Informal workers and the use of mobile technology and communications:
Findings from key informant interviews




WIEGO
Women in Informal Employment Globalizing and Organizing

VITAL WAVE℠

mHEALTH ALLIANCE

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Acronyms

AeT	Asiye eTafuleni (Zulu for "come to the table"), an NGO in the inner city of Durban, South Africa that supports trader organizations
ARB	Association of Wastepickers of Bogota, capital city of Colombia
HNSA	Homenet South Asia, the regional organization of home-based workers in South Asia, based in Ahmedabad, Gujarat state, India
HNT	Homenet Thailand – an umbrella organization for home-based workers and contract agricultural laborers, headquarters in Bangkok, with centers in the north, east and south-east of Thailand
KKPKP	Kagad, Kach, Patra, Kashtakari Panchayat, a trade union of some 4000 waste pickers in Pune, Maharashtra state, India
SEWA	Self Employed Women's Organization, working in 13 states of India, with more than half of its more than one million members in Gujarat state
SNI	Streetnet International, the international umbrella body for street traders and market vendors. There are regional organisers, one of whom is in West Africa (SNI-WA)
UFBA	Federal University of Bahia, Salvador City, Brazil, where the Institute of Collective Health has a Program of Environmental and Workers Health
WIEGO	Women in Informal Employment: Globalizing and Organizing, a global research and advocacy organization, which has consolidated its work in two focal cities, Accra (Ghana) and Lima (Peru)

Other acronyms

HBW	Home-based worker
MBO	Member-based organization
NGO	Non-governmental organization
NHIS	National health insurance scheme
OHS	Occupational health and safety
PHC	Primary health care
SUS	Brazilian health department

1. Introduction: Aims, method and sample

This short study was done as one component of the overall collaborative work being done by Vital Wave and the mHealth Alliance, in collaboration with WIEGO. The aim of that project is to explore how mobile phones are being used, and might be better used, to improve the health of informal workers. The findings reported here are from a rapid survey involving key informants in ten organizations (identified in the Acronyms and Brief Description of Organizations on the previous page). They were from member-based organizations (MBOs), international alliances of MBOs, non-governmental organizations (NGOs) supporting MBOs, WIEGO co-ordinators of city level work, and a workers' health programme within a university department of public health. All of these have a commitment to supporting very poor informal workers.

The study explored their involvement in health education, health campaigns, access to health services, and health insurance. It identified existing and planned modes of communication between organization leaders and members, and within regional and national alliances. It investigated in particular the use of mobile phones in health-related work and activities.

Interviews were conducted via Skype and lasted about an hour each.

2. Sample profile

Information is presented here on the workers in the organization, or in the worker population served by the organization giving the interview.

Sex: One organization (SEWA) works exclusively with women. Two (ARB and AeT) work with both women and men about equally. The remaining ones work mainly with women, but with some men as well.

Socio-economic status: All of the organizations purposely focus on poorer informal workers. Within this, globally, the waste pickers are the poorest group.

Type of occupation: Three organizations work with or in a variety of occupational sectors (WIEGO in Lima and in Accra, HNSA in South Asia). Three work exclusively with street and market vendors (SNI globally, and in West Africa, and AeT in Durban, South Africa), two work exclusively with waste pickers (KKPKP in India and WIEGO with ARB in Bogota), one works with home-based workers (HBWs), and one with both home-based workers and contract agricultural workers (Homenet Thailand - HNT). Home-based work contains great diversity: HNSA partners for example include garment workers, weavers, shoemakers, football makers, food processing, chemicals, production of jewelry, surgical instruments, and traditional paintings, bidi (cigarette) rollers, incense stick rollers and forestry workers, among others.

Geographical area: All except two work only in urban areas. Two MBOs – SEWA and HNT – also work in rural areas, as do some partners of the regional HNSA.

Cell phone possession: There is a very high estimated ownership or usage of mobile phones among informal workers. Most said all or nearly all had them; in three cases interviewees said that all would have at least one member of the family with a cell phone, even if only about half of the workers themselves would have one in their own possession. Multiple cell phone ownership by individuals was reported in Accra and Lima. More detail is given about usage later in the report.

