

The Role of CBO in Social Protection – some experiences of the Self-Employed Women’s Association (SEWA), India

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**Rethinking Economy: Social/Solidarity Economy in China and the World, Beijing, China
27-28th April 2013**

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The World of Work in India

About 400 million workers constitute the working poor of India. They are mostly engaged in the informal economy, and do not have work and income security. They have no fixed employer-employee relations, and many are self-employed. They work long hours for very low wages or earn very low income. They work in difficult and often hazardous conditions.

Over 94% of the Indian workforce constitutes the informal economy. Women are a significant proportion of these workers. They work from dawn to dusk. Apart from little or no work security, they hardly have any social security. This means that they have no sick leave, no health or accident insurance, no maternity benefits nor child care. And in their old age, they have neither pension nor provident fund.

Thus, most workers in our country are left to fend for themselves for survival. They are the most vulnerable of our citizens. They often have to face multiple and frequent risks which compound their poverty and vulnerability.

SEWA

In 1972 our founder Ela Bhatt felt the need to organize women workers from the Informal Economy in form of union. The Self Employed Women's Association (SEWA) is a labour union of almost 1.8 million women workers engaged in the informal economy, based in Ahmedabad, Gujarat. SEWA members have no fixed employer-employee relationship nor are they covered by protective labour legislation as they are from informal economy. SEWA's membership can be categorized into four main occupation groups: (1) manual labourers and service providers, for example, agricultural labourers, construction workers and cleaners; (2) street vendors; (3)

home-based workers, for example, incense stick rollers and embroiderers; and (4) small-scale producers, for example, gum collectors and craft workers. These women work long, hard hours, and because of the nature of their employment, they do not obtain even basic social protection such health insurance, maternity benefits and sick leave.

Being the poorest of workers, and living most often in environments without basic water and sanitation, SEWA members and their families are often sick. The high cost of health care often prevents an informal sector worker from seeking treatment, which may result in the worsening of her state of health. The poorest quintile of Indians is 2.6 times more likely than the richest to forego medical treatment when ill, and despite higher rates of illness, is only one-sixth as likely to undergo hospitalisation (Peters, Yazbeck et al. 2001). Poor health, when it results in lost wages and/or health care expenditures, leads to indebtedness, loss of assets and further poverty. According to an analysis by Peters, et al. (2001, p. 157), at least 24% of all people hospitalised in India in a single year fell below the poverty line because of this. In theory, government provision of health care should cover the poor, but in practice it often does not.

It was in this context that SEWA began to organise women for their economic rights three decades ago. Our goals are to organise workers for full employment and self-reliance – both economic and in terms of decision-making and control. Full employment includes security of work and income, food security and social security.

Importance of Work Security

The life of a worker is a long struggle for work and income. If we speak to working people in any village or urban neighbourhood, the first thing that strikes one is that they all have the same priority—work security, so that they can earn and feed their families and have enough income to obtain the bare essentials. Without work security, people cannot obtain food security, as they need income to purchase food. Similarly, without work and income, they cannot obtain social security. For the poor, work is survival. If they work, they survive. Hence, work and income security are the top priorities. All working people want regular, continuous work and income. They want full employment at the household level—every family member must have enough work and income to cover their basic human needs, and for all twelve months of the year.

Work Security and Social Security

While work is central, people often say:” How can I work and earn, if my child is sick? Or when I am sick?” “How can I go out to work with my baby?” “What will happen when I am old and can no longer work?”

Sickness, accidents, the need to care for a young child, old age and other events in a worker’s life cycle affect her ability to work and earn. Without social security that takes care of these needs, a worker cannot attain work and income security. Lack of social security to take care of the various risks, restricts workers’ productivity as well. How can she earn in peace if she has no child care? Or what should she do when she is pregnant and needs to rest but has to work and earn?

Conversely, without work security, a worker cannot have access to health care and other services, because she needs money to pay for these. But with no work and income security, she has to borrow from money-lenders and others, pawn her jewellery and even sell her land and other assets.

Thus, for working people, both work and social security make sense. Both are needed. One without the other has limited value. They are two sides of the same coin.

Social security is a part of full employment. Along with work security, income security and food security, social security is essential, if workers are to emerge from poverty and move towards self-reliance.

Social Security for Informal Workers

Social security includes basic services that provide protection to workers and promote their well-being. It is the means through which workers can make their lives secure, safe and productive. It is an economic support to them. In fact, it is an economic security, as with these services and protection, their economic situation is safeguarded. Once they have some social security, they do not slip deeper and deeper into poverty. They may even come out of poverty and move towards self-reliance.

Social security must include at least the following elements:

- health care — preventive, curative and promotive care

- child care — holistic care of the young child, including nutrition, health care and child development activities
- insurance — protection against as many risks as possible, including sickness, accident, maternity, assets
- shelter and basic amenities — a roof over one's head with water, sanitation and electricity
- pension — to provide regular income in old age.

This is the bare minimum required by working people and their families. There may be other social security needs like unemployment insurance.

Our approach:

- Women-centred, women-run and women-owned.
- Sustainable---both financially and in terms of women using, running and owning their organization which, in turn, provides services.
- Comprehensive and holistic—providing as many services as possible.
- Integrated, and especially with work security.
- Low cost and tailor-made services; simple, appropriate, affordable, contributory and convenient to women workers.
- Decentralised (at women's doorsteps) and democratically-run.
- Partnerships with government and others, thereby facilitating access to services and programmes.
- Action for policy change, based on grassroots level needs and issues identified by the women workers.

1. Child care

SEWA's child care programme has been one of its earliest services. Our members asked for child care so that they could go out to work, knowing their children were well cared for. In the absence of state-supported child care or services provided by the employers, SEWA began crèches for the women worker's children, through its child care cooperative, Sangini. 657 women are share holders of the child care cooperative.

The women found that with child care they could work and earn more, and with peace of mind. It helped their families emerge from poverty. According to the National Family Health Survey's III data, about 46% children in India are still malnourished. Of these, infants and young children are the most vulnerable. It is these young children who are our focus.

Our experience of providing child care for the last forty years has convinced us that child care is a basic right of the working poor. When child care is available, their earnings increase by over fifty percent, they can work in peace as their children are in safe hands. They obtain nutritious food because of increased earnings, malnutrition decreases, older siblings especially girls can go to school as they no longer have to take care of their younger siblings, women get regular employment and 100% of children who have been in crèche's go to primary school.

We are running 27 child care centers in Ahmedabad city through the childcare cooperative, Sangini, according the parents' hours of work. A total of 960 children are enrolled in the 27 creches or child care centers in 2011. 33% of the total children belong to the 3 months to 2 years age group.

Activities in the child care centers

The following activities are undertaken for infants and children under six years in our child care centers:

- Nutrition – Freshly cooked hot food for lunch and a nutritious snack at tea time are provided. The meals are cooked by the child care workers based on the local diet.
- Health care – Monthly weighing and check-ups of all children ensuring their full immunization. Where required children are referred to specialist doctors in hospitals with whom we have developed a network, particularly public hospitals.
- Child development – Preschool education, recreation, and learning through play encourage the children to learn and play together. We share SEWA's values based on Gandhian thought, like tolerance and respect for all communities with the children.
- Capacity-building – of our child care workers (balsevikas) and parents on child health, nutrition and development.

Impact in a Nutshell

1. With full-day child care, women's earnings increase by at least 50%.
2. Women can go out to work in peace, knowing children are safe and cared for.
3. Young children (0-6 years) get proper care: full nutrition, health care and early childhood care. Thus malnutrition is reduced, health improves.
4. 100% of children in child care centers enroll in primary school; majority stay through high school.
5. Older siblings, especially girls, start going to school, as they are freed of child care responsibilities.
6. Child care is focal point for community organising and community development. Parents of all communities come together.
7. Children of all communities play, learn and grow together, promoting harmony and nation –building.

2. Health Care

SEWA has been implementing a range of women-led maternal and child health interventions in Gujarat for over twenty-eight years, through its health cooperative, Lok Swasthya SEWA, promoted by SEWA. More than 1100 women are share holders of the health cooperative.

We began with health education for our members and gradually added a range of services, such as health promotion, preventive health care and curative health services to meet the health care needs of the members and their families. These interventions, implemented through a cadre of 400 trained grass-root level women workers have improved the lives of women and children of their communities. As the grass-root level women workers are from the community, there is a greater understanding of the needs of the community.

An innovative midwife training program was developed, which also led to the creation of the first state-level organization of midwives in Gujarat. Primary health and reproductive health are the focus of our health education program. Linkages are also created with the public health system (for providing referral care) and maternal health programs of the state. Community monitoring

and women-led advocacy are also undertaken for ensuring that the state's health services and programs effectively reach the poor.

The activities we are currently undertaking are:

- a) Health education---with women, adolescents mainly. Outreach is about 2,00,000 persons but mainly women workers. It includes "Know Your Body", basic knowledge of primary health care, information on government programmes, schemes and their health rights, gender perspective, especially sex ratio and occupational health. We give a preventive and promotive focus...i.e. how to stay healthy, take control over our own health and our own bodies (and care for our families and communities also). Focus is on what we can do ourselves first, reducing dependency on doctors and others; simple do's and don'ts.
- b) Occupational health---developing and designing simple, low cost tools and processes to safeguard workers' health (with National Institute of Design (NID), National Institute of Occupational Health, (NIOH) etc), making these tools and equipments available at low cost and ensuring that welfare boards etc take these up on a large scale for workers. We also provide health education, including yoga asanas and ayurvedic remedies.
- c) Referral care---linking with public and private hospitals and dispensaries to ensure that our members and their families get good quality, prompt and low cost care (we negotiate the fees and even obtain fee waivers).
- d) Linking with government programmes, schemes and services for better and transparent access. Now that government is providing many services, we have cut back on our services and are using our collective strength and bargaining power to ensure that services reach the workers, by strengthening local committees like the Village Health Sanitation & Nutrition Committee (VHSNC).
- e) New programmes and focus areas: mental health, non-communicable diseases---education and referral for these.
- f) Actively contributing our experience to policy efforts, especially on universal health care.

Our health program also focuses on increasing access to low cost medicines, both allopathic and Ayurvedic. We found that many of our members were using medicinal plants for treating various illnesses. Traditional Ayurvedic medicines have been found to be effective cures for many diseases, have no side effects and can be made locally by the women themselves, thus

providing them with employment. Hence, Lok Swasthya SEWA Cooperative decided to produce and market Ayurvedic medicines. The cooperative has a license to produce these medicines.

Additionally, Lok Swasthya SEWA has created access to low cost allopathic medicines for the women workers and their families, through its four medicine shops in Ahmedabad city. As the allopathic medicines are purchased at wholesale rate we are able to provide it to the women and their families at a lower cost than what is available in the open market. Integrated health services are also provided to the women at these outlets. The sale of Ayurvedic and allopathic medicines generate modest revenues which have led to the viability of the cooperative.

Further, the health cooperative through its 'Technical Resource Cell' (TRC) has been engaged in capacity-building of other organizations in India, enabling them to implement health programs at local level. This includes both classroom and practical field-level trainings on primary health care and reproductive health.

Lok Swasthya SEWA's health program was initiated in Ahmedabad city and Ahmedabad district. It is being scaled up in Gandhinagar district, Surat city and Tapi district in Gujarat, and Jodhpur district in Rajasthan. In 2012 – 185,105 women participated in health education sessions and 108,620 women were linked with government health programs and services.

3. Microinsurance

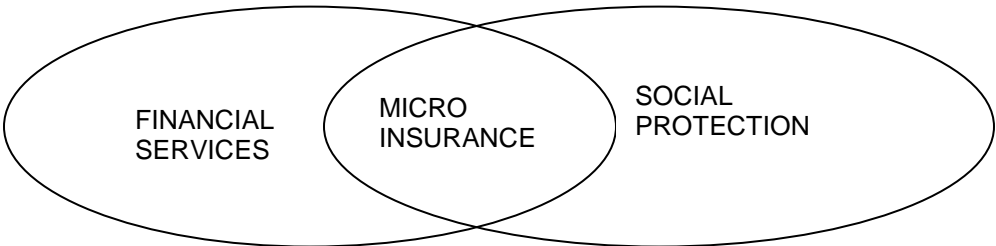
The past decade has seen the growth of microinsurance in many different countries. In India, too, several people's organizations and NGOs have been experimenting with microinsurance. While the long-term viability of these efforts is yet to be established, what is increasingly clear is that the poor are insurable.

Just as forty years ago, in the early years of the microfinance movement, the poor, and especially women, had to prove that they are creditworthy and 'bankable', they have had to show that they are not to be dismissed as 'bad risk'.

In fact, microinsurance is being increasingly accepted as both part of essential financial services required by the poor to support their efforts to emerge from poverty, and also as much-needed social protection against the multiple and frequent risks they face.

SEWA’s experience with providing microinsurance services to women workers over more than a decade points to the fact that microinsurance must be integrated with both financial services (savings, credit and pension) and social protection (health care, in particular), and also with poverty reduction programmes. It must be part of a strategy that aims to reduce poverty by focusing on employment/livelihoods with social security. It is this holistic and integrated approach which will eventually reduce vulnerability and stem the decapitalisation that occurs when risks and crises confront poor families.

Our experience leads us to an understanding of microinsurance that places it at the frontier of both financial services and social protection, incorporating elements of both. Like other microfinance services, it must be run in a financially viable manner, but it needs the universalisation that comes with the social protection approach. Universalisation—making insurance available to all citizens regardless of socioeconomic status-- or at least maximizing coverage to include as many citizens as possible, and especially the poorest, is not only equitable, but also makes ‘good business sense’ from an insurance viewpoint. The larger and more diverse the pool of insureds, the greater is the spread of risk and, consequently the greater the chances of viability.



The products

It is clear from the evidence on the ground that the poor face multiple risks—or perils, if we use appropriate insurance terminology. Our experience shows that the major insurable perils faced are:

- sickness
- death
- accidents
- asset loss—especially loss of animals, house, tools of employment and of standing crops.

Of all of these, coverage for sickness is the main priority, as it leads to large expenditures, loss of daily income and ultimately sale of assets to meet this crisis. The end result, of course, is that it pushes families into poverty. Thus, health insurance is the top priority of women workers and their families. Details of products are given in Appendix A.

SEWA's experience also points to the need to insure a package of perils—both life and non-life—which could develop slowly according to local people's needs and their ability to pay the required premiums. This package not only serves their immediate needs, but also helps in the viability of microinsurance, as we shall see below.

Affordability and Willingness to Pay

When insuring the poor, affordability is a real issue. Sums insured have to be of an order that prevent the downward slide into poverty and indebtedness. For example, at least Rs. 5,000 is the amount our members cite as their minimum sum insured required during hospitalisation. Ten thousand rupees would be the ideal coverage. But these amounts would require premiums that are unaffordable at present, especially since members want and need other non-life and life coverage.

Along with affordability, 'willingness to pay' is an important issue to understand. The premium may be affordable, but a member may not be willing to pay out the amount because she/he is

not convinced about the necessity of such a pay-out or does not find it useful. In a situation of competing demands on scarce resources, there may be other priorities. Or an insured person may say, as they often do:

“Nothing has happened over the past few years since I’ve been insured. So I don’t want to waste my money.”

In sum, the, we have learned that poor people will pay out insurance premiums provided:

- a) insurance products are useful to them and tailor-made to their needs;
- b) they trust the insurer (preferably their own organization) and
- c) the services they obtain are useful, timely and of good quality.

Servicing

At SEWA, time and again we have seen that the poor, and particularly women workers, will pay or at least contribute substantially towards the cost of services, if they are appropriate and of acceptable quality. Once they are convinced of the service’s utility, no further marketing is required. This is equally true of microinsurance.

In our experience, there are two aspects to the servicing of microinsurance:

- Claims-servicing—must be timely, simple procedures and at women’s doorsteps; cash-less systems for sickness coverage through tie-ups with hospitals are required.
- Contact with the insured—as frequent contact as is possible, and at least twice before renewal of insurance is required; even if they do not face any crisis, members need to feel involved and connected—such face-to-face contact (individual, house-to-house or in small meetings) presents a good opportunity for preventive health education as well as education on insurance and our schemes.

Currently there are two main methods of reaching the poor and providing microinsurance services in India:

- 1) Partner-agent model—here the insurance company bears the risks and the people's organization/NGO acts as an agent, collecting premium, linking with the insurance company and even processing and servicing claims.
- 2) Provider model—here a hospital run by an NGO develops a microinsurance scheme, usually for health insurance.

Marketing

Marketing of microinsurance bears some similarity to marketing in the mainstream insurance industry, in that it has to be sold to customers. Microinsurance policies have to be sold to poor people, as they are sold to people of other income brackets. What appears to work best is the face-to-face and house-to-house selling of microinsurance. It is also the most expensive marketing method, pushing up transactional costs considerably.

Other ways of marketing microinsurance that we have used are:

- small and large meetings (sammelans)—these need to be held repeatedly
- gram sabhas or village-wide meetings
- linking with SHGs—livelihood-based groups, savings and credit groups and others to get a “chunk of insureds” on the one hand, and lowering transactional costs on the other
- developing special premium payment plans—monthly savings towards annual premium, one-time lump-sum payment which is put in fixed deposit (and the interest accrued is used to pay the annual premium), loans for fixed deposit-linked insurance
- linking with loanees of SEWA Bank
- linking with individual depositors of SEWA Bank and taking premium directly from their savings accounts with their consent
- linking with NGOs in other states
- linking with specific groups of workers—like members of a cooperative

Viability

Microinsurance can be viable. However, there are very few examples world-wide of large and viable microinsurance programmes, especially those including health insurance. Also, most microinsurance programmes tend to focus on life insurance which is easier to administer and can be viable faster than health insurance can. The viability of life insurance is due to the nature of this product, and that there is less possibility of moral hazard and fraud. Health insurance which is dependent on many variables, and most importantly hospital care, is more volatile and prone to fraud and other adverse situations.

From our experience, if microinsurance is to be viable, three things have to be tackled:

- Outreach has to be large and to increase steadily (number of insured persons has to keep increasing)
- Renewal rate of insureds has to be around 75%
- Transactional costs have to be reduced and under control—these have to keep pace with outreach; if outreach increases appreciably then costs are spread more evenly—so the issue of cost containment is heavily dependent on outreach

For the viability of health insurance, containing costs of medical care is essential. This can be done through developing tie-ups with providers (public, charitable trust and private hospitals) with a careful watch on quality. The latter includes ensuring that rational medicine is practiced, preferably according to fixed, globally-accepted protocols for various diseases.

Our experimentation with hospital tie-ups so that insured members obtain timely and good care and without paying out (cashless system) themselves, is providing some indications as to how health insurance can be organized in a manner that is workable and useful to the insured members. Under the system we have experimented with, members call up when they are hospitalized at a facility with which we have a “tie-up”. The SEWA Insurance (Vimo SEWA) organizer (staff person) then visits the patient in the hospital, ascertains her expected costs with the help of the doctors, and makes a part payment (80%) on the spot. The rest of the charges are paid out at the time of discharge and submission of all relevant documents.

Transactional costs—especially if one is to reach the poorest and in the most remote of villages—are high. But as mentioned above, these can be offset by increases in outreach and balancing out by obtaining “chunks” of insurance from groups in other areas.

Another strategy which has worked well for us is selling a family package, whereby in one contact the entire family is insured. Through this method, the whole family obtains protection from risks, and costs are lowered due to the increased outreach obtained by insuring many persons within one household.

Table 1: VimoSEWA’s Performance 2008-2012

YEAR	PREMIUM (INR MILLIONS)	MEMBERSHIP (LIVES COVERED)	CLAIMS PAID (INR MILLIONS)
2008	12.72	1,03,080	22.54
2009	12.95	1,19,477	14.98
2010	12.41	1,01,397	10.77
2011	16.27	99,117	10.61
2012	18.11	1,00,297	12.36

Enabling Policy Environment

The importance of an enabling environment in support of microinsurance cannot be over-emphasised. In India, at present, there are two main policy-level issues:

- developing regulations for microinsurance that not only facilitate the growth of this service but also control for the entry of exploitative, unscrupulous elements.
- reducing the capital requirement to enable people’s organizations/NGOs to run their own microinsurance cooperative/company.

In case governments match workers’ premium contributions, they should do so as follows:

- give the matching premium as a lump sum to people’s organizations (unions, cooperatives, Self-Help Group (SHG) federations) and NGOs, in order to ensure that

they actually reach the poor. Systems will, of course, have to be developed to ensure proper audit and accountability.

- develop an implementation mechanism that involves the above organizations, rather than subsidizing premiums through government departments and insurance companies which have limited outreach and services vis-a-vis the poor.

