



Health Vulnerabilities of Informal Workers

May 2013

Problem Statement and Key Messages

Informal workers face substantial risks and vulnerabilities due to insecurity surrounding their employment status and lack of control of the conditions of their employment. In addition, informal workers have limited access to affordable and appropriate health care for themselves and their families, and they may not seek care if they have insecure legal status, or due to the potential expense or loss of income. The combination of high vulnerabilities and inadequate social protections (including insufficient access to affordable health services) results in high incidences of injury, illness, susceptibility to chronic diseases and poverty.

Key Messages

1. Informal employment is often invisible, as workers are mostly excluded from national labor laws and regulations, social protections, and high-level discussions. As a result, they fall through the cracks in systems, including most UHC schemes, that serve formal workers on the one hand and unemployed on the other.
2. **Employment insecurity** and inadequate health care are common to all informal workers and increase health vulnerabilities; specific health issues vary in prevalence among informal workers because of differential **working conditions**, exposures and health risks.
3. Over 700 million informal workers live in extreme poverty, and often cannot bear the financial and/or opportunity costs of receiving health services and losing a day's work.
4. Women make up the largest proportion of the most vulnerable informal workers due to a combination of factors: they occupy the lowest paying informal jobs, maternal health needs are not met by employment conditions, and working conditions often subject them not only to bodily harm but also psychological and sexual abuse.
5. No one-size-fits all solution will address the geographic, health, and occupational differences among informal workers. Some countries (esp. in Asia and Latin America) are addressing health care accessibility via national or tailored insurance. In Asia, Latin America, and (less so) Africa, countries have devised worker-specific programs, particularly in urban areas.
6. Opportunities for engagement on health and informal workers issues include **population-level** or **worker-level** efforts. Scattered funding and variable interests have led to a patchwork of policies and programs focused on national interest or type of worker. Often the health vulnerabilities of informal workers are addressed as one small component within a broad range of activities.
7. The invisible nature of informal work results from and contributes to the dearth of systematic data. Informal workers are not "seen" so are not counted – limiting estimates of scale and scope, and exacerbating the practice of overlooking this population and their needs. Similarly, systematic health data generally does not designate employment status and reveals very little about specific "health vulnerabilities."

Definitions of Key Terms

Term	Definition
The ILO's Informal Employment Definition	All remunerative work that is not recognized, regulated, or protected by existing legal or regulatory frameworks and non-remunerative work undertaken in an income-producing enterprise. Unlike formal employment, informal jobs are not subject to national labor legislation, income taxation, social protection, or certain benefits (advance notice of dismissal, severance pay, paid annual or sick leave, maternity leave, retirement/pension, etc.).
Informal Worker	An individual engaged in informal employment.
Informal Sector	Self-employment or small businesses not subject to regulation or taxation. People can be informally employed in the formal sector and formally employed in the informal sector.
OHS	Occupational Health and Safety – policies and programs that address the working conditions.
Employment Conditions	The formal or informal conditions of an employer-employee relationship involving labor regulations, and employment-based social protection (e.g., hours, pay or compensation, time-off, and benefits).
Working Conditions	Workplace and physical conditions of work, including repetitive or stressful motions required to perform work; materials, chemicals, and hazards with which workers come into contact and provision of protective gear and training; and the space, building, location, street, or place where work is performed.
Non-Wage Workers	Workers who are not paid a salary or minimum wage, e.g., employers; owners/operators of small informal enterprises; self-employed and own-account workers – example: street vendors; and unpaid family workers.
Wage Workers	Workers employed by other people, paid by the hour or piece/job. Examples: domestic workers, home-based workers, temporary and part-time workers, migrant workers, unregistered workers, and casual workers without a fixed employer.
Informal Workers Included in Search	Agricultural, construction, domestic, home-based, manufacturing, transportation workers, and street vendors and waste pickers. Migrant workers are included within these occupational categories.
Population-level Approach or Worker-level Approach	Activities may be conducted at the population level (e.g., for all informal workers; national health insurance and international guidelines) or at the worker-specific level (e.g., subsets of informal workers; providing some types of workers access to local health care or micro-insurance coverage for health issues, or extending corporate benefits to informal workers in the formal sector).

Problem Assessment

- Informal workers number 1.8 billion (60% of the global workforce) and comprise a diverse population in terms of type of occupation, and social and legal status. They face greater job insecurity and stress than workers who are formally employed, and they have little to no access to affordable, quality health care. These conditions increase informal worker vulnerability to poor health, injury and illness. Furthermore, working conditions are often unsafe and unhealthy.
- Accessing health care requires leaving work, which reduces the income of informal workers and adds health care expenses. However, most informal workers have few resources – more than one-third receive <\$1.25/day for their labor.
- Informal worker vulnerability is exacerbated by political systems that do not recognize them, global economic conditions that hurt the formal sector, national economic systems that see informal work as a drain on resources, inconvenient and underfunded health systems, poor education and training systems, and socio-cultural norms that permit gender discrimination.

Dynamism Assessment

- Two dynamic approaches that are gaining momentum to address the problem are: a) creating access to health care via insurance, with the goal of Universal Health Coverage (UHC) and b) partnering with grassroots efforts to strengthen outreach and access to primary care.
- Regional progress varies. Asia has been proactive and Latin America fairly successful in designing strategies and bridging grassroots and government partners. Though pockets of progress in implementing UHC exist, dynamism is lower in Africa.
- Barriers to success include prohibitive expenses for informal workers, governments and providers; and efforts that do not account for the highly differential health needs of informal workers. Limited data and evaluation are also problematic.

Landscape Assessment

- Gaps in health care and coverage are partially addressed through a project-level patchwork of activities and programs, funded by the public and private sector, multilateral institutions, and philanthropic donors. In addition to limited multilateral efforts, grassroots organizations (e.g., WIEGO and SEWA) are working to reduce the “invisibility” of some subsets of informal workers.

Impact Assessment

- Expanding access to health care for all informal workers (e.g., through the expansion of UHC) and building local capacity to help a subset of informal workers are dynamic activity spaces with substantial challenges to scaling up. The first option does not ensure that informal workers will use the services and the second would only serve a small fraction of informal workers. Both options require partnerships for sustainability.

What is the scale and scope of the problem? Why is the problem pressing?

Scale: Why It Is Important



Informal workers are a large group. Growth is expected to continue in the next 50 years because of economic conditions globally.

- They total more than a billion in developing countries and 1.8 billion worldwide, or 60% of the world's working population, per OECD.
- Of new jobs created in developing countries, most are in informal employment.
- The proportion of informal workers is higher (>40%) in developing than in high-income countries (~5%), and accounts for a greater proportion of GDP (25-60% of GDP in developing countries and 5% or less in high-income countries).
- The informal sector is a crucial "sparkplug for the engine of development" worldwide – better employment conditions translate to higher productivity and a greater contribution to the economy.

Informal workers are susceptible to health problems due to poor employment conditions and inadequate access to health care. Many types of informal workers face unsafe or poor working conditions.

- 700 million informal workers live in extreme poverty (<US\$1.25/day), contributing to their vulnerability to poor health.
- Informal workers face poor employment conditions: excessive hours; no sick time; high stress and insecurity; no health or social protection.
- 70-90% of informal workers have no or few benefits, according to several studies and organizations working with informal workers.
- Informal workers face poor working conditions: physical overexertion or repetitive motion; high risk of injuries, exposure to toxins, violence and sexual assault; and limited access to training and protective gear.

Scope: Global Relevance



The informal economy is a major force in Asia, Africa and Latin America. Estimates derived from World Bank, OECD and ILO data:

- **East and South Asia:** 1.26 billion informal workers (67% of the workforce); 705 million in agriculture, 552 million in non-agriculture.
- **Latin America:** 178 million informal workers (63% of workforce); 64 million in agriculture and 114 million in non-agriculture.
- **Sub-Saharan Africa:** 152 million Informal workers (45% of the workforce); 63 million in agriculture, 98 million in non-agriculture.

Types of informal workers vary in global prevalence.

- With >950 million, **agricultural workers** are the largest type of informal worker, followed by >170 million **home-based workers**.
- Construction, domestic, and manufacturing workers each include >50 million informal workers, as does street vendors. Waste pickers and transportation workers are each <50 million.
- Of the >215 million migrant workers, most engage in informal work, adding legal complexities to health and other measures.

Penetration of health insurance and social protection is low among informal workers, even with national health insurance.

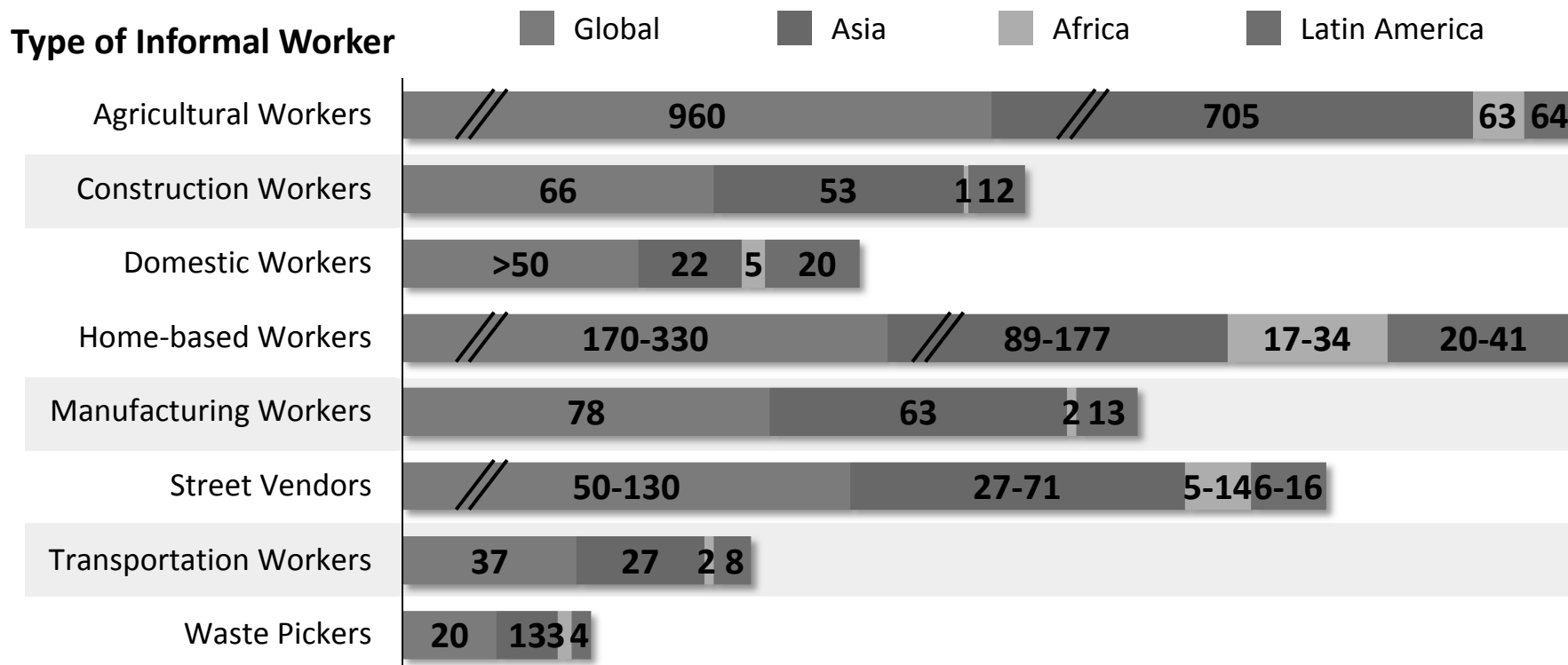
- SE Asia and UHC – Vietnam & Indonesia: many informal workers not covered. India & Bangladesh – low coverage.
- Workers in Africa, rural women and casual workers are the least likely to have insurance against work accidents or injury.
- In Latin America, on average 35% in informal work categories have access to health systems compared to 60% of workers.

Informal workers are poorer and more vulnerable than formal workers, experiencing higher rates of injury and illness because of insecure and unhealthy employment conditions and inadequate health care.

Informal Worker Summary: Estimated Scale

Regional estimates of informal workers indicate that Asia has the largest number of informal workers, about 7-times more than in Latin America and 8.4-times more than in Africa.

in Millions



Most numbers are estimated based on R4D calculations with data from World Bank and ILO/WIEGO datasets. Bars with a gray background represent only the 32 countries reporting in the ILO/WIEGO database.

What is the impact on the lives of poor or vulnerable people?

Impact on the Lives of the Poor or Vulnerable



Informal employment is associated with increased levels of illness and injury because informal workers are exposed to greater health risk due to poorer work- or occupation-related conditions as compared to formally employed workers.

- **Many workplaces are unsafe – resulting in illness and injury:** Nearly half of all wage workers in Bangladesh and Latin America reported unsafe workplace conditions, while more than 60% of the informal women workers in India reported physical weakness due to poor working and living conditions. In South Africa, the incidence of work injury was 7.2 times higher in the informal versus formal sector; in the Philippines, >50% of non-fatal injuries are incurred by self-employed informal workers. In addition, children may suffer direct health issues from parent's work, e.g., lead poisoning due to home-based battery manufacturing and asthma among street vendors' children who go to work with their parents.
- **Some workers are particularly at-risk:** Older and younger populations are most vulnerable and most affected by ill-health. Migrant workers often engage in agricultural and domestic work, which have high health risks. Disaggregated informal workers, e.g., domestic and home-based workers, most of whom are women with high health risks, are harder to reach with health services.

A key driver of poorer health among informal workers is inadequate access to health care and coverage, which combined with higher health risks increase vulnerability, particularly for migrant workers, who may also face legal obstacles and are least likely to seek services.

- **Inadequate access to health insurance:** Only about one-third of domestic workers and non-wage workers have health insurance in Latin America, compared with three-fourths of salaries workers in private organizations with 6 or more employees and 90% of salaried public workers. In Ecuador, Mexico, Panama, and Peru, access to healthcare diminishes according the number of workers in a business (small businesses tend to be informal); in businesses with 100 or more employees health coverage is close to 90% vs. 15% in businesses with 1-5 workers.
- **More restrictions on women for general and work-related health conditions:** Lower incomes, disaggregated workplaces and lack of power restrict access to care beyond insurance coverage. Many female informal workers are unable to leave work for basic health care, maternity leave or prenatal care, or mental health services, despite facing increased health concerns, such as physical and sexual abuse.

































Illness and injuries create hardship among families due to loss of income and expenses incurred in the course of treatment – particularly for chronic or debilitating conditions; yet delaying care also has costs related to an increasing severity of conditions requiring more expensive care.













- **Many informal workers have few resources:** In India, about 80% of the informal workers are poor; in Cambodia, >55% are below poverty line.
- **Occupational injuries are costly to families:** Street vendors in Ghana reported that work-related injuries (e.g., chronic back and joint injuries from repeated motions, dehydration and infection) could cost 2-6 weeks of income. In India, 92% of survey respondents noted loss of income due to illness, 17% lost their job, and 57% lost up to 10 days pay. In Bangladesh, poor families lost about a month's wages/year due to illness.

Due to insecure employment conditions, informal workers' families face financial hardship.

Informal Worker Summary: Health-related Issues

Differential health-related issues are important to consider when framing an intervention or setting priorities, as they suggest mechanisms and level of commitment required.

Type of Informal Worker	# of Serious Health Issues	Severity of Health Risks	Social Protection	Migrant Workers
Agricultural Workers				
Construction Workers				
Domestic Workers				
Home-based Workers				
Manufacturing Workers				
Street Vendors				
Transportation Workers				
Waste Pickers				

 High Proportion of Workers Affected	 Risk of Death, Serious Injury or Disease	 Over Half Insured	 Significant Subgroup
 Few Workers Affected	 Risk of Acute Illness or Chronic Non-fatal Conditions	 Few Insured	 Some Reported
 Very Few Workers Affected	 Few or Un-severe Occupational Health Issues	 Very Few Insured	 Very Few to None Reported

¹Aggregation: How physically grouped the workers are as a proxy for how easy it might be to reach them with either a health care intervention or to organize/mobilize.

What are the root causes at play? What systems failures are causing or exacerbating the problem?

Poor access to health care as well as gender and economic inequalities are particularly detrimental to the health of informal workers – they limit a person’s ability to mitigate the impact of health risks.

System Failures: Underlying constraints that exacerbate the vulnerability of informal workers

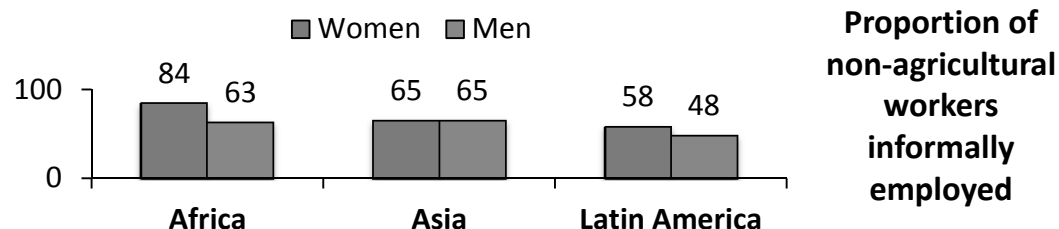
Political System Informal workers are often invisible, thus marginalizing them in policy making. They often are not empowered to raise their profile and advocate and fight for their rights.	Economic System Formal sector policies often do not include informal workers, who may be seen as sources of public expense not revenue, as they do not pay taxes and have low income levels.	Health System Low government health care expenditure, an infrastructure skewed to urban areas, and inadequate UHC implementation limit system accessibility for informal workers.	Socio-cultural System Cultural norms and practices may include restrictions that hinder access to opportunities, particularly for women who face discrimination.	Education System Lack of adequate education and training makes a large portion of the workforce depend on low-skilled jobs with little room for negotiating better employment conditions.
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Root Causes: Main drivers that directly contribute to vulnerability

Poor Health Care Access & Coverage Urban-concentrated health infrastructure, low focus on primary and preventive healthcare, poor quality of services, and poor insurance coverage and use make for unsatisfactory health outcomes.	Gender Inequalities A high proportion of women in home-based work, domestic work and unpaid family labor, coupled with poor employment conditions and lower earnings for women compared to men, increase women’s health vulnerabilities.	Economic Inequalities Poor economic conditions, limited access to capital or other assets for micro- and small-business owners, and limited access to educational and formal sector opportunities inhibit informal worker economic growth.
Excess Unskilled Labor Lack of employment opportunities and low levels of skills training, combined with a large and growing population, forces large numbers workers to take jobs characterized by poor employment conditions.	Inadequate Regulatory Support Social protection regulations are not effectively designed to suit the needs of informal workers; lack of awareness among workers about the regulations is due to limited marketing and outreach initiatives.	Disorganized Networks Informal workers may have social and family but limited occupational ties – problematic particularly for workers in disaggregated locations. Further limits the voice and opportunities contacts for informal workers.

What are the relevant gender dimensions of the problem?

Women are over-represented in lower income occupations (e.g., home-based and domestic workers) and under-represented in the higher income strata (e.g., employers of other workers).



Women in the Informal Workforce	Estimated # Women	% Women
Agricultural workers	413 million	>40%
Home-based workers	>136 million	>80%
Domestic workers	28 million	>50%
Manufacturing workers	26 million	>33%
Construction workers	13 million	12%
Transportation workers	2 million	5%

Women's unique health needs are not met | The type of work affects women's health | Women have fewer options and resources

- **The importance of maternity benefits:** women in informal work remain in their jobs until labor pains start and return to work soon after delivery. Such behavior not only endangers the health of the women but also their lives and the lives of their unborn or newborn child. Access to primary care services is essential.
- **Domestic workers are vulnerable to physical, psychological, and sexual abuse,** as they are isolated, work very long hours, and get little pay, especially migrant workers. They face increased risk for asthma and other respiratory problems associated with the regular use of toxic cleaning agents, and injuries due to heavy lifting.
- **Women tend to be concentrated in the most informal and insecure jobs** within the agricultural sector and receive the lowest pay. In the agricultural sector, in Chile, 53% of temporary workers but only 5% of permanent workers are women; in South Africa, 69% of temporary or casual workers are women compared to 26% in permanent employment.
- **Homeworkers have reported reproductive health problems** including ovary-related problems, abdominal pain, miscarriage from working paddle driven machines, disturbance of fetal position during pregnancy from excessive sitting (sometimes leading to need for C-section), and lack of antenatal care services.
- **Physical labor exposes women to many debilitating health conditions that have long-term consequences.** Manufacturing, food processing, and the garment industry workers are at risk of repetitive use injury of hands and feet, lung disease, hearing loss, accidents, and exposure to biological hazards. Agricultural workers have reported muscular, psychological, stomach, eye, and skin problems. Female street vendors (mainly those over age 40) reported illness and injury, e.g., burns, cuts, headaches, and musculoskeletal problems.
- **Women are prevalent in home-based work because it allows women to simultaneously care for children and homes,** and addresses cultural limits to women's mobility. Exposure to hazards in the home are disproportionate because they also affect children and can potentially cause life-long impacts.
- **Pesticide poisonings disproportionately affect women** due to their higher levels of body fat and have been documented to produce birth/reproductive defects.
- **Women's concentration in insecure employment makes them targets** of sexual harassment by supervisors responsible for renewing contracts.

What are the prevailing perspectives on this problem?

Activities to secure access to health and address employment insecurities for informal workers are based in part upon perspectives on the role and permanence of the informal sector. All four perspectives have a following, are being applied in developing countries, and are based in promoting equity for informal workers.

<p>The “Drive to Formalize” Approach</p>	<p>“The formal sector is optimal; efforts should be made to translate it to the informal sector.” This view is based on a good governance model of economic efficiency in which businesses conform to OHS regulations and provide some employer-based benefits, including health insurance or access to health care. This view considers the informal sector a temporary state and is prominent among multilaterals (e.g., ILO, The World Bank, OECD) and among traditional economists.</p>
<p>The “From the Bottom Up” Approach</p>	<p>“Benefits and policies for the informal sector should be designed by the workers, who understand their needs and the existing barriers to access to health care.” Workers have organized via trade unions, community groups, NGOs, and other forums to promote health and safety. Benefits may also include housing supplements, care for older family members, maternal and child health, and food security. This approach is promoted by organizations like WIEGO, SEWA, HomeNet, and StreetNet.</p>
<p>The “Health for All” Approach</p>	<p>“Improving health and accessibility for all includes informal workers and their families.” By focusing on health affordability and improved infrastructure, governments can ensure that informal workers do not “fall through the cracks.” This approach includes insurance schemes to work toward UHC; enhanced clinics and training for work-related care; and expanded access to primary care. This approach is used by governments (e.g., India and Thailand) to meet health needs.</p>
<p>The “Rights Based” Approach</p>	<p>“Focus on improving health rights and protection of informal workers.” NGOs and international research organizations have been actively involved in demanding recognition of the right to health and improving employment conditions for informal workers. This approach, promoted by academics and international organizations, uses research and policy advocacy, and international conventions (e.g., the Universal Declaration of Human Rights) to promote health access.</p>

The context is important in determining which approach (or combination of approaches) will be most effective in meeting the needs of informal workers. Some of the most interesting actions seem to be arising when partners work together across approaches.

What has and has not worked?

Past efforts have taken many forms, including provision of health insurance, to increase the resources of informal workers and promote regulations to improve safety.

	What Has Not Worked	What Has Worked
Efforts to Prevent Ill Health	Many national Occupational Health and Safety policies do not include the informal sector. This may avoid burdening informal businesses or protect employers but it puts informal workers in high-risk situations, e.g., lack of bars on windows resulted in fatal falls of domestic workers.	Targeted programs/policies can be effective in achieving specific goals by focusing on local authorities and including informal workers. Example: In 2009, the Indian government enacted a national urban policy (Street Vendors Bill) that allowed state/municipal authorities to provide preventive and curative health coverage.
Efforts to Improve Access to Health Care	Some government-mandated programs to provide health insurance have not worked well because they do not meet the needs of informal workers. India's <i>Rashtriya Swasthya Bima Yojana (RSBY)</i> , national insurance program (2008), provided publicly subsidized care and secured private insurance via a competitive process. Early results show that services focused less on commonly needed preventive care and OHS, and more on costly but less needed services such as surgery.	Programs that highlight health priorities of informal workers can be successful. <i>HomeNet Thailand</i> played an active role in the national commission leading to the "30 baht health insurance scheme," subsequently UHC with 99% population coverage. UHC scheme in Thailand was implemented with support of multiple stake-holders (NGOs, community, private organizations, public officials, and informal worker representatives), resulting in better coverage, greater commitment to success and higher rates of acceptance of the scheme.
Efforts to Improve Work Security	Extending schemes designed for formal workers to cover informal workers without understanding the needs of the informal workers has mostly led to poor uptake. Ethical trade initiatives to lead to improvements in health and safety conditions are rarely directly tied to poorer workers. Two examples in Chile and South Africa (horticulture industry), and Thailand and Philippines (garment industry) show that efforts to curb the industry were more directed toward buyers than workers – there was little effect on informal workers.	Customized and well-designed schemes that incentivized registration. In Thailand, registration for voluntary health insurance under Social Security Law was re-designed for informal workers by adjusting the contribution payments and modifying risks covered. Collective action by informal workers can lead to not only specific actions but also a voice. <i>SEWA</i> has been influential on national commissions and meetings on health, UHC, and support services (e.g., child care). <i>Kagad Kach Patra Kashtakari Panchayat (KKPKP)</i> , Indian waste pickers' trade union) and South Africa's <i>Asiye eTafuleni</i> are designing carts that are easier to maneuver and lighter to pull.

The unique employment and working conditions of informal workers require their participation in developing and implementing solutions – top-down, one-size-fits all solutions generally fail to account for such factors.

2) Dynamism Assessment

Purpose

- The Dynamism Assessment aims to identify the primary opportunities that could be catalyzed to address the problem. It also aims to identify emerging issues and future trends that could influence these opportunities, and the potential risks or uncertainties that could inhibit transformative change.

Key Findings

- Partnerships among actors – e.g., government, private funders, worker-led organizations, NGOs, and private insurance companies – have focused on population-level (national insurance/UHC) or worker-specific (smaller, tailored) programs, contributing to scattered and geographically oriented progress.
- The most dynamic forces are: a) the growth of partnership models to foster programs/policies, b) an increasing awareness of informal worker health issues among informal worker groups and external actors, and c) the acceptance of UHC as a goal to promote health for all. The level of activity (window of opportunity vs. tipping point) is country-specific.
- Focus on the health and health vulnerabilities of informal workers is often part of broader programmatic work that includes education, child care, economic and components that contribute to quality of life.
- Several grassroots organizations are addressing informal worker health needs, but usually not as a stand alone focal issue. Health-based organizations often do not track people by employment status, so their level of engagement with informal workers is often difficult to gauge.
- Emerging trends include a) addressing economic systems failures through coordination among national and international institutions, and b) promising advances in the use of technology for communication and information-sharing could facilitate identifying/tracking informal workers.
- Greater coordination of health and employment data collection efforts is needed to identify health needs and access patterns, and to reduce the level of uncertainty about the scale and scope of these issues.

What forces are creating windows of opportunity?

Forces Contributing to Dynamism

Population-level Forces

- **Bilateral and Multilateral Organizations: World Bank, Sida, DFID.** These entities provide much of the funding in the space, including for projects on informal workers, health systems, and health care. In 2012, the World Bank increased funding on social protection and worker training – these programs will include, but are not directed specifically to, informal workers.
- **Multilateral Organizations:** Decent Work Agenda (ILO, 1999) and Social Protection Floor (ILO/WHO, 2009/2012). These entities promote extending health and social protection to improve employment and working conditions, with an emphasis on vulnerable (including informal) workers. These efforts pressure governments to respond and they engage/motivate informal workers.
- **National Governments.** Most countries start by enrolling formal workers and easy-to-reach populations, with informal workers added later. UHC results are mixed but lessons are being learned about affordability, income insecurity, and services needed/wanted; evaluation will guide refinement and expansion. Countries in intermediate stage: Ghana, Indonesia, Philippines, Rwanda and Vietnam. Countries in early stage: India, Kenya, Mali, and Nigeria.

Worker-level Forces

- **Women-focused Organizations: WIEGO, SEWA, and HomeNet Thailand.** These organizations have been effective in organizing women. They develop systems and processes designed for informal workers, including better-suited insurance schemes, tailored options for informal worker needs, a market for health micro-insurers and providers. WIEGO's health work focuses OHS, e.g., in Thailand (with HomeNet Thailand) and Tanzania for domestic workers. SEWA emphasizes health education, treatment, preventive and primary care, and referrals to public hospitals and dispensaries.
- **Other Worker Organizations: StreetNet International and others.** These organizations work with specific groups – e.g., StreetNet with street vendors to promote access to health care among other benefits and to enact agreements for greater protection, such as in India, Ghana, and Nicaragua.
- **Bill & Melinda Gates Foundation.** The Foundation is a major funder of global health and also has micro-insurance and other relevant projects, e.g., they had a program to improve conditions of waste pickers in urban environments but the scope was too broad to accomplish desired outcomes.
- **Information exchange.** Knowledge management is a current trend in global health, with mHealth and K4Health and others leading the field and providing valuable health information to all. Though these programs do not target informal workers, they are constantly evolving and adding new pieces.

Areas of Dynamism

International bodies are now accepting the role of the informal workers and their health issues. This opens the opportunity for high-level initiatives that provide a framework for national and sub-national policies and standards.

































Expansion of UHC is highlighting what works and what does not work. As countries expand and evaluate UHC expansion, they learn lessons about reaching the diverse population of informal workers.













Groups that organize informal workers are now promoting safety and health; providing services or increasing primary care access; expanding insurance options, and encouraging opportunities for informal worker representation. These efforts support informal worker health by listening to their needs.

Growing awareness of the health issues of informal workers among funders and other actors. The greater the awareness, the greater the possibility for new partners, new funding and new ideas.

Informal Worker Summary: Momentum

Momentum is a multi-faceted concept visualized through several parameters. As priorities for engagement on informal worker health issues are set, the balancing of these parameters suggests activities and interventions.

Type of Informal Worker	Attention ¹	Partners ²	Funders ³	Maturity ⁴
Agricultural Workers				
Construction Workers				
Domestic Workers				
Home-based Workers				
Manufacturing Workers				
Street Vendors				
Transportation Workers				
Waste Pickers				

 New Literature & Media	 Several Active Organizations	 Several Active Funders	 Local, National, International Work
 New Literature OR Media	 A Few Active Organizations	 A Few Active Funders	 Local, National Work
 Little Recent Activity	 No/Limited Potential	 No/Limited Potential	 Local Work

¹**Attention:** Coverage of health issues in the media and in the peer-reviewed or gray literature; ²**Partners:** Availability of actors from various sectors who could partner with RF on projects; ³**Funders:** Relative number of funding organizations currently working on health issues for informal workers; ⁴**Maturity:** Level of progress of work related to informal workers, with some types having only locally-focused programs and others having national or international policies and programs on which to build.

What are the primary opportunities that could address this problem?

There are multiple intervention points for various actors within each Area of Dynamism.

Organizing Grassroots – Worker-level Activity

By engaging informal worker organizations, grassroots organizing efforts have increased access to health for informal workers.

Building coalitions: Make connections between workers to identify priorities and develop solutions that meet worker/family needs.

Building advocacy capacity: Educate workers on using their voices to advance an agenda.

Developing a platform: Empower and influence existing networks (e.g., mHealth and K4Health) to promote health care and share knowledge.

Participating in research: Develop mechanisms in which data can be collected and analyzed to compile lessons learned and best practices.

Promoting preventive health care: Find ways to dispense primary care near home or work.

Applying Large-scale Insurance Plans – Population-level Activity

Governments and private sector actors have increased their activity in developing health insurance that is affordable and appropriate.

Building evidence base: Develop ongoing research protocols and collect data on health and informal workers (baseline and annually).

Innovative financing: Work with private sector partners to develop and implement financial and investment mechanisms that fund health access for informal workers and their families.

Implementing policies: Develop, support, and apply affordable/appropriate UHC and health insurance at national and community levels.

Dispensing grants: Fund NGOs, researchers, and others to develop innovative approaches.

Acknowledging Informality – Population-level Activity

International institutions and national governments are recognizing informal workers via standards, policies, and opportunities.

Building sustainability: Develop standards and guidelines for national-level programming and policies that will reduce health vulnerabilities.

Engaging thought leaders: Promote forums for discussion and development of innovative ways of meeting informal worker needs.

Innovative financing: Work with governments and private sector partners to develop and implement investment mechanisms on health access for informal workers and families.

Influencing partners: Support new actors and engage existing health or informal worker partners in developing new tools and funding.

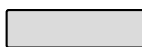
Fostering the Growing Awareness of Informal Workers – Worker-level Activity

Greater knowledge and understanding of informal workers and their health vulnerabilities will inform discussions at all levels and bring about increasing public pressure for meaningful action that will facilitate the development and implementation of new policies and programs.

Branding and marketing: Enhance positive messages about informal workers to engender general and government support.

Promoting effective communication and knowledge-sharing: Increase interaction of informal workers via mobile technology.

Developing learning forums: Increase learning and dialogue to generate new ideas and engage partners at all levels.

 Highlighted initiatives reflect the most dynamic opportunities for further exploration. Dynamism is determined based on size of potential impact on poor/vulnerable and the opportunity for a donor to be uniquely additive or accelerating.

What potential tipping points are emerging?

	Description	What Would Have to Happen to Reach This Tipping Point?
Positive Potential Tipping Points (Actions & events that could catalyze large-scale positive change)	Established partnerships at the intersection between health and informal worker issues provide an opportunity for further action. <ul style="list-style-type: none"> Population-level – example: UHC underway in Ghana, India, Indonesia, Kenya, Mali, Nigeria, Philippines, Rwanda, and Vietnam. Worker-level – example: SEWA has provided health access for women informal workers at clinics and hospitals in several cities in India. 	<ul style="list-style-type: none"> Population-level action: Cooperation between public sector agencies and with private sector and informal worker input is needed for progress in countries. Worker-level: Small-scale progress can supplement large scale efforts or provide interim solutions; trade unions and other organizations can negotiate terms.
	Increased attention to informal workers has raised their visibility, generating political will to act and attention to specific occupations. <ul style="list-style-type: none"> Population-level – ex.: Brazil's World Cup-related focus on street vendors. Worker-level – example: Gates Foundation work with waste pickers. 	<ul style="list-style-type: none"> Attention by external actors can generate interest in informal workers that could attract others to engage. Short-term events/activities could become long-term with leadership from public and private sector actors.
Negative Potential Tipping Points (Thresholds beyond which there is no going back)	The cost of providing health care and health access for the full range of health issues (both general and work-related) may derail efforts. <ul style="list-style-type: none"> Health care will have costs for everyone – governments, providers and users. If costs are too large for any of these three groups, service provision may fail – balancing everyone's needs and resources is a key consideration. 	<ul style="list-style-type: none"> Programs require external funding sources , which could limit operations and sustainability. Workers refuse to commit resources to a program. Providers are unable to meet the demand for services or a to provide care at an affordable rate.
Too Early to Tell (Potential tipping points that require further monitoring to define and size)	<ul style="list-style-type: none"> Health insurance schemes implemented in countries (e.g., India) have not been well-evaluated; research findings could steer the next steps. Schemes that include informal workers need to determine whether health improved with improved access. Technology and accessing primary and preventive health and safety information. The availability of mobile devices and online platforms has been effective in primary care programming; informal workers could benefit from the mHealth and K4Health models. Policies (e.g., Street Vendor Bill) initiated in the past five years to protect the health and safety of some informal workers have not been well-evaluated. Specific health outcomes and broader issues related to implementation of these policies need to be assessed. Private sector corporations and funders could catalyze expansion of activities, particularly health insurance options for informal workers. Corporate involvement via CSR and in providing health insurance options, as in India's RSBY program, require review. Leverage of existing health or economic structures. The Millennium Development Goals (MDGs) provided a framework for progress on issues including health and poverty. Post-MDG/post-2015 framing may be useful, given informal workers' vulnerabilities. 	

What are emerging issues and future trends that could influence these opportunities?

Connecting the Economic and Social Agendas

Following the recent global economic downturn, international organizations and nations realized the importance of balanced reforms in support of economic growth, social stability, and health coverage to address common global concern about and interest in preventing or mitigating the impact of future “economic shocks.” This led to:

- Promotion of the “social protection floor” agenda by the ILO and WHO that brings informal workers into the framework.
- Increased openness by International Financial Institutions to account for fiscal costs of universally extended minimum social protection to the informal worker population.
- A re-examination of labor services and links between economic losses and poor Occupational Health and Safety standards with the goal of providing insight into potential OHS policy.

Willingness to Build on Prior/Current Efforts

Over the past several years, many countries have implemented efforts to reach a goal of Universal Health Coverage. With health initiative implementation, many countries have made progress in including informal workers in primary care and insurance plans:

- Integration of vertical programs led to progress in Argentina, Brazil, Chile China, Ethiopia, Ghana, Rwanda, and Thailand.
- Countries in intermediate UHC reform: Ghana, Indonesia, Philippines, Rwanda, and Vietnam; countries in early UHC reform: India, Kenya, Mali, and Nigeria.
- Additional experiences with micro-insurance schemes for health and market prospects for health insurers and providers, and targeted health provision for some informal workers.
- National legislation on financial support mechanisms and rights, advanced by grassroots campaigns and gender-focused groups.

Recognizing Informal Workers in the Economy

Recognized higher profile of and appreciation of informal workers, which has led to:

- An increased interest in building a strong fiscal revenue base that invests in people and health, including informal workers.
- An increased understanding of informal employment in the economy – e.g., the insecurity of informal workers’ ability to contribute to the economy.
- Recognition of the need for rigorous and systematic global data collection, and comparisons across countries and employment status – esp. with regard to informal workers and benefits.

Emergence of Support and Awareness

Increased interaction and communication – e.g., on the complementary roles of public and private sectors – between countries, informal workers, and others has increased the awareness of informal worker needs. Examples include:

- Communications tools (e.g., mobile phones, internet) to house health information, access service availability, and registration.
- Enhanced impact of media and civil society action to promote health and informal worker issues , such as organizing.
- Increased availability of technical support on health system infrastructure from external sources and informal workers.

What are potential risks or uncertainties?

Action on health issues for informal workers may be derailed or diminished if their needs are not considered and if attention is not paid to the development and implementation processes.



3) Landscape Assessment

Purpose

The Landscape Assessment aims to identify the key players and opinion leaders in the field, what organizations are doing innovative work, who provides funding, and the gaps in funding.

Key Findings

- Although there are technically many actors (e.g., various government agencies, NGOs, corporations, etc.) around informal workers' health, **the funding support in the nexus is shallow** and, except for strong support from the grassroots organizations, commitment to informal workers is not high on many priority lists.
- Activity on informal worker health issues is not currently directed by a particular actor – some work is focused on population-level activities that benefit all informal workers, while other activities focus on worker/occupation-oriented activities. **Most activities are limited in scale, scope and geographic reach.**
- Funding levels directed to the health vulnerabilities of informal workers are nearly impossible to discern, as generally **projects are part of a larger portfolio** and **few programmatic funds support work on health vulnerabilities**. Similarly, national funding specifically directed to extending health insurance to the informal worker population are subsumed within the overall health budget and thus not readily available.
- A few opinion leaders, particularly WIEGO and SEWA, link grassroots efforts with philanthropic organizations, health insurance companies, multilateral and bilateral institutions, and local, regional, state and national governments, with the goal of making “invisible” informal workers more readily apparent to policymakers.
- Differences in occupational health and health vulnerabilities of informal workers vary by workplace, type of work, sector, and country. These gaps are addressed via a patchwork of policies, activities, and programs.
- Corporations and foundations are supporting, testing, and funding approaches that focus on specific worker populations and different levels of intervention. This work creates opportunities to learn about what works.

Who are the key players and opinion leaders for informal workers?

The key players and opinion leaders at different levels engage in different types of activities – this is important when selecting partners or planning engagement.

Key Activities	Prominent Actors	International	National	Informal Worker-specific	Sub-national
Research	World Health Organization, International Labour Organization, World Bank, Institute for the Study of Labor	●	●	◐	◐
Technical Cooperation	World Health Organization, International Labour Organization, World Bank	●	●	◐	◐
Agenda-setting	World Health Organization, International Labour Organization, G20 Leadership Summit, 2013	●	◐	◐	◐
Informal Unions	HomeNet Thailand, SEWA (Self Employed Women's Association), International Domestic Workers' Network, StreetNet International	◐	◐	◐	◐
Grassroots Organizing	StreetNet International, SEWA (Self Employed Women's Association), WIEGO (Women in Informal Employment: Globalizing and Organizing)	◐	◐	◐	◐
Policy and Program Research	MoH (various), Abdul Latif Jameel Poverty Action Lab (J-PAL), United States Agency for International Development, Department for International Development (UK), World Bank	○	◐	◐	○
Health Insurance	LIC's extending UHC to informal workers (e.g., Ghana, Indonesia, Rwanda, Vietnam, Philippines), MFI (e.g., ACODEP, BRAC, GRET), private firms (e.g., MicroEnsure, and Zurich Bolivia Group)	○	◐	◐	◐
CSR Interventions	Mars Incorporated, Lipton, Starbucks Coffee Company, Unilever	○	○	◐	◐
Health and Technology/Design	Worker's Unions, The Bill & Melinda Gates Foundation, The Hershey Company	○	○	◐	◐

● Very Active Diverse actors, many projects: large scale	◐ Active Several actors, a range of projects: mixed scale	◐ Some Activity A few actors and projects: smaller scale	◐ Little Activity Some small projects: small scale	○ Not Active No projects identified
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Who are the key players and opinion leaders in the field?

Many players are loosely engaged with informal workers' health by addressing either health or informal workers, but the nexus of these issues is largely neglected.

Population-level Players

Governments and Bilateral Donors

National governments: Fund health systems, UHC activities, and national health insurance schemes. The level of funding varies by country and some are only beginning to include informal workers.

Bilateral donors: CIDA, SIDA, DFID currently fund areas that related to the target of health vulnerabilities of informal workers, though these projects may include minimal funding and attention to this specific topic.

Multilateral Organizations

Programs: The Social Protection Floor escalates social protection for all, including informal worker health, and unites the ILO and WHO around a new agenda. The ILO's Decent Work Agenda addresses the health and safety of workers and explicitly recognize informal workers; countries develop an action plan. The UN Food and Agriculture Organization works with rural informal workers and unions on health issues.

Funders of health or informal workers: World Bank, ILO, UN WOMEN, the UK Community Fund

Worker-level Players

Global Networks, Trade Unions and Civil Society Orgs.

Global Networks: WIEGO, a global action-research-policy network seeks to improve the status of the working poor in the informal economy, especially women. WIEGO's social protection program focuses in part on providing reproductive health services and compensation for work-related accidents and injuries.

Informal Worker Trade Unions and Initiatives: Work on behalf of specific types of informal workers or to achieve objectives. Examples: IDWN (domestic workers), StreetNet (street vendors), HomeNet (home-based workers), SEWA (women), and Worker Rights Consortium. **Civil Society:** Micro-finance initiatives offer loans and health micro-insurance for health access – e.g., Cashpor, Grameen in Bangladesh, and NRSP Microfinance Bank in Pakistan; meetings and skills trainings also discuss reproductive and other issues.

Population- and Worker-level Players

Funders and Opinion Leaders

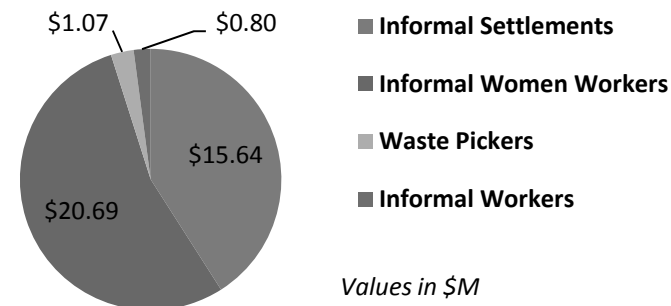
Foundations and Corporations: Bill & Melinda Gates Foundation, Ford Foundation, Packard Foundation; Corporations: Mars Inc, Starbucks, Lipton, and Unilever, among others.

Thought/Opinion Leaders: Juan Somavia- ILO Director-General who initiated the Decent Work Agenda; SEWA Founder, Ela Bhatt who pioneered working women's unionization in India and extended it globally, WIEGO - Martha Chen, Francie Lund, Vilma Santana bringing voice and visibility to women in informal work.

Who is providing funding in this space?

Funding Landscape: Key Observations – Foundation Support

- In 2008-2012, four major philanthropic foundations* collectively funded approximately **\$38 million** (92% from the Gates Foundation) in projects related to informal workers, of which a small fraction funded health activities.
- Funding is difficult to track because most foundations fund a larger program of activities and do not map grants to “health vulnerabilities”. Determining the specific amount for health of informal workers is particularly problematic.
- Z Zurich and Munich Re Foundations support micro-insurance research, which may include informal sector health products.



* Ford, Gates, Packard and Rockefeller Foundations

Funding Landscape: Key Observations – Public Sources, Bilateral and Multilateral Agencies

Funder, \$M*	2009	2010	2011	2012
CIDA	0	14	0	0
DFID	67	27	0	72
SIDA	1	0	1	1
World Bank	8	59	67	200
Total	75	100	68	274

*\$ in Millions 2012 USD

- **\$274M** funds a broad array of programs, with a portion supporting health.
- AusAID and GIZ support work related to the health of informal worker populations, such as informal workers' social protections, health insurance, and health interventions, but did not report project-level amounts.
- The ILO, UN WOMEN, IDRC, USAID, ADB, and IADB work in related areas of informal sector social protection and occupational health and safety.

Funding of health systems for informal workers and efforts to extend UHC to informal workers by national governments is generally not separated from overall health system funding, so it is not readily available.

While funding for informal workers and for health overall may be significant, it seems very little is currently focused on health vulnerabilities of informal workers.

Matching funder goals with those of informal workers can yield new approaches to addressing health issues for informal workers.

Population-level Activity	Promoting Health Insurance: Evaluate What Works and What Doesn't	<ul style="list-style-type: none"> • Understanding how health insurance works with an informally employed population means figuring out how to a) make it work, b) ensure its uptake and usage, and c) make it acceptable. <ul style="list-style-type: none"> – The Gates Foundation, World Bank, ILO and DFID are interested in health insurance mechanisms. – Despite service innovations, reaching informal workers remains a challenge; there is scant evidence of improved health outcomes and reduced expenditures among those who use health insurance.
	Acknowledging Informal Workers: Corporations Finding Ways to Work with Informal Workers	<ul style="list-style-type: none"> • Meeting informal workers in the middle to make progress on common health concerns. <ul style="list-style-type: none"> – CSR activities deliver health services to workers where they work, which may reduce costs on all sides. – Micro-finance Institutions are packaging health services, insurance and education with loans and other micro-finance services. – Most projects aim to assess vulnerabilities; provide better work, education and health; and understand ways to extend social protection coverage – all of which require informal worker buy-in.
Worker-level Activity	Organizing the Grassroots: Building the Capacity of Informal Workers to Address Health	<ul style="list-style-type: none"> • Recognizing the value of convening multiple-stakeholders when it comes to solving community problems – enhancing the capacity of informal workers to develop and apply practical skills. <ul style="list-style-type: none"> – WIEGO is training market-women to convene and enlist city officials in helping make public markets (their workplaces) more sanitary and healthy. – Participatory health research by the ILO and WHO among groups of informal workers increases occupational safety and reduces workplace injuries using community self-help techniques.
	Raising Awareness: Bridging the Gap between Health and Home	<ul style="list-style-type: none"> • Finding new ways to think about health for informal workers by thinking about how it relates to home and opportunities for convenient delivery of health care services. <ul style="list-style-type: none"> – Mapping informal slums, including the presence/absence of primary health care clinics, and supporting self-help initiatives to secure tenure, install toilets, and build houses. – The National Street Vendor's Association of India (NASVI), funded through member dues, helped bring about a national policy recognizing a vendor's right to livelihood and to occupy urban space.

What organizations are doing innovative and/or high-impact work?

Although we identified many existing interventions in the space, few organizations are doing highly innovative and impactful work that is directly focused on the health vulnerabilities of informal workers. A sample is included below.



Microinsurance Innovation Facility: The Bill and Melinda Gates foundation partnered with the ILO in 2007 to launch MiF with a \$34 million grant. In its first five years, MiF studied and learned from microinsurance innovators. It supported 67 grants to develop and test new microinsurance products, models, and strategies; provided capacity-building assistance to 57 individuals and organizations; gave academic research grants; helped build South-South Communities of Practice. MiF will now begin promoting good microinsurance practice and work to dramatically expand low-income market services. It will work to strengthen insurers and widen the availability of better risk-management practices.



Department
for International
Development

Construction Worker Health and Safety: Between 2007 -2011, DFID funded a £300,000 (\$450,000) capacity building project among construction workers in Tanzania. Members of the UK organization Engineers Against Poverty (EAP) led the project alongside Institution of Engineers Tanzania (IET). A core group of men and women drawn from all the major stakeholder organizations, including the Occupational Safety and Health Authority (OSHA) and the Contractors Registration Board (CRB), in construction health and safety was trained. Construction is a key area because of its high accident risk, and exposure to dust, noise, vibration or chemicals. This core group then in turn trained their co-workers and employees.



NRSP Microfinance Bank Limited

این آر ایس بی مائیکرو فنانس بینک



International
Finance Corporation
World Bank Group

National Rural Support Program: In 2011, with additional investments from Acumen Fund, KfW, and the International Finance Corporation, a traditional community-based MFI in Pakistan was transformed into a regulated Microfinance Bank. This will enable NRSP to access new sources of finance and scale-up its loan activity, which is focused on loans to low-income clients and small farmers across Pakistan. NRSP Microfinance Bank currently has more than 120,000 active clients. The organization expects to reach nearly 625,000 borrowers over the next five years.

Coverage Drivers

- Rural to urban migration: Coverage has been driven by increased migration of workers from rural areas to urban centers in large emerging market economies in Asia and Sub-Saharan Africa. Coverage is also driven by pressures on governments to address health and safety protections for largely unskilled workers.
- In Southeast Asia, media coverage focused on household domestic workers, which are considered part of the informal economy. Most are women. They are particularly vulnerable to violence and abuse by their employers, and often work in fear of losing their jobs and deportation.

Gap Analysis

- There was little media discussion of the unique problems of informal workers and their ability to demand greater government services and protection. Media did not focus on the fact that high economic growth rates in many developing countries are significant drivers of a growing, cheap, often informal work force, and did not highlight the need for governments to work toward transitioning these workers into the formal economy.
- The problems of domestic workers in Asia received more media attention than other economic sectors where informal workers exist – such as urban transit systems, agriculture, construction, and mining.

Volume, Geography and Tone

- Key geographies were: China, India, Indonesia, Thailand, Nigeria, Kenya, and Ghana.
- Total volume over 10 years was approximately 1,500 relevant articles in both English and native language media.
- Social conversation over the past 12 months was modest, and led by journalists, development organizations, and worker rights NGOs.
- Tone was neutral, with some criticism of the need for governments to adopt policies to better integrate informal workers into the formal economy.

Highlights from Coverage

- **The unique problems of informal workers:** Informal workers tend to be mobile, undereducated and low-income earners. This combination creates unique difficulties for government service providers to ensure provide health services and worker safety. These populations lack the political clout to effectively advocate for safety and health protections.
- **Domestic workers:** Across Southeast Asia, female domestic household helpers (maids) – who are defined as informal workers – suffer from workplace abuses and insufficient healthcare coverage. They are not considered “skilled workers,” and are highly susceptible to violence, exploitation, unpaid wages or other forms abuse from employers.
- **Healthcare access:** Even though migrant workers may be allowed to access public healthcare facilities, reports showed that they are at risk because they are hesitant to seek care due to language barriers, perceived or real discrimination, fear of arrest for not having proper documents, or an inability to pay for healthcare. Consequently, they often self-medicate or wait to seek treatment until their illness is at a critical stage.
- **Workplace safety:** Media coverage highlighted the need to prevent workplace injuries and increase healthcare coverage for informal workers. There were reports of high rates of injuries (such as hand and arm fractures) in “black factories” in Guangdong and Shandong provinces in China. These black factories are highly mobile and bosses can simply pick up and move their operations when injuries occur.

White Space Recommendation

- Media coverage of informal workers received extensive attention in China, India, and across Southeast Asia over the past decade, where the trend of migrating workers has deeply impacted these emerging economies. However, coverage in Sub-Saharan Africa is just beginning, as economies across that region are just now beginning to experience the impact of informal workers migrating from rural to urban areas.

5) Impact Assessment

Purpose

- The Impact Assessment presents an early view of the impact potential in this space, outlining how we think change could happen based on the dynamism assessment, and using scenarios to illustrate different impact ranges.

Key Findings

- Early work on potential impact in the space points to several areas that potentially could be catalyzed given their current degrees of momentum to address the problem:
 - Increasing informal worker access to preventative health care
 - Making health care less costly for informal workers – reducing out-of-pocket costs and lost income/job,
 - Reducing gender disparities – participation of women in discussions and addressing health needs, and
 - Building sustainability by improving policies, regulation, and funding mechanisms.
- The illustrative scenarios for impact assume a \$100 million investment over 10 years with an impact goal of: *improved employment and working conditions that lead to better health outcomes for workers whose livelihood depends on informal employment.*
- Two potential scenarios for change are profiled, based on their current momentum, potential for leadership and impact, and ability to address the high-level outcomes:
 - Universal Health Coverage – particularly working with countries with efforts underway,
 - Grassroots organizing and partnerships – two examples: working with partners to facilitate the development of health and social protection measures for informal workers, and an innovative combination of health care training/provision and data collection.

How We Think Change Could Happen

Areas of Dynamism That Could be Catalyzed Towards High-level Outcomes

Informal workers are preventing work injury and illness by addressing risk, e.g., street cart design

Community health workers are providing primary preventive care

Partnerships (e.g., trade unions, providers, funders) are offering primary care to the community

Informal worker groups are increasing access to health care facilities

Trade unions and others are using local care to reduce job time lost and promote occupational health

Some government insurance plans now include informal workers

Informal worker groups are providing support services, like child care so women can seek health care

Groups of workers are providing women-specific services

International organizations have started recognizing informal workers, opening social protection options

Governments are improving laws covering informal worker safety, e.g., street vendors

High-level Outcomes That Would be Required to Achieve the Impact Goal

Healthier Workers:
Reduced need by informal workers for health services

Greater Access to Care:
Improved access to convenient and quality health care

Lower Costs from Illness:
Decreased income lost related to health issues and health care seeking

Address Gender Disparities:
Reduced gender differences in access to health and safety

Improved Policy:
Improved policies and practices to assure health and safety

Potential Impact Goal

IMPACT GOAL:
Improved employment and working conditions that lead to better health outcomes for workers whose livelihood depends on informal employment.

There are opportunities to provide health services to informal workers through both worker-specific level activities and population-level activities.

Illustrative Scenarios for Impact

These scenarios present selected choices around which a potential development strategy could be designed. They highlight options that focus on either all types of informal workers in a less direct but more inclusive strategy, or on targeted subsets in a more direct intervention.

Scenario 1: Population-level

Universal Health Coverage has been rolled out in a number of countries, with varying degrees of implementation and evaluation. A number of activities at the population-level could be scaled to reach informal workers:

Occupation-related issues could be covered, to address differential health risks of informal workers. Primary care, such as access for families and to preventive services (e.g., reproductive, maternal and child, and general health), could improve the health outcomes of informal workers and their families. Health care professionals could be trained to identify and treat the types of conditions experienced by informal workers. Gender issues, such as access to women's health could be addressed at the population-level.

Potential Activities:

- Registration and enrollment of informal workers – this is challenging – reluctance to formalize, cannot afford premiums/fees, etc.
- Make use of mobile and online technologies to reach informal workers within a country.
- Work with governments and other partners to evaluate current efforts and then to pilot lessons learned and assess outcomes.

Options include: working with countries in the intermediate stage of implementation, the early stages or those who have not started.

Scenario 2: Informal Worker-level

Organizing informal workers and expanding partnerships with other actors has been used to bring the health focus work to informal worker subgroups. A number of activities could be extended to informal worker groups through increased organizing and partnerships:

Informal workers and their families could receive greater primary care, particularly reproductive, maternal and child, and general health. Occupational health risks could be addressed by training informal workers in workplace health and safety and by increasing the number of health care providers to identify and treat conditions of informal work. New technology outreach efforts could increase worker access to health services, potentially through mHealth or K4Health.

Potential Activities:

- Informal workers in urban or in rural settings may share some health issues – e.g., access to facilities, environmental exposures –engaging them where they work may be an option
- Training informal workers to be advocates for health care access.
- Increasing work-related health care by training primary health care providers to recognize symptoms, providing services and reporting on best practices and scale/scope issues on a national level

Options include: working in a very active space (Asia), a moderately active space (Latin America) or a relatively inactive space (Africa).

Illustrative Scenarios for Impact Vision of Scale

Affected Populations

Population-level: Universal Health Coverage

This affected population includes all types of informal workers, urban and rural. The options focus on registering informal workers and on identifying what has worked in other countries further along in the process.

Est. number of informal workers/country:

- Kenya: 7 million
- Mali: 1.2 million
- Nigeria: 23 million
- Thailand: 9.6 million
- Rwanda: 3 million
- Philippines: 15 million
- Ghana: 9.3 million

Worker-level: Grassroots Organizing

This affected population includes subsets of the total informal worker population - women. For the first option, Latin American women have organized more in urban centers, but not as much in rural settings. The second option focuses more on urban women, who are engaged in several occupations.

Est. number of female informal workers/region:

- Latin American rural women: 10 million.
- Latin American urban women: 20 million.

Possible Solution Spaces

Work with governments and other partners to **register informal workers**, including using communications technology, in three African countries that are in the early stages of implementing UHC programming in their countries: **Kenya, Mali and Nigeria.**

Work with governments and other partners to **evaluate mechanisms for applying UHC to informal workers** in an effort to **enroll informal workers** in countries that are early in the process: **>90% enrolled – Thailand and Rwanda; >50% enrolled – Philippines and Ghana;** piloting phase: TBD.

Work with local organizations and global groups like WIEGO to **mobilize rural women informal workers** to advocate for access to quality health care. Develop training materials, using **online platforms** and **communications technologies**. Training includes: teaching advocacy methods and building capacity to train trainers.

Work with local organizations, global groups like WIEGO, and medical schools to **train providers and to provide treatment for work-related vulnerabilities, injuries and illnesses of urban women informal workers. Develop mechanisms to enable women to use health services, and track and share information.**

Vision of Scale

Indirect benefit to informal workers – easier to process into health insurance if registered.
Direct benefit to informal workers – able to convey information on health during registration.
10-year goal: register 50-75% of informal workers (15-22 million people for all 3 countries).

Indirect benefits to informal workers – informal workers' health-care needs will be better understood, improving program effectiveness.
Direct benefit to informal workers – increased enrollment will improve health outcomes.
10-year goal: survey 5% of informal workers (2 mil.); pilot/eval. new program: enroll up to 5 million; survey 1 million to evaluate program

Indirect benefit to informal workers – thousands will have greater access to health information resources.
Direct benefits – new trainers will increase effectiveness of outreach.
10-year goal: 15,000-20,000 advocates trained; active website reaching more informal workers.

Indirect benefit to informal workers – increased capacity of health care system to address informal worker needs.
Direct benefits – improved program design increases the quality of care of informal workers.
10-year goal: establish programs in 8-10 medical schools; reach 50% of population (10 million).

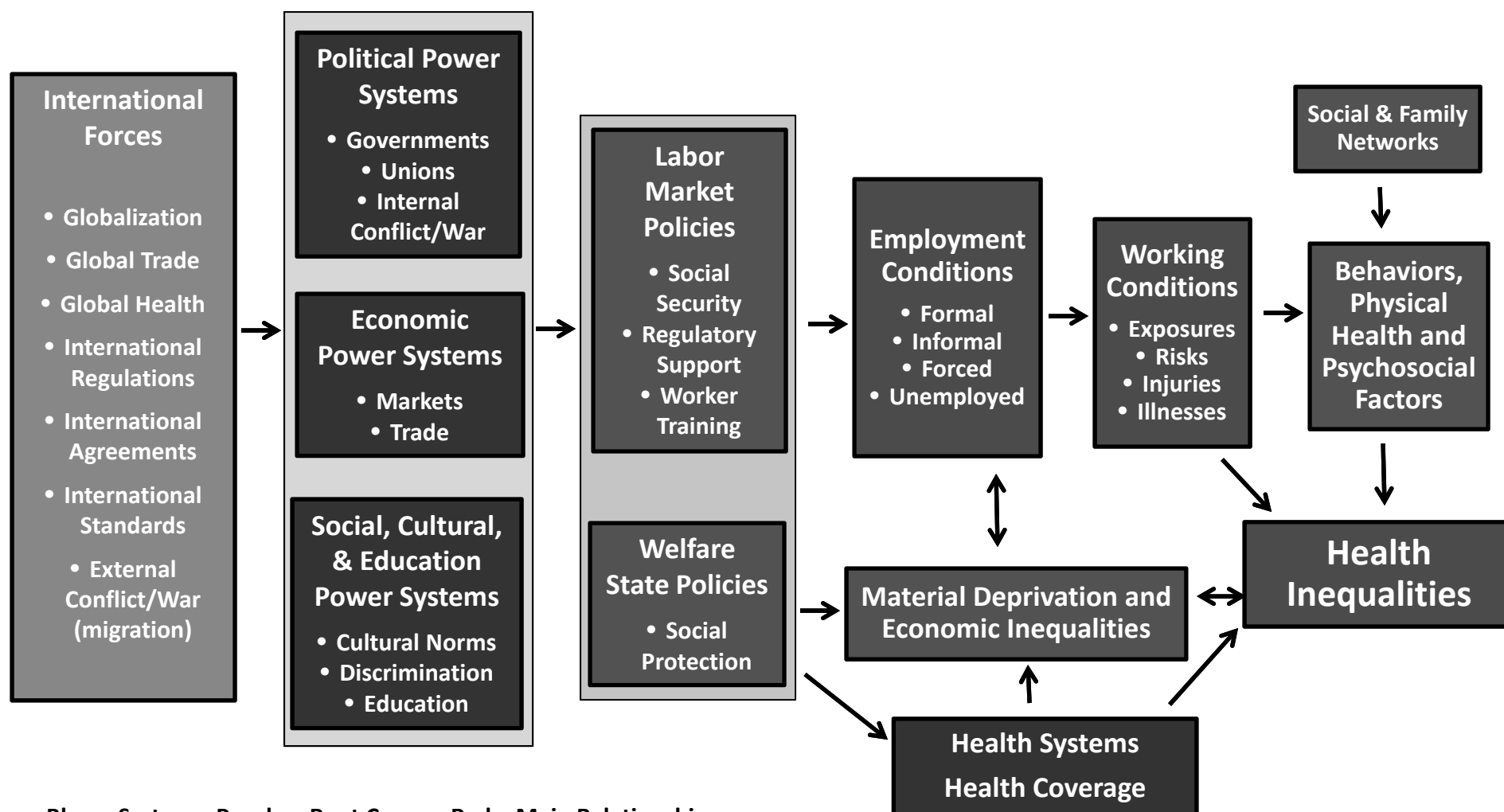
Appendix

Content in the Appendix	Slide Number	Summary of Content
Conceptual Framework	34	<ul style="list-style-type: none"> Demonstrates relationship between employment conditions and health vulnerabilities, with influencing factors included
Preliminary Theory of Change	35-36	<ul style="list-style-type: none"> Detailed description of activities, inputs, outcomes and overall goal of the Search as a Preliminary Theory of Change for a Potential Full Initiative in Execution Application of TOC to the population-level and worker-level
What is not known?	37	<ul style="list-style-type: none"> Identification of key areas for additional research
Health Insurance	38-40	<ul style="list-style-type: none"> Describes the distinctions between UHC and micro-insurance Describes the application of social and community health insurance Describes the current developments related to UHC in 9 countries
Organizations Doing Innovative Work	41-42	<ul style="list-style-type: none"> Describes several organizations who are doing work in Asia
Trade Offs around Entry Points and Momentum	43	<ul style="list-style-type: none"> Graphic to assess potential intervention points' momentum and relevance for health vulnerabilities or occupational health and safety
Sources for Impact Scenarios	44-45	<ul style="list-style-type: none"> Documentation for developing the population- and worker-level impact scenarios
Profile Summary Slides – Type of Worker	46-53	<ul style="list-style-type: none"> Describes the health problems, dynamism, landscape and impact experienced by eight types of informal workers
Profile Summary Slides – Regions	54-56	<ul style="list-style-type: none"> Describes the health problems, dynamism, landscape and impact experienced in Asia, Africa and Latin America
Profile Slides – Type of Worker	57-89	<ul style="list-style-type: none"> More detailed information about the eight types of informal workers (agricultural, construction, domestic, home-based, manufacturing, and transportation workers, and street vendors and waste pickers)
Profile Slides – Regions	90-103	<ul style="list-style-type: none"> More detailed information about the three regions – Africa, Asia, Latin America
Works Cited	104-129	<ul style="list-style-type: none"> References cited in the main slide deck (107-121) and appendix (122-132)

Proposed Theoretical Framework

Population-level Action: Activities and Interventions

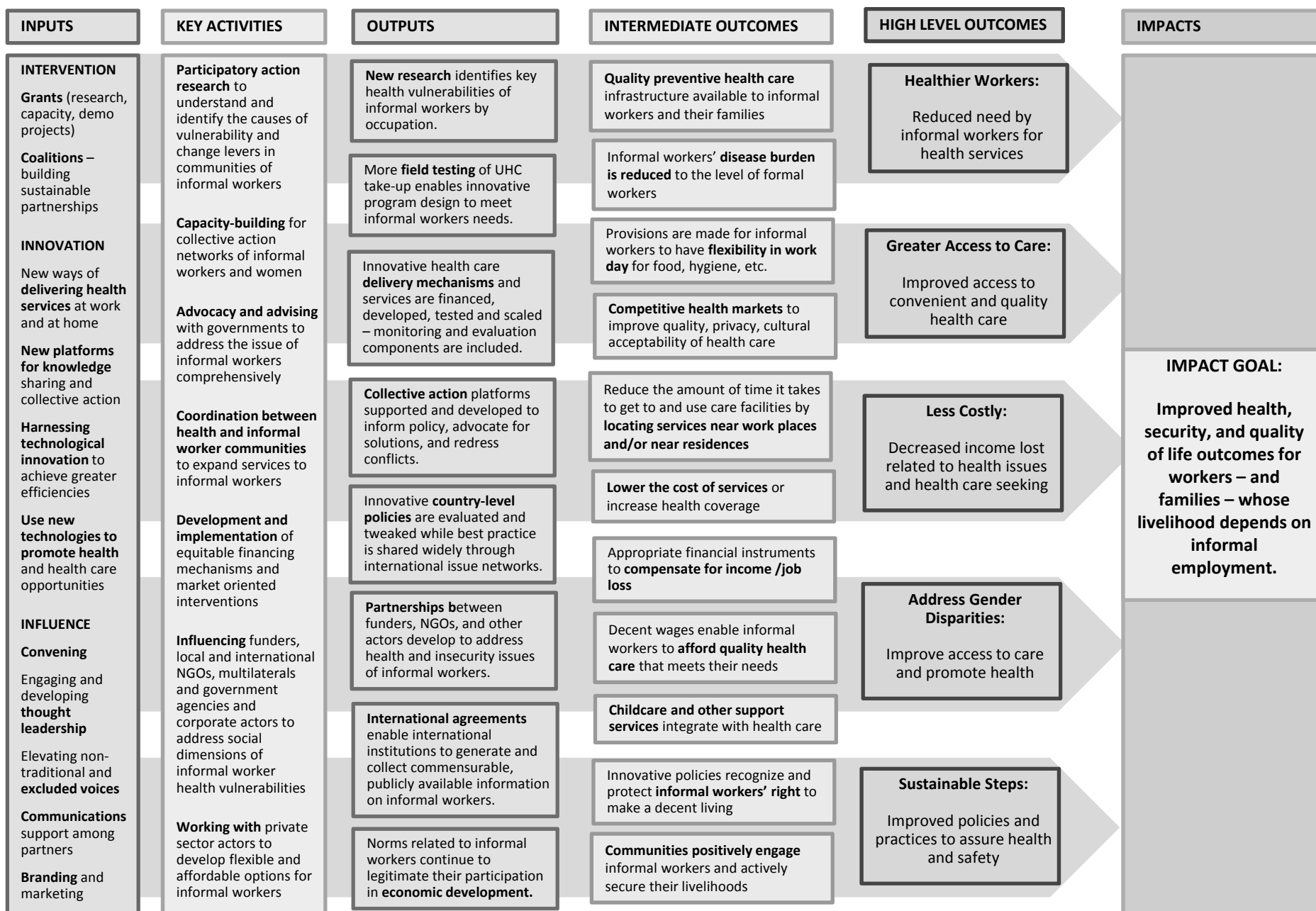
Worker-level Action: Activities and Interventions



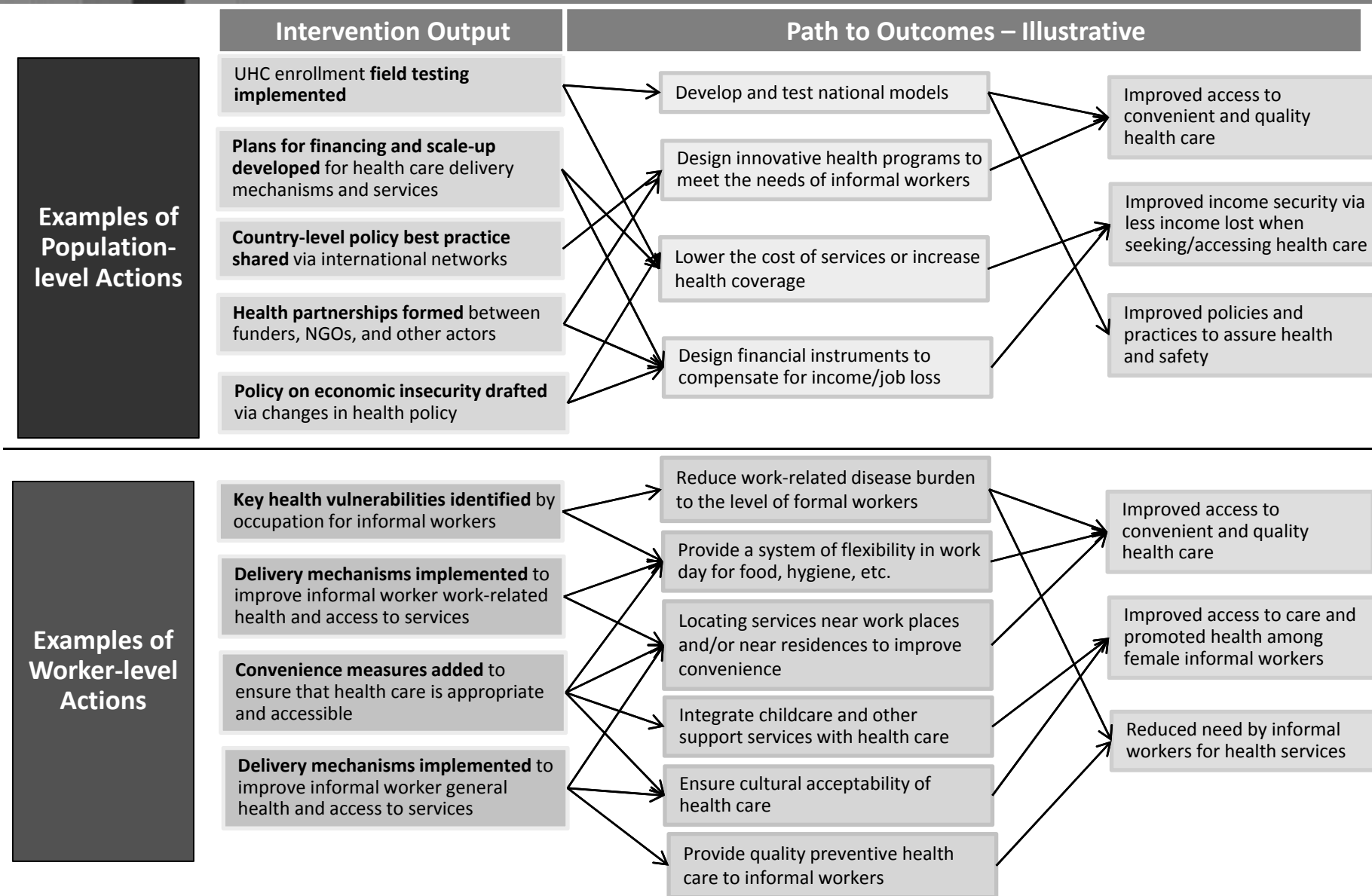
Blue = Systems; Purple = Root Causes, Red = Main Relationship

Adapted from Benach, Muntaner, Santana, 2007 to show primary relationships

Preliminary Theory of Change for a Potential Full Initiative in Execution



How do population-level and worker-level actions lead to achieving the high-level outcomes?



The Need for Research

Linking Health and Employment Status

The relationship between informal economy/informal employment and health issues (either related to the insecurity and vulnerability of informal work or due to occupation-specific health outcomes) are not heavily studied or reported in the literature.

- Most of the available research is qualitative descriptive case studies or community-based surveys that compare informally to formally hired workers. A more systematic data collection method is needed.
- There is a need for the development of theoretical frameworks showing the links and pathways that lead from employment conditions to poor health outcomes. Explanatory models are needed for guiding public health interventions and evaluation of policy intervention.
- The full complexity of employment status – formal/informal, temporary, self-employed, multiple jobs, and so on – needs to be incorporated into health databases to examine the associations between work and health, and with other aspects of household structure and functioning and family health issues.
- The differential analysis of health risks and outcomes experienced by types of informal workers, stratified by geographic region and gender, is essential to understand the links between informal worker status and health.

Understanding Informal Employment

The lack of official statistics related to informal workers, their occupation-specific distribution, and the uniqueness of workplaces provide challenges for policy and programming efforts, as the scale and scope of the population is not apparent.

- Data and statistical analyses that include the heterogeneity of occupations, trades, job arrangements, and workplaces are needed – the lack of these key measures impedes formative and evaluation research.
- The lack of accepted standard definitions makes comparability across studies or surveys difficult or impossible.
- Root causes, mechanisms, and multiple factors associated with informal employment form a complex set of pathways that require systematic measurement and analysis to determine which are the most amenable to intervention.
- Employment status data are not always available or lack quality in large demographic or health-related databases., neither is a sophisticated representation of social protection measures available (or not available) to informal workers.
- The impact of technology, trade, globalization and other large-scale economic drivers on the growth of the informal employment sector is not well understood.

Health insurance offers a way of compensating an individual for the financial loss associated with health expenditure by pooling the regular small payments of many individuals over time.

Universal Health Coverage

A goal to ensure that “all people obtain the health services they need without suffering financial hardship when paying for them” (WHO)

- **Countries in intermediate reform:** Ghana , Indonesia, Philippines, Rwanda and Vietnam; **Countries in early reform:** India, Kenya, Mali and Nigeria **Other countries committed to UHC:** Bangladesh, Brazil, Columbia, China, Georgia, Jordan, Mexico and Thailand.
- **UHC Inclusive of Informal Workers?** According to the World Bank, most countries have at least one scheme targeting vulnerable populations, such as informal sector workers . However, inclusion of the poor requires government subsidies to cover those unable to pay.
- **UHC Schemes are found to** “improve access and utilization of services” may reduce Out of Pocket Expenditure, and show mixed evidence on health impacts due to few, high quality studies.

Micro Insurance

Micro-insurance is a financial protection service designed for low-income payers. It includes a wide range of products from crop and life insurance to Health Microinsurance (HMI).

- **Principally used in India:** The ILO reports an estimated 40 million are covered under HMI, principally in India.
- **Includes of informal workers?** Some HMI schemes specifically target informal sectors workers as the unit of organization.
- **Access to HMI Schemes** is found to reduce “out-of-pocket health expenses, especially for catastrophic health events, and improves access to quality health care for those who are insured,” according to a ILO report. However, little is known about household and health impacts of MHI, and participation is voluntary; only those who can pay can benefit.

Community-Based (CBHI) and Social Health Insurance (SHI) are the primary instruments used to insure informal workers’ health in low-and middle-income countries.

Community-Based Health Insurance

- Government-sponsored health insurance.
- Managed at the community level either through a non-governmental organization (NGO), a local governmental unit, or a private firm.

Social Health Insurance

- Nationally mandated programs among formal workers extended to informal sector on a voluntary basis
- Schemes involve some tax financing.
- Premiums well below actuarially fair price.

SHI and CBHI schemes are used alone or in combination, depending on country resources, health infrastructure, targeted population, government support, stability, and community organization (among others).

Instruments: Social and Community Health Insurance

Social Health Insurance		Community-based Health Insurance	
Structure	<ul style="list-style-type: none"> National Health Insurance extended to informal workers. Compulsory enrollment. Contributions & benefits specified by law. Financing: Taxes and contributions. 	<ul style="list-style-type: none"> Initiated at village, district, or group level. Voluntary participation. Locally operated with varying levels of government support. Financing: Member contribution, some government subsidy. 	
Pros	<ul style="list-style-type: none"> Administrative structure may be shared with formal-sector Social Insurance. Premiums below actuarially fair price. Higher willingness to pay and trust due to social contract. Stable revenue, partly funded by taxes, and contributions. 	<ul style="list-style-type: none"> Community control -> more transparency, accountability, services close to home. Premiums below actuarially fair price. Full scale-up possible (over time, geography) with government endorsement, subsidies, administration. 	
Cons	<ul style="list-style-type: none"> A reduced benefits package may be offered to informal sector workers, or restrictions on providers limit quality of coverage. 	<ul style="list-style-type: none"> Voluntary participation can lead to adverse selection. Small size and limited financial protection. Excludes some who cannot pay. Small, undiversified risk pools subject to shocks. 	
What Has Worked or Has Mixed Results	<p>Utilization - does not always increase utilization. Different utilization rates reported for the same large SHI in China and Vietnam. Two studies report different results for Mexico. Utilization may differ by outpatient and inpatient care.</p> <p>MIXED</p> <ul style="list-style-type: none"> Utilization - does not always increase utilization – different rates reported for same large SHI in China and Vietnam. Two studies report different results for Mexico. Utilization may differ by outpatient and inpatient care. Out of Pocket Expenditure - OOP expenditure declined for the insured in studies done in China, and Mexico; SHI report more modest results than CBHIs. 	<p>Enrollment</p> <ul style="list-style-type: none"> Better user understanding of insurance for higher enrollment. Higher levels of education and wealth increase enrollment . Trust in the insurer (i.e., an affiliation with a trusted MFI) increases the chance an informal workers actually enroll in health insurance. <p>Utilization – studies report a positive effect of insurance on utilization more than for extended SHIs.</p> <p>MIXED</p> <ul style="list-style-type: none"> Out of Pocket Expenditure – CBHI studies reported greater success, however using less rigorous study methods . 	
What Did Not Work	<p>Enrollment – uptake declines with distance to health clinic, and with less awareness and trust in public programs.</p>	<p>Enrollment – distance to health facility, chronic illness, gender of household head have no effect on insurance uptake rates.</p>	

Ghana, India, Indonesia, Kenya, Mali, Nigeria the Philippines, Rwanda, and Vietnam have undertaken national-level reforms designed to implement UHC. All have developed ways of reaching informal sector workers on a voluntary basis.

- Providing health insurance to informal sector workers is a particular problem because the conventional infrastructure for collecting pre-payments and delivering quality care breaks down with hard-to-reach populations.
- Ghana, Indonesia, the Philippines, Rwanda, and Vietnam are at the intermediate-stage of making reforms, whereas India, Kenya, Mali and Nigeria are in the early-stages of reform.
- The percentage of the population enrolled varies widely from a high of 92% in Rwanda, to a low of 3% in Mali and Nigeria.

	Country	Program	Targeted Population	Share of population enrolled (2012)
Intermediate Reform Stage	Ghana	NHIS	Entire population	54%
	Indonesia	BPJS	Entire population	63%
	Philippines	PhilHealth	Entire population	76%
	Rwanda	Mutuelles, RAMA, MMI	Entire population	92%
	Vietnam	VSS	Entire population	42%
Early Reform Stage	India	RSBY	Individuals below poverty line	8%
	Kenya	NHIF	Formal sector, expanding to informal sector	20%
	Mali	Mutuelles, RAMED, AMO	Entire population	3%
	Nigeria	NHIS	Civil servants expanding to informal sector	3%

What Organizations Are Doing Innovative and/or High-Impact Work – Health

Not many international organizations specifically work on health issues of informal workers. Local NGOs, such as SEWA, BRAC, and Grameen, are involved in financing healthcare and making it affordable through micro-insurance schemes. While most of the interventions are not directed towards informal workers, they do have an indirect impact on health affordability of informal workers as well.

Best Case Practices:



Access Health is an international organization that provides research and advisory services to improve access to quality and affordable health care for the poor in developing economies. They assess success and impact of current interventions in health financing, health service delivery, and health technology space. Joint Learning Network is an initiative by them to share and promote learning on universal health coverage across member countries. They have also worked in health insurance evaluation and assessment of health PPP's in India.



SEWA is an Indian trade union registered for poor self-employed women and a pioneer in the movement for organizing and supporting informal workers. SEWA offers many services like micro-finance, micro-insurance, capacity building, etc. to help informal women workers gain social and health security. One of their high impact interventions has been the insurance scheme called VimoSEWA or SEWA Insurance, that provides composite package (health, life, assets, maternity) at an annual premium of less than USD 3. The insurance started in 1992, has enrolled almost 2 million people in the span of twenty years, with over 50000 claims processed.



Micro Insurance Academy is a not-for-profit entity in India providing assistance to organizations that focus on micro-insurance. They provide research, training and advisory services to organizations implementing insurance schemes for low-income communities. Currently they are implementing a micro-insurance project in India and assessing its impact, to investigate aspects of successful implementation of the community based health insurance scheme.



Health remains an integral component of BRAC's development intervention since its inception in 1972. The BRAC has introduced a micro-insurance scheme that provides subsidized services such as medical consultation, pathology testing and medicines for an annual premium. BRAC targets poor and ultra poor in Bangladesh, and charges premium based on the economic capacity of the individuals.

What Organizations Are Doing Innovative and/or High-Impact Work – Employment

Several international organizations and networks aim to organize informal workers, protect their rights and improve their employability in Asia. While improving health and safety conditions of informal workers is one of key intervention areas, they do not exclusively focus on it.

Best Case Practices:



StreetNet is an alliance of street vendors formed in 2002, which works towards advocating and implementing social protection for street vendors in different countries. They introduced the World Class Cities Campaign in India in 2009-2010 to send out a message to the government about the inclusion of street vendors in the cities and also mobilizing street vendors in a big way. The campaign was carried out in Delhi, Kolkata, Orissa, Tamil Nadu, and in Karnataka with the help of NASVI. The campaign impacted street vendors and hawkers to understand their rights and help them affiliate to NASVI. Governments also responded to the campaign, for example, the Tamil Nadu government started a survey of street vendors and eventually registering them under Tamil Nadu Petty Shops and Street Vendors Welfare Board.



HomeNet Thailand has been consistently advocating for the better rights and protection of homeworkers in Thailand. The organization considers social protection as one of the key demands for the home-based workers. In 2001, they initiated a pilot social protection scheme in Chiangmai. The homeworkers in the area began their health insurance scheme, with 110 members contributing their own fees. The organization has undertaken research studies to understand the need of social security of workers. The organization has also worked extensively on Occupational Health and Safety by conducting workshops and applying decent work conditions prescribed by ILO across work places within Thailand.

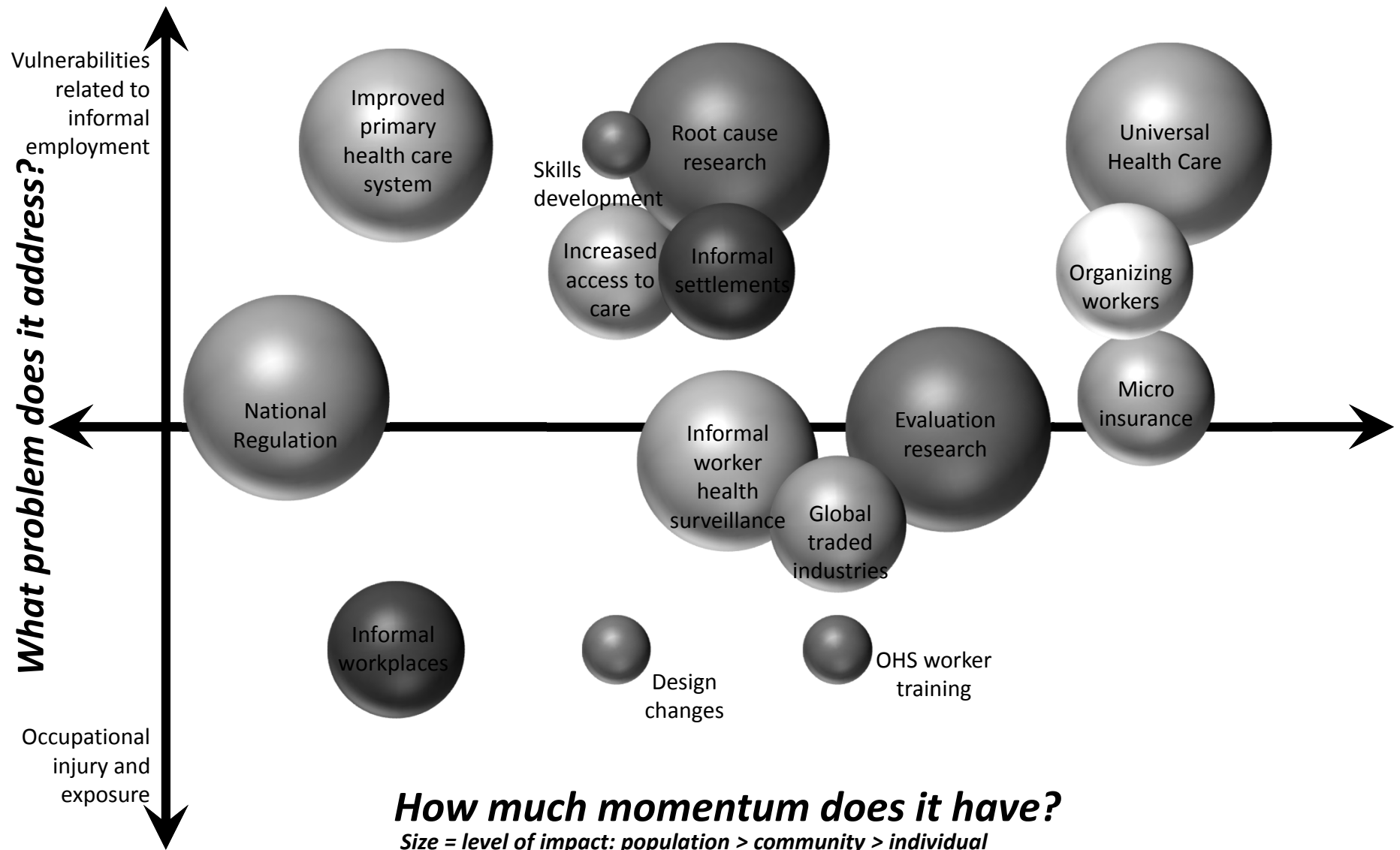


LabourNet, based out of Bangalore, India, seeks to provide job placement to workers from informal sectors, especially construction and service sectors. They also provide services such as training, access to health insurance and bank account to workers for a nominal membership fee. Currently, they have registered 44,000 workers for their services, provided accident insurance to 39,000 workers, and health insurance to 1500 workers, provided training to 6300 workers and registered about 20,000 workers with Construction Welfare Board.



Based out of Bangalore, India, Babajob seeks to help bring together informal workers and employers who provide them with jobs. It is an online platform, with very easy to use features on a simple cellphone. It serves to break information barriers at the touch of a button on a handset or at the click of a button.

Trade Offs Around Entry Points and Momentum



Population-level Impact Scenario

Initiative/Study	Description	Impact
Extension of Social Security to the Informal Economy in Thailand	The Thai Social Security Office and the ILO cooperated to extend social security to informal workers, through the modifications of current schemes and the establishment of new schemes, as appropriate. Timeframe: 2004 – 2006 prep and planning; 2006 – present implementation	GOAL: Expand voluntary health coverage to 20 million informal workers, targeting individuals with 1) lack of official and legal status; 2) limited and irregular incomes; 3) priority for social security; and 4) no employer. ACTUAL: 6.9 mil insured persons in Dec 2002 (~11% of population). As of 2006, health insurance coverage was 97.8%. From 2002–05, outpatient use and hospital admission rates increased annually by 4.3% and 2.2%.
Extension of National Health Insurance Scheme in Ghana	Government of Ghana, with ILO tech. support, replaced existing health schemes with National Health Insurance Scheme to provide basic health-care services via mutual and private health insurance; to register, license and regulate insurance; to accredit/monitor providers; and to establish a National Health Insurance Fund. Timeframe: Passed in 2003; Operational in Nov 2004	GOAL: aims to incorporate 50–60 per cent of the residents into NHIS in the next five–ten years (from 2007) ACTUAL: 47% of nat'l pop (10.3 of 22mil) registered as of June 2007. 20% of those registered work in the informal sector (2 mil of 9 mil estimated informal workers). By 2009, premium contributors = 4,132,783, or 29% of total membership and about half of Ghana's estimated informal sector workforce. By 2012, 2012: 54% of national population is registered.
Enrolling informal workers: KaSAPI PhilHealth	In 2005, Philippines PhilHealth launched KaSAPI initiative to boost and sustain enrolment of informal workers, via strategic partnerships with cooperatives, NGOs and rural banks, many of which serve informal workers. Good partnership between government and private sectors. Timeframe: Launched in 2005, implementation ongoing	GOAL: Universal coverage, particularly targeting informal workers and individuals in the 20-60% income bracket (lower to lower-middle) ACTUAL: In 2004 42% of families had 1+ member with a Philhealth card; for the poorest 30% of families, it was only 28%. By 2006, had reached 79%, mostly those in formal employment. Coverage of 15.5 million informal workers (45%). In 2009 there are 28,000 KaSAPI members.
Extension of National Health Coverage: Rwanda Muetelles	In 2010, the Rwanda Social Security Board set a coverage goal of >70% of working population by 2015. Extending coverage to informal sector via joint partnerships with informal sector institutions, designing benefit packages for informal sector, simplifying admin. procedures to reduce compliance costs, and strengthening services. Timeframe: Started in 2010, ongoing	GOAL: 1) extend coverage to >70% of workers by 2015; 2) increase overall coverage from 7-70% in 2015 via in informal workers; 3) ensure 95% adhesion of all workers in organized groups in the informal sector by 2015. ACTUAL: In 2009, 7% of >4 million workers were covered; >93%, mainly informal sector, were not covered. By 2011, >200 cooperatives and associations formed via informal sector mobilization. In one year, informal sector coverage from 7% to 18%. National enrollment = 92% in 2012.
Registration of workers: LabourNet	LabourNet has nonprofit and for-profit sections. Within the Informal sector, LabourNet activities focus on the construction and maintenance sectors: 1) link informal sector workers with clients who need skilled workers; 2) register migrant informal sector workers; 3) provide workers access to services (accident insurance, bank accounts, healthcare services, etc.) Timeframe: Started in 2005, ongoing	GOAL: Reach out to 1 million workers by 2012 and open 36 worker facilitation centers, extending operations to a new city in next four years. ACTUAL: LabourNet has registered over 36,000 workers, including over 18,000 covered under accident insurance; opened 12,000 PNB bank accounts, prepared 9 trade videos for training workers who normally are averse to training, provided job information to 6,000 workers and directly facilitated jobs for 3,000 workers. Suggesting sustainability and scalability, LabourNet expanded from its pilot in Bangalore to Haryana government.

Worker-level Impact Scenarios

Initiative/Study	Description	Impact
A participatory approach to health promotion for informal sector workers in Thailand	Participatory Action Research with workers in four local occupations in different regions. Qualitative and quantitative data was collected from questionnaires, industrial hygiene instruments, group discussions. Results: participatory approach is an effective tool for promoting informal sector health safety.	GOAL: promote occupational health in the informal sector in Thailand by using a participatory approach. ACTUAL: Working conditions of the informal sector met necessary standards after completing the participatory process. Also, the post-test average scores on 1) the occupational health and safety knowledge, attitudes and behaviors measures and 2) the work practice improvement measures were significantly higher than the pre-test average scores.
Networking Grassroots Efforts to Improve Safety and Health in Informal Economy Workplaces in Asia	From participatory training to improve safety and health in Asia, ILO strengthened partnership efforts with local people to improve safety and health of informal workplaces via action-oriented training workshops in which workers and employers identify priority safety and health actions. Timeframe: 2005	ACTUAL: Workers and owners in the target informal economy workplaces wanted to improve safety and health and needed support. They identified safety and health priorities. Follow-ups confirmed that many actions were taken using low-cost available materials. In Cambodia pilot, 414 home workers trained in the first year. In Thailand, the training program spread nationwide through the home workers' networks. In Mongolia, trade union members from different provinces trained as trainers.
Experience Sharing & Advocacy Workshop	Workshop to share experiences of five organizations implementing gender-responsive policies and work practices; train organizations in advocacy. Field workers and management staff from each org. were trained; >200 from local gov't, employers, civil society, academia and home-based workers present. Timeframe: January 2011, 2-day training	GOAL: Train all labor market stakeholders including Government, Workers, Employers, Media, and political leadership of Sialkot regarding the significance of HBWs' work and advocating for their due rights. ACTUAL: Over 200 trained, including 10 partner staff, over 50 HBWs, more than 20 from local government, and over 30 from media and academia.
Extending OHS through primary care in Thailand	With financial and tech. assistance from ILO, MoPH trained PCU staff in basic OSH. PCUs target informal workplaces and visit 1-2X/mo. for: risk assessment, workplace improvement; work-related and chronic disease monitoring & educ.; provide safety equip. Timeframe: 2004-2005 pilot; Feb-Nov 2007 model expanded to informal workers economy at 8 PCUs	GOAL: Establish a national model to extend OHS services to all workers, including informal workers, through primary care. ACTUAL: Pilot project completed as planned. PCU staff experienced in OSH services and promoting services. Pilot reached informal workers. A workshop moved forward estab. a nationwide model for basic occupational health services at PCUs in other provinces. Health volunteers have been trained to work as service providers for primary health care in communities
SOLVE: Integrating Health Promotion into Workplace OSH Policies	SOLVE : interactive educational program based on a training of trainers method to develop policy and action on workplace health promotion. Focus: policy tools for workers and employers; preventive programs, plans of action. Timeframe: Implemented for the past ten years	GOAL: Focus on preventing psychosocial risks and promoting health and wellbeing at work via policy design and action. Audience: managers, supervisors, workers, occupational physicians and safety engineers with interest in preventive programs. A secondary audience is policy-makers and government officials, workers' and employers' organizations with a direct interest in this area.

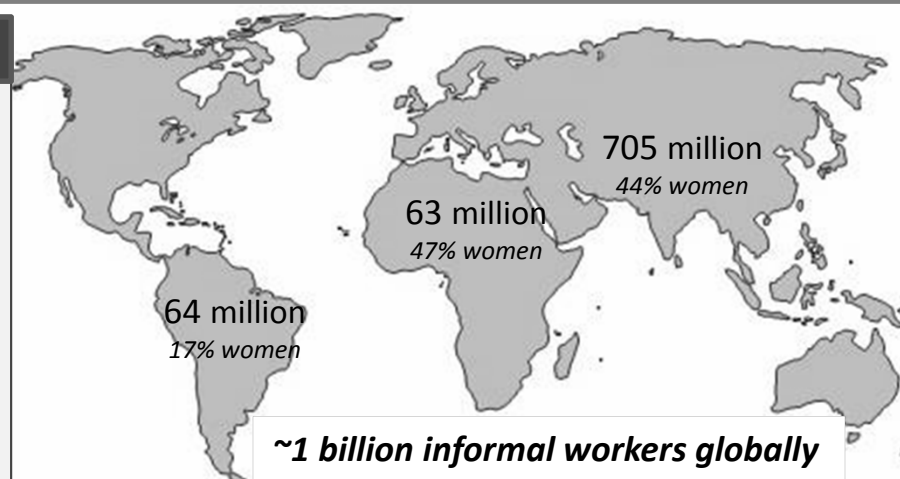
Appendix Profile: Agriculture Workers

Largest Sector by Far, Moderate Participation of Women

Size: Nearly three quarters of the roughly 1.3 billion agricultural workers are informal, making it by far the largest sector of informal workers. 75% of the world's absolutely poor (living on less than \$1 per day) depend primarily on agriculture for their livelihoods; agricultural workers, especially informal ones are among the occupational groups with the highest incidence of poverty.

Gender: Participation of women varies. It is higher in areas with high rural to urban migration of men. Women tend to be concentrated in the most informal and insecure jobs within the agricultural sector. Female agricultural workers are particularly vulnerable to insecure employment, long working hours, lack of health protections, and being targets of sexual harassment by supervisors responsible for renewing contracts.

Geography: The majority are in Asia.



Health Issues – Common and Potentially Severe

- **High occupational hazards** – Agriculture is one of the three most dangerous occupations; according to the ILO at least 170,000 agricultural workers die every year as a result of workplace accidents.
- **Pesticide exposure** – Affects 40,000 annually. Though developing countries consume about 20% of the global production of pesticides, they experience about 70% of the total number of acute poisonings (1.1 million cases annually). Pesticide poisonings disproportionately affect women due to their higher levels of body fat (where pesticides accumulate) and have been documented to produce birth/reproductive defects.
- **Malnutrition, anemia, and maternal mortality rates** are higher for plantation workers in studies in South Asia.
- **High levels of intestinal problems** and sickness from a lack of clean drinking water and unsanitary toilets.
- The **spread of infectious diseases**, such as TB, cholera, and STDs is linked to the seasonal migration of workers.
- Agricultural workers are disproportionately poor; few can afford healthcare and most have very small contributory capacity for insurance. Employers have little incentive to supply health insurance to workers that only stay with them for a few months out of the year.

Attention and Momentum – Low to Moderate

- In the 2000s, countries began to recognize the need for **extending labor protections to seasonal and temporary agricultural workers**. However, national legislation is difficult to enforce due to administrative and labor inspection deficiencies. Much existing legislation is outdated and relatively ineffective.
- Some large international companies carry out voluntary initiatives to improve health within the agricultural communities they work with. This is a growing sector as new **partnerships among actors within global value chains** (suppliers, agricultural enterprises, their employees/ unions, NGOs, and governments) emerge.
- Global standards and monitoring systems (**ETI Labor Standards, GLOBAL GAP, SA8000**) mostly target commercial farms. Some standards incorporate worker health, safety, and welfare as an objective. Employers are incentivized since compliance is increasingly important for accessing export markets. Based on the **ILO's (2001) Safety and Health in Agriculture Convention**, the first international standards to guide practices in agricultural workers' health. Such codes have led to improvements in safety training, sanitation, protective equipment, and working hours.

Appendix Profile: Construction Workers

Moderate Size, Low Participation of Women

Size: At least 66 million globally according to the ILO/WIEGO database, with some estimates as many as double that. Both the number of informal construction workers and the proportion of informality in the construction sector have increased over the past 30 years.

Gender: Mostly men: 97% in Africa and Latin America and 86% in Asia (ILO/WIEGO database). Some estimates have female engagement in India as high as 30% or 50% of the informal construction laborforce. Women work at the lowest levels and do the most unskilled work. There is widespread pay discrimination and some women are not paid directly, instead working as part of a family unit.

Geography: The majority are in south Asia. Three quarters of the global construction workforce is in developing countries, despite the fact that only one quarter of the construction output resides there.



Data from ILO/WIEGO database, 32 countries reporting (Asia=8; Africa=8; Latin America=16)

Health Issues – Common and Potentially Severe

- **High incidence of injuries from accidents** is the most common health risk, resulting from unsafe work sites, and lack of appropriate protective equipment and training. An estimated ¼ to all of informal construction workers are exposed to occupational hazards. Accidents are so common that they are considered an inevitable part of the work. WIEGO estimates 16-18% of workers are injured in south Asia each year. Workers bear responsibility for their health in the aftermath of accidents.
- **Chemical exposures** are common and can cause metal poisoning, damage to the central nervous system and liver, dermal and respiratory allergies, cancers and reproductive disorders.
- **Asbestos exposure** is a serious risk and can cause cancer.
- **Musculoskeletal injuries and disorders**, including back injuries from carrying heavy loads, and joint pain.
- **Respiratory disease** from inhaling dust.
- **Poor living conditions** for the many workers who also live on site include overcrowding, poor sanitation, high prevalence of disease vectors such as rats and mosquitoes, and continued exposure to construction dust, leading to water-borne disease, dengue fever, and respiratory problems.

Attention and Momentum – Low to Moderate

Limited activities focus around OSH training, improved regulation, and micro insurance.

- ILO's on Work Improvement in Small Construction Sites produces training materials and example photo books focused on decreasing workplace hazards and reducing occupational injury and exposure.
- In Mongolia, trade union members provide OSH training using action checklists and good example photos. Workers and managers collaborate to develop practical improvement proposals.
- The Construction Industry Development Board in Malaysia is pioneering a scheme requiring every construction worker to undergo a one-day safety and health course to obtain a "green card", without which they cannot enter work sites; contractors failing to send workers to training will be blacklisted.
- There are a variety of micro insurance initiatives, including: the Association of Construction and Informal Workers in the Philippines; SEWA in India, working on accident insurance for female construction workers; CUPPEC in Kathmandu; UMASIDA mutual health insurance scheme for informal workers in Tanzania.

Appendix Profile: Domestic Workers

Moderate Size, Mostly Women

Size: According to ILO estimates, at least 53 million, totaling 3.6% of waged employment worldwide. Much of the domestic work sector is informal and has grown rapidly over the past 15 years, increasing by more than 19 million since 1995. The increasing demand for domestic work is expected to continue as developing countries get richer and more women work outside of the home.

Gender: Women account for 83% of domestic workers and outnumber men in every region of the world. Globally, 7.5% of all female wage earners are domestic workers. In 2008, ILO reported that 37% of all female migrant workers were employed by households. The ILO estimates an additional **15.5 million children** are domestic workers globally and more girls under 16 work domestically than any other kind of child labor.

Geography: Latin America and the Caribbean: 8% of total employment and 17% of female employment; Asia/Pacific: 1% of total employment and 23% of female employment; Africa: 1% of total employment and 23% of female employment.



Health Issues – Moderate, with Risk of Severe Abuse

- **Physical, sexual, and psychological abuse** – WHO reports victims of sexual violence are more likely to suffer from depression, eating disorders, STDs, and other gynecological problems. Research in the UK found 18% of DWs have experienced physical abuse, over 50% psychological abuse, and 3% sexual abuse. A study in Thailand among DWs from Myanmar found 14% experienced unwanted physical contact from an employer; for 1% this culminated in rape.
- Increased risk for **asthma, chronic bronchitis, and other respiratory problems** associated with the regular use of toxic cleaning agents.
- **Injuries due to heavy lifting.**
- DWs have an annual incidence of non-fatal work injuries of 7.3% compared to 5% for the working population in general.
- **Poor living conditions** including inadequate sleeping arrangements and lack of food.
- **Working hours are long and unpredictable.** Findings from occupational health studies show that the long working hours, night working, & patterns of irregular shifts have the greatest negative effect on workers' health.

Attention and Momentum – Moderate

No longer invisible and with policies on the books, domestic workers are garnering attention and increasing levels of protection.

ILO's 2011 **Convention Concerning Decent Work For Domestic Workers** establishes global DW rights consistent with other workers. 4 countries have ratified and many others are in the process of revising national legislation to conform.

Bilateral contracts between migrant DW sending and receiving countries are an emerging trend in the Middle East and Asia, and help regulate legal protections of migrant DWs. However, enforcement mechanisms and penalties are often weak.

Flexible Visas for Migrant Domestic Workers reduce the risk of DWs staying in an abusive environment, however length of stay is often limited to prevent permanent immigration.

In Vietnam and Uruguay, **Regulation of third-party recruitment agencies and employers** gives the gov't the right to investigate working conditions of any private household which employs a DW.

Some countries receiving large amounts of migrant DWs have established **protections for victims of domestic violence**, such as shelters for abused DWs in the Philippines.

Appendix Profile: Home-based Workers

Second Largest Sector, High Participation of Women

Size: Available statistics for developing countries suggest that over 10 per cent of non-farm workers in most countries and as high as 20-25 per cent in some countries are home-based. Combined with data from the World Bank and ILO/WIEGO databases, this yields an estimate of 170-330 million workers, which is consistent with Mehrotra and Biggeri's estimate of 250 million.

Gender: The majority are women, often because homework allows them to combine work with responsibilities of caring for children and the home, and don't require women to leave the home in areas where women's mobility is restricted.

Geography: More than half of the total are in South Asia. Those in Asia and Latin America are more often piece-rate homeworkers, whereas in Africa they are more often self-employed in microenterprises.



Health Issues – Not as Severe, but Very Common

- **Health problems from poor working conditions and postures**, including: eye strain and eyesight problems from low light and concentrating long hours on fine work; joint, shoulder, and back pain from poor work posture, long sitting, cramped work spaces, and continual bending; cough and bronchial problems from inhaling dusts and poor ventilation
- **Reproductive health problems** including ovary related problems, abdominal pain and miscarriage from working paddle driven machines, disturbance of fetal position during pregnancy from excessive sitting (sometimes leading to need for C-section), lack of antenatal care.
- **Exposure to workplace hazards** due to lack of protective equipment and workplace regulations, including: electric shocks, chemical exposure, dust and fiber inhalation. Use of toxic materials exposes other members of the household even if they are not involved in production.
- **Limited time or money available for seeking health care** due to long hours and little pay, in addition to no health benefits from employer and no access to health care initiatives that are employer centered. Low price per piece also means that other family members, particularly children, are often engaged to increase piece production – thus exposing them to the occupational hazards as well.

Attention and Momentum – Moderate

Though dispersed and hidden, and therefore potentially difficult to organize or serve, there has been notable momentum around home-based workers.

- **International standards** like the 1996 ILO Convention on Home Work have helped define the vulnerable parties and their needs.
- **Worker organizing** has been very active, led by groups like WIEGO, SEWA in India, and HomeNet in South and Southeast Asia.
- **National support mechanisms** include India's Worker Welfare Funds and Bolivia's program providing child and health services.
- **OSH training initiatives** seek to improve home work conditions, by training workers, as in ILO's Work Improvement for Safe Home program, and providers, in Thailand's Safe Work Program.
- **Health worker outreach** such as Save the Children's partnership with the Philippine MoH to train community health workers to collect data on and provide OSH training to home-based workers.
- **Extension of health insurance protection**, to include homeworkers in national health insurance, as with the Philippines KaSAPI PhilHealth, or to extend microinsurance to homeworkers, as with Grameen Bank and BRAC in Bangladesh and HomeNet in Thailand.

Appendix Profile: Manufacturing Workers

One of the Largest Sectors, High Participation of Women

Size: At least 80 million globally, though homeworkers are likely undercounted. The number has grown over the past thirty years, as manufacturing boomed first in east Asia, then southeast, then south Asia and Latin America, leading to increases in manufacturing workers overall, and an increasing proportion of informal workers.

Gender: Women play a significant role in manufacturing; they make up more than a third of manufacturing labor in some countries, and almost one-half in some Asian countries. Food processing and garment industry workers are predominantly women, as well as most homeworkers.

Geography: Subcontracting, and thus informal manufacturing workers, is more prevalent in middle income countries, such as east Asia and Latin America, but in lower income countries, as in south Asia and sub Saharan Africa, it is becoming a more common aspect of the domestic manufacturing market.



Health Issues – Moderate with Risk of Severe Accidents

- Exposure to high levels of dust, noise, and repetitive, stressful use of hands and feet in textile factories often results in **lung disease, hearing loss, and repetitive strain injuries**.
- Food manufacturing is associated with many **repetitive strain injuries, a high accident rate, and exposure to biological hazards**.
- **Carpal tunnel syndrome and hand and wrist tendonitis** is common in factory workers.
- **Chemical exposure** is common, specifically with goods like metal and plastics and in the case of some dyes.
- A high proportion of homeworkers suffer health impacts of their work. **Shoulder pain and backache** are the most commonly reported. Few homeworkers seek treatment. Poor work environments are common. Family members are also subject to occupational exposures.
- Incense making results in **injury to the skin and eyes**, and inhalation of toxins which cause **lung irritation** and can lead to **asthma**.
- Poor factory conditions and employer practices can directly endanger workers' health, as in the case of **building collapses** and **factory fires**.

Attention and Momentum – Moderate to high

- **Ethical Trade Initiatives and Corporate Social Responsibility** – Some apparel retailers and international food producers have voluntarily adopted codes regarding ethical work practices and worker protections that improve conditions for the workers in their supply chain, and can also have a positive effect on business.
- **Workplace training** – ILO's Work Improvement for Small Enterprises program and Work Improvement for Safe Home program demonstrate good work practices, help workers check available local solutions, and plan and implement actions which will be useful for improving working conditions and productivity.
- **Regulation** – ILO's Better Factories Cambodia emphasizes the importance of increased oversight and onsite inspection as important aspects of factory safety.
- **Social Protection** – UMASIDA is an umbrella health insurance organization for the informal economy in Dar es Salaam. The government of India established Worker Welfare Funds for several categories of informal workers, providing a variety of social protections, including access to health facilities.

Appendix Profile: Street Vendors

Size and Gender Participation Unclear, both Likely Moderate

Size: Estimates of street vendors vary widely. Some name street vendors as one of the largest non-ag sub-groups of the informal workforce. The ILO reported the group as 2-9% of total nonagricultural labor in developing countries, and Jacques Charmes as 3-8%. Only a handful of countries have reported any actual counts for this sector. Statistics likely undercount the number of street vendors as it is usually a secondary, seasonal, temporary, or part-time income-generating activity and tends not to be reported in labor force surveys.

Gender: Women represent 30%-90% of street vendors, except in countries restricting women's mobility (e.g. India, Tunisia).

Geography: There is little country or regional level data.



Health Issues – Not as Severe, but Very Common

- **Lack of proper sanitation infrastructure** such as running water, toilets, and solid waste removal systems.
- **Accidents:** Street vendors are exposed to market fires and, when occupying roadsides, to traffic incidents, pollution and exposure to the elements.
- **Pulmonary problems (bronchitis, asthma)** from constant exposure to dust and pollution. 30% of Indian vendors have chronic respiratory problems.
- **Eye-related problems** and blurry vision caused by dust and pollution.
- **Strains and joint pains** from inappropriate work posture and heavy lifting. 25% of Indian street workers suffer from backache.
- **Stress-related diseases** including migraine, hyper acidity, hyper tension and high blood pressure.
- **Stomach and liver problems** including food poisoning from ingestion of food prepared in areas with poor sanitation. 38% of Indian street vendors have stomach problems and about 24% have liver problems.
- **Malaria**, transmitted by mosquitoes in stacked sacks of rubbish, blocked gutters and stagnant puddles.
- **Dehydration** from continued exposure to sun and heat.
- **Chronic headaches** from car fumes, dust, and heat.

Attention and Momentum – Moderate to High

- There has been increasing attention on street vendors recently, but little of it is focused specifically on health outcomes or interventions targeting their health.
- National and international initiatives are geared towards formulation of policies allowing informal street vendors to access formalization in a more inclusive way as street vending is illegal in most countries and perceived as a nuisance.
- Street vendors associations are being developed at international, regional and national levels in order to raise awareness, strengthen the voice and bargaining capacity of informal workers, implement street vendor friendly urban policies, and promote solidarity between organizations of street vendors and hawkers.
- Though there is increasing awareness of the need to address urban spaces, this focuses more around rights to safe living and working places, and sanitation more broadly, rather than health in particular.

Appendix Profile: Transportation Workers

One of the Smaller Sectors, Low Participation of Women

Size: : 37 million in the 32 countries included in the ILO/WIEGO database. Grew substantially over the past two decades; likely to continue growing.

Gender: : The vast majority are men, though there is slightly higher female participation in Latin America.

Geography: The majority are in Asia, with the largest groups in India, Pakistan, and the Philippines.

Health Issues – Moderate with Risk of Severe Accidents

Transportation workers include not only drivers and conductors, but also supportive workers, such as mechanics, fuel vendors, porters, warehouse workers, cleaners, guards, queue marshals, food vendors, and touts, as well as fisheries workers in some definitions. As a result, health impacts vary greatly. There is significantly more information available about road transport workers than any other group, and much of the following applies to them.

- **Weak lungs, coughs, colds, rhinitis, headaches, and cancer**, from inhalation of pollution including carbon monoxide, sulfur oxide, volatile organic compounds, toluene, and fine airborne particles.
- **Back aches, overall muscle aches and pains, and sprains** from lifting too heavy objects, managing freight without appropriate equipment, and long exposure to whole-body vibration.
- **Serious injury and death** from traffic collisions, due in part to poor maintenance of vehicles and roads; crowding of vehicles with passengers and freight; and lack of adherence to safety regulations.
- **Lack of protection from the elements** including rain, sun, extreme temperatures.
- **Fatigue and sleep deprivation** from long and irregular hours and overnight work, contributing to accident risk and exacerbating other health problems.
- **HIV/AIDS** exposure common among long distance truckers in Africa and parts of Asia.
- **Drug use** common among overnight and long distance drivers.
- **Hearing damage** from prolonged loud noise exposure.



Data from ILO/WIEGO database, 32 countries reporting (Asia=8; Africa=8; Latin America=16)

Attention and Momentum – Low

Although some organizing has been done in this sector, little of it has focused on health issues.

- A number of trade unions and worker associations have formed for informal workers, or allowed informal workers to join. Though their primary purpose is often to maintain or raise levels of income for their members, a number have established basic social protection schemes, such as micro insurance or mutual aid health schemes, as well as campaigning for inclusion in state-administered social protection programs.
- There is an important role for national and local governments. Government policy can increase transport worker income by reducing fuel prices; raising fares; reducing taxes, duties, permit and registration fees; and curbing extortion and harassment. Government regulations can increase worker safety, by paying incentives to scrap older, unsafe vehicles, banning leaded fuel, and passing laws requiring use of helmets and other appropriate safety equipment. When regulations do already exist, enforcement of the law is often weak.

Appendix Profile: Waste Pickers

One of Smallest Sectors, Women's Participation Unclear

Size: 20 million informal waste pickers (about 1% of the urban population in developing countries) is involved in informal scavenging.

Gender: Little information is available on gender repartition.

Geography: There is little country or regional level data.

Health Issues – Significant

- **Accidents and injuries happen 10x more often for solid waste workers** than for the baseline population and as a result, solid waste workers have a up to **30% higher mortality risk**. The risks are greater for waste pickers working at open dumps and landfills compared to street waste pickers. They are caused by dog bites, moving trucks and exposure to toxic fumes.
- **Informal waste pickers are faced with greater dangers than formal waste pickers** because their living and working environments often overlap: they live in informal settlements, on the streets or at and on the landfill sites.
- **Waste related safety hazards** - Waste is an ideal habitat for **disease vectors** (flies, insects, rats) and can be contaminated by fecal bacteria or animal carcasses. **Toxic materials** in waste expose pickers to high concentrations of pollutants. **Sharp objects** (needles, nails, knives, broken glass) cause cuts during collection and sorting. Exacerbated by **a lack of safety equipment**.
- **Pulmonary problems (bronchitis, asthma)** are 1.4- to-2.6-times more frequent for solid waste workers than for the baseline population.
- **Lacerations** can lead to infections, such as tetanus, hepatitis or HIV.
- **Strains and joint pains** are twice as frequent for solid waste workers than for baseline population.
- **Dizziness, headaches and nausea**, from exposure to emissions of methane, carbon dioxide & monoxide.
- **Risk of infections and parasites** are 3 to 6 times higher for solid waste workers than for the baseline population.
- **Stomach problems** such as acute diarrhea (linked to consumption of or contact with waste foods) happens 10x more often for solid waste workers than for the baseline population.



Attention and Momentum – High

Waste pickers have received increased attention recently. Much of this attention has been focused in a few key areas:

- Raising group awareness .
- Legalizing and including informal waste pickers within the formal system (e.g. India and Brazil).
- Suggestions from researchers to improve health conditions.
- Medical insurance initiatives, as in Pune, India, and the Philippines.
- Provision of safety equipment.
- Design of improved collection tools including carts.

International initiatives – IWPAR Project (Project for Informal Waste Pickers And Recyclers organized by Enda) aims to promote the protection and inclusion of popular collectors and recyclers of waste in Colombia, Ethiopia, Madagascar and Vietnam and will last from 2011 to 2013.

National and regional initiatives include raising awareness for legal recognition and integration of informal waste pickers.

Appendix Profile: Africa

Smallest of the Three Regions

Population: As many as 152 million informal workers (R4D calculation). ILO/WIEGO reports 32 million informal workers in 8 countries. Estimates place the share of non non-agricultural employment in sub-Saharan Africa that is informal at 72-80%.

Gender: About half of informal workers in sub-Saharan Africa are women. In the region 84% of women non-agricultural workers are informally employed compared to 63% of male non-agricultural workers, according to the International Poverty Centre in 2008. Most women in the informal economy in Africa are either self-employed or unpaid workers in family enterprises, mostly working as own-account traders and producers or casual and subcontracted workers. Women are under-represented in high income activities and over-represented in low income activities such as subcontracted work.

Sector: Agriculture is the largest sector. Africa has less export manufacturing than Asia and Latin America, though there are export processing zones and domestic manufacturing is increasing. There are a significant number of home-based workers in Africa, who are generally own account workers rather than piece rate workers.

Sectors of informal work	# of workers (R4D estimate)	# of workers (WIEGO, from 8 countries)	% of informal work	% women
Agriculture (<i>not including small scale farmers</i>)	63 mil	13 mil	41%	47%
Home-based workers	17-34 mil	--	11%-22%	~50%
Street Vendors	5-14 mil	--	3%-9%	<i>unknown</i>
Domestic workers	5 mil	--	3%	73%
Waste Pickers	3 mil	--	2%	<i>unknown</i>
Transportation		2 mil	16% of WIEGO data	3%
Manufacturing		2 mil	15% of WIEGO data	22%
Construction		1 mil	7% of WIEGO data	3%

Health Issues

- Sub-Saharan Africa has 11% of the world's population and 24% of the global disease burden, but holds only 3% of the world's health workers.
- Few countries in sub-Saharan Africa have free comprehensive health care services available to citizens. In some places, state-funded health care has completely disappeared. In those that offer a limited service, there has been a steady movement back towards a 'user pays' principle.
- In most low-income developing countries, such as Tanzania, not more than 5-15% of the working population and their dependents are covered by statutory social insurance, mainly for pensions and health.
- World Bank estimates the risk of fatal and non-fatal occupational injury in the Sub-Saharan Africa economic region at five times higher than in Europe and North America (non-fatal: 160/1,000 workers; fatal: 21/100,000 workers).

Attention and Momentum – Low

- The African experience has shown that, rather than create new organizations, greater emphasis should be placed on respecting, strengthening and developing organizations to which individuals have freely decided to belong.
- The most successful programs in Africa have occurred when private organizations use, adapt and take ownership of the methodology.
- Though there is not as much worker organizing as Asia, the WIEGO database lists at least 190 informal economy associations in Africa, including Member Based Organizations of the Poor (MBOPSs), Community Based Organizations, cooperative, NGOs, and Trade Unions. A number of these provide some form of micro health insurance, or advocate for informal worker access to other health services.

Appendix Profile: Asia

Largest of the Three Regions

Population: Estimated 1.25 billion informal workers (70% of 1.8 billion global informal workers), per World Bank with ILO/WIEGO. Asia has a number of high population countries with high proportions of informal labor, most notably India. Informal labor is differently categorized in China, so estimates are likely low.

Gender: Women comprise 30-50% of the non-agricultural informal workforce, except in India (150 million men, 35 million women or 19%) and Pakistan (20 million men, 2 million women, or 9%). Informal agricultural wage employment rate is 12-40%; informal agricultural self-employment rate is 27-52%. The vast majority of home-based workers are women.

Sector: Agriculture is the largest sector. Manufacturing is the second largest, representative of a large export market in addition to domestic manufacturing.

Sectors of informal work	# of workers (R4D estimate)	# of workers (WIEGO, from 8 countries)	% of informal work	% women
Agriculture	705 mil	372 mil	56%	44%
Home-based workers	89-177 mil	--	7%-14%	80%
Manufacturing		63 mil	15% of WIEGO data	30%
Construction		53 mil	7% of WIEGO data	14%
Street Vendors	27-71 mil	--	2%-6%	unknown
Transportation		27 mil	16% of WIEGO data	4%
Domestic workers	22 mil	--	2%	81%
Waste Pickers	13 mil	--	1%	unknown

Approaches to Health Coverage

- **Community based health insurance programs** – Cambodia’s SKY program gives access to primary care, emergency transportation, RX, etc. Targets populations not covered by schemes for salaried employees; individuals need income to afford the premiums. India’s SEWAVimo includes basic health programs for informal workers who are SEWA members and health benefits including primary and maternity care.
- **Universal health services** – The Sri Lankan government provides universal health services for all of its citizens, including informal.
- **National health insurance** – Thailand’s National Health Security Act in 2002 provides health insurance to the 25% of its population that did not qualify for existing health schemes.
- **Converge multiple programs** – Laos combined 4 separate social health protection schemes to reach universal coverage.
- **Involve local gov’t** – China’s central gov’t allows municipal gov’ts to grant informal workers access to the basic health insurance program.

Attention and Momentum – High

- This region has seen the most momentum around informal workers. There is more data from Asia than any other region, more worker groups, and more interventions.
- Recently, the large manufacturing sector in south Asia has gotten renewed attention following a series of devastating factory fires and collapses in Bangladesh.
- Worker organizations have been extremely active in Asia bringing attention to the informal sector. These include WIEGO and SEWA based in India, as well as HomeNet, StreetNet, LaborNet and others.
- The ILO office in Southeast Asia has been particularly active around worker training in occupational safety and health and worker organizing and networking.
- Although there is much attention in this region, the vast scope of the informal sector means there is still much that is unaddressed.

Appendix Profile: Latin America

Largest of the Three Regions

Population: Estimated 178 million informal workers (R4D calculation). ILO/WIEGO reports 145 million informal workers (over 60% of total employment in Latin America), in 16 countries reporting. Informality as a proportion of total employment varies: Below 40% in Uruguay, Panama, Costa Rica, Chile; 55-65% in Brazil, Mexico, Argentina, and over 65% in Venezuela, El Salvador, Guatemala, Nicaragua, Ecuador, Paraguay, Peru, Bolivia.

Gender: More women (53.7%) than men (47.8%) work in the informal sector. Domestic workers alone account for 17.4% (18 million) of total female employment. The percentage of women employed in the informal sector increases dramatically as income bracket decreases.

Sector: Agriculture is the largest sector.

Sectors of informal work	# of workers (R4D estimate)	# of workers (WIEGO, from 16 countries)	% of informal work	% women
Agriculture	64 mil	52 mil	36%	17%
Home-based workers	20-41 mil	--	11%-23%	>50%
Domestic workers	20 mil	--	11%	92%
Manufacturing		13 mil	14% of WIEGO data	50%
Construction		12 mil	12% of WIEGO data	3%
Street Vendors	6-16 mil	--	3%-9%	unknown
Transportation		8 mil	8% of WIEGO data	8%
Waste Pickers	4 mil	--	2%	unknown

Health Coverage

- In Latin America, around 35% of workers in categories which are generally informal have access to health systems compared to 60% of workers on average.
- Access to healthcare diminishes according the number of workers in a business (small businesses tend to be informal). In businesses with 100 or more employees health coverage is close to 90% vs. in businesses with 1-5 workers it is 15% (data from Ecuador, Mexico, Panama, and Peru 2009).
- Only about one third of domestic workers and independent and family workers have health insurance in Latin America, compared with 3/4 of salaries workers in private organizations with 6 or more employees, and 90% of salaried public workers.
- Informal workers are most covered by UHC schemes in Costa Rica, Cuba (publicly funded), and a mix of public and private institutions in Uruguay, Brazil, and Chile.

Attention and Momentum – Moderate

Extension of health coverage to informal workers – Caja de Seguro Social (Costa Rica) and EsSalud (Peru) are contributory national initiatives created in 2010 offering health coverage for independent workers and their families, includes benefits such as outpatient care, hospitalization, emergencies, medications, and co-pays for exams. Financed by voluntary contributions from workers based on number of dependents.

Microinsurance – In Nicaragua the government extended its national health insurance plan to informal workers via MFIs through a pilot among street-vendors. Financed by voluntary contributions as flat monthly installments of \$15, with a two month premium of \$171.

Mutelles are mechanisms of collective savings, where funds are managed autonomously by a community of workers, often through unions or collectives. Asociacion Mutua del Campo created in 2000 in Nicaragua includes dental coverage and family co-pays for medication and is financed through shared contributions between employers and workers.

Community based health insurance – Obra Social de Vendedores Ambulantes de la Republica de Argentina (street vendors), OSMU Trenque Lauquen (Argentina): Created in 1992 at the municipal level to benefit community members without health coverage, OSMU is financed through a combination of contributions from members, the municipality, and worker organizations representing its beneficiaries.

Agricultural Workers: Introduction

Number and Distribution of Agricultural Workers

- **Definition: Waged agricultural workers** (40%) labor in crop fields, orchards, glasshouses, livestock units, and primary processing facilities to produce the world's food and fibers. They may work on anything from a small farm to a large industrialized plantation. They do not own or rent the land they work and are oftentimes temporary or seasonal workers. **Self-employed farmers** (60%) own or rent the land they work and are oftentimes permanent workers. The majority are informal small-scale farmers. (WIEGO)
- **Population:** Roughly 1.3 billion agricultural workers – ~960 million informal; in most developing regions over 70% is informal. 75% of the world's absolutely poor (living on less than \$1 per day) live in rural areas and depend primarily on agriculture for their livelihoods; agricultural workers- especially informal ones- are among the occupational groups with the highest incidence of poverty. (WIEGO, ILO 2003)
- **Geography: Asia: 705 million** informal agricultural workers (373 million in ILO/WIEGO database countries, representing 72% of all agricultural workers, 56% of informal employment, and 38% of total employment). **Latin America: 64 million** informal agricultural workers (52 million in ILO/WIEGO database countries, representing 81% of all agricultural workers, 36% of informal employment, and 23% of total employment). **Africa: 63 million** informal agricultural workers (13 million in ILO/WIEGO database countries), representing 38% of all agricultural workers, 41% of informal employment, and 19% of total employment). (R4D calculations based on WB and ILO/WIEGO databases)

Categories of Informal Employment:

Most agricultural workers are either **seasonal, temporary, or contracted out by third party agencies**. Many agricultural workers who work for formal enterprises are still considered informal and may work only part of the year, for multiple employers, or as migrants. In North America, estimates put the number of **migrant agricultural workers** (most from Mexico) at approximately 5 million, or almost 75% of all agricultural workers in the U.S. Social protection is particularly complex since employers have little incentive to supply non-permanent workers with coverage. For workers who own their own land, the majority are **small-scale farmers** who are considered informal by the informal nature of their business. Most rely on **unpaid family labor**, the most informal type of employment. As a result, the majority of agricultural workers do not have labor contracts and regulations are difficult. (ILO 2003, Barrientos 2002, WIEGO)

Continuum of Horticultural Employment

FORMAL EMPLOYMENT

- Permanent work (a small core usually with contracts of employment);
- Regular temporary or seasonal work (with or without contracts of employment);
- Casual and irregular work for short periods of the season or on a daily basis (with or often without contracts);
- Contract labour employed by a third party labour contractor (often without contracts);
- Migrant labour employed directly or through a contractor (often without contracts);
- Small holder production, often involving family labour (paid or unpaid).

INFORMAL EMPLOYMENT

"Extending Social Protection to Informal Workers in the Horticulture Global Value Chain" (Barrientos 2002)

Agricultural Workers: Problem Assessment

The informal agricultural sector involves high levels of job insecurity and health risks combined with low levels of income and social protection – a bad combination for workers.

Root Causes and System Failures

- Much of the agricultural sector is comprised of temporary or casual workers. This is because **the majority of agricultural work is seasonal by nature**, concentrated around growing seasons which may only last a few months, depending upon the product. For instance the coffee harvesting season in Rwanda is only 4 or 5 months per year. (WIEGO 2011)
- The **effects of globalization** have increased pressure on developing countries to boost productivity while volatile global markets have increased the flexibility of labor in export-driven sectors.
- **Women tend to be concentrated in the most informal and insecure jobs** within the agricultural sector. In Chile, for instance, 53% of temporary workers compared to 5% of permanent workers are female. And unpaid family labor accounts for 20% of women's informal employment in Ghana, 34% in India, and 85% in Egypt. (WIEGO, ILO 2003)
- Increasingly prevalent, particularly in Latin America, is the use of **contract labor and migrant labor through third-party recruitment agencies**. Such contractors become responsible for the employment conditions and wages of their workers, thus removing the responsibility from employers. (WIEGO)
- Oftentimes **labor contractors take advantage of seasonal unemployment** within peasant communities by providing their recruits with advance payments. (ILO 2003)
- Few agricultural workers are entitled to labor contracts, social protections, or health benefits and most struggle to make a living due to insecure employment and piece-meal wages. According to the ILO, **likely not much more than 5% of the world's 1.3 billion agricultural workers have access to systems for labor inspection and less than a quarter have access to social protection**. Barrientos (2009) and Oxfam (2004) found that the majority of migrant workers on export pineapple farms in Ghana and laborers on Chilean fruit farms did not have written contracts.
- **Countries are relaxing their labor laws in export-driven sectors to become more competitive on a global level**. For instance, a 2002 Colombian labor reform negatively impacted workers in the export flower industry by lengthening the work day, cutting overtime pay, and introducing more flexible contracts.
- **Female agricultural workers are particularly vulnerable** to insecure employment, long working hours, and lack of health protections. Studies have also found women's concentration in insecure employment makes them targets of sexual harassment by supervisors responsible for renewing contracts. (WIEGO 2011, Smith 2005, Oxfam 2004)
- Because **third-party agencies are generally more difficult to monitor** than stationary employers, they pose an additional challenge to the extension of labor standards or social protections.
- **Forced labor and exploitation** arising from workers indebted to labor contractors is problematic. An estimated 200,000 people work under forced labor conditions in Brazil. Bonded labor also exists in South Asia and Africa. (ILO)

Agricultural Workers: Problem Assessment – Health Issues

High Occupational Hazards

Agriculture is one of the three most dangerous occupations- according to the ILO at least 170,000 agricultural workers die every year as a result of workplace accidents; 40,000 are from exposure to pesticides. However, most of these deaths are preventable. The need for developing countries to boost productivity has spurred greater intensity of production and the increasing use of toxic agrochemicals in fertilizers and pesticides. Both of these developments have negatively impacted workers' health. For instance, while developing countries consume about 20% of the global production of pesticides, they experience about 70% of the total number of acute poisonings (1.1 million cases annually). Pesticide poisonings disproportionately affect women due to their higher levels of body fat (where pesticides accumulate) and have been documented to produce birth/ reproductive defects. Although international standards on the use of agrochemicals are now available, the challenge lies in monitoring their application in practice- particularly among informal workers, many of which are ill-trained, lack protective clothing, or cannot read labels. (ILO 2003, WIEGO 2011)

Excessively Long Hours

Because of the short, labor-intensive harvesting seasons, working hours are generally excessive and overtime, though often compulsory, is inadequately compensated. In the U.S. at the height of harvesting season, tomato pickers (the majority of which are migrants) work up to 11 hours a day 7 days a week without overtime because U.S. federal law excludes them from this right. Oxfam (2004) similarly found tight shipping deadlines for fruit pack houses in South Africa led up to 8 hours of overtime paid at normal hourly rates. Oftentimes agricultural workers only find out about overtime the day of. Short-notice overtime work proves particularly problematic for women who must incur extra costs to make alternative childcare arrangements or leave children at home unsupervised. Because agricultural work is arduous by nature, long hours with limited rest can contribute to exhaustion among other health problems in this sector. (Oxfam 2004, Smith 2004, WIEGO 2011)

Disease Bred from Poor Living and Working Conditions

Working conditions and pay for agricultural workers decline as informality increases. Barrientos (2003) found that in South African apple farms and packhouses, permanent workers had the best working conditions followed by seasonal workers, with contract and migrant workers at the bottom. Since many large-scale commercial plantation workers actually live on the farms they work- often with their families, health issues arise from overcrowded, unsanitary living conditions and poor nutrition. Health data from South Asian countries consistently shows malnutrition, anemia, and maternal mortality rates are higher for plantation workers than the general population. Lack of clean drinking water and toilets also leads to high levels of intestinal problems and sickness. Also problematic is the spread of infectious diseases, such as TB, cholera, and STDs. In sub-Saharan Africa the spread of HIV/ AIDS which is linked to the seasonal migration of workers has caused pandemics on some plantations. A recent study of commercial farms in Kenya for instance revealed disproportionately high levels of HIV among agricultural workers. (ILO 2003, WIEGO, World Bank 2002)

Lack of Health Insurance and Benefits

Although farming is one of the most dangerous sectors, agricultural workers are one of the least protected occupational groups. Social protection where it does exist usually applies to permanent workers, leaving the non-permanent majority vulnerable. Because agricultural workers are disproportionately poor, few can afford healthcare on their own and most have very small contributory capacity for insurance. Yet, employers have little incentive to supply health insurance or benefits to workers that only stay with them for 4 months out of the year. The combination of seasonality, flexibility, and informality of agricultural labor creates a challenge in providing these workers with health insurance. Even when seasonal or temporary workers are legally entitled to benefits, in practice employers only recognize these rights for permanent employees. For instance, a study among South African fruit growers found that female seasonal workers did not receive the paid sick leave or maternity leave they were entitled to. And, although Rwandan law mandates employers register all workers with the national Social Security Fund, which covers the costs of occupational injuries and diseases, in practice very few workers in the seasonal coffee and tea sectors are covered. (World Bank 2002, Oxfam 2004, ILO 2003, IFAD 2010)

Agricultural Workers: Dynamism Assessment

National Action

In the 2000s, countries began to recognize the need for **extending labor protections to seasonal and temporary agricultural workers**.

- **Chile**'s Plan Nacional helps small-holder raspberry farmers comply with global labor standards. Chile requires employers to issue written labor contracts for temporary workers and make payroll contributions to social insurance programs when employed through third-party contractors.
- **India** (Maharashtra sugar cane cutters) and **Argentina** – in both cases inclusion of informal agricultural workers into public health insurance plans was facilitated by pressure from local unions. In Argentina, the farmers' union UATRE worked with government to create National Registry for Agricultural Workers and Employers (RENATRE) that included informal temporary workers and migrants. (ILO 2003)

Risks: National legislation is difficult to enforce due to administrative and labor inspection deficiencies – e.g., in South Asia, the ILO found social security provisions for plantation workers are generally in place but most legislation is outdated and relatively ineffective. (ILO 2003, World Bank 2002)

Global Market Codes and Labor Standards

Global standards and monitoring systems (**ETI Labor Standards**, **GLOBAL GAP**, **SA8000**) mostly target commercial farms. Some standards incorporate health – e.g., GLOBAL GAP standards include proper sanitation facilities and pest control; standards for tea growers include worker health, safety, and welfare as an objective. Employers are incentivized since compliance is increasingly important for accessing export markets. Based on the **ILO's (2001) Safety and Health in Agriculture Convention**, the first international standards to guide practices in agricultural workers' health, including a right to health insurance against occupational injuries and diseases and training in chemical use, election of a safety representative, and the right to stop working under hazardous conditions. Such codes have led to improvements in safety training, sanitation, protective equipment, and working hours of agricultural worker in developing regions. (World Bank 2002, ILO 2003)

- **Risks:** International standards cover permanent workers in formal enterprises the most and informal contract or migrant workers the least. National governments have largely been unable to implement or enforce the ILO standards regarding social protection schemes. (ILO 2003, World Bank 2002)

Corporate Social Responsibility Initiatives

Some large international companies carry out voluntary initiatives to improve health within the agricultural communities in which they work. This is a growing sector as new **partnerships among actors within global value chains** (suppliers, agricultural enterprises, their employees/ unions, NGOs, and governments) emerge. Such initiatives can increase productivity, enhance brand reputation and create company loyalty among farmers.

Examples of successful programs include the **Chiquita Code of Conduct**, which established minimum labor standards and freedom of association for all company owned farms in **Central America and Colombia**. The code resulted from negotiations among Chiquita, the IUF, and the regional banana union. In **Indonesia**, **Starbucks** partners with Save the

communities, doubling vaccination rates, improving health among workers, and quadrupling the number of community health posts. Other programs: Mars, Inc. (**Ghana and Côte d'Ivoire**), British American Tobacco (**Bangladesh**), Unilever (**Kenya**), and Dunavant (**Zambia**). (ILO 2003, Rachel's notes)

- **Risks:** Research on voluntary corporate codes from Kenya, South Africa, and Zambia suggests the assumption of permanent employment and limited informal seasonal sector reach. Many only address specific health issues – e.g., limited housing improvements, childcare and access to clinics. Suppliers may be too removed from employees; worker representation in negotiations and effective monitoring is crucial. (World Bank 2002)

Agricultural Workers: Landscape Assessment

International	State	Regional	Funders
<p>Advocacy groups and researchers, standard-setters, NGOs, and multi-nationals</p> <p>ILO (STEP), World Bank, EU, ECLAC, WHO, ISSA, WIEGO, GLOBAL GAP, IUF, SAI, FHI 360, Ethical Trade Initiative</p> <p>Multi-nationals- ex: Starbucks, Chiquita, Unilever, various supermarkets (UK)</p>	<p>Grassroots movements and unions representing agricultural workers</p> <p>NUPAWU (Uganda)</p> <p>UATRE (Argentina)</p> <p>SEWA (India)</p> <p>CONTAG (Brazil)</p> <p>Kuapa Kokoo (Ghana)</p> <p>Among others...</p>	<p>Fair-trade certified networks among countries</p> <p>CLAC (Latin America)</p> <p>African Fair Trade Network (AFN)</p>	<p>Funders of Value Chain Projects in Agriculture</p> <p>DFID (UK), USAID, FAO (UN), ITC, Gates Foundation (WIEGO)</p> <p>Other Funders of Health Related Projects</p> <p>WIEGO, MNE suppliers of agricultural exports (Ex: Mars Inc., Starbucks, Unilever), World Bank, UNESCO, World Cocoa Foundation, CIDA</p>

Gaps in Funding and Knowledge

- **Under-capitalization in agriculture by national governments** – A 2008 study of Africa found only 19% of countries had met their 2003 goal of dedicating more than 10% of national expenditure to agriculture. (Economic Report on Africa 2009)
- **Lack of research specifically focusing on the link between health and working environments of informal agricultural workers** – Although the link between occupational hazards, health, and pesticide use has been established, little is known about longer term, less easily observable conditions, such as mental illness and muscular problems, which tend to go undiagnosed as work-related.
- **Few Value-Chain Analyses address informal employees within formal enterprises** – Most target only small-holder farmers, or entrepreneurs rather than informal employees. (WIEGO 2011)
- **Lack of established research on the shifting forms of migrant and contract agricultural labor.**

Agricultural Workers – Impact Assessment

Health vulnerabilities suggest **four high-level outcomes** to prioritize.

HIGH LEVEL OUTCOME	Healthier Workers:	Greater Access to Care:	Lower Costs from Illness:	Improved Policy:
	Reduced need by informal workers for health services	Improved access to convenient and quality health care	Decreased income lost related to health issues and health care seeking	Improved policies and practices to assure health and safety
	Minimum health and safety standards are set and enforced.	More affordable and conveniently located health insurance options increase health coverage for informal agricultural workers and their families.	AWs are better able to afford medical attention and female workers are less disadvantaged by temporary employment status.	CSR initiatives are more efficient, comply with international health codes, and reflect workers' needs.
	Forced labor and exploitation of migrant or seasonal AWs reduced.	CSR and national initiatives provide access to childcare and clinics in rural areas; perhaps through community health posts or roaming health care.	The issue of unpaid family labor is addressed by national legislation and women gain right to jointly held land.	Longer term, less observable illnesses among AWs are properly diagnosed as occupation-tied and treated as such.
INTERMEDIATE OUTCOMES	Informal AWs and families receive better housing, sanitation & water and reducing incidence of infectious disease and intestinal problems.			
	Corporate and international labor codes are extended to include non-permanent AWs and incorporate health and safety as a priority.	Occupation-tied insurance is not linked to just one employer or a specific number of days worked in a row; is expanded include seasonal workers who may switch between employers. Special insurance provisions are created for small-holder farmers.	Small-holder farmers incorporated into fair trade agreements.	Better monitoring of pesticide use and global standards by national labor inspectors or corporate suppliers.
	Seasonal, temporary, and migrant AWs and small-holders are incorporated into national labor legislation; employers and third-party agencies are monitored.		All employers and employees sign a contract at the start of employment, guaranteeing a minimum wage based on hours worked, rather than in-kind pay. Overtime is non-compulsory and properly rewarded. Sick days/ maternity leave is provided.	Health and safety education is brought to rural communities (existent projects target pesticide use, HIV/ AIDS, and malaria).
	Investment in the living conditions of AWs (on-site or in community), particularly migrants and seasonal workers on large-scale plantations.	All employers and employees sign a contract at the start of employment and a national registry of all AWs is created to guarantee access to publicly provided health care.	Governments, employers, NGOs, or other actors establish policies to deal with seasonal unemployment within the agricultural sector.	The gains to partnerships among actors in global value supply chains (private companies, governments, NGOs, and employees/unions) are realized.
OUTPUTS				The links between health and informal agricultural work is better established by researchers.

Construction Workers: Introduction

Number and Distribution of informal construction workers

- **Definition:** Unregistered workers, including masons, carpenters, steel benders, small-scale plumbers, house-wiring electricians, carpenters, and unskilled laborers, who are mostly male, aged between 20 and 40, and are mostly school dropouts, often working on a piece-rate or daily basis. (*Rinehart 2004*)
- **Population:** 66 million in the 32 countries included in the ILO/WIEGO database. ILO estimated over 110 million total construction jobs in 2001, of which the majority are informal, BWI estimated up to 180 million construction jobs worldwide in 2006, mostly informal. More than 2/3 of all construction workers are informal (*Pais 2002; Wells and Jason 2010; WIEGO*) Both the number of informal construction workers and the proportion of informality in the construction sector have increased over the past 30 years. (*WIEGO; Wells 2007; Wells 2001; Wells and Jason 2010*)
- **Gender:** Mostly men: 97% in Africa and Latin America and 86% in Asia (ILO/WIEGO database). Some estimates have female engagement in India as high as 30% or 50% of the informal construction laborforce. (*Wells 2001; WIEGO*) Women work at the lowest levels and do the most unskilled work, mostly head-loaders carrying bricks, cement, sand, and water; other unskilled jobs such as digging earth and breaking stones; or some semi-skilled work like plastering or concrete mixing. (*Wells 2001; Jhabvala and Kanbur 2004*) There is widespread pay discrimination and some women are not paid directly, instead working as part of a family unit on a piece-rate basis. (*WIEGO; Wells 2001; Jhabvala and Kanbur 2004*)
- **Geography:** The majority are in south Asia. According to the ILO/WIEGO database, India has the most with 43 million, followed by Brazil (4.6 mil), Vietnam (2.9 mil), and Mexico (2.7 mil). ¾ of the global construction workforce is in developing countries, despite the fact that only ¼ of the construction output resides there. (*Wells 2001*)

Health Issues

- **High incidence of injuries from accidents** is the most common health risk, resulting from unsafe work sites, and lack of appropriate protective equipment and training. The ILO reports that 70% of these accidents are foreseeable and preventable.
- **Chemical exposures** are common and can cause metal poisoning, damage to the central nervous system and liver, dermal and respiratory allergies, cancers and reproductive disorders.
- **Asbestos** exposure is a serious risk and can cause cancer.
- **Musculoskeletal injuries and disorders**, including back injuries from carrying heavy loads, and joint pain.
- **Respiratory disease** from inhaling dust.
- **Poor living conditions** impact health including water-borne disease, dengue fever, and respiratory problems.

POPULATION*	TOTAL	Asia	Africa	Latin Am.
# of informal construction workers	66 mil	53 mil	1 mil	12 mil
% of construction workers that are informal	86 % (out of 76.6mil)	90% (out of 58.8mil)	59% (out of 1.8mil)	73% (out of 16.0mil)
% of all informal workers that are construction workers	16.5% (out of 399 mil)	18% (out of 292 mil)	7% (out of 14 mil)	12% (out of 93 mil)
% of informal construction workers that are female	12% (8 mi)	14% (7.6 mil)	3% (.04 mil)	3% (.32 mil)

*Data from ILO/WIEGO database on Informal workers. Asia = 8 countries: China, India, Indonesia, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam. Africa = 8 countries: Cote d'Ivoire, Liberia, Mauritius, Namibia, South Africa, Tanzania, Uganda, Zambia. Latin America = 16 countries: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela.

Actors in the Space

International Labor Organization; local and national worker groups and trade unions, such as Tanzania Association of Informal Construction Workers, Philippines' Association of Construction and Informal Workers, India's National Federation of Construction Labour, The Central Union of Painters, Plumbers, Electro and Construction Workers-Nepal, SEWA; some **governments**, such as India (national, and Kerala state), Malaysia.

Construction Workers: Problem Assessment

The Impact of informal construction work on health

Informalization has pushed construction workers out of social protection and diffused responsibility, at the cost of workers' health.

Informalization of the construction workforce

Over the past 30 years, explosions in population and infrastructure have fueled an expansion of the construction sector. Simultaneously, growing international competition in construction, including multinational companies with large and efficient infrastructures, has pushed bidders to compress labor costs and lead to a rise in subcontracting. As a result, there has been a shift from formal to informal labor, with a substantial increase in the temporary use of informal workers through intermediaries or small firms, particularly in developing countries. Informality has become the new norm, encompassing more than 2/3 of all constructions workers.

How informality impacts health

Subcontracting blurs and diffuses responsibility for working conditions and workers' health. The key motivation in the shift to informal labor is the desire to lower costs, which impacts workers' health through reduced wages, longer hours, less training, failure to provide safety equipment or coverage for accidents, and poorer working and living conditions, and means workers do not receive health benefits and are not covered by legal or social protections. Informal workers fall outside of government protections and firms using informal labor often also fail to comply with regulations. Workers in precarious jobs of short duration also leads to lower union density.

High risks, little protection

Although most construction accidents are preventable, informal workers receive inadequate training and protective equipment. Lack of awareness among the workers as well as the absence of regulation lead to high incidence of occupational injuries and exposures. Accidents on construction sites are very common and the workers have to bear responsibility for their health in the aftermath of accidents. It is estimated that ¾ to all of informal construction workers are exposed to occupational hazards. Many workers also live on site, frequently in poor conditions including overcrowding, poor sanitation, high prevalence of disease vectors such as rats and mosquitoes, and continued exposure to construction dust.

Common health problems

Injuries from accidents are so common that they are considered an inevitable part of the work. WIEGO estimates 16-18% of informal construction workers are injured in south Asia each year. Occupational exposure is also common, to chemicals, dusts, and asbestos. These exposures can cause metal poisoning, damage to the central nervous system and liver, dermal and respiratory allergies, reproductive disorders, and cancer. Musculoskeletal injuries and disorders are common, including back injuries from carrying heavy loads, and joint pain, as well as respiratory disease from inhaling dust. The poor living conditions can lead to water-borne disease, dengue fever, and respiratory problems.

Barriers to care

Low pay, and irregular income means fewer funds available for health expenditures. Informal workers generally earn less than minimum wage, and income is irregular. As a result, many can't even afford to buy into state health insurance schemes when they are eligible. They have no employer provided benefits, and declining union participation excludes them from union provided benefits as well.

Construction Workers: Dynamism Assessment

Current Interventions

- ILO's program on Work Improvement in Small Construction Sites produces training materials and example photo books focused on decreasing workplace hazards and reducing occupational injury and exposure. Trainings have been conducted in several countries.
- India has a Worker's Welfare Fund for construction which registers workers and includes them in welfare schemes such as health insurance.
- In Mongolia, trade union members provide OSH training using action checklists and good example photos. Workers and managers collaborate to develop practical improvement proposals.
- In Vietnam, low cost improvements carried out to address occupational hazards were coupled with development of company safety and health policies based on risk-assessments carried out jointly by workers and managers. The effort succeeded due to employer buy in and ILO technical support.
- The Association of Construction and Informal Workers in the Philippines provides members who are current with their dues grants to address immediate needs in times of hospitalization, disability, or death.
- SEWA, in India, is working on an accident insurance scheme for female construction workers.
- The Construction Industry Development Board in Malaysia is pioneering a scheme to make every construction worker undergo a one-day safety and health induction course, after which he is issued with a "green card". Those without the card would be barred from entering work sites while contractors who fail to send their workers to the training will be blacklisted.
- In Nepal, CUPPEC established a health cooperative in Kathmandu, with members making small monthly contributions for subsidized health care for themselves and one dependent. They organize in the urban areas by targeting the communities where construction workers are living.
- UMASIDA is a mutual health insurance scheme for informal workers in Tanzania, based on joint research by the ILO and Muhimbili University. Members and their immediate families are entitled to all primary health-care services at a scheme selected private health-care provider.

Potential Interventions

- Require bidders to include costs for worker protections and health, or take the costs of health and safety measures out of competition by including them in the prime costs of a competitively tendered contract.
- Ratify and implement the Safety and Health in Construction Convention, 1988 (No. 167), and the Asbestos Convention, 1986 (No. 162).
- Establish, or enforce compliance with existing, occupational safety and health legislation, and have a single government agency responsible for the administration and enforcement of policy.
- Require registration of labor intermediaries.
- Occupational safety and health management by contractors should be monitored on-site.
- Use legislation to define accountabilities, supplemented by succinct regulations and industry-led codes of practice or guidelines.
- Enact legal provisions allowing workers to remove themselves from hazardous or dangerous work conditions without risk of dismissal.
- Provide protection for workers to unionize.

Challenges

- Short term, scattered, and unrecorded work yields few reliable data. Lack of insurance means that accident reports are not filed, making it difficult to get good statistics on occupational injury as well.
- While many countries have safety and health legislation pertinent to construction, compliance and enforcement are sometimes lacking or minimal, particularly for informal sites. Government administration and enforcement are also fragmented.
- When social protections are theoretically available, such as voluntary membership in a government scheme, construction workers often don't know about them or are too poor to access them.

Construction Workers: Impact Assessment

Root causes that drive health vulnerabilities among informal workers suggest **four high-level outcomes** to prioritize for a potential Rockefeller Foundation initiative.

Healthier Workers:

Reduced need by informal workers for health services

- Ensure adequate OSH training for workers, and provision of protective equipment.
- Monitor occupational safety and health management by contractors including on-site inspection.
- Enact legal provisions allowing workers to remove themselves from hazardous work conditions without risk of dismissal.
- Improve worker living conditions.

Greater Access to Care:

Improved access to convenient and quality health care

- Ensure informal workers are eligible for national social protections where available.
- Support trade union and worker association negotiations for member access to affordable health services.
- Have mobile clinics or community outreach workers visit sites where workers live.
- Conduct education and outreach to ensure workers are informed of available health care.

Lower Costs from Illness:

Decreased income lost related to health issues and health care seeking

- Provide accident protection or disability insurance through national schemes or worker groups.
- Underwrite group health insurance schemes provided by worker associations to ensure viability.
- Erase cost of entry for informal workers into national health insurance schemes.
- Hold employers responsible for medical costs associated with occupational injuries and exposures.

Sustainable Steps:

Improved policies and practices to assure health and safety

- Require inclusion of OSH costs in contracts, or take the costs out of competition by including them in the prime costs of a competitively tendered contract.
- Encourage states to ratify and implement the Safety and Health in Construction Convention and the Asbestos Convention, and establish or enforce OSH legislation, with a single government agency responsible for enforcement.
- Require registration of labor intermediaries.

Domestic Workers: Introduction and Landscape

Number and Distribution of Domestic Workers

- **Definition:** Domestic workers work in the private households of others, performing a range of domestic services. Women are concentrated in cleaning and child-care, while men tend to have higher paying jobs as gardeners, drivers, and security guards. *WIEGO*
- **Population:** According to ILO estimates, at least **52.6 million**, totaling **3.6%** of waged employment worldwide. Much of the domestic work sector is informal and has grown rapidly over the past 15 years, increasing by more than **19 million** since 1995. The increasing demand for domestic work is expected to continue as developing countries get richer and more women work outside of the home. *ILO*
- **Gender:** Women account for **83%** of domestic workers and outnumber men in every region of the world. Globally, **7.5%** of all female wage earners are domestic workers – several are migrants. In 2008, **37%** of all female migrant workers were employed by households. *ILO*
- **Child Labor:** The ILO estimates an additional **15.5 million** children are employed as domestic workers globally and more girls under 16 engaged in domestic work than any other kind of child labor. (*ILO 2013, WIEGO, Anti-Slavery Int.*)
- **Geography:** **Latin America and the Caribbean** – **7.6%** of total employment and **17.4%** (18 million) of total female employment. **Asia and the Pacific**– **1.2%** of total employment and **2.5%** (17.5 million) of total female employment. **Africa**– **1.4%** of total employment and **2.5%** (3.8 million) of total female employment. **Middle East**– **5.6%** of total employment and **20.5%** (1.3 million) of total female employment. *ILO*

Actors in the Space: Funders include UN Women, WIEGO, Ford Foundation

International	Regional	National	Migrant DWs
<p>Advocacy groups, researchers informing the debate and organizations that link and strengthen movement:</p> <ul style="list-style-type: none"> • ILO • WHO • WIEGO • International Trade Union Confederation • International Domestic Workers' Network • Human Rights Watch • Amnesty International 	<p>Ties individual grassroots movements, NGOs, unions, etc. together to form regional associations:</p> <ul style="list-style-type: none"> • CONACTRAHO – Latin America • Asian Domestic Workers Network <p><i>Sources: WIEGO, Bonner 2010, ITUC</i></p>	<p>Grassroots movements representing domestic workers and providing services on the ground:</p> <ul style="list-style-type: none"> • Namibia Domestic Allied Workers' Union • Federation of Asian Domestic Workers' Unions (FADWU) – Hong Kong • SEWA – India • SADSAWU – South Africa • FENATRAD – Brazil 	<p>NGOs offer help with visas, emergency assistance, and accessing healthcare abroad:</p> <ul style="list-style-type: none"> • HOME- Singapore • Kalayaan – United Kingdom <p>Community based organizations:</p> <ul style="list-style-type: none"> • Association of Philippine Migrant Workers – Belgium <p><i>Regional organizations:</i></p> <ul style="list-style-type: none"> • Asian Migrant Domestic Workers' Alliance

Domestic Workers: Problem Assessment – Health Issues

DWs have limited access to protections – even migrants in high-income countries.

Physical, Sexual and Psychological Abuse

Research linking domestic workers and health on a global level are lacking, but several case studies exist. Kalayaan, an NGO which works with MDWs in the UK, found **18% of their registered workers to have experienced physical abuse**, over **50% psychological abuse**, and **3% sexual abuse**. A study in Thailand among MDWs from Myanmar found **14%** experienced unwanted physical contact from an employer; for **1%** this culminated in rape. WHO reports victims of sexual violence are more likely to suffer from depression, eating disorders, STDs, and other gynecological problems. (*Kalayaan 2008, WHO, ILO 2013*).

Excessively Long Hours

Working hours globally are long and unpredictable for DWs, particularly in Asia. In Nepal and Indonesia domestic workers average 52 hour weeks, Malaysia 66 hours, and Thailand 58 hours. **No upper limit on regular weekly working hours exists for 56% of the world's domestic workers**. Findings from occupational health studies show that the long working hours, night working, and patterns of irregular shifts domestic work entails have the greatest negative effect on workers' health. For live-in domestics, the divide between work and rest is blurred; children and pregnant women are especially vulnerable. (*ILO 2013*)

Poor Working and Living Conditions

Many live-in DWs face poor living conditions- including inadequate sleeping arrangements and lack of food. Over 40% of DWs registered with Kalayaan in 2006 were not allowed regular meals and/or their own bed. Some DWs are paid so little they cannot afford adequate food for their families. In the US, **23% of DWs (many of whom migrated from developing regions) are paid below the state minimum wage; 20% reported not having enough money to buy food in the previous month**. DWs also face health risks on the job, esp. increased risk for asthma, chronic bronchitis, and other respiratory problems associated with the regular use of toxic cleaning agents, and injuries due to heavy lifting. DWs have an annual incidence of non-fatal work injuries of 7.3% compared to 5% for the working population in general. In the US, **23% of workers who had been fired from a domestic job said the reason was complaining about unsafe working conditions**. Since 2000, 75 maids in Singapore have fallen to their deaths in high rises while trying to clean the outside of a window. The government tried to ban this practice but faced too much resistance. (*Home Economics, Kalayaan 2008, ILO 2013, Smith 2011*)

Lack of Health Insurance and Benefits

Most DWs do not receive health insurance and some are not granted sick days- or are afraid to take them fearing they will lose their job. This varies by country and is largely dependent on the good will of the employer. Some DWs interviewed in Indonesia were not allowed to seek medical attention when they were ill; those who were could not afford hospitalization or medication. **Globally, 44% of female DWs, compared to 47% of male domestic workers and 64% of the total urban workforce, contribute to pension and/or health schemes; 36% of women employed in private households globally have no legal entitlement to maternity leave**. This varies among regions: in Asia ¾ of DWs lack the right to take maternity leave. **Micro-insurance** tends to be inexpensive, immediately available, and relies on scalable partnerships. **Naya Jeevan (Pakistan)**, which partners with 10 multinational companies, reaches DWs through employers. When privately provided micro-insurance relies on employers to buy in, as skeptics of **DomestiCare (South Africa)**, argue there is no tangible incentive for employers to support it. **Public insurance models** mandate that employers make compulsory payments into state subsidized funds. In **Uruguay and Argentina** employees are provided with health insurance, social security, maternity and sick leave. (*WIEGO, ILO 2013, Amnesty Int. 2007*)

Domestic Workers: Problem Assessment – Causes and Systems

National Labor Standards Geared towards DWs

- National legislation regarding maximum working hours, minimum rest/ vacation, ban of dangerous chores/materials, and minimum wage (per ILO).
- For live-in DWs, standards should include a bed and nutritious food supply.
- DWs should be explicitly included under domestic violence/ sexual abuse laws; authorities should be trained to deal with this group.

Third-party Regulation and Enforcement

- A formal contract between employee and employer.
- A third party (NGO, national labor division, or even an existent recruitment agency) could play a monitoring/regulatory role and serve as a formal mechanism for filing worker complaints.
- Giving DWs a way to voice grievances allows for targeted inspection and removal from dangerous situations.

Special Policies for Migrant DWs

- Key protection for MDWs is a visa, as legal status is not linked to an employer. Allows MDWs to leave abusive employer without deportation if they find work in another household.
- MDWs should be covered under labor standards of host country or contract between countries.
- MDWs should have access to a third-party agency that can assist with accessing healthcare.

Better Provision of Health Insurance and Benefits

- Most DWs with health insurance are covered under universal insurance schemes; emerging efforts are to provide DWs with occupation-tied micro-insurance initiatives in which the employer contribute small monthly payments to private insurers.
- Challenges: incentives for employers to buy into the plan and ensuring that DWs can afford it.
- DWs need access to maternity leave, and compensated sick days.

Root Causes and System Failures

- **Because their work is done in the private sphere, domestic workers are among the most invisible groups within the informal economy.** Labor laws and regulations generally miss them and where labor standards do exist, they oftentimes remain un-enforceable in the private setting of an employer's home.
- **It is difficult to count domestic workers, since most remain unregistered,** and even more difficult to assess their specific health needs on a global level.
- **The employer-employee relationship is unequal, exacerbated by social inequalities** embedded in society. An employer's social status outside of the home may erode the power of domestic workers (who are oftentimes poor and from marginalized communities) to negotiate and enforce contracts.
- **Women are subject to gender discrimination, prejudice, and stereotyping** in relation to work, which is undervalued and regarded as low status.
- **Migrant domestic workers (MDWs) are the invisible of the invisible** because their legal status as migrants is oftentimes linked to their employers. Many are recruited by exploitative third-party agencies which do little to inform them of their rights or ensure safe working conditions. (Kalayaan 2008, WHO)
- **Domestic workers are highly susceptible to exploitation from employers,** either through physical violence, withholding of wages, or poor working conditions. Live-in domestic workers are especially vulnerable since most depend upon their employers for food and shelter. (WIEGO, Kalayaan 2008)
- **As a result domestic workers suffer from a range of “decent work deficits.”** The proportion with labor contracts or social protections is very low compared to other occupations. In a recent study in Indonesia, none of the domestic workers interviewed received a written contract and in Latin America only 20% do. (Amnesty Int, ILO, Tokman)
- **MDWs are particularly vulnerable** to abuse since employers, may take advantage of their status as migrants by seizing passports and using them as forced labor. This subgroup requires special attention. (Kalayaan 2008, WHO)

Domestic Workers: Dynamism Assessment

No longer invisible and with policies on the books, domestic workers are garnering attention. There are windows of opportunity on all levels, but potential risks to consider.

National Action

Regulation of Third-Party Recruitment Agencies and Employers

In Vietnam and Uruguay the labor code gives the government the right to investigate the working conditions of any private household which employs a domestic worker. (*Daily Star, WIEGO*) **Risks:** There is a belief that labor standards cannot be applied to the private sphere, which is the general risk with any regulation of domestic work.

Protections for Victims of Domestic Violence

Some countries, particularly those receiving large amounts of MDWs, have set up shelters for abused domestic workers (e.g., the Philippines). In Indonesia, The Domestic Violence Act mandates that victims of domestic violence be provided with health care and are taken to a government-sponsored crisis center or shelter. (*HRW, Amnesty Int.*) **Risks:** Crisis centers in Indonesia are only in major cities. Many DWs did not know services existed. Cases of domestic violence are difficult to prove, and sex before marriage may viewed as taboo.

Incorporating Domestic Workers into National Labor Laws

More national governments are granting DWs basic labor rights and legal protections. In Argentina a new law will give DWs fairer wage terms, a maximum 48 hour work week, and maternity leave. In Brazil an amendment ensures DWs receive the same benefits as other workers. Since the ILO Convention on Decent Work for Domestic Workers was adopted, Venezuela, Bahrain, Spain, the Philippines, Thailand, and Singapore have passed new laws improving DWs' labor and social rights. Legislative reforms have also begun in Namibia, Chile, and the US. (*The Argentina Independent, WIEGO, HRW, IDWN*) **Risks:** Most families who benefit from DW have political clout in society while DWs are poor, un-organized, or migrants. (*CNN*)

International-level Action

- In June 2011, the ILO adopted the **Convention Concerning Decent Work For Domestic Workers**. This is the first set of international labor standards geared specifically towards domestic workers. The standards establish that DWs globally have the same basic labor rights as other workers – limits on hours, a weekly rest of 24 consecutive hours, clear information on terms and conditions of employment, freedom of association.
- 4 countries (Uruguay, the Philippines, Mauritius, and Italy) have ratified; becomes legally binding Sept. 2013.
- Dozens of other countries are currently in the process of revising national legislation to conform to these recommendations. (*ILO 2011, ILO 2013*).

Bilateral Action

Bilateral Contracts Between MDW Sending and Receiving Countries

- Emerging trend in the Middle East/ Asia of bilateral/multi-lateral contracts to regulate legal protections of migrant DWs: Indonesia and Malaysia; Sri Lanka and the UAE; Sri Lanka, Indonesia, and Jordan; and the Philippines with several countries. **Risks:** Most bilateral agreements of this kind have weak protections and unclear enforcement mechanisms or penalties. (*HRW*)

Flexible Visas for Migrant Domestic Workers

- The UK (with a push from Kalayaan) passed the Overseas Domestic Workers' Visa, which allows MDWs to change employers if they continue to work in a private household. Most MDWs emigrate to richer countries to send wages back home as remittances, so they have a strong incentive to retain their legal status as migrants. Flexible work visas reduce the risk of staying in an abusive environment. **Risks:** To limit immigration, the UK reverted to 6month visitors' visas; this is a problem, esp. in Singapore and Malaysia, where workers are on 2-year visas linked to a single employer.

Domestic Workers: Impact Assessment

Health vulnerabilities among domestic workers suggest **four high-level outcomes** to prioritize.

HIGH LEVEL OUTCOMES	Healthier Workers:	Greater Access to Care:	Lower Costs from Illness:	Improved Policy:
	Reduced need by informal workers for health services	Improved access to convenient and quality health care	Decreased income lost related to health issues and health care seeking	Improved policies and practices to assure health and safety
	Domestic workers are prevented from performing dangerous chores or using toxic materials. Limits on weekly working hours and adequate time off.	Safe houses for victims of domestic violence are accessible to domestic workers and MDWs have access to healthcare abroad.	Domestic workers receive compensated sick days and maternity leave as per ILO decent work standards.	Domestic workers in abusive households have a forum to voice their concerns. Exploitative recruitment agencies and employers are punished.
	Live-in DWs receive adequate sleeping quarters and food.	More affordable and conveniently located health insurance options increase coverage for domestic workers and their families.	Minimum wage and overtime paid at regular intervals assured through direct deposits into a bank account or similar instrument.	The link between domestic work and health is established on a global level. Individual nations and NGOs share best practices, allowing them to better address the health needs of their domestic workers.
INTERMEDIATE OUTCOMES	Forced labor and trafficking among migrant domestic workers is reduced.			
	Domestic violence and sexual assault are reduced. Migrant DWs can more easily escape dangerous households.	Innovative insurance models geared towards domestic workers are studied and best practices adopted- ex. How to incentivize employers to buy in or scale up to limit expenses?	Employers and employees sign a contract at the start of employment, guaranteeing a minimum wage based on hours worked, rather than in-kind payments.	DWs' rights and awareness are furthered at the international level, helping reduce the stigma attached to domestic work.
	Targeted policies for migrant DWs, such as flexible workers' visas tied to employment status rather than a single employer.			
	Individual countries ensure DWs are protected under national labor and domestic violence legislation, following ILO Decent Work standards.	Increase special support services for MDWs via third party agencies (such as Kalayaan) which provide assistance with accessing healthcare in their new country and serve as shelters for workers in abusive homes.	Individual countries ensure DWs are covered under national labor legislation, following ILO Decent Work standards	New research identifies key health vulnerabilities of DWs (esp. child, live-in, and migrant workers) and how organizations on the ground are currently addressing them.
OUTPUTS				Third- party regulation of DWs through a formal contract, complaint system, and monitoring of targeted households.

Home-based Workers: Introduction and Landscape

Number and Distribution of Home-based Workers

- **Definition:** Home-based workers are informal workers who carry out work for the market, either contractually or on their own account; within their homes, surrounding grounds, or other premises apart from their employer. (*Sudarshan and Sinha 2001; Sinha 2006, WIEGO, ILO 1996*)
- **Population:** 100 million and growing. (*Sinha 2006, ILO 2011, Sudarshan and Jhabvala 2009*)
- **Gender:** The majority are women: ~50% in Africa, over 50% in Latin America, and 80% in South Asia. (*Sudarshan and Sinha 2001, ILO 2011, Charnes 1997, Hiralal 2010*)**
- **Geography:** Over 50 million, more than half of the total, are in South Asia. Those in Asia and Latin America are more often piece-rate homeworkers, whereas in Africa they are more often self-employed in microenterprises. (*WIEGO, ILO 2011, Sudarsha and Jhabvala 2009, Chen et al 2002, Hiralal 2010*)

Health Issues and Responses

Health Issues

- **Health problems from poor working conditions and postures**, including: eye strain and eyesight problems; joint, shoulder, and back pain; reproductive health problems; cough and bronchial problems.
- **Exposure to workplace hazards** due to lack of protective equipment and workplace regulations, including: electric shocks, chemical exposure, dust and fiber inhalation.
- **Limited time or money available for seeking health care** due to long hours and little pay, in addition to no health benefits from employer and no access to health care initiatives that are employer centered.

Policies, Programs and Interventions

- **International standards** like the 1996 ILO Convention on Home Work have helped define the the vulnerable parties and their needs.
- **National support mechanisms** include India's Beedi Workers Welfare Fund which reimburses workers for health procedures and Bolivia's program providing home-based child care for informal workers, including access to health services.
- **Occupational safety and health initiatives** seek to improve home work conditions, including by training workers, as in ILO's Work Improvement for Safe Home training program, and providers, in Thailand's Safe Work Program.
- **Health worker outreach** such as Save the Children's partnership with the Philippine Ministry of Health to train community volunteer health workers to target home-based workers, collecting data and providing OSH training.
- **Extension of health insurance protection**, to include homeworkers in national health insurance, as with the Philippines KaSAPI PhilHealth, or to extend microinsurance to homeworkers, as Grameen Bank and BRAC have done in Bangladesh and HomeNet Thailand did in Chiang Mai.

Actors in the Space

- **Multilaterals:** International Labor Organization (ILO); World Health Organization (WHO)
- **Regional and national networks:** Women in Informal Employment: Globalizing and Organizing (WIEGO); HomeNet South Asia, HomeNet Southeast Asia; Self Employed Women's Association (SEWA)
- **Active governments:** India, Pakistan, Thailand, the Philippines, Bolivia
- **NGOs:** Save the Children (SC); Bangladesh Rural Advancement Committee (BRAC), Grameen Bank, Japan International Labour Foundation (JILAF); Rahnuna Family Planning Association of Pakistan; Thardeep Rural Development Program
- **Donors:** ILO, WHO, Ford Foundation, Canada's International Development Research Centre, World Bank, UNDP, UN Women

Home-based Workers: Problem Assessment

The Impact of Home-based Work on Health

The rise of home-based work is tied to global economics, but impacts the health of individual workers and their families.

Global economics drive the rise in home-based work

Liberalization and globalization push productivity and supply driven economic development, resulting in sub-contract competition at the cost of working conditions and worker protection. Particularly in Asia and Latin America, homeworkers are prevalent in export industries, whose complicated supply chains make it easier to hide bad working conditions. Lack of formal sector jobs, unemployment compensation and social protections drive poor workers to home-based work despite substandard work conditions and little pay.

Poor conditions lead to significant health problems and little health care

Home-based workers fall outside employment regulations and worker protections, e.g., OHS requirements. They work long hours in poor conditions, e.g., too little light, cramped work spaces, unhealthy work postures, inadequate ventilation, and lack of protective equipment. They have no employer-provided health benefits and are excluded from health schemes that require access through an employer. Long work hours imposed by inadequate pay and preexisting poverty make it difficult to take time or limited household resources to access care. The relative isolation of home-based workers makes it difficult for them to organize or have bargaining power which could pressure employers or authorities.

Health problems are common and varied

Health problems are routinely reported in surveys of home-based workers, many of them chronic. Research by the ILO, HomeNet South Asia, and WIEGO report the most common health problems as:

- Eye strain and eyesight problems from low light and concentrating long hours on fine work.
- Joint, shoulder, and back pain from poor work posture, long sitting, cramped work space, and continual bending.
- Reproductive health problems including ovary related problems, abdominal pain and miscarriage from working paddle driven machines, disturbance of fetal position during pregnancy from excessive sitting (sometimes leading to need for C-section), lack of antenatal care.
- Field specific injuries, such as electric shocks, chemical exposure, hand problems, coughs and bronchial problems from inhaling dusts and powders.

Health problems related to poverty, rather than work conditions, are also reported, including malnutrition and anemia from insufficient food intake and tuberculosis from crowded living quarters.

Impact of health problems

Access to care is very difficult for home-based workers and their dependents – delays in accessing care can exacerbate health issues. Untreated conditions can worsen or become chronic, causing life-long impairment, and impacting work ability, decreasing income and further restricting work opportunities and access to care. Maternal health impacts child health; the majority of home-based workers are female and have children at home. Conditions/exposures experienced as a child impair short- and long-term health.

Home-based Workers: Dynamism Assessment

Though challenges exist, there is a strong foundation to build from in seeking to address the needs of home-based workers.

Perspectives and Ways Forward

- **Three approaches to improving home-based worker health:**
 - Ensure home-based workers have access to health care.
 - Minimize their occupational risks and health impacts.
 - Deem the health and safety risks of this work as being too high to be acceptable and change business practices or laws and regulations to prevent it.
- **Success will require working across sectors.** Though clear links between work and health are seen, tackling the issue calls for looking beyond the immediate work context, and for looking for synergy between development and social protection approaches. *(Sudarshan and Sinha 2011; Sudarshan and Jhabvala 2009)*
- **Importance of participation.** The participatory approach is an effective tool for encouraging workers to participate in improving the quality of their own lives. Home-based workers working together is essential to create better working conditions. *(Manothum and Rukijkanpanich 2010; Rinehart 2004)*
- **Social responsibility of business in labor protection.** Large employers and their subcontractors should be involved in protection schemes for homeworkers. When supply chains have been made visible, consumers have been successfully engaged in holding companies accountable for worker conditions. *(Rinehart 2004; Chen, Jhabvala, and Lund 2002)*
- **Utilize existing institutions.** Instead of creating new parallel structures, existing ones, such as trade unions, training institutions, or health facilities, should be utilized and strengthened for better outreach to the target communities. *(ILO 2011)*

Opportunities

- Advocacy efforts by groups such as WIEGO and HomeNet have increased awareness of the size, importance, and problems of the informal economy generally, and home-based workers specifically.
- ILO and WHO have developed extensive tools for training on occupational safety and health and implementing experience that can be built upon.
- A number of countries are currently developing universal health coverage which can provide access to home-based workers, and can build in strategies to ensure these workers are included.
- Surveys of women in health micro-insurance schemes show relatively high demand for maternity care. Promotion of schemes that offer maternity care and/or cash benefits could therefore be a first step towards a more comprehensive intervention package, and a way to promote improvement in other aspects of working and employment conditions. *(Rinehart 2004)*

Challenges

- There is a lack of good data on home-based workers, and in particular on the health effects of home-based work. The 'place of work' variable is not included in many labor force or population surveys, and there are variations in the definition of home-based workers in existing data.
- Home-based workers are isolated and can be hard to find or organize.
- Extreme poverty of many home-based workers, and their position at the bottom of the value chain, make it hard to contribute to schemes.
- The global economic forces driving the increase in home-based work are beyond the reach of most interventions.

Home-based Workers: Impact Assessment

Root causes that drive health vulnerabilities among informal workers suggest **four high-level outcomes** to prioritize for a potential Rockefeller Foundation initiative.

Healthier Workers:

Reduced need by informal workers for health services

1. Preventive health
2. Work-related flexibility for food, hygiene, etc.

Greater Access to Care:

Improved access to convenient and quality health care

1. Improve access: location and hours, etc.
2. Improve quality issues

Lower Costs from Illness:

Decreased income lost related to health issues and health care seeking

1. Reduce risk of income/job loss when using care
2. Reduce cost of care

Sustainable Steps:

Improved policies and practices to assure health and safety

1. Support services
2. Policies to recognize informal workers

- Provide primary care services, esp. maternal, newborn, child and reproductive health issues.
- Improve the quality of food available to home-based workers.
- Ensure home-based workers have adequate protective gear or equipment for their work and for their families who may be exposed.

- Develop convenient service delivery - may need to deliver home-based care.
- Ensure that home-based workers have access to trained personnel (esp. for vision, repetitive motions, etc.), diagnostics and treatment.
- Use technology to promote excellence in medical record documentation.

- Develop protections against job loss for time taken to seek health care.
- Implement insurance or other mechanisms for work-related health issues (e.g., vision, ergonomics, etc.).
- Promote costs of treatment/equipment, including eyeglasses, physical therapy, medication, etc. to alleviate symptoms.

- Increase the visibility of home-based workers and their health concerns through awareness-raising campaigns.
- Promote child care programs to assist mothers who need to seek health care.
- Support policies that enable an upgrade of facilities (homes) to reduce health problems and to meet OHS regulations.

Manufacturing Workers: Introduction

Number and Distribution of Informal Manufacturing Workers

- **Definition:** Informal manufacturers generally work in labor-intensive consumer goods industries such as garments, footwear, toys, handicrafts, and consumer electronics. Tiered networks of contractors make finished goods for foreign buyers. Some informal manufacturing workers are employed in factories or workshops, generally with fewer than 100 workers, and as many as half or more are homeworkers. Together they form the bottom layer of international value chains. Manufacturing homeworkers receive raw material from a contractor or intermediary and follow strict instructions to produce a good that is marketed by others. In many countries, the garment industry is the largest sector employer in manufacturing; it has a particularly high proportion of homeworkers.
- **Population:** There are at least 75 million in the 32 countries included in the ILO/WIEGO database. Because a large portion are homeworkers, and the database numbers for some countries may only include factory based workers, this is likely a significant underestimate. The number of informal manufacturing workers has grown over the past thirty years, as manufacturing boomed first in east Asia, then southeast, then south Asia and Latin America, leading to increases in manufacturing workers overall, and an increasing proportion of informal workers.
- **Gender:** Women play a significant role in manufacturing; they make up more than a third of the manufacturing labor force in some countries, and almost one-half in some Asian countries. The food processing and garment industry workers are predominantly women, and most homeworkers are women. As production becomes more technical, however, men squeeze women out and take the more skilled jobs. Factories tend to hire women before they are married or pregnant, and let them go when they are. Homeworkers are often also balancing household work and child care.
- **Geography:** Subcontracting, and thus informal manufacturing workers, is more prevalent in middle income countries, such as east Asia and Latin America, but in lower income countries, as in south Asia and sub Saharan Africa, subcontracting is becoming a more common aspect of the domestic manufacturing market as well. The manufacturing boom in Asia led directly to an expansion in informal workers, whereas in Latin America workers were pushed from formal to informal employment as companies strove to maintain internationally competitive prices. In only a few African economies is subcontracting from formal to informal sector enterprises widely found. Manufacturing homework is common and found in both rural and urban areas in Asia. It is less common in Latin America, and only in the cities. In Africa there is little manufacturing homework. In Asia, manufacturing homework households tend to cluster, based on the kinds of goods they produce.

Health Issues

- Exposure to high levels of dust, noise, and repetitive, stressful use of hands and feet in textile factories often results in **lung disease, hearing loss, and repetitive strain injuries**.
- Food manufacturing is associated with many **repetitive strain injuries, a high accident rate, and exposure to biological hazards**.
- **Carpal tunnel syndrome and hand and wrist tendonitis** is common in factory workers.
- **Chemical exposure** is common, specifically with goods like metal products and plastic boats and in the case of some dyes.
- A high proportion of homeworkers suffer health impacts of their work. **Shoulder pain and backache** are the most commonly reported. Few homeworkers seek treatment.
- Incense making results in **injury to the skin and eyes**, and inhalation of toxins which cause **lung irritation** and can lead to **asthma**.
- Poor factory conditions can directly endanger workers' health, as in the case of **factory fires**.

POPULATION*	TOTAL	Asia	Africa	Latin Am.
# of informal manufacturing workers	78 mil	63 mil	2 mil	13 mil
% of manufacturing workers that are informal	60% (out of 129 mil)	67% (out of 94 mil)	51% (out of 4 mil)	42% (out of 31 mil)
% of all informal workers that are manufacturing workers	20% (out of 399 mil)	21% (out of 292 mil)	15% (out of 14 mil)	14% (out of 93 mil)
% of informal manufacturing workers that are female	34% (26 mil)	30% (19 mil)	22% (.45 mil)	50% (6.5 mil)

*Data from ILO/WIEGO database on Informal workers. Because such a high proportion of informal manufacturing workers are homeworkers, which are difficult to count, these are likely underestimates. Asia = 8 countries: China, India, Indonesia, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam. Africa = 8 countries: Cote d'Ivoire, Liberia, Mauritius, Namibia, South Africa, Tanzania, Uganda, Zambia. Latin America = 16 countries: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela.

Manufacturing Workers: Health impacts

Factory-based Workers

- **Textile factories** expose workers to high levels of dust, noise, and repetitive, stressful use of hands and feet, which often results in lung disease, hearing loss, and repetitive strain injuries. *(Goldman and Hatch 2000)*
- **Food manufacturing** is associated with many repetitive strain injuries, high accident rate, and exposure to biological hazards. *(Goldman and Hatch 2000)*
- Manufacturing is one of the highest risk sectors for **occupational hazards**, and ¾ to all of manufacturing workers may be exposed. *(Benach et al 2007)*
- Use of factory machinery or improperly sized tools can result in carpal tunnel syndrome and hand and wrist tendonitis. *(WHO 2006)*
- **Chemical exposure** is common, specifically with goods like metal products and plastic boats and in the case of some dyes. *(Benach et al 2007)*
- **Irregular work availability**, and therefore income, fluctuating with buyer driven demand, as well as **long and irregular working hours**. *(WIEGO)*
- Many informal workers work in **unregulated factories** that do not meet industry code, illegally constructed and lacking proper fire safety measures such as fire extinguishers and emergency exits, which can result in devastating **factory fires**.
 - In Bangladesh in Nov 2012, 120 workers were killed at a Tazreen Fashions factory making clothes for several European brands.
 - Fire at a Smart Export Garments factory in Jan 2013 killed 7.
 - More than 700 people have died in Bangladesh factories since 2005, mostly in the garment industry. *(Business Insider)*
 - Since Nov 2012, Bangladesh has also experienced 18 other nonfatal factory fires. *(New York Times)*
- The **mass fainting** of workers has become a regular occurrence in garment and shoe factories in Cambodia, affecting dozens to several hundred workers at a time, with 2,400 workers fainting in 2011 alone. *(Merk 2012)*
 - Investigations identified several contributory factors: inadequate ventilation; noxious chemicals; low blood sugar; malnutrition; dehydration; food poisoning; long working days; and mass hysteria.
- **Export Processing Zones** are often associated with poor work environments and work practices, including un-paid overtime work, inhuman working hours and deficient health and safety. In some factories workers are locked into the workplace during working hours, and workers have died in fires while being locked in. Poor ventilation, failure to provide medical attention, and lack of proper accommodation are other examples of EPZs employment practices. *(Benach et al)*

Homeworkers

- An empirical analysis of factors affecting women homemaker's health in India and Pakistan concluded that overall **health status was more associated with poverty**, rather than their work.
- The exception was Incense making, which was found to have a negative effect on health. It involves exposure to toxic chemicals, normally handled with bare hands, leading to discoloring and injury to the skin. Workers inhaled dust and toxins causing irritation in the upper respiratory tract that resulted in asthma in many cases. In none of the cases treatment sought, despite awareness of the health problem. *(Mehrotra and Biggeri 2002)*
- In the same study, **48% of homeworkers reported health problems due to work**. In all sectors some 30 to 71 per cent of homeworkers faced work related health problems. Shoulder pain and backache were the most commonly cited problems. *(Mehrotra and Biggeri 2002)*
- Homeworkers are generally subject to poor environmental conditions, sometimes hazardous occupations or processes, poor lighting and ventilation, non-availability of safety devices, exposure to toxic substances, dangerous gases, and postural and spinal disorders. *(Mehrotra and Biggeri 2002)*
- Homeworkers **rarely have appropriate protective equipment** and may be unaware of safety measures. *(WIEGO)*
- **Low price per piece** means that other family members, particularly children, are often engaged to increase piece production – thus exposing them to the occupational hazards as well. *(WIEGO)*
- **Use of toxic materials** exposes other members of the household even if they are not involved in production.
- Health risks for homeworkers, and consequently their families, in the garment industry include repetitive strain, dust from cloth pieces and, in the case of some dyes, exposure to poisonous chemicals. *(WIEGO)*

Manufacturing Workers: Interventions

Voluntary Codes of Conduct

- Some apparel retailers have voluntarily adopted codes regarding ethical work practices and worker protections that improve conditions for the workers in their supply chain, which can have a positive effect on the business as well.
- The **Ethical Trading Initiative** is a tri-partite membership organization made up of companies, NGOs and Trade Unions. Member companies are required to adopt the ETI Base Code, which is derived from core International Labor Standards, and to commit to ensuring compliance with the Base Code throughout their supply chains.

Workplace Training

- ILO's **Work Improvement for Small Enterprises (WISE)** program relies on the initiative of the local people, entrepreneurs and workers. They are guided to look at good local examples, check available local solutions, plan and implement actions which will be useful for improving working conditions and productivity.
- ILO's **Work Improvement for Safe Home (WISH)** program responds to the immediate needs of homeworkers and provides them with practical, easy-to-implement ideas to improve their safety, health and working conditions. These improvements will also contribute to higher productivity and efficiency of their work and promote active participation and cooperation of home workers in the same workplace or in the same community.

Regulation

- Increased oversight, and in particular onsite inspections, are an important aspect of factory safety.
- Publishing compliance with indicators, at the factory level, including the naming on clients, encourages unwilling manufacturers and buyers to address health-threatening violations.
- ILO's **Better Factories Cambodia** project seeks to improve working conditions of factories in Cambodia and compliance with international labor standards. Manufacturers must participate in order to earn an export license. Factory monitoring is key and factories must sign an MOU allowing full access to ILO monitors, of premises, documents, and interaction with workers. BFC has produced "Good practice sheets" and comic books on other topics, such as health.

Social Protection

- Social protections can reduce the financial shocks of an injury or health event, which can devastate an entire family, by providing access to affordable health care.
- **UMASIDA** is an umbrella health insurance organization for the informal economy in Dar es Salaam, whose main objective is to provide health care to all its members and their families on an insurance basis.
- The government of India established **Worker Welfare Funds** for several categories of informal workers, providing a variety of social protections, including access to health facilities. Among the adult women workers, those covered by the funds are much more likely to seek health care.

Current interventions to improve the health of informal manufacturing workers are of several distinct types.

Manufacturing Workers: Impact Assessment

Root causes that drive health vulnerabilities among informal workers suggest **four high-level outcomes** to prioritize for a potential Rockefeller Foundation initiative.

Healthier Workers:

Reduced need by informal workers for health services

- Regulate and inspect factories to improve working conditions.
- Provide training to workers and employers on safer working practices.
- Ensure provision and use of appropriate protective equipment.

Greater Access to Care:

Improved access to convenient and quality health care

- Provide mobile health services at factory sites, or in EPZs.
- Use outreach workers to link workers with existing care facilities.
- Increase community clinics in areas accessible to home-based workers.
- Flex hours at community health clinics.

Lower Costs from Illness:

Decreased income lost related to health issues and health care seeking

- Ensure informal workers can access and afford entry into existing national schemes.
- Hold employers liable for costs associated with work place injuries and health impacts.
- Compensate workers for wages lost while seeking care.

Sustainable Steps:

Improved policies and practices to assure health and safety

- Hold international companies responsible for conditions all the way down the value chain of their products.
- Publicize level of compliance with international labor standards.
- Require EPZs to meet international labor standards.

Street Vendors: Introduction and Landscape

Definition and Overview of Street Vendors

- **Definition:** Street vendors constitute an heterogeneous group.
 - They sell goods and services in public places without a permanent or legal built-up structure from which to sell. In many countries, they are relocated to public markets that are privately owned and converted to off-street markets.
 - Street vendors can be non-mobile or mobile (use of cars, bicycles etc.).
- **Population:**
 - Along with home-based workers, street vendors are the largest sub-group of the informal workforce. Both groups represent 10-25% of non-agricultural workforce in developing countries and >5% of total workforce in developed countries.
 - Statistics likely undercount the number of street vