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Background Note

Work, Health and Rights

-Prabir Chatterjee, Jashodhara Dasgupta, Sukanya Rangamani and Jagdish Patel[1]

What is work?

Earlier the activities of a human being were simplistically divided into Rest, Recreation and Work. However, the divisions are often blurred when we see that Work may include the same actions as Recreation or even those done by most people in the Rest period (sleeping or sitting on duty for an emergency service or guard, and having sex for a sex worker) - but if so they are generally paid to do these activities.

Various forms of compensation both monetary and in kind are prevalent, but there are also many situations where work is done without any direct compensation such as work within the domestic sphere, including both housework and work on the family farm, or in the family trade and so on. There is also work done for the community, such as collective activities carried out for the general welfare or well-being. Those who carry out the work are not paid for this work- but may get something in return (which is not measured out as payment by quantity or related directly to the time spent working).

When we speak of Work, Health and Rights, we need to differentiate clearly between organized and unorganized labour. In the current global milieu of a declining worldwide economy, weakening of the leftist forces and of the trade union movement, there is a decline in direct employment and an increasing trend to recruit workers through contractors, especially visible in areas of home-based work. The National Council of Applied Economics Research (NCAER) calculated that the *informal economy/ unorganised sector* – generates about 62 per cent of GDP, 50 per cent of gross national savings and 40 per cent of national exports (Chen et al, 2001). The First National Commission on Labour defined *unorganized sector* as "that part of the workforce who have **not been able to organize** in pursuit of a common objective because of constraints such as casual nature of employment, ignorance and illiteracy, small size of establishments with low capital investment per person employed, scattered nature of establishments and superior strength of the employer operating singly or in combination."

Even this definition cannot cover, for instance, the situation of a woman who collects minor forest produce like sal leaves and sells it regularly to a local dealer or contractor; or those who sort through garbage and collect metal pieces or other recyclable materials and sell them to scrap dealers. Here the words 'establishment' or 'employer' are not applicable. Neither can these workers be called 'entrepreneurs' since it is basically unskilled work. Then if we consider those who work on family farms or are engaged in the family trade (like weavers for example) – they too would also not see the head of the family as their 'employer' for there is no paid remuneration. The situation is more stark in the case of women engaged within families in domestic work, as 'home-makers' (whether or not they are employed elsewhere in wage work).

For those who are engaged in sex work, or garbage sorting or other as child labour, all of which are not recognized as being legal, the situation is even more complicated. Sex workers or garbage collectors do not have any employers, but while they are engaged in work, they have no workers' rights. In the case of Manual Scavenging, they are engaged by government officials in railways and municipalities but they are made invisible in official documents since this practice is officially 'outlawed'. In the case of child labour, the matter is more complicated since it is banned but everywhere, they are engaged in work, and some are engaged in learning family occupations and some in exploitative situations that keep them out of school. So their rights and safety as workers is impossible to formally safeguard since they are not meant to be doing paid work in the first place.

An interesting anomaly is the government law on

[1]*Emails: prabirkc@yahoo.com, sukanr@gmail.com, jasodhara@sahayogindia.org, jagdish.jb@gmail.com*

employment guarantee (Mahatma Gandhi National Rural Employment Guarantee Act). This mandates 100 days of employment for families who apply, but does not guarantee all the entitlements provided by organized labour, such as the right to unionize, the right to maternity protection or the right to health coverage. Neither is the government accepting full responsibility for the millions of workers as their employer! There is a partial provision for hospitalization through RSBY which stretches to Rs 30,000 but not beyond, and does not cover out-patient care or medication. (This money too does not stretch very far if unscrupulous private practitioners drain the card's resources through irrational care and unnecessary treatments.)

Thus the rights of the 'worker' vis a vis the 'employer' becomes very difficult to define in all these cases, so by default the state becomes responsible for safeguarding and fulfilling the rights of those who work in the unorganized sector. The problem that emerges in our context of privatization, and needs focus in our current meeting, is that more and more sections of the population are steadily being pushed into the unorganized sector.

What is work place?

If work takes place for home, family or community it is generally done in the space occupied by the home/family/community. If there are common property resources (forest, grazing land, river, water body, sea, marketplace, etc.) - the community workplace may be in one of these common property resources. It is the site where extraction of value/production/activity/occupation/trade is performed.

In the case of organized work the place is more often owned or rented by the organizer/organization. Thus a home worker (unorganized) like a bidi worker works at home. The organized bidi labourer works in a shed/shop/factory. The Industrial Revolution, the 'factories' in the colonies, the great institutions (Writers' Building/Temple/Palace/Bank/Exchange) prepared the way for the shops, factories, hospitals and offices with 9 to 5 timing and 40 hour weeks. Currently these are changing to suit various economies: FEZ-s, malls, corporate hospitals, ATMs, flexi-time work are some recent variations.

An issue that feminist economists have raised is around domestic work that occurs within the 'private sphere', which challenges the older more formal definitions of what constitutes workplace. We have 'paid domestic work' (which is getting more visible with some unions coming up), and then we have the full-time home-makers, almost always women, who work very long hours for their families and are not paid. It is meant to be part of their socially accepted 'role in the family' and the unending drudgery is garbed in terms such as 'motherly love' and 'selfless caring for the family members' which exploit women's emotions. In fact the women home-makers are often actually deprived of access to family resources including food and economic resources like money or property. The lack of economic powers can create a vicious cycle in which women are unable to opt out and compelled to continue with this role. They also stand the risk of facing domestic violence in their 'workplace'. As this work is largely invisible in the economy of a country, there is no concept of labour rights, fair working hours or any other assurance. Complicating the issue further is a dual role that many women play of productive and reproductive labour, in which they participate full-time in the paid workforce, and then come home to a full load of housework that is not shared by other family members.

Workplace poses also the threat of hazards to the living space when these are shared. For example, the living environment of the plantation workers has been the working environment of the plantations, thus exposing them to the hazards of pesticides in their water, soil and air of the living and working environment. Similarly, a local basti in a metropolitan city may house a community of agarbathi workers or dyers. The very fact of the work being carried out from their living environments poses hazards for the women and men, the children and the young adults. Thus workplace has to be broadly defined to include all forms of economic work being carried out.

Philosophical Question about Liability, Person, Employment State and Others in Formalization of Work

Just before and after the expropriation of the Commons (colonial acquisition in many African, American and Asian countries) and expansion of the Industrial Revolution there were a series of reactions to the apparently faceless, unstoppable trans-national forces. These manifested as Campaign against Slavery, Parliamentary System (Magna Carta), 8 Hour Day, Women's Emancipation, Freedom Movements, Peace Movement, and Green Movement, Revolutions (French, American, Russian, and Chinese). In general these sought to establish the rights of a section of society with respect to the state, society, employer. Each of these actions tried to establish the identity of the common person or worker.

However there remain questions with respect to unorganized groups - particularly in relation to unorganized labour. Low compensation, "begar", bonded labour, slavery, pauper status (see Dickens' *Oliver Twist*), vagabond status (see George Orwell in *Down and out in Paris and London*), mercenary armies, forced conscription, caste-based conservancy work are various examples where no rights exist for the worker. There is no obvious legal liable individual/organization. The state is theoretically expected to prevent this – but often fails. Then health, prevention of disease and mental hygiene are compromised and no one is called to respond. Often the victim is blamed. And often it is suggested that organized labour is the solution. However it must be remembered that traditional Occupational Health also finds it difficult to keep organized labour healthy. In the 'Third World' and especially in the Indian

context of a fast industrializing nation, questions of occupational health expand to absorb the whole gamut of unpaid and poorly paid labour conditions that form the foundation of surplus generation.

Workers' health and safety needs to include all health conditions and issues of workers and health problems related to and arising from work into holistic issues that need a comprehensive approach. For example, women workers in cashew processing factories are exposed to pesticides sprayed within the factory and succumb to pesticide poisoning. This is not acknowledged as an occupational health problem but skirted as 'malnutrition' or 'mass hysteria', thus ridiculing their labour. As much as it is urgent to prevent pesticide poisoning at workplace (regulatory changes, change of process, preventive measures to reduce exposure, health monitoring of workers etc.), it is also important to bring in enabling conditions (at health system, at workplace, regulation) that could acknowledge the context of workplace health problems and therefore address them.

As mentioned above, if we take up the unpaid work of women in the domestic sphere, the question arises as to who is the employer? In the growing informalization of work and promotion of small entrepreneurship, home-based work and piece rate work are becoming increasingly prevalent. In such a case, there is no formal 'workplace' (it is done either at home like weavers or bidi-workers or sex workers, or at the worker's own convenience like gathering Minor Forest Produce) and the person who purchases the final output can deny any employer obligations. Occupational health hazards (caused by animals in the forest or falls from trees or hillsides, or just long hours of working in bad posture or poor light in the home, and most certainly unwanted pregnancies or infectious diseases from sex work) will lead to additional health problems, but since there is no formal 'workplace', the official regulatory frameworks for occupation safety will also not apply! Such questions also would have to be asked about self-employed men, as in autorickshaw drivers, domestic electricity workers, plumbers, construction servicemen hamalis, who work at occupations with serious health and accident hazards.

We also need to look beyond Occupational Safety and Health coverage (prevention and treatment of illness or injury caused by the nature of work) to issues like overall health coverage for general problems, and then some specific gender questions like Maternity Entitlements (fully paid leave, breastfeeding support, nutrition supplements and crèche facilities for both men and women workers). It is imperative that the health coverage of such informal sector workers and small entrepreneurs become the responsibility of the state, which makes it essential to bring about Universal Health Coverage.

How far do Education and Research Look at these Issues of Work, Health And Rights

Traditional occupational health education has always been restricted to specific diseases and conditions. It is true that epidemiology and public health research have been able to widen the knowledge on occupation and health effects. But the average medical student or a practicing doctor is not oriented to consider occupation as a determinant of health. A 3-month course on Industrial Health, offered by the Ministry of Labour is the additional qualification required of Factory Medical Officers of Hazardous Process Industries under the Factories (Amendment) Act, 1987. This is the mainstay of additional qualification for a medical student to delve into workers health in industrial settings. Very recently, a Masters Programme is offered in few institutions as a distance course. Thus Occupational Medicine as a specialization is not available in India as compared to western nations that mandate a 3 to 4 years of specialist training in occupational medicine. One wonders why there is less commitment from the academia and regulators in not demanding of better skills for the majority of the nation's people (as every adult is a worker).

Work Health and Safety- The Directorate General Factory Advice Service and Labour Institutes (DGFASLI) under the Ministry of Labour comprising of the Central Labour Institute, Mumbai, Regional Labour Institutes at Madras, Kanpur, Kolkata and Faridabad are the other government bodies who need to conduct research, training and ensure Occupational Health safety in factory settings. Their work is just not enough; it is grossly lacking in addressing the concerns of workers in all factory settings.

Such educational effort is also necessary to integrate safety into the main subjects of engineering education, which for example cover topics building construction, metallurgy, chemical technology, without adequate stress on the safety and health aspects of the discipline and technology. There is one exception. Education in nuclear power engineering deals with radiation safety as part of the main subject curriculum, however, the larger question of nuclear power remains.

Workers'/Occupational Health Research - The NIOH, Ahmedabad and its branches are the only organizations to look into the various aspects of worker's health (chemical toxicity, ergonomics, physiology). But the gender questions around work, health and rights (see above) are not directly addressed by them. However, very little of the OHS research is fed back to medical colleges, policy level changes. The NIOH was pro-public health when their study findings on health effects of endosulfan were debated and the ban on endosulfan was brought about. But with respect to asbestos, they have been alleged to be pro-industry.

The Indian Association of Occupational Health comes out with the journal IJOEM that publishes research on Occupational Health issues. The doctors are also part of the organized industrial sector, and have played a limited role (albeit none) to address occupational health challenges nationally. In some instances like the workers affected by mercury of the erstwhile Hindustan Lever factory that produced mercury

thermometers, the medical team of the company has been hostile, irreverent to workers' concerns and also misleading during the court proceedings.

Occupational and Environmental Health research and policy change is mired with too many power players- industry is the foremost with its corporate interests, also the departments of agriculture, industry, labour, commerce. Health is the last concern of these governmental bodies. The culture of precautionary principle has been rapidly eroded by the neo-liberal market driven policies.

Workers' Health is linked to Environmental health and these need to be addressed together. When there are struggles for environmental justice, workers are usually pitted against the communities (interplay of caste, class, social, economic dimensions). The Environmental movements in various parts of India realized that both OH and EH were battling against common forces of neo-liberalism and corporate power and so systematic attempts to break the divide between workers and communities were integral to many environmental struggles.

Role of media: The media does have a few articles (eg., the series on farmers' suicides). A much larger role is possible. More well positioned analyses of industrial health and accident issues would help to some extent in building a cultural atmosphere that is attuned to the risks borne by the underprivileged for society's benefit.

The Limitation of ESI/CGHS/RSBY How to Cover the vast Informal Sector

Workers' Health services – ESI system: The ESI system has been specifically envisioned to address the health needs of the workers. But they have failed to address the occupational health concerns of workers. There has been a gross underuse of funds by the ESIC, especially in the functioning of the medical benefits schemes. Recently, ESIC has opened many medical colleges, postgraduate institutes of medical service and research and also a national institute for occupational and environmental health research. While the ESIC administers the social security insurance scheme providing for benefits, the medical services are provided through the State Government, causing friction in management of services. This is of concern as basic primary health services through the ESI Dispensaries are still lacking.

The ESI dispensaries are/were lacking in basic primary health care (antenatal care seems to be an exception in this regard) and would refer to the referral ESI hospital for further management. The limitations of ESI dispensaries in Gujarat with regards to doctor-patient ratio, availability of doctors and services and accessibility of services is described in the background paper 'ESI scheme in Gujarat: Who does it serve?'

The workers are so hesitant to access the ESI due to the complex procedures of registration, unfriendly attitude of staff at the dispensary and the Local office where benefits are claimed, the apathy of medical system to address their health concerns with respect to the pressure of loosing job due to absenteeism under a highly profit driven shop floor industry.

The performance audit of ESI by the CAG identified the following deficiencies -

- Lack in governance mechanisms,
- Underutilization of funds earmarked for benefits
- Building infrastructure
- Underutilization of existing resources
- Shortage of manpower
- Did not enroll workers commensurate with the growth in number of factories.

(CAG, 2006. Ch1: Ministry of Labour, Report no 2 of 2006 available at http://www.cag.gov.in/html/reports/civil/2006_2_peraud/2%20OF%202006/04_Chapter_1_report_2_2006_ESIC.htm).

ESIC has established Occupational Disease Centres in four places in India to assess and report occupational diseases among workers. The reports are reassessed by the Medical Board of ESIC to determine the amount of compensation for any worker diagnosed with Occupational Disease. One has to study the functioning of this mechanism.

Recently, there has been a flurry of recruitments of doctors, faculty for medical colleges, resource strengthening and transparency in disbursement of benefits through computerization of records of insured persons under the ESI Scheme. How much of this would lead to improvement in worker's health has to be studied. There is immense potential to expand the ESI medical services to provide universal health coverage for workers.

Management of ESI

The medical services are provided by the State Government and case benefits are paid by ESI Corporation. This two agency approach is a hurdle. ESI Corporation has resolved that it is prepared to take up Medical Services also if the State Governments resolve to that effect but State Governments do not do that either. Local groups may be directed to discuss the issue and press concerned State Governments to hand over facilities to ESI.

ESI and CGHS cover a small fraction of society while much labour is unorganized, as described above.

RSBY is supposed to be a step towards covering unorganized labour. However the implementation has been far from ideal. Devadasan et al's findings in Gujarat and the PHRN study in Chhattisgarh are relevant.

In general, the structure of the ESI seems potentially more useful to deal with the problems of workers

who are at risk. Its considerable benefits include the grant of paid sick leave to disablement benefit from insurance for the worker who is diagnosed sick. Such an advanced welfare system does not exist even in the Aarogyasri programme. However, it is essential to consider how it would be possible to extend ESI to cover workers from sectors like auto rickshaw drivers, agricultural labourers, self-employed servicemen, sanitation workers, sex workers. It is possible that such an active extension would go a great distance in enabling proper coverage for the people in the emerging conditions of the economy.

When we talk of Workers Health Rights specific groups of workers have specific problems. Cutting across all economic activities these groups face more problems than others due to their social status.

1. Dalit workers 2. Tribal workers 3. Women workers 4. Minority workers 5. Child labor.

Workers Health/ OHS problems may be compared between groups also like - Permanent workers Vs. contract workers OR Unionized workers Vs. non-unionized workers OR Public sector workers Vs. Private sector workers and so on.

Major Issues of Work, Health and Rights

1. Lack of data on occupational diseases and injuries (even for the sectors where OHS (Occupational Health and Safety) law is applicable. There are multiple agencies like ESI, Factory Inspector, and Compensation Commissioners who have these data. We do not get any combined data. Data of all these agencies differ which is natural
2. Even where laws are applicable workplace environment is not monitored (and there is no question in other work places) and hence there is no conclusive Indian data on dose-effect relationship.
3. Jagdish Patel, Amulya, Samit Carr, PRIA and others have documented how weak the ESI has been in compensating silicosis victims.

Diagnosis is not done - in most cases of dust related lung diseases they stamp TB. Many people suggest that it is due to medical education system we have but some are of the opinion that this is purely class issue and that is the only reason. Another logical reason is, in most cases workers either do not give complete occupational history or not being sought by the doctor. Even if a doctor is interested workers would not know what dust it is- silica or ant other or other data like amount of dust or particle size. In case of chemicals workers do not know the names of chemicals. Giving information to the workers or building their capacity is an issue. If some workers know the name of the chemical, the doctor will have to refer the literature to know the hazards associated with it- or he may have to consult some agency that has hands-on information.

4. No laws for huge numbers of workers in both organized and unorganized sector workers. Transport workers have an Act but the Act has no provisions for Workers' Health or safety. Similarly there are no such provisions in Shop and Establishment Act. Workers in health care, education, banking and finance, general administration (Government servants) are unionized but have no law to protect Health and Safety at work
5. We have no information on OHS status of huge number of workers engaged in different occupations.
6. Role of the trade union in Workers' Health: Occupational health has never occupied centre stage in the agenda of the Indian trade union movement. The compulsions over the last half-century that forced unions to address other issues to the detriment of health as an issue are manifold, and even justified. The task of prioritizing health as a central issue facing working class families and poor communities has just gotten tougher owing to the rising desperation among the poor, and the sweeping environmental and labour 'reforms' that have revoked many of the labour and environmental rights that we once took for granted. (Paragraph quoted from Concept note on CHESS 2008 workshop)

Thinking on the Way Ahead

1. A strong framework of occupational health and safety regulations that is comprehensive to include all forms of informal, unorganized work and workplaces is necessary.
2. Transparency and accountability of institutions that need to safeguard worker's health and safety has to be developed.
3. Unions have a major role to be aware and sensitive on occupational health issues. One of the ways is to seek for workers participation in safety committees in workplace (organized settings) and form such committees in unorganized settings.
4. Trade Union representatives are involved at all levels in ESI. They need to be more active to resolve the problems. Act may be amended to give them more rights. At present they are just advisers and advice is not binding.
5. People's report on worker's health and safety could be a step towards building the knowledge base for change. Mainly because workers' health or safety data in unorganized sector is limited.
6. Cost benefit studies that document workers' illness and injuries to productivity may be necessary.
7. Corporate accountability has to be spelt out in any Occupational Health research, Work and Health campaign or Government regulation.
8. Health systems need to build capacities in understanding, managing, treating worker's health issues.

Background Note

Occupational Health Movement in India

-Jagdish Patel[1]

Historical Background

The movement for occupational health is now a little over three decades old, though the labor movement is more than a century old. The Bombay Mill Hands Association formed by Narayan Meghaji Lokhande and his colleagues demanded for weekly holiday in textile mills in 1880s, and if weekly rest is considered an occupational health issue, then the movement is certainly a century old. The first trade union was formed in 1920 and the Trade Union Act was enacted in 1926. Trade Unions have played an important role in various labor rights but for various reasons they have not been able to play a major role in either making workplaces healthier or identifying victims of occupational diseases or getting them justice. In that sense organized and systematic efforts were initiated by PRIA (Participatory Research in Asia) in the early 1980s. Individual workers, victims or trade unions may have taken up struggles at local level for limited purposes which are not documented well and such efforts may not be labeled a 'movement' as such. Early, Dunu Roy and Imrana Qadeer authored an excellent article for *Social Scientist* (1989) entitled "Work, Wealth and Health: Sociology of Workers health in India."

PRIA's Contributions

PRIA in the eighties either carried out or supported some social research and published documents in Hindi and English, it organized advocacy meetings and workshops. Among other publications, *Ghatak Dhool* (Hindi) was published in October 1984, just a few months before Bhopal. The booklet describes problems of silicosis among slate pencil industry workers in Mandsaur in Madhya Pradesh. Later, it published several other important publications on the subject. In 1984, the Bhopal tragedy took place which gave a great boost to their efforts and underlined the need and void that existed then. Vijay Kanhere was the main force behind it. With his organizational skill, he was able to encourage several youngsters to join the efforts and built their capacity with great patience and empowered them. Dr.Murali, Harsh Jaitly, Sanjiv Pandita, Pralhad Malvadkar and Jagdish Patel are some of the people whom he groomed. They all continue to contribute in the field of Occupational Health. Sujata Gothoskar also wrote on OHS problems of women workers. PRIA has ceased to work on Occupational health since long except for running distance courses. It is still a CIS Collaborating center.

[1]*Email:jagdish.jb@gmail.com*

Popular Publications and Papers on OSH

Dunu Roy, a chemical engineer from IIT Bombay, got interested in Environment Planning and Occupational Health and started working in Shahdol in Madhya Pradesh He worked there from 1970 to 1980. He worked with workers of a paper mill and a caustic-chlorine plant on mercury exposure as well as jute mill workers. He published some popular publications. V.T.Padmanabhan, a freelance journalist, documented the plight of the rayon plant in Gwalior, where workers were exposed to Carbon Disulfide, a well known neuro-toxic chemical that left several workers paralytic. Another toxic material caused heart attacks in this unit. PUCL published this report in 1983.

Mukul Sharma, a Delhi-based writer prepared a report on the unsafe work conditions in the stainless steel utensil industry leading to serious accidents in Wazirpur around Delhi. The Delhi General Mazdoor Front published the report in 1989. Lok Vigyan Sanghatana, Bombay, published an informative booklet in Hindi on byssinosis in 1983. In 1987, BGIA (Bhopal Group for Information and Action) published a booklet on byssinosis in Hindi and Urdu. Jan Chetna Manch, Dhanbad with SAHAJ, Vadodara, published a popular publication on pneumoconiosis among coal miners in Hindi titled *Kala Fefda* (1988). These all were marvelous efforts, and educative material, to draw attention of civil society towards the appalling work conditions that prevailed. But these efforts neither continued nor it helped workers from their groups to continue the struggle to bring about a positive change in their lives. These efforts did help understand the situation behind closed doors and these all were pro-poor but hardly classifiable as a 'movement'. Publications are important aspect of any movement and publications can give birth or momentum to movement but publications alone cannot be termed as a movement in itself. It is important to note here that barring one, none of these publications came from any national or local, independent trade union. Efforts by the late Shankar Guha Niyogi, founder of Chhattisgarh Mukti Morcha, a labor union run in the town of Dalli Rajhara Mines in Chhattisgarh, need mention. He set up the Shaheed Hospital for workers. Still his efforts on occupational diseases, if any, in not known to the author. Dr.Murali, Dr.Veena and Vijay prepared a book on disability assessment and using this book, some groups got the disability assessed locally. Vijay prepared several publications on Occupational Diseases for PRIA. He wrote in English as well as in Marathi. His Marathi booklets

include *Nuksan Bharpai kashi milvita yete?* (How compensation may be claimed?), Aurangbad madhil safai kamgar (Cleaning workers in Aurangabad), Bahirepana (Noise induced deafness), *Main Sewer kamgaransathi aarogya* (Bombay High Court's order for OHS Scheme for Main Sewer Workers), etc. Based on the work done by the Lokmanya Medical Foundation Research Centre, the Pune National Safety Council published a popular booklet on prevention of hand injuries in 1983 in Hindi and English.

The Lokmanya Medical Foundation Research Centre, came out also with its experiences of handling patients exposed to chlorine and other industrial exposures in 80s. Dr.Haresh Shah, the then in-charge of Jayaben Hospital, Ankleshwar also documented his experiences of treating patients with chemical exposures in this period. Hospitals in industrial areas have very rich experiences but these remain undocumented. There is a wide scope for sharing such experiences. They can also greatly contribute in recording and reporting occupational diseases and generate scientific data.

Judicial Activism on OSH

Another form of activism was filing public interest litigations on issues related to occupational health. The Consumer Education and Research Centre (CERC), Ahmedabad filed a PIL in the Supreme Court to protect workers exposed to asbestos in 1986 - following an article published on the situation in an asbestos cement plant in Ahmedabad and other asbestos units in India in the New Scientist. The Supreme Court gave its judgment in 1995 setting, inter alia, rules and conditions. The Hon'ble Court passed an order on compensation for victims. No one knows how well these are followed and how far it has succeeded in protecting workers from asbestos exposure. The Lok Adhikar Sangh in Ahmedabad filed a the PIL in the Gujarat High Court on the plight of agate workers. Several such instances of judicial 'activism' can be cited. These efforts helped the movement to some extent, even though these were not initiated or supported by either victims or exposed workers. Again filing petitions only without having any infrastructure to follow up and going to the logical end cannot be said to be a movement in itself. Not that groups active on OSH are not using law. They are indeed actively using the law, filing claims in courts at all levels for instance, but that is as part of their larger work and not just limited to filing compensation claims. PRASAR (People's Rights and Social Research Centre) filed a PIL in 2006 in the Supreme Court of India on silicosis and Shilpi Kendra joined them as co-petitioner later. PTRC (People's Training Research Centre), Vadodara, is very active in this regard - filing claims under ESI Act and EC Act. It has filed several petitions in the Gujarat High Court. In some cases based on the work done by PTRC, the Gujarat High Court has taken suo moto notice. OHSA, too, has raised issues of OHS and on the serious failure of legal enforcement of the orders of the Gujarat High Court. Some groups are exclusively working on OSH while some work on other related issues too.

