

## SOCIAL SECURITY AND PREVENTION

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# Work-related social protection for informal workers

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**Abstract** The informal workforce is growing worldwide, and changes in the global structure of employment and in places of employment mean that work is a source of hazard and ill-health for many poorer workers. Yet informal workers do not have access to work-related social security. They face high work-related risks, but have little or no access to reliable formal or informal social protection. Citizen-focused social security programmes, such as cash transfers, do not give enough attention to the needs of able-bodied adults who work. Further, informal workplaces are not covered by the traditional discipline and practice of occupational health and safety (OHS), which is a necessary component of overall work-related social security. In particular, poorer informal workers are ill-placed to make use of possible preventive interventions, as they may lead to loss of income in the short term. A more inclusive approach will require changes in the institutional arrangements governing OHS, and should involve especially local authorities and informal worker organizations, who are developing influential international sectoral networks. In this regard, promising examples of negotiated and inclusive OHS policy reforms are presented. The broader challenge is to develop an expanded OHS that specifically includes informal workers as “workers”, rather than as “vulnerable citizens” who qualify only for poverty-oriented social protection programmes, and that explicitly addresses preventive measures.

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## Introduction

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Increasing numbers of people worldwide work informally in physical spaces that are not normally covered by labour regulations. These may be vendors working on streets and in public parks, industrial outworkers and professional consultants operating from their own private homes, or waste workers taking their pickings from the streets or from publicly- or privately-owned waste dumps. Whether self-employed or waged workers, they are generally excluded from social protection programmes designed for “vulnerable groups”, as they are working-age adults. They are also not covered by social security programmes for work-related disease or injury. Their places of work are not regulated by conventional occupational health and safety regulations.

The last two decades have seen a gradually wider acceptance in the global North and global South of the reality and importance of the informal economy as part of the “normal” economy, and as making a contribution to a country’s economic wealth. Alongside this, in the field of social security or social protection, there has been a greater recognition of the positive and substantial role that states can play in social protection, and that social spending should be seen as an investment in a country’s development (Mkandawire, 2004; Cook and Kabeer, 2010, for Asia). Yet specifically work-related social security for informal workers *as workers*, rather than as people with general entitlements *as citizens* to social protection programmes is missing. This pertains to provisions such as access to health insurance, to savings for retirement, and to on-the-job training. It also pertains to health and safety measures at the workplace, and to protection against hazards deriving from the nature of the workplace and production processes.

This article, as one contribution to the special issue on “social security and prevention”, speaks to this last point. The reason for this is as follows: in the first instance, and to a very large extent, conventional contributory approaches to social security for workers extend only to workers in the formal (regulated) economy. Ambitions to extend social security programmes addressing work-related risks to people working in the informal economy are commendable and necessary, but they are largely constrained by the exclusive legal and institutional reality of conventional social security provisions for workers. Affecting change to this reality will not come easily or quickly. Therefore, in support of extending social security measures — and preventive measures in particular — that address workplace risks to informal workers specifically, it may be easier to argue a stronger case for action that prioritizes improvements in workplace safety and health.

A number of international agreements and instruments accord rights to informal workers. Article 23 of the Universal Declaration of Human Rights includes the right of all people to “just and favourable conditions of work”; Article 12 of the International Covenant on Economic, Social and Cultural Rights refers to state obligations to ensure the “prevention, treatment and control of . . . occupational and other diseases”, with occupational health seen as one component of the universal right to health. Women’s right to occupational health is specified in Article 11 of the Convention on the Elimination of all Forms of Discrimination Against Women, and migrants are similarly covered by Article 70 of the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families. A number of International Labour Organization (ILO) Conventions cover occupational health and safety, the most important of which are the Social Security (Minimum Standards) Convention of 1952 (No. 102); the Occupational Safety and Health Convention of 1981 (No. 155), and its accompanying Recommendation (No. 164), which deal with setting up national policies; and the Occupational Health Services Convention of 1985 (No. 161) and its accompanying Recommendation (No. 171), which deal with enterprise-level occupational health services (Alli, 2001, pp. 13-14).

Yet these rights and Conventions are not realized in the field of occupational health and safety, and they will not easily be realized — just as conventional approaches to contributory and budget-financed social security often do not address the risks faced by the working-age population in “atypical” work. This article argues that the mainstream discipline of occupational health and safety (OHS)<sup>1</sup> is too narrow to accommodate the majority of the world’s workers, and the institutions for health and safety regulation are not aligned with changes that have happened globally in the structure of employment and in work processes. At the same time, there are as yet few large and powerful organizations of informal workers who can represent informal workers’ interests.

Others have called for an expanded discipline and practice of OHS (see for example Barten, Fustukian and de Haan, 1996; Quinlan, 1999). These calls have been framed in terms of extending existing OHS practices to more people, and assume a relatively well-defined employer-employee relationship. In terms of practical interventions, the ILO developed programmes on extended OHS through its Work Improvements in Small Enterprises (WISE), Work Improvements for Safe Homes (WISH), and Work Improvements in Neighbourhood Development (WIND). These focus on self-employed people in relatively small enterprises, and largely deal with self-regulation by small-scale employers.

