Thanks to all at Flinders University for inviting me to deliver the Southgate Oration here in Adelaide today. Special thanks to my friend and colleague, Dr Frances Baum, for bringing me to Australia and for her warm hospitality.

I am very honoured to deliver this oration in memory of Dr Deane Southgate. I learned that he was a passionate public health practitioner and was deeply committed to health promotion, preventive health action and the overall well-being of communities here in South Australia, and especially young people. At SEWA, the organization which I am representing here today, we like Dr Southgate, believe in the power of local people to take action to promote and safeguard their own health. So as we say in India: Dr Southgate ko hamara salaam----we salute you today, Dr Southgate.

Today is also Dassehra, the festival where in India we celebrate the victory of Lord Ram over the demon King Ravana, and also that of Goddess Durga vanquishing the evil demon Maheshasura, whom none of the other male gods could conquer. This is a day of celebrating the triumph of all that is good in our world over the darker aspects. While we still have a long way to go before we achieve health for all in both Australia and India, a cause for which Dr Southgate worked all his life, we can certainly take some pride in where we have reached in both our countries vis-à-vis our people’s health and well-being.

Let me begin by telling you about the Self-Employed Women’s Association, SEWA, a national union of almost 2 million women workers of the informal economy. It was founded in 1972 by Ela Bhatt, a lawyer and labour organizer whose family was close to Mahatma Gandhi, the leader of India’s independence struggle. Heeding Gandhi’s call to work with the poor as part of nation-building in post-Independence India, Ela Bhatt began organizing workers in the Textile Labour Association, a union of mill workers in the city of Ahmedabad. This union, one of India’s first, was set up by Mahatma Gandhi, who himself led the first strike for better working conditions for workers, including financial support for workers during the epidemic of plague at that time.
Ela Bhatt soon realized that it was the vast informal workforce in India that constituted the poorest of workers, without any labour laws or basic access to social protection. And within this large workers’ group, it was women workers who were the most vulnerable, invisible and marginalized of all. Thus, she began organizing street-vendors, agricultural workers, waste recyclers and craftswomen. She understood the power and importance of organizing workers, building their solidarity and thereby increasing their bargaining power in their workplaces, in their families and in society at large.

Today SEWA is not only a national movement with SEWAs in 14 Indian states, but also has counterparts in neighbouring South Asian countries, in South Africa and Thailand, to mention a few. It is spearheading an international movement of informal workers for full employment at the household level, including work and income security, food security and social security. SEWA’s goal is to organize women for self-reliance---both financial and in terms of decision-making and control of their lives. We have learned that full employment is the road to self-reliance. I will speak to this later on. We have also learned that women and their families cannot emerge from poverty and move towards self-reliance without health care and health security.

The journey towards health security and health equity, in turn, must begin with people in the centre, where they live and work, how they raise their families and their hopes and dreams for a better future for their children. This is what Mahatma Gandhi, and many others, taught us years ago. Gandhi gave us what he called a talisman – that all action should be undertaken with the poorest and most vulnerable central to all our endeavours. And so I will begin today’s oration with sharing the lives of three of my SEWA sisters, all informal workers and also from among the poorest of communities in India.

Rajiben Chavda is a small farmer. She and her husband have small plots of land in a chronically drought-prone area of Gujarat – Viramgam. Their land has no irrigation. When the monsoons fail or are delayed like this year, they eke out a living as migrant labourers breaking stones to build roads in the town nearby. Rajiben belongs to the poorest and most excluded of castes in India – the Dalit community.

She is also a health worker in SEWA’s health cooperative, Lok Swasthya, where she and 400 others like her spend part of their day as health educators, provide support for referral care and link women and their families with the public health system. The cooperative compensates her for her time and services. She says: “Our lives centre around getting work and income. We don’t have the time and knowledge to get access to health services and government programmes. Who will help us get access to the better work tools that we need? So women like me joined SEWA and decided to take action through our own health cooperative.”