In the eighties, Construction Workers' Unions came together to launch a national campaign to press for a law for construction workers. After a decade long struggle, India's Parliament passed the Building and Other Construction Workers' Act in 1996. The law has provisions for safety and health at work and to some extent it may have helped prevent accidents. For the welfare of workers, a separate Act was passed under which States collect cess on certain construction projects for welfare fund. Important among the welfare schemes is relief in case of accidents. Building and Woodworkers International (BWI), an international federation, has helped the movement greatly. Still, the construction unions do not seem to be working on occupational health nor does any State Government have any welfare scheme for victims of related occupational diseases.

Contribution of Government Institutions

In any socialist welfare state such as India, the State has a constitutional duty to protect the health of citizens, i.e., Right to Life.

During British rule, what we know as the industrial system of production started and a new class of people came to exist. Following laws in Britain, the colonial rule brought in similar laws in India. Though this note is on the OHS movement, we nevertheless have to appreciate the role played by government institutions. Industrial Toxicology Research Institute, Lucknow (now renamed as Indian Institute of Toxicology Research, IITR), National Institute of Occupational Health (NIOH) and Central Labor Institute (CLI) have played an important role in promoting OHS. These are institutes under Council of Scientific and Industrial Research (CSIR) or ICMR (Indian Council of Medical Research) or under the Union Ministry of Labor. CSIR is under the Ministry of Science & Technology, ICMR is under Ministry of Health and CLI under Central Ministry of Labor & Employment. There may be some more Government institutions dealing with the subject to some extent. All of these have carried out scientific research in the field of OSH which has provided important information. This research has either initiated or shaped the OSH movement in India. One can cite a few specific examples. Following an ITRC study of agate workers, a PIL was filed by Lok Adhikar Sangh and later VSSM (Vyasayik Swasthya

Suraksha Mandal) and PTRC took up the cause of reducing the incidence of silicosis among agate workers. In another case, NIOH carried out a study on byssinosis which triggered a program of action under the National Campaign on Dust Related Lung Diseases. Organizations associated with the campaign located workers identified suffering from byssinosis in this study and helped them get compensation from ESIC. In a recent instance, a small note in the NIOH Annual Report led MLPC (Mine Labour Protection Campaign) to take up a campaign to identify and locate workers suffering from asbestosis so as to help them get justice.

How Workers Suffering from Occupational Diseases are Identified

There are three or four ways by which this is done. One is through scientific studies taken by Government institutions as described above. Another is OSH groups on their own initiative identify and diagnose through their own clinics and doctors. A third is when workers are suspected to be suffering from an Occupational Disease, either by themselves or through an OSH group or Trade Union and/or both, ESI medical officers are approached and the condition gets diagnosed.

Contribution of Local Grass Root OSH Groups

Vijay helped form many local groups and nurtured them enhancing their knowledge and capacities in the process. Occupational Health and Safety Center (OHSC), Mumbai, was his own creation as local group in Mumbai. The author formed the VSS Mandal (VSSM) in Baroda in 1986. Sanjiv Pandita joined Asia Monitor Resource Centre (AMRC), Hong Kong, and helped strengthen the OSH movement in Asia.

Since its formation, VSSM supported local struggles in and around Vadodara on OSH - important among them are the glass factory workers' struggle in Baroda, chrome factory workers' union's struggle, power plant workers' struggle in Ahmadabad, ceramic workers' efforts for silicosis and other issues, and textile workers' struggle against byssinosis. Later, VSSM supported formation of the Occupational Health and Safety Association (OHSA), Ahmedabad and Kamdar Swasthya Suraksha Mandal (KSSM), Ahmedabad. OHSA worked with power plant workers and later with asbestos cement plant workers. KSSM initially worked with textile workers for byssinosis and later for sewage workers or manhole workers. Unfortunately, the movement did not spread beyond Gujarat and Maharashtra. Nagarik Mancha is one old group in W. Bengal, engaged in getting victims of occupational diseases compensation from ESIC. Of late, groups have come up in Delhi, Rajasthan, Jharkhand and Madhya Pradesh.

The majority of the groups described here have been established by workers themselves, utilizing their first hand experience of working in a polluted workplace. The source of commitment required to sustain the struggle come from the horrible experiences they have gone through. The groups that have some up in last decade - PRASAR in Delhi, MLPC in Rajasthan, OSHAJ in Jharkhand and Shilpi Kendra in MP are lead by activists who have not worked as workers in the respective field. All these groups have led the struggle in a legal and constitutional way and are very participative, creative and peaceful. Majority of them have worked in the organized sector but some have ventured in unorganized sector too.

Major Issues

Compensation has remained the core of the strategy of OSH groups - either claiming from ESIC under ESI Act or from employer or insurer under the E.C.Act or holding the State responsible under constitutional provisions (Right to Life). **In the past, asbestos workers have claimed compensation from a trust formed by the multinational corporation upon its bankruptcy**.

For any compensation claim to be filed, the affected person needs a certificate issued by a medical professional to the effect that he/she is suffering from an occupational disease listed in the Act. Involving medical professionals for this purpose is the most important part of the activity. Different groups have different strategies to get diagnosis done. Some have doctors in their group as staff or as a volunteer. Some have active collaboration with a medical college. Some have not been able to have any one to give them such this service on a regular basis. In most cases, groups are working with victims of different forms of pneumoconiosis - mainly silicosis and asbestosis. In these diseases, an X-ray is an inevitable tool for diagnosis. Groups who do not find a local medical professional who can give written opinion, have to rely on the few available volunteers in Mumbai or Kolkata. Doctors are also required to assess the extent of disability.

For lung diseases, the lung function test is an important indicator. Lung function tests can be carried out by trained paramedicals. OHSC and PTRC have bought spyrometers. OHSA and PTRC have ILO standard pneumoconiosis X-ray plates. Both have audiometers also to get audiograms done for workers exposed to high noise. OHSC has been able to help hundreds of workers claim compensation for NIHL (Noise Induced Hearing Loss) using this instrument and they have been travelling to other parts of country to help others organize diagnosis camps.

The groups have succeeded in claiming compensation for dermatitis, occupation related asthma, chromium

toxicity (nasal septum perforation, cirrhoses of liver, asthma, etc), NIHL, silicosis, asbestosis, byssinosis, etc. The number of successful claims though would be small compared to the probable number of victims. For the unorganized sector, groups have filed complaints before the National Human Rights Commission (NHRC). The NHRC has passed recommendations in a few complaints. A group in Rajasthan followed up the recommendation, victims were organized into an Union and the Union organized protests to press the Government to implement NHRC recommendations. Finally, the Rajasthan Government paid Rs. 3 lakh to each of the 21 widows who lost their husbands due to silicosis. In another petition on November 12, 2010, the NHRC recommended that the Government of Gujarat pay Rs.3 lakhs to the next of kin of 238 workers who died of silicosis. The Government of Gujarat has still not implemented this recommendation.

OSH groups have also - within their capacity and share of limitations - done some successful advocacy. PTRC organized several programs with ESIS. PTRC is invited by civil society groups to deliver lectures on OHS. For awareness generation, VSSM initially and PTRC later, carried out several exhibition events. In 1988, it started publishing a newsletter, Salamati, in Gujarati, and is being published even today. Salamati is the only OHS news magazine of its kind in India. Information dissemination is done through this news magazine. OSH groups have taken up social research at times and published reports. PTRC is very active in imparting training to grassroots activists. Till now, it has trained several hundred workers. Care and support and rehabilitation, of victims and their families, is an area where these groups have not yet ventured in big way.

Networking

Upon a suggestion from AMRC, PTRC convened a meeting on Jan 30-31, 2006 at Delhi to discuss networking needs. As a result Occupational & Environmental Health Network India (OEHNI) was established. For next two years, it remained dormant and again a meeting was convened by Environics Trust at Delhi at the behest of AMRC in April 2009 when it was decided to activate the network. It has since worked well and OEHNI is now an active network of OSH groups in India. Some have left the network half way and some have not joined while some new organizations have joined as members. Cultural and political differences would always be there and we are doing our best to narrow down the gap. OEHNI and individual members are members of Asian Network of Rights of Occupational and Environmental victims (ANROEV). Individual organizations are members of other national and international networks.

In 1990, PRIA initiated the National Campaign on Dust Related Lung Diseases. Groups active in OHS at that time joined. The campaign was successful in Gujarat and some other parts. Several textile workers could claim compensation for byssinosis. The Campaign lasted for two years after which it subsided for various reasons. Since then, during the last 20 years there has been no national campaign. There are several issues around which a campaign can be initiated.

Scope of Work for OSH Groups

Still there is lot of scope for awareness programs and training. We need to support local initiatives in different parts of country. We need to do mapping of the problems in different parts of the country and for that we need information from the workers themselves or local medical practitioners. We can think of programs like “Shodh Yatra.” We can have annual conference of OSH groups to share the information to generate regional reports. Literature in local languages and popular publications is also a dire need which can be taken up. All such activities need financial resources and investment.

Issues which may be taken up for a National Campaign

Groups may decide on National Campaign on many areas of common concern. Some serious issues may be listed as under. The list is not exhaustive and may be extended:

NHRC recommendations on silicosis affected victims.

Lack of reliable data on Occupational Diseases

Poor notification of Occupational Diseases under Factory Act, Mines Act and BCOW (Building and Other Construction Workers’) Act

ESI Services: Special Medical Boards, Disability Assessment and Compensation issues .

Ratification by India of ILO Convention 155

Amendment in Factory Act and ESI Act. Review of Sch.II of Factory Act and Sch.III of ESI Act and E.C.Act, empowering TUs and NGOs to prosecute violations

Enforcement of existing laws for prevention: Weakened labor departments.

This back grounder is meant to give a small introduction to the past and present of the OSH movement in India and also to the great challenges ahead. The movement has had its share of ups and downs and successes and failures.

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Informal Labour: Elementary Aspects

Notes for MFC 2013

-R. Srivatsan[1]

What does the term 'informal labour' mean?

The term 'informal labour' comes into existence from the mid-1970s onwards. It means labour without any formal employment guarantees, no written procedures, no rules or regulations. In India, there has historically been widespread use of informal labour. Bonded labour and traditional trade apprenticeships are examples. On the other hand, women working in every house are examples of informal labour. Informal labour is marked by low wages, long working hours and repetitive work. Sometimes, there are no wages paid (housewives, bondage). As the economist Nirmala Banerjee pointed out, a housewife does not get promotions, raises or improvements in status over a life time. There is no recognition of skill and no reward for diligence.

In general, informal work can be terminated immediately by either the worker or the employer. When the worker stops working, it is usually because of some health or family crisis. When the employer terminates a worker, it is because the work is not needed. Therefore the termination of labour is not an equally easy option for worker and employer. In summary, informal labour is a form of employment where the employer uses the worker's labour without any return commitment on his part.

What is the difference between 'organized labour', 'unorganized labour' and 'informal labour'?

Organized labour is unionized. The presence of a trade union is a guarantee that the worker gets a fair chance in any dispute – he has political support and his interests are protected. Capitalist industry would like to organize the workers according to the needs of production and division of labour but they would not like workers to organize themselves. Capitalism abhors trade unionization and worker organization. However, once workers are organized by capital, they develop a class consciousness for themselves and organize politically to protect their interests.

Unorganized labour means usually labour which is not unionized. This means bargaining power doesn't exist, and there is no back-up support for the worker in his struggles in the factory. Small scale factories and cut rate industries use unorganized labour through labour contractors, thus paying a contract rate to the contractor for a group of workers. Contract workers, who have always existed (e.g., in the construction industry) have usually no unions to support them.

Both the terms organized labour and unorganized labour belong to an era of factory based industrialization, employment and economy.

The term 'unorganized labour' was used more generally till the 1970s. 'Informal labour' begins to become more popular from this period onwards. This change comes with the beginnings of feminist economics. For instance, Ester Boserup uses the term 'casual worker'. Nirmala Banerjee uses the term 'informal labour' alongside the older term 'unorganized labour'. Maria Mies uses the term 'subsistence labour' an older term, but gives it a new meaning. All these terms are used to describe kinds of work that do not have the potential for unionization - most often women's labour.

Many feminist economists demonstrated that women's labour which constituted the work of 50% of the world's adult population was invisible. Women's contribution to the economy was invisible. Their reproduction of the working population and the process of gathering, cooking and feeding that population were invisible to both liberal and Marxist economics. Both women's work in the family to make its economy function within national economy, and the role of women's work in the history of the world, were unacknowledged. This was what Sheila Rowbotham argued in her pathbreaking work *Hidden from History*.

What is the link between liberalization and the new use of the term 'informal labour'?

The World Bank, in its study *Gender and Poverty in India* uses the term 'informal labour' in a different way. While the older feminist writings used 'informal labour' to describe the dispersed, unorganizable, traditional practices of women's work, the World Bank document uses 'informal labour' as a positive term to describe women's labour. Women, who were earlier seen as workers suffering from the absence of organization, support and improvement in their lives were now projected by the Bank as intelligent 'managers of poverty'. There is no doubt that this is true, but the World Bank uses this changed meaning of the word to describe a new way of working. Informal labour becomes the goal for all labour. In fact, the World Bank and capitalism in general subtly, and some times not so subtly, pushes for the feminization

[1]*Email: r.srivats@gmail.com*

of the labour force. This is because women make more disciplined, docile and predictable workers (when they do work formally!)

In another direction, the neoliberalism exerts pressure on India (and other developing countries) to minimize labour laws and protection so that all labour becomes informal labour and thus artificially high wages are reduced. This is part of the economic restructuring and liberalization that comes with the 1990s. There are two main reasons for this policy to spread effectively – one, many third world countries need to borrow funds from the World Bank and the IMF, and the IMF lays 'conditionalities' for the loan. One of the pressures exerted by these conditions of lending is that the laws that support artificially high wage rates are removed. Thus all labour protection should slowly become minimal. This means that labour organization cannot seek *legal* remedies, and unions are forced to function illegally, sometimes resorting to violence, thus becoming illegitimate. The second reason for this is that with the fall of the Soviet Union, unionization loses the political support of communism. The threat to capitalism vanishes. For these two reasons, and with the Indian capitalists and the bureaucratic and political elite (PV Narasimha Rao, Manmohan Singh, Montek Singh Alhuwalia, Chidambaram) embracing liberalization, informal labour becomes the model. After this, even large industries begin to employ contract labour in vast numbers and eliminate unionized labour (Jindal, Maruti and others begin to follow the old Birla model of using as much contract labour as possible).

The informal sector is that part of the modern economic sector which consists of informal labour. One of the guarantees of modern employment in industry is that the individual gets a chance to improve his or her condition and enjoy life with modern amenities, housing, education and health care. Capitalism's original promise was that it would make/create a modern society where everybody would live a comfortable life. This was guaranteed to be so because organized labour (another term for the division of labour) would produce enough goods for every individual for the first time in history. This guarantee was backed by the threat of legal action against the employer if he didn't give the labourer his due share of benefits. However, by the 1970s, this promise faded and the mechanism of legal redress to the employee weakens considerably. With the fall of the Soviet Union, the promise was more or less abandoned. Informal labour may be seen as that labour that ends with the ejection of the labourer from the charmed circle of the promise of the Modern.

When labour organization is thus subverted, and the right of the worker to work, livelihood, safety, health, speech and association are abrogated, the worker is practically no longer a citizen. She cannot fight her battles in the court of law since rights don't work any more – and she would lose her wages if she wasted time in courts. Such an 'organization' of people - unilateral, disempowered, and left to their own resources - may be called, in the terms of the political theorist Partha Chatterjee, 'populations'. This term does not refer to the national population as a whole, but to that statistically discrete collections of women and men (who in our case, work in different industries).

What are the problems of occupational health in the informal sector?

In the informal sector, the worker loses security of employment. Security of employment means some long term guarantee of the job, health, accident, pension and death benefits. These are the means through which the original promise of modernity was to be delivered to the worker. The Social Security system in Britain and later across Europe and the United States provided these benefits to the national population as a whole. However, there was always a legal obligation on the part of the employer to take care of the worker with the possibility of penalty for negligence to do so. This legal obligation was the labourer's guarantee of the labourer's right to work, to livelihood and ultimately to happiness in the modern world. These modern rights were mostly paid lip-service in third world countries. A short life

Putting Out and Beedi Work: 'Putting out' is the process is where the employer subcontracts jobs to people who either work at small informal locations, or at home. Putting out has a long history from medieval times, but its revival in neoliberal economics is of a different scale and order and with an entirely new purpose – docile and predominantly feminine labour, which cannot come together to organize.

An old, yet contemporary example of 'putting out' is in the manufacture of beedis. Typically the piece rate of payment is Rs 50 for the manufacture of 1000 beedis by women at home. Though the health problems of handling tobacco are documented, it is difficult to do much about it. And yet, even in these extreme conditions, the Beedi Workers' Union is born! We need to study beedi rolling as an example of informal work: how were beedi workers unionized historically? Who supported them? How was formal legalization was possible? What kind of occupational health care is feasible? What are the pitfalls and difficulties? What lessons could we learn?

of misery, often ending brutally was more of a reality. With liberalization this reality is the only guarantee.

Occupational health is part of work security, and informal labour has no guarantees of occupational health. If a labourer falls ill, he loses a wage. If he has an accident the company disowns him. If she needs to s tay home because the child is ill, or another is born, there is no compensation, no help, no health care from the employer. If the informal laborer's slum is destroyed by an industrial accident (Union Carbide Bhopal is an extreme example), she loses her job, home and possibly lives in her family (including her own) without any possibility of compensation.

With liberalization, loss of labour laws resulting in 'informal insecurity' for the labourer, these problems of occupational health expand to employment sector as a whole. Traditionally abandoned problems in specific pockets like chromium poisoning, tannery toxicity, asbestosis, sanitation work diseases, etc., are joined by industrial accidents, and loss of pay and service due to other illnesses as possibilities of insecurity.

While political parties may involve themselves in finding solutions to the health problems of working and unemployed populations, they usually don't address issues of occupational health. In such cases in India, human rights organizations and civil societal groups have moved the courts (and mountains literally) to find compensation and justice for the worker. Examples are a) in relation to industrial catastrophe, the struggle to sue Union Carbide and find justice for those whose lives were destroyed by the accident; b) the support of the movement against the Koodankulam nuclear power plant

Tentative Questions to think about for the MFC Annual 2013

1. What is the strategy required to tackle the problem of occupational health in India?
   a. What would be a critical policy approach? What kind of advocacy strategy is to be planned?
   b. What would be a useful incidence strategy – i.e., how should activists who work on occupational health think about actual cases in the informal sector? Are there specific strategies?
2. Is it necessary to have a formal network of occupational health activists to exchange information, progress, methods and cases?
3. Is there a link between the provision of occupational health and universal access to health care?
4. Is theoretical work on how occupational health issues should be thought about and tackled necessary?
5. Do we need studies that look at comparative data from other countries, analyse possibilities and make proposals?

[These elementary notes for the practicing activist have been written by R. Srivatsan. They draw largely on the extended email discussion on informal work with Prabir Chatterjee, Veena Shatrugna and Anand Zachariah over the three month period July 2012-September 2012. Readers who are interested in history of the concept of 'informal work' may see background note "A historical sketch of the concept of informal labour" – forthcoming!]

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A Short Note on the Unorganized Sector in India

-Jashodhara Dasgupta, SAHAYOG[1]

Size and Nature of the Unorganized Sector in India

An extremely high percentage of India's workforce is estimated to be employed in the unorganized sector; according to the NCEUS report (2007), 422.6 million workers or 92 percent of the total workforce are part of the unorganized sector. According to the NSS 64th Round (2004-05) out of the total estimated workforce of 457.5 million workers, 148 million are women (roughly 38 percent). Out of the total female workforce of 148 million, 142 million or nearly 96 percent of all female workers are in the unorganized sector; making an overwhelming proportion of women workers in low paid, unskilled jobs.

Workers in the unorganized sector, unlike their counterparts in the organized sector, have little or no social security, little negotiating power in terms of choice of work, are often 'unskilled' and work in poor conditions. However the unorganized sector is extremely complex and there are wide differences in nature of work, employer employee relation, wage levels, degree of informality, size of enterprise and skill across the sector. On the one hand there are tribal communities who collect forest produce for a contractor and on the other hand there are home-based or piece rate workers who do not have a direct employer-employee relationship. Similarly a vegetable vendor who sells his produce, or a fisherman who sells fish, does not have a direct employer who would be responsible for workers' benefits.

The First National Commission on Labour defined unorganized sector as "that part of the workforce who have not been able to organize in pursuit of a common objective because of constraints such as casual nature of employment, ignorance and illiteracy, small size of establishments with low capital investment per person employed, scattered nature of establishments and superior strength of the employer operating singly or in combination." The Second National Commission of Labour recognizes several characteristics of the enterprises and employment in the informal sector which makes workers in this sector extremely vulnerable. It also mentions decline in direct employment and an increasing trend to recruit workers through contractors, especially visible in areas of home-based work.

Table 1.1: Estimate of Organized and Unorganized Workers/ Employment by Industry (Million)

Category	Combined		
	Male	Female	Total
Total Workers	**309.4**	**148.0**	**457.5**
Agriculture	151.2	107.7	258.9
Non-agriculture	158.2	40.3	198.5
Organised Worker	**28.8**	**6.0**	**34.9**
Agriculture	2.0	0.8	2.9
Non-agriculture	26.8	5.2	32.0
Unorganised Worker	**280.6**	**142.0**	**422.6**
Agriculture	149.2	106.9	256.1
Non-agriculture	131.4	35.1	166.5

The National Commission for Enterprises in the Unorganized Sector (NCEUS)

The NCEUS, headed by Professor Arjun Sengupta, was appointed by the national government in September 2004 to make recommendations to improve conditions of workers in the unorganized sector. According to the NCEUS, almost the entire farm sector in India can be characterized as informal while, roughly 80 per cent of the work force in the non-farm sector is also informal. Ninety per cent of the poor are casual workers and 74.7 per cent of the 'self-employed' are poor.

An analysis of the possession of industry-wise skills (in terms of levels of education) among informal workers shows that 98-99 percent of those engaged in agriculture, construction and trade works, are illiterate. Among other sectors, 90 per cent of the informal workforce is found to be illiterate.

The NCEUS report (2007) also indicates that Indian agriculture is getting feminized with 73 per cent women being associated with it compared to 52 per cent men. The gender break-up of the workforce in the informal sector, computed from unit level records of Employment-Unemployment Survey, 55th round of NSS, 1999-2000, shows an increased presence of female workers over male workers engaged in the informal sector in India — 95 per cent of female workers and 89 per cent of male workers

Economic Contribution of the Unorganized Sector

While the unorganized sector employs the majority of the workforce, its economic contribution is often neglected. The ILO report "Decent Work and the Informal Economy, 2002" notes that the informal economy contributes to economic growth in at least two ways. First, the output and the low wages of informal workers assist the growth of industries, including key export industries, in many countries. Second, the output of informal enterprises also contributes to economic growth.[2] The National Council of Applied Economics Research (NCAER) calculated that the informal economy/ unorganised sector – generates about **62 per cent of GDP, 50 per cent of gross national savings and 40 per cent of national exports**

(Chen et al,,2001). But conditions of workers who create so much wealth are abysmal. Though most of the labour laws in India are generic enough to apply to informal sector, they are rarely followed. The workers themselves are not aware and consider the laws not relevant to their situation.

Legal Framework for Protection of Unorganized Sector Workers

The nature of the unorganised sector, makes workers in this sector extremely vulnerable. Poor wages, irregular availability of work, extremely difficult conditions of work and little social security to fall back on in case of a contingency like ill health has made it necessary to put in place a legal framework and policy prescriptions that protect these workers. The state has over time formulated several legal measures as well as social policies to provide workers in the unorganised sector with safeguards.

While there are numerous legislations for regulating conditions and work and ensuring social security, very few of them cater to the unorganized sectors, even though they are most vulnerable. The NCEUS report has made classification of various labour laws and the extent to which they can be applied to the unorganized sector. Some of these laws have been listed below.

The above laws are directed specifically at workers and are meant to ensure minimum conditions of work, wages and compensation.

Table 1.2: Legal Framework for Rights of Unorganized Sector Workers

Laws which apply to All Sections of the Unorganized Sector	
Law	**Provisions**
Equal Remuneration Act, 1976	✓ The Act is applicable to the women workers and provides for the payment of equal remuneration to men and women workers for same work or work of a similar nature. ✓ By same work or work of a similar nature is meant work in respect of which the skill, effort and responsibility required are the same, when performed under similar working conditions. ✓ The Act also provides against discrimination while recruiting men and women workers.
The Bonded Labour System (Abolition) Act, 1976	✓ The Act defines 'bonded labour' as a service rendered under the 'bonded labour system' - a system of forced, or partly forced labour under which the debtor enters into an agreement, oral or written, with the creditor. ✓ This law provides for the abolition of bonded labour system.
Laws Which Apply to Some Sections of the Unorganized Sector Labour	
The Minimum Wages Act, 1948	✓ The Act is applicable to the workers engaged in the scheduled employments[1] and provides for fixing minimum wage rates by the government in certain employments. It is applicable to agricultural, non-agricultural and to rural as well as urban workers. ✓ The Act covers wage workers, home-based workers but not the self-employed.
The Trade Unions Act, 1926	✓ The Act is applicable to trade unions and provides for the registration of trade unions. ✓ At least 10 percent of the members or 100 worker (whichever is less) engaged or employed in the industry with which the trade union is connected should be the members of the trade union.
The National Rural Employment Guarantee Act 2005	✓ The Act is applicable to those working under the NREGA ✓ In case of accident of accident or injury at work place, there is provision of free medical treatment. ✓ In case of death or permanent disablement during work, there is provision for cash compensation. ✓ The act provides for facilities of safe drinking water, shade for children and periods of rest, first-aid box with adequate material for emergency treatment for minor injuries and other health hazards connected with the work. ✓ There is provision for crèche in case the number of children below the age of six years accompanying the women working at any site are five or more.
Laws Extendable to the Unorganized Sector	
Workmen's Compensation Act, 1923	✓ The Act is applicable to workmen and provides for the payment by certain classes of employers to their workmen of compensation for injury by accidents arising out of and in the course of his employment with certain exceptions. ✓ The Act also specifies a list of diseases, which, if contracted by the worker, would be deemed to be occupational disease peculiar to that employment which shall be deemed to be an injury by accident liable for compensation under the Act.

