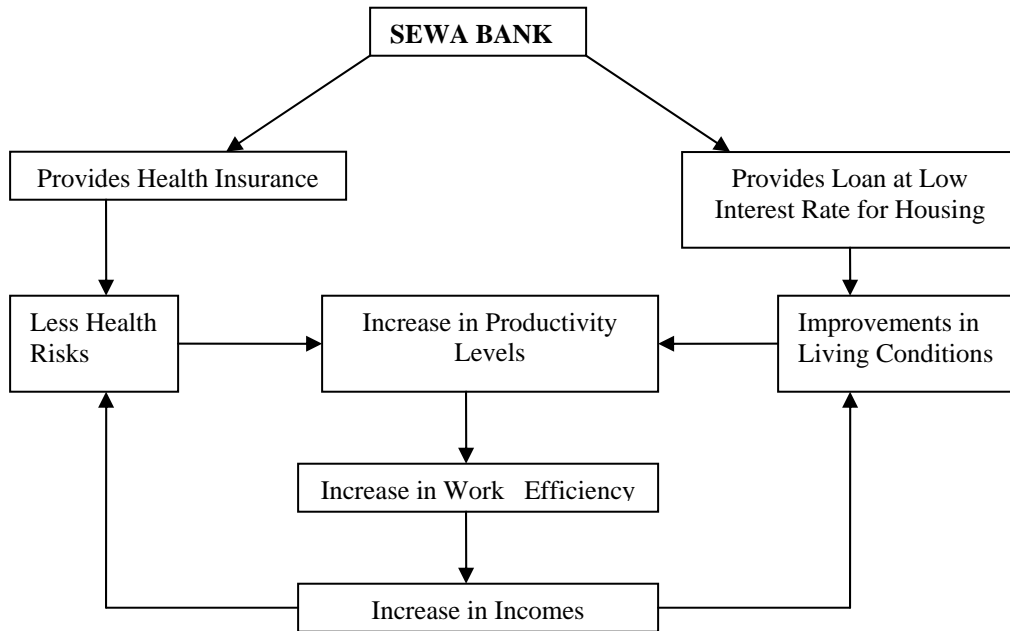
become the backbone of the SEWA movement. It provides financial services to its members through savings, loans and insurance.

3.1.1 : Chief Objectives and Activities of the Bank

- To provide facilities for savings and fixed deposits, thus encouraging thrift in women;
- To provide credit to further the productive, economic and income generating activities of the poor and self-employed;
- To extend technical and management assistance in production, storage, procuring, designing and sale of goods and services;
- To provide facilities to rescue their jewelry from pawn brokers and private moneylenders and giving loans against jewelry; and
- To adopt procedures and design schemes suitable to poor self-employed women like collecting daily savings from their place of business or houses, or providing saving boxes and giving training and assistance in understanding banking procedures.

The SEWA Bank realizes that its members need loans for a variety of objectives such as the purchase of income earning assets, raw materials, and improvement of housing or repayment of old debts. In the absence of traditional collateral, a regular savings record over a period of one year is taken as a form of security. A SEWA Bank field worker is then sent to conduct a pre-loan check at the woman's home. The fieldworker's report is used as the basis for deciding the amount of loan to be sanctioned. Several loan options are available to the women. Sanjivani is a loan specially designed for the wives of mill workers who have been laid off due to closure of mills. It is packaged together with business counseling from the bank and marketing services from SEWA. It is suitable for women keen to start new businesses or to expand existing ones. Unlike traditional financial institutions, SEWA is willing to provide housing loans to women. These loans can be availed for purchase, repair or extension of a house. However, a loan for purchase of house is given only if the house is registered in the name of the woman borrower, thus ensuring that an asset is created in her name.

Fig. 2 : Role of SEWA Bank in Empowerment of Women



The SEWA bank has stressed upon its *micro-credit programme* to finance women enterprises in rural areas and informal sector. The support of government and supportive policies has strengthened its role in the rural areas. SEWA bank is people friendly and also acts as a ‘mobile bank’ to facilitate deposits by home-based workers. Members are encouraged to save money which has direct bearing on their overall living conditions. SEWA banks give special incentives to those members who have taken a minimum of two loans and have paid their installments regularly (SEWA, 2000). The interest rate of the bank varies according to the capacity of the member to repay. The SEWA Bank has thus enabled women to enhance their income earning capacity and given them greater control over their money. They are now able to periodically put away small sums of money that were earlier frittered away or taken away by their husbands. They now have adequate shelter, and wherever necessary, space for work and storage of raw material and finished product. Many of them now own their work tools and other means of production and no longer have to pay high rents out of their meager earnings. Their upgraded work and business skills too have raised their income. This has led to improved health, nutrition and education of the women and their families. The women today have greater self-esteem and confidence and command a better status in their community. The Bank has enabled women members in managing and handling their financial matters of their enterprises and also family savings and loans. This has given them enough confidence to do financial transaction in the business community.

3.2 Empowerment through Health Care Services of SEWA

Health is directly related with the ability to work and the productivity levels and the income generated thereafter. SEWA realizes that its members need to be healthy to avoid loss of workdays. Therefore, most activities at SEWA have a health component and health actions in turn are linked to producers' groups, workers' trade committee, self-help groups and their economic activities (SEWA, 2004). The Shramshakti report of the National Commission on Self- Employed Women also looked at the health problems of these women. The Report finds that in addition to their household chores, the women were putting in up to 16 hours a day in income generating activities. This work was carried out in tiny rooms without proper lighting, ventilation and toilet facilities. The women were exposed to hazards like toxic chemicals, dust and fumes without adequate protection. They were often required to sit in the same posture for many hours. Despite this hard work their earnings were poor as a result of which they were undernourished and anemic. The burden of frequent pregnancies took a further toll on their health. Alcoholic husbands and quarrelsome in-laws sometimes made their plight worse. To cap it all was the physical and financial inaccessibility to proper health care.

To promote health and link it with other SEWA economic and financial activities, social security organization including Lok Swasthya SEWA Health cooperative, Sharamshakti cooperative, Sangini Child Care and Vimo-SEWA were initiated. The integrated health services are provided by a team of dedicated trained leaders (aagewans) and paramedical staff (barefoot doctors and mid-wives) at the door step of the Members. There is a strong component of training the health workers for delivery of cheap medicines and primary health care services. Likewise, communities are made aware of their (mainly maternal and child health) health and nutrition needs and basic hygiene by these trained health workers. Recently, SEWA has started health insurance (Vimo-SEWA) service for hospitalization care, largely in the urban and peri-urban settings. This has helped members in getting quality emergency care and save them from debt burden for hospitalization. Health services at door step concept has also promoted the SEWA membership and employment generation for many SEWA members. Lok Swasthya SEWA cooperative has joined hands with local PHCs and other organizations in facilitating the immunization, TB and HIV/AIDS programmes. Production and distribution of low cost indigenous medicines initiative is unique experiment towards low cost health delivery. In the process SEWA has produced lot of reading and audio-visual material to disseminate the basic health care knowledge among its members and wider civil society.

SEWA's Main Health Activities are:

- Health promotion and preventive health care through health education, immunization, micro-nutrient supplementation, involvement in water and sanitation activities and family planning;
- Curative care through rational drug therapy and referrals, especially including tuberculosis care;
- Occupational health care including provision of protective equipment such as sickles for agricultural workers to reduce body strain;
- Promotion of low-cost traditional medicine treatment, use of local herbs, massage and acupressure;

- Sale of low cost drugs through three shops and 50 health centers.

While following up on loan defaulters, it was realized that an illness in the family frequently led to disruption in the work cycle, loss of income and ultimately default in loan repayment. The rate of maternal mortality among defaulters was alarming. Lack of sterile conditions at the time of birth was one reason for this. The other reason was the poor economic condition of the mother. A body weakened by the lack of proper nutrition and over burdened by the need to work until the final stages of pregnancy posed a threat to the safety of both mother and child. SEWA initiated a **maternal protection scheme** under which an expecting mother could register herself by paying a small fee. She was then entitled to prenatal services through SEWA. At the time of childbirth she was given some money and a kilogram of *ghee* (clarified butter) to provide her some nutrition. SEWA also trains traditional midwives or *dais* working in rural areas in scientific maternal and childcare.



