

Lok Swasthya SEWA Trust

Annual Report

Year 2014-15



Lok Swasthya SEWA Trust

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Introduction-Lok Swasthya SEWA Trust

Lok Swasthya Sewa Cooperative is a member-owned, state-level health cooperative promoted by SEWA, and was registered in 1990 with the mission to enable women workers and their families to have access to life-saving health information, prevent illness, obtain services when required, and ultimately lead healthy and productive lives. This is achieved through providing community-based, preventive and curative health care, in a financially sustainable manner, while also promoting decision-making and control by informal women workers themselves.

The Lok Swasthya Sewa Trust (LSST) was developed by SEWA's health cooperative, and was registered in 2005. LSST undertakes health promotion and educational activities to promote wellness and well-being of our members who are self-employed women workers. LSST works in four districts of Gujarat: Ahmedabad, Gandhinagar, Surat and Tapi. Its focus areas are:

1. Health Education and Awareness
2. Referral Services (curative care)
3. Occupational Health and Safety
4. Mental Health
5. Programmes for Adolescents
6. Tuberculosis Control
7. Health Camps (eye, gynaecological, Non Communicable Diseases (NCD) and general)
8. Linkages with Government Programmes and Community-Based Monitoring
9. Insurance (RSBY, VimoSEWA or SEWA's insurance cooperative)

Given below is a detailed description of the major programmes implemented by LSST in the period of 2014-15.

Tuberculosis- Education and DOTS Centre

In collaboration with the Ahmedabad Municipal Corporation (AMC), LSST has been managing two DOTS (Directly Observed Treatment Short Course) centres in Ahmedabad city, catering to a population of approximately one lakh people of Asarwa and Chamanpura. In addition, curative care prevention is a major focus in both the wards, implemented through the 'Urban Slum Scheme' programme in partnership with AMC. Information is imparted through awareness programmes on TB, various related topics like nutritious diet, vaccination, addiction, HIV/AIDS and Non-Communicable Diseases and so on and forth. The following activities were organized during April 2014- March 2015.



Activities on Tuberculosis Awareness and Treatment during April 2014- March 2015			
SR. NO	ACTIVITIES	GROUPS	TOTAL NO. OF PARTICIPANTS
1	Area Meetings	98	1484
2	Exposure Visits	5	93
3	. Overview of TB	11	197 students
4	Home Visits	99	
5	Video Show (TB Related topics)	1	23
6	Education/Counselling (by in-house Doctor)		881
7	Cleanliness Drive	1	
8	Exhibition	1	44
9	Rally	1	17
10	School Education	3 Schools	86
11	Diabetes Check-up		30 patients
	Total		

The details of TB patients from both wards, who registered and followed the treatment schedule is mentioned in the table below;

Details of TB Patients Registered		
SR.NO	PARTICULARS	
1	Registered	217
2	Category- I TB patients	121
3	Category-II TB patients	75
4	MDR (Multiple Drug Resistant) TB patients	20
5	XDR (Extensive Drug Resistant) TB Patients	1
6	HIV Referrals	133
7	HIV positive persons	8

During this year, an increase in the number of Multiple Drug Resistant (MDR) patients, and for the first time an increase in Extensive Drug Resistant (XDR) patients was registered, as opposed to the previous year. Education and awareness programmes through area meetings, exhibitions, video-shows, and home visits covered a large number of people and helped in educating people about preventive measures and the significance of adhering to treatments. The increasing number of MDR patients indicates the need for greater awareness among the community members and active involvement of families in the treatment of TB patients. With these focus areas we saw some encouraging results, as can be seen below:

Tri-monthly Report of 2014-15						
	WHO Standards	April' 14 to June'14	July'14 to September'14	WHO Revised Standards	October'14 to December'14	January'15 to March'15
Conversion rate	90%	100%	100%	90%	82% (3 patients converted to category II)	82%(4 patients reports not received)
Cure rate	85%	94%	86%	85%	93%	93%
Failure rate	4%	1%	14% (one patient)	9%	7% (1 MDR)	2%
Death rate	4%	0.0%	0.0%	4%	0%	0%

Occupational Health and Safety

Over the years the focus of LSST has been to promote primary preventive healthcare and enhance the productivity of women workers in the informal sector. The major activities undertaken during this year were:

1. Facilitating use of tools/prototypes by workers.
2. Health education and awareness sessions
3. Exhibitions
4. Video replays
5. Capacity-building and training of community based health workers
6. Workshop to respond to heat-related emergencies for street vendors and rag pickers
7. Tripartite workshop: Occupational Health and Safety in the construction sector

Community-Based Activities

Through our activities we were able to reach out to a number of women workers, including home-based workers such as garment workers, embroidery workers and kite workers; construction workers, agricultural workers, sugarcane cutters and waste recyclers.

OHS Activities during April 2014- March 2015			
SR. NO	ACTIVITIES	GROUPS	TOTAL NO. OF PARTICIPANTS
1	Area Meetings	57	1212
2	Education and Awareness	274	5375
3	Video Replays	2	50
4	Exhibitions	69	3295
5	SEWA Sabha	1	120
6	Sale of Tools/Prototypes		8 Chairs
7	Capacity-building of Health Workers	1	30 Health Workers

Workshop to Respond to Heat-Related Emergencies

Three workshops were conducted by SEWA Social Security in association with Indian Institute of Public Health Gandhinagar, for our members to prepare them for and respond to heat-related emergencies and inform them of the measures to be taken to protect themselves from such problems. Around 150 street vendors and waste recyclers participated in this workshop.

Tripartite Workshop: Occupational Health and Safety in the construction sector

A tripartite workshop was organised on 4th December, 2014 to focus on occupational health and safety in the construction sector, bringing together the construction workers, their employers and the government labour department.

The objective of this workshop was to draw upon the knowledge and experience of the participants, around 20 of who came from diverse backgrounds including the workers board, trade unions, employer associations, government labour department, research institutes and the private sector. Dr. Anil Patel, Chairman, Construction Workers Welfare Board, Gujarat was the guest of honour. The workshop provided the participants with a platform to voice their opinions on the most urgent problems at construction sites in Gujarat. Many suggestions for future collaborations to better the environment at the construction sites and possible interventions to address some of the emerging issues were discussed. The foremost solution that was echoed by all present was to formalize the construction sector by registration of construction workers and small contractors.

It was also suggested that portable cards be made available for the workers, which will not only act as an identity card or registration card, but also as a health card so the workers can benefit from the available government health schemes. This kind of centralization would check duplication as well. A need was felt for a partnership between the government, the construction companies and the workers, to spread awareness for the safety of the workers and the use of available resources for awareness programmes and educational sessions.

The recommendations suggested by the participants were presented to the Chairman of the Construction Workers' Welfare Board. The inputs of the workshop will enable SEWA to strengthen

programmes designed to improve construction workers' health and safety at work sites. The recommendations that emerged from all participants at the workshop are given below.