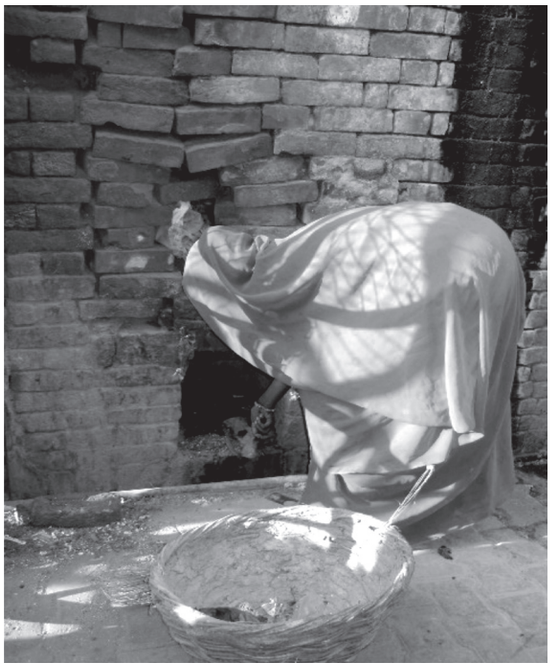
[1]From *Crisis of Maternity - Healthcare and Maternity Protection for Women wage workers in the Informal Sector in India*, Sahayog, 2012.

[2] International Labour Conference, 90th Session 2002, Report VI - Decent Work and the Informal Economy.

[3] The Act provides a schedule of employments to which this Act is applicable.

Manual Scavengers and their Health

-Rashtriya Garima Abhiyan



Introduction

The greatest scourge of untouchability is felt by manual scavengers whose daily living is based on cleaning feces from public and private latrines and dispose of dead animals from the village setup. Deemed to be a polluting and filthy occupation, this job is preformed exclusively by Dalits, and that too, by a sub-caste of Dalits who are considered even by other Dalits sub-castes to be wretched and 'untouchable.'

Manual scavenging is not only a violation of human rights but also a disgrace to human dignity and humanity at large. This situation persists despite the fact that the Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act, 1993, is in enforcement, which provides for the prohibition of the employment of manual scavengers as well as construction or continuance of dry latrines and for the regulation of construction and maintenance of water-seal latrines for assuring the dignity of the individual, as enshrined in the Preamble to the Constitution.

Manual scavenging continues to exist in India, despite being unacceptable and hazardous as a method of disposal of human waste, despite scientific and technological advancement on various fronts that saves manual labour, and despite the availability of simple and low-cost alternatives which can eradicate the twin problems of manual scavenging and safe disposal of human excreta. It passes on from generation to generation. A culture of acceptance prevailing among them is also depriving them of their basic rights

Most importantly, governmental rehabilitation programmes have mainly failed due to lack of reliable estimate of the number of manual scavengers and provision of meager financial support. An estimation based on the Census 2011 data gives the figure of approximately 12 lakh manual scavengers as being involved in manual scavenging practice. The Government of India has fixed a time limit to end this inhuman practice since it was outlawed. However the deadline has been continuously extended by the Central Government.

At the same time, the National Advisory Council adopted a number of recommendations for the elimination of scavenging, while the Union Government on 27 August 2012 had cleared the Prohibition of Employment of Manual Scavengers and their Rehabilitation Bill, 2012. In addition, the Government has expressed speedy elimination of scavenging practice in the 12th five-year plan approach paper.

Rashtriya Garima Abhiyan's Approach

Manual scavenging is primarily a socio- political issue, it denies life with dignity. This is one prime reason why every attempt to address it through livelihood approach never succeeds in eradicating it. The occupation of Manual Scavenging has its roots in the caste system, which renders the community invisible and powerless. Further, the condition and status of women pitches this issue into the area of gender and women rights. Manual scavengers are not only forced into the occupation, but also face multiple situations of vulnerabilities and denial of rights and justice within all spheres of life. Thus this unfortunate dalit community faces the dual challenge of 'Liberation' and 'Rehabilitation' - liberation from the inhumane occupation and invisibility to lead a life with dignity and comprehensive rehabilitation encompassing social, religious, economic and political aspects.

Concerns with the prevailing situation say that "this is entirely a question of self-esteem and dignity; and no financial assistance/ help or government schemes can search an answer to this question." There is an urge to make sincere efforts from both sides: firstly, this vulnerable community should stop doing this work and secondly, society should accept this vulnerable community by giving them equal status without any discretion.

Manual Scavengers and Health Related Issues

The life of manual scavenger is at risk at every stage: looking it as a health related issue will give a clearer picture of the problem. The working conditions of these sanitary workers have remained virtually unchanged for over a century. Apart from the social atrocities that these workers face, they are exposed to certain health problems by virtue of their occupation. These health hazards include exposure to harmful gases such as methane and hydrogen sulfide, cardiovascular degeneration, musculoskeletal disorders like osteoarthritic changes and intervertebral disc herniation, infections like hepatitis, leptospirosis and exposure to helicobacter pylori, skin problems, respiratory system problems and altered pulmonary function parameters.

Women Manual Scavengers

Women working unprotected are in grave danger of contacting countless diseases through their daily and close contact with human waste. Some of these diseases, in addition to TB, include: campylobacter infection, cryptosporidiosis, giardiasis, hand, foot and mouth disease, hepatitis A, meningitis (viral), rotavirus infection, salmonella infection, shigella infection, thrush, viral gastroenteritis, worms and yersiniosis. Facing the dangers of daily contact, "Ninety percent of all manual scavengers have not been provided proper equipment to protect them from faeces borne illness," said a 2007 TISS report (Jan 2007) on occupation related safety. This includes safety equipment like gloves, masks, boots and/ or brooms. The use of hands by women manual scavengers, along with the certainty that they will have direct skin contact with human waste, is a very dangerous combination that is contributing to serious health conditions. Chronic skin diseases and lung diseases are very common among women manual scavengers.

Sewage and Manhole/Sanitation Workers

Most of the municipalities in India are not equipped with the latest machines to clean the sewage system and therefore, sewage workers are employed under compulsion to enter the underground sewerage lines through the manholes and clean them wherever and whenever the lines are clogged for whatever reason. The job of the sewer worker is to inspect and maintain the underground network pipes that make up sewerage system. Sewage workers have to remove solid substance wastes which responsible for blockage of flow of fluid waste in sewage system. For that sewage workers regularly enter into manholes which contain very poisonous gases.

The working conditions of sewage workers are very dangerous; they are provided with a rope and bucket to clean the manhole manually. While working this, they have to face various poisonous gases which are harmful for their health and sometime it causes their life. Due to that, sewage workers usually have had cuts, injuries, irritation of eyes and suffer from skin rash and related health problems. The existing protective equipments are neither adequate nor up to the standard quality. Also, most of the sewage workers are not educated to use protective equipments. Most sewage workers are recruited on contract basis and on daily wages. A large number of sewer workers die before retirement. While working on busy road area, there is always fear of accidents from moving vehicles.

Manual Scavengers in the Indian Railways

Institutions like the Indian Railways, Municipal Corporations and Gram Panchayats employ manual scavengers on contract bases. The Indian Railways is the major employer of manual scavengers, and manages some of the longest rows of open latrines in the world. The open-hole lavatories in every railway compartment/coach that is in service in the country turns the largest rail network of the world into big lavatory that drops raw human excreta and other waste on rail track and over people and vehicles - where the rail line runs above roads. It is a common scene in every railway station in the country, railway employees cleaning with a broom, railway sleepers coaches covered with human excreta waiting to be cleaned. Indian railways run one of the most complex rail networks in the world. It manages a network of over 63,000 km with over 13 lakh employees. Approximately 13000 train runs daily out of which 9000 are passenger trains with 13 million passengers travelling every day. As per the Nanda report, the railway department has cited several reasons for the delay in improving toilet facility, including prohibitive costs, with one estimate pegging the amount required for bio-toilets at Rs. 1,600 crore. With the Indian railways running a total of 50,000 coaches on date, of

which 43,000 coaches are engaged in the passenger service, this means that there are a total of 1,72,000 toilets which are functioning today using no modern technology but an improper mode of service which requires the use of manual scavengers to clean the human excreta which is directly discharged on to the railway track.

Reasons of Continuation of the Manual Scavenging and Failure of Act, Government Policy and Programmes

- An important reason for the failure of government rehabilitation programmes since 'Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act, 1993', came into force, is that, rehabilitation schemes and programme has been aiming at male workers rather than female workers who make up to 98 percent of the people held captive by the oppressive tradition of manual scavenging.

- An example of a particularly self-defeating government programme is a scholarship for the children of the victims (Scholarship for the Children of Families involved in incline occupation) which require the families seeking the benefit to have been engaged in manual scavenging for at least 100 days in a year. This scholarship scheme provides a perverse incentive to the Dalit households to continue in this occupation.

- Government programmes have emphasized the financial aspect of rehabilitation and failed to address the caste-based oppression and related social conditions that have perpetuated this practice for centuries.

- Government programmes have completely ignored the Muslim communities, such as Hela and Halalkhor, who inhabit in several states of India and have been as much a slave of this exploitative tradition as the Dalit Hindu communities. It is notable that the actual victims in this case too are primarily women.

- Several states have refused to implement the Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act, 1993, by denying the existence of dry latrines and manual scavenging in their jurisdictions despite evidence to the contrary. In other states, implementation has suffered because the Act itself is deficient on several counts: it neither lays down clearly the areas of responsibility nor provides penalties for non-enforcement of the law.
- No national or state-level body exists that will monitor the implementation of the Employment of Manual Scavengers and Construction of Dry Latrines (prohibition) Act, 1993. The Safai Karmachari commissions that exist at the centre and at some states do not play their role effectively either.

- There are other laws – namely, Scheduled Castes and Scheduled Tribes (prevention of atrocities) Act, 1989, Protection of Civil Rights Act, 1955, and Bonded Labour System (abolition) Act, 1976 – that are completely ignored and stand violated because of the continued practice of manual scavenging. People have rarely been booked under sections of these Acts for harbouring the practice of manual scavenging even when such violations have been brought to the notice of the administration.

- The government needs to realize that loan and subsidy make for only an apology for rehabilitation. The people enslaved by this inhuman tradition over many generations can hardly be expected to transform their lives with the paltry sum of money they receive in the form of loan and subsidy, especially when they continue to be discriminated against. These oppressed families deserve larger financial assistance in the form of grants, rather than loans, such as inclusion in the BPL list and related various benefits thereof, housing under Indira Awas Yojana, etc.

- There have been serious mistakes and errors in the surveys that seek to identify and rehabilitate the victims. The most glaring distortion of the reality is that more men have been shown to be the victims of manual scavenging than women. The surveys also leave out a large number of deserving people from the list of potential beneficiaries while including people who and their families have no longer anything to do with manual scavenging. The surveys have also been biased in favour of urban areas, leaving out large swathes of the rural population.

Thus, to summarize, Scavenger and Sewage Workers suffer mainly from chemical and biological hazards. This can be prevented through engineering, medical and legislative measures. The engineering measure should focus on making the process more mechanical. These workers should also be benefited from occupational health services, which should include pre-placement and periodic health monitoring. Further effective implementation of the Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act, 1993, will help in the abolition of manual scavenging. Also, regular awareness programs should be conducted to impart education regarding safer work procedures and use of personal protective devices. *For more information, see http://www.mailamukti.org*

Strategizing Occupational Health and Safety in Sex Work Settings: A Case Study

-Smarajit Jana and Protim Ray[1]

Background

Sex work as a livelihood option for a section of women in our country came into the limelight in the era of HIV epidemic, primarily for the sake of HIV prevention program. The sex worker who provides sex services to multiple partners are at a higher risk in accusing HIV and other sexually transmitted infections. Globally priority was given to sex workers' intervention program judging it from the epidemiology of HIV transmission. The sex worker was termed as 'core group transmitter' and the intervention strategy was designed to provide education on HIV and AIDS, provision was made for STI treatment and condoms were made available to sex workers following behavior change communication (BC) strategy. However, over a period of time slowly but steadily the strategy of HIV Intervention Program made a shift through adopting elements of occupational health interventions. The change in programming approaches is linked to the experience of a unique demonstration project called Sonagachi intervention program which was started in one of the largest red light districts in Kolkata, having a population of more than seven thousand sex workers in 1992. The intervention program was mooted by the Government of India and was implemented through the All India Institute of Hygiene and Public Health, a premier public health Institute of the country, with the objective of developing an appropriate model of HIV intervention program among sex workers and as to what could be replicated throughout the country. The experimental strategies and activities of Sonagachi Intervention Program including its outcome immensely influenced national ntervention programs and policies and strategies. The program made a significant contribution in modifying the public health intervention strategies of HIV intervention program globally.

Process of Development

The HIV Intervention Program was steered through a 'peer led' approach. Peers are sex workers who are provided with training on HIV/AIDS followed by they being recruited as health workers to carry out health education and condom promotion among the community members. Interaction with these peer workers helped the project implementers to know and learn many intricate issues related to the life and occupation of sex workers. It was learnt, for instance, the prime concern of sex workers is police harassment and not HIV. Sex-workers' inability to protect themselves from sexually transmitted infections including HIV is linked to their 'powerlessness' - as reflected in their inability to negotiate effectively with the clients including other stakeholders in the sex trade They try to avoid interaction with outsiders whom they consider as representative of main stream society who always wanted them to get rehabilitated as they look down upon women in sex work and depict them as 'bad' or 'fallen' women. Keeping all these issues in mind the demonstration project of Sonagachi in consultation with the sex workers took an effort to develop a set of guiding principles .The basic approach is summed up as three 'R's', namely, Respect, Reliance and Recognition. That is to respect sex workers as human beings, reliance on their potential and skill to make changes in their lives and recognition of sex work as her livelihood option including basic human and citizenship rights. In practice, the project implementer made an effort to lay down strategies and activities through building a relationship of mutual trust and rapport between the community of sex workers and the staff members of the project. This led to the modification of the project design through incorporation of other development elements based on the perceived needs and demands of the community members, e.g., education, micro credit, cultural activities, etc. Availing a 'social space' thus created through this intervention program, sex workers started articulating their issues and strategies challenging the common perceptions of society. They argued that "I don't kill or hurt anybody, I don't force anybody to avail services, I don't take bribe nor do I steal - so why am I depicted as 'bad' or 'fallen'? I provide only entertainment for which I charge a fee so what is wrong about it? Is entertainment a sin and those who sell entertainment services would be considered as bad or criminal? And why all these 'social activists' join hands with the police who is our enemy to oust us from our livelihood opportunity?"

[1]*Email: smarajitjana@gmail.com*

Even if one accepts their logic, it was difficult for the team members of the intervention program to ac¬knowledge their views as it pivoted around a strong social value and belief system built over centuries. In order to skirt direct debate, many of the project personnel tried to circumvent the real issue and raised questions related to their life and occupation, regarding their mode of entry into the sex trade and so on and so forth. However, all these interactions surrounding these issues led to the foundation of a new intervention policy and approach. It becomes apparent that the community wants to consider their work like any other occupation. Like labor in any other work is exposed to various occupational hazards they do consider themselves as similarly exposed to STI and HIV because of the hazardous working environment. As the project implementers were committed to follow a community centric approach they took an effort to modify intervention strategies as per the perception of the community. Gradually various other activities to influence the working environment were incorporated into the HIV intervention strategies. The unsafe working condition that enhances sex-workers' vulnerability to sexually transmitted infections (STIs) and HIV became a target for intervention activities.

When the project was initiated in 1992, condom use rate was a meager 2%, STI prevalence rate was as high as 81% and HIV prevalence was found to be around 2%. However, based on the new realization, the intervention program added components of advocacy and negotiation with the stakeholders of sex trade, e.g., police, administration and local political bodies. It became clear that the basic obstacles behind safer sex practices are not the poor attitudes or lack of initiative on the part of the sex worker to ensure safer sex. The predominant role is played by the power brokers which includes police and local goons who govern her life and occupation. Various factors pertaining to the working environment of sex work limits her ability to engage in safer sex practices. It is the power and proximity of other stakeholders in the sex trade who play a determining role regarding what sort of sex practices would be followed. Sonagachi intervention program soon strategized to pacify these powerbrokers .From the angle of HIV intervention program, it was conceived that in one way or other these powerbrokers of the sex trade will influence the 'outcome' of HIV Intervention program.

Outcome of New Intervention Approaches

The peer-based HIV interven¬tion program of Sonagachi resulted in the collectivization of the sex workers leading to the formation of sex workers' collective by 1995, the Durbar Mahila Samanwaya Committee (DMSC). This collective of 'fallen women' grew primarily out of the need to fight against police harassment and not necessarily to address HIV but the very programming approach of Sonagachi created an unique opportunity for collectivization and capacity building of sex workers. The collective of sex workers over a period of time created history in developing and managing not only HIV intervention program but led to many other development initiatives of their own like education, cultural activity, microcredit, anti-trafficking and other programs aimed at improving the quality of life of sex workers and their children.

The program brought about a resounding success and can be verified based on the evidence collected from the scientific studies conducted in successive years in Sonagachi:

Table 1: Percentage of Sex Workers using Condoms at Sonagachi

Year	1992	1993	1995	1998	2001	2005	2009
No. of SW surveyed	442	612	582	506	614	560	250
Condom %	2.7	69.3	81.7	90.5	84.5	85.7	91.0

Table 2: HIV Prevalence among Sex Workers at Sonagachi

Year	1992	1993	1995	1998	2001	2005	2007	2009	2011
No. of SW surveyed	442	612	582	506	614	560	250	250	250
HIV %	1.13	1.15	4.81	5.53	11.73	5.18	5.20	5.17	5.20

Table 3: Result of Serological Tests for Syphilis (1:8 and above dilution) among Sex Workers at Sonagachi

Year	1992	1993	1995	1998	2001	2005	2007	2009	2011
No. of SW surveyed	417	607	475	506	614	559	250	250	250
VDRL Positive % (Above 1:8)	25.4	28.5	14.1	11.5	8.76	4.82	3.20	2.17	2.20

Perhaps shifting of programming strategy from BCC to occupational health and safety could be one of the underlying reasons behind the success of Sonagachi intervention program. The Government of India took this lesson forward and articulated this element of intervention as 'creating enabling environment' in what became an integral and budgeted component of HIV intervention programs in the country thereafter. Based on the review and analysis of Sonagachi intervention model it also revealed that the process of collectivization did play a significant role preceded by the creation of 'safe space' for the sex worker community. The collective bargaining power of sex workers (like the workers' union in other industry) initiated changes in the power equation in the trade with respect to promotion of safer sex practices. The Ministry of Health and Family Welfare, Government of India, captured this learning and brought this component into the mainstream HIV intervention strategy as 'community organizing and ownership building' to improve the quality and coverage of HIV intervention program. The Government of India laid down a process with adequate financial support with an objective to replicate the same strategy throughout the country. This could be considered as a significant shift from the traditional public health approaches. Soon many other global policy makers including major donors adapted this model of intervention that made it a paradigm shift in the concept and designing of the HIV intervention programs globally. However, it was not smooth sailing to begin with as there were many others in the field of health and in other development sectors who opposed this viewpoint from their perspective and more likely from the ideological view point of sex and sexual morality.

But this success of Sonagachi intervention model is not restricted to health intervention programs. Only DMSC's engagement in other development arenas is emphatic and indeed it was and is an extraordinary development in comparison to many other programs in the country but a close look into all these strategies and activities would highlight the potential of a community led approaches in development.

Building Economic Security

Economic insecurity, coupled with extraordinarily extortionate money lending practices that exist in sex work sites, has always been part of the lives of the sex workers. They could not save their incomes and it was impossible for many of them to escape debt traps. To change this, the sex workers' collective took one of the most significant steps by registering a co-operative society by 1995 (Usha Multipurpose Co-operative Society Limited, or Usha). Usha is of, for and by the sex workers. The sex workers' collective succeeded in persuading the Government of West Bengal to remove a clause that prohibits sex workers in opening their co-operative as they do not bear 'good moral character'. The clause was finally removed giving way to registration of a co-operative of 'sex workers' – a first of its kind in the country. The registration of the co-operative marks an important development for the sex workers in their struggle to re-frame the definitions and meanings of their occupation. This has bolstered their campaign for social recognition as sex workers and their right to self-determination. Usha runs a micro-credit program for sex workers, creates alternative jobs for out-of-work or retired sex workers and does social marketing of condoms.

Sex Work and Trafficking

The underpinning of the occupational health and safety model adapted in the HIV intervention program of Sonagachi open ups avenues for significant developments in other arena. It became important to

The Success Story of USHA

	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
Members	94	104	214	483	1801	2219	2712	4771	5901	7242	8084	8568	10016	10284	13824	16332
Working Capital (lacs of Rs)	0.6	8.45	9.91	12.65	62.33	95.68	115.33	180	250	350	446.24	450	650	675	850	925
Loan to members (lacs of Rs)	0	0.97	2.2	3.59	2.61	3.41	17.7	23.69	44.64	200	123.59	230	250	280	325	450
Turnover (lacs of Rs)	3	15	17.5	20	40	150	180	350	525	800	900	925	975	1075	1025	1175

the sex workers' collective to keep eye on various rights issues while implementing health interventions such as their right to choose work, safe working environment, provision of health and other services and freedom from violence. The DMSC took the responsibility to address issues of violence including trafficking of women and girls in the sex trade through the establishment of a Self-Regulatory Board (SRB) - a concept duly translated into activities following the development of a partnership framework between them.

Local government and the sexworkers' collective: It simulates the role of workers in the occupational safety committees usually created in the industry who took active role in shop floor management. DMSC decided that as they consider sex work is like any other work there should not be any coercion and entry of minor into the sex work should be stopped and as the existing system is inefficient they took the responsibility to manage the same. The board is presided over by the local Councilor or the sitting member of the Legislative Assembly, and in rural areas, by the Panchayat members. Along with them, there are representatives from the social welfare department .The board also include a lawyer and a doctor of repute from the local area. DMSC manages the secretarial job of the Board. Other than anti-trafficking activities, the Board also looks after the cleanliness and maintenance of the roads, adequate supply of drinking water, and other issues. They also arrange for Voter Cards and Ration Cards for the sex workers; arrange residential schools, crèches, and vocational trainings for the children of sex worker.

Number of Underage and Unwilling Girls Removed During Successive Years: Through 33 SRBs

Year	Underage Girls*	Unwilling Women	Total
2001	29	02	31
2002	26	07	33
2003	53	08	61
2004	129	20	149
2005	21	14	35
2006	82	23	105
2007	61	16	77
2008	97	16	113
2009	55	14	69
2010	58	11	69
2011**	57	20	77
Total	668	151	819
**Underage: Age at rescue less than 18*			
*** Upto December 2011*			

For all new entrants into the sex trade, one has to appear before the Board. The Board would first verify her age and assess her willingness to join or is there any coercion behind her entry into the sex work. If she is underage or unwilling to join, the councilor of the board would counsel her and make arrangement to send her back to her home or would provide a choice to attend a boarding school or a vocational training program, as she would not be allowed to join as sex worker. The success of this program can be judged based on the number of women removed from the sex-trade in west-Bengal

Discussion

By giving women in sex work a voice - and a space to grow - the collective slowly has cultivated their natural leaders. Uneducated women now have mastered the courage to enter into government offices demanding their dues and asserting their rights, asking for entitlements. Their demands started focusing deeper issues like 'decriminal¬ization of sex work' so that they can live safe¬ly and to choose their options either to continue in the sex trade or to move out to other occupation. DMSC expanded their organization though out the state of West Bengal and succeeded in creating a new image by identifying themselves as sex workers as opposed to being called a prostitute (synonymous with bad or fallen women). Carving out a new identity has helped to build their self-esteem and confidence to aspire for a better and healthier life for them and for their children.

Incidence of violence is extremely high and often perpetrated by the law enforcing agencies; sex workers' access to social or legal redressal system is almost nil. Although women in sex work are citizens of the country, they do not enjoy the same rights as other women or citizens of India. Almost all human rights are denied to these women – because they are in sex work. The structure and functioning of SRBs has made a significant change in influencing the working

Category	1992 (%)	1995 (%)	1998 (%)	2001 (%)	2005 (%)	2010 (%)
Illiterate	84.4	68.6	53.3	57.4	54.4	47.2
Just literate	12.2	17.3	13.9	11.5	19.5	24.3
Primary Level	2.6	8.4	27.5	26.0	20.9	23.7
Secondary Level	0.8	5.7	5.3	5.1	5.2	4.8

environment in sex-work settings. It is interesting that till the point HIV came into the focus, they were not even visible for the mainstream society, which includes progressives and scores of social activists barring a section of them who were active in chanting 'rehabilitation' program for sex workers.

Stigma attached to sex and sex work, the organization of sex trade, government policies and legislations related to sex work and the overall social control mechanism centering around the ideological construct of 'morality' – altogether pushes the sex worker to live at the margins of the society and reduces her capability to enforce safer sex. Stigma attached to 'sex and sex workers' is rooted in the construct of a patriarchal society – that appears to be the major factor that keeps women in general, and sex workers in particular, from accessing rights and social justice including social entitlements as citizens of the country. The vulnerability of the sex worker is based on her 'social position' determined by the criminalized status of her occupation conferred through existing legislation. In addition, the judgmental stand of a section of policy makers who treat them as 'subhuman' based on the preconceived notion and values linked to sex and sexuality further alienates sex workers and marginalizes them. However, getting a minimal opportunity and space they could challenge the social construct as articulated in their manifesto declared in the First National Conference of Sex Workers held in Kolkata in 1997. "It was crucial to view us in our totality – as complete persons with a range of emotional and material needs, living with a concrete and specific social, political and ideological contexts which determine the quality of our lives and our health - and not see us merely in terms of our sexual behavior."

Why they felt the need to start 'education program' for themselves as articulated in the 'Brief Profile' of DMSC is amply clear. "Our experience has taught us that for a marginalized group like us to achieve empowerment, it is imperative that we improve our self-esteem and begin a process of self-actualization. We have realized that in striving collectively against all social injustice, we must protect our right to information and our accessibility to appropriate instruction and educational opportunities. Our long-term goal is to achieve our desire for a better life, for a better tomorrow for ourselves and for our children".