Picture4: Trained Dai (Mid-wife)

This pressurized the Gujarat state government to launch a maternity scheme for the benefit of landless agricultural workers. In 1987 the Government of Gujarat began implementing such a scheme through its labour ministry. Under this scheme women workers are entitled to antenatal care, 4-6 weeks' wages as compensation, a safe delivery kit, a kilogram of *ghee* and a baby-care kit for the new born. SEWA is now exerting pressure on the Central Government to launch

a similar scheme at the national level.

SEWA has tackled health issues by trying to reduce the incidence of illness, by reducing the cost of treatment and providing health insurance to cover the cost of hospitalization. By improving income-earning capacity of the members, it has improved their nutritional status. By providing facilities for improved housing and sanitation it has tried to soften health threats from the immediate living and work environment.

The Lok Swasthya Health Cooperative of SEWA was established in 1990 to bridge the gap between healthcare needs and healthcare availability, and help women and their families move towards health security and overall well-being. Its multi-faceted approach ranges from creating health awareness and health education to providing primary health care, including access to quality medical facilities, affordable medicines, prevention programmes and helping influence policies which reduce hazards and improve health care. Lok Swasthya, along with the AIDS Control Society of Ahmedabad Municipal Corporation, has taken up AIDS awareness and prevention activities. Lok Swasthya and Ahmedabad Municipal Corporation also have a programme for the detection and control of tuberculosis (Various SEWA Publications).



Corporation also have a programme for the detection and control of tuberculosis (Various SEWA Publications).

Vimo SEWA, SEWA's insurance cooperative, offers a health insurance package to its members. Modeled on a

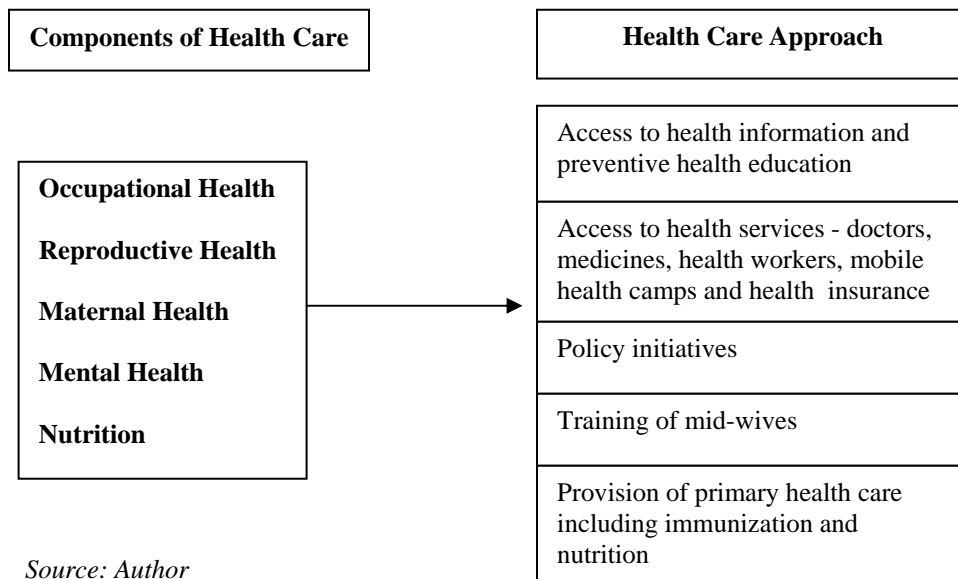
group plan offered by the nationalized general insurance companies, it reimburses hospitalization and related medical expenses of members. Members can opt to insure the health of husbands and children. With effect from the year 2005, it also reimburses hospitalization charges for diseases like hypertension (cardiac) and cancers, which were earlier, excluded from its coverage.

Picture 5: Beneficiary of Family Health Insurance

Fixed deposit members get the additional benefit of coverage for maternity, dentures and hearing aids (Sinha, 2006).

Occupational Health: Poor wages for long hours of work are not the only problem confronting the members of SEWA. The poor quality of their work environment also adversely affects their health. The amount of lighting and ventilation in their work areas is insufficient. Occupational hazards also include postural problems for paddy transplanters and bidi and incense stick rollers. Others are exposed to toxic dyes and fumes and dust from tobacco and ground spices. SEWA selected some literate young women from each trade group and teamed them with some health workers to study the health problems specific to their trade. SEWA exerted pressure on the National Institute of Occupational Health to establish a Women’s Cell. This cell has worked in close association with the National Institute of Design and the ILO on postural problems of women workers. The collaboration has resulted in improved design of handcarts, sewing machines and worktables and other furniture.

Figure 3: SEWA and Health Reach



Source: Author

3.3 : Empowerment through Housing

Most of SEWA’s members are slum dwellers. They have tiny, overcrowded living quarters, which are usually poorly lit and lack proper ventilation. The living space is also used as storage space and working space. The makeshift housing cannot provide protection against natural elements. They also lack in basic facilities like electricity, water supply and

sanitation. SEWA Bank provides loans to its members for the purchase of new houses and for expansion of existing ones. Loans are also available to members wishing to repair walls, roofs or floors, or to undertake any other maintenance work on their houses.

SEWA initially provided loans for purchase and up-gradation of housing through its bank but considering the growing demand for improved housing and infrastructure conditions from members, the SEWA Executive Committee decided in 1992 that the housing related activities of SEWA and SEWA Bank required consolidation and expansion. Thus the Gujarat Mahila Housing SEWA Trust (MHT) came into existence in 1994. Its objectives were to improve the overall living environment of SEWA members through improved access to finance and legal and technical assistance for housing purposes. In partnership with the Ahmedabad Municipal Corporation (AMC) and the community, SEWA launched a programme to provide seven infrastructure facilities in the slums. These facilities are individual water supply, individual sewage, individual toilets, paved roads, streetlights, basic solid waste management and storm water drainage. MHT also facilitates the formation of community-based associations to interface with AMC to effectively maintain the newly acquired infrastructure. By March 2006, 9775 households in 60 slums had been upgraded.

Ujala Yojna (slum electrification programme) has also provided electricity to many households and has enhanced their work capacities (for e.g. women engaged in livelihood through sewing), which has resulted in increased incomes. The surplus income is further saved in the SEWA bank and used to improve their living conditions. Mahila Health Trust (MHT) has implemented the Sardar Awas Scheme of government of Gujarat for providing pucca (brick) house to rural areas and providing better sanitation facilities.

Achievements, health impact and wider implications of the above SEWA entities are described below using social determinants approach.

4.0 Addressing Achievements and Impacts of SEWA Entities : Social Determinant Approach to Empowerment

Social determinants of health (SDH) are the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment. This perspective is the key to understanding patterns of health and illness.

The major objective of SDH includes decreasing **social stratification** by reducing inequalities in power, prestige, income and wealth linked to different socioeconomic positions; decreasing **specific exposures**; lessening the **vulnerability** of marginalized people; intervening through **healthcare** to reduce the unequal consequences of ill-health and prevent further socioeconomic degradation among disadvantaged people who become ill (WHO, 2005). Institutional, community or individual actions towards these health domains help to reduce health inequities.

The methodology to understand the determinants would include both process indicators and outcome indicators. There are various ways of understanding the SDH including stakeholder's analysis, institutional analysis, vulnerability mapping, and development of

indicators. The health care process includes components of affordability, wide coverage, accessibility, referral services and health insurance.

According to Sri Lanka's experience of health development, the following objectives should be kept in mind. First, to ensure delivery of comprehensive health services to reduce disease burden and promotion; Second, to empower communities toward more active participation in maintaining their health; Third, to strengthen stewardship and management functions of the health system; Lastly, to improve human resources for health development and management; and to improve health financing, resource allocation and utilization (Public Health Agency of Canada, 2007). Sri Lanka's significant improvements in health indicators have been the outcome not only of performances within the health sector but also of major socio-economic developments in other sectors beyond health. What lessons we learn from SEWA entities towards health gains of the community while empowering its members through social and economic interventions is illustrated below.

