

The Informal Workers Health Project

Summary Report based on the final project report by Francie Lund & Rhonda Douglas

Introduction

In 2015, Women in Informal Employment: Globalizing & Organizing (WIEGO) together with its partner organizations, Asiye eTafuleni (AeT, based in Durban, South Africa), HomeNet Thailand (HNT), and the Self Employed Women's Association (SEWA, based in India),¹ participated in the Rockefeller Foundation's Informal Workers Health Programme, which has the aim of developing innovative approaches to addressing the health needs of informal workers. Understanding that these needs are often complex and that using a number of different approaches might be more effective than a single approach, the programme sought to develop interventions which were "multi-modal" in nature.

Working in three cities – Ahmedabad in India, Bangkok in Thailand, and Durban in South Africa – the WIEGO team developed three context-specific multi-modal interventions. Common across the interventions were that they were designed to bridge the divides between the realities of urban informal workers and the design and delivery of health services. A key theme was the question of how best to link relevant institutions on the supply side of health (public health officials and service providers) and on the demand side of health (organizations of informal workers).

This short report provides a summary of the interventions developed by WIEGO and its partners, focusing particularly on the issues which informed the process of development. These included an analysis of:

- i. the nature of the health problems prioritized by informal workers;
- ii. the barriers they experience when attempting to access health systems; and
- iii. the constraints and opportunities presented



This first aid stand was set up in the Warwick Junction markets in Durban, South Africa as part of Asiye eTafuleni's safety project. Photo: A. Buckland

¹ Asiye eTafuleni (AeT) is a non-profit organization focused on providing urban design solutions to informal workers. Both HomeNet Thailand and SEWA are grassroots membership-based organizations of informal workers.



In Bangkok, Thailand, a worker sorts plastic for recycling. The work is hard on the hands as the chemicals from the plastic can cause damage to the skin over time. Photo: Paula Bronstein/Getty Images Reportage

by the context in which they work and live. The report concludes with a reflection on the aspects of the interventions which WIEGO and its partners continue to take forward.

The Nature of Health Problems Impacting Urban Informal Workers

Informal workers who are poor suffer many of the same health problems faced by poor people in general. Non-communicable diseases (NCDs), such as cardiovascular disease and diabetes, are becoming an increasing problem in the urban centres of the developing world, and this project found that informal workers in Ahmedabad, Bangkok, and Durban are no exception.² The global move towards Universal Health Coverage appears to be neglecting the provision of preventive health measures. Yet, prevention of ill-health – particularly long-term chronic disease – is centrally important for informal workers who face the loss of their livelihoods when they are unable to work over a long period of time.

In addition, informal workers have health problems directly related to their work. One of the most commonly reported problems

across all sectors is musculo-skeletal pain as a consequence of the poor postures workers take in order to do their work with equipment that is often ill-fitting, as well as repetitive movements and the need to carry very heavy loads.

Less directly related to the work tasks are hazards associated with infrastructure at the workplace, whether this be a worker's own home or a market stall. A focus group of garment workers in Ahmedabad mapped out the problem caused by the shortage of electricity infrastructure: *"The garment workers use manual sewing machines because of the cost of electricity. Working on the machines the whole day leads to leg pain, swollen feet. Work cannot be done continuously, and income is lost."* In Durban, workers talked about the impact of the poor toilet conditions on their health and their ability to attract customers. *"We also do not have toilets, as a result, in the places where we work you get these funny smells, we get sick, there are flies and many other unpleasant things which make it unattractive to customers."*

What this means for our interventions...

NCDs are attributed to lifestyle; they can be effectively tackled by preventive measures over the life cycle. Tackling NCDs can involve a number of different strategies, from those focused on the structural drivers of disease, such as transforming food systems, to more individual level interventions, such as improving education and knowledge among informal workers and their families. The prevention of ill-health is key to protecting livelihoods and should be a key part of interventions targeting informal workers.

Preventive health work can also take the form of design interventions. Better design of work equipment and working environments can make a big difference to the overall health and safety of informal workers. The imaginative and practical design work done by both SEWA and AeT in the past and present has been a direct attempt to address these work-related health problems.

The social determinants of health, and the relationship with infrastructure and services, such as water and electricity, impact both the health and productivity of informal workers. Local government is vitally important in the provision of urban infrastructure – water, sanitation, and lighting for example. This means that holistic health interventions targeting informal workers may need to look outside of the usual domain of health departments, and towards local government and other stakeholders involved in the regulation of the urban environment.

² Lund, F & Douglas, R. 2015. Informal Workers' Health: Third Report on Health Prototype Development in Ahmedabad, Bangkok and Durban. WIEGO, AeT, SEWA & HNT.



Ice cream vendors bike along the beach in Durban, South Africa. Accessing clean facilities, such as toilets, can be a challenge for vendors in the city. Photo: P. Carney

Barriers to Accessing Health Services

The barriers to accessing health services that informal workers face, even when services are free at point of access (as public health services are in all three countries), exist on two levels. First level barriers directly exclude informal workers from accessing health services. These include:

Little information about what sorts of services are available: Even if health facilities are available, little information is relayed about where and at what times the facilities are open and what services are offered.

Formal rules of exclusion: The focus of this study was on urban informal workers. Yet the boundaries between rural and urban areas are not necessarily clearly defined. Informal workers may oscillate between the two or live in the peripheral space between urban and rural – and in both Bangkok and Durban we saw how this has implications for access to health. In Durban, many informal workers live far from the economic hub of the city, commuting long distances into work. However, they are turned away from the health facilities nearest their workplaces because they do not have proof of residence for the inner city and are told to use the facilities closest to where they live. This is against formal health policy, but has become an “entrenched practice”, as one doctor put it. In Bangkok, to get access to the Universal

Coverage Scheme (UCS) which is free to all citizens, workers must be registered at a particular health facility, and this is likely to be near where they live, not where they work – they can change registration, but this takes time and money, and many do not know how to do it. In Ahmedabad, informal workers are excluded from health insurance designed only for formal workers, while the facilities covered by the insurance have capacity and could easily take in informal workers.

If workers do gain access to the health system, they continue to face a second level of barriers to access which discourage them from using the services. These include:

Lack of coordination: This is an issue that occurs between different facilities where referrals are not synchronized. People visiting health systems get lost in one system or fall between the cracks of different systems. In Bangkok, health providers can’t cross-refer between municipal and national levels. There are bureaucratic obstacles between systems in Durban, where different agencies run different systems, but also within systems (public) as well as between public and private sectors.

The **time** taken in queues, waiting for service, and waiting in the wrong queue, is time away from work, with implications for lower productivity and incomes. Women had to take time off work to visit health services both for themselves and for their



*Samnvay Tocharoen's work in a small silverware factory poses a number of occupational health and safety issues, which she and others, as members of HomeNet Thailand, have been addressing.
Photo: Paula Bronstein/Getty Images reportage*

younger and much older family members. The **poor quality of clinical care** is a disincentive to return to the service, where there is also not enough **preventive care**. Universal health care without a primary focus on prevention makes no economic sense, and is antithetical to ideas about the right of all to fulfil our human potential to the fullest degree possible. There is **limited or expensive access to medicines** and, in India, to diagnostic tests.

What this means for our interventions...

Demand side interventions, which focus on promoting better information and health education in an innovative manner, are important. There are current windows of opportunity for innovative health interventions along these lines in all three countries; all three countries have excellent ICT capacity and high mobile phone ownership.

However, work is also needed to address exclusions and improve the supply side performance of the health system so that informal workers face less barriers to accessing health care. Workers can and should exercise their own agency in pursuing better health where they can, but the systemic problems are severe – the inefficiencies in bureaucracies, people receiving wrong information about services, long queues for service which is of a low quality – and must be the focus of advocacy efforts.

Context

The context in which informal workers live and work provides both constraints and opportunities for improving access to health services. This includes the nature of the national health systems, the organization of workers, and the previous involvement of worker organizations in policy advocacy around health provision.

National Health Systems: In all three countries, there have been large-scale reforms, or proposed reforms that have attempted to be inclusive and to favour the poor: the well-known Universal Coverage Scheme (UCS) in Thailand, the post-apartheid removal of user fees in South Africa followed more recently by proposals for a National Health Insurance (NHI) with an emphasis on improved primary level care,³ the implementation of the Rashtriya Swasthya Bima Yojana (RSBY) health insurance scheme in India, and the recommendations of the High Level Expert Group on Universal Health Coverage for India instituted by the Planning Commission of India.⁴ However, there have also been countervailing trends in all countries brought on by economic recession, austerity in social spending, social instability and the rise of more conservative political regimes.

In both Thailand and South Africa, the central state retains a firm hold on how the system is structured though administration is done through regions (Thailand) and provinces (South Africa). In India, the federal state is only partly responsible for funding, while the individual states have more autonomy as to how much they allocate to resources for health. The differences between states are stark. As it happens, over time, the nine South African provinces have been very uneven in their ability or will to deliver health services, and the health function in two provinces has had to be taken over by central government. Both the Bangkok Municipal Authority (BMA) and the Ahmedabad Municipal Corporation (AMC) play an active role in health care provision. The eThekweni Metro (the Durban municipal government) controls a few health services and facilities, but its major role in public health is disease and pollution control.

³ Department of Health, Government of South Africa. 2015. National Health Insurance for South Africa: Towards Universal Coverage (the White Paper).

⁴ Government of India. 2011. High Level Expert Group Report on Universal Health Coverage for India.



A waste picker pushes her cart in Ahmedabad, India. Every day she will face a multitude of health issues, such as exposure to unsanitary waste, broken glass or other harmful materials. Photo: Paula Bronstein/Getty Images Reportage

What this means for our interventions...

Although recent political and economic changes have limited the opportunities for advocacy, spaces still exist for the promotion of progressive health policies in South Africa, Thailand, and, to a lesser extent at present, India.

Different levels of government play different roles in health care. Success with health interventions depends on the promoters interacting with the right people in the right health departments about the things over which the different actors have some influence and control.

Organization: A significant asset for informal workers across all three cities was their membership in organization(s). In Ahmedabad and Bangkok, the main organizations were those from which the research teams were drawn – SEWA and HNT respectively. In Durban, the project was driven jointly by AeT and WIEGO, who in turn deal with organizations of market traders, mostly with leaders of the nine markets in Warwick Junction. Improved access to health services are most likely when informal workers are organized and when their organizations can advocate for more inclusive health policies, and develop appropriate models for health provision, which would be more difficult for individual informal workers to do.

Levels of involvement in, and nature of, policy advocacy:

In all three cities, organizational leaders have years of experience in dealing with

state authorities. There are very clear country differences in terms of the involvement of informal workers and/or their allies and advocates in health policy development, in structures for ongoing governance, and in monitoring and evaluation. Thailand stands out for its decade-long inclusion of civil society organizations in an alliance for health reform, including HNT, when universal health coverage was introduced.⁵ HNT was again involved when the 30 baht scheme was replaced by a free UCS and thereafter in the monitoring and evaluation of implementation.

In India, SEWA has been involved at many levels in the structures for participation in health policy reform and implementation. It participates in the Women's Health Committees at the local level and has been, among other significant instances, active in the High Level Expert Group on Universal Health Coverage for India, the National Planning Committee, the Commission on the Unorganized Sector, and the Commission on Child Care. In the absence of adequate state health services, SEWA has also developed its own health programmes for its members, including the VimoSEWA health insurance scheme, a cooperative of frontline community health workers who act as the link between workers and the public health system, and low cost pharmacies.

⁵ Alfors, L & Lund, F. 2012. Participatory Policy Making: Lessons from Thailand's Universal Coverage Scheme. WIEGO Policy Brief No. 11.



*A group of women listen during a nutritional meeting about healthy foods at the BALSEWA center which serves as a daycare and meeting center.
Photo: Paula Bronstein/Getty Images Reportage*

In South Africa, AeT, along with WIEGO, has long been active in promoting more inclusive policies for informal workers at the local government level, especially in Durban. More recently, AeT has worked to develop a programme on occupational health and safety for informal workers, with a focus on working with the municipality to promote urban and architectural design solutions which improve health and safety in informal trading areas throughout Durban.

What this means for our interventions...

The long history of the partners' contributions to health policy reform and, also importantly, to building bridges between informal workers and officials around specific health and other issues constitutes an important foundation on which to build future work.

The organization of workers is crucial to improve the voice, visibility, and validity of informal workers to health policymakers and health administrators. Health interventions should simultaneously contribute to the organization of informal workers.

The Proposed Interventions

Drawing on the health needs, barriers to access, and the constraints and opportunities presented by the context in which they operate, the three organizations developed a preliminary set of multi-modal interventions for improving the health of informal workers. The following section provides a summary of the proposed interventions, followed by an analysis of some of the overarching themes. It should be noted that these interventions are seen as part of a larger effort to advocate for improved public provision of health services to informal workers.

SEWA's intervention for Ahmedabad

Building on its existing cadre of community health workers, SEWA proposed to establish health information hubs for use by informal workers. The hubs would be staffed by community health workers, providing information on and linking workers to the public services available, providing basic health education, and running diagnostic health assessments for workers near their places of work. The hubs would attempt to use both innovative digital technologies to complement more traditional health education techniques, and also provide feedback to public health services to aid in the improvement of service delivery, and to act as a model for how the delivery of services can be structured in such a way so as to reach the very poorest workers.