Their effort to build a better life and career for them and their children showed significant change over the years as follows with the improvement in educational status:

Conclusion

Decriminalization of sex trade is consistent with human rights of individual sex workers. It would mean that sex workers can openly access health and other services. Decriminalization will place sex work¬ers in a stronger position to resist demands for unsafe sex, or to avoid violence. Decriminalization would also reduce the gen¬eral level of violence in sex work.

The Immoral Trafficking Prevention Act (ITPA) that criminalizes various aspects of sex work, makes sex workers vulnerable to abuse, makes it harder for them to insist upon condom use with the clients, makes it difficult for them to access appropriate health and other services too. Current laws regulating sex work thus substantially contribute to the vul¬nerability of sex workers to HIV. The reduction of their vulnerability towards HIV will be achieved in an environment where sex work¬ers are empowered to take more effective control over the terms and conditions on which they trade in sex.

The experience of the Sonagachi intervention program suggests that the empowerment of sex worker as individual, and as a bread winner of the family, is dependent on how effectively social and political spaces are created for the community through adopting a process not imposed from the top but bringing in community members as their own changemakers. To initiate this process, there is need to carve a new social identity followed by leadership building from and within the community. Thus empowering strategies for a marginalized community cannot be restricted at individual level only but it should stress on empowering approaches focusing both at community as well as at societal levels.

Silicosis: Action Research leads to Legal and Policy Interventions

*-Dr Ashish Gupta, Amulya Nidhi, Navneet Wadkar **

Background

In recent estimates from India, there are over 3 million workers exposed to silica dust, whilst 8.5 million more work in construction and building activities, similarly exposed to quartz dust. Several recent reports on lung function assessment show both restrictive and obstructive patterns. Studies on silicotic pencil workers in Central India demonstrated high mortality rates; the mean age at death was 35 years and the mean duration of the exposure was 12 years.[1] In Gujarat, the quartz crushing factories in Godhra and Balasinore manufacture quartz powder of different mesh size that in turn is supplied to glass, ceramic and many other industries which are in great demand. These industries are notorious for their poor health and safety standards at work.

Silicosis[2] is a fibrotic lung disorder caused by inhalation and pulmonary reaction to crystalline silica, a major portion of earth's crust, and exposure occurs during mining, stone crushing and quarrying. It is a notifiable disease under the Factories Act and is included in the list of diseases for which compensation can be claimed in Workmen's Compensation Act, 1923 and the ESI Act. In Godhra, factories are covered under the ESI Act but factories in Balasinore are not. But, despite large number of workers contracting silicosis, none of the workers have had any evidence of having worked in the factory, like an identity card issued under the Factories Act or an ESI card. They have had no evidence which could help them in realizing their legal rights.

Background of the Studies

In Madhya Pradesh, tribal people from Alirajpur, Jhabua and Dhar migrate to Gujarat and Rajasthan and work in quartz or stone crushing factories. Livelihood protection and food security for many families are in danger - hence a number of families migrate in search of work to nearby places as they do not get work near their own homes. People who migrate to Gujarat and Rajasthan and work in quartz or stone crushing factories eventually end up suffering from the silicosis disease.

Aims of the Study: This action research was done in three districts of Madhya Pradesh, India, i.e., Jhabua, Alirajpur and Dhar, in order to assess the spread of silicosis along with knowing the socio-economic impact of this disease, impact on family living conditions – and impact on especially women and children. It was used as an advocacy strategy for mobilization of silicosis-affected families, for review of the legal and policy issues, at the state and national levels, for unorganized migrant workers and the possible means of their rehabilitation.

** Emails: ashishguptaa33@gmail.com, amulyabhai@gmail.com*

Methodology

The study was undertaken using both quantitative and qualitative methods. The main instrument used in the survey was a comprehensive household questionnaire. The responses obtained from the structured interview schedule in the survey, were analyzed qualitatively and quantitatively.

Besides the questionnaire, information was also collected through village meetings, discussions with panchayat representatives, health care providers and examination of medical records. All cases reported with silicosis were confirmed by a medical specialist on the basis of occupational history, clinical diagnosis and chest X-rays (which are considered sufficient for diagnosing silicosis). In some cases, grading of severity was done by using the ILO International Classification of Radiographs of Pneumoconiosis, Revised Ed 1980. Spirometry was done to assess the loss of breathing function by medical specialists.

Outcome of the Studies

In 2006, the initial survey that was done in 21 villages of the Alirajpur tehsil of Jhabua district (now Alirajpur district) by Shilpi Kendra - and published as 'Destined to Die' in 2006-2007 - revealed that 489 persons from 218 households had a definite exposure to silica out of which 158 were found dead and 266 were ill, i.e., 86% (424) are either ill or dead. There are 70 children below the age of 18 who were affected out of whom 31 have died due to silicosis. The second study report published in 2008 revealed that a total of 385 persons were exposed and out of 385 cases, 41 were found dead and 344 were ill. Hence the total number of affected person increased from 424 to 809 from 40 villages of 3 districts during the period 2007

to 2008. It was also found that 117 children from 10 villages have lost one or both parents to this dreaded disease. Along with compilation of information, related information found in panchnama (self-attested affidavits), disability certificates, etc., the letters sent by affected families and the letters to the Government have been compiled.

In 2011, a third study was carried out in 14 blocks covering the majority of the villages (51 out of 211 villages of Jhabua, 33 out of 191 villages of Alirajpur and 18 out of 382 villages of Dhar) from the 3 affected districts of Jhabua, Alirajpur and Dhar of MP. In all these villages, a total of 743 families were found wherein at least one person from these families had migrated for work in quartz or stone crushing factories and thereby got exposed to silica dust. Currently all these families have at least one suspected silicosis patient who was initially the source of income and currently unable to work and earn for his/her family. Hence a total of 4331 people from these families are directly or indirectly affected by silicosis.

Spread of the Silicosis in 3 districts of M.P. (2008-2011)

Sr. No.	Name of District	Sick		Sub Total	Dead		Sub Total	Total
		M	F		M	F		
1	Alirajpur	200	142	342	153	104	257	599
2	Dhar	151	82	233	28	12	40	273
3	Jhabua	343	280	623	126	80	206	829
	Total	678	491	1169	307	195	503	1701

As already mentioned in the "Destined to Die -I" report, 424 persons were affected from 21 villages of Jhabua district in the year 2006-2007. The 2008 "Destined to Die-II" report revealed that 809 persons were affected from 40 villages of Jhabua, Alirajpur and Dhar districts. While covering 102 villages of three districts, it can be observed that the number has increased from 809 in 2008 to 1701 in 2011 while the death toll has increased to 503.

It was found in all 362 persons (see above table on No. of Orphans, Widow and Old Aged in the Family) were affected out of 202 families from 3 districts of Madhya Pradesh. It was found that 57% persons were orphaned out of 378 vulnerable persons in all the 3 districts. Besides those orphaned, there were also a large number of children who lost their one parents due to silicosis.

Amount Spent by the Patients on Treatment

(in rupees)

Amount Spent	Alirajpur	%	Dhar	%	Jhabua	%	Total	%
0-5000	20	13.3	9	8.8	80	30.9	109	21.3
5000-25000	63	42	32	31.4	30	11.6	125	24.5
25000-50000	25	16.7	25	24.5	31	12	81	15.9
50000-1 lakh	35	23.3	19	18.6	68	26.3	122	23.9
More than 1 lakh	7	4.7	17	15.9	50	19.3	74	14.5
Total No of Patients	**150**	**100**	**102**	**100**	**259**	**100**	**511**	**100**

The table (on Amount Spent by the Patients on Treatment) indicates that out of 511 persons who were affected with silicosis, 74, i.e., 14% have already spent more than Rupees 1 lakh in treatment of the disease. Out of 511 affected persons who had gone for treatment, 277 or 54%, have spent more than Rs.25,000 in getting treatment of a non-curable illness.

Impact

The first report, "Destined to Die Part-I" that was published in 2006 was submitted to the National Human Rights Commission as part of a complaint by Juwan Singh, one of the affected victims with support from Shilpi Kendra, Khedut Majdoor Chetan Sanghatan (KMCS) and Silicosis Peedit Sangh. Based on the complaint and study report, the National

No. of Orphans, Widows and Old Aged in the Family

Orphan/ Widow	Alirajpur		Dhar		Jhabua		Total	
	No. of families	Number	No. of families	Number	No. of families	Number	No. of families	Number
Orphan	23	61	13	28	32	127	68	216
Widow	37	37	8	10	19	64	64	111
Old Age	23	25	15	16	10	10	48	51
Total	**83**	**123**	**36**	**38**	**83**	**201**	**202**	**362**

Human Rights Commission in 2006 identified silicosis as an important health problem and nominated a task force to work out a plan. .

When NHRC had started hearing the complaints regarding silicosis from different states, a PIL was filed in the Supreme Court by PRASAR (Writ Petition (Civil) 110 of 2006); another organization KMCS filed an intervention petition. NHRC then stopped its hearing and joined the Supreme Court petition as a party. In the course of the hearings, the Supreme Court passed an order on March 5, 2009 directing NHRC to go ahead with issue of compensation in case of confirmed cases of deaths due to silicosis and rehabilitation in case of workers living with silicosis.

Pursuant to this Supreme Court order, NHRC passed an order in November 2010 and recommended that the Government of Gujarat give a sum of Rs Three Lakhs each to the next of the kin of the 238 deceased. It also recommended that 304 persons who are suffering from silicosis and staying in the state of Madhya Pradesh be given a rehabilitation package by the MP Government.

Before the study in 2005, the exposed persons were generally identified as a case of tuberculosis and neither the people nor the health officials were aware about the deadly disease.

Policy Interventions

The Labour Department of Government of Madhya Pradesh has passed an order dated 15th July 2011 that all 304 silicosis-affected families are entitled to the benefits of the Madhya Pradesh Slate Pencil Kamgar Mandal, Mandsour. The study and campaign have made an impact on the issue of compensation. In India, compensation for injuries and occupational diseases is covered mainly by two laws, Workmen's Compensation Act, 1923 (WCA) and Employees' State Insurance Act,1948 (ESI). Guidelines for compensation have been developed by the National Human Right Commission and submitted to Parliament as a special report on silicosis.

Livelihood Opportunity

With a sustained campaign in Dhar district, silicosis-affected families have started getting work with less physical work under MGNREGA.[3] Its benefits for the family members of silicosis-affected members were extended up to 200 days.

Campaign Strategies through Action Research

The issues was identified by the people as "Godhra ki factory wali bimari: (illness from factory of Godhra) and then followed by a team of researcher-cum-activists. A community based study tool was developed based on Standard Protocol to identify silicosis as an illness. This action research is being used as an advocacy tool to bring about change in labour laws, legislations, and apolicy for unorganised workers. A monitoring board was established and provisions in MGNREGA Act 2005 to provide livelihood opportunity to affected families were accordingly changed. It has also opened a dialogue between those working for labour rights and and the – the State is equally responsible in worker's health and rights. . It also has expanded the scope of study from a factory-based study to a community-based study.

Conclusion

The intervention of the issues initiated in 2006 based on the research study report, "Destined to die" has led to the strengthening of the struggle for rights of the silicosis-affected victims. Besides, it has resulted in the National Human Rights Commission making a special report to the Parliament on the incidence and prevalence of silicosis; the NHRC has also suggested changes in labour welfare-related legislations in the country. It also has suggested that effective legislations and an implementation system for automatic compensation as well as directed that social security benefits be made available to affected persons; the NHRC has also directed that all available technology and scientific means be put in place to prevent silicosis related deaths.

This action research done by a team that includes persons given here in this endnote.[4]

Endnotes

[1]Ref: http://www.allcountries.org/health/silicosis.html

[2] www.nlm.nih.gov/medlineplus/ency/article/000134.htm

[3] Mahatama Gandhi National Rural Employment Guarantee Act 2005, ensures guaranteed employment for 100 days in a year.

[4] Dr Ashish Gupta, Mr Amulya Nidhi, Mr Navneet Wadkar, Manisha Gawade, Dr G.D Verma with support from Mohan Sulya, Rakeash Sastiya, Kamal Awashya, Monalisha Suna, Deepmala Patel, Shankarbhai, Magan, Kematbhai, Bhau Saheb Aher, Sanjay, Sapna, Mona Baghel,Dinesh Raisingh, Kuwar Singh, Bhurubhai, and others. This paper is the collective team effort of members of Shilpi Kendra, Khedut Majdoor Chetna Sanghatan, Silicois Peedit Sangh, Adivasi Dalit Morcha and Nai Shuruwat.

Maternity and Women Wage Workers in the Informal Sector

*-Jashodhara Dasgupta**

This paper sets out some experiences with maternity of poor women wage workers in the informal sector, and the cross-cutting determinants of maternal health such as women's livelihoods, social security benefits, food security and nutrition, and women's access to health care. Currently around 96% women workers, estimated at 142 million in NSS 64th Round 2004-05 (NCEUS 2007) in India are part of the unorganized sector, not covered by labour laws.

Women Workers in the Informal Sector

Our concern arises from the fact that informal sector women wage workers, largely invisible and therefore vulnerable - are outside the parameters of state mandated labour legislations regarding wages, hours of work, occupational hazards, and welfare provisions such as paid maternity leave. Women who are in advanced stages of pregnancy or immediately following childbirth, miscarriage or abortion, may be compelled to continue working in hazardous occupations in the absence of any social security for maternity.

Lacking the collective bargaining activities of unions, these women have been unable to negotiate fair compensation for income lost during pregnancy and after childbirth, or remove the unjust preconditions relating to the number of living children they have, that disqualify them from maternity benefits. While each episode of maternity exacerbates their vulnerability and they are never sure of child survival, the state has failed to ensure unconditional maternity protection in a period of increased impoverishment and high expenses.

The gender break-up of the workforce in the informal sector, computed from unit level records of Employment-Unemployment Survey, 55th round of NSS, 1999-2000, shows an increased presence of female workers over male workers engaged in the informal sector in India - 95 per cent of female workers and 89 per cent of male workers. Out of the total female workforce of 148 million, 1**42 million or nearly 96 percent of all female workers are in the unorganized sector**, making an overwhelming proportion of women workers in low-paid, unskilled jobs.

Women's Work: Invisible and Unpaid

It is important however to take into account not just women's paid work but also unpaid work, which is invisible yet takes up substantial portion of her time and has significant impact on her health. The conventional definition of 'work' often refers to a woman's contribution within the household. This may include daily domestic duties carried out at home (cooking, washing, cleaning and home maintenance, childcare or attending to the elderly and sick) or outside (fetching water, fuel and fodder), as well as important managerial functions such as handling the family budget or servicing social networks (clan and community) that provide emergency support when needed. This also includes women's unpaid contribution to household economic enterprise such as helping on the family farm or looking after family cattle or even contributing to a family trade or business. None of this, however, guarantees that women can take independent economic decisions or access family income for her personal needs, pleasure or relaxation.

Much of this 'work' that women engage in however is invisible, even though it substantially contributes to household economy and thus to national economy. The productive **contribution of women to household maintenance, provisioning and reproduction has traditionally been ignored** in macro-economic calculations. As a result, inadequate attention is paid to the conditions of women's work and its economic value and most of women's work goes unacknowledged and unrecognized. Internalizing the world's view of their work, most of the times women themselves do not consider themselves 'workers', even though their work is arduous, often unending and handled without support from male family members.

The *Shramshakti* (1988) Report highlighted the invisibility of women's work through stories of women in different enterprises and industries in different parts of the country. The major Indian sources of data in this matter, the Census of India and the National Sample Surveys (NSS), have increased their attempts to recognize women's work by asking probing questions that seek to establish women's involvement in economic activity. However, this is still defined to include only participation in work for the household farm or enterprise, and does not include housework, childcare, care of the sick and old, and related activities associated with social reproduction. It also does not include related work necessary for provisioning for the household, whether it is fuel and fodder collection in rural areas, or attempts to obtain access to clean water in urban areas, activities that are typically the responsibility of the women of the household.[1]

**On behalf of the National Alliance on Maternal Health and Human Rights*

Any attempt to understand impact of work on the health of women workers, must take into account not just paid work but also unpaid work within the household.

Maternity Benefits for Women Workers

Women as bearers and rearers of children provide the foundation for generating future workers for any economy. Reproduction involves not only procreation but also the nurture and care of a growing child.

The International Labour Organization believes that maternity leave is important as it reduces the risk of complications following labour and allows time to establish breast feeding (ILO, 2000). As early as 1919, the ILO had laid down maternity related entitlements for women workers. Women workers were entitled to 12 weeks of leave with cash benefits; daily breaks for nursing and protection against dismissal during leave. It also stipulated that medical benefits provided should include prenatal and postnatal care by a midwife or a qualified medical practitioner or a hospital, if necessary. More recently, the ILO Convention 2000 extended the minimum paid maternity leave to 14

Table 1: Important Legislations for Maternity Protection

Employees State Insurance Act,1948	✓ The Act is applicable to non seasonal factories using power and employing ten or more persons and non power using non seasonal factories employing twenty or more persons (eg shops). ✓ Maternity Benefit is payable to an insured woman (or pregnant woman) in the following cases subject to contributory conditions: ✓ Confinement is payable for a period of 12 weeks (84 days) and miscarriage or MTP (Medical Termination of Pregnancy) is payable for 6 weeks (42 days) from the date following miscarriage. ✓ Sickness or complications arising out of Pregnancy, Confinement, Premature birth is payable for a period not exceeding more than one month. ✓ In the event of death of an insured woman during confinement leaving behind a child, maternity benefit is payable to her nominee. ✓ Maternity benefit rate is double the Standard Benefit Rate or is roughly equal to the average daily wage.
Maternity Benefits Act, 1961	✓ The Act is applicable to the women workers in establishments engaging 10 or more persons. This Act does not apply to any factory or other establishments to which the provisions of the Employees' State Insurance Act, 1948 apply. ✓ The Act prohibits employment of, or work by, women during the six weeks period immediately following the day of her delivery or miscarriage. ✓ Women workers are entitled to maternity benefit at specified rates for specified periods. It also provides for payment of maternity benefit to the nominee in case of death, payment of medical bonus, leave for miscarriage for a period of six weeks immediately following the day of her miscarriage, leave for illness arising out of pregnancy, delivery, premature childbirth, or miscarriage, nursing breaks etc.
Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) New Guidelines (MNREGA)	✓ Pregnant and lactating women (at least upto 8 months before delivery and 10 months after delivery) as a special category, with a mandate for the provisioning of special work which is less strenuous and close to their homes ✓ Provision for crèche for children of women wage labourers ✓ In addition there is also provision for treatment and compensation in case of accident, disability or death due to work

weeks with a compulsory leave of six weeks after the birth of the child (ILO 2000). The convention also provides for allowances to be paid out of public funds for women who do not qualify.

In the Indian Constitution, the Directive Principles recognized the importance of maternity benefits, stipulating that States should make provisions for securing just and humane conditions of work and for maternity protection. In the years following independence, two important legislations, Employees State Insurance Act (1948) and the Central Maternity Benefit (MB) Act of 1961 became operational.

In the seventies and eighties, the women's movement was able to bring back focus on women's work and its invisibility. Two important reports namely the 'Towards Equality Report '(1974) submitted by the Committee on the Status of Women in India (CSWI) and the 'Shramshakti' Report (1988) by the National Commission on the Self-Employed Women were both crucial in highlighting contribution of women's work and need for strong institutional arrangements for maternity benefit and child care arrangement.

The above two major maternity protection schemes (ESI and the MB Act) are designed to basically cater to workers in the organized sector and are biased towards permanent, full-time workers, workers with identifiable employers and/or a designated place of work. Although "contract workers" are included in the MB Act, they need to be shown on the books of the employer to be eligible. Thus a large number of women workers who are a part of the informal sector fall out of the safety net provided by these two acts.

Data from NSSO (61st round) shows that female workers aged 15-49 who are eligible for maternity benefits form a mere 3% of workers (Lingam and Krishnaraj 2011). Hence, the reach of maternity benefit schemes on the basis of employment status is very small. The three segments of workers completely left out of the ESI and MB Acts are agricultural workers in the monetized sector; temporary and informal non-agricultural workers in both rural and urban India and the invisible workers everywhere – workers without a designated site of employment and/or an identifiable employer such as unpaid family help, self-employed poor, home-based workers, workers in private households and migrant labourers.

Hence, the government's support for maternity is limited only to public sector (permanent) employees, which as pointed out is a very small fraction of the workforce. Thus a woman's employment characteristics like – the industry in which she is employed and her occupational status (paid, unpaid, self-employed, regular, casual, etc), the sector of employment (organised or unorganised) and the nature of employment (formal or informal) – critically determine the quality of employment and entitlements like social security cover in general and maternity benefits in particular (ibid).

Other Benefits

Other than the above mentioned legislations, a number of schemes and programmes are also crucial for poor pregnant women in providing them nutritional support and monetary support during pregnancy and child birth.

The MB Act of 1961 also put in place a scheme for maternity benefit for all women; the National Maternity Benefit Scheme (NMBS) which provided a sum of Rs 500 during pregnancy. The NMBS was recognized by the Hon'ble Supreme Court as being part of the essential support for better nutrition during pregnancy (PUCL vs. UOI, SC order of 20 November 2007) and mandated to be provided to all pregnant women 2-3 months before childbirth. Despite this, the Ministry of Health and Family Welfare has sought the discontinuation the NMBS and has replaced it with a post-delivery conditional cash transfer scheme entitled the Janani Suraksha Yojana.

The Integrated Child Development Scheme (ICDS) which provides supplementary nutrition for pregnant and lactating women and the Janani Suraksha Yojna (JSY) which provides cash to women who give birth in government institutions are important schemes for maternity care. The Rashtriya Swasthya Bima Yojna (RSBY), an insurance scheme for Below Poverty Line (BPL) households, provides cashless hospitalisation and covers normal deliveries and caesarean section, so that women can deliver free of cost in any empanelled hospital. The most recent intervention to ensure maternity protection is the Indira Gandhi Matritva Sahyog Yojana (IGMSY). Some of the key features and of scheme are discussed in the next section.

The Indira Gandhi Matritva Sahyog Yojana (IGMSY)

The revised maternity benefit scheme that has been launched in 2011 by the Union Ministry of Women and Child Development is entitled the Indira Gandhi Matritva Sahyog Yojana (IGMSY) for pregnant and lactating women, a centrally-sponsored conditional cash transfer scheme, implemented through the platform of Integrated Child Development Scheme's Anganwadi centres. The IGMSY is currently being rolled out as a pilot project in 52 identified districts from all the states and union territories. Under the IGMSY, the government will provide Rs. 4000[2] in installments to women fulfilling the given criteria mentioned in Table 2. In addition, there are two

disqualifying criteria, in which women who are pregnant with their third living child do not qualify for the benefit, and women who are below 19 years of age during this pregnancy are also disqualified. These were intended by the government to promote the small family norm and discourage early marriage.

However, Lingam and Yelamanchili (2011) have expressed concerns over the exclusionary criteria of the IGMSY scheme; they hold that it will lead to women from most vulnerable sections of society being disqualified as they will be unable to satisfy the eligibility criteria. Using the NFHS 3 data they have shown that:

- 48% women will be ineligible if exclusion criteria as per the IGMSY are adopted
- 59% women having any one of the vulnerabilities in terms of caste, class or education will get left out.
- 56% of Scheduled Caste/Scheduled Tribe, 63% of the poor and 66% of the uneducated women will be disqualified for this scheme

Findings from the study of IGMSY Pilot Phase: Maternity as a Crisis

The National Alliance for Maternal Health and Human Rights (NAMHHR) was concerned about the exclusionary criteria for the IGMSY and conducted a small study of its implementation. Due to delays in rolling out the scheme in December 2011-March 2012 (the period of the study) the impact of the IGMSY on beneficiary women could not be studied. Instead the NAMHHR group examined the impact of the exclusionary criteria that would deprive some women of the proposed maternity benefit.

The study covered 57 women identified as 'vulnerable' through various criteria,[3] from a sample of 546 women who had given birth in the last six months in four blocks of one district each in the states of West Bengal, Odisha, Uttar Pradesh and Jharkhand; and also interviewed 24 ICDS department functionaries and officials. Of the 57 women, only one had a MNREGA job card in her own name. The RSBY card meant to cover hospital costs for BPL women was not available in West Bengal at all; in the other three districts, only 16 of the women had a BPL status and out of them only 11 actually had an RSBY card.

Working in an unregulated sector with no social security and low employment security, these women had risked loss of income each time they stayed away from work owing to ill-health or pregnancy. Women worked until the 8th month in all study sites except West Bengal. Across all the four study sites the costs of 'rest during maternity' involve losing wages for two to 18 months. Direct monetary losses range between 800 to 12,000 rupees across the various sites. Most of the women across the four study sites report having

Table 2 : Conditionalities under the Indira Gandhi Matritva Suraksha Yojana (IGMSY)

Cash Transfer	Conditions	Amount (In Rs.)	Means of Verification
First (at the end of second trimester)	• Registration of Pregnancy at AWC / health centres within 4 months of pregnancy • At least one ANC with IFA tablets and TT • Attended at least one counselling session at AWC / VHND	1500	Mother & Child Protection Card reflecting registration of pregnancy by relevant AWC/ Health Centres and counter signed by AWW
Incentive under JSY	• JSY package for institutional delivery including early initiation of breastfeeding and ensure colostrum feed.	As per JSY norms	
Second (3 months after delivery)	• The birth of the child is registered. • The child has received: ▪ OPV and BCG at birth ▪ OPV and DPT at 6 weeks ▪ OPV and DPT at 10 weeks • Attended at least 2 growth monitoring and IYCF counselling sessions within 3 months of delivery.	1500	Mother & Child Protection Card, Growth Monitoring Chart and Immunization Register *would also be available for still births and infant mortality.
Third (6 months after delivery)	• Exclusive breastfeeding for six months and introduction of complimentary feeding as certified by the mother • The child has received OPV and third dose of DPT • Attended at least 2 growth monitoring and IYCF counselling sessions between 3rd and 6th months of delivery.	1000	Self certification, Mother & Child Protection Card, Growth Monitoring Chart and Immunization Register

had to take loans to meet survival needs ranging from Rs.2000 to Rs.16000 from moneylenders (at 10% interest) or neighbours. In order to pay these off, they report having to take up additional work, cut back on food or returning to work early.