4.1 : Social Impact Assessments of SEWA Activities

The members of SEWA face many other disadvantages in addition to those that come from being women in India As Martha Chen puts it, "SEWA members tend to be from the poorest and most disadvantaged communities." (Martha Chen: Profiles of SEWA Membership.) Most of them belong to the lowest economic strata --- half of them belong to households that survive on less than 1 US \$ a day and the rest of them are not much better off. Most of them also belong to the lower castes or are members of minority religious groups. More than one-fifth of its urban membership is Muslim and more than 90% of its members in urban as well as rural areas belong to Scheduled Castes, Scheduled Tribes or other backward castes. (Martha Chen: Profiles of SEWA Membership). Suffering from such multiple disadvantages, these women would be in no position to empower themselves without external support and guidance. There are no laws for their protection, as they are not recognized as workers. Invisible and vulnerable, they were fighting their battles individually until SEWA provided them a common platform to articulate and share their problems and join forces to fight for their just dues.

In order to assess the impact of SEWA on the lives of its members, a few economic and social indicators have been considered. These are:

I : Economic security

- Income and employment
- Access to credit
- Ownership of assets

II : Social Security

- Improved housing
- Education and training
- Access to health care

The evidence for assessment has been taken largely from *towards economic freedom*, Martha Chen's review of the impact of SEWA.

4.2 : Economic security

4.2.1 : Income and employment

For poor and largely illiterate women, economic vulnerability is one of the major factors contributing to the powerlessness of SEWA members. Deprived of education and professional training in their childhood, they enter the labour market at the lowest level. They do not have a steady income nor is the flow of work regular. Before the formation of SEWA some of them depended on middlemen and contractors to provide them with work while others were exploited by those who hired their services. They also had to bribe policemen and employees of Ahmedabad Municipal Corporation in order to avoid harassment. After joining SEWA, members were able to fight against exploitation at the hands of middlemen, contractors and employers. SEWA issued them identity cards that protect them from harassment at the hands of policemen and other authorities. Membership of SEWA cooperatives helps them in procuring raw material at cheaper rates and also in sale of products. SEWA also provides them opportunity to upgrade their professional and business skills. This, combined with the social services offered by SEWA, has helped members in finding regular employment and earning a higher income.

Three-quarters of SEWA urban members reported that their employment and income were more regular than in the past. Much of this was attributed to the availability of child - care services and housing improvement in the form of electricity and water connections.



“I have a lot of faith in SEWA. SEWA is my mother, I have benefited a lot. There is now land in my own name and due to my leadership experiences, I enjoy both at home and outside too. Everybody gives me respect. After joining SEWA, my income has increased and my health has improved. My food habits have also improved. Before doing savings, I was illiterate, but after that I learnt how to read and write.”

Leader of SEWA Rural Savings and Credit Group (Chen, 2005)

This allowed women to devote more time to income-generating activities. In rural areas too, improved availability of water reduced time devoted to water collection by 1 to 3 hours everyday. They were also provided opportunities to diversify their sources of income. Nearly one-half of the members who borrowed from SEWA Bank and invested in their businesses had increased their income while several other members used credit from the bank to settle old debts.

Despite some increase in income, only a miniscule percentage of SEWA members managed to move out of abject poverty. This means that their earnings are below the minimum wage rate. Also, increase in income can be largely attributed to longer working hours. This may be lead to self-exploitation by members and should be a cause for worry. They were also found to be earning less than self-employed men because men either produced or sold a larger volume or a different range of goods and services. Among street vendors, for example, men sold non-perishable goods while women sold perishable goods like fruit and vegetables. As men used push carts or bicycles, they could sell their wares over a larger area as compared to

women who carried their goods in a basket or sold from a piece of cloth spread on the ground. It may be necessary to encourage women to break the gender barrier and enter into trades so far dominated by men.

4.2.2 : Access to Credit

SEWA members have small earnings, which are barely enough to meet their day-to-day requirements. There is little scope for putting any money aside in the form of savings. Yet, every now and then they have to incur some non-routine expenditure that may be related to illnesses, meeting of social obligations (for example, marriage of children), performance of rituals, house repairs or life cycle events like births and deaths. To meet such foreseen or unforeseen expenditures they had to borrow money from moneylenders or to pawn their jewelry. SEWA Bank has played a major role on the economic front by providing credit to its members. This has freed many of them from the clutches of private moneylenders who provide loans at exorbitant rates of interest. Loans have been used by members to expand businesses and to purchase tools and other assets needed for their work. Loans are often packaged together with training to enhance their business and marketing skills. Housing loans have been used by members to buy houses and to improve or expand existing ones. Improvement in the quality of housing has had a beneficial effect on their work as well as on their health. As houses have to be registered in the name of members, women become owners of property which would ordinarily have been owned by male members of the family.

4.2.3 : Ownership of assets

As discussed above, loans from SEWA Bank have allowed women to own productive assets. A third of SEWA's urban members reported an increase in assets. However, the value of these assets was lower than the assets owned by male members of the same household. SEWA Bank did help women in owning financial assets as most members had savings accounts and a majority of the women were able to save some money on a regular basis.

4.3 : Social security

4.3.1 : Improved housing

More than 90% of SEWA members in Ahmedabad live in slums or tenements once built by cotton mill owners for their workers. In both cases there is a question mark over the legal status of their dwellings. This is a great source of mental stress to the members.

Lack of adequate housing in terms of size and quality was another major handicap for SEWA members. A large number of them are home-based workers and their living quarters double up as work space for them. This is also where they store raw material and finished products. The semi-permanent dwelling units are not weather proof and these goods are often damaged by rain, sun and dust, leading to financial loss to members.

Most urban members lacked basic infrastructure including water supply, electricity and drainage connections as well as street lighting, water drains and underground sewerage in their neighbourhood. Rural houses too were without water and toilets. In the absence of toilets women had to wait until dark to relieve themselves and this caused not just physical discomfort but also bowel and bladder problems. Kuccha (semi-permanent) houses also needed repair more often, thus requiring both time and money.

With loans from SEWA bank and the Housing Trust, members were able to buy new houses and expand and repair old ones. 82% of rural members and 61% of urban members had renovated their homes. Provision of electricity connections at home allowed them longer hours at work, thus increasing income earning opportunities. Easy availability of water reduced the time devoted each day to collect water, and also allowed members to maintain a higher level of hygiene. Access to toilets reduced discomfort and the humiliation of having to relieve themselves in the open. In a nutshell, provision of basic infrastructure had resulted in improved health, increased school enrolment, increased scope for home-based income earning opportunity, longer work hours and greater productivity. (Martha Chen: Profiles of SEWA Membership).

My home is my workplace, after the earthquake my house was completely collapsed. Through SEWA housing campaign, we got a new house with a toilet and a roof tank for harvesting rainwater. This changed my life because all of the time I used to spend to collect water, I can use it to embroider. This is income generating. With this income now-a days, I can save 20 Rs per month. I could take a loan for my house. I feel very secure in SEWA bank. I think that it will never close and will continue to provide the financial services that people need.

Gauriben, Embroiderer, SEWA (Chen, 2005)

Box 1 : PARTNERSHIP FOR CHANGE: THE PARIVARTAN PROGRAMME

One of the foremost objective of SEWA's Mahila Housing Trust is to improve the housing and infrastructure conditions and overall living environment of SEWA members. A large number of SEWA members live in slums where living conditions are most appalling. Mahila Housing Trust (MHT), in partnership with Ahmedabad Municipal Corporation (AMC), SEWA Bank, Community Based Organisations and some private sector organizations, Undertook a slum upgradation programme called "PARIVARTAN".