3. Communication with members

3.1 Reaching out, organizing

Interviewees were asked how members made contact with the organization in the first place, and how communication was maintained:

- The most common way, across all organizations, is face-to-face contact: word-of-mouth or visiting people where they work or live are the most important.
- Using organizational structures (where organizations were local and well organized) is a key method of getting messages to people. This was notably the case for AeT, HNT, KKPKP, SEWA, WIEGO in Lima and, to a lesser extent, in Accra.
- Mobile phones (which will be discussed in Section 6) are frequently used for organizing meetings. The voice function is used a lot in reaching out to members, but text much less so, as text messages are unreliable – one person pointed out the unreliability of text messages (no certainty that a message got through).
- There was limited mention of additional means such as emails (which were not reliably answered, and were expensive), direct landline calls (which were expensive except in Ghana), newsletters, and mentions of posters, fliers and loudhailers when organizing campaigns.
- Two interviewees – the WIEGO focal city coordinators in both Lima and in Accra – have promoted the interests of informal workers through the national media such as TV and radio, and find this to be important in making contact with informal workers beyond their immediate area.

3.2 Communication challenges

- The expense of time and travel in order to meet face-to-face.
- The expense of phone calls, though this is decreasing in some places.
- The timing of visits to homes and to places of work, given the long hours that many informal workers work. 'You have to be where they are, at a time when they can listen to you' (SEWA interview, 13th March 2014).
- Language was mentioned as a barrier in different ways. Writing text in a local language can be time-consuming; the local language may need a different kind of script, for text messages. The regional organization, HNSA, working in South Asia, finds that language is the greatest barrier. In Asia, each different country has a separate language, and English is not widely spoken. This is not the case for example in South America, or in francophone West Africa.
- Electricity breakdowns interfere with telephones, and with battery recharging.
- Attendance at meetings, when a) it interferes with earning time (time away from the street is potential income lost) and b) in a city like Durban, a by-law states that street vendors may not leave their stalls during working hours.

4. Health-related activities

4.1 Health insurance

Two organizations directly operate health insurance schemes:

- KKPKP, the waste pickers union in India, runs insurance in collaboration with the Pune municipality. Around 4,000 workers belong to this.
- SEWA in India has its insurance scheme VimoSEWA as an important component of its work. It offers an integrated insurance package of life, hospitalization and asset insurance. It has built up the scheme over some thirty years; the organization is constantly trying to reform and improve its products as the work process changes. Membership of VimoSEWA is voluntary for SEWA members, and more than 200,000 of SEWA's more than one million members belong to it.

WIEGO in Accra and in Lima have assisted informal workers to get access to Ghana and Peru's national health insurance schemes. In Accra, registration drives were held with the marginalized women headload porters (kayayei), with about 4,000 registering over a few days. A follow-up monitoring study was being done at the time of interview.

The SNI-WA organizer reported that affiliated organizations in Togo have started a health insurance scheme, MUPROSI, and organizations in Senegal are lobbying for a health insurance scheme. Interviewees in Thailand and Brazil said that health insurance was not necessary given that there was free universal health care.

4.2 Direct provision of health services by the informal worker organization

SEWA was the only organization to provide health services directly, in the form of a network of 400 health promoters, and a further group of *dais* (traditional birth attendants). The health promoters do occupational health and safety, provide low cost medicines (allopathic and ayurvedic), health awareness, and a referral service when members need a higher level of care. SEWA is considering a move to focus more on mental health, using barefoot counselors, taking into account the high levels of stress amongst working women and their children.

When a *dai* visits a woman who goes into labor, she phones a doctor or other health professional in SEWA's network of 'friendly providers', giving them warning that the woman is about to arrive at the health services, making an appointment for her, and asking that the health services watch out for her. Under the national government's 'safer motherhood' program, the *dais* encourage the delivery of babies at the health services, and they get a small financial incentive for taking the women in labour to the health services.

The Environmental and Workers Health Program at UFBA in Brazil collaborates with the national health department of health, the SUS, in training Community Health Agents to visit HBWs, to assist these workers to identify hazards and risks in the home, and how to monitor injuries.

4.3 Assistance to access health services provided by others

A number of organizations (HNT, SEWA, WIEGO in Accra and Lima, KKPKP) played a bridging role between their members or affiliates and public health services, and this was a major plank in their health education work.

4.4 Occupational health and safety

The health discipline of occupational health and safety (OHS) reaches only formal workers in formal workplaces, and a critical issue in promoting informal workers' health is to push that discipline – its concepts and curricula, and its regulatory and institutional practices – to be more inclusive of all workers and workplaces. The majority of those interviewed (six out of ten) had done or were doing work on occupational health and safety for informal workers (this would be higher than in a general sample of informal workers organizations, because of WIEGO's interest in the area).