Rajiben promotes both the government’s health insurance for Below Poverty Line families and SEWA’s own insurance, VimoSEWA, for all workers, including those who do not qualify for such programmes, but are still poor and vulnerable.

She says women informal workers need primary health care, basic health education, free medicines and a system of timely and affordable referral care. This is what she focuses on every day, in addition to working on her small farm.
Fatimaben Shaikh makes kites for a living. Ahmedabad, the city of her birth, celebrates the kite festival with special gusto every January. She and thousands of others prepare for this event by making kites, squatting on the floor, with a wooden board on which to work. They are given work by a contractor and are paid a piece-rate. This means that speed and skill are both important. She makes 1000 paper kites per day working from her small ten by fifteen feet room that serves as both home and workplace. Often her back and shoulders hurt. She cannot afford to stop and rest. She needs the Rs 120 or US $ 2 that she earns daily to keep her family fed and her children in school.

She suffers from heavy bleeding and the doctor advised a hysterectomy. She does not have the money nor does she have access to the government’s health insurance, because she did not qualify for the government’s Below Poverty Line category. Besides, her daughter had to have an emergency appendectomy which ate into their meagre savings. It cost them Rs 15,000 or US $ 230. Their daily family earnings are Rs 700 or US $ 11. A few years ago, she joined SEWA. Now she leaves her youngest son in the SEWA child care centre so she can work and earn more. She learned about VimoSEWA, SEWA’s insurance cooperative, from its local insurance promoter, also a kite worker, and plans to pay the premium for health insurance soon.

Lataben lives in the forests of Tapi district in South Gujarat. She is from the Gamit community, one of our Adivasi, or aboriginal people. India’s aboriginal or indigenous people are about 104 million-strong or 8.6% of our population, according to the latest Census of 2011. They are, as in many countries, the poorest and most vulnerable of all. Despite years of special support under the Indian Constitution, including affirmative action, Adivasis are exploited and neglected, their unique culture and many languages neither understood nor appreciated. Lataben is a relative new-comer to SEWA. We met this shy but fearless local leader a few years ago, when she exposed the nexus of corruption between local officials and elected functionaries, and organized the women of her village to obtain the wages that were their due.

She is a small farmer, and in the hot summer months, she joins others in her village in building a road and other infrastructure, as part of the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS). This programme, as the name suggests, guarantees a hundred days of work for one member of a rural household. In districts like her’s which are entirely of indigenous people, there is additional work for asset-building, like a well on their land or a pond to harvest rainwater.

As she organized women first into their own union, and later to join the health cooperative where Rajiben is also a share-holder, she learned about sickle cell anemia for the first time. Her son was often sick, but it was only after the health cooperative’s education sessions that she understood that he has a hereditary condition, endemic among the Adivasis.

Rajiben’s, Fatimaben’s and Lataben’s lives and health needs mirror millions of those engaged in the informal economy in India and other countries across the globe. In Australia, the informal economy is only about 15% of the workforce. But in India, more than 93% of the workforce is informal. This is about 430 million workers. They are poor, hard-working and do their best to plan for a better future for their families. Their’s is a life-long quest for some basic security in their lives, including both work security and social security.
In India, and at SEWA, by social security we mean at least health care, child care, insurance, shelter with basic amenities like a tap and toilet in every home, and pension. As in many countries, health care tops the list. Lack of basic health care leads million of families into poverty. It is estimated that about 60 million Indians fall into poverty every year due to sickness and health expenditure (1).

A recent McKinsey Global Institute report on poverty in India calculated that 680 million Indians, or about 56% of our population, are without basic services in which health care, water and sanitation top the list (2). In India, out-of-pocket expenses account for about 67% of all health care costs (3). People sell their land and all else they have to save a loved one. In our own women’s cooperative bank, SEWA Bank, sickness is the number one reason for taking loans. Thus, we see repeatedly, and across the country, that people are trapped into the poverty-debt-poverty cycle. Efforts in the direction of health security and equity, must address these issues which both have impact on people’s health and also are essential anti-poverty measures.