1. This article makes deliberate use of the terminology occupational health and safety (OHS), eschewing occupational safety and health (OSH). The shorthand terminology “informal worker” is used to refer to those who work in the informal economy.

In this article, and building on work started in 2005 (Lund and Marriott, 2011), an informal workforce lens is used through which to view the challenge for change and inclusiveness, that is relevant for both waged and self-employed people, and that foregrounds the needs and interests of poorer workers. Inclusiveness implies rights, roles and responsibilities of a number of interest groups who benefit from the labour inputs of informal workers — informal workers themselves, as well as states, firms, formal workers and the general public. Primary level prevention of injury and disease, as a necessary role of social security systems, alongside the provision of cash and health care benefits, is receiving little attention in current calls for universal health coverage. Examples will be given of a number of initiatives that have the potential to address the health and safety needs of informal workers, and which are supportive of the preventive component of social security systems especially.

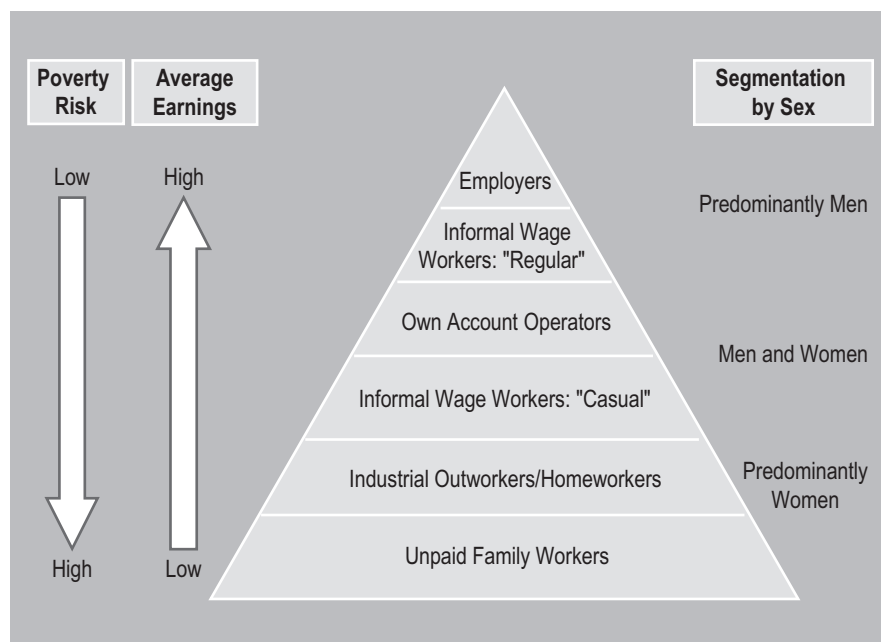
### The informal economy

The informal economy is large in most developing countries. Informal work comprises about one half or more of all non-agricultural employment in most developing regions, and rises to 84 per cent of non-agricultural employment in India (ILO, 2011).<sup>2</sup> In developing countries, except in the North Africa and Middle East region, women are more likely than men to work in the informal economy (ILO, 2002). “Non-standard” work is likewise growing in many countries in the global North. The patterns are clear whether measured by the share of all workers, the share of enterprises, or share of contribution to GDP. The ILO and the International Expert Group on Informal Sector Statistics promoted an expanded definition of the informal economy and status in employment that was endorsed by the International Conference of Labour Statisticians in 2003: the diversified set of economic activities, enterprises and workers that are not regulated or protected by the state. It identifies different categories of employment:

- Self-employment in informal enterprises: Self-employed persons in small unregistered or unincorporated enterprises, including employers, own-account operators (who do not employ others), and unpaid contributing family workers.
- Wage employment in informal jobs: Wage workers without social protection through their work who are employed by formal or informal firms (and their contractors), by households, or by no fixed employer, including non-standard employees of informal enterprises, non-standard employees of formal enterprises, casual or day labourers, and industrial outworkers (also called homeworkers).

2. There are substantial difficulties in collecting reliable data on agricultural employment, and this article focuses on non-agricultural employment.

**Figure 1.** Segmentation of the informal economy by sex, average earnings, and poverty risk



Source: Chen (2005).

The first major distinction is between self-employed and wage workers, with some of the self-employed employing others in their informal enterprises. Other dimensions of segmentation are shown in Figure 1, which depicts the distribution of gender, income and risk (Chen et al., 2005) across different employment statuses.

Employers predominate at the peak of the pyramid, and the majority of them are men; here, risks are lowest and incomes highest. This is the segment of informal work that is most easily captured in labour-force and other surveys. The lower down the pyramid, the more women predominate, and the higher the risks associated with informal work, and the lower the income derived from it. Employment at the bottom of the pyramid is recorded inaccurately, if at all, in most labour-force and other surveys.

Widely held misconceptions about the informal workforce are for example that all informal workers are poor, that all informal work is illegal, or that informal workers are there by choice. With regard to the first, the vast majority of informal workers are poor and some very poor indeed; however in many countries there is a segment of high earners. Some informal work is manifestly illegal, but the vast majority of informal workers work in sectors and trade in goods that are legal,

though their enterprises might not be registered. Some people choose informal employment, but very many have no choice but to do the work they do. This may be because of high rates of unemployment in the formal sector; or because formal employers have contractualized their work and made it informal in order to shift some of the costs of employment on to the worker; or because employment is denied to them because of class or caste or gender or other constraints. Some people do of course choose self-employment, because of issues of autonomy and flexibility, or because “the business runs in the family”, or because of perceived opportunities for higher earnings.