1. **Registration of workers:** All construction workers must be registered and provided with an identity card, enabling them to obtain benefits from the Construction Workers' Welfare Board constituted to provide these and to improve the working conditions of construction workers. Conditions which have been barriers to registration, like the 90-day certification by employers, must be removed. The Board, with a tripartite structure, has already collected considerable funds through the cess, a requirement under the Construction Workers Act. These must now be used for the well-being of workers, once they are registered.

The registration may be conducted in different ways including self-certification, certification by unions and campaigns conducted by the Board in collaboration with workers' organizations, employers and contractors. This should be undertaken as the first essential step by the Board.

Each worker should be given a portable smart card like the RSBY card which will have all the necessary information about her/his occupational health history, the benefits received and other information.

2. **Registration of contractors:** Registration of contractors at construction sites should also be undertaken by the Board. This will enable greater collaboration and cooperation by all concerned.
3. **Health education and awareness:** Activities for these must be supported and promoted by the Board, and diagnostic and screening camps for early detection of both occupational and other health problems, including and especially gynecological camps for women workers, must be organised. The option of using Mobile Health Units should be explored, especially for migrant construction workers.
4. **Legal Know-How:** Education on existing laws for the workers, including sexual harassment in the workplace, must be organized, both at the health camps and in special awareness sessions.

5. **Personal protective equipment (PPE):** Such equipment like helmets should be provided by the Board to all workers, and awareness sessions for their proper and effective use should be organised.
6. **Schemes:** Those already developed for the workers must be reviewed, and where necessary, should be updated and amended. These should include insurance coverage, scholarships for children of workers, housing and other benefits on the lines of the Bidi Workers' Welfare Board.
7. **Skill upgradation:** Training for the same to enhance workers' productivity, skills and income should be organized and workers should be given certificates to enable them to obtain more skilled work and higher incomes.
8. **Child Care:** The Board should support the running of crèches for infants and young children of construction workers, and should arrange for the appropriate training of crèche teachers for holistic child development, including health, nutrition and early childhood education.
9. **Database of workers' health:** The Board should use the health registers developed by some companies to build a data-base on workers' health.

Exposure Visit to Brazil



A team of six members went to Brazil from 12th October to 18th October 2014, and visited the cities of Salvador and Victoria De Conquista. The team members were Jasuben Harjibhai, Rajibahen Parsottambhai, Sarojbahen Ranchhodbhai, Ramilaben Dineshbhai, Pannaben Rajesh and Susan Thomas.

The purpose was to participate in a technical visit aimed at understanding the Brazilian National Health System, the SUS, with focus on the organization of the National Network of Occupational Health(RENAST), State networks (CEREST), Family Health/Community Health Agents Strategy, as well as coverage of informal workers by social protection and health services.

Major Learnings

- a) There is a pressing need to understand, in detail, the health problems associated with specific occupations, diagnose causes, risk factors, and take adequate measures to address these. The diagnosis and treatment of any medical complaint at the primary level should take into consideration the occupation of the patients and analyse the working conditions, work related risks and hazards, number of working hours, etc. This is essential to address health issues related to specific occupations and take preventive measures. In India the PHCs should be oriented and equipped to address these issues.
- b) Occupational health and safety can be effectively integrated into primary health care, and systems for operationalising this can be worked out at the local level, as in the Brazilian case.
- c) Data collection, storage and maintenance are decentralised. It is used effectively at the local level, as well as national level, to address health issues of people and understanding the trends related to different occupations and to influence policies in favour of workers and putting pressure on employers to improve work conditions.
- d) Workers of the informal economy in Brazil have some basic social protection which is effective. For example, the employers of domestic workers pay 12% of social security coverage, in addition to one month's bonus and vacation. Domestic workers pay out 8%. Although there are employers who exploit the workers, the domestic workers union is addressing such cases and doing so quite effectively. They have a success rate of winning 99% of the cases that come to them.
- e) Social participation is an integral and important component of SUS. Social participation in health has been institutionalised by the Brazilian constitution which has led to the formation of health councils at all levels. These councils are made of users, health workers and service providers. These councils assess the health situation and propose directives for health policies. Such committees should be formed at all levels, particularly to monitor quality of services and suggest amendments in the system from time to time.



- f) Under the SUS, decentralisation of Family Health Unit/Centre has resulted in an increase in and easier access to primary health care which in turn has increased the coverage of health services. While improving access to integrated care, the family health unit provides a platform for the prevention and management of chronic diseases.
- g) The Family Health Centre helps in fixing appointments for patients to higher levels of care. This is done online in the Centre of Regulations and Procedure. Referral slips generated in this centre are handed over to the patients by Community Health Agents, CHAs, or can be accessed online. This system has reduced long waiting hours to see doctors and ensures quality care and appointments with specialists less cumbersome.
- h) The CHAs maintain individual family health data and have data of each and every household they have to cover. This helps in closely monitoring treatments, controlling epidemics and providing education and awareness as per needs. The CHAs are also able to provide personal attention and nursing care to elderly who are sick at their homes, and doctors and nurses also visit them. We visited a few such homes and interacted with the patients---one was paralysed, another had leprosy and the third was a diabetic patient whose foot had to be amputated. All the three patients expressed their satisfaction towards the services provided to them.
- i) While visiting different departments and health centres, the coordination between them was quite apparent as we could see they were sharing information and data with each other.
- j) The integrated approach at the CEREST with a team of doctor, nurse, psychologist, physiotherapist, and social workers addressing OH problems, and giving necessary advice seemed to be a very good system. Workers with multiple problems could seek advice for problems ranging from musculoskeletal issues to mental health. Moreover, at the CEREST, a team of experts from diverse backgrounds could further explore and analyse the causes and risk factors pertaining to specific occupations and take necessary preventive measures by lobbying with the employers.
- k) The health surveillance by CEREST (local level), CESATI (State level) and RENAST (national level) helps identify trends and major problem areas which can be addressed at different levels by influencing policies, lobbying with unions and employers. The surveillance also helps in developing various interventions and programmes for the workers to create awareness about these issues and to promote preventive measures.

The visit to Brazil was an excellent learning experience for the entire SEWA team. Integrating OH at the primary health care level is something we are trying to do. However, there is a need to upscale this effort and further advocate at policy level to integrate OH at the primary health care centres. We also think we should maintain more data of informal workers in the context of OH- the health issues related to specific occupations and analysis of the same. This will help us develop appropriate programmes for specific occupations to create awareness about health issues and possible measures to reduce the same. Also, it would be important to share this information with public and private health providers to orient them to understand, diagnose and treat with an OH lens. The work that has been initiated in Gujarat should be implemented in other states where SEWA is working particularly, as we have seen that promoting primary preventive health care enhances the productivity and efficiency of informal workers and has a positive impact on their lives.

Community-based action for mental health

Lok Swasthya SEWA Trust initiated a project, 'Community Based Action for Improving Mental Health of Women Workers of the Informal Economy', to reach out to our members with a broader objective to address and facilitate the mental health needs of women from poorer sections. A few activities have been planned with the following objectives;

Objective of the study

1. To assess mental health needs of a sample of SEWA members and mapping of available services/facilities for mental disorders
2. Increasing awareness about mental health among members and health service providers.
3. Capacity building of health workers, nurses and doctors for early detection and first response for psychiatric disorders and psycho-social interventions, and common mental health problems, substance use and domestic violence.
4. Early detection and linkages to mental health services for those living with mental illnesses.

During the reporting period, needs assessment and mapping exercise to identify services and facilities to address mental illnesses available in and around the target area was done. This project is being implemented in New Delhi, Ahmedabad City, Surat City and Dehgam Block of Gandhinagar District. Given below are the details of the same;

Activities in Gujarat

1. Team Orientation
2. Needs Assessment
3. Mapping

Team Orientation

The SEWA health team including health workers and the grass root workers were oriented about the project in the month of June. A detailed discussion on the concept, objectives, areas to be surveyed and mapping of the mental health facilities available in the respective work areas and the time line for the activities was carried out. In addition to this, the participants shared their views on

depression and its symptoms particularly in the context of their respective geographical areas. The majority of our health team members felt the project has come about at an opportune time and will be very helpful for our members.

Needs Assessment

A needs assessment was undertaken to study the prevalence of issues associated with mental illness in both urban slums and rural villages. We selected 10% of the total members (840) randomly from each unit; a unit in this case was village/ward for the study. Overall it showed that 3 percent women suffer from severe depression, 14 percent have moderately severe depression while 25 percent are moderately depressed and majority of the respondents interviewed have some kind of depression (97%) ranging from minimal depression to severe depression.

Since the survey questionnaire missed out on the qualitative aspects of the study and the coverage did not substantiate different dimensions of the mental health problems, the survey will be continued for the same respondents using another tool keeping in mind the areas that have not been included.

Mapping

A mapping exercise was conducted to identify various available services and facilities to address mental disorders in the target areas. Noted in the table below are the findings of mapping done in target areas.

Available facility for Mental Health Care (G: Government & P: Private)			
Particulars	Ahmedabad	Surat	Gandhinagar
Departments in Hospitals	7(3 G, 4 P)	1(1 G)	0
Trust Hospital			1 (G)
Staff Details : Doctors	7	1	
Nurses	7	1	
Counsellors	4	1	

In the second quarter we organised meetings with the government mental health department and organized a five-day ToT for our master trainers from March 16th to 20th, 2015. Some of the challenges faced during implementation of the project were;

- a) Identifying doctors and health facilities for referrals in all the target areas
- b) Discussing sensitive issues on mental health at the community level was difficult for the health workers during the survey.
- c) During the survey we found that there was no awareness among the community members on mental health
- d) We also found many women with early symptoms of mental illness and depression who were in need of guidance and counseling

Activities in Delhi

Lok Swasthya Sewa Trust (LSST) and SEWA Delhi team met the Hans Foundation/Sarthak Trust on 8th July to discuss plans to kick off the project in Delhi as well as Gujarat. It was decided in the meeting that Sarthak team would share their research and assessment tools and orient the SEWA Delhi team to conduct FGDs in the field areas .We also discussed about OPD and mobile van facilities of Sarthak trust and how they can be used to provide clinical services to SEWA members and their families.

A team of Sarthak Trust visited our field area in Sundernagri located in Delhi, on the 29th August 2014 to understand SEWA's work, identify points of integration for mental health and gain insights that would help the team design future trainings and interventions. SEWA Delhi team initiated the process of resource mapping. Currently all the seven areas in Delhi are being covered.

Strengthening African People's Organisations and NGOs- "Setu- Africa"

Over the years, SEWA has developed close associations with people's organisations in South Africa, Ghana and Nigeria to promote the rights and well-being of informal workers, especially women. Based on these interactions, it was felt that there is a huge scope for exchange of ideas and a need for an interaction platform between SEWA and its counterparts in African Countries.

As a part of this approach, VimoSEWA and its sister organizations including Lok Swasthya SEWA Trust are undertaking the SETU - AFRICA project to develop an understanding of the needs of poor people, especially women, in five African countries. If there is substantial interest, SEWA is hoping to promote collaboration, mutual learning and exchange of ideas and experiences on the following activities:

1. Microfinance—promotion of self-help groups to provide integrated financial services (savings, credit, insurance and pension), their capacity-building and extension of financial literacy.
2. Microenterprise and Livelihood Promotion---examining what are feasible markets and helping organisations set up their own viable micro-enterprises.
3. Micro-insurance---developing plans for extending micro-insurance to local communities, especially women, and capacity-building to help local organizations implement this.
4. Health and Child Care---developing appropriate systems (tailored to local conditions and needs) to reach local communities, especially women and children, with basic primary health care including health education and life-saving information.
5. Capacity-building for leadership, management of their own activities and running their own organizations.

Exposure visit of SEWA's grass-root team to Ethiopia

A twelve-member SEWA team of grass-root leaders including a Health Worker and Child Care Worker visited Ethiopia from 14th to 28th, September 2014. The team interacted with different organizations and its members to get an in-depth idea about issues from local people, especially the women's perspective.

Exposure visit of SEWA team to Tanzania

A SEWA Team, including senior leaders, visited Tanzania from November 9th to 24th, 2014. The objective of this exposure visit was to promote an integrated approach to poverty reduction and self-reliance for women and their families, through microfinance, microenterprise and livelihoods promotion, micro-insurance, health and child care and capacity-building for leadership and management by local people, especially women. The visit aimed to promote mutual learning, understanding and sharing about these issues, to promote further organizing, and to encourage Tanzanian colleagues to build their own membership-based organizations.

Child Care Programme

The child care centres cater to the needs of the children by providing nutrition, pre-school education, immunisation, health check-ups, referral services, nutrition & health education, parents' counselling and regular meetings with the parents on parenting and child care. The Dalyan Foundation supported the following six centres;

Idgah
Parikshitnagar
Saiyad ni darga
Saijpur
Santoshinagar
Aman Chowk



Centre Name	Centre wise no. of children in December 2014				
	No of children				Total
	0 - 2 years		2 - 6 years		
	Boys	Girls	Boys	Girls	
Idgah	4	4	11	11	30
Parikshitnagar	7	4	10	9	30
Saijpur	6	5	18	6	35
Saiyad ni Dargah	5	5	8	12	30
Aman Chowk	5	6	11	10	32
Santoshinagar	4	6	11	9	30
Total	31	30	69	57	187

Activities

The children in our centres come from diverse backgrounds and surroundings. It is therefore important and useful to put together a wide spectrum of activities that suits the diversity and mix of

cultures they represent. Besides this, for their overall development, an integrated and holistic approach that includes the following activities is crucial.

Healthy nutritional practices

As mentioned above, all the children in our centres come from very poor families who work in the informal sector. Their mothers are too busy making the two ends meet and have very little time to attend to the needs of their children. When the children take admission at the centre, a good number of them are in Grade 2 or Grade 1, which is a moderate condition of malnutrition but needs additional attention and care and some are also in Grade 3 and Grade 4. The balsevikas work very hard feeding these young ones and encouraging healthy eating practices among them. A well planned menu to ensure a balanced and healthy diet is followed in all the centres and a fixed schedule is prepared which is strictly followed in each centre.



No.	Days	Daily Menu	Amount of food per child
1	Monday	Porridge	40/30gm
2	Tuesday	Rice and lentils	15/50gm
3	Wednesday	Moong (lentils) with porridge	40gm
4	Thursday	Rice with vegetables cooked in oil	50/10gm
5	Friday	Lentils with rice	40/40gm
6	Saturday	Rice flakes	50gm

Health Care

Children between the age group of 0-6 years are susceptible to infections and need close monitoring and supervision. SEWA's doctor makes scheduled visits to each centre. Health check-up of each and every child is done periodically and their progress is documented. One-



to-one meetings with the mothers whenever needed are conducted in case of children who need extra care and attention.

In addition to these, linkages with government health facilities are formed by the health team of SEWA. Mothers and children who need higher levels of care are referred to these facilities by our doctor. Thereafter, follow-up of such cases is done by the balsevikas to ensure the treatment schedules are adhered to and to prevent recurrence of the illness.

Care and Development

Care and development of children between 0-6 years is very important and requires a comprehensive set of interventions. This is the period wherein good health care, balanced nutrition including essential micronutrients, opportunities for playful exploration and interaction and a clean, safe environment is essential. Additionally, opportunities for learning through play and exploration, quality pre-school and access to a variety of play, learning materials, and books is necessary. In order to achieve this we plan the following activities in our centres.

Daily Activities at our Centres	
Time of centre	Activity
9.30 to 10 am	Cleaning of centre/ Welcoming of our children
10 to 10.30 am	Prayer and exercises
10. 30 to 11.30 am	Pre -primary education, like days of the week, self introduction, names of colours
11.30 to 12 noon	Creative work like drawing and clay modelling
12 to 1 pm	Physical exercise, action songs.
1 to 2 pm	Lunch followed by cleaning the centre
2 to 2.30 pm	Play with toys
2.30 to 3.30 pm	Rest hour
3.30 to 3.45 pm	Children wake –up
3.45 to 4.30 pm	Story-telling and snacks time
4.30 to 5pm.	Children leave the centre; cleaning of the centre

Involvement of parents and balsevikas to help children build the skills for a secure future is significant. This has been our emphasis and through all the above activities we have been successful in supporting the parents and the children during their most rapid period of growth and change.

Capacity-Building

The balsevikas are the strength of our childcare centres. The commitment and dedication demonstrated by them is commendable. Regular reviews and evaluations to assess their performance help in identifying the gaps, and trainings to address them are periodically organised. Their representations in workshops and seminars as well as exposure visits further develop their skills. Our efforts are to bring in new and innovative methods of education and better understanding of emerging issues pertaining to child care and education.



Counselling

We organise regular counselling sessions with mothers through our in-house doctor. These sessions have been very helpful as many of them are able to share their problems and appropriate guidance is given to them. Our balsevikas have also been trained on some basics of counselling and this has certainly helped in identifying cases at the grassroots level and for follow-ups.

Conclusion

Child care is an initiative of SEWA with the aim of reaching out to working mothers and providing infants and young children with appropriate childcare services. SEWA acknowledges the need for good child care for the wellbeing of young infants, children, working mothers as well as the child's siblings.

The child care centres were certainly a support to our members and their impact was significant. Besides visible changes in the overall development of the children, the impact was seen in the socio-economic status of their families. The mothers were able to better manage their multiple responsibilities and focus a lot more on their work. This has resulted in increased earnings, and

enhanced living standards which translated into improvements in the health of the entire family, establishing the importance of a multi-faceted approach to address the issues of women in the informal sector, with child care being a central and fundamental need.

Early childhood care and development is crucial to ensure a secure and healthy future which is very difficult for these women, particularly because of their low economic status, inability to balance work with care of children and household chores, irregular work hours and, most importantly, the lack of appropriate education and information.

Providing a range of services to address the underlying complexities that surround the lives of poor women workers of the informal sector has been one of the key strategies for SEWA all through the years. The children are always the most vulnerable and therefore our focus is to overcome the gaps and ensure a balanced and healthy growth. Hence, a number of activities are organized keeping in mind the social, physical and mental development of the children.

Education Programme

Yasin Khan Pathan is a child studying at one of the Balsewa child care centres in Amanchowk. Her mother has been a member to SEWA and has been associated with the child care centre at Amanchowk for many years. Rizwanaben is a home-based, readymade garment worker. She has five children; all of them have studied at the Amanchowk centre.

In the year 2011, an Exposure Dialogue Programme, EDP, was organized for German guests who visited Rizwanaben's home. They experienced the life of this family and listened to the hardships they had gone through. Munirbha, a heart patient is unable to get full-time employment due to his health condition. Afreen is the only earning member of the family and she is assisted by her mother Rizwanaben. Both sew garments to keep the family going.

The guests were deeply touched by the challenging situations this family had to encounter on a daily basis. Jean Louis De Montesquiou and Christine Schuebel agreed to take on the responsibility of the education of their children to cover school fees, books, additional tuition fees, and other expenses related to their education for the next 10 years. Having completed sewing lessons, with the help of the aid provided by the EDP guests, to further her skills she is now doing tailoring work from home. Nagma, Muskan and Yasin are studying in school. Rizwanaben is able to take care of the house and all of the children, and assisting her daughter in the sewing and tailoring activities. The house runs on the income generated by the joint efforts of Afreen and Rizwanaben.



Rizwanaben and Nagman

Sankalit SEWA Project

The UNDP- Lok Swasthya SEWA Trust (LSST) partnership for the Sankalit SEWA project was signed in the first week of June 2013, effective from 4th June 2013. A partnership with another project co-financer, American Jewish Joint Distribution Committee had already been initiated from 1st of June 2013. Another contract was signed with Unitarian Universalist Holdeen India Program for co-financing of the project. The given report covers the total programme progress in the year.

This project called 'Sankalit SEWA' literally means 'Integrated Services'. Through this project we are organising workers and working on five key activities: (1) livelihood support, both input-based and market-linked (2) health care, including preventive care and access to health services and child care (3) housing with basic amenities like water, sanitation and energy (4) financial services, including savings, credit and insurance and (5) capacity-building, including leadership training. The focus of the project is to promote self- managed women's organizations for providing sustainable need-based services to its members for enhanced incomes and social security with the following objectives;

1. To develop membership-based organizations of women workers to undertake activities and programmes leading to self-reliance.
2. To provide services for, by and with women workers, thereby leading to basic security and ultimately for their self-reliance, including livelihood support, microfinance, social security with housing, water and sanitation, and capacity-building.
3. To strengthen and build local women's leadership, enabling them to lead and run their own services, programmes and organizations.
4. To plan for the long-term sustainability of all activities and programmes through women's own organizations.

Outreach

In the year 2014, work had begun in 30 villages in Vyara block of Tapi district and further expansion into other blocks was initiated, thereby reaching out to a total of 56 villages in Vyara, Valod, Songarh, Uchhal and Nizar blocks of Tapi district.

Organizing and strengthening membership-based women's organizations

- **SEWA Union membership**

During this year, 10800 women from Tapi district had become members of the SEWA Union. These women and their leaders (aagewans) have also now begun to deliberate on entitlement issues related to water supply, public distribution system, legal electricity, educated unemployment, public transport, etc.

- **SEWA Sabhas**

SEWA Sabhas (village level meetings) were also organized on a regular basis. SEWA Sabha is a forum where the members are provided information on government entitlements and encouraged to access the same with support from the aagewans. In the current year, 32 SEWA Sabhas have been organised in 44 villages in which around 1300 to 1400 people have participated. In seven villages, a mobile van was used to enable usage of audio-visual techniques.



- **Training on Organising**

In addition to these LSST undertakes village-level trainings for women on the need and benefits of organising. The focus is on creating awareness among the members on the importance of collectivization, the roles and responsibilities of members and the power of a women's collective. In the year, six trainings on organizing women were conducted in villages and at Vyara office in which 223 women participated.

Leadership development is an inherent component of organising. Therefore, trainings to enhance the leadership skills were also organized for 91 aagewans. The training programmes proved to be very effective as aagewans were observed to be pursuing organization development in their villages after that.



The 'Tapi District Megha Adivasi Mahila Agriculture Producers' Co-operative' has been registered on 17th February 2014; with 439 women contributing towards the share capital. The first Annual general Body Meeting (AGM) of the cooperative was held on 22nd May 2014, in which 950 women from all blocks of Tapi district participated.

- **Linkages with existing health, credit or insurance cooperatives**



Around 1088 women have become members of the existing health and/or credit cooperatives which are extending their operations in the district.

Efforts are also going on to link the women from Vyara to the Gujarat State Lok Swasthya SEWA Mandali (Health Cooperative) and the Surat District Women's Credit Cooperative. Nearly 251 women have become members of the health cooperative, while 837 women have contributed share capital for the membership

of the credit cooperative.

Increased livelihood and social security for tribal households

- **Linkage with APMC**

In the month of December, we conducted training for improved practices for vegetable farmers in which 32 women participated from 7 villages. We identified a Sankalit Saathi also for mobilizing farmers and linking them with the Vyara APMC. As per the decision of Megha Mandli board, the vegetable shop of the Mandli was launched on 5th February.



- **Providing animal husbandry training and exhibitions of agricultural tools**

Nine trainings on animal husbandry with over 300 women were conducted, primarily focussing on usage of mineral mixture and cattle feed.

- **Linkage with Krishi Vikas Kendras, KVKs**

A total of 10 agriculture-related training sessions were conducted in close coordination with KVKs in which 370 farmers participated. The major topics covered in these training sessions were related to kitchen gardens, organic farming and different farming techniques to increase their productivity.

- **Organising and training of women's groups around MGNREGA for securing work**

To understand the different issues faced by members in getting regular work and to work out the required facilitation, we developed a questionnaire and conducted a primary survey of 2650 members in 19 villages of Tapi district. To create awareness, a two-day TOT of MGNREGA aagewans was conducted on 24-25 November, 2014. In this training total of 32 aagewans participated.

- **Collective marketing of agricultural produce**

A team of 11 Megha Mandli members participated in Satvik Mela held from the 20th to 22nd December in Ahmedabad. This annual mela, or fair, is organized to stimulate demand for local crops and their varieties from different regions of Gujarat, thus promoting their consumption and a market for small farmers. It also helps in linking them directly to the market so that they can get good prices for their produce directly, eliminating middlemen. The Megha Mandli arranged two stalls, one for their agricultural produce and another for the local Adivasi (tribal) food. The Megha Mandli was one among the very few participating organizations from tribal areas, and the only women's co-operative from Tapi district.

Village-level aagewans

Around 32 trained health aagewans and 62 trained livelihood aagewans at village level and 6 (block level) Aagewans, 1 for savings and credit and, 3 for livelihood and 2 for health activities, are providing incentive based services in 32 villages.

The process of identification and training of local workers to engage in health education and promotion activities has been initiated in all 44 villages. In 32 villages, the health workers (aagewans) have already initiated awareness generation activities through door-to-door campaigns, exhibitions and trainings. Besides, 20 women leaders have been identified as aagewans for livelihood activity promotion. This includes 8 agriculture aagewans, 8 animal husbandry aagewans and 4 aagewans for

marketing activity at block level. Besides the above, aagewans for MGNREGA were also identified in 10 villages during the year.

- **Community-Based Trainers (CBTs)**

Further, three Community-Based Trainers (CBTs) for health activities are already providing their services in the area. In addition to these; 3 new CBTs for health programme; 3 energy, water and sanitation promoters and 3 internal auditors cum CBTs for SHGs have also been identified. The focus during this year as well as the next will be on building capacities of these aagewans.

- **Training Health Aagewans**

The three CBTs have been participating in the monthly health refresher training undertaken by Shri Gujarat Mahila Lok Swasthya SEWA Cooperative Ltd (Health cooperative) at Ahmedabad. Besides 12 monthly Health trainings for arogya sathis (health aagewans) have been conducted. A total of 300 training person days of aagewans on the issue of health have been provided.



Reaching out to women for increased social protection

The health team conducted a range of activities over the year in 50 villages. The activities focused on increasing social protection among the members. Door-to-door health education activities have been undertaken by the health aagewans in 50 villages covering around 5700 households. Further, the CBTs have undertaken 522 group level health trainings over the last year generating a cumulative of 10759 health training person days in 50 villages. These training programmes focused on issues of nutrition and anemia, sickle cell anemia, leptospirosis and malaria. About 15 of these training programmes have been organised with a total 371 adolescent girls.

Health Activities during April 2014- March 2015			
SR.NO	ACTIVITIES	GROUPS	TOTAL NO. OF PARTICIPANTS
1	Door-to-door Education		58450
2	Area Meetings	125	1934
3	Education and Awareness	522	10759
4	Exhibitions	83	2907
5	Health Camps	28	1320
6	Referrals		123
7	Linkages with ICDS		294
8	Linkages government programmes		1723
Total			77510

- **Advanced Financial Counselling Trainings**

In this year, 8 advanced Financial Counselling training (two-day trainings) have been undertaken for SHG presidents and secretaries, as part of developing aagewans for financial services. 68 Self Help Groups have been formed in 20 villages with 866 women. The focus is on strengthening of these SHGs and ensuring proper systems and procedures.

- **Women Agro-Extension Workers (aagewans) Trainings**

Four training programmes on roles and responsibility of an agriculture cooperative were also conducted in Vyara for Megha Mandli board members. Livelihood aagewans received 9 trainings about provision of services through aagewans.

- **Trainings on livelihood and social security aspects through trainings/workshops**

Around 465 women have been trained on animal husbandry, 512 on improved agriculture and horticulture practices, 10759 women and adolescents on health and 429 on financial services; through conducting of 23 trainings/ workshops and 522 CBT based village level health trainings.

Kitchen/ Homestead Gardens

As a part of the project, we are attempting to undertake a demonstration on the combined effects of all these three on the nutrition levels of a woman. Towards this, the first step is the promotion of a kitchen garden, to ensure availability of fruits and vegetables at the household level. There are 64 kitchen gardens in Vyara. In coordination with KVK and Suruchi, a local NGO that produces low cost

agricultural tools, kitchen garden kits and agricultural equipment was sold to the members of Megha Mandli. These equipments not only reduce the drudgery in farming but also increase their overall productivity.

Creating models for integrated and sustainable development

Demonstrations of Agriculture, WATSAN and/or Energy Efficiency, along with nine types of demonstrations on agriculture, animal husbandry and energy efficiency have been undertaken in the villages. All the activities of health, livelihood and microfinance as mentioned above are organised in the 5 villages selected as potential model villages. In addition to this, energy efficiency training sessions have been organised for 40 women from these villages. Water quality management, providing microfinance to construct household toilets, building smokeless chulhas and training the members about the use of energy efficient CFL bulbs are some of the activities that would be initiated in the model villages. The health team will be focussing on activating the Village Health Sanitation Nutrition Committees (VHSNCs) as well as setting up referral services here.

Project Management Systems in place

The project Steering Committee has been set in place. Staff recruitment/deputation for the project has been completed. Project physical and financial monitoring and reporting systems are in place. Monthly planning and monitoring meetings are being held with staff and aagewans. Three quarterly coordination meetings with Steering Committee for review of project progress have also been conducted. The project MIS software has been developed and staffs are being trained to use the same.

Capacity-building of Traditional Birth Attendants (TBA)

During the year, LSST conducted two trainings of Traditional Birth Attendants (TBA) on maternal and newborn care in selected intervention villages of Riga block of Sitamarhi district and Mohanpur block of Gaya district, in Bihar in partnership with Save the Children. The training focussed on two key objectives:

1. Enhance the skills of traditional birth attendants on basic obstetric and newborn care (including mouth to mouth assisted breathing) and clean delivery techniques, use clean delivery kits for every delivery and post natal care.
2. Develop capability of TBAs in the area of early detection of danger signs of pregnancy and high risk pregnancy and ensure referral accordingly in coordination with ASHAs, AWWs and ANMs of the area.



Needs Assessment

A team from Lok Swasthya SEWA Trust went to assess the needs of the Traditional Birth Attendants (TBAs) on Safe Delivery and develop a module for the same in Mohanpur block of Gaya district and Riga block of Sitamarhi districts of Bihar. A meeting with the local PNGOs, Atragami India (AI) and CHARM, was organized to understand and discuss the local level practices of the dais or TBAs. Meetings with the TBAs, pregnant and new mothers, and ASHA workers were organized to assess the experiences of home and institutional deliveries from each of them.

Meeting with TBAs

The discussions brought forth various practices the TBAs follow while taking care of pregnant women and during delivery, such as the use of locally available traditional remedies, belief in black magic, superstitions and traditional customs, consulting untrained health practitioners during pregnancy and delivery, and so on and forth. They also shared that they cannot deal with

complications during pregnancy which puts to risk the lives of both mother and child. It was observed that they cannot identify if a pregnant mother is anaemic and hence cannot give proper advice and guidance. Safe delivery practices like cleanliness are not followed by the TBAs.

Unsafe and unhygienic practices such as taking out the placenta by inserting their hands are followed by the TBAs. They also put external pressure on the stomach of the pregnant mother to push the baby down. If the position of the child in the womb is not correct then the TBA uses her hands to correct the position. Lack of proper knowledge of neo-natal care was also observed among them. For example, instead of feeding mother's milk, the child is first given honey, tea, among others and after two hours the child is fed mother's milk. The TBA puts pressure on the mother's stomach if the placenta expulsion takes time. Hot oil is poured on the navel of the newborn to help it dry sooner. Remoteness of villages and lack of transport facilities force many families to take help of the dais for deliveries, thus putting at risk the lives of both mother and child if complications occur.

They shared that they have no formal training in child delivery nor do they have any official identity of being a TBA. The behaviour of the families they conduct deliveries for, changes depending on the sex of the child born. They accepted the fact that they use traditional methods of delivery and people now prefer institutional deliveries, hence they are losing out on their livelihood. They expressed their desire to learn new methods and increase their knowledge which could give them more employment.

Meeting with mothers

Meeting was organized with the women of the village who had delivered in the past 6 months to discuss their experiences with regard to home and institutional delivery. They shared that the TBA takes them to the hospital when there are complications or when a premature baby is born, but they also shared that the TBAs should be given proper training to deal with complicated situations.

Those new mothers and pregnant women who had an institutional delivery and who were going to the hospital for regular check up felt secure with the services offered in the hospital. They registered themselves at the Anganwadi and got benefits of regular immunization and check-up. From their experience they shared that the family members and the pregnant woman should keep money, transport facility and contact numbers of the ASHA worker, ANM worker, hospital and

doctor handy so that in case of any emergency, the pregnant woman can be taken to the hospital in time. They also mentioned that the TBAs in their villages accompany them to the hospital which is very helpful.

Meeting with ASHA workers

The ASHA workers have been trained to provide primary care and counselling to pregnant women. They also have an important role to play in the Village Health Sanitation and Nutrition Committee (VHSNC) and Village Health Sanitation and Nutrition Day (VHSND). They further shared the importance of both identifying and helping pregnant and lactating women.

The pregnant women go to the Anganwadi (ICDS) for ANC and PNC related regular check up, immunization, IFA tablets and registration. They shared that complications and risks occur during delivery which the TBAs are not trained to handle with. They expressed the need for the TBAs to be trained in neo-natal care as they follow practices that are not hygienic, involving a lot of risk of infections. Though the ASHA workers were against home deliveries, they accepted that in remote villages with no transport facilities, the TBA plays an important role. ASHA workers suggested that to cope with such situations, the TBAs should be given proper training and their wrong beliefs and practices should be addressed which would enable them to conduct safe deliveries. According to them, special focus should be given to those villages or areas where more deliveries are conducted by the TBAs.

From the above mentioned discussions with all the three groups, a common thread that flows is the urgent need to train the TBAs and give them proper knowledge regarding care during pregnancy, delivery procedures, neo-natal and post-natal care. Though the role of the TBA was highlighted in each of the meetings, but it also brought to the forefront the unsafe practices followed by them. Hence it necessitated the need to train the TBAs and address the practices they followed in a proper way.

TBA Training

Following the needs assessment, a module was developed for a ten-day training in Sitamarhi for 35 TBAs and thereafter another ten-day training at Bodhgaya for 35



TBAs. The entire module was planned not in a lecture mode but through movies, pictorial representations, role plays, posters, demonstrations, exhibitions and group work. The reason for doing this was to keep the attention of the TBAs at a constant level throughout the 10 days, and secondly, since the TBAs were illiterate they could understand better through pictures. The different methods mentioned above were used for each topic so they could understand and remember each detail taught and to make the sessions more interesting.

During the course of 10 days, the topics discussed included the human anatomy, ANC, PNC, complications during ANC, INC and PNC, care of the new born, identifying signs of danger in the new born, care of premature baby (safe delivery, referral, etc.), family planning, anaemia, healthy and nutritious food, leucorrhoea/white discharge, menstruation cycle, X and Y chromosomes, pregnancy process, miscarriage and its reasons, tuberculosis, HIV/AIDS, vaccination and the role of the TBAs. A hospital visit was also organized where they were shown the general ward, operation theatre, laboratory, OPD, gynaecologist ward, ANC, PNC, new born care, care of premature baby, breast feeding practices and visit to the Nutrition Rehabilitation Centre (NRC) to understand the care given to the mother and child.

Overall the training was useful and it addressed various issues/practices the TBAs followed. It gave them new confidence in themselves and through continuous role plays, the TBAs understood all aspects of pregnancy and safe delivery practices taught to them in a detailed manner.

After the completion of the training, a meeting was organized with the local team to share the experiences and feedback of the 10 day training. Follow-up and a close monitoring system were developed to ensure that the TBAs follow what they learnt from the training by often conducting meetings with them and interacting with the family they offer their services to. A format for this purpose was also shared with the local team.

Health Needs of Informal Workers



LSST was a partner in this project, supported by the Rockefeller Foundation, to develop prototypes for urban informal workers health in Ahmedabad city in the state of Gujarat in India. This project focussed on six neighbourhoods in Ahmedabad city which are home to informal workers, predominantly home-based workers and street vendors, but also some construction workers and domestic workers. Many of the women workers in these

neighbourhoods are members of SEWA. The neighbourhoods are: Pathan ni Chaali, Anil Starch, Bapunagar Panna Estate, Khodiyarnagar, Ramrahimnagar and Rajiv Nagar.

The components of the prototypes we have developed for use in these six areas are:

- **Information Centres** to facilitate a two-way flow of information of government and private services and programmes to women workers, and that of their needs and the outreach of services to the providers, along with issues and challenges that are encountered in the process of obtaining access.
- **Health camps** for early diagnosis and screening for health problems, including gynaecological and eye problems and non-communicable diseases like diabetes.
- **Use of mobiles and hand-held technology** to both impart information on various government programmes, common illnesses and preventive measures, and to collect data on how many women obtained access to the various programmes, thus monitoring access.
- **Scaling out low-cost pharmacies** which provide medicines at an affordable rate, thus improving both access to care and the likelihood of people taking the full treatment that is indicated.
- **Scaling out health insurance by VimoSEWA**, SEWA's insurance cooperative so that informal women workers and their families have some financial protection in times of sickness.

Health Issues of Women Workers in the Informal Economy

Women workers suffer from a number of health conditions and problems connected to their workplaces and their living situations. These problems often compound each other and are frequent.

These include communicable diseases like tuberculosis, malaria, diarrhoea and respiratory infections, and now, increasingly, non-communicable diseases such as heart disease, diabetes and kidney diseases. Also important is the fact that their health problems also include work-related ones, predominantly of a musculoskeletal nature such as lower back pain, pain in the joints, neck, limbs and shoulders, eye-strain and other eye-related problems, especially among home-based workers. In addition to long hours of work both at home and outside, they put in many hours of unrecognized household work like cooking, cleaning, washing and taking care of children and the elderly. As a result of this, they often suffer from health hazards, sleep deficits, physical and mental stress and, in many cases, chronic diseases.

Construction workers are engaged in the most dangerous of occupations as they are often injured and even fall from heights as they work. Street vendors face sun-stroke and even accidents as they negotiate traffic while selling their wares. They also slip and fall on the uneven roads and suffer from fractures.

Problems with the Health System and Services in India

- **Insufficient Investment in the Health Sector**

One of the major issues plaguing the health sector in India is the insufficient investment in public health expenditure – only 1.1 per cent of the GDP in 2012.

- **Limited Attention to Urban Health**

Further, as 80 per cent or more of Indians at the time of independence lived and worked in the rural areas, the focus was almost entirely on the health of rural residents. Scant attention was paid to the health of urban Indians, which was left up to the municipalities. While the latter did provide some health care, largely through hospital-based tertiary care, the smaller towns did not spend much on health care.

Even though about a third of India's population is now urban, with some states like Gujarat being over 40 per cent urban, the focus of public health until very recently has continued to be on rural health care. In addition to the almost exclusive focus on rural health, the public health system has not focused on the workers of India's large and growing informal economy. Women workers have been even more invisible in the public health system, with no services developed to take care of their occupational health and safety issues. Although, they do recognize their identity as mothers,

this limits the perception of these women as workers, thereby resulting in major focus being on maternal health, especially on the high number of deaths during child-birth.

- **Insufficient Focus on Primary Health Care**

The investment in primary health care has been low and insufficient for a country of its size, and with so many different health problems that its citizens, especially the poorest and workers, face. This has resulted in a curative focus, with workers having to seek care in the large, tertiary care hospitals. They have to stand in long lines for care, even for minor ailments like coughs and colds.

Fortunately, the Ahmedabad Municipal Corporation (AMC) is at the forefront of organizing health care for citizens living in urban areas. It has established a network of Urban Health Centres (UHCs) over the past few years, and is slowly increasing the range and quality of services. The UHCs are still not including occupational health services to workers, though they have been asked. It is mainly a question of exposure and sensitization to work-related health issues of people, especially women.

- **Poor Quality of Care, Limited Access to Medicines and Diagnostic Tests**

Another major issue that urban workers face is the poor quality of care at government hospitals. They have to stand in long lines, giving up their daily wages and spending money on transport to the hospitals, and they often get poor care. There is a huge patient load, at least 60 to 70 per cent of which could be treated at UHCs. Furthermore, medicines are most often not available free of charge at the government facilities. Similarly, while many diagnostic tests are available at the public hospitals, several are not. These then have to be obtained from private laboratories whose charges are unaffordable for workers. Medicines alone account for about 70 per cent of out of pocket (OOP) expenditures in India.

- **High Expenditures on Private Health Care**

One outcome of the often poor quality of care and the time taken to obtain care coupled with lack of medicines, is that workers seek care at private facilities. These may or may not provide better quality of care, but it takes less time to access the service. The result of this is that OOP expenditure is very high – about 70 per cent is borne by individuals in India, with the result that there is

impoverishment and indebtedness. It is estimated that about 60 million people in India fall into poverty each year as a result of large OOP expenditures on sickness.¹

- **Location and Timings of Public Health Facilities**

So far, very few primary care public clinics and dispensaries are located near workers' homes or workplaces. This is changing with the establishment of UHCs. However, in some areas on the periphery of the city, where often the poorest workers live and work, there are no such facilities. The Primary Health Centres (PHCs) in rural areas do not serve these semi-urban populations, and they do not get access to care in urban areas either, thus falling between the cracks.