Finally, the policy directive of the Insurance Regulatory and Development Authority, IRDA to private insurers to reach the poor by fixing a percentage of their business to be conducted in the rural and social sectors has had positive impact, in that it has resulted in their partnering with Microfinance Institutions (MFIs) and NGOs to reach the poor.

What we have learned over the years

We have seen that four essential courses of action need to be taken:

- Building Voice and Representation through organizing and building economic organizations.

If the poor are to obtain their rightful place in the economy and in society, they must organize—unite and build their solidarity across caste, community, gender and geographic regions. Uniting and building their own membership-based, democratic, economic organizations is the first and essential building block in the struggle for justice.

Whatever gains SEWA members might have made over the years is entirely due to their organizing, taking leadership and building their own movement. Organising has resulted in visibility, voice and representation.

Organising is not easy. It is a slow process of coming together, acting collectively for the common good, building trust across the many barriers that divide us and ultimately pushing for changes—in the home, in the community and in the economy and society at large.

Next, workers need to build their own, sustainable and representative organizations—owned, managed and used by the poor. These organizations not only address their needs and the many injustices they face, but also unleash their creative energies. They develop constructive alternatives to the economic structures that oppress, bind and restrict them in their quest for self-reliance. The forms these could take are many, and the issues they may initially address are diverse.

- Financial Inclusion through provision of integrated financial services—savings, credit, insurance, pension and financial literacy—and primarily to women. Asset-building should be undertaken, and in women’s names.
- Social Security—at least universal health coverage, child care, insurance, shelter and basic infrastructure.
- Capacity-building—both to enhance technical capabilities and for skill-building. But also for leadership and to manage workers’ own alternative organizations.

All of these need to be acted upon in tandem, in an integrated and holistic manner. One without the other will have limited impact.

Next in all of these efforts, women should take the lead. When women workers lead, they ensure that the poorest are included and that the whole family benefits. They also are future-oriented, and create sustainable organizations, including for health insurance and overall social security.

APPENDIX A

VimoSEWA PRODUCT SUMMARY

SR. NO.	PRODUCT NAME	PRODUCT FEATURES	PREMIUM PER ANNUM	RISK CARRIER
1.	Swastha Parivar 1	Family Floater health insurance covering family of up to 2+4 members for a maximum of Rs 10,000 per year.	Rs 400	New India
2.	Swastha Parivar 2	Family Floater health insurance covering family of up to 2+4 members for a maximum of Rs 25,000 per year.	Rs 1,000	New India
3.	Sukhi Jeevan 2	Individual life insurance for Rs 10,000 without return of premium	Rs 100	LIC
4.	Sukhi Jeevan 3	Individual life insurance for Rs 30,000 without return of premium	Rs 150	LIC
5.	Jeevan Madhur	Savings Linked Life Insurance with death benefit ranging from Rs 3,000 to Rs 30,000 with return of premium and bonus. Policy term can be from 5 to 15 years.	Rs 1,200 to Rs 3,000 p.a.	LIC
6.	Credit Life	Life Insurance covering the loan amount. Issued to banks and MFIs.	Various	LIC and Metlife

7.	My Jeevika _ PA	Accidental death and permanent total disability for Rs 50,000.	Rs 50	L&T General Insurance
8.	My Jeevika – Hospital Cash	Fixed daily allowance of Rs 250, 500, 1000 for every day of hospitalization up to maximum 30 days in a policy year. Policy covers individuals only.	Rs 198. Rs364, Rs 728	L&T General Insurance
9.	Saral Suraksha Yojna	Family floater policy covering a family of up to 2+2 offering a daily allowance of Rs 200 for every day of hospitalization for maximum of 15 days in a year. Also covers accidental death of primary insured (woman) for Rs 100,000 and spouse for Rs 50,000.	Rs 150	Hospital Cash risk borne by VimoSEWA. Personal Accident cover by New India.
10.	Sukhi Parivar 1	Integrated product covering health for Rs 2,000, life for Rs 10,000, accidental death for Rs 25,000 and assets for Rs 10,000. Available on individual as well as family basis.	Rs 200, Rs 390 and Rs 500.	Health risk carried by VimoSEWA, life by LIC and asset and PA by New India.