A rapidly increasing global trend is the fragmentation of production and work processes, with an associated externalization of work. A person who has been in full-time employment with a range of social benefits such as health insurance, pensions savings, and parental leave, gets “externalized”. He or she moves to a new form of contract — doing the same job, for the same person or corporate entity, but becomes “self-employed”, and on a commercial, not labour, contract. Commonly, this precludes the worker’s access to regulated grievance procedures, and absolves the firm (for whom the contractualized person is in effect still working) from responsibility for worker health and safety (Theron and Godfrey, 2000).

This process has implications for the health and safety of workers in four ways. First, much of the externalization of work activities would appear to have gone to smaller organizations and, in particular, small and medium sized enterprises, which possess less adequate and less sophisticated systems of risk management. Second, problems can arise with regard to the coordination of such management in situations where subcontractor and temporary staff work in physical proximity to in-house personnel. Third, inter-organizational contracting can have a detrimental impact on channels of “collective voice”. Finally, associated commercial contracts can potentially limit the ability of those organizations engaged in the supply of labour or the provision of manufacturing and other services to invest in preventive health and safety measures (James et al., 2007).

At the national level, the fragmentation of production and work processes heightens the challenge for extending coverage under social security programmes, especially if this leads to a reduction in the number of workers formally employed and when legal coverage is limited to the enrolment of employers with, say, ten or more employees. In turn, growth in self-employment and microenterprises, in atypical places of work, present challenges to already stretched and under-financed labour inspection agencies.

Informal employment is characterized by insecurity and by lack of access to social protection. An improvement in the position of the working poor requires at least two things: they should be able to accumulate and sustain assets; and they should be able to reduce the risks associated with work through finding ways

of preventing, reducing or mitigating these risks. Key risks faced are injury and ill-health.

### Work, health and poverty

A core assumption underlying welfare regimes in industrialized countries is that paid work brings security, and employment is the main guarantee of financial security and a pathway to a better life for one's children. The early social security model was of a society with (almost) full employment, and with wages at a level where the worker would be able to fulfil the needs of himself and his family: "himself" and "his", because initially the normative model of welfare provision was that men would be the workers, or "main breadwinners", with women being responsible for housework and bearing and raising children. The worker could expect to be insured against work-related disease or injury and know that his spouse and dependants would receive a widow's or family pension in the case of his death. Historically, in most countries, social security benefit programmes providing compensation for work accidents were among the first programmes legislated for and implemented.

Thus work was supposed to bring a measure of security. The relative measure of this expectation has lowered in many countries, even for Member countries of the Organisation for Economic Cooperation and Development (OECD). Nevertheless, OHS was developed in the expectation that it would aid the prevention of work-related injuries and diseases, and mitigate them if and when they occurred. Yet for millions of informal workers worldwide, work is itself a source of risk. Where poverty is related to poor education and few market-related skills, the body is an important asset. Physical strength is vital to the ability to work. Work under deleterious conditions can deplete that strength. When poor health leads to the inability to continue to work, income is lost. Poorer informal workers are also exposed to diseases that are related to poverty, and are associated with poor housing and inadequate sanitation, ventilation and water. Further, informal workers face other risks associated with poverty, such as unreliable incomes and poor nutrition, which in turn may lead to their physical depletion. Poverty reduces the option to refuse hazardous work. This heightens the risk of illness, accident or impairment, which contributes to further loss of earning ability, and exclusion.

All workers — formal and informal — should be able to expect, as a right of working, measures to prevent ill-health, the mitigation of work-related risks, and access to ex post facto responses to work-related illness, disease and injuries. However, common policy responses to the absence of such measures include poorer workers — both waged and self-employed — having to protect themselves against risks, through self-regulation; improving their work environments, through education about protection against hazards; and getting access to health

services, for example by building their own micro-insurance schemes. However, people in poor communities, in hazardous or unhealthy workplaces, do not necessarily have any control over external factors such as water and sanitation, cannot easily co-insure, and cannot afford private health insurance.

All of these factors have a bearing on the relevance of traditional occupational health and safety approaches to informal and non-standard working situations.

### **The traditional occupational health and safety model**

The ILO's nine core contingencies or branches of social security are: health care, sickness, unemployment, old age, employment injury, support to family, maternity care, invalidity and survivors benefits. The ILO social security regime is the outcome of annual contestations between workers, employers and governments over what the benefits are, and whose responsibility they are. Formal workers in industrialized countries expect to have, through their work, access to the prevention of — or coverage against — all of the nine contingencies.

OHS has its background in industrial medicine, and in colonial countries, in health services for especially transport and mine workers. The benchmark Social Security (Minimum Standards) Convention of 1952 (No. 102) followed the earlier establishment of OHS in a number of developing and industrialized countries. It is important to note that in industrialized countries, and outside of the institutional context of the ILO and its agreements, OHS was a part of social security, but it was not linked to other health and welfare programmes. It was not foregrounded as a component of social protection when the shift from “social security” to “social protection” took place.