Another issue is that of the opening hours of the facilities. Public health facilities, unlike private ones, follow a schedule that is not geared to informal workers hours of work. Hence, by the time the workers finish work, the facilities are closed for the day, leaving them to seek emergency care in the large public hospitals or in private facilities which have more appropriate opening hours from the workers' viewpoint.

- **Formation of Local Health Committees**

Local health committees for preventive health care and health education were being formed in 2014 by the AMC. These are called Mahila Arogya Samitis (MAS) or Women's Health Committees. The MAS are supposed to decide on health priorities of their areas, provide health education and to link their neighbourhood's people to the public health system and services. This process has only just begun, and it remains to be seen how these MAS will be set up and to what extent they will be functional and effective.

- **Little or No Health Education and Health Information**

Very little health education and information, especially that which is worker-sensitive and gender-sensitive, is available to urban informal workers. Whatever is available does not reach women workers in the informal economy. Information and education in the form of fliers is available to workers when there is an epidemic of gastroenteritis or hepatitis. At those times, house-to-house campaigns are undertaken but are not sustained once the health crisis is over.

¹ Shepherd-Smith A., "Free Drugs for India's Poor", The Lancet, 2012, 380 (9845): 874

One of the key requirements to improve workers' health is providing simple information and education with a preventive orientation. The emphasis should be on how to stay healthy - simple dos and don'ts using accessible language and visuals especially aimed at non-literate or barely literate people.

- **No Orientation or Understanding of Occupational Health and Safety for Informal Workers**

As mentioned above, there is almost no orientation for health care workers – doctors, nurses and others – with regard to work-related health issues. In case of history-taking, questions about a worker's occupational health-related issues is not asked, nor is work history considered with a view to understanding how it impacts overall health.

- **Little or No Focus on Non-Communicable Diseases (NCDs)**

The working poor in India now have to face the double burden of both communicable and non-communicable diseases. Ahmedabad's workers are no exception. Recently, both public and private providers have recognized this and have started to develop both preventive and curative services.

The Ahmedabad Medical Association (AMA) has been reaching out to us, and we have jointly organized camps to screen for NCDs. Other private doctors are also reaching out and linking with us for eye check-ups, screening for diabetes, cancer and renal problems. This is the advantage of a city – there are doctors available who can be approached and who approach us.

- **Insensitive Attitude of Some Care Providers**

Some of the nurses and doctors are insensitive to women, especially during child-birth. Many women have reported to us that the nurses pay little attention to them during labour, and even taunt them at this difficult time. We have documented such cases and taken these up with the hospital authorities. We pro-actively try to build up a rapport with nurses and doctors so that they care for women and others in a more sensitive way.

- **Poor Implementation of Public Health Programmes**

One of the ironies of our public health programmes is that they are run poorly in urban areas, even though human resource issues like shortages of personnel are much less serious in towns and cities. This is in part due to the rural bias of the health care system mentioned previously.

Furthermore, the information and fliers that are prepared to promote these programmes also have a rural focus and are not tailored to urban populations. Finally, many of these programmes do not provide any information to workers, including where and how such programmes can be accessed by them.

The prototypes we have designed will address some of these gaps and problems in the health system, especially with regard to the lack of primary health care, the lack of information on services and programmes, the need for linkages with public health services and programmes to increase access, the issues of location and timings, provision of affordable medicines and financial protection during catastrophic illness to prevent indebtedness and drastically reduce incidences of falling deeper into poverty. They are also designed to show how appropriate, affordable and people-centred services can be developed by, with and for informal women workers, with their needs and priorities central to all efforts.

Response to the Prototypes

- **Information Centres**

We have so far obtained a very positive response from the informal women workers about our information centres. Large numbers of members – 3541, 2,621 of whom are women – have registered at our information centres in the short period that we have developed and tested out this prototype. We have provided them with information and with services, including hand-holding for referral care once they are screened, either through our hand-held technology or through camps. The flow of women, and 920 male informal workers, the men-folk of the women we are serving, is a testimony to their interest.

- **Health Camps**

Doctors and informal women workers are both keen, in our experience, to come together in health camps. Our health workers can mobilize a good number of women workers, thus making the doctors feel it is worth their while to participate. They get the benefit of access to patients whom they may then refer to their public hospital or their own private practice. This has been the case with camps where we screen for diabetes. As the public health system is yet to develop services for diabetic patients, the private doctors fill the gap. As far as women are concerned, obtaining diagnosis and screening at their very doorstep is very convenient, and they appreciate this service. This can be seen by the significant number of women who participate regularly in these diagnostic camps.

Five hundred women have attended 19 camps in the last three months — 8 were eye camps and 11 were for diabetes screening, blood pressure and kidney problems. These were organized with the help of private providers like the doctors of the Ahmedabad Medical Association (AMA). They availed further care with the support of our referral team which accompanied them to large hospitals and ensured that they got the referral services they required.

An indication that we are able to influence their health-seeking behaviour, at least to some extent, is the number of referrals: 460 and an additional 29 for further tuberculosis screening. We were also able to assist an additional 309 women in obtaining entitlements under various public health, nutrition and early childhood care programmes, thereby providing useful services and building the credibility of our prototypes at the same time.

- **Use of Technology**

With the support of the Public Health Foundation of India (PHFI), SEWA's partner, we introduced the *Swasthya* Slate or Health Tablet. This tablet is a blue-tooth enabled integrated diagnostic kit that works with an android-based mobile system to perform a range of diagnostic tests. The applications will help increase access to health care and health education. The medical history of the patients is recorded during registration and on-the-spot diagnosis also be done.

Technology has proved to be very popular with both our health workers and the informal women workers coming to our information centres. Health workers have been fast learners, using the hand-held devices with great aplomb! It is a new skill and they have embraced it fully. It gives them confidence and a new status in society.

- **Scaling out Low-Cost Pharmacies**

There is clear evidence, given the rising foot-fall of patients and our increasing sales, that the scaling out of our pharmacies is required and will be a useful prototype. There is a huge demand for affordable and good quality medicines. It is an unmet need, and will continue to be so till the government steps in with free essential drugs. However, the need for affordable surgical equipment and laboratory tests will remain, unless these too are provided at low or no cost.

- **Scaling out Health Insurance**

There is no doubt about the need for health insurance. The evidence is the rising demand and growth of VimoSEWA's outreach and premium collection. This year, 94,000 women enrolled and the

premium collection crossed Rs 20 million or about US \$333,333. This is the largest collection in VimoSEWA's history so far, and points to both the need for the service and a willingness to pay premium from women workers' own earnings.

As can be seen from the above activities, LSST has had a year full of action, implementation and new avenues for organising women and their families around issues of social protection that included a wide spectrum of initiatives on Tuberculosis, Health and Child Care, Capacity Building, Programmes focussing on Occupational Health and Mental Health and addressing health needs of informal workers. It has worked at the grassroots level in Gujarat, shared its experiences in other parts of India like Bihar and Delhi, and even overseas - in three countries of the African continent.