Their labour is arduous, and in addition are the dual responsibilities of managing household work, which is resumed shortly after childbirth (as early as 7-10 days after the birth in the study sites of UP, Odisha and Jharkhand). In the absence of food security, they are compelled to compromise on their own requirements, even in pregnancy. They report poor nutritional intake, 'weakness' and pregnancy losses (especially in the study sites at UP and Odisha). Dietary patterns reflect scarcity of food experienced as a regular part of everyday life. The staple diets across the sites are heavier on carbohydrates and very low in protein content. About half the women were beneficiaries of the Supplementary Nutrition Programme of the ICDS, but the quality goes downwards from study sites in West Bengal, Odisha through Jharkhand and the worst in UP. The women report producing inadequate breast-milk that also compels them to introduce the infant to other sources of food.

An ill equipped health system compounds the problem. There are high opportunity costs in seeking ante-natal services that are often not available. Many of the women delivered in hospitals, but they report unaffordable expenses for seeking care, including direct costs (transportation, medicines, tests, supplies) and indirect costs like wage losses, food expenses and demands for informal payments. After childbirth too, household expenses may soar, if there is treatment needed for the baby, or special food and care for the mother or celebration.

When such women undergo pregnancy and childbirth, it is seen as a period of financial crisis as it may mean several weeks or months away from work. However due to absence of any maternity benefit women often continue with physically strenuous wage work till the eighth month and shorten their post partum rest. They cannot take their babies to the workplace in the absence of crèches,[4] and are compelled to stay home to breastfeed, although that impacts on family incomes. Supplementary nutrition is crucial at this juncture; however, the Public Distribution System and Anganwdi services were reported to be irregular and inadequate.

This study once again brings to light the abysmal conditions of women wage workers in the informal sector, especially at the time of maternity, which is viewed as a period of crisis by these women. In this context the launch of the Indira Gandhi Matritva Sahyog Yojna (IGMSY) is especially significant for women workers in the unorganized sector. Yet it is clear that the exclusionary criteria are going to prevent the most vulnerable women from accessing the benefits of this scheme: poor women, women belonging to the Scheduled Castes, Scheduled Tribes and illiterate women. While each episode of maternity exacerbates their vulnerability and they are never sure whether the baby will survive, the state has penalized them for having more than two living children and yet failed to ensure other forms of maternity protection in a period of increased impoverishment and high expenses.

Conclusion

Civil society organizations have concluded that unconditional maternity benefits, and universal food security for all women, in combination with state-financed maternal care of high quality, are primary requirements for the improvement of maternal well-being in India. While the IGMSY is a step in the right direction, it needs to disengage from the Conditional Cash Transfer model and provide universal maternity benefit to all women. It also needs to be rationalized with the daily wages so that the family income is not adversely affected by each period of maternity. The NAMHHR and the Right to Food Campaign have called for a maternity benefit equivalent to nine months of paid leave for all women, to promote and safeguard maternal nutrition and ensure adequate rest and recovery time for women.

Endnotes

[1]Jayanti Ghosh (2010): 'Uncovering Women's Work', in Missing Half the Story – Journalism as if Gender Matters, ed. by Kalpana Sharma, Zubaan, New Delhi pp.255-262.

See http://infochangeindia.org/200709196492/Agenda/Women-At-Work/Uncovering-women-s-work.html

[2]In Odisha the amount is Rs 5000, as the Odisha State Government has added Rs 1000 to make the benefit equal to that given under the MAMTA scheme which is operational in the other districts of Odisha. MAMTA is a state sponsored conditional cash transfer maternity benefit scheme which is operational in all the districts of Odisha, except the two IGMSY districts. The MAMTA scheme has the same eligibility criteria and conditions as the IGMSY, except that the amount of money that is given as maternity benefit under the MAMTA is Rs. 5000.

[3]Such as working in the informal sector in precarious employment, belonging to the Scheduled Caste or Tribe, not literate, lowest income, not possessing a Ration Card and having a large family size.

[4]If they do bring babies to the workplace, their babies are kept in cloth cradles under the shade of a tree and usually an older child looks after the baby.

Revisiting the theme of Women as Workers and Women's Work

*-Padmini Swaminathan**

The Story So far

Feminist scholarship across the globe has a long and rich engagement with the theme of **unpaid** work, emphasizing in particular the fact of "extraordinary persistence" of gender – based inequalities in the world of unpaid work across time, geographical location and traditions. The complex manner in which unpaid work is tied to the functioning of the economy, [i] whether developed or developing, and, [ii] *within each* between poor/non-poor, employed/unemployed, and, [iii] among different strata of women *within* each of the categories of poor/non-poor, employed/unemployed, not only manifests deep rooted inequities but has also forced feminists to go beyond intra-household inequalities and map the trajectory of the linkage between unpaid work and the rest of the economy. Comprehending, contextualizing and mapping this linkage is crucial to unravel the differential priorities and assumptions that underlie the social and economic policies of different countries and how these impact, in particular, women's access to, and, intensity and level of engagement with paid employment.

A quick reading of the ever growing literature on unpaid work immediately brings home the significance of the ***development context*** undergirding the differential preoccupations of feminists analyzing unpaid work. While by and large, developing country studies centre-stage the theme of poverty and its relationship to the disproportionate amount of time women spend on unpaid work, developed country studies reveal why addressing poverty and its related aspects alone does not diminish gender inequality in time spent on unpaid work.

In the specific case of India, notwithstanding the relatively high rates of GDP growth, and expansion of employment in the tertiary [service] sector, the overwhelming majority of those fortunate enough to be counted as workers are however condemned to sweat it out in the unorganized sector as informal workers. For women in general and women workers in particular the inability of the economy to translate growth into development has phenomenally increased their work burdens without concomitant compensation to them either in terms of time or money. Worse, there is remarkable consistency in the manner in which larger numbers of women [than men] and their 'work' either become invisible or get captured in categories that fall outside the purview of protective legislation.

Women Work but How and in What Capacity?

We categorize unpaid work as follows:

Unpaid family workers – those workers, usually women and frequently children, engaged in economically productive activities of family enterprises, and where men of the household generally undertake the market related sale and purchase tasks.

Subsistence Work – this work involves collection of free basic necessities like fuel wood, water, forest produce for sale and consumption at home, fodder for animals as well as raw materials for family enterprises.

Unpaid household work – involves both household maintenance as well as care of children, sick, elderly and disabled family members.

From a feminist perspective what needs to be repeatedly emphasized is not just the disproportionate burden of unpaid work shouldered by women, but, equally important, the significance of this work to the economy. Households do not simply supply labour to the economy; rather, in contexts where economic growth has failed to be inclusive, as in the case of India, more and more households are forced to fend for themselves by resorting to different kinds of *production* activities – a phenomenon captured to some extent by official data.

For a more nuanced understanding of the burden of unpaid work thrust on women because of the maldeveloped nature of the economy, we examined the dimensions of Unpaid work as captured by the different Rounds of NSSO in its Employment-Unemployment Surveys. Scholars familiar with NSSO data are aware that Activity Status data are categorized into 99 codes. Three of the Codes provide us with an idea of the number of [male/female] workers involved in Unpaid work.

Data reveal:

That Unpaid Work is a Gender issue; neither location [rural/urban] nor years of development have been

**Email: pads78@yahoo.com*

of any consequence. In other words, whether rural or urban, whether 1983 or 2009-10, whether India or a relatively developed state like Tamil Nadu, substantial numbers of women [upwards of 45% of women] are involved in work that is unpaid.

Issues for Discussion

How does one comprehend and engage with the continuing phenomenon of large numbers of women returned as 'Unpaid Workers'? Given levels of rural poverty and the continuing phenomenon of high food prices, how do households in rural areas make ends meet in such a context?

For labour studies research and labour economists this particular statistic of large numbers of women returned as unpaid workers is of no consequence. But studies from a feminist perspective have engaged frontally with this theme and continue to grapple with it, academically and politically. There is now a considerable body of literature documenting, among other things, the official bases undergirding most programmes ostensibly aimed at alleviating poverty and simultaneously empowering women. What these studies specifically emphasize is the increasing manner in which women, and particularly women in rural areas of the country, are not just overburdened with performance of services that should legitimately be provided them as citizens of the country but how women's labour expended on these services subsidizes the economy even as the women themselves are denied the status of workers and therefore the rights and benefits due to them as workers under law of the land.

Based on paper presented at the 54th Annual Labour Conference held at BHU, Varanasi, Dec 17-19, 2012.

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Social Security Budgets in India: A Critical Assessment

*-Ravi Duggal**

Social security is the hallmark of a mature welfare state. Strong welfare states, like the social democracies of Europe, spend over 25% of its GDP (for the year 2005) on social security of which one-third is on healthcare. The global average is 8.39% of GDP (2.67% on healthcare) and ranges from 4.05% (0.95% healthcare) in India to 12-13% in South Africa, Brazil and Russia (3-4% healthcare) and 29.40% (6.8% healthcare) in Sweden.[1] What do we understand by social security? The ILO definition is as under:

"The notion of social security adopted here covers all measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from

(a) lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;

(b) lack of access or unaffordable access to health care;

(c) insufficient family support, particularly for children and adult dependants;

(d) general poverty and social exclusion. (see Box 1 below)

Social security thus has two main (functional) dimensions, namely "income security" and "availability of medical care", which are specifically identified in the ILO Income Security Recommendation, 1944 (No. 67), and the Medical Care Recommendation, 1944 (No. 69), respectively, as "essential elements of social security".

What distinguishes social security from other social arrangements is that: (1) benefits are provided to beneficiaries without any simultaneous reciprocal obligation (thus it does not, for example, represent remuneration for work or other services delivered); and (2) that it is not based on an individual agreement between the protected person and provider (as, for example, a life insurance contract) but that the agreement applies to a wider group of people and so has a collective character."

In India, there is a wide range of social security measures available to various sections of the population but unlike the OECD countries and elsewhere they are poorly structured and institutionalized, despite clear constitutional mandates (see Box 2 below). Then there is also at the global level mandates from ICESCR on right to social security and health through Article 9 and Article 12 of the covenant:

**rduggal57@gmail.com*

Article 9: The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 12: 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.

Also Articles 7 and 11 include health provisions: "The States Parties ... recognize the right of everyone to ... just and favourable conditions of work which ensure ... safe and healthy working conditions; ... the right to ... an adequate standard of living."

Box 1: Branches of Social Security Prescribed by ILO

- Medical care: Includes any morbid condition, whatever its cause, pregnancy, confinement, Preventive medical care is also intended to be covered.
- Sickness benefit: Includes incapacity for work resulting from a morbid condition leading to suspension of earnings.
- Unemployment benefit: Includes suspension or loss of earnings due to inability to obtain suitable employment.
- Old-age benefit: Includes survival benefit beyond a prescribed age normally years and above).
- Employment injury benefit: Available in case of incapacity for work, invalidity or a loss of faculty due to an industrial accident or a prescribed occupational disease.
- Family benefit: Includes responsibility for the maintenance of children, i.e. under school-leaving age or under 15 years of age.
- Maternity benefit: Maintain earnings for working mothers before and after giving birth.
- Invalidity benefit: Inability to engage in any gainful activity where such inability is likely to be permanent or persists after the period during which the beneficiary is entitled to benefit from temporary incapacity.
- Survivors' benefit: Compensation for loss of support suffered by the widow or children as a result of the death of the breadwinner.

India ratified the ICESCR on April 10, 1979 making it obligatory to honour the provisions of the covenant. But even today more than three decades later the social security legislations and provisioning in India are not in line with the above provisions. In fact, in the 1980s there were significant efforts under the Minimum Needs Program through which public investments in social sectors saw a boom period – 6th and 7th Plan periods – but at the turn of the nineties the SAP reforms put a stop to this progress and took us many step backwards. Since then India may have enhanced its economic growth rate but inequality and exclusion of the bottom half have got exacerbated under this new political economy. The few benefits that we have in India today are spread across various Ministries ranging from administrative departments to Ministry of Labour, Social Welfare, Social Justice, Women and Child Development, Ministry of Health, etc., resulting in segmentation and fragmentation.

What must also be noted is that the nature of social security provided varies a lot for different sections of the population (see Box 3 and 4). At one end of the spectrum, the civil services employees of Central and State governments get a full range of benefits as defined by the ILO. For instance, their retirement benefits alone (pension, PF, gratuity etc., excluding healthcare) were Rs.1,66,170 crores in 2010-11[2] (as much as 2.11% of GDP). At another end are the below poverty line (BPL) population who get ad hoc benefits under various welfare and social assistance schemes. For instance in 2010-11 such benefits across the country amounted to Rs.1,46,248 crores or 1.85% of GDP (social assistance schemes/pensions for BPL, SC, ST, nutrition, housing and labour welfare for unorganized sectors).[3] If we include healthcare and water supply and sanitation this figure increases to Rs. 2,48,456 crores.[4] Thus in the Indian context we need to differentiate these different benefits that range from comprehensive social security (civil service employees) to ad hoc social assistance programs targeted at different poor and vulnerable groups.

In Table 1 some of the key social security/assistance expenditures over the last two decades have been listed. We do see a growing trend but still India remains a little over half of the global average as a proportion to GDP. Infact the larger increase has been in the proportion of social security benefits to civil servants, thanks to the 5th and 6th Pay Commissions – from 27% share in 1990-91 of all such benefits to over 40% presently.

So it is clear from budgetary allocations/expenditures that social security benefits in India are highly discriminatory. Civil servants, who anyway benefit from their secure and well-paid employment, have life-long social security of a very high standard. On the other hand, those who struggle for an existence all their life get ad hoc benefits from residual resources of the budget, in most cases if they are below the poverty line, through a variety of social assistance/ welfare programs. Let us illustrate this with two contrasting examples. A person working with the Indian army retires in the rank of Major and gets PF and gratuity totaling Rs 20 to 25 lakhs as retirement benefits. Then for life he gets half of his last drawn salary as inflation-indexed pension, which today is over Rs.50,000 per month. If he dies, his spouse gets a family pension of half that amount, that is Rs.25,000 for her life. Apart from this they have unlimited free healthcare, outpatient, inpatient, dental, ophthalmic etc. In addition they get subsidized groceries and all possible consumer products through the canteen services. They also get continued access to the mess and clubs so that they remain socially connected to their "community". This is the best case scenario and about 15% of the households in

Box 2: Social Security Constitutional Mandate in India

- Matters relating to social security are listed in:
- Directive Principles of State Policy
- Concurrent List
- Social security issues mentioned in the Concurrent List (List III in the Seventh Schedule of the Constitution of India):
- Item No. 23: Social Security and insurance, employment and unemployment.
- Item No. 24: Welfare of Labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pension and maternity benefits.
- Directive Principles of State Policy:
- Article 39(a): that the citizens, men and women equally, have the right to an adequate means of livelihood;
- Article 41: Right to work, to education and to public assistance in certain cases.
- Article 42: Provision for just and humane conditions of work and maternity relief.
- Article 46: Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and other weaker sections

Box 3: Social Security for Organized Sector in India

- Employees' Provident Funds and Miscellaneous Provisions Act, 1952
- Welfare legislation enacted for the purpose of instituting a Provident Fund for employees working in factories and other establishments.
- Applicable to establishment employing 20 or more employees.
- Implemented through the following three schemes:
- Employees' Provident Funds Scheme, 1952
- Employees' Deposit Linked Insurance Scheme, 1976
- Employees' Pension Scheme, 1995
- Employees' State Insurance Act, 1948
- Provides for health care and cash benefit payments in the case of sickness, maternity and employment injury.
- Applicable to non-seasonal factories using power and employing or more employees and non-power using factories and certain other establishments employing 20 or more employees.
- Covers employees whose wages do not exceeds Rs. 15,000 per month
- Payment of Gratuity Act, 1972
- Provides for payment of compulsory gratuity to employees at the time of termination of service either :
- on superannuation
- on retirement or resignation
- on death or disablement due to accident or disease.
- Applicable to establishment employing 10 or more employees.
- Maternity Benefit Act, 1961
- Enacted to promote the welfare of working women.
- Prohibits the working of pregnant women for a specified period before and after delivery.
- Provides for maternity leave and payment of certain monetary benefits for women workerssubject to fulfillment of certain conditions during the period when they are out of employment on account of their pregnancy.
- Maximum period for which a woman can get maternity benefit is 12 weeks.
- Workmen's Compensation Act, 1923
- Imposes an obligation upon the employers to pay compensation to workers for accidents arising out of and in course of employment.
- New Pension Scheme (NPS)
- NPS is a voluntary defined contribution pension system in India.
- NPS is managed, regulated and reviewed by Pension Fund Regulatory and Development Authority, Ministry of Finance, Government of India

Box 4: Social Security for Unorganized Sector in India

- The National Rural Employment Guarantee Act, 2005 (by definition NREGA is not social security, except when the dole is paid)
- Aim at curbing unemployment or unproductive employment in rural areas.
- Focuses on enhancing livelihood security to rural people, as it guarantees productive wage employment for at least 100 days in a year.
- Unorganized Workers' Social Security Act, 2008
- Targets at extending social security measures to unorganized sector workers.
- Aims at extending to workers in informal sector - status and benefits similar to that of formal sector workers.
- Domestic Workers Act, 2008
- Aims at regulating payment and working conditions of domestic workers and entitles every registered domestic worker to receive pension, maternity benefits and paid leave that is a paid weekly off.
- Various cess based Welfare Funds for different Occupational groups – plantation workers, Mine workers, construction workers, beedi workers, cinema workers, headload workers, mathadi workers etc.. both under central and state laws which the NCEUS has sought to integrate under the UWSSA 2008
- Various social assistance schemes like PDS, ICDS, Indira Awas Yojana, Mid-day Meals, old age and widow pensions, RSBY and other social insurance schemes etc targeted at specific groups (and not universal access)

Table 1: Social Security and Social Welfare Expenditures 1990-2012: Combined Central and State Governments

Rs. crores

Selected Social Security Benefits	1990-91	2000-01	2005-06	2009-10	2010-11 RE	2011-12 BE
1. Pension and retirement benefits for civil servants*	5183.63	38818.67	60871.14	139551.19	160086.09	171659.34
2. Social Assistance, social welfare, nutrition and SC/ST welfare	3883.17	15006.80	27099.84	83790.82	107422.44	103064.36
3. Natural Calamity Relief	867.46	3717.24	7980.24	7972.08	11339.13	7687.15
4. Labour Welfare	731.75	2079.34	2918.22	5492.54	7367.64	8109.31
5. Housing	766.45	4156.22	6300.83	17535.82	22220.54	23713.68
6. Health and WSS	7496.38	27186.63	45485.63	89038.17	105738.29	118295.78
TOTAL@	**18928.84**	**90964.90**	**150655.90**	**343380.60**	**414174.10**	**432529.60**
GDP (market prices)	586212	2168652	3693369	6457352	7674148	8980860
Total as Percent of GDP	**3.23**	**4.19**	**4.08**	**5.32**	**5.40**	**4.82**
Civil servant pension as % of GDP	**0.88**	**1.79**	**1.65**	**2.16**	**2.09**	**1.91**

**Please note that these benefits to civil servants are only the monetary ones and excludes healthcare and other benefits that various pensioners enjoy, making this figure an underestimate. Also social benefits of in-service civil servants are excluded.*[5]

@Food subsidy is not included in the above data as it is not part of the ILO definition. If we add food subsidy then the % share of the GDP for social security would increase by 0.4 – 0.9% across different years.[6]

Source: Compiled from Ministry of Finance, 2012: Indian Public Finance Statistics 2011-12, GOI, New Delhi (Table 1.1 pg 1 and Table 1.9 pg 16)

India have this kind or something similar as social security benefits earned from their "organized" sector employment.

In contrast there is the BPL family of a daily wage worker, whose daily wage depends on the market – if they are lucky they may just manage to earn about Rs. 5,000 for the entire household in a month. They have access to education and healthcare services from government facilities but there is no guarantee that they would get what they need and often they have to pay for it. The children may not go to school because they may have to work to sustain the family's basic needs. They have no savings, PF, gratuity or any other work related benefits. They have to continue working much beyond the retirement age. If they fit the parameters then they may get a small sum of Rs. 200-500 per month as an old age or widow pension that is not indexed to inflation. If both husband and wife are qualified to get old age pension then only one of them will get it. If they are lucky they may have been registered for RSBY or a similar health insurance cover so that if there is a catastrophic illness their healthcare bill is at least partly paid. This is the worst case scenario with two thirds of the households in India experiencing an existence of near about this kind.

The remaining 20% "middle" classes have to struggle to make their own arrangements for social security through their savings, extended family/community support – they did not get the organized sector benefits and they are not eligible for the various social assistance programs of state and central governments.

Given the above political economy of social security in India the challenge is huge. We are committing only about 6% of GDP for social security and about half of this goes to the top 15% of India's population. In the last decade or so there has been a growing trend in committing more resources to the remaining 85% of the population but this is being done in a very

ad hoc manner through targeted schemes where the focus of the target is electoral catchment and not the development of a sustainable mechanism to deliver basic social security. Under the UPA regimes, the flagship programs have basically tried to do precisely that and substantial budgetary allocations have been committed but the approach has been very fragmented with the consequence that outcomes in the form of improvements in for example the MDG indicators has been poor.

Thus NREGA, NRHM, SSA, NSAP, RSBY, IAY, ICDS, etc, have seen useful changes towards increased social security but because of the segmented/ fragmented approach their impact has been feeble. Further these programs are spread across departments which do not coordinate with each other and thus bureaucratic meddling and management failures derail all efforts and render wasteful the precious investments made. The NCEUS tried to bring some convergence of such social assistance schemes to universalize social security for the unorganized sector. It did lead to a national legislation, the Unorganized Workers' Social Security Act 2008 which became operative in 2009 but the legislation turned out to be toothless and at best remains an enabling legislation which has to wait for the right political will to get it going. All this legislation has done is to appropriate ten existing schemes by adding them to its Schedule 1. These schemes are: (i) Indira Gandhi National Old Age Pension Scheme, (ii) National Family Benefit Scheme, (iii) Janani Suraksha Yojana, (iv) Handloom Weavers' Comprehensive Welfare Scheme, (v) Handicraft Artisans' Comprehensive Welfare Scheme, (vi) Pension to Master craft persons, (vii) National Scheme for Welfare of Fishermen and Training and Extension, (viii) Janshree Bhima Yojana, (ix) Aam Aadmi Bima Yojana (Life Insurance Scheme for Common People), and (x) Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme).

Continuing the above trend the UPA government is now launching another major initiative with respect to all such social assistance schemes by converting them into direct cash transfer (estimated by the Finance Minister at Rs 2,00,000 crores for 2013) to the targeted population thus absolving itself of implementation responsibilities on one hand and using it as a carrot for reaping electoral favours. This strategy is very clearly indicative of the government's weak policy and inadequate strategy towards social security and this will definitely take us further away from moving towards universal access to social security.

On another front there is a growing interest in social security issues in civil society and various peoples' movements and CSOs are increasingly engaging with them. One such initiative is the pension parishad that is demanding universal pensions that are linked to atleast half the minimum wage or atleast Rs. 2000 per month per family. Then there is the universal healthcare coverage initiative which has partly emerged through the Jan Swasthya Abhiyan, mfc and other health groups advocacy efforts, including contributions through the HLEG. These are under the 12th Five Year Plan consideration. These efforts of civil society need to be increased manifold so that universal access to social security and healthcare become strong political concerns.

To conclude, the various progressive policy targets that have been initiated, like 3% of GDP for healthcare, 5% of GDP for education, and expansion of the social security net as per ILO norms to take comprehensive social security beyond the civil servant and organized sector for which the UWSSA has provided the first step, have to be now translated into effective rights of citizens by ensuring that maximum available resources are made available to secure them. The numerous social assistance schemes have to be consolidated and restructured into a comprehensive social security program that is not targeted but is transformed into a universal access benefit for citizens as a right. First steps in education have happened, universal coverage of healthcare is under debate and what we now need is to merge all this into a universal social security access. As seen in Table 1 we are already spending close to 6% of GDP, including food subsidy, for social security and health. This needs to be doubled at the minimum so that we reach the middle income country levels as quickly as possible. Resources are there if adequate political will and civil society pressure is exerted – uncollected taxes and revenues forgone account for over 6% of GDP. In addition, regulation of capital and unaccounted outflows to tax havens, estimated at one-third of the GDP, are clear opportunities to move our Tax: GDP ratio from the present 16% to close to 30%. This will bring in all the resources we need to provide universal access to social security. All we need is political will and political champions who will back this cause

Endnotes

[1]ILO 2010: World Social Security Report 2010-2011 - Providing coverage in times of crisis and beyond, International Labour Organization, Geneva. (Table 25, pp 259-262).

[2] CAG 2012: Combined Finance and Revenue Accounts 2010-11: Volume 1, Comptroller and Auditor General, GOI, New Delhi. Table 7, page 17.

[3] CAG 2012: op. cit. compiled from Vol 3.

[4]ibid.

[5]As an illustration in 2010-11 the armed forces spent Rs. 5913.99 crores on health and medical benefits and of this Rs. 1058 crores was on pensioners and their eligible family members. This translates into a princely amount of Rs.6000 per capita (Rs.7708 per capita for serving officer/soldier and families and Rs. 2939 per retired officer/soldier and families, perhaps indicative of what spending is needed for good health security (CAG, 2012: Performance of Medical Establishments of Defense Services 2010-11-Report No.18 of 2012-13).

[6]The food subsidy figures in Rs. crores are: 1990-91=2492; 2000-01=12553; 2005-06=24240; 2009-10=62120; 2010-11=64054; 2011-12=63676 (Source: Same as Table 1).

A Note on the Finances of Selected Social Health Insurance Programs

-Ravi Duggal[1]

India ratified the ICESCR on April 10, 1979 making it obligatory to honour the provisions of the covenant. But even today more than three decades later the social security legislations and provisioning in India are not in line with the ICESCR provisions. In fact in the nineteen eighties there were significant efforts under the Minimum Needs Program through which public investments in social sectors saw a boom period – 6th and 7th Plan periods – but at the turn of the nineties the SAP reforms put a stop to this progress and took us many step backwards. Since then India may have enhanced its economic growth rate but inequality and exclusion of the bottom half have got exacerbated under this new political economy. The few benefits that we have in India today are spread across various Ministries ranging from administrative departments to Ministry of Labour, Social Welfare, Social Justice, Women and Child Development, Ministry of Health etc., resulting in segmentation and fragmentation.