OHS is an intellectual discipline, within the health sciences. It is also a component of labour regulation, with its services and practices including regulation of the place of work. Some of its work is aimed at primary prevention, for example in improved ventilation and the safe handling of toxic materials. Others deal with the consequences of occupational injury and disease, such as insurance to cover health care when accidents and disease occur.

The industrial and organizational archetype for OHS is large firms with full-time employees. Key characteristics, described by Quinlan (1999), are that there are a known number of people working on fixed premises that are designed for work, such as factories, shops, offices, and mines. The premises are controlled by one or more employers, and OHS measures are part of the employer's legal obligations. There is a body of inspectors with clear guidelines for norms and standards and tools for the identification and measurement of hazards, as well as of injury or disease. There are clear paths of reporting the occurrence of injuries and diseases, appeal mechanisms for workers and employers, and rules regarding compensation (Quinlan, 1999). OHS focuses on the individual worker, at his or her place of



work, which is taken to be separate from the place of residence. The worker is divorced, as it were, from the family, community and residential environment.

None of these characteristics is relevant for the majority of the world's contemporary workforce. Many work in public places such as on streets or in informal roadside market places. Others work in private homes. Workers' own homes are used as a site of production of goods, with the homeowner perhaps employing others as well. Other workers may work in someone else's private home — for example, the millions of domestic workers and paid carers worldwide, who may be classified as formal or informal workers depending on the country context. Some previously formal places of work may have converted to housing informal workers — for example, the informal factories that are set up in older central city office blocks. Large numbers of people now work as waste pickers in a very atypical workplace: on garbage dumps, sorting and recycling materials. Such places may be owned by municipalities or private corporations, with the difference in ownership having different implications for the regulation and safety of the site.

Different dynamics are at work in these differing work environments in terms of the degree of autonomy or control the worker has over — or at — the workplace, and over work tasks. The public streets on which street vendors work are owned by the local government, which in certain respects may be thought of as a proxy employer. That is certainly how the local authority is viewed by many street vendors: it controls their access to streets, it permits or forbids vendors to operate on sidewalks or at traffic intersections, and it allocates sites for built markets. For industrial outworkers who produce from their own or others' homes, the local authority exerts powerful control in allowing or disallowing homes to be used for business purposes. Local authorities are also influential in determining homeworkers' exposure to risks and health hazards, as this relates to the provision of infrastructure such as sanitation, water, garbage removal services and roads. This has a direct impact on workers' ability to prevent risks and ill-health.

There is a major structural and institutional disconnect with regard to the levels of government that have *de jure* and *de facto* authority and control over the OHS component of social security. In most countries, policy, legislation, norms and standards, and governance of OHS are set at the national level, often within the labour ministry, but sometimes in the health ministry, and sometimes in both labour and health. The inspection function is also determined nationally, but often under-resourced. In most countries the level of government that practically, on a daily basis, interacts with and controls the informal labour force's working conditions, and risks associated with their work, is local government. Municipalities see people within their domain as citizens, "the public", and do not have a worker orientation.

Thus there may be a lack of institutional vertical "fit" between nationally-derived policies and the application on the ground of these policies; there may be

an actual vertical mismatch between national and local approaches. At local level, there may be a further lack of institutional horizontal “fit”, with different departments in the local authority being responsible for different domains, such as environmental health, public health and cleansing and sanitation, for example. In practice, in the streets and markets of the world, occupational health is difficult to separate from environmental health. Environmental health itself does not have a worker focus. To the extent that environmental health integrates and becomes more sensitive to issues of climate change, it has growing common interests with “green movement” politics. Yet the predominant focus of the environmental movement is on environmental damage, with the health and safety of workers in second place.

Traditional OHS needs to continue in the situations for which it is appropriate. However it needs to be complemented by, and integrate, an expanded and more inclusive approach that takes into account global changes in employment, and particularly in those occupations such as street vending, domestic work and home-based work, in which millions of workers are active. The social determinants of health, that lie outside of the workplace, and the consequences of structural forces that translate into workplace hazards, must be factored in, as was recognized by the global Commission on the Social Determinants of Health (CSDH, 2008). In the new expanded and inclusive framework, it will be vital that preventive health is given priority — both as an issue of rights and of improving the productivity of poorer informal workers.

### **Primary prevention of work-related risks for informal workers**

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One of the fundamental principles of OHS is that the focus should be on “primary prevention at the workplace level” (Alli, 2001, p. 18). There is evidence that inexpensive preventive interventions can have high payoffs (Rosenstock, Cullen and Fingerhut, 2006; Cointreau, 2006). Effective prevention avoids costs associated with, inter alia, disruption of production/service processes, compensation of affected workers, and the payment of wages and training for replacement workers. However, it is hard to think optimistically about realistic interventions that might be able to scale up, given the structural changes in the nature of employment globally, the dominance of global capital relative to the ability of states to regulate capital, and relative to the overall weakening of the voice of organized labour.