Scaling out low cost pharmacies and VimoSEWA: SEWA runs three low-cost pharmacies in Ahmedabad, and a well-known micro-insurance scheme, VimoSEWA. SEWA would like to explore options for scaling out of these programmes, using them simultaneously as models for how the Indian state could provide such services to informal workers.



*Incense rollers in Ahmedabad, India, often deal with health issues related to breathing in dust from the incense.
Photo: Paula Bronstein/Getty Images Reportage*

HomeNet Thailand's intervention for Bangkok

Focusing on improved dissemination of information using digital technology, HNT proposed to combine health messages for individual workers with messages to workers about health services. It would like to develop a mobile health app in Burmese for migrant Burmese domestic workers.

Using existing community health volunteers, who are attached to the Bangkok Municipal Authority (BMA), HNT would like to improve the dissemination of information to informal workers about the UCS and the services it offers. HNT would train the volunteers in how to access the Department of Public Health's information, and the volunteers in turn would advise HNT members through existing organizational zone structures.

Policy Dialogues would bridge the divide between informal workers and health providers and can be used to advocate for the inclusion of services into the UCS that are specifically aimed at informal workers – such as those relating to occupational health and safety. Also, this would possibly form the basis for institutionalized Local Health Committees which include informal workers.

Asiye eTafuleni's intervention for Durban

AeT proposed the development of an integrated urban health platform. This would link informal workers to different government departments which, at different levels of the state, have an impact on health, including municipal environmental health departments, public health authorities (national and local), as well as non-state actors, such as university medical schools, who could provide additional support to workers. The platforms would be used both for policy advocacy, to challenge barriers to access, and to initiate joint activities, such as hazard mapping activities, and diagnostic health assessments in the workplace.

Information hubs located in the workplace, would have a focus on disseminating health information, as well as including a health education component, using both digital technology and more traditional forms of health education.

AeT specializes in providing design solutions to informal workers. The design/urban design mode is linked largely to participatory interventions which focus on improvements to work tools, working environment and to work organization so as to improve health and safety.

Commonalities across interventions

The interventions proposed by WIEGO's partners during the Informal Workers Health Project have many similarities, drawing on their organizations' and workers' experiences of accessing health care. All three have a focus on **preventive health** – whether through education or design. They all want a role for **health education** for the workers themselves, using **digital technology**. The most common examples given were for protection and prevention at the workplace (for example stressing the importance of posture). They all want to use digital technology to convey **information** about health services to individual workers, in a direct attempt to tackle the exclusion of informal workers by lack of information. This would include where the facilities are, what services they offer, the times of opening, among others, and to supplement this with hard copies of messages. All also want to use the technology to **collect data about workers' health status**, as well as to **convey information back to the health services** in an attempt to secure better services, give early detection and monitoring of epidemics.

Prototypes of mobile technology are potentially scalable. Informal workers have high rates of ownership of cell phones. Health messages can be sent. But then the big question is: *what additional modes of support work best in securing behaviour change as a result of improved information?* In line with good adult education practices, all also want **additional human contact (such as health volunteers, community health workers)** to reinforce and encourage compliance and to complement this with hard copies of health materials. A core part of the Bangkok and Durban models are platforms which are **intended to create bridges for ongoing advocacy, communication**

and negotiation between informal workers, health authorities, and other stakeholders. SEWA has, over the course of many years, built up relationships with the AMC as well as national health authorities, and thus did not include platforms in its prototype components.

Taking the Interventions Forward

Since the conclusion of the Informal Workers Health Project, AeT, HNT and SEWA have further developed their interventions and, in some cases, started the process of implementation. All three organizations continue to be actively involved in policy dialogues and advocacy work to improve the access of informal workers to public health services on an ongoing basis. Additionally,

- SEWA has worked intensively on efforts to sustain and scale out its pharmacies and insurance scheme, and has also started to implement its health hubs, which are known as the SEWA *Shakti Kendras*. The organization will shortly be implementing three *Shakti Kendras* with a focus on the prevention of NCDs.
- HNT will be working to improve the access of informal workers to the Community Health Funds which exist under the UCS. Funds can be used by organizations of informal workers to promote practices to improve the health and safety of their members while at work.
- AeT is initiating a pilot project to improve toilet facilities in informal trading areas in three areas of Durban, using a variety of methods including innovative urban design, and working with informal workers and the municipality to think through ways in which public toilets can be better managed in urban informal workplaces.