What must also be noted is that the nature of social security provided varies a lot for different sections of the population (See Box 1 and 2). At one end of the spectrum, the civil services employees of Central and State governments get a full range of benefits as defined by the ILO. For instance, their retirement benefits alone (pension, PF, gratuity, health care, etc.) were Rs.1,66,170 crores in 2010-11 (as much as 2.11% of GDP). At another end, are the below poverty line (BPL) population who get ad hoc benefits under various welfare and social assistance schemes. For instance in 2010-11 such benefits across the country amounted to Rs.1,46,247 crores or 1.85% of GDP (social assistance schemes/pensions for BPL, SC, ST, nutrition, housing and labour welfare for unorganized sectors) . Thus in the Indian context we need to differentiate these different benefits that range from comprehensive social security (civil service employees) to ad hoc social assistance programs targeted at different poor and vulnerable groups. Let us look at some of these key schemes related to healthcare security.

[1]<*rduggal57@gmail.com*>

ESIS: The ESIC, created by an Act of Parliament in 1948, is the most important social health insurance program for the organized sector working classes. It today has an annual budget of over Rs. 10,000 crores and reserve funds of more than Rs. 25,000 crores. With 32,349 hospital beds, 20,346 medical personnel and 18,501 other staff and per employee medical spend of Rs.2,,551 it is a huge medical establishment, somewhat similar to the armed forces (38,328 beds and Rs. 5914 crore medical expenditure – Rs.19,713 per employee) and Railways (13,963 beds and Rs. 1,370 crore medical expenditure – Rs.9,660 per employee). Table 1 details ESIC expenditures over the last five years.

The ESIS is not an ideally functioning social health insurance program. It looks huge in numbers with a coverage of 6.18 crore beneficiaries with a per capita expenditure of Rs.1,253 which is 2.5 times of general government health expenditure for the same year. But it is not universal access even for the organized sector employees; in fact it covers only 42% of the organized sector employment and by design it is largely targeted at blue collar workers thus fragmenting social security even in the organized sector. While huge investments have been made in ESIS as evidenced by the infrastructure and human resources for healthcare, all this is poorly structured and managed. Despite having a robust hospital and clinic network the utilization and occupancy rates are very low. One reason could be poor quality of services (vacant positions of doctors and specialists are huge) and the other a growing reliance on out sourcing to private practitioners and private hospitals, especially the latter.

The limited data available in the Annual Reports shows that outpatient care, especially in larger cities where private practitioners called insurance medical practitioners provide services the latter is used more frequently. For instance in Mumbai which is the largest ESIS hub having the largest hospitals in 2009-10, 52,203 outpatients were treated at ESIS facilities

Table 1: ESIC Finances					
					Rs. Crores
	2008-09	**2009-10**	**2010-11**	**2011-12RE**	**2012-13BE**
Income					
Contributions	3699	3896	5749	6800	7350
Interest	663	1110	1132	1177	1099
Others	90	79	100	108	109
TOTAL	**4452**	**5085**	**6981**	**8085**	**8558**
per employee contributions Rupees	***3115***	***2944***	***3919***	***4386***	***4697***
Expenditures					
Medical care	1123	1627	2124	3008	3992
Cash benefits	381	427	494	616	654
other benefits	2	2	2	5	6
TOTAL Benefits	***1506***	***2056***	***2620***	***3629***	***4652***
Admin	413	504	524	724	874
Maintenace, taxes Deprc	113	113	126	127	151
Transfer to Capital Fund	37	39	58	68	74
Total Revenue Expenditure	**2069**	**2712**	**3328**	**4554**	**5750**
Excess Income over expd	***2383***	***2373***	***3653***	***3531***	***2808***
Capital Expenditure	256	902	1579	2500	1995
Invested Reserve Funds	***19583***	***21546***	***25044***	28000	
Ratios					
Medical care per employee Rupees	946	1229	1448	1940	2551
medicalcare % to contribution	30	42	37	44	54
Cash Benefit per employee Rupees	323	324	338	401	422
cash benefit % to contribution	10	11	9	9	9
ESIC employees (millions)	11.9	13.2	15.4	15.6	15.7

in contrast to 129,447 by private panel doctors and similarly for specialist care 48,557 attended ESIS facilities and 63195 attended private clinics. Increasingly hospital care is also being paid for to use over 600 empanelled private hospitals (reimbursed Rs. 180 crore in 2009-10) keeping the occupancy rates of ESIC's own hospitals below 50% (in the largest ESIS hospital, the 700 bedded MGM hospital in Mumbai the occupancy was as low as 31%).

Anecdotal stories tell us that the ESIC doctors are primarily used to obtain medical certificates so that workers can access the various cash benefits under the scheme. In 2010-11 there were a total of 4,06,000 hospitalizations and 2.34 crores outpatient incidence (4.39 crore contacts). This seems to be a very low utilization rate when compared with the NSSO morbidity surveys for the general population. For outpatient care an annual incidence of 390 per 1000 as against 45 per 1000 for 2 weeks as per NSSO and only 6.8 per 1000 hospitalizations annually compared to 26 per 1000 as per NSSO. Is this low morbidity and utilization because of poor quality services or is it that the ESIS covered population is healthier because it is well looked after? Or is it that even ESIS covered persons are using the private sector and paying out of pocket? We definitely need more evidence on this.

Another issue that emerges when we assess the information from the Annual Report is that in the last few years, while the canvass of ESIS has expanded due to the increase of wage ceiling to Rs.15,000 per

month, the attention of ESIC is moving away from the employee who has contributed to a new arena of action – medical education. The ESIC Board has sanctioned 18 medical colleges and 9 dental colleges besides 12 PG institutes. The establishment for these is under full swing as can be seen from the increasing capital expenditures coming from the reserve funds. Should a social health insurance agency be entering the field of medical education? This is likely to further damage the reputation of ESIS as well take it into a direction which will not be in favour of the working class (or is it that insured persons have been promised a quota of medical seats?).

What is also striking when we look at ESIC budgets is that even when the ESIC has a huge surplus every year the state governments have to continue to subsidize medical care expenses of ESIC from the general health budget. Thus in 2010-11 the total medical care expenditure was Rs 2,124 crores but more than half of this, that is Rs.1,294 crores came from the general health budgets of the state and union governments.

CGHS: The Central Government Health Scheme covers all central government employees whose salaries come from the civil budget estimates, that is all central govt. employees with the exception of Railways and Defense services. Surprisingly, information on CGHS is very scanty indicating lack of transparency about this scheme. At end of fiscal 2008 there were a total of 8.58 lakh CGHS cardholders (2.57 lakh being pensioners) and 32.10 lakh beneficiaries. So it is much smaller in numbers compared to the ESIS but on per capita basis much larger in terms of medical care benefits that civil servants both serving and retired get.

CGHS runs its own dispensaries for outpatient care which are well resourced and uses public hospitals or empanelled private hospitals for secondary and tertiary care. In 2010-11 Rs. 650.52 (Rs.11,149 per employee) was spent for serving civil servants, MPs etc., and this comes entirely from the general budget of the Ministry of Health. However for the pensioners it comes from the pension account head and in the same year the pensioners received medical care worth Rs. 645.49 crores or a whopping Rs. 24,807 per pensioner. A large proportion of this expenditure happens in the private sector, especially for hospitalizations. It is interesting to see that pensioners seem to get a much better deal in terms of benefits but perhaps this may be due to hidden expenditures for the serving civil servants that we don't see as line items in the budgets. Since CGHS caters to the bureaucracy the benefits structure is also hierarchical, unlike the ESIS which is equitable. Thus if you are in a higher pay band then you get more liberal benefits like a single room as compared to a general wardsay for what is called a Class IV employee. So the CGHS is certainly not a model that one would aim for in a universal SHI program.

Armed Forces: It is well known that the armed forces health services are one of the best in the country in terms of comprehensiveness and equity in access. Again data availability is not easy to come by. Last year the CAG conducted an audit of armed forces medical services and hence some recent information is available on health expenditure of the armed forces. Thus in 2010-11 the armed forces spent a total of Rs.5,913.99 crores or Rs. 5,973 per beneficiary, including retired personnel (Rs. 2939 per beneficiary for pensioners and a whopping Rs.7708 for serving personnel. Whether you are a soldier or officer you get access to the same services with reasonable equity. Unlike CGHS and ESIS this is not contributory. These health services provide evidence of what a good healthcare service that is comprehensive and equitable would cost, albeit on a very liberal scale. It must also be noted that for tertiary care the armed forces are also increasingly using private hospitals, especially for retired personnel under the ECHS.

Railways: This sector is another star performer on the social health insurance front with robust health infrastructure and a well managed Health Directorate which runs the health services providing both medical care to employees and pensioners as well as dealing with public health issues in railway colonies. (in case of the armed forces the latter is generally managed by the Cantonment Boards). Tables 2 and 3 below show the trend in railways healthcare spending. In terms of costing the Railways services seem to be more reasonable, a little over Rs. 2000 per capita.

Table 2: Railway's Medical Department Expenditures

Year	Medical Expenditure Rs. Crores	Percent of total expenditure	Med Exp per employee Rs.	Med Exp per beneficiary Rs.
2006-07-	700	1.87	4894	1113
2007-08	798	1.94	5621	1271
2008-09	1114	2.05	7897	1777
2009-10	1384	2.10	9660	2160
2010-11	1370	2.11	9134	2107

Table 3: Breakdown of Railway Medical Expenditure by main heads 2003-04

Category of Expenditure	Expenditure Rs. crores	Percentage to Total Medical
1. Human Resources Medical	337	51
2. Hospital and Health Units admin	9	1.4
3. Medicines	108	16.4
4. Reimbursement Medical Exp	32	4.8
5. Public Health and Sanitation	170	25.8
6. Maintenance Equipment etc.	4	0.6
TOTAL	**660**	**100**

Source for Tables 2 and 3: Railways Annual Reports and Accounts

This translates into Rs 2500 billion or 3.5% of GDP if extrapolated for the country. In Table 3 a breakdown of the costs is also presented. From this we see that about half the resources are spent on salaries and the other half on other components of care like medicines, maintenance, public health measures etc..

RSBY: This scheme is directed towards the unorganized sectors not covered by any existing scheme, including selected occupational groups but more generally what is called the Below Poverty Line population. In 2012-13 the total allocation for this was Rs. 767 crores, of which Rs. 660 crores was for the main scheme and the balance for street vendors, beedi workers and domestic workers. In preceding two years it was Rs. 535 crores (2011-12 RE) and Rs. 512 crores (2010-11 actuals). The RSBY as on 1st Dec 2012 covers 3.3 crore families and 16.5 crore beneficiaries (RSBY Connect Dec 2012). This translates to Rs. 46.5 per capita of public expenditure for the covered population. Recently a number of studies looking into the RSBY functioning have been published and most of them see more problems in it than resolving healthcare needs of the members of the scheme, one major problem being high out of pocket expenditures of those who accessed RSBY.

Conclusions: The above review of expenditures of some of the key social health insurance schemes show that the schemes designed for Railways and Armed Forces are clearly the better performing ones. The ESIS which covers the largest segment of the organized workforce is resource rich but does not perform as well as the Railways or armed forces in providing benefits to its membership. There is a clear pressure to discredit ESIS and transform it (as also CGHS) using a public-private partnership model by involving insurance companies. RSBY is a living

example of the failures of the insurance model and we should protect the ESIS and CGHS going that way. The ESIS moving into medical education also needs to be rejected. What we perhaps need is to strengthen both ESIS and CGHS by merging them with the general health services so that the voice of the organized sector can be used to make public health services at large stronger and steer it in the direction of universal access to healthcare and social security for all.

Box 1: Social Security for Organized Sector in India

- **Employees' Provident Funds and Miscellaneous Provisions Act, 1952**
  - Welfare legislation enacted for the purpose of instituting a Provident Fund for employees working in factories and other establishments.
  - Applicable to establishment employing 20 or more employees.
  - Implemented through the following three schemes:
    - Employees' Provident Funds Scheme, 1952
    - Employees' Deposit Linked Insurance Scheme, 1976
    - Employees' Pension Scheme, 1995
- **Employees' State Insurance Act, 1948**
  - Provides for health care and cash benefit payments in the case of sickness, maternity and employment injury.
  - Applicable to non-seasonal factories using power and employing or more employees and non-power using factories and certain other establishments employing 20 or more employees.
  - Covers employees whose wages do not exceeds Rs. 15,000 per month
- **Payment of Gratuity Act, 1972**
  - Provides for payment of compulsory gratuity to employees at the time of termination of service either :
    - on superannuation
    - on retirement or resignation
    - on death or disablement due to accident or disease.
  - Applicable to establishment employing 10 or more employees.
- **Maternity Benefit Act, 1961**
  - Enacted to promote the welfare of working women.
  - Prohibits the working of pregnant women for a specified period before and after delivery.
  - Provides for maternity leave and payment of certain monetary benefits for women workerssubject to fulfillment of certain conditions during the period when they are out of employment on account of their pregnancy.
  - Maximum period for which a woman can get maternity benefit is 12 weeks.
- **Workmen's Compensation Act, 1923**
  - Imposes an obligation upon the employers to pay compensation to workers for accidents arising out of and in course of employment.
- **New Pension Scheme (NPS)**
  - NPS is a voluntary defined contribution pension system in India.
  - NPS is managed, regulated and reviewed by Pension Fund Regulatory and Development Authority, Ministry of Finance,

Box 2: Social Security for Unorganized Sector in India

- **The National Rural Employment Guarantee Act, 2005** (by definition NREGA is not social security, except when the dole is paid)
  - Aim at curbing unemployment or unproductive employment in rural areas.
  - Focuses on enhancing livelihood security to rural people, as it guarantees productive wage employment for at least 100 days in a year.
- **Unorganized Workers' Social Security Act, 2008**
  - Targets at extending social security measures to unorganized sector workers.
  - Aims at extending to workers in informal sector - status and benefits similar to that of formal sector workers.
- **Domestic Workers Act, 2008**
  - Aims at regulating payment and working conditions of domestic workers and entitles every registered domestic worker to receive pension, maternity benefits and paid leave that is a paid weekly off.
- **Various cess based Welfare Funds** for different Occupational groups – plantation workers, Mine workers, construction workers, beedi workers, cinema workers, headload workers, mathadi workers etc.. both under central and state laws which the NCEUS has sought to integrate under the UWSSA 2008
- **Various social assistance schemes** like PDS, ICDS, Indira Awas Yojana, Mid-day Meals, old age and widow pensions, RSBY and other social insurance schemes etc targeted

The Emerging Experience of RSBY in Chhattisgarh: What can the Informal Sector Workers Expect?

-Sulakshana Nandi, Dr. Rajib Dasgupta,*
Dr. Madhurima Nundy,
Dr. Ganapathy Murugan, Kanica Kanungo

In India, health insurance has always been mostly limited to workers in the organized sector and to people who can purchase insurance privately. There have been very few health insurance schemes catering to the needs of the informal sector. These have been in the form of community-based insurance schemes mostly run by non-governmental organizations with limited coverage and scope. However, the past decade has seen an increase in the number of insurance schemes being introduced by central and state governments with a focus on protecting the poor and the informal sector workers against catastrophic expenditure on health. The Yeshasvini Health Insurance Scheme in Karnataka in 2003 and the Rajiv Aarogyasri Scheme in Andhra Pradesh in 2007 were precursors to the Rashtriya Swasthya BimaYojana (RSBY) launched by the Ministry of Labour, Government of India in 2007. The RSBY seeks to address workers in non-formal sectors and those self-employed.

RSBY provides an annual cover of Rs. 30,000 per family of five persons for hospitalizations. The packages included are for surgical procedures and also for reimbursements for hospital admissions for medical causes. Though the central scheme restricts this to those below poverty line (BPL), few state governments like Kerala and Chhattisgarh have extended it or are planning to extend it to the whole population. While seeking to protect the BPL families against catastrophic health expenses increase their access to healthcare and expanding their choice of providers, in a bid to make this a win-win proposition RSBY has also been conceived of as a 'business model' in which "all the stakeholders as the service provider, the insurance company etc. have direct benefits, (and) would take a proactive role in making this scheme successful".[1]

The state government selects the insurance provider (private or public) through a bidding process. The insurance company in turn empanels the hospitals and selects the Third Party Administrator (TPA), which is responsible for enrolment, annual renewal of cards and processing claims.

This paper briefly relates the experience of RSBY, gauged through a series of studies in Chhattisgarh. The list of studies is given in Table 1 and the related publications and other references are given at the end of the paper:

While it is still early days for the RSBY, the emerging experience of issues related to coverage, availability of services and hospitals, impact on the public health system and the private sector are pointers to the potential benefits and limitations that the workers in the informal sector may experience.

Which hospitals are being empanelled and where?

Though in many states, more private hospitals have been empanelled than public hospitals, in Chhattisgarh, the number of public facilities is higher than private ones. This is also because a number of Community Health Centers (CHCs) and Primary Health Centers (PHCs) have also been empanelled. The private facilities are concentrated mainly in the mainstream areas and cities. Lesser number of private hospitals is available and therefore lesser number is empanelled in rural, tribal and remote areas. For example, 40% of the private hospitals empanelled are in the state capital of Raipur. In order to increase the reach of the scheme, smaller (4-5 bed) private hospitals have been empanelled; the quality of these institutions is not being adequately examined through pre-empanelment inspections.

Who are being enrolled and who are left out?

Enrolment is annual and is being done by the TPA, which was considered a conflict of interest by a few respondents, including a senior administrator.

Enrolment rates vary widely across villages, districts, regions and demographic groups. Beneficiaries were often found to be concentrated in the easier to reach villages and left out in the hard to reach villages or hamlets, particularly in tribal majority blocks; this was confirmed by some of the empanelled local institutions too. Enrolment in such areas ranges from 30%-50%. One study found that only 32% of Particularly Vulnerable Tribal Group (PTG) families had been enrolled even though they are the poorest and most vulnerable.

Our study in Durg district showed that 37% of respondents had above five members in their family (benefits are limited to only five members

**Email of corresponding author: sulakshana.nandi@gmail.com*

Table 1: List of Studies on RSBY in Chhattisgarh

Study	Year	Type	Sample	Data Collection	Agency
Study to analyse implementation of RSBY in Chhattisgarh	2010	Quantitative	52 beneficiaries in public hospitals and 50 in private hospitals in Durg district	Patient Interviews Secondary data	Public Health Resource Network (PHRN)
Study on enrolment	2012	Quantitative	270 Villages 32 Blocks 18 Districts	Village level questionnaire	Jan Swasthya Abhiyan Chhattisgarh
Study on design issues in RSBY through mapping provider perspectives	2012	Qualitative	5 public hospitals 9 private hospitals 4 non-for-profit hospitals 50 respondent interviews	Rapid Appraisal Procedures (RAP)	PHRN and Centre of Social Medicine & Community Health, JNU
Study on access of Particularly Vulnerable Tribal Groups (PTGs) to health and nutrition services	2012	Quantitative	1200 PTG families	Household questionnaire	PHRN, SHRC CG and local NGOs

in a family). This begets the possibility of the most vulnerable members of the family, like the aged, the widows or the disabled getting left out. This is doubly significant for Particularly Vulnerable Tribal Groups as their family sizes are much larger, as since 1979, the state government has imposed restrictions on them for permanent methods of family planning in an attempt to increase their once dwindling populations. This was done ignoring the fact that extremely high mortality rates (which remains high even today) and not low fertility rates was the reason for the population decrease.[2] Therefore they have been forced to have large families who are now just partly covered through RSBY.

Our studies have also found that though RSBY cards are to be given to the beneficiaries within a few hours, there are considerable delays, up to months. Therefore, though a family may be 'enrolled', they are not able to utilize the scheme till they receive the card. Disruptions in utilization also happened because of the practice of yearly renewals. Moreover, people receive inadequate information about the services and hospitals under this scheme and are unaware about specific entitlements under RSBY.

Table 2: Summary of Findings[3]

Range of Services Provided		
Private	**Not-for-Profit**	**Public**
▪ Narrow and selective range of services- Cherry picking	▪ Large range of services	▪ Limited range of services
▪ Fewer medical conditions than public ▪ Largely simple and uncomplicated conditions, rest referred to public	▪ Medical conditions plus surgeries ▪ Eg. Orthopedic procedures and chemotherapy	▪ Mostly medical conditions ▪ Surgical procedures less except in Medical College
Impact on Hospital		
▪ Increase in caseload ▪ Small hospitals biggest gainers ▪ Corporate hospitals- 5-10% RSBY occupancy	▪ Increase in caseload	▪ Decline in patients ▪ Decline in range of services ▪ Increase in patients in tribal block
▪ Increase in income	▪ Losses if calling surgeons from outside	▪ No significant increase in revenues ▪ Previous maintenance funds withdrawn
Suitability of Packages and Practices Followed		
Private	**Not-for-Profit**	**Public**
▪ Most packages priced lower than hospital rates	▪ RSBY packages usually higher than hospital rates	▪ Not possible to provide long-drawn hospitalization, cost intensive treatment
▪ Fixed number of beds for RSBY	▪ Cost-cutting measures, without compromising quality ▪ Eg. Silk sutures	▪ Patients admitted for OPD-level conditions ▪ Cost of treatment escalated
▪ Hysterectomy preferred but not cesarean section ▪ Ophthalmology- more cataracts	▪	▪ Commonly- diarrhea, respiratory infections, anaemia, weakness, hypocalcaemia

How are the public and private and not-for-profit hospitals functioning differently under RSBY?

Our study on design issues in Chhattisgarh found that the private sector was cherry picking profitable procedures and providing narrow and selective range of services; most hospitals reported a rise in incomes. They were treating simple and uncomplicated conditions, and referring the complicated cases to the public sector. They were also treating fewer medical conditions (malaria, typhoid etc.) than the public sector. In many private facilities, a fixed number of beds were earmarked for RSBY patients. RSBY inpatients were few and far between in corporate hospitals that were capable of delivering tertiary care or complicated procedures; catastrophic health events were thus not being covered adequately.

The CHCs and PHCs were mostly treating common medical conditions including diarrhea, anemia, malaria, and typhoid. It was only in the district hospitals and medical colleges that surgical and other conditions are being treated, most commonly, cancer chemotherapy and animal bites. However, within medical conditions, the conditions requiring longer hospitalizations like snake bite, poisoning and burns are not being treated under RSBY, as the packages are inadequate.

The public hospitals (particularly, CHCs and PHCs) were often buying medicines from private shops at retail prices whereas much of those medicines should be available at the facility free of cost. The pressure on the public health system to show higher utilization and incentives to staff was resulting in irrational hospitalizations and prescriptions.

The not-for-profit hospitals were providing a larger range of services and experienced increases in patient load. Most RSBY rates were somewhat higher than

what they usually charged (their patients, outside of the RSBY) and therefore they also reported increase in incomes.

The findings on the range of services being provided, the impact on the hospitals and their nature of practice under RSBY are summarized in Table 2.

Is insurance like RSBY the way forward for ensuring health of the informal sector workers?

The gaps and concerns emerging from our studies are also echoed in the findings of the recent external evaluation of RSBY in Chhattisgarh commissioned by the State Nodal Agency, RSBY (CTRD 2012). Much of the morbidity in the community is of primary illnesses, treatable at the primary level. The RSBY (and many insurance schemes) focuses on specific treatment procedures rather than on treatment of illnesses and therefore conditions treatable at primary level end up being admitted (for example, for uncomplicated anemia or diabetes mellitus) or transferred to secondary/tertiary levels. This also results in public funds being shifted from primary level care to secondary and tertiary level care, or to private providers (JSA 2012).

RSBY seems to be incentivizing irrational hospitalization and procedures. This is borne out by our findings as well as and from subsequent reports of mass hysterectomies (under RSBY) in Chhattisgarh and Bihar. Increase in irrational and expensive procedures implies that the cost of care is also being artificially inflated. The most vulnerable communities and remote areas are once again being 'underserved' in this scheme and issues of exclusion and discrimination against patients exist.

There is no real choice to the consumer. For them 'choice', especially with respect to the private sector, is restricted to the range of services the particular hospital has chosen to provide them. There is no service guarantee at the facilities, neither by the level (primary/secondary/tertiary) not by the specialty (surgery, gynecology, eye and so on). While private hospital are 'cherry picking' the most profitable conditions/procedures, public hospitals are unable to compete. However, in tribal areas, the public facilities are seeing an increase in patients. The lack of transparency at all levels and near-absent grievance redressal mechanisms is shocking especially as RSBY is utilizing public funds.

Though intended to cover catastrophic health expenses, facilities are not able to provide long-drawn hospitalization (burns or poisoning), cost-intensive treatment (high-tech and thus the most expensive surgeries) or treatment of chronic diseases like hypertension, heart disease. High out of pocket expenditure has been a consistent finding in all studies including the independent official evaluation. Therefore, the poor are scarcely protected from catastrophic expenditure, the raison d'être of the RSBY. The penchant for a 'business model' has become an obstacle for inclusiveness and comprehensiveness of services.

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Legal Provisions for Protection of Health and Safety at Work in India

-Jagdish Patel[1]

Laws regarding protection of health and safety at work in India have been looked at in this paper. Provisions of Factory Act, Mines Act, Construction Workers Act, ESI Act, Employees' Compensation Act, Shops & Establishment Act, Plantation Workers' Act etc. have been examined. Several other have still been left out like Electricity Act, Boiler Act, Explosives Act, Petroleum Act and so on. Limitations of the legal provisions have been spelled out at the end.

Historical Background

It was in 1881 that under the pressure of British mill owners, the British government ruling India then, enacted the Factories Act. The British mill owners argued to provide them fair and equal conditions for business, as the British mills were supposed to follow provisions of Factories Act enacted in 1833 while for the Indian mill owners there were no legal provisions to follow. The first mill in India was set up in Mumbai in 1854. The first strike was reported in 1877 in the Empress Mill, Nagpur. (Source: http://www.lawisgreek.com/trade-union-history-of-trade-union-in-india)

The Bombay Mill Hands Association was established by Narayan Lokhande in 1890 which demanded weekly leave on Sunday for textile mill workers. The Bombay Mill Hands Association highlighted the terrible conditions and misery of workers caused by excessive work load, long working hours, low wages and horrible working conditions. The Factories 1881 Act was amended several times. Major changes came in 1987 following the Bhopal tragedy.

(In India the 1881 Factories Act was basically designed to protect children and to provide few measures for health and safety of the workers. This law was applicable to only those factories, which employed 100 or more workers. In 1891 another factories Act was passed which extended to the factories employing 50 or more workers. In 1948 the new Factories Act has been passed to strengthen the position of workers, working in the factory across India. The Factories act is a social act which has been enacted for occupational, safety, health, and welfare of workers at work places. It applies to factories covered under the Factories Act, 1948. It applies to the industries in which ten (10) or more than ten workers are employed on any day of the preceding twelve months and are engaged in manufacturing process being carried out with the aid of power or twenty or more than twenty workers are employed in manufacturing process being carried out without the aid of power, are covered under the provisions of this act. Source: http://www.lexvidhi.com/article-details/the-factories-act-and-its-compliances-263.html)

The 7th edition of Labor Problems and Social Welfare by R.C.Saxena published in 1959 reports: "... the employers do not report occupational diseases and many times no compensation is paid in deserving cases, because a cause of disablement or death due to occupational disease is not properly diagnosed.." (p.535).

We are still struggling with the same problem. It adds,"… the Industrial Health Research Unit of the Indian Research Fund Association has also undertaken some surveys regarding occupational diseases, especially in case of lead intoxication in printing presses and toxicity of industrial dust. In Bombay also a Research Laboratory has already been set up for the purpose. The All India Institute of Hygiene and Public Health has also compiled "A Review of Occupational Health Research in India." The organization of Chief Advisor, Factories, also carries out surveys for locating occupational hazards in certain specified industries. It may be mentioned that the occupational diseases are one of the important causes of bad health of industrial workers."(p.536). Now, we do not know which of these institutions have survived and what impact have they left.

Major Legal Provisions

Factories Act

The Act is applicable to the manufacturing activities as defined by the Act. It is applicable to whole of India. Provisions are equally applicable to ALL workers – casual, contract, permanent or temporary as Act do not make any differentiation. Major provisions are regarding health, safety and welfare. State Governments notify State Rules and have adequate powers to apply the law to the industry and the number of employees as they wish. Normally the law is applicable to units employing 10 or more workers but for certain industries it is made applicable to the units employing 5 or more or even 1! In 1987, Chapter IV-A was introduced for hazardous units. Threshold limit values were introduced for the first time in the Act then for 117 substances. But the list has neither been reviewed nor expanded. It was expected that the workplace environment will be monitored but in most cases that is not done. In the absence of data on work environment it becomes difficult to correlate the impact on the health of workers. There is no provision to employ an Industrial Hygienist.

[1]*Email: jagdish.jb@gmail.com*

There is also no clear provision for the monitoring of workplace environment. The major problem is with the lack of adequate manpower for enforcement and administration. Particularly after the implementation of the Sixth Pay Commission, erosion in manpower has picked up at a fast pace. In Gujarat, presently only 40% of the sanctioned staff is in place. Another problem is that of corruption. Both the problems can be overcome to some extent by giving powers to the workers/TUs/civil society organizations to prosecute units for violation. Presently the powers rest with Government only. Private complaints may be filed with prior permission from Government. In Hazardous units it is mandatory to employ Factory Medical Officers (FMO) who are qualified in Industrial/Occupational Health. Medical Practitioners/owners are expected to notify incidents of occupational diseases listed in Sch.III of the Act but that has remained very very poor and the state is not making any efforts to resolve the problem. Positive incentives for notification may be one of the changes that may be made in the Act. Civil society too has done nothing on its own to generate reliable data. Data on occupational disease is altogether a different subject and is not dealt with here in depth. Professional medical associations have been protecting interests of business. Individual workers too know their interest well and help in hiding the facts on occupational diseases. Labor laws and the judicial system have failed in instilling trust among the workers. Trade Unions have developed as labor wings of political parties and they might be waiting for the political power to come in their hands when they can influence. Left rule in W.Bengal for more than 25 years has not left any encouraging results with regard to diagnosis, reporting and recording of occupational diseases. Exemplary fines or jail are not imposed on violators. In most cases workers are made to work for 12 hours with tacit state approval, without being paid for over time wages and in violation of total hours for overtime permitted. Data on serious injury remain largely under-reported.

ESI Act & Employees Compensation (E.C.) Act

The Act is applicable to the units employing 10 or more workers in a geographically notified area. Again, in the unit where it is applicable, employees earning Rs. 15,000 or less are covered. In some states, the Act is applicable to educational institutions, cinemas and so on. It is observed that units do not cover all their workers - temporary, contract and some permanent workers are not covered, thus violating the law. For those who are covered, employers play tricks with records by showing lesser attendance so as to pay less amount of contribution towards insurance. As a result, workers are not able to get benefits as all the benefits have attached conditions. Several examples may be quoted. The most glaring example is that of tribal workers from Gujarat, Rajasthan and Madhya Pradesh working in quartz crushing units in Gujarat. More than 2000-3000 workers might have died of silicosis over last 30 years but none could claim compensation from ESIC for lack of coverage or lack of adequate attendance.

In case of occupational diseases, workers are paid compensation from the date of their examination by Medical Board and not from the date of onset of the disease. Workers who get diseases after leaving employment find it extremely difficult to claim compensation. Also, the workers who do not fullfill the condition of employment for specified period also cannot get compensation. Because employers play with the records, workers cannot prove the complete employment period and then are deprived of the benefits. Standards for evaluating the disability due to diseases are not developed and are being done in arbitrary fashion by the Medical Board. Assessment by the Board are in most cases most dissatisfactory and unscientific. ESI dispensaries and hospitals are run by the state health departments. These facilities are often understaffed and lack most basic equipments. ESI Medical manual is not well enforced and ESI Corporation has failed in monitoring these facilities. ESI Act and rules need to be amended to give powers to the workers/TUs/civil society organizations to prosecute units for violation. In Employees Compensation Act in last few years welcome changes have been made. Still, the list of occupational disease in Sch.III need to be changed in both the Acts (is common in both) to include list of occupational diseases prepared by ILO. In case of Employees not covered under ESI Act can claim compensation under Employees Compensation Act. If the unit has not bought insurance for E.C. Act if becomes difficult for employee to claim compensation as one is afraid of being fired. There are few who take risk, get fired and file claim. When the Compensation Commissioner passes order in favor of the claimant, the employer would refuse to pay or simply not pay. There are large numbers of such claims when workers are not paid despite favorable orders. Some legal provision need to be taken to prevent such action on part of employers.

Mines Act

In India the Mines Act was first enacted in the year 1901. The original Mines Act was replaced in 1923 and subsequently in 1952 the Parliament has enacted the present Mines Act. The Act was last amended in 1983. It has provisions for safety, health and welfare. In 1983, it was amended to prohibit laborers below 18 yrs of age, inspection of mines by workers representatives, safety committees and to regulate the use of machinery to take care of the hazards associated with the introduction of new types of machines. In 2011, the Act was again amended mainly to keep

pace with the liberal policy for investment and increase penalties for violations. In the statement of objectives for amendment it stated that "Operations are getting more and more mechanized with introduction of heavy machines, shallow deposits are getting depleted and mines are becoming deeper and complicated and operators from other parts of the world have started acquiring mining rights and managing mining operations within our country. This has created a new safety and health risk scenario at the work places in these sectors." But when you look at the amendments, you do not see any amendment regarding safety as such. These amendments in the Mines Act, 1952 envisage extending the Act to the whole of India including territorial waters, continental shelf, exclusive economic zones and other maritime zones of India substituting the definition of owner so as to make it more comprehensive and specific; define the 'foreign company' with reference to the Companies Act, 1956; provide for appointment of officials in addition to agent of employer in the mines; increase in the penalties provided in various sections and to shift the burden of proof upon the person who is being prosecuted or proceeded against. Here, too, identification of occupational diseases and compensation for the same have remained a matter of concern. Still, it may be stated that comparatively DGMS is better than DGFASLI as DGMS has better data on Occupational diseases than DGFASLI. There is huge number of illegal mining and workers engaged in such mines and who remain out of the purview of the legal provisions.

Plantation Act, 1951

In this Act, there are provisions for heath and welfare like drinking water, sanitation, medical facilities for workers and their families, hours of work, weekly holiday, etc. It provides for reporting of accidents at work. No provisions for safety, i.e., prevention of accidents or occupational diseases.

The Motor Transport Workers Act

The Act provides for welfare of motor transport workers and to regulate the conditions of their work. It is applicable to any motor transport undertaking employing more than 5 persons and State Govts are empowered to make it applicable to the units employing even less. The Act provides for hours of work, first aid facility, medical facility, uniforms, rest rooms, daily intervals of rest, restricted employment of young persons, wages for over time, annual leave with wages,etc. There are no provisions to maintain safe conditions in the vehicle. Transport workers are exposed to heat (of engine as well as environment), vibrations (whole body), glare of light, illumination, fuel fumes and dust, noise and so on. There are no threshold limit values to maintain the vehicles in safe condition.

The Beedi and Cigar Workers (Conditions of Employment) Act, 1966

This Act provides for welfare of the workers and regulates conditions of work. For health and welfare, it provides for cleanliness, drinking water, latrines and urinals, washing facility, crèches, first aid, canteens, etc. It also provides for regulation of working hours, weekly holidays, leave with wages, etc. Here, too there are no provisions to regulate tobacco dust or monitor work environment to prevent accidents or occupational disease.

The Bombay Shops and Establishments Act, 1948

The Act applies to local areas mentioned in the schedule. The State Government has powers to apply provisions to such other local areas having population of 25,000 or more and may also apply to such local areas having population less than that. The Act provides for monitoring hours of work and wages including daily and weekly hours, holiday, interval of rest, wages for overtime, leave with pay, cleanliness, ventilation, illumination. No standards have been set for these. No provisions to prevent accidents or occupational diseases. Interestingly there are no provisions for sanitation, drinking water, access, lifting of weight, provision for seating, etc. Now in the Mall culture workers are exposed to several hazards. No exposure limits arebprescribed. In shops, various different activities are carried out like restaurants, aatta-chakki (workers are exposed to grain dust and silica dust), hair cutting (workers are exposed to hair and filth with it, powders, solvents, soap etc), glass (exposed to glass dust). Standing for long hours, dealing with public has hazard of violence and so on. There are no studies of health conditions of these workers.

The Building and other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996

The Act provide for establishing Advisory and Expert Committees at Central and State levels. It applies to establishments employing 10 or more construction workers but does not apply to residential houses for own cost not exceeding Rs. 10 lakh. It provides for drinking water, latrines and urinals, free accommodation, crèche, canteens, etc. For safety and health it provides for appointing safety committee and safety officers (for units employing 500 or more employees), notifying accidents and 15 occupational diseases listed in Sch.II. State Governments are empowered to make rules for preventing accidents. The Act provides prosecution powers to the Inspectors appointed under the Act, Trade Union and any NGO registered under Societies Registration Act. Still, individual worker is not given such powers.

State rules provide detailed rules for prevention of accidents, for provision of safe work conditions, personal protective equipments, etc. The Gujarat rules provide for TLV only for noise and carbon monoxide. There is a cursory reference to vibrations but does not even refer to national standards. In rule 73 it talks of monitoring dust and fumes but no safe levels have been prescribed but refers to 'National Standards'. Similarly for illumination, rules refer to national standards without giving any safe levels. Sch. XII gives TLVs for chemicals which is replication of Sch.II of the Factories Act. But there is no provision to maintain record of the noise levels. Rules provide for periodical medical examination and in some case pre-employment medical examination, appointment of medical officer, working hours, weekly holiday and payment of overtime wages, equipments for communication, etc. Interestingly there are no specific provisions to prevent exposure to asbestos or silica dust.

Dock Workers, (Safety, Health and Welfare) Act, 1986, Regulations 1989 and Rules, 1990

Regulations provide for cleanliness, access, stairs, escape in case of fire, excessive noise, fire protection, illumination, life saving appliance, fencing, ladders, working space, protection from dangerous and harmful environment, safety of lifting appliances, dock railway, conveyors, loading-unloading, personal protective equipments, handling of dangerous goods and tetraethyl lead, solvents, notification of accidents and occupational diseases (owner is required to inform family of the employees -no other law has such provisions which is required), employing safety officers, drinking water and sanitation, ambulance room, pre and periodical medical examination, OH services, safety committee. Sch.IV lists 11 notifiable occupational diseases which includes pneumoconiosis. No TLVs except noise has been prescribed.

Limitations

As seen above we have laws for protection of H & S at work for workers in manufacturing, mines, construction and docks. There are laws for beedi and cigar workers, plantation workers, motor transport workers, shop workers and may be many more occupations - but as seen above these laws do not have adequate provisions to protect H & S at work. Generally it is believed that there are no laws for workers in unorganized sector but as far as protection of H & S at work there are no laws for workers in organized sector. Workers in service sector in particular like health care, education, bank and insurance, municipal workers, telecommunication, post and courier, etc are not governed by any law. In manufacturing sector, workers employed in units employing less than 10 workers have no law for their protection of H & S at work and there is a huge number of such workers. In Gujarat, pesticide formulations, dyes and intermediates and many more hazardous chemicals are manufactured by such units.

The major workforce is in agriculture where there is no law for protection of these workers from snake bites, pesticides, tractor accidents and injuries by other implements, infectious diseases, etc. In Gujarat, since last 15 years, each year, on average 200 agriculture workers die of leptospirosis. The Insecticides Act, 1968 and Rules 1971 provide for notification of cases of poisoning. It does not provide for protective equipments for the workers engaged in it use. The Dangerous Machines (Regulation) Act, 1983 and Rules 2007 apply to the manufacture of threshers, chaff cutters, sugar cane crushers, etc. The Act provides for the standard specifications of the machines which need to be adhered to by the manufacturer. Such machines then, by design, prevent accidents in agriculture. These are two legislations which may be said to have some connection with protection of health and safety of these workers at work.

Violence at work, sick building syndrome, repetitive strain injury (RSI), bullying at work have remained out of legal purview. Criterion for assessment of disability due to occupational diseases has not been well developed. Sexual harassment at work has been taken care of to some extent by way of Supreme Court ruling in Vishakha versus State of Rajasthan. ILO convention 155 deals with protection of H & S at work for workers in all economic sectors irrespective of number of workers employed. All BRICS countries except India have ratified this convention. When we talk of UHC we will have to think of establishing OHS services for workers in all economic sectors. There are several laws but implementing agencies are different, e.g., Factories Act is enforced by state labor department, Boilers Act 1923 is enforced by a separate wing of the Labor department (in Gujarat), Electricity Act is enforced by the state industry department, Explosives Act, Petroleum Act and Rules framed under it like SMPV Rules, Gas Cylinder Rules, Calcium Carbide Rules are enforced by Central Ministry of Heavy Industries and Public Enterprises and so on. Several organizations have recommended rationalization and simplification of these laws to avoid duplication and more effective enforcement. In 1990, the National Labor Law Association recommended setting up a National Commission of H & S as well as Central and State Boards of OSH.

Later the Second Labor Commission in the year 2000, recommended setting up of OHS Commission and OHS Committee. The Commission recommended enacting of new laws called OSH Bill and included draft of the Act in its report (Ch.11).

ILO Conventions and India

-Jagdish Patel[1]

International labour standards are legal instruments drawn up by the ILO's constituents (governments, employers and workers), setting out basic principles and rights at work. They are either conventions, which are legally binding international treaties that may be ratified by member states, or recommendations, which serve as non-binding guidelines. In many cases, a convention lays down the basic principles to be implemented by ratifying countries, while a related recommendation supplements the convention by providing more detailed guidelines on how it could be applied.

Recommendations can also be autonomous, i.e., not linked to any convention. Conventions and recommendations are drawn up by representatives of governments, employers and workers and are adopted at the ILO's annual International Labour Conference. Once a standard is adopted, member states are required under the ILO Constitution to submit them to their competent authority (normally the parliament) for consideration. In the case of conventions, this means consideration for ratification. If it is ratified, a convention generally comes into force for that country one year after the date of ratification. Ratifying countries commit themselves to applying the convention in national law and practice and reporting on its application at regular intervals. The ILO provides technical assistance if necessary. In addition, representation and complaint procedures can be initiated against countries for violations of a convention they have ratified. ILO Conventions and Recommendations carry great importance for working population anywhere. Whenever the convention is ratified by a member country, importance of that particular convention for that country increase immensely. After ratifying the convention, the member state is obliged to send the progress report of its implementation in law and in practice regularly to ILO. Ratifying country has to give place in their National Statute to the convention ratified. In most cases, the convention is, supplemented by the Recommendation which lay down detail general or technical guideline to the convention.

Information on progress on implementation of the convention can also be sent by Trade Unions or Employer's organizations. The progress reports received by ILO are examined by the independent expert committee at ILO and its findings are discussed by ILO conference held every year.

ILO conventions has so far covered following subjects 1) Freedom of association 2) Prohibition of forced Labour 3) Equality of opportunity and treatment 4) Human resources and employment 5) Labour Administration 6) Industrial relations 7) Wages 8) Weekly rest and paid leaves. 9) Occupational Safety and Health 10) Social Security 11) Employment of Women 12) Employment of children and young persons 13) Migrant Workers 14) Tribal and Indigenous peoples 15) Hours of work.

History of Ratification by India

India is an ILO member since 1919, i.e., since its inception. Even before India became free of British rule, it had ratified 14 conventions. Within 4 years of independence 4 more conventions were ratified, by which time ILO had passed 107 conventions.

In 1954 Government of India appointed a Committee to make recommendations on ratifying ILO conventions. Following recommendations of this Committee, Government of India ratified 5 more conventions, totaling 23. The Committee also recommended to ratify convention No. 63 and 99 (Minimum Wage fixing (Agriculture) Machinery Convention. 1951; but till date these have not been ratified by the Govt. of India.

In a decade after 1958, enthusiasm to ratify the convention seemed lost: in the 10 year time till 1968, 5 conventions were ratified and by 1978, 4 more conventions were ratified, totaling 32. After 78, in next 12 years not a single convention was ratified. By 1998, 4 more conventions were ratified. A convention regarding ban on bonded labour, passed by ILO in 1957 was ratified after 43 years on 18/5/2000.

Let us see, how many important conventions on different subjects have been ratified so far. Out of 5 conventions on "freedom of association" only one, viz. No. 141 (Rural workers organization) has been ratified. Both conventions on Bonded Labour have been ratified, Equality of opportunity and treatment 2 out of 3, Human Resources and employment 2 out of 5, Labour administration 3 out of 7, Weekly rest and paid leaves 1 out of 4, Occupational Safety and Health 3 out of 15, Social Security 1 out of 3, Employment of workers 2 out of 4 on and 1 out of 6 on Child Labour have been ratified. Not a single convention has been ratified on subjects like migrant workers, Indigenous and Tribal people, wages and industrial relations.

Fundamental Conventions

The following 8 conventions in Table 1 are considered to be fundamental and ILO places great emphasis on

[1]*Email: jagdish.jb@gmail.com*

ratifying them.

The Government of India has ratified only 4 of these fundamental conventions (Nos. 29, No. 105, No. 100 No. 111). These were ratified in year 1954, 2000, 1958 and 1960 respectively.

Our neighbors - Pakistan, and Sri Lanka have ratified all 8, Bangladesh and Nepal have ratified 7 conventions while China has ratified 4 and Myanmar has ratified 2 conventions.

Out of total 185 nations that are members of ILO, 136 members have ratified all the fundamental conventions.

Ratification World Over

Till now, ILO has passed 189 conventions (8 fundamental, 4 Priority and 177 technical), 202 recommendations and 5 protocols. The last convention passed by ILO was in year 2011 titled "Decent work for domestic workers". 43 conventions are ratified by India out of which 41 are in force and 2 have been denounced. Out of these 41, 4 are fundamental, 3 are priority and 36 (out of 177) are technical conventions.

In China 25 and in USA only 14 conventions are in force. A small country against which America waged war -Iraq- has 66 conventions ratified but Iran is nearer to USA by ratifying 13 conventions. Difference between communism in China and Cuba can be seen from the number of conventions ratified by them: China 25, Cuba-90. Brazil is competing with European countries with 96. Four other countries which have ratified more than 90 conventions are Belgium (100), Bulgaria (101), Finland (101) and Netherland (107). But, Norway (109), Italy (111) and France (124) have ratified more than 100 conventions. With 133 conventions Spain is ahead of all. Fourth smallest country in the world Tuvalu, situated in pacific ocean has ratified 1 convention.

The Empire which boasted "no sun set" once upon a time - Britain - has ratified 86 conventions while Russian federation which was the first country to successfully replace King by Proletarian revolution ratified only 68 conventions. Nepal joined ILO in 1966 and has ratified 11 conventions while Korea joined in 1991 and has ratified 28 conventions.

Attitudes of Governments of different countries can be known from the number of ratifications, but it is not enough to know the actual status of workers in different countries. ILO conventions form a moral binding and it generates international pressure. Though, member state has not ratified a particular convention, the convention remain valuable. As and when the convention is accepted, information about it spreads world over which helps in generating awareness on that particular subject. Even if that convention is not ratified, parts of it is reflected in future statutes or implemented in practice. India has

Table: 2 Status of Ratification of Fundamental Conventions

No. of ratifications	No. of countries
No ratification	005
2 conventions	003
3 conventions	004
4 conventions	005
5 conventions	009
6 conventions	008
7 conventions	018
All conventions	136
Total	185

Table: 1 Fundamental Conventions

Convention NO	Title and year	No.of ratifications	India ratified in
29	Forced Labour Convention, 1930	175	1954
100	Equal Remuneration Convention, 1951	169	1958
105	Abolition of Forced Labour Convention, 1957	172	2000
111	Discrimination (Employment and Occupation) Convention, 1958	170	1960
87	Freedom of Association and protection of right to organize, 1948	151	-
98	Right to organize and collective bargaining, 1949	161	-
138	Minimum Age Convention, 1973	163	-
182	Worst forms of child labor, 1990	175	-

not ratified number of conventions, though parts of these conventions have been included in different statues, e.g., compensation for occupational injury, convention No. 121 of 1964, is not ratified by India.

But important aspects of this convention are included in Factory Act and E.C. Act. One of the reasons for non-ratification is the ILO constitution which requires the member-nation to accept the convention in toto. In such cases members prefer to include the acceptable portions of the convention into National legal framework but do not ratify the convention. We all know that just by ratifying a convention or make a law does not automatically change the ground realities.

Conventions on Occupational Safety and Health

Protection of Health and Safety at work is one of the important tasks of ILO. Number of conventions have been passed by ILO on this subject. By 2012 ILO had passed 189 conventions and 202 recommendations out of which 13 conventions and 16 recommendations were directly related with the subject.

List of important conventions on the subject can be found in Table 3. These conventions include subjects like Occupational Health Services. Protection from Radiation, Chemicals. Asbestos, Benzene, Workplace environment, H and S in construction, Machine Guarding etc. Out of 13 conventions on OHS, India has ratified only 4 (C- 115,174,127 and 136) conventions.

Convention no, 155, Occupational Safety and Health convention, 1981, applies to all branches of economic activity and to ALL workers. It provides for formulating a National Policy on occupational safety, occupational health and working environment, in the light of national conditions and practice. It provides detailed actions to be taken by the ratifying state. It provides for the measures to be taken right at the design stage of the technology and provides workers with necessary protective gears. It also provides workers to refuse work which has imminent or serious danger on one's life, without undue consequences (Art.13). It provides for publishing annual data. In Gujarat, since last more than 25 years, the state government has stopped publishing annual reports by Chief Inspector of Factories (now known as Director, Industrial Safety and Health). It also provides for "Inclusion of Question of Occupational Safety and health and the Working Environment at all levels of education and training including higher technical, medical and professional education...." (Article 14). It empowers workers or their representatives to bring in experts from outside to make an inquiry (Article 19). Convention 121, Employment Injury Benefits, 1964 provides for the competent authority to define occupational accidents and diseases for which certain compensation benefits shall be provided. These benefits include payment for medical care and rehabilitation services for workers sustaining work related injuries and impairments. They also include income maintenance for the injured workers and their dependents during the period of temporary and permanent disability or in case of death. Sch. I of the convention 121 provides a list of occupational diseases that are common and well recognized. The list can be amended as per the procedure given in convention.

In 1980, the list was amended. But, the list does not include some of the diseases faced by the workers in this age, e.g., effects of closed modern buildings, Hazards of electronic office equipments, exposure of tobacco to non-smokers, hazard of HIV/AIDS to healthcare workers, effects of shift work, effects of number of chemicals, cancer due to quartz dust, repetitive strain injuries, or stress related diseases etc. In 2002, Recommendation 194 was revised to give a new list of occupational diseases. The new list includes a range of internationally recognized occupational diseases, from illnesses caused by chemical, physical and biological agents to respiratory and skin diseases, musculoskeletal disorders and occupational cancer. Mental and behavioral disorders have been, for the first time, specifically included in the ILO list. The list also has open items in all the sections dealing with the aforementioned diseases. The open items allow for the recognition of the occupational origin of diseases not specified in the list if a link is established between exposure to risk factors arising from work activities and the disorders contracted by the worker.

When small countries like Vietnam and Mongolia have ratified convention No. 155, the country which boasts itself to be world's largest democracy needs to take a step towards offering legal cover for the workers in hundreds of occupations.