First, insecure informal workers have sources of vulnerability that may undermine the likelihood of their being reached by innovations (Lund and Marriott, 2011). The urgency of earning a living may take priority over personal health and safety. Rongo et al. (2004) point out that many informal enterprises operate “illegally” in the sense that they have no security of location; without this they are not

likely to invest in material improvements to premises. For piece-rate workers, the pace of work is crucial to income earned, and safer work might in fact mean slower work, for example if protective equipment slows the pace of work (Lund and Marriott, 2011, pp. 23–24). Thus, workers themselves may be “responsible” for ignoring basic safety rules.

Second, where there is no clear boundary between place of work and place of residence (for example, for industrial outworkers working from home) or where it is blurred (as is often the case in agriculture), then prevention has to include the homes and family members of workers. This may of course be a benefit — for example, if a garment worker introduces more ventilation and lighting, her whole household may reap the health advantages — but it is not clear that traditional OHS could or should bear this responsibility. Rosenstock, Cullen and Fingerhut (2006, p. 1133) suggest that in some developing countries, on-site work-related health services, though they may be limited, may be the only available health service. They hold that there may thus be a case to be made for situating more general health services at this work-related facility, in a more holistic approach:

... the blurred distinction between “general health” and “occupational health” in societies where people live and work in the same community and environment, and where children and spouses of workers may share common exposures and adverse conditions with workers, serves to confer some advantage to a more holistic approach to health services often best provided at or near the workplace itself.

Third, “universal health coverage” (UHC) is again back on the health policy agenda, promoted actively by a consortium of influential agencies and foundations, through the Joint Learning Network for Universal Health Coverage. In the past, UHC meant a health service that was publicly provided, available to the whole population, and with comprehensive services. In contemporary policy debates, UHC can mean services targeted to poorer people, possibly means tested, and with contributory insurance, with the service in either private or public facilities. In India’s *Rashtriya Swasthya Bima Yojana* (RSBY) national scheme, launched in 2008, the federal government and to a lesser extent the different states subsidize the service, and secure the services of private insurance firms through a competitive tender process (Jain, 2012). Early assessments show that the use of private insurance firms leads to the rapid neglect of the preventive component of OHS and indeed of primary health care (PHC): the private firms have no incentives to do preventive work, as this would reduce the numbers presenting for health care; the firms receive subsidies for curative services. Where the services are available through private health facilities, there is early evidence of increases in unnecessary surgery, while there are no visible interventions in favour of preventive health care (Jain, 2012).

Ghana's 2003 health policy reform, the National Health Insurance Scheme, was specifically intended to include informal workers. Interviews with street vendors suggest that it may disadvantage informal workers owing to the very long queues for health services, which lead to loss of income (Alfers, 2012). Apoya and Marriott (2011) hold that the design of the scheme, which is underpinned by a government-owned national health insurance scheme, gives incentives to a bias towards curative and not preventive care.

The changed places of work, the mobility of workers between workplaces, the lack of boundaries for many rural and urban workers between place of work and place of residence, the lack of regulation — all of these pose challenges to an expanded, inclusive and regulated OHS. Furthermore, there are countries where the state is so weak, and the resources available are so limited, that no amount of signed treaties and Conventions will succeed as a spur to practical action on the scale required. There are, however, some promising examples of innovation. Those presented below all have a preventive component, and all involve workers' organizations.

### **Breaking the impasse: New directions for a preventive, inclusive health and safety regime for informal workers**

Before moving on to look at selected promising examples, some comment is first required. The problem of forging a system of work-related health and safety for informal workers is daunting. The answer cannot be a call for the formalization of all informal work. Indeed, informal work is becoming a norm in many countries, and this has major ramifications for the design of sustainable and inclusive national social security systems too. However, the answer equally cannot be all in the realm of self-regulation, with poorer informal workers bearing all the cost and responsibility.

Any new models or reforms require better data about work-related disease and injury among informal or atypical workers. There have been significant improvements in the measurement of the informal economy and the informal workforce in the last decade, which itself depended on clearer agreed-on classification of informal employment. This is likely to raise awareness of the economic contribution made by the informal workforce. There have not been parallel improvements in the measurement of the incidence of work-related disease and injury among various types of informal workers. Rosenstock, Cullen and Fingerhut (2006) summarize recent findings from developing countries, and identify the lack of reliable data globally. There is also scarce data on the consequences of work-related incidents in both high income and poorer countries (Cointreau, 2006, p. 11).

There is thus little way of knowing which sectors are most affected and which types of injuries most common. Consequently, there is little basis for prioritizing

preventive interventions. Rosenstock, Cullen and Fingerhut (2006) cite research that finds that fairly elementary interventions in education for prevention can make a difference; this mirrors the experience of the ILO preventive interventions in OHS for informal workers (see below). However, none of these programmes has gone to scale.

*Inclusion of informal worker organizations in platforms  
for policy reform and development, implementation  
and monitoring*

As with formal workers, those working informally have the right to participate in the design and implementation of policies that affect them. They can do this best through properly constituted organizations that represent their own interests on platforms where policies are developed and influenced, and on permanent platforms for ongoing negotiation about working conditions. The growing organizations and global networks of informal workers present some very promising experiences of participation in policy bodies, at local, national and international levels that can promote prevention.

Secure and safe sites for trading are themselves measures of prevention, and the Durban municipality in South Africa embarked on a participatory process of outreach to informal workers, especially street traders. The aim was for a negotiated solution that could reconcile the city's need for effective and safe street-level management, with the traders' needs for secure and safe space in busy parts of the city (Lund and Skinner, 2004). In Bogota, Colombian waste pickers, through their recognized organizations, were involved in protracted negotiations with the planning authorities about their rights to collect materials from certain routes through the city, and won the battle in 2012. In 2010, StreetNet Ghana Alliance and other trader organizations in Accra embarked on a systematic series of workshops with the national Institute for Local Government Studies to prepare informal workers to engage in a focused and informed way for negotiations with the Accra Municipal Assembly around health and safety issues (WIEGO, 2012). In particular, fire hazards in the markets were identified as the most serious safety problem, and filthy blocked drains were identified as a serious issue for the health of both market workers and the public.

At the national level, in Thailand the umbrella network supporting homeworkers, Homenet Thailand, played an active role in the national commission that led to the introduction of the "30 baht health insurance scheme", that was later replaced by the universal health insurance scheme. Homenet Thailand continues to be involved in evaluating and monitoring the scheme. India's well-known Self-Employed Women's Association (SEWA) is a mixture of trade unions and

cooperatives of poorer women who work informally. Its membership in 2010 stood at 1.33 million women. It is represented on the Indian prime minister's national advisory council. It has actively participated in and been influential on national commissions on the informal sector, child care, and on high-level expert groups on universal health coverage, among others. Its members participate in village health and sanitation committees, and the realities and changing needs of grassroots members feed into the national policy deliberations. SEWA's work on disaster management is well-known for its focus on getting people back to work as soon as possible so they can start generating their own incomes. Their insurance programme also includes disaster cover.

SEWA's leaders have actively participated in a number of global commissions, such as the Commission on the Social Determinants of Health (CSDH, 2008). Also at an international level, in 2011 the International Domestic Workers Network (IDWN) was a forceful leader in the successful campaign for the ILO Recommendation (No. 201) and Convention (No. 189) on Domestic Workers, adopted in 2011. The focus for organizing around social protection for domestic workers includes both the repetitive stress injuries associated with long hours of manual work and the prevention of sexual harassment of domestic workers by employers.

Associations of informal workers, and campaigns such as the above, raise visibility and assist the public, government and formal enterprises to accept the legitimacy of informal work. Organizations are also the institutional terrain on which poorer workers, and especially women, learn to articulate their interests collectively. Personal empowerment feeds into the ability to negotiate for better working conditions, including demands for better health and safety.

### *Trend towards integration of occupational health and safety into primary health care*

In a number of countries OHS is being integrated into primary health care (PHC). Both OHS and PHC have as a premise that good health, and the absence of disease and injury, is a right, and a focus on prevention is included in the fundamental principles of both. OHS has a more concentrated focus on the cost effectiveness of preventive interventions and how these link with the greater productivity of workers and firms. PHC has a stronger focus on reproductive health care, especially for women. There might thus be advantages to be gained from this integration of OHS into PHC.

A cautionary note is needed. Is there a danger that the *worker* focus of OHS will be lost in the PHC framework with its *citizen* focus? It has been noted that traditional OHS operates with a narrow focus on the worker in a formal place of work, divorced from family and community. Will the broader PHC approach be able to

accommodate the worker focus that is needed for OHS? A traditional OHS specialist confronts worker health at the place of work, not at home, and focuses on the individual worker. Will the PHC specialist “see” that it is something in the work environment that is damaging to a worker’s health, and be able to respond to it?

Homenet Thailand has developed a relationship with the Thai public health system over a decade, participating in policy development, and forming an alliance for monitoring health service delivery with eight other networks from civil society — people with disabilities, HIV/AIDS, farmers, indigenous people, urban poor, women, children and youth, and the elderly. In 2011 the alliance embarked on a three-year pilot programme with government, with the aim of practically integrating OHS services into PHC services in numerous PHC units in three provinces. It has started with a focus on the health needs of homebased workers. The core demands of the alliance are for free and fair services, and (important for this article) for preventive, promotive and curative services. One of the services will be an annual health check-up for those with high work-related risks.

Thailand is known for its exceptional commitment to public health, and allocates reasonable resources to it. This pilot policy innovation should thus be followed with interest to identify how workers’ health fares within a public health framework and to see whether and how far the preventive component endures, and under whose influence. It may also teach useful ongoing lessons about the role of organizations in civil society, including organizations of homeworkers, in health system reforms.

### *Interventions in the production process*

It is relatively easy to identify roles for the state and for informal workers themselves in OHS, and especially in prevention. It is more difficult to find ways to secure commitment from the owners of firms who “employ” informal workers, though this employment may be concealed, disguised, or genuinely ambiguous. Many multinational firms have hundreds of people producing for them, but do not directly employ the workers — labour brokers stand between the disguised employer and the people doing the work. James et al. (2007) presented the case for a specific focus on the regulation of health and safety through supply chains. For many years, in certain industries in India, a “cess” or levy is paid by employers and allocated to welfare funds which are safeguarded for benefits for workers, such as for children’s education.

A suite of case studies (Lund and Nicholson, 2003) used a value chain methodology to consider how different workers were excluded from or gained access to measures of social protection in the garments and horticulture industries. The purpose was to identify the points along the chain where contributions could be made by employers/owners — calling this a “labour benefit” approach, rather than

a “value-added” approach. In Chile and South Africa (horticulture), and Thailand and Philippines (garments), it was clear how employers had removed themselves from responsibility for many aspects of the social wage, but in different ways. The seasonal work in horticulture meant that workers received no income or benefits at all for large parts of the year. The horticulture industry (Barrientos and Ware Barrientos, 2003) had a far greater potential for leveraging contributions to improve working conditions than did the garment industry (Doane, Ofreneo and Srikajon, 2003). From the workers’ perspective, owners and employers in the garment industry were relatively invisible, compared to the situation in horticulture. It was easier to monitor compliance with firm codes of conduct in the buyer-driven horticultural industry, than in the garment industry (Lund and Nicholson, 2003, pp. 114-115). Subsequent studies by Heeks and Duncombe (2003) concluded that while there have been some successes in ethical trade initiatives leading to improvements in health and safety conditions, the majority have little or no impact on poorer workers.

*Evaluate and build on existing work done by ILO  
on WISE, WISH and WIND*

**24**

As noted earlier, the ILO developed a set of training programmes in Asia geared towards informal workers. The premise of Work Improvements in Small Enterprises (WISE), also known as “Higher productivity and a better place to work”, is that improved work conditions will lead to greater productivity, with benefits to both owners of small enterprises and workers. Work Improvements for Safe Homes (WISH) concentrates on homeworkers. Work Improvements in Neighbourhood Development (WIND) focuses on agricultural workers. All of these programmes have been carefully piloted with their own training materials. All of them reported significant practical improvements after the training. All of the programmes, however, allocate the responsibility for change on owners and workers, with no identification of the roles and responsibilities of agencies such as the local authority or of contracting firms. Learning messages are, for example, “Make sure that the employees drink lots of cool water”, which bears no reference to whether potable water is available; likewise “Make sure the environment is kept clean” bears no reference to whether sanitation and garbage removal services are available and affordable.

It could be useful to evaluate the programmes with a view, first, to developing further materials for local authorities, specifically identifying the infrastructural services that would assist small businesses to become more sustainable in improved environments. Second, evaluations could identify interest groups and agencies that could practically assist in the prevention of injuries and diseases.



Third, the programmes could be assessed for their potential to go to scale at a significant level.

### *Designing equipment and space for the informal economy*

A large and commercially profitable activity within traditional OHS is ergonomics with its development of work-related equipment and environments that promote or protect worker health, with a view to both worker well-being and productivity. Within the emerging new informal worker movement, attention is being given to the design of equipment that will be appropriate to the work being done, that is sturdy and robust enough to endure use within rough conditions, and designed such that workers will actually make use of it. Partnerships have been formed between informal worker organizations of waste pickers and of street vendors with design institutes, architects and urban planning institutes in a number of cities. *Kagad Kach Patra Kashtakari Panchayat* (KKPKP), a trade union of waste pickers in Pune, India, and a South African waste recyclers' support organization, *Asiye eTafuleni* in Durban, are undertaking advanced work in the design of carts suitable to be pulled by men and women waste pickers. The carts have to be able to negotiate busy streets in order to move waste products from firms and private residences to depots set up by the municipality. KKPKP's work is supported by the state design institute in Maharashtra State. In Gujarat State, India, SEWA is working with India's National Institute of Design to develop tables at which women workers can more comfortably align their bodies and posture for rolling incense sticks and *poppadoms*. Design and engineering work in this regard has also started in Salvador City, Bahia province in Brazil, under the auspices of the Institute of Collective Health at the federal university.<sup>3</sup>

The design processes in these initiatives are built on participatory work with the workers themselves. It is not too ambitious to think of a "Design Fair" that brings these initiatives together, offering rewards and incentives to bright young designers to develop their commitment to preventive equipment for poorer workers.

### *Creating links with other social protection programmes*

OHS is one part of the broader arena of social protection. Given that informal workers at present have little access to OHS services, are there possibilities for linkages to other forms of social provision that could also serve to reduce risk,

3. See WIEGO OHS Newsletters at <<http://www.wiego.org>>.

provide access to preventive services and contribute to more secure lives? Possibilities considered here are access to health services, unemployment insurance and cash transfers.

When asked to identify priorities within social protection, informal workers frequently prioritize access to health services. As described earlier in this article, in some countries OHS is being integrated into PHC. In Ghana (Alfers, 2012; Apoya and Marriott, 2011) and in India (Jain, 2012), new policy reforms integrate informal workers into national health insurance programmes. In both countries, little had been done to inform workers about what services were available, what the opening hours were, the procedures for enrolling, and, in the case of Ghana, what premium had to be paid. Once at the health facilities, long queues took up much of the workers' time. For informal workers, time spent navigating the system is lost potential income, and they thus face reduced income precisely at a time of ill-health when needs are great and costs are higher. A valuable way of linking informal workers into health would be that the health services themselves provide accurate information and disseminate it widely. As stall holders in the massive informal markets in Accra said, they themselves could be valuable purveyors of this information (Alfers, 2012).

Unemployment insurance provides at least temporary cover for formal workers who lose work, and it is usually contributory — the recipient has to have been formally employed and to have contributed to the fund. For unemployment insurance to work, some defined contract is necessary that recognizes the work as work, and that identifies the employer. Some countries — for example Peru and South Africa — have recently extended unemployment insurance to domestic workers and set a basic minimum wage. In Brazil, domestic workers now must be allocated with the “Work Card” that is necessary to allocate benefits to workers; employers are encouraged through tax incentives to cooperate in ensuring their domestic employees have such cards.

Another possible linkage for informal workers could be to cash transfers, a form of social assistance that is gaining recognition for its contribution to income security, poverty reduction and enterprise development and, indeed, overall national development. Cash transfers, however, have thus far typically been designed for those outside the labour market: for very young children, elderly people, and people with disabilities so severe that they are excluded from work. At the core of the new campaign for “social protection floors” (SPFs) is advocacy for cash transfers over the life cycle for children, unemployed adults and informal workers, the elderly and people with disabilities, and access to affordable health services (Bachelet, 2011).

In South Africa, poorer informally-working mothers are eligible for the very modest Child Support Grant (about USD 35 per month). In a household near Durban, the 28 year old daughter of a street trader took over the headship of a

household of nine people when her mother died of AIDS-related illnesses. The daughter received the child benefit on behalf of her two children aged 3 and 11. The grant for the younger child was used entirely for crèche fees, and this child care enabled her to go into town daily to do her trading in clothes and producing cooked food for lunchtime commuters. The grant for the bright 11 year old daughter paid for transport to another township where the quality of schooling was much better than at the local school (Lund, 2011). This is a clear case where modest state support enables livelihood production for the informal worker and her family, and an improved education that might improve the possibility of her children escaping poverty.

It is hard to imagine a cash transfer designed for informally-working adults, unless it were to be a universal Basic Income Grant (Hanlon, Barrientos and Hulme, 2010). This is unlikely to become a reality in many low-income countries in the immediate future. A concern is that SPFs may actually have a tendency to address citizens' needs and risks before the different but, when considering the conventional roles of social security, equally important needs of, and risks faced by, workers.

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## Conclusion

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The changing structure and nature of work means that work has become an increasing source of risk and insecurity for millions of informal and other workers. Informal workers have no access to work-related social security. Traditional OHS is out of step with global changes in the working environment. It is oriented towards formal workplaces and it assumes a defined relationship between employers and workers. Some informal workers may find ways of getting access to insurance to cover for contingencies such as injuries and disease. However, of the three parts of work-related social security — preventive, promotive, curative — the preventive and promotive are unaddressed. The article suggests that recent policy moves to expand OHS coverage to informal workers are still unlikely to focus on prevention. This is especially so when private insurance firms enter partnerships with government, as the private sector has no incentive to do the preventive work in such a way that would reduce demands on the health services.

The current global social policy arena is alive with enthusiasm for cash transfers as a way of tackling poverty, with hard evidence that cash transfers can be both effective and efficient ways of reaching other developmental goals as well. Yet specifically work-related social protection for informal workers *as workers*, rather than as people with general entitlements *as citizens* to social protection programmes is missing. The convergence of opinion about the positive effects of cash transfers is commendable. The SPF concept identifies children, people with

disabilities and elderly people as three of the four pillars, with unemployed people and informal workers as the fourth. It is harder to design and deliver concrete interventions for the unemployed and informal workers than for the other three groups.

The need for a more expanded and inclusive OHS for informal workers is clear to see. The challenges, however, are daunting. There are already promising examples of new practices in a number of countries, but change takes time and experience. SEWA's interventions in insurance and in design are built on a 40-year history of experiences; Homenet Thailand went through a decade of work with national government before it could become a partner in the pilot scheme with government in integrating OHS into PHC in a number of health facilities.

One will not solve the problem of a narrow and increasingly inappropriate (because it is too constrained) OHS through calls to formalize all informal work. This is not going to happen, not even in advanced industrialized countries of the global North. Likewise, though, the answer cannot be in self-regulation alone: informal workers' poor working conditions are caused and sustained by external agents and their practices.

The distance between what traditional OHS offers and the realities of working life for the majority of the world's workers is so great that OHS will be required to formulate a response. Informal workers' organizations are growing rapidly and are demanding inclusion in policy reforms. International and national institutes of occupational health, and international regulatory bodies, have power, influence, knowledge and resources and could contribute to the development of a more relevant and inclusive practice. Ergonomic design schools could be encouraged to shift their attention towards equipment for the working poor. Forward-looking local governments and trade unions, with informal workers' organizations, could be part of new enduring platforms for negotiations around the rights of informal workers.

Given the diversity within the informal economy, it is conceptually and empirically helpful to approach these challenges sector by sector. The article has indicated how different occupations have different levels of autonomy and control over the places they work in; this has implications for who might and should get involved in preventive interventions. The solutions will have to be both global and local, and this article has argued that the role and responsibility of local government needs to be more clearly envisioned, articulated and integrated into the discipline and practice of OHS — a fundamental component to the realization of overall work-related social security.

Finally, it is time to call for a social security that acknowledges the need to rebalance social policy, with attention given to different interventions to meet the different needs of workers as such, in addition to programmes based on citizenship alone.

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