As mentioned above, the vast majority of Indians, and especially women, are engaged in the informal economy. Work is central to their lives, and in countries like India with still very little social insurance and other economic support, it is the only way they can survive, feed themselves and have some access to health care and education for their children.

Further, for workers of the informal economy, their body is their only asset. This is even more so for women, the most vulnerable of informal workers. Time and again, our SEWA sisters say: “As long as we are healthy, we can work and earn, and we can feed our children.” Often, even when they are sick, women work as they are always worried about feeding the family.

When they get an injury or are sick and stay away from work, they not only lose their daily wages or income, but also they have to incur heavy expenses for doctors, for medicines and laboratory tests, and for hospitalization. We have seen over the years that our sisters borrow from relatives and friends, pawn their jewellery or work tools, borrow from money-lenders and landlords or big merchants, and even sell their land and other hard-earned resources.

In addition, informal workers’ living conditions affect their health. They often live in homes without basic amenities like water, toilets and proper sanitation. Some do not have electricity and their homes are often small and poorly ventilated. All of this affects their overall health. This is further compounded by poor levels of nutrition and by the impact of their work, leading to musculoskeletal problems, exposure to toxic chemicals, dangerous machines and dust. Injuries are common and often lead to disability. All of these risk factors, and their outcomes, are well-known and well-documented now in India.

While staying healthy is important for all, for informal workers it takes on a special significance, as their very being is dependent on their ability to work. In addition, they do not have access to paid sick leave nor health insurance. Thus staying healthy, having access to basic levels of nutrition and social security like insurance, and low cost or free health care is critical for workers of the informal economy.
SEWA recognized the deep connection between workers’ health, their productivity and ability to earn, and eventually become self-reliant, from the very early days of organising women into their own union and cooperatives. We saw our sisters succumb to tuberculosis because they did not have the money to pay for the medicines, or develop chronic cough due to tobacco dust exposure. We saw that they had miscarriages as they continued to lift loads at construction sites or pulled hand-carts through the streets of Ahmedabad, using their bodies as brakes.

We also began to explain to our sisters that health care is their right, because it is guaranteed in the Indian Constitution, in the international declaration for Universal Human Rights that India is a signatory to and also because of their significant contributions to India’s economy and society. In fact, we explained to them that India’s growth and prosperity was due to their contribution. Over 50 per cent of India’s GDP is from the informal economy. It also accounts for about 55 per cent of national savings and 47 per cent of exports.

Further, while we agreed that it is the responsibility of the Indian state to ensure a measure of public health for all, we also agreed, from SEWA’s very inception, to take care of our own health, that of our families and communities. We resolved to do this by ourselves learning about our bodies and how to stay healthy, by becoming more aware of what we need to do and how to act for health.

Our first health action was to develop preventive equipment for workers to safeguard their health. We partnered with the National Institute of Occupational Health (NIOH) and the National Institute of Design (NID) to develop safer equipment and work tools and processes. The next was to ensure that our sisters had good quality care during childbirth, as maternal deaths, particularly in the early years of SEWA, were not uncommon. From these initial health initiatives, SEWA developed a larger and more holistic approach to the health of its members.

Since 1984, we have focused on health education and awareness by, for and with our members. Our sisters were trained to be health workers for their communities and neighbourhoods, providing primary health care. In addition to health education, they sold low cost medicines and provided support to members for referral care at large hospitals.

In the thirty years of working with SEWA sisters and their families for improving their health and overall well-being, our approach to health at SEWA has become clearer. Our approach has also evolved and changed, both according to the needs of our members and also because the government has expanded its services through the National Rural Health Mission (NRHM), and now the National Health Mission (NHM), with greater provision of both rural and urban health services.

What is clearer than before to us now is that improvements in our health or health security can only be achieved through action on the social determinants of health, with organizing as the first essential building block. This was also documented with solid evidence in the WHO’s Commission on Social Determinants of Health (CSDH) where Dr Fran Baum and I served as Commissioners. Experiences and evidence from country after country, both developing and developed, pointed to how critical action on the social determinants of health is for health equity.
and social justice more broadly. The report of the CSDH also highlights the importance of organizing or agency of local people, especially women.

Organising is the continuous process of uniting people and building their solidarity through membership-based organizations that they themselves develop, own and manage. These include unions, cooperatives, Self-Help Groups (SHGs) and their federations, producers’ groups and other such local organizations. These organizations by their very nature are inclusive, focusing on the poorest and most vulnerable, who now increasingly understand that change, including in their health, can only be achieved through collective action. Conversely, action around health issues is a good rallying point or ‘entry point’ for organizing the poorest, especially women, for their collective strength, visibility and voice.

In addition, at SEWA we have learned that it is women, especially at the grassroots level, who are ready to take the lead to transform their communities’ health and to work for the overall well-being of all. Let me share how organizing, and with women in the lead, has led to action on the social determinants and slowly, to better health.

The story of our journey towards health security for informal women workers in India dates back to 1972, when Ela Bhatt set up SEWA. The first of its kind, SEWA began to organize street-vendors, head-loaders, home-based workers like garment workers and incense-stick rollers at a time when their labour was hardly considered work. Recognising that work was women’s life-line to survival, Ela Bhatt and her small team of SEWA pioneers, had to face their first struggle – the struggle of concepts, of women themselves, their families and the outside world not even acknowledging women’s work and significant economic contribution.

The first group of women workers, head-loaders, approached Ela Bhatt, popularly called Elaben or Sister Ela, for support. They could not make ends meet carrying loads on their heads or in their push-carts, earning just a few rupees a day. The injustices faced by the head-loaders opened Elaben’s eyes to the vast and unprotected labour force that was the informal economy. One of the many struggles she noticed was around pregnancy. These women carrying loads or pulling carts frequently had accidents and miscarriages. However, they had no access to compensation for injuries, nor access to affordable health care during pregnancy.

Slowly, SEWA began to take up these issues and more women brought in their problems and challenges. One of their most pressing needs was for financial services. They were tied to money-lenders or large merchants who charged exploitative interest rates that kept them indebted and in poverty—often 10 per cent per day! The women approached banks, all nationalized at that time, for assistance but were turned away and told they were not bankable. Hence, women decided to form their own bank—SEWA Bank—by pooling their wages of Rs 10 or 16 US cents per day as initial share capital. Thus, in 1974, with just Rs 40,000 or US $ 666 as share capital, 4000 plucky SEWA members formed India’s first all-women cooperative bank. Today SEWA Bank has 500,000 depositors and a total working capital of Rs 2.5 Billion or about US $ 41 million.

SEWA’s health journey began with the head-loaders and with SEWA Bank. When analyzing reasons for non-payment of loans taken by women, we found that illness was the number one
Women wanted to re-pay loans, but had to spend the money to pay for medicines and doctors’ bills. We probed further and were shocked to learn that of 500 women not re-paying regularly, 20 women had died, 15 of them in childbirth. These findings, along with SEWA members demanding that we act to improve their health, resulted in a community-based, primary health care programme, where women themselves would learn about their bodies and their health as a first step.

I remember well the very first group of SEWA members that I met at Shankarbhuvan, a lively settlement of street-vendors and other informal workers on the banks of the Sabarmati River in Ahmedabad. It was these SEWA sisters who taught me much of what I know about the social determinants of health. They explained that they had neither running water nor toilets. Further, they told me that they had to have four to six children so that two or three survived. Living in small, unventilated homes in close proximity, and with not enough to eat, TB was widely prevalent. They were all self-employed and sharp businesswomen, but had to face daily harassment from the police and municipal authorities who treated them as if they were a nuisance and traffic obstruction. Most of them needed credit for their businesses but did not even have a bank account. Living in a low lying area, flooding during the monsoon was common. They left home at dawn, often carrying their young children in their vegetable carts – they had no child care.

To add to their difficult living and working conditions, being women, they faced discrimination and inequality at every step. Customary laws were unfairly loaded against them at every step, and they had no knowledge of their statutory rights. Who was there to tell them? Most had not been to school.

Palliben, a vegetable vendor and local leader explained: “Look at our lives, the struggles at every step. We want to be healthy. Our bodies are our only assets. As long as we are healthy, we can work and earn and feed our families. We need to know how to be healthy and also access the public health services.”

Over the years, I have heard these words innumerable times, in rural and urban low income areas, and across the length and breadth of India. Women explain that they cannot be healthy unless they have the basics of life, and have work and income security. And in turn, they cannot emerge from poverty and become self-reliant without health.

The challenges were enormous but as usual, the SEWA sisters showed the way. They asked for simple ‘Know Your Body’ health education as a start. It was the Shankarbhuvan colleagues who set aside their vegetable carts and baskets and began to learn about their health and to serve as the first of SEWA’s health workers. They began with TB education and control – linking their neighbours with the free public services for TB, including medicines. Then they began to ensure that women in their neighbourhoods had safe child-births by registering them in clinics nearby, encouraging them to have regular ante-natal check-ups and to eat well. Gradually, the health worker team swelled to 50 women from other urban areas, and then nearby villages. Comprehensive primary health care, with a special focus on health education, became their main service.
They also organized women into our union, many of them obtaining relief from the police and municipal officers who regularly confiscated street-vendors’ goods and evicted them from our traditional markets, and often openly asking for bribes. The union supported their negotiations with the authorities and in the courts, and eventually in the Supreme Court of India which upheld their right to livelihood and protected them from further evictions. They also opened bank accounts for their sisters, helping them to save, and freeing them from the clutches of money-lenders. Later when SEWA initiated insurance services, they enrolled women in policies offering life, accident, health and flood insurance. After some years, SEWA set up a housing and basic amenities organization – Mahila Housing SEWA. At long last, the Shankarbhuvan sisters got a tap and toilet in every home, then paving and street-lights. Meanwhile, the union ranks swelled from 4000 to 20,000 in a few years by the late eighties.

With no blue-print but a long-lasting commitment to work shoulder-to-shoulder with our sisters, all informal workers, today SEWA articulates its goal: self-reliance for informal women workers and their families, through full employment. The latter, as mentioned earlier, includes work and income security, food security and social security. Social security includes at least health care, child care, insurance, pension and shelter with basic amenities, as our Shankarbhuvan sisters explained to us, many decades ago. Without our knowing it at that time, SEWA’s vision matches the one expressed in the report of the Commission of the Social Determinants of Health, and many organizations and researchers around the globe, like those in the Southgate Institute, working on the social determinants of health.

Self-reliance is part of SEWA’s core values. It is what we learned from Mahatma Gandhi, whose ideas inspire our action. It includes both financial sustainability and decision-making and control in the hands of informal women workers themselves.

We also soon learned that it is nearly impossible for a poor, working woman to achieve self-reliance and emerge from poverty single-handedly. She needs her group and her organization, preferably membership-based, so that each member has voice and visibility, all are included and valued. After SEWA in 1972, the next such organization was SEWA Bank. Soon the first 50 health workers decided to promote their own health cooperative, another first for them and the state. It took us two years of struggle and of convincing the authorities that such a cooperative could be viable. In 1990, our Lok Swasthya SEWA Mandli, or People’s Health Service Cooperative, was born and this year, we celebrated 25 years together. From 50 women, today we are 2000 health workers, all share-holders.

All the services are provided by the health workers of the cooperative. Apart from health education, they provide local women and their families information on public health programmes, where and how to access these, occupational health services including low cost tools to reduce the everyday aches and pains, referral services, insurance and counseling for mental health. The government has now improved its primary health care, especially maternal and child health and TB, and so the health workers, no longer focus as much on these. Rather they ensure that safe child-birth is a reality for all by working with the public health nurses and paramedics.
One of the hallmarks of the cooperative is a chain of low cost pharmacies, run by women, which provide generic and branded medicines at well below market rates. This is possible because we pass on the numerous discounts and special benefits to the patients. Two of these pharmacies are located outside large public hospitals, where low income patients obtain treatment. They are run around the clock and are now widely acknowledged as providing useful services as well as saving people’s hard-earned money. In fact, we recently calculated that over the years of their existence, these shops have saved about Rs 10 million or US $ 167,000, which hopefully would have been used for food, education and other life’s essentials of the working poor. Since 1990, when the first pharmacy was set up in SEWA’s office, we have sold Rs 340 million or US $ 56 million worth of medicines. At the same time, we found that even with low prices, we generated substantial revenues—enough to make our health cooperative viable and with profits that could be invested in new activities like our Ayurvedic medicine production, and into non-income generating activities – health education, referral services and mental health care.

It was not always smooth-sailing. Local goons tried to frighten our sisters in the medicine shops into pulling down the shutters, as we were cutting into the huge profits of the private chemists nearby. In fact the chemists association of Ahmedabad called for a boycott of our shops – no one was to supply to us. Fortunately, we survived because of the goodwill of so many—patients, doctors, local leaders and even medicine wholesalers who supplied us through the back door!

Perhaps most of all, it is the share-holders of Lok Swasthya health cooperative who continue to come up with creative ideas, are full of enthusiasm and self-belief. Today the cooperative is not only self-financing but also has been recognized year after year as the top performer in the service category in the state, belying the doubts of the cooperative registrar years ago.

Another learning is that acting on the social determinants of health comes naturally to our SEWA sisters. While many of us struggle to think holistically and comprehensively, informal women workers like SEWA members, not only know that this is the way to go for health security and overall well-being, but they actually act to change their own living and working conditions, and those of their communities. They do this through organizing into unions, cooperatives and other local organisations, building their strength and sisterhood with determination and persistence.

They shared their experiences and insights with the WHO’s Commission on the Social Determinants of Health (CSDH) during the meetings held in India, explaining all the connections and inter-connections between various aspects of their lives and livelihoods.

It is hard to quantify how the social determinants of health actually translate into health security and health equity, especially for women like Rajiben, Fatimaben and Lataben whom we met at the beginning of my presentation. Some impact studies undertaken by researchers have shown that our collective action for health, health education and other activities like early childhood care and financial services, indeed improve women’s health, and keep them out of poverty. Most of all, it is the testimonies of the women themselves that bring out the impact of multi-faceted action and the importance of their own organization and agency.
From them we have learned that to emerge from poverty and move towards self-reliance, the following four ‘pillars’ are essential – and all are needed simultaneously.

First, financial services to help women strengthen their work, improve their homes, build up their businesses and educate their children, among other basic needs. Importantly, asset-building, and in women’s name, must be undertaken so that they have land, a buffalo, a sewing machine and other work tools of their own.

Second, social security, the elements of which – health care, child care, insurance, pension and housing with basic amenities – were mentioned earlier.

Third, capacity-building for women so that they can run their own organizations, upgrade their skills, obtain new knowledge and information, and develop as strong leaders.

Fourth, voice and representation for women in all matters concerning their own health and well-being, including a place at the policy table.

All of these should preferably be made available through their own membership-based organizations which are democratically run and owned by them.

I am not suggesting that poor women in India or anywhere else should be solely responsible for their own health. We would agree that it is the primary responsibility of any modern, democratic society and state to ensure the well-being of its people, including their health security. However, in countries like mine which are large, diverse, complex and quite ungovernable by one centralized or ‘one size fits all’ approach, it is these small, localized and decentralized organizations, preferably run by women, that can move their communities towards health security. And it is not just SEWA which has unearthed this finding. Community-based organizations, unions, cooperatives and NGOs across India are finding that there are things that governments like our’s can and should do, and some that they cannot. Implementation of public health programmes right down to the grassroots, or any other poverty reduction programme for that matter, have generally not been carried out effectively. This is now openly acknowledged by policy-makers in India from district, state and national levels.

In fact, building on experiences of civil society, our National Health Policy 2015 has laid out significant roles and responsibilities for local health committees at the village and urban, low income neighbourhood levels. Women are to be at least 50 per cent of these committees, and our SEWA sisters have been bringing their skills and experiences to these committees in villages and towns across the country. Similarly, low cost medicine outlets are now mainstreamed into the policy, but other aspects like occupational health and mental health services, are barely mentioned.

One of the offshoots of our health organizing at the grassroots is that it throws up many policy issues. Over the past four decades of SEWA’s existence, there have been so many health and related issues on which we have joined hands with others in civil society, with academics and even our government. One example that comes to mind is that of the International Conference on Population and Development (ICPD) in Cairo in 1994. Up until then, India’s public health system was more a family planning one, with resources mostly invested in controlling fertility,
with little attention to the social determinants, and women’s health and rights. Our members were constantly demanding more by way of primary health care. We organized several regional and grassroots consultations across India in preparation for Cairo, often entering into lively debates with our health ministry officials. But in Cairo, we joined hands, including with our government, and argued for reproductive health and other services for women and girls. One of the highlights was when my SEWA sister, Chandaben, old clothes vendor and founder member of SEWA Bank addressed the dignitaries. She said: ‘If men were able to have babies, we would not be having this debate. How can we deprive women and girls of their basic health knowledge and rights? I have had six children but nobody provided basic health education. I want my grandchildren to know about reproductive and also overall health.’

I have already mentioned the Commission on Social Determinants of Health and how women workers contributed to the discourse. There are many such small and other quite substantial breakthroughs. I have found that when women themselves speak out and share their insights, policy-makers and legislators are often moved to act. And the grassroots experience of organizing, building women’s own organizations, and in a democratic and transparent way, acting on multiple fronts for the well-being of all, especially the most vulnerable, provides workable examples and experiences. One such is our ongoing recommendation that our government set up Workers Facilitation Centres, run by unions, cooperatives and other local organizations, to bridge the information gap on the many health and other anti-poverty programmes of the Indian government. Poor, informal workers are even willing to contribute in cash or kind for some of the services and for such information, if it brings them greater access and quality services.

Policy breakthroughs, in turn, give women and others at the grassroots level hope and a heightened understanding of their collective power to change the forces that keep them unhealthy, and in poverty. This then encourages them to organize further and harder for health security, health equity and their overall well-being.

There is still so much more to do – new opportunities and new challenges. Among the many challenges is the lack of political will for health care. While all our political parties have committed themselves to greater investments in public health, we see little progress in this direction. While GDP growth has been prioritized, improving the health of all Indians has not, if one were to go by financial outlays. Further, there is tremendous pressure on our government to roll back some of our patenting laws for drugs. On the one hand, India is called the ‘pharmacy of the developing world’ and on the other, efforts are underway to curb our low cost drug manufacturing for Indians and all global citizens. It is difficult to see how health security and health equity will be a reality, if drugs are out of the reach of people. Similarly, despite having the largest number of under-nourished children, India has not yet invested adequately in comprehensive early childhood care. In fact, as in health, we are seeing budget cuts.

In addition to these macro-level challenges, there are the everyday challenges of bringing together informal women workers, in a country where we are divided by caste, religion, ethnicity and more. As we attempt to tread the path laid out by Gandhi, we are increasingly told that we
are an anachronism, that his ideas of well-being for all, especially the most vulnerable, are out-
dated.

This year our health cooperative celebrates its twenty-fifth year and the SEWA movement, its
forty-third. Despite the nay-sayers, we are committed to Gandhi’s path of ‘Doosri Azadi’ or the
Second Freedom, the first being our political freedom. The Second Freedom is freedom from
poverty which Mahatma Gandhi believed was violence by society on its own people. Over the
year we have learned that it is the local people, led by women, who will lead us to the Second
Freedom in India, and which may offer some lessons for other nations. The Second Freedom
necessarily involves a holistic and comprehensive approach, a social determinants approach,
with building solidarity at the community level for collective action as the first step. At SEWA, we
have no doubt that it is our sisters like Rajiben, Fatimaben and Lataben who will lead us on the
path to the Second Freedom or Doosri Azadi, a society with health equity and health care for all.
References

4. Ibid, p.3.