The *chief objectives* of the programme were:

- To improve the basic physical infrastructure within the slums and in the homes;
- To enhance the process of community development ;
- To build a city-level organization for environmental up gradation of the slums.

The package of *services* includes:

- Water supply to individual households
- Underground sewerage connection to individual house holds
- Toilets to individual households
- Paving of internal roads, lanes and by lanes in the slum localities
- Storm water drainage
- Street lighting
- Solid waste management
- Landscaping
- Community development programme to be initiated after infrastructure installation
- An informal tenure of ten years provided to the community.

Partnership in slum networking (finance) :

The cost of physical development (Rs.6000.00 per household) was shared equally by AMC, the private sector & each house hold.

The cost of community development (Rs.1000.00 per house hold) was shared by AMC (Rs.700.00) and SEWA (Rs. 300.00).

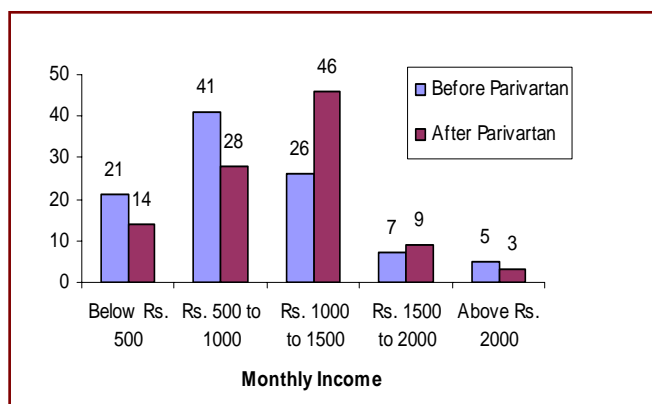
The cost of linking each house hold with the main city infrastructure (Rs. 3000.00 per house hold) & the cost of house hold toilets (Rs. 4500.00 per house hold) was borne entirely by AMC.

The Community Corpus for maintenance (Rs. 100.00 per house hold) was paid by the Community member.

IMPACT:

The impact of the programme was wide ranging, with improvements in productivity , income, health, school attendance and social status.

Figure4 : Income before and After Parivartan in Babalablabinagar (in per cent)



The results of a study in Babalablabi Nagar are summarized in the following table.

Table 1- Impact of Parivartan Programme In Babalablabi Nagar:

Componant of Impact	Before Parivartan	After Parivartan
School Going Children Between 6 To 10 Years (%)	66	72
Increase in Average Number of Working Hours	7	8
% of House-Holds With Monthly Income < Rs.1000	62	42
% of Households with Monthly Income Between Rs.1000-1500	26	46
% of Residents taking Bath Every Day	74	96
Incidence f Illness (%)	19	7
Avg. Monthly Expendiure on Health(Rs.)	131	74
% of Respondents Reporting Improvement n Social Status	--	94

Picture 6: Sinheshwari Nagar, Naroda Road Ward

Before Parivartan Programme

After Parivartan Programme



Source: *Parivartan and its Impact: A partnership Programme of Infrastructure Development in slums of Ahmedabad City, SEWA Academy*

4.3.2 : Capacity Building - Education and Training

SEWA has laid stress on provision of education for its members and their children. Literacy classes are organized for its members. Young girls are provided skills training and job placement services. Provision of electricity connections in homes and improved access to water and transport were also believed to have a positive impact on enrollment and attendance. While school enrollment for boys was indeed higher among SEWA members, little impact was seen in the case of girls. This shows that SEWA has not been able to overcome the bias against educating girls. Households are not

prepared to invest money in educating their daughters, as it is believed that it will benefit the marital and not the parental family. Security issues also come into play when the school is not very close to the house. Not much importance is attached to education in SEWA households because income is derived from traditional skills, which are acquired on the job and experience counts more than formal education.

SEWA through their various campaigns and training programmes (Annexure II, III) tries to equip



the working women with necessary skills for their work opportunities. 375 computers will be installed in the villages with SEWA membership of 11 rural districts of Gujarat. This will serve multiple purposes including improved communication within SEWA, access to information and markets, administrative and design tasks for SEWA collectives, vocational computer training of SEWA members and computer based education for children in government schools. SEWA's effort here is to alleviate illiteracy and makes women more empowered through information technology. Education contributes to health and prosperity by equipping people with knowledge and skills in understanding their health and well being increases

Picture 7: Video-SEWA

opportunities for job and income security, thereby improving people's awareness to disseminate health inequities.

Women are now becoming more aware of their needs and requirements. Capacity building along with the access to more resources and intra and inter sectoral linkages are some of the strategies to achieve the objectives of women's development and welfare. SEWA is working towards skill enhancements of the community (accounting, managerial, marketing and technical skills) through her various training programmes in the SEWA Academy.

SEWA also runs an educational programme for rural women called 'Jeevan Shala' and also has begun a manager's school which focuses on developing women managers at grass root levels. In this regard availability of funds, capital, water, electricity and land are the key inputs required to make the organizations sustainable. Gyan Vigyan Kendras or Knowledge and Science Centers have used the information and technology (IT) in strengthening the marketing linkages for the SEWA members. Various campaigns in the field of education, health, and livelihood, living conditions are undertaken by SEWA to empower women (already discussed in the first section). SEWA's strategies therefore include training, literacy, research, publication (Ansuya) and Video-SEWA

4.3.3 : Access to Health Care

SEWA members realized that their earning capacity depended on their health and the health of their family. Health security has therefore been a major thrust area in its programmes. Health insurance, health awareness, immunization, training of midwives, and sale of low cost drugs has been part of the strategy to improve the health status of SEWA members. A significant number of members believe that their association with SEWA has improved their health status and also led to lower expenditure on health. However, studies do not has improved their health status and also led to lower

Picture 8 : Sale of low cost drugs at door step



expenditure on health. However, studies do not show much difference between SEWA members and control groups in terms of health improvement, reduction in expenditure on health and health behaviour. While SEWA members did make use of more prenatal and postnatal care, a higher percentage of them in both rural and urban areas delivered at home as compared to the control group. On the plus side, use of modern contraceptives was twice as high among SEWA members.

Many more SEWA members had medical insurance in comparison to non-members. Reimbursement of medical expenditure provided great relief from the burden of catastrophic hospitalization. Despite this, members did not submit claims for nearly three quarters of the estimated episodes of hospitalization. Another disconcerting finding in the case of hysterectomies was that the quality of care ranged from excellent to potentially dangerous. This possibly holds true for other health problems as well because SEWA does not control the quality of health care availed by its members. Some corrective action is certainly warranted in this regard.

Box 2 - VIMO – SEWA

Insurance plays a comprehensive role in the development and empowerment of women. SEWA has considered insurance as an important means to achieve *social security* to enhance the productivity and income of its informal women workers and their families. SEWA insurance scheme provides an integrated package of insurance coverage against any loss of productive assets due to calamities or communal violence, against accidents and illness. It is important to note that according to the labour laws, workers in informal sector are not identified for any compensations. SEWA's role in insuring its workers for health and assets loss or assets creation has given them a more dignified position in the society.

Insurance programme of SEWA Bank was initiated after realizing that almost all the workers were indebted to money lenders and their bulk money deposited in the bank goes to clear health-related debt. Further, SEWA bank also noticed that the non-repayment of loans by its member was because of their untimely deaths, constant illness, chronic disease problems, deaths during pregnancy and delivery etc. This factor led to the incorporation of the goal of insurance by SEWA Bank to all its workers along with its other goals of asset creation, and assuring credit and loans.



Picture 9: A Vimo-SEWA worker selling health insurance.

Women are highly vulnerable due to extreme poverty, constant illness and financial crisis. This results in high mortalities among both mothers and infants. *Health insurance* and *assets insurance* at the times of calamities, accidents, communal violence have helped these SEWA women worker to cope up in such crisis and lessen their vulnerabilities. SEWA encourages women to save money and deposit it in SEWA Bank. Under its social security schemes such as insurance SEWA has linked up savings with insurance. The interest accrued from savings are integrated with the annual premiums of the insurance scheme.

The *Integrated Social Security Scheme* of SEWA initiated in **1992** has incorporated insurance for life, widowhood, sickness, maternity benefit, and asset loss. This was called *social insurance* which was provided to its member in conjunction with the nationalized insurance companies. The members were given the option of paying their yearly premium or accruing interest from their fixed deposits (i.e. savings) in SEWA Bank. Hence the various risks and vulnerabilities of SEWA worker are addressed under integrated insurance scheme. This has strengthened their economic and social securities.

4.4 : Summary of quantitative and qualitative impacts of SEWA

Determinant	Indicators Used	Outcomes	
		Qualitative	Quantitative
1. Employment	i) whether employment has increased? ii) whether more creation of activities?	-Increase in the regularity or security of work -Increase in employment and incomes -Increase in working hours -Licenses for primary activity	-40 per cent of household resettled under Sukhi Reservoir Resettlement Scheme reported an increase in income and employment -Half of the members able to expand or improve their business -2/3 rd of SEWA members entered a new types of employment -58 percent reported multiple activities across the year (2002) -Mothers who left their children at SEWA day care centre reported an increase in employment -63 percent of SEWA urban members had licenses
2. Income	i) whether the members earn more now? ii) how many SEWA services they are associated with?	-Credit and saving services of SEWA have raised household and individual's income -Housing improvements were found to have increased the average number of working hours and consequently the incomes.	-Nearly 73 percent of SEWA urban members reported an increase in wages and income -Around 28 percent of women experienced more income after they sent their children to ICDS-SEWA day care centre -Over 2/3 rd of SEWA urban members reported that their income has increased after they joined SEWA. -80 percent of SEWA members reported that they earn more now than in the past.
3. Housing	i) whether savings and loans are used for improving housing condition? ii) whether improved housing conditions have resulted into increase in income and better health?	-SEWA bank and Housing Trust have entered into partnerships with government and private sector to provide infrastructure services to slums in Ahmedabad city. -SEWA provide housing to targeted population who are resettled because of the developmental activities or were affected due to the calamities -More SEWA members have renovated their houses -SEWA bank members spent more on their housing improvements	-SEWA constructed 5000 pucca houses covering 30 percent of its members who lost their homes in earthquake -SEWA trained 200 women and 400 men to help in the construction of houses -57 percent of household under the Sukhi Reservoir Resettlement Scheme had acquired pucca houses
4. Health Care	i) physical and psychological well-being ii) incidences of illness iii) costs of medical treatment	-Reduction in health risks -Reduction in health expenditures -Increased health insurance coverage	-Knowledge of various possible risks during pregnancy was slightly higher among SEWA rural members than the control group -Higher percentage of SEWA members were attended by trained personnel -More numbers of SEWA members had contact with a health worker or visited health facility within 48 hours after delivery -Residents of slums who participated in a slum infrastructure project in Ahmadabad reported a decrease in the average monthly expenditure on health

Interventions

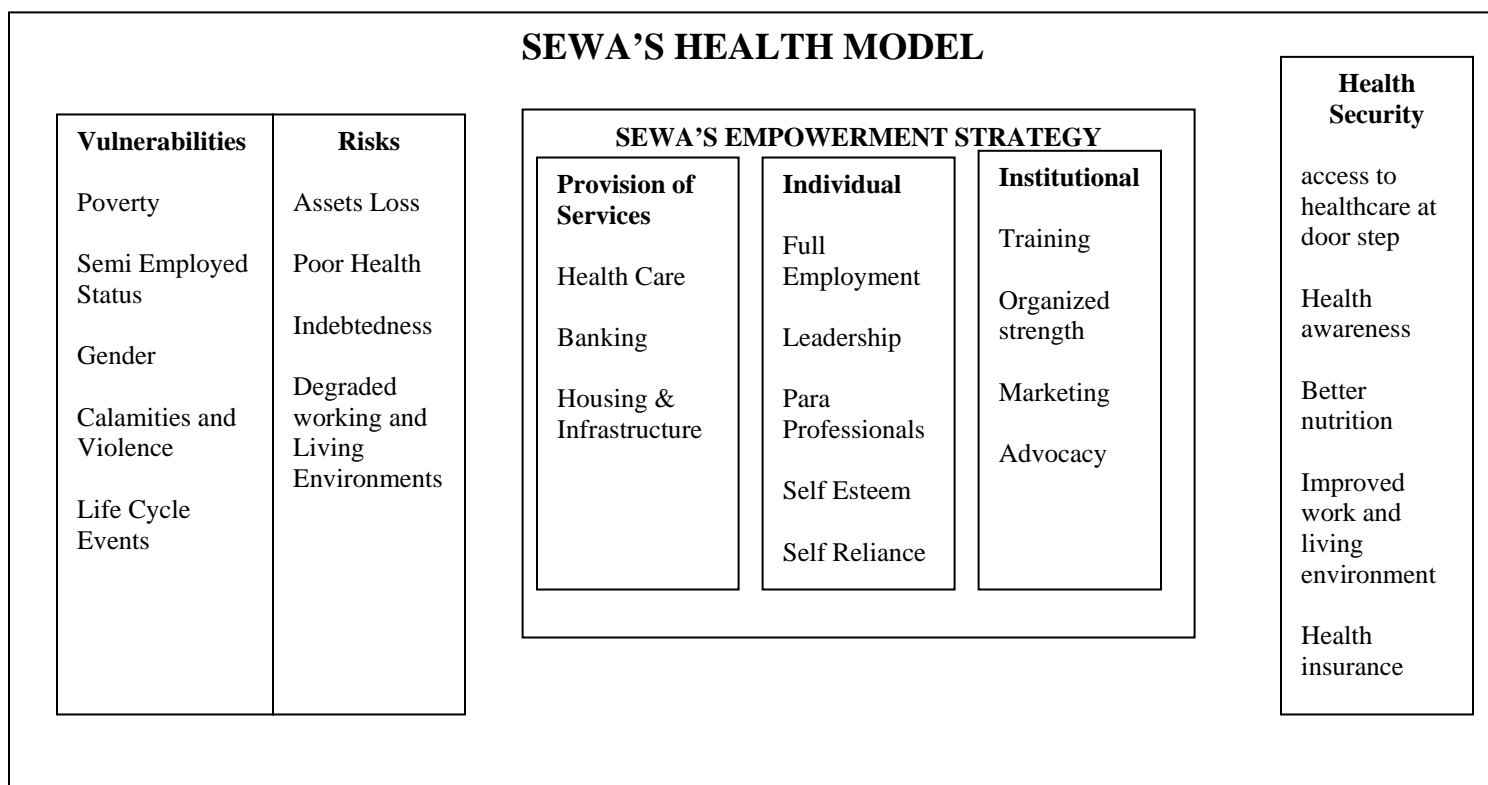
Source: Derived from Martha Chen's *Towards Economic Freedom, 2005*

4.5 : Qualitative Analysis of the Impact of SEWA

Problem Areas	SEWA Intervention	Impact
Income -Lack of Skill and Education -Little time for work due to responsibility for household chores -Exploitation by middlemen -Loss of income due to ill health -Lack of capital to purchase tools, raw material	-Imparting skills and education -Provision of child care - improved access to water, electricity connection -Formation of cooperatives -Elimination of middlemen -Provision of health care and health insurance -Credit availability	Increase in income but earnings still low
Access to credit -Borrowings from money lenders at high rate of interest	-Credit available from bank at low rate of interest	Freedom from indebtedness to money lenders
Poor quality of housing -Lack of finances for expansion or improvement of housing -Lack of infrastructure like water, electricity, toilets, drains, sewerage	-Credit available from MHT -Provision of infrastructure	Improved quality of housing Cleaner neighborhoods
Assets -Low incomes, no savings -Non-availability of credit -Registration of assets in the name of male members of _____	-Increased income, encouragement to thrift and savings through bank activities - Credit available through bank - Registration in name of women - Precondition to process of credit	More financial assets More physical assets
Education -High illiteracy among members -Bias against educating girls	-Literacy classes for members -No direct intervention -Availability of child care services, water supply	Improvement of functional literacy of some members Improvement in enrollment of boys, not much impact in case of girls
Access to health services -Poor awareness -Poor access to health care	-Create awareness -Improved access because of its programmes, increased income, health insurance	Improvement in social determinants of health
Organization and decision making -Not organized -Low self esteem -Little say in decision making at home	- Organized unions, cooperatives -Increased self esteem because of recognition of workers - increased economic role and enhanced self esteem	Greater decision making role at home and in community