- **Training:** AeT, WIEGO in Accra, and the Environment and Worker s Health at UFBA, have offered training in OHS to traders (AeT and WIEGO in Accra) and to HBWs (UFBA and HNT).
- **Tools for identifying risks and hazards:** WIEGO in Lima, UFBA, and WIEGO and AeT in partnership, have developed or are developing participatory techniques for identifying and mapping risks and hazards in various types of workplaces.
- **Workplace improvements:** There have been direct interventions, such as HNT's active collaboration with hospitals to improve work-place conditions for HBWs (ventilation, lighting, and personal protective equipment, for example).
- **Design of equipment:** Three of the organizations have done innovative work in the design of equipment, involving the participation of workers themselves. This is done for the health and safety of workers, and also explicitly to try and increase productivity. KKPKP and AeT have worked with waste pickers on carts for transporting waste that can be managed by workers, and KKPKP has done intensive work on sorting sheds, and on gloves and sickles for the collection from dumps. SEWA has invested a lot in working with Indian institutes of design on a variety of products – tables for incense stick rollers and for embroiderers, agricultural implements that suit women, for example
- **Policy reform:** WIEGO in Accra and Lima, UFBA, KKPKP, HNT and SEWA work actively to promote the expansion of OHS, as well as public health and environmental health, to include informal workers and workplaces.

4.5 Health education

Health education was seen by a number of organizations both as important in its own right, and also as an organizing tool. Three were directly involved.

AeT has run diagnostic and preventive health camps in the heart of the city of Durban. It has also done first aid training with a group of about 20 trader leaders. Funding has been received (from The Rockefeller Foundation) by WIEGO to work in collaboration with AeT on a 'Safer, Healthier Warwick Junction' pilot project, which will lead to the development, by traders and officials, of a zonal risks and hazards map, and a strategy for disaster management.

For some years, HNT has been active in promoting occupational health and safety for its HBW organizations. It has worked in collaboration with local hospitals to develop improved safety conditions in workers' homes – for example around ventilation, lighting and work equipment. HNT has been active in policy reforms in Thailand. It integrates into its health education the basic rights and entitlements of informal workers to health services. Furthermore, every year it submits to the Thai national health department its recommendations from worker organizations, on areas where health services need to be improved. This feedback to government is seen as integral to the idea of health education.

India's SEWA has health education as a major plank of its overall commitment to better health for its members. They use pamphlets, posters, videos, diagnostic camps and campaigns to supplement the personal interaction with members and non-members. SEWA has experimented with a toll free phone line for reproductive health, and the development of a portal where younger people can use a touch screen to ask intimate questions about reproductive health across the life cycle. Both these interventions were very popular.

KKPKP, and WIEGO in Accra, both said they do health education only through informal discussion, or through occasionally organizing health education experts to come in.

4.6 Campaigns

Interviewees were asked if they had run specific health campaigns over the last five years. Very interesting examples were presented.

- AeT ran an eye care diagnostic camp, as well as a primary preventive health care camp, with tests for blood pressure, glucose, and HIV.
- SNI-WA has supported HIV campaigns in Congo and Togo.
- WIEGO in Accra and in Lima did the registration drives for informal workers to join the national health insurance scheme (NHIS).
- Homenet Thailand is currently involved in a campaign against the government's attempt to revert back to a paid 30 baht health system, after the move only a decade ago away from the 30 baht system towards proper free universal health care. A big majority of doctors and nurses are in favor of keeping the current system. Homenet Thailand was one of the network of nine organizations involved in the move to free universal healthcare, which brought benefits to informal workers.
- KKPKP had a major primary health care and eye care screening in 2008 and 2009 of 4,000 people – then 60 percent of its members.
- SEWA has had a recent preventive campaign around jaundice and hepatitis.
- SEWA had a campaign around the rational use of drugs – promoting awareness of the misuse, in the health system, of injections, drugs and drips.
- SEWA is presently campaigning against malpractice in the recently introduced national health insurance RSBY, which has provided a financial incentive to doctors to perform unnecessary surgery; SEWA is especially concerned about unnecessary hysterectomies on younger women.

- UFBR had a campaign to raise awareness about reporting home-based work-related injuries to emergency services.

4.7 Challenges to health education and to campaign work

- Perhaps most importantly, health education is not a once-off intervention – there is a need for awareness and education to be reinforced and reiterated a number of times and in a number of ways.
- There may be a great lack of knowledge in the general population, including poorer and sometimes less educated workers, about simple health issues and diseases, as well as stigma towards particular health conditions (such as TB and HIV/AIDS).
- At the same time, the health conditions may be structurally caused, and beyond the ability of poorer individuals to affect the situation:

  'In one industrial city in Pakistan where our partner organization works, the water is contaminated with industrial effluent, and 85 percent of women age 30 to 37 in the low-income area have hepatitis B. They continue with their home-based work because they have to. It is painful just to talk to them, to understand the scale of this problem. The water supply has to be made safe – this has to be an industrial solution.' (HNSA interview, 16th March)
- In Durban, a city by-law prohibits informal street traders from leaving their stalls. This prevented informal workers from attending the diagnostic camp.
- In Bogota, the low self esteem among some waste pickers is related to a poor quality of self care, a kind of 'immediatism', which in turn leads to avoidance of health education.
- In Brazil, local area violence led to field workers being unable to do their work.

5. Data collection

Interviewees were asked whether they collect data in relation to their work, and if so, who collects it, where, and who analyses it. There were very varying answers:

- 'No we don't': SNI-WA, WIEGO in Lima and Bogota
- 'No we don't but we should and we would like to': HNT
- 'Yes we do – studies in relation to assessing impact of programmes': AeT on first aid training, and KKPKP on the insurance scheme and on work injuries. KKPKP was collecting data on OHS, and said:

  'It is expensive to have staff allocated to collecting data specifically, but if you want good consistent collection this is what you need. Our regular activists struggle: many of them are also poor, and are not comfortable collecting data. When there is other work to do, collecting data seems secondary compared to immediate concerns. They fill out forms badly, they get units wrong.' (KKPKP interview, 12th March 2014)

- 'We have manually collected mountains of data': SEWA collects data on, for example:
  - Numbers attending health education sessions
  - The level of retention of messages from these sessions
  - Numbers who come to camps, get referred to health services, and what happens to them then
  - Data on TB - which is a big problem amongst SEWA members
  - Amounts and types of medicines being sold by the health promoters
  - Numbers of members who have been helped with access to RSBY (India's relatively new national health insurance scheme).

SEWA spoke of the need to systematize the data it has, and knows it needs assistance with knowing how to use it (from collection, to interpretation, to using it via simple graphs and visualization): 'We are good at telling stories about workers' lives, but we need to add numbers to this as well.'

The data is collected by SEWA at local level. The older health promoters are not formally well educated, and some find data collection difficult. The younger members are very switched on to technology (more later). SEWA is exploring the use of hand held tablets, where the data is transferred to a central place in real time.

WIEGO as a global organization runs small and large surveys frequently. The Informal Economy Monitoring Study (IEMS) is a ten-city study (which includes Accra, Lima and Bogota) investigating the driving forces affecting the informal economy for homebased workers, street and market vendors, and waste pickers. The first round of qualitative and quantitative interviews and focus groups has been completed (see WIEGO website). There is rich information on the impact of local government investment in infrastructure such as sanitation, storage, water, and on the productivity and health of informal workers in all sectors studies.

6. Members' and organizations' use of mobile phones

As noted earlier, there is a very high estimated ownership or usage of mobile phones among informal workers. Interviewees noted that ownership was high even among the very poor. Where informal workers themselves did not own a mobile phone, then there would surely be access through a family member.

Mobile phones were used by the organizations and their members for many work-related purposes: to inform about meetings, to find out about prices, to inform about opening hours and special bargains, to warn of impending evictions, among others. In Bihar state in India, mothers had been taught by their children how to use the mobile phone so that they could be in touch with their absent husbands who were migrant laborers.

Voice: Informal workers and the organizations use mainly the voice function. As someone summed it up: 'The voice function is comfortable, convenient and clear.' The exception was AeT staff who have to communicate with market leaders in the busy and extremely noisy Warwick Junction markets. The noise gets in the way of hearing the phone and so text is often used, with the text alert itself being difficult to hear (there is a good argument to try and mount a 'lower-the-noise' campaign – mainly from very loud music being played in multiple stalls - in this set of markets). Voice calls were said to be affordable in Accra and Pune, and still expensive in Lima. In Accra, mobile phones were used to follow up on the registration drive for the headload porters:

> 'In order to do the monitoring study [following the registration], we contacted the workers who registered on the scheme through the cellphone numbers they had given the NHIS registration people. We organized meetings, and then interviewed them face-to-face. However, there was a problem with this: the women are often shy. They will only register the number of their boyfriends and/or husbands so that you have to go through the men first before you speak to the women.' (WIEGO Accra interview, 11th March 2014)

Texting: This is used far less than voice, and more by younger workers. Two people pointed out that its lack of use is not necessarily because people are not literate, but because they are slow to write. It just takes too much time, according to respondents. Organizational leaders use texts for organizing meetings, and to remind people for example to make their insurance contributions. Voice is used to take up individual members' issues and problems.

An interesting example of the use of texting comes from the waste pickers organization ARB in Bogota:

> 'Since the recognition of waste pickers as service providers in the collection and transport of recyclable waste for the municipality, approximately 4,700 of waste pickers in Bogota are enrolled in a single payment program every two months. Payment is set according to the amount of material they have collected and transported in those two months, as calculated by one of the 250 collection centers that are authorized to register this information. Payments are made into a bank account by the municipality, and the waste picker manages the account from his cellphone. This in turn has meant that the recyclers now have cellphones, take care of them and learn to handle them, whereas before they didn't really know how to.' (WIEGO Bogota interview, 14th March 2014)

A good example of the mixed use of voice and text comes from KKPKP, in its study of why workers are absent from work. Data on 'absenteeism' among informal worker are very scarce, and statistics on work-related injuries are very rare. As part of their work on occupational health and safety, KKPKP maintained a database on reasons for waste pickers being absent from work:

> 'Activists would go to the workplace of a group of workers, find out who was not at work that day, and phone the workers to confirm their absence and find out why. The activists would then send a text message to the office, giving us the data. But we have had to lay off a lot of staff. We only have 10 staff members left, whereas before we had 100 in the field, with activists keeping in touch with the workers all the time. Other things have to take priority.' (KKPKP interview, 12th March 2014)

Internet (Facebook, web browsing etc.): Almost no use is made of this, apart from some younger members in Lima and Bangkok. The chief barriers are lack of Internet access, the expense of Internet, and the expense of smartphones (in India where an informal worker's income might be 100 rupees a day, it would take 80 days of income to afford a smartphone).

Filming: Leaders of ARB waste pickers in Bogota have repeatedly used mobile phones to film the statements of government on issues of interest to waste pickers, and these clips are shown in meetings and assemblies. They also record the abuses by police. The mobile phone is thus useful for real time reporting and advocacy.

7. Exploratory initiatives and future potential

There was much enthusiasm about the potential of mobile phone technology and other IT, but it remains generally expensive if pushed beyond using it for voice messages. It was pointed out that many informal workers have old models of phones, which cannot be used to download pictures. Nevertheless, there have been and are exploratory initiatives which are potentially scalable:

- Free phone call-back system for information on reproductive health.
- The portal for reproductive health.
- Reminders to individuals about the need for immunizations.
- HNT is piloting the use of mobile phones and smartphones for health policy advocacy.
- A number of organizations are using, or seeing the potential for using, mobile phones to inform members of their rights and entitlements to health, and the processes needed to address their issues via their rights – for example as the bridge to health services.
- Community health workers use phones to extend and improve their referral care.
- Community health workers to assist HBWs with identifying risks and hazards in their work environments, and how to address them. Programs designed to assist formal workers to do their own risk assessments in factories (random 'internal auditing' mentioned by UFBA; also decibel measuring at workplaces) could be reviewed for their relevance to and implementation by informal workers.
- Field workers using hand held tablets for data collection.
- Monitoring the access by informal workers to public health services, with the aim of ensuring that delivery happens, further than 'pious paper policy statements'.
- Phoning in on practices of bribery and corruption within the health services.
- Affordable mass-based voice messages to inform members about meetings, major events.
- The use of mobile phones to effect payments of workers who are under contract.
- Improvement of statistics about work-related injuries, and absenteeism.

8. Conclusion

Some areas for further exploration and development were given in Section 7. We conclude with three final points that stand out as fundamentally important.

First, it is clear that organizations of informal workers have used and will continue to use, and need, multiple mixed methods of communication. This should be investigated in a more systematic way. There is clear space for development of appropriate and scalable mHealth. There are generational differences at work in the uptake of IT, and some of this will disappear with time. However, perhaps more important are the structural barriers to communication, in terms of the expense (especially for access to Internet), as well as of the inadequate infrastructure for communication.

Second, there is a need for further exploration of different needs in different occupational sectors (as was done in the Rockefeller Foundation's background presentation for this work). Some pointers to this appeared in some of the interviews: the relative isolation of both domestic workers and home-based workers; the respiratory problems of specific occupations such as newspaper vending; the huge loads carried by market porters; and the fires that so frequently occur in built markets.

Third, informal workers organizations use health as an organizing tool. If the health of informal workers is to be addressed, this will be through, among other things, advocacy about rights to health information and services. And part of this can in turn be supported by presentation of feedback about health services to health authorities and those who influence health policy. mHealth surely has a significant role to play in this.