ILO instruments on its own may not improve conditions at grassroots in any given socio-economic situation in any country. Many activists criticize ILO as toothless and that is true. What to expect from these instruments is left to us. I remember a slogan floated by the then Prime Minister Indira Gandhi during the Emergency:

"Kathor Prishram ka koi vikalp nahi" (No alternative to hard work). Likewise there is no Alternative to struggle for workers to improve their conditions. ILO can only help give ideas and draft legislations. ILO offers civil society organizations to send them reports on implementation but there is no way that ILO secretariat can press individual member countries to ratify any particular instrument. It is left to the forces within the country, workers' organizations and other civil society organizations to create an enabling social environment leading to favorable decisions. A

Table: 3 Important Conventions on Occupational Safety and Health

Name of convention	Number	Status	If ratified by India
1. Occupational Safety and Health Convention, 1981	C 155	Up to date	NO
2. Protocol of 2002 to the Occupational Safety and Health Convention, 1981	P 155	Up to date	NO
3. Occupational Health Services Convention, 1985	C 161	Up to date	NO
4. Promotional Framework for Occupational Safety and Health Convention, 2006	C 187 Up to date NO	Up to date	NO
5. Radiation Protection Convention, 1960	C 115	Up to date	Yes;17-11-75
6. Occupational Cancer Convention, 1974	C 139	Up to date	NO
7. Working Environment (Air Pollution, Noise and Vibration) Convention, 1977	C 148	Up to date	NO
8. Asbestos Convention, 1986	C 162	Up to date	NO
9. Chemicals Convention, 1990	C 170	Up to date	NO
10. Prevention of Major Industrial Accidents Convention, 1993	C 174	Up to date	Yes; 6-06-08
11. White Lead (Painting) Convention, 1921	C 013	To be revised	NO
12. Guarding of Machinery Convention, 1963	C 119	To be revised	NO
13. Maximum Weight Convention, 1967	C 127	To be revised	Yes;26-03-10
14. Benzene Convention, 1971	C 136	To be revised	Yes;11-06-91
15. Hygiene (Commerce and Offices) Convention, 1964	C 120	Up to date	NO
16. Safety and Health in Construction Convention, 1988	C 167	Up to date	NO
17. Safety and Health in Mines Convention, 1995	C 176	Up to date	NO
18. Safety and Health in Agriculture Convention, 2001	C 184	Up to date	NO
19. Underground Work (Women) Convention, 1935	C 62	Interim status	NO
20. Safety Provisions (Building) Convention, 1937	C 45	Out dated	Yes;26-03-38

society governed by capitalist forces lead citizens to think of immediate economic gains most of the times. People tend to decide considering the economic assumptions. The author is of the belief that however weak ILO may be it helps give fresh ideas from international community and create atmosphere in favor of instruments being discussed. Our labor organizations and public health organizations need to empower themselves to be able to generate reports on implementation of ratified ILO instruments on one hand and continue present arguments in favor of ratifying instruments which have not been yet ratified. It is slow process and would need a lot of volunteers and resources but that is the only peaceful way to attain what we aim for. ILO may not be as helpful to the workers in industrialized countries but it may be helpful to those in underdeveloped economies. Again, ratification may not be the sole criterion to judge workers' conditions in any particular country. Still, it may give some indication. Number of ILO instruments ratified by USA may be much less than even India or many other countries but national laws may be ahead than ILO instruments in protecting rights of the working population and conditions of workers may be much better than the workers in countries ratifying more instruments. If a national TU movement is stronger it may not wait for ILO instruments. In fact, we have examples where ILO has followed laws passed by some countries. Convention 155 is one such example. It was OSH Act in US that was passed in 1970 which was followed by UK in 1974 by enacting Health and Safety at Work Act. ILO followed this experience in 1981 to come up with Convention 155. ILO offers common platform to international experience and expertise which takes international community ahead. Representative employers' and workers' organizations play an essential role in the international labour standards system: they participate in choosing subjects for new ILO standards and in drafting the texts; their votes can determine whether or not the International Labour Conference adopts a newly drafted standard. If a convention is adopted, employers and workers can encourage a government to ratify it. If the convention is ratified, governments are required to periodically report to the ILO on how they are applying it in law and practice. Government reports must also be submitted to employers' and workers' organizations, which may comment on them. Employers' and workers' organizations can also supply relevant information directly to the ILO. They can initiate representations for violations of ILO conventions in accordance with procedures under Article 24 of the ILO Constitution. Employer and worker delegates to the International Labour Conference can also file complaints against member states under Article 26 of the Constitution. If a member state has ratified the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144), as more than 110 countries have done to date including India, it is obliged to hold national tripartite consultations on proposed new instruments to be discussed at the Conference, on submissions of instruments to the competent authorities, on reports concerning ratified conventions, on measures related to unratified conventions and recommendations, and on proposals regarding the denunciation of conventions.

Women as Workers - Sexual Harassment at Workplace

A Brief Note for the MFC Meeting, Feb 8-9, 2013

-Renu Khanna[1]

The workplace is a site where power inequalities play out, with implications on health of individuals. Sexual harassment is one specific form where gender inequalities play out. In India, the seminal Supreme Court ruling in 1997 in the Vishakha and Others vs Rajasthan, recognised, for the first time, sexual harassment at the workplace, and set out Guidelines on sexual harassment in the workplace and declared these Guidelines as constituting the law of the land until further action was taken by the legislature.

The definition of sexual harassment according to the Supreme's Court Order, is:

Any unwelcome: a) Physical contact and advances. b) Demand or request for sexual favour. c) Sexually coloured remarks. d) Display of pornography. e) Any other unwelcome physical, verbal or non-verbal conduct of a sexual nature.

Non-verbal conduct includes making unwelcome sexual gestures, suggestive or obscene letter, notes or invitations, displaying of sexually evocative objects or pictures/ pornography, cartoons or postures, indecent exposure in the workplace. Verbal conduct means making or using sexually explicit language, derogatory comments, remarks/jokes about women's bodies, suggestions and hints, graphic comments with sexual overtones, and/ or jokes, pressure for dates, obscene phone calls and making verbal sexual advances or propositions. Physical conduct relates to touching/brushing against a co-worker, assault, impeding or blocking movements, leaning over, invading a person's space or physical touch/contact.

The Supreme Court observed that gender equality includes protection from sexual harassment. The Court held that such conduct would constitute discrimination if a woman has reasonable grounds to believe that objecting to the conduct would disadvantage her in terms of her recruitment or promotion or if it creates a hostile work environment. Furthermore acts amounting to sexual harassment also include objectionable acts in the workplace that either humiliate the woman or threaten her health and safety.

The Guidelines are applicable to all Government and private sector organizations, hospitals, universities. They provide protection to all working women whether drawing salary, honorarium, or working in a voluntary capacity, whether in Government, public or private enterprise.

What has been the effect of the Vishakha Guidelines?

Review of Some Studies

Implementation of these Guidelines, however, is another story. Many public and private institutions have not established Complaint Committees or amended service rules. Few women are able to effectively translate guidelines to make workplace safer and gender equitable. Mechanisms for redress are seldom impartial. This is evident from some of the recent research reviewed.

A Population Council study of four Kolkata hospitals ("Sexual Harassment in the Workplace: Experiences of women in the Health Sector," by Paromita Chaudhri, *Health and Population Innovation Fellowship* (HPIF), Working Paper No. 1, 2006.) showed that 77 respondents (out of 135 women employees - doctors, nurses, hospital attendants, nonmedical staff) reported experiencing sexual harassment, 29 of these reported multiple experiences - psychological (45), verbal (41), touch (27), sexual gestures/exhibitionism (16).

The perpetrators were: doctors (41), patients and their families (42), senior nonmedical (24) and administrative staff (15) and others (11). Older doctors reported verbal harassment by senior doctors and consultants at times leading to their discontinuing their studies. Younger doctors said patients and their families abused them over perceived negligence. Nurses reported subtle and indirect harassment from doctors and those in positions of authority. An intern dentist said that a senior doctor 'in his 70s...' called her on the pretence of showing 'good books' which turned out to be pornography. A nurse reported that a senior consultant would call and say 'A private room is empty, why don't you come along?'

Power imbalances characterised the experiences of sexual harassment – doctors and administrators harassed other doctors, nurses, non medical staff. Nurses experienced doubled edged harassment, from doctors as well as from patients and families. Private nurses were the most vulnerable because they were non permanent staff.

Few sought redress – only 27 out of the 77 made formal complaints. When doctors were perpetrators there were less likelihood of reporting than if the perpetrator was any of the other. Out of the 27 cases reported, action was taken only in 10 cases, not in a single case against a doctor. The action taken was in most cases non confrontational, non systemic. Action was taken against a harasser if he was in a junior position to the woman who made the complaint – there was an example given of a complaint by a doctor about sexually explicit message in the women's toilet and the person punished was the cleaning staff! When the harasser was a senior doctor or a consultant, the management protected their interests – the example was of forcing the young woman who complained to resign.

Factors underlying non action by the 50 women out of the 77 who did not complain were related to:

Attitudes – they would be blamed for provoking the incident, fear of loss of reputation, a feeling that sexual harassment is 'normal', 'harmless', an 'occupational hazard'; Power dynamics – fear of dismal, loss of wages, blocking of promotion, victimisation in terms of undesirable duty hours, duty location; Lack of awareness of and confidence in complaint mechanisms - fear of confidentiality being compromised.

Another study in the health sector, "Sexual Harassment at Workplaces: Lessons from a Web based Survey" conducted by Mala Ramanathan et al (*IJME* Apr-June 2004), reported that they received 13 web based responses (actually they received 24 responses but 11 were frivolous/false/fabricated). The profile of women who are harassed is: young, relatively powerless women, PG students, field workers, contract employees.

[1]*Email: sahajbrc@yahoo.com*

The types of harassment that they reported ranged from physical contact, to sexually coloured remarks, demand for sexual favours, display of pornographic material. Most of the perpetrators were men in supervisory or senior positions, very few were co workers. About redress, the study reported that four of the 13 harassed said that either there were no institutional mechanisms for redress or they did not have any knowledge of these. Eight out of the 13 reported and resolved the problem – those who did complain did so after a prolonged period of self doubt. Complaints registered collectively rather than individually had a better chance of redress – for example, a professor was asked to resign after a group of PG students complained about sexual harassment by him. This study also brought out that redress was swift if the abuser was relatively powerless.

Oxfam India conducted an opinion poll on Sexual Harassment at Workplaces in India in 2011-12. Sixty six out of 400 respondents reported 121 incidents of harassment, 102 out of the 121 were non physical and 19 were physical. The three top categories of workers who felt most unsafe were: labourers (29%), domestic help (23%), those in small scale manufacturing (16%). Majority of the respondents felt that women in the unorganised sector were most vulnerable to sexual harassment. 26% respondents reported to be the sole earning members in their families and said that economic vulnerability made them vulnerable to harassment at workplace. The reasons that women gave for not taking action were – fear of losing their jobs, absence of complaint mechanisms, fear of getting stigmatised, not being ware of redress mechanisms. Respondents (80%) felt the need for separate law for dealing with sexual harassment at workplace.

Criticisms of the Vishakha Guidelines

The limited amount of evidence that is available, shows that the Complaint Committees have not been appropriately constituted by employers, they do not meet regularly, records are not kept. Patriarchal attitudes prevail and prevent sexual harassment from being considered as a serious offence. The internal grievance mechanism is vaguely defined in the Guidelines and leaves room for manipulation. Workers in the unorganised sector - the bulk of the work force - are left out of the purview of the Guidelines and are deprived of a formal system of redress for sexual harassment at workplace. While labour laws provide safeguards which protect an employee from termination or any other discrimination during the course of any dispute, these safeguards do not extend to cases of disputes relating to sexual harassment. This means that women are often reluctant to bring a claim for fear of the repercussions.

Sexual Harassment at Workplace (Prevention, Prohibition and Redressal) Bill, 2012

This Bill drafted by the National Commission for Women in 2005 and subsequently revised in 2007 and then 2010 finally passed muster in the Lok Sabha in September 2012. It is being lauded for the contents of the Preamble which states that sexual harassment is a violation of a women's fundamental rights to equality and life and that women have a right to a safe work places, free from sexual harassment. The Bill lays down a uniform procedure for conducting enquiries into complaints of sexual harassment across a very wide range of employers including the Government, armed forces, private organized sector as well as the unorganized sector. It envisages that every workplace, whether organized or unorganized, should have a forum to take up complaints pertaining to sexual harassment. It also defines 'aggrieved women,' bringing students, research scholars, patients and women in the "unorganized sector" within the ambit of the sexual harassment law. The Bill makes a specific provision for the inclusion of the unorganized sector through the setting up of a Local Complaints Committee (LCC) which is to act as a redressal mechanism outside of the workplace. An LCC would be set up whenever it was not possible to set up an Internal Complaints Committee and would be set up by the district officer at the block level. The Court can impose a fine of no less than Rs 10,000 on any workplace which fails to constitute either an Internal Complaints Committee or LCC (if applicable) or which fails to initiate action within a reasonable time upon a complaint being lodged alleging sexual assault.

An Alternative View....

Ratna Kapur in an Op Ed in *The Hindu* (September 14, 2012), while welcoming the Sexual Harassment Bill which upholds women's fundamental rights to equality and safe work spaces, raises some interesting issues. She points out '*....in its zeal to provide an enabling environment for women in the workplace, the legislature has cast the net very wide — sexual gestures, offensive remarks, lurid stares, embarrassing jokes or unsavoury remarks might be among the litany of conduct and expression that could be caught by the new law. The central question is whether we want the heavy hand of the law to block the lurid stare or suppress the sexual joke, which may be somewhat embarrassing to some? Should embarrassment and shame on the topic of sex inform how we regulate sexual conduct in the workplace and elsewhere?*' She makes a point that sexual rights, including the right to sexual expression may be compromised in a society which is repressive. Her second point is that while proving that a comment or gesture was 'unwelcome', there is a danger that a woman's way of dressing, or past intimate relationship with a colleague in the workplace may be used to determine whether the conduct was welcome or unwelcome. She cites existing case law and states that a woman's dress, conduct and even profession – bar room dancers, waitresses, performers - may be used to disqualify a claim of sexual harassment. Ratna ends her essay by stating '*Sexual harassment is a serious problem and the new act marks an important step in recognising a concern that affects most women. But there is a need for courts as well as rights advocates to ensure that women's rights to equality in the workplace are not secured through the regulation of sexual conduct, muzzling of sexual speech, or moral surveillance of women's lives. Such strategies have historically only perpetuated sexual stereotypes, sexual orthodoxy, and compromised on women's fundamental rights*.'

The recent film 'Inkaar' by Sudhir Mishra brings out some of the issues that Ratna talks about – what comprises sexual harassment in different cultural contexts – like advertising firms where sex and sexuality are actually used to sell products? Or, where sexual terms, jokes and so on, are part of everyday language of not only men but also women? What is the fine line between flirting and sexual harassment?

These nuances and dimensions then need to be considered while framing codes of conduct to uphold women's rights as workers.

Women's Work and Bone Health

Veena Shatrugna, et al.[1]

The two papers discussed here are part of the larger work on women, work and bone health done at the NIN (2005 and 2010). I have summarized the papers, and the original papers are uploaded at the Annual Meet 2013 background papers folder at the mfc website, for those who would like to read them.

The two studies highlight the problem of poor bone health of women from the low-income group, engaged in repetitive work. Load-bearing occupational activities were not associated with better bone health probably due to the absence of adequate nutrition. In fact repetitive bone loading work resulted in early onset of osteoporosis at the vertebrae. It also raises important questions regarding the role of nutrition and specially low calcium high cereal-based diets (which are acid producing, and remove calcium from the bone) for women workers, in whom osteoporosis sets in as early as 40 years of age.

Paper 1

Veena Shatrugna, Bharati Kulkarni, P. Ajay Kumar, K. Usha Rani, N. Balakrishna. "Bone status of Indian women from a low-income group and its relationship to the nutritional status." *Osteoporos Int* (2005) 16: 1827–1835.

It is well known that women from the low socio-economic groups in India have osteoporosis and hip fractures 10-15 years earlier than western women. Their mean age of osteoporotic fractures is around 59 years compared to 75 years in the west. (See, Shatrugna V, et al (1990) Back pain: the feminine affliction. *EPW*, 25:WS2–WS6; and Shatrugna V (1998), "Osteoporosis in the Asian region: newer questions." In: Shetty P, Gopalan C, Eds (1998). *Diet, Nutrition and Chronic Diseases.* Smith-Gordon, UK, pp 81–83).

What is osteoporosis?

Osteoporosis is bone thinning, the bone is normal in osteoporosis, but there is less bone in the bone.

Every osteoporotic bone may not result in a fracture, but it may be the cause of bone pains, back pain and other so called non specific symptoms.

How do we reach the maximal Bone Mineral Density also called peak bone mass?

Bone growth and formation takes place during childhood and adolescence, but further mineral deposition may continue till the age of 30 years reaching the peak **Bone Mineral Density (BMD)** at 30 years. The BMD plateaus for 10-15 years and then bone loss starts with age related changes.

The following are essential for reaching Peak Bone Mass:

Nutritional status of children is important, Children who have adequate intakes of good quality protein (milk etc.), calcium and multiple vitamins and minerals have a better BMD. In addition bone loading exercises like walking, jogging, jumping, help stimulate bone accretion. These **bone loading exercises** prevent bone loss at older ages. A normal body weight works like a bone loading stimulus. A good **Muscle mass** also helps bone density by its push and pull action on the bone, during walking or exercising

Why do we get Osteoporosis?

If a person has not reached an optimum BMD during adolescence, then the normal age related losses after 40 years may result in early osteoporosis. Other factors are inadequate nutrition specially low calcium intakes, low body weights, poor muscle mass, absence of bone loading exercises, early menopause to name a few, Chronic use of drugs like steroids, anti epileptics, anti TB drugs etc. can also hasten osteoporosis.

How is osteoporosis diagnosed?

Experienced radiologists can read osteoporosis from an X-ray film, but grading the extent of bone loss is difficult on the x ray. Now a DXA scan is considered a gold standard.

Criteria for diagnosis of Osteoporosis (WHO)

T score – Deviation of a person's BMD (in terms of SD units) from a reference population of normal young adults

- Normal: T score above –1
- Osteopenia: T score between –1 and –2.5
- Osteoporosis: T score at or below –2.5
- Severe osteoporosis: T score –2.5 or lower in the presence of 1 or more fractures

A study was carried out in 289 women from the low socio economic group. Their mean height, weight and body mass index (BMI), which are important indicators of the nutritional status, were 149.1, 49.2kg and 22.1 respectively. The mean parity was 3.3. Of these, 119 (41%) women were postmenopausal and 170 (59%) were premenopausal. The mean age at menopause was 40.8 years, in postmenopausal women.

[1]*Email of corresponding author: veenashatrugna@yahoo.com*

Table 1a: Mean Food Intakes (gm)

Food group	Intakes (gm/day)	Recommended Dietary Allowances (Least cost diet)
Cereals Millets	367	440
Pulses	22.3	40
Oils	23	40
Milk and milk products	62	150
Green leafy vegetables	11	60
Fruits	31	Nil
Flesh foods	7.0	Nil
Fish	0.3	Nil
Sugar	26	30
Other vegetables	57	60
Roots	31	50
Nuts Condiments	14.7	Nil

Table 1b: Nutrients Intakes (Mean)

Nutrient	Intakes	RDA
Energy(Kcals)	1,776	2,225
Proteins (g)	37.3	50
Fat (g)	26.0	30
Calcium (mg)	270	600
Phosphorus(mg)	842	
Vitamin A (ug)	208	950
Thiamin (mg)	0.5	1.1
Riboflavin (mg)	0.5	1.3
Niacin (mg)	9.2	14
Iron (mg)	6.8	30
Folic acid(ug)	35	100

They subsisted on a cereal based diet with little protective foods like milk, fruits, vegetables, meat, fish etc. They had deficient intakes of all nutrients such as calories proteins, vitamins and minerals (Table 1a and Table 1b). These women were employed in the non formal sector such as Beedi and agarbatti makers, sweepers, construction workers, vegetable vendors, dhobis, petty shop owners, domestic helpers etc.

Attempts were made to study the relationship of age, nutritional status (Weight & BMI) and menopause with early onset of osteoporosis.

Age - When women were divided into the different age groups, it was clear that the mean T-score at the spine was in the osteoporotic range as early as 45 years of age (T-score < - 2.5), however osteoporosis set in after >55years at the neck of femur (Table 2)

Table 2: T-Scores at Neck of Femur and Spine by Age

Age (yrs)	<35	35-45	45-55	>55
Neck of Femur	–1.33	–1.69	–2.15	–3.05*
Spine (L1-L4)	–1.64	–2.14	–2.78*	–3.63

Weight - When women were divided into the different weight groups, the spine was osteoporotic at a body weight of 40-45 Kg, however in the case of neck of femur, osteoporosis sets in only when the body weight is below 40 Kg (Table 3).

Table 3: T-Scores at Neck of Femur and Spine by Weight

Weight (Kg)	<40	40-45	45-50	50-55
Neck of Femur	–2.45	–2.31	–1.93	–1.56
Spine (L1-L4)	–2.85	–2.58	–2.38	–2.06

BMI - Women are osteoporotic both at the femur and spine when they have BMIs below 18.5 (Table 4). This goes hand in hand with the data on weight.

Table 4: T-Scores at Neck of Femur and Spine by BMI

BMI	<18.5	18.5 -23	>23
Neck of Femur	–2.45	–2.02	–1.31
Spine (L1-L4)	–2.77	–2.39	–1.94

Menopause - Women who menopause have osteoporosis setting in very soon (Table 5), specially at the spine.

Table 5: T-Scores at Neck of Femur and Spine by Menopause Status

	Women without Menopause	Women with Menopause
Neck of Femur	–1.62	–2.09
Spine (L1-L4)	–1.98	–2.61

Conclusions: It is important to recap that the mean adult weights of women from the rural areas is around 44 Kg, and 35% of them have BMIs which are less than 18.5. They also menopause early (40-45 years). Indian women from the low-income groups (urban and rural) consume diets that have inadequate calcium (270 mg per day vs RDA of 600 mg to 1 gm) coupled

with too few calories, poor quality proteins and have many vitamin and mineral deficiencies.

In the multiple regression analysis, apart from body weight, age, menopause and calcium intake were the other important determinants of BMD ($p<0.05$). In addition to the above, as expected, height was an important determinant of Whole Body mineral content (WB-BMC), because height provides the necessary volume for mineral storage. In fact the peak WB-BMC should be around 2400 gm, however women from this group have WB-BMC of only 14-1600 gm (see paper).

This study highlights the serious consequences of under nutrition defined in terms of weight, height, BMI, low calcium intakes with multiple nutrient deficiencies on the bone health of women from the poor socio economic group. Osteoporosis and bone thinning sets in by the age of 40+ itself which may explain the early onset of fractures. Bone health is expensive to monitor, and more difficult to treat, and by the time osteoporosis and fracture sets in, the condition is irreversible.

Paper 2

Veena Shatrugna, Bharati Kulkarni, P. Ajay Kumar, N. Balakrishna, K. Usha Rani, G. Chennakrishna Reddy and G. V. Narasimha Rao. "Relationship between women's occupational work and bone health: a study from India." *British Journal of Nutrition*, (2008), 99, 1310–1315.

Table 6: Background information of the women (BM, S, CW)

Number	158
Age	40.4 Yrs
Weight	48.0 Kg
Height	148.6 cm
BMI	21.6
Parity	3.1
Post Menopausal	41.4%
Daily Calcium intake	304 mg/day

Table 7: Prevalence of osteoporosis (T-score, < 2.5) by occupation of women (%)

Occupation (N)	Femoral Neck	Hip	Spine
Beedi Maker (53)	28·3	22·6	26·4 [a]
Sweepers (52)	25.5	23.5	57.7 [b]
Construction worker (53)	32·1	20.8	49.1 [b]
Total (158)	28·7	22·3	44·3

(N) Number of women. a, b values in a column with unlike superscripts are significantly different. ($p<0.05$)

The results of the above study (Paper 1) confirmed the fact that osteoporosis sets in by the age of 40-45 years in women from the low socio economic group. We next addressed the impact of their work in the non-formal sector on their bone health. It is known that exercise and other bone loading exercises improve mineral accretion in the bone. The present study investigated the relationship between occupational activities and their bone parameters measured by dual-energy X-ray absorptiometry in 158 women from a low-income group. Three groups of women were selected who worked as Beedi makers (BM), Sweepers(S) and Construction Workers (CW) since over 5 years. Their background details were comparable and therefore the information has been pooled in Table 6.

Summary: Women involved in three occupations with different bone-loading patterns (beedi makers, sweepers and construction workers) were included in the study. Bone mineral density (BMD) values of the overall group at all the sites were much lower than those reported from developed countries.

Femoral neck and hip - It was expected that standing and walking would improve the BMDs at the femoral neck and hip in construction workers and sweepers. The BMDs were not different in the three groups in spite of marked differences in activity patterns. However, bone area in the femoral neck was higher in the beedi makers compared with sweepers probably due to the squatting position adopted by beedi makers.

Lumbar Spine - Beedi makers had significantly better lumbar spine BMD when compared with the sweepers. The sweepers and construction workers had a higher prevalence of osteoporosis in the lumbar spine. Normally activity and weight bearing is beneficial for bone health, but in the absence of calcium and other nutrients repetitive work which is bone loading worsens the already thin bones. However, prolonged weight-bearing due to a squatting without movements seems to helps the upper body and is associated with better BMDs.

The present study thus indicates that long hours of repetitive work which involves weight bearing (bone loading) might adversely affect bone parameters in undernourished women.

The present study highlights the problem of poor bone health of women from the low-income group engaged in repetitive work. Load-bearing activities were not associated with better bone health probably due to the absence of adequate nutrition. It also raises important questions regarding the adequacy of cereal-based diets (which are acid producing, and remove calcium from the bone) for women workers in whom osteoporosis sets in as early as 40 years of age.

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MFC Convener

Convenership: Sunil Kaul, Jennifer Liang, Raju Narzary and Shelley Dhar. Address for contact : the ant, Udangshri Dera, Rowmari, P O Khagrabari, via Bongaigaon
Dist Chirang (BTAD), Assam 783380
Email: sunil@theant.org
Ph: 094351 22042 (m) 03664 293803 (r)
the ant Office: 03664 293802
MFC Website: <http://www.mfcindia.org>

Editorial Committee: Anant Bhan, Dhruv Mankad, Devaki Nambiar, Sukanya Rangamani, V.R. Raman, Mira Sadagopal, Shelley Saha, C. Sathyamala, Sathyashree, Mira Shiva and 'Chinu' Srinivasan.
Editorial Office: c/o. LOCOST, 1st Floor, Premananda Sahitya Bhavan, Dandia Bazar, Vadodara 390 001.

Email: chinusrinivasan.x@gmail.com. Ph: 0265 234 0223

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