Source: Derived from Martha Chen's *Towards Economic Freedom, 2005*

4.5.1 Towards Health Model based on SEWA's Empowerment Strategy



4.6 : Development of Health Improvement Index (HII) based on SEWA Approach and Health Outcomes

Health Improvement Index (HII) Indicators for poor women and family (SEWA experience)
➔ Access to micro credit (financial security)
➔ Membership of a women trade organization (solidarity)
➔ Leadership quality (self confidence)
➔ Full employment and on job training (economic security and self reliance)
➔ Social networking (community participation)
➔ Access to basic health services and government health programmes at doorstep (reduced friction of distance)
➔ Health insurance of family linked with financial services (freedom from health-related indebtedness)
➔ Access to low-cost medicines and alternate systems of medicine
➔ Access to drinking water and basic sanitation at door step (freedom from water- borne disease burden)

5.0 : Utility and Success of SEWA's Approach Towards Women Empowerment

Ela Bhat is rightly considered the founder of SEWA. However, the idea to found SEWA did not strike her all of a sudden. SEWA was born when a group of poor and mostly illiterate women head loaders and cart pullers decided to join forces and fight against exploitation and demand their rights. The need to do so arose from within them, but they did not know how to go ahead with their struggle. They approached Ela Bhat, an educated, middle class lawyer, for advice and support. Already familiar with the plight of poor, self-employed women because of her work with the wives and daughters of textile mill workers, Ela Bhat provided the necessary leadership and guidance to translate the felt need of the head loaders and cart pullers into what eventually became the SEWA movement.

SEWA provided visibility, recognition and dignity to the work of self-employed women. Its initial success inspired more and more women to join it. Most of those who joined were from the lowest strata of society and were seeking to empower themselves. But also among those who joined the movement were some highly educated middle and upper class women from India and abroad, who wanted to help in creating conditions conducive to such empowerment. Women from all classes have teamed up to steer SEWA towards the goals they have collectively identified. The functioning of SEWA is totally democratic and fully participatory. Members sit together and discuss issues that concern them. Each member is free to voice her opinion. Having examined all aspects of an issue they identify their problems and decide on the course of action to be followed in seeking solutions to them. Many of the grassroots members have acquired the confidence and the ability to assume leadership roles. The more educated middle class women who joined SEWA at different stages of its growth rarely imposed their ideas and values on the group. This is perhaps where the strength of SEWA lies. It has not tried to challenge existing power structures in the open and upfront manner that the more radical and aggressive middle and upper class feminist groups would like it to do. Instead it has chosen to move gradually towards empowering the most vulnerable women in the way they choose to define it. This goes with the SEWA ideology of joining together to plan with rather than plan for poor women.

In brief, SEWA has contributed to the empowerment of its members by providing:

- Organizational strength
- Advocacy
- Networking
- Partnership
- Leadership
- Intersectoral approach
-

5.1 : Organizational Strength

The strength of SEWA lies in its membership. The 1970s and 1980s saw a gradual but steady increase in the numerical strength of its membership. The expansion of its rural activities in the 1990s lead to a dramatic rise in SEWA's membership from 25,911 in 1990 to 318,527 in 2000. Recruitment of members in the aftermath of crises like the 2001 earthquake saw a further rise in membership to 704,166 in 2003. The All India membership in the year 2005 was 796,755 (Annual Report 2005).

Membership of SEWA and its sister institutions is a great source of strength to its members. This is evident in the pride with which they show their SEWA identity cards.



Member after member narrates stories of how membership of SEWA has empowered her and enhanced her self-esteem. Collectively, the members have fought for their rights and struggled for fair remuneration for their hard work. They have raised their voice against harassment at the hands of the police and other authorities. They are better informed and have the confidence to approach contractors and middlemen to

Picture 8: SEWA members in a Meeting

negotiate and bargain with them for their own selves and for others. Their success inspires others and they serve as role models for them. Even at home and in their communities they are treated with more respect and consulted on important matters.

5.2 : Advocacy

The organizational strength of SEWA has enabled it to strongly advocate the cause of its members. What began as a small struggle by a group of women head-loaders and cart pullers and then took the shape of a trade union gradually grew into a movement of self-employed women. It is really an amalgamation of three different movements – the labour movement, the cooperatives, and the women’s movement. (Rekha Mehra, 1997, p 146). It represents a struggle by poor, self-employed women in pursuit of recognition for their economic contribution and a quest for life with dignity. At the first instance, members themselves learnt to see themselves in the role of workers and service providers rather than as poor and helpless women. Through their struggle as a self-employed workers’ union, they made the public at large aware of their existence and utility as an economically productive work force. Their show of collective strength forced state authorities to sit up and take notice of their problems and take remedial action. As stated earlier, it was as a result of lobbying by SEWA that the central Government of India agreed to set up a Commission on Self-employed Women in 1987 with Ela Bhat as the Chairperson. It was on the basis of the recommendations of this Commission that the Government of India introduced a Women’s Credit fund and a Childcare Crèche Fund. In 2003 the Central Government invited SEWA to be a member of the second National Commission on Labour to draft the first ever umbrella legislation for workers in the unorganized sector. In 2004 the Government of India set up a National Commission on Enterprises in the Unorganized/ Informal Sector and invited SEWA to be on the Advisory Committee. SEWA also lobbied for a National Policy on Street Vendors under which vendors will get legal status, social security and legitimate Hawking zones. Having transcended state and national borders, SEWA now provides voice and lends support to self-employed people in many parts of the world. It has forged alliances with national and international organizations like the National Alliance of Street Vendors of India (NASVI), HOMENET India (an association of home-based workers), and HOMENET South Asia. In 1996, HOMENET lobbied with the

International Labour Organization to pass convention 177 addressing the needs of home-based workers. It has helped or is associated with workers movements in other countries like South Africa, Ghana, Nigeria, Zambia, Turkey, Yemen, Thailand, Cambodia, Korea, Philippines, Pakistan, Afghanistan, Bangladesh, Sri Lanka and Nepal. It is a founder member of STREETNET, an international organization of street vendors, and WIEGO (Women in Informal Employment globalization and Organization) (SEWA Annual Report, 2005).

5.3 : Networking

Networking is an important tool used by SEWA members for empowerment. SEWA's networking is at state, national and international levels. It has networked with non governmental organizations and private bodies working in India and other countries to further the cause of self-employed workers. As stated earlier, it has helped in the formation of bodies like STREETNET, HOMENET, WIEGO and NASVI. Together, they have lobbied with local, state and national governments and international bodies to secure legislative and policy changes in favour of those they seek to represent. Their own network of providing integrated health, banking, and housing services through another network of cooperatives to its members is a classic example that gives full credence to networking concept. Without the integrated network, the attainment of social, income and full employment security to its members would have been a difficult task. This network has also helped to turn SEWA into a social movement.

5.4 : Partnership

SEWA has also worked in partnership with other agencies to secure resources and services for its members. A public-private partnership was forged with the Ahmedabad Municipal Corporation, industry and community to provide infrastructure for slum-up gradation in Ahmedabad. In 1981, it launched a group insurance scheme for its members in partnership with Life Insurance Corporation of India. In 1992 it undertook a joint insurance scheme with government insurers including United India Insurance Company and the Life Insurance Company of India. It has often partnered state and national government agencies in implementing their programmes. In 1989 SEWA's Sangini Women's Childcare Cooperative was asked to run 25 Integrated Child Development Scheme (ICDS) centres. In 1995, 1996 and 2003, SEWA was asked by the Government of Gujarat to partner it in implementing the Reproductive and Child Health (RCH) programme. SEWA has also collaborated with the Government in providing water to and rehabilitation to victims of natural disasters and communal violence. In this way, partnership approach has helped SEWA in pooling resources, human and financial, and technologies from other organizations to achieve their goal of empowerment. The concept of self-reliance, so much advocated by SEWA, perhaps need to be modified while living in a globalizing and integrated world.

5.5 : Leadership

SEWA members are not passive recipients of welfare programmes. They play an important role in identifying areas of concern and in finding suitable solutions to them. Many of them have risen to hold important positions in various SEWA institutions which are structured in a manner such that leadership roles are assumed by grass root members. Members of SEWA in Ahmedabad are organized into trade groups, cooperatives and slum area

associations. Members in rural Gujarat are organized into trade groups, cooperatives, village associations and savings-and-credit groups. Local groups elect local leaders; whose only essential qualifications are that they must be committed to the cause of the institution, have basic understanding of its issues and a sense of responsibility. Trade groups elect representatives to Trade Committees and the Trade Committee in turn elects representatives (Pratinidhis) to Central Trade Council. The pratinidhis then elect representatives to the Executive Committee of the SEWA Union. The grass root members do not have just a token presence in the Executive committee but play an active role in planning, monitoring, reviewing and evaluating its activities.

5.6 : Intersectoral Approach

Soon after the formation of SEWA Union, the need was felt for financial and enterprise development services. The aim of these services was to strengthen members economically through asset formation and investment in economic activities, through repayment of old debts and increased productivity and skills to produce and market goods. When it was realized that poor health of members and their families impinged negatively on their ability to work productively, SEWA provided health services that included preventive health care as well as curative and referral services at affordable costs. It also provided insurance to cover members against risk to health and property. Its housing services, including infrastructure development, provided better living and workspace that served to increase productivity and improve health. Provision of child care services helped to improve health and development of children resulted in increased enrollment of children in school and freed mothers from the responsibility and stress associated with caring for children or having to leave them without adequate supervision. Not only this, SEWA has often been the first to provide succour and relief to victims of natural disasters and communal violence. It may be safely concluded that to its members SEWA is like a friend that is ready to meet their every need. Evidently, the component of health outcome brought together the related financial/ banking sector along with housing and health sectors within SEWA setup. They could demonstrate better health outcomes with synergy building within related sectors. In government organizational setup it is extremely difficult to bring intersectorality due to diverse interests. However SEWA experience demonstrates that partnerships and working with other sectors is possible if an organization is more homogenous and its objectives are multidimensional and human development oriented.

6.0 : Challenges , Barriers and Lessons Learnt : SEWA Experience

6.1 : Challenges

- How to popularize VIMOSEWA despite its visible positive health outcomes, and reducing the burden of emergency and hospitalized health care indebtedness? Vimo-SEWA is less popular in urban areas and faces acute problem of dropouts in both rural and urban settings. Affordability for payment of premiums, renewal of membership and complexities in claim processing hinders its attractiveness.
- There is not much evidence to measure the organized strength of SEWA. SEWA records provide data on the size of its membership and on the number of membership-based-organizations in the sisterhood of SEWA institutions. But there is little data on the other dimension of organized strength, including the degree of

solidarity and trust within the membership-based-organizations and SEWA union as a whole (Martha Chen, 2005).

- Goal of SEWA to provide full employment has not reached to a satisfactory level according to various impact studies. However, there has been some increase in number of work hours, number of activities and diversification of current activities.
- Even though SEWA has created sufficient self reliance among its members through various capacity building programmes and services, SEWA's own sustainability and self reliance can be questioned if external partnerships and alliances become weak due to political, administrative and financial hardships. Further, with growing independent functioning of several SEWA organizations the interactions and interdependencies (intersectorality) is getting fragile. The attempt to create self-reliance among members has not reached a full potential as yet.
- How to break the prevailing sexual division of labour and allow women to enter into occupations dominated by men because they are the better paying jobs? At least the skilled members need to be mainstreamed in higher-level jobs beyond the umbrella of SEWA. Right now they feel protected and secure with their low wages and earnings. The concept of self-reliance is good up to a certain level of basic needs and beyond that member needs integration with the wider economy. Unfortunately that is not happening and members are satisfied with low wages as long as they are within the safety network of SEWA.
- Impact studies indicate only a marginal increase in family income (\$ 1-\$2/day), which is not enough to maintain a sustainable quality of living conditions. How to bring majority of the families above the poverty line is still a challenge?
- SEWA has to prepare its members to face emerging challenges like corporatisation of the retail sector and marginalization of the informal sector by the processes of globalization and free trade regimes.
- SEWA must make a more concerted effort to change oppressive social and religious institutions and beliefs that pose major obstacles in the way of women's empowerment. Effective economic empowerment may not be possible unless accompanied by social change (viz. domestic violence, expenditures on social obligations, alcoholism among males) and SEWA needs to address this dimension as well.
- Even though SEWA programs have improved the accessibility to services like health care and improved housing and related infrastructure, the ability of members to benefit from these have varied with their income levels. Health inequity concern is still there, despite SEWA being a more homogenous entity
- Despite concerted efforts by Lok Swasthaya SEWA Cooperative through its leaders, the coverage for child health services has largely been confined to urban or its surrounding areas and needs to be spread in remote rural areas.

6.2 : Barriers

- Inability to achieve a major breakthrough in economic enhancement is a barrier in affecting improvement in the other social determinants like health.
- Poverty is still a barrier towards health seeking behaviour.
- Laissez-faire and globalization forces (market driven) affect poor more indirectly through price fluctuations of essential commodities like food and medicines. The meager income increase and savings do not provide cushion to such fluctuations.
- Lack of interaction and cooperation with Gujarat state government on various legislative, political and administrative matters. This results in not getting many government aided programmes for the poor through SEWA as is possible for central government aided health and housing programmes .

6.3 : Lessons Learnt from SEWA Experience

- Organizational capacity to expand membership and form trade and service cooperatives at local, regional and national level. Organizational strength through unionization gives SEWA members sense of ownership, belongingness, visibility and pride. That makes SEWA different from other social organizations.
- Partnership of SEWA with rural, urban, parastatal, NGOs and other line agencies in programmes like health awareness, slum improvement, disasters relief and rehabilitation, communal riots, integrated rural development demonstrates its effectiveness in reaching the poor for social benefits.
- Delivery of primary health care including antenatal, post natal, immunization and reproductive health services can be more effective if these are delivered at the door step of the vulnerable groups. The poor and particularly women find physical and social constraints to reach/access the formal structures of healthcare.
- Empowerment of vulnerable groups is possible through promoting leadership quality, skill enhancement, self-reliance, and by meeting social needs like health, housing and full employment.
- Networking is easier in situations where social commitment is high and the institutional setups are more uniform. Success of effective health care delivery within SEWA could be possible largely due to a well established network of paramedical staff at various geographic scales .
- Lobbying and advocacy is a good instrument for improvement in labour laws and legislation for social and economic securities.
- The SEWA experience proves beyond doubt that poor, self-employed women are bankable and insurable.

- Highly motivated and committed trained leadership that emerges at local level is essential for the success of women empowerment process. The leaders themselves can serve as role models for other members.
- A programme that aims to empower the poor must be prepared to listen to the poor. When a marginalized group is involved in planning for its empowerment, the programme is more successful than one in which they are passive recipients of welfare schemes.
- A participatory, bottom-up approach that strengthens local institutions will be more successful than a top-down approach.
- A holistic approach that links economic benefits with social gains is more acceptable to poor families rather than a programme that focuses a single issue.

7.0 : Conclusions and Recommendations

- Health development model and Health Improvement Index as developed in this study, based on SEWA experience, can be tried for poor communities in different settings.
- To understand the specific impacts of SEWA activities and programmes on its members, more comprehensive and scientific studies with a large database and spatial coverage need to be undertaken. Notwithstanding this hiatus, limited and sporadic studies show potential for replicating the SEWA approach to empowerment of women.
- State, national and international publications on gender and women issues could integrate the SEWA approach of empowerment. Considering the linkage between health security and economic empowerment through SEWA approach, UN organization like WHO can adopt social determinants of health as identified in this study.
- There is scope for discussion of SEWA approach at national and international fora along with other institutional strategies on similar issues.
- National government could explore the possibility of adopting SEWA's integrated strategy for the empowerment policy of marginalized communities with respect to health and employment.

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Annexure 1 : Historical Milestones of SEWA

SEWA UNION		
National	1972	SEWA registered as a national trade union based in Gujarat, Trade Union Act of India
State	2001	SEWA registered as a trade union in Uttar Pradesh
	1988	SEWA registered as a trade union in Madhya Pradesh
SEWA COOPERATIVES		
State	1979-2000	First time registration of new types of all-women cooperative federation ltd. SEWA Cooperative Federation Ltd.
	2001	SEWA Health Care Services helped form a cooperative of male health educators
	1992-93	Gujarat State Women's SEWA Cooperative Federation Limited registered
SEWA DISTRICT ASSOCIATIONS		
District	1992-2004	First time registration of All Women District Associations
SEWA BANK		
National	1993	SEWA bank obtained permission from RBI to operate in five districts
	1989	SEWA bank obtained license to undertake banking work in whole of the Ahmedabad district
State	1974	SEWA bank registered as women worker's cooperative bank
SEWA HOUSING TRUST		
State	1994	SEWA Mahila Housing Trust established and registered
SEWA ACADEMY		
State	2000	SEWA registered 'Shri Gujarat Women Video SEWA Information and Communication Limited'.
	1996	SEWA registered Anasooya Trust
SEWA HEALTH		
State	2001	SEWA health care services helped form a cooperative of men who are health educators
	1994	Krishna Dayan Co-operative Limited started midwives
	1990	Mahila SEWA Lok Swasthya Cooperative
Local	1992	Two medicine counters were opened which helped to lower prices in the open market and thus reduce health expenditure

Source: Derived from SEWA publications

Annexure II : SEWA's Organizations

<p>1. Cooperatives : 96 78,000 members</p>	<ul style="list-style-type: none"> • Bank-44.6% of total membership • Service cooperative- health, childcare, video cooperative-38% membership • Dairy cooperative -32.7% membership • Artisian-13% of membership • Vendors-13% of membership • Land- based crop
<p>2. Producers' groups 3200 groups</p>	<ul style="list-style-type: none"> • Artisan • Land based • Forestry • Nursery raising
<p>3. Saving and credit groups</p>	<ul style="list-style-type: none"> • Ahemdabad saving and credit group • Kheda SCA • Gandhinagar SCA • Mehsana SCA
<p>4. Social security organization</p>	<ul style="list-style-type: none"> • Lok Swasthya SEWA health cooperative • Shramshakti cooperative • Sangini Child care • VIMO-SEWA(largest membership)
<p>5. Gujarat state women cooperative federation- 96 cooperative,78,000 membership</p>	
<p>6. Associations of producers groups</p>	<ul style="list-style-type: none"> • Banaskantha district Mahila SEWA associations • Kutchcraft associations • Sabarkantha Khera Mandal • Sukhi Mahil Mandal
<p>7. Ansooya Trust Newsletters (1996)</p>	
<p>8. Mahila housing SEWA Trust</p>	
<p>9. SEWA Gram Mahila Haat Trust with support from state government</p>	
<p>10.SEWA Trade facilitation Centre or Unnat bazaar</p>	<p>Bridge between the rural Micro-level and global market</p>

Source: Derived from SEWA publications

Annexure III: SEWA's Campaign

SEWA's Campaign	Important years of Movement	Objectives	Current Status
Home-based worker's campaign	1996	For the right of home-based workers.	SEWA is spreading a national and south Asian movement for the rights of home based workers.
Vendors campaign	1996 1997 2001	To en forcible eviction of vendors and to obtain alternative vending sites.	A national on street vendors was developed at national level and still continues.
Clean Ahmedabad campaign	1994	To generate awareness about problem and raise awareness among poor.	Operating at block levels and district level. Women involved are known as "Arogya Bhagins".
The Water campaign	1995 2005	Safe drinking water for drinking and irrigation purposes.	
Campaign for forest workers		To provide technical support for forest producers.	National and state level campaign
Campaign for Agricultural labour	2004 2005	To provide support for agriculture	Organized consultation between women and commission.
Campaign for reorganization of Dais	2004	To provide primary health services.	Founder member along with 6 NGO's.

Source: Derived from SEWA publications

Annexure IV: Capacity Buildings through SEWA

SEWA Training Programmes	Objectives	Spatial reach of training programme
1.Vocational Training	Vocational programs are designed to help women's financial security and self-reliance by increasing their capacity in traditional and non-traditional skills.	
2.(a) Capacity Building Training		
<ul style="list-style-type: none"> • <u>Member Education</u> 	It's a leadership development programme. To build identity, unity and an understanding of collective action among SEWA members.	District level.
<ul style="list-style-type: none"> • <u>SEWA Movement/Basic Leadership Training</u> 	Basic Membership Training programme to take a course that prepares them to be members of the grassroots training team.in operation from 1996 to 2004.	Local level
<ul style="list-style-type: none"> • <u>Advanced Leadership (Kadam) Training</u> 	Kadam means "a step" and the programme is considered a step forward from the basic leadership training. To generate better understanding of SEWA's philosophy and operation among the leaders of SEWA. This programme is in operation from 1993 to 2001.	
<ul style="list-style-type: none"> • <u>Training of Trainers (TOT)</u> 	Leaders who complete the Advanced Leadership Training programme are eligible to take a course that prepares them to be members of the grassroots training team.	Local level
2.(b)Technical/Professional Programs		
<ul style="list-style-type: none"> • <u>Rural Association/Cooperative Training</u> 	These programs facilitate women's involvement in income-generating activities such as crafts, salt farming, and diary farming. These training programs address marketing and technical skills	At village and district level.
<ul style="list-style-type: none"> • <u>Research Training</u> 	SEWA members have been trained to develop the essential skill of generating and communicating scientific information about women in the informal sector. This programme is in operation since 1997.	Field research
<ul style="list-style-type: none"> • <u>Communication Training</u> 	To train people in video and print media	International level

<ul style="list-style-type: none"> • <u>Natural Resources Training</u> 	<p>SEWA's capacity building program trains women in the technical skills necessary to manage these natural resources that significantly affect their livelihood. These programs increase women's self-confidence, their individual and community livelihood and decreasing their reliance on the government.</p>	
<ul style="list-style-type: none"> • <u>Health Care</u> 	<p>This training has not only developed the capacity of the individual women but also supplies critical, safe healthcare to communities by providing safe and modern childbirth practices, basic emergency care, and preventative care such as immunizations.</p>	<p>Both at rural and urban level</p>
<ul style="list-style-type: none"> • <u>Financial Services</u> 	<p>Member-trained financial managers assist in managing all aspects of SEWA's financial services including savings, credit, and insurance programs. A team of trusted grassroots bankers have been trained to collect deposits in isolated villages, provide "hand holding" consultations about SEWA's range of financial services, and manage rural savings and credit groups.</p>	<p>At local level in rural area</p>
<p><u>3.Exposure and Dialogue Programs</u></p>	<p>Exposure and Dialogue Programmes (EDP) is a means to sensitise members, organizes, colleagues, and institutional leaders towards the poverty and work-related issues faced by our members. EDP helps participants move beyond a theoretical, abstract understanding to experience first-hand the realities of village life, the needs of self-employed women, and the effect of SEWA's services, and the strengths of the women. In operation since 1991</p>	<p>At international level</p>
<p><u>4. Literacy and Non- Formal Education</u></p>	<p>To provide education to women this will be helpful in their day to day life in operation since 1991</p>	

Source: Derived from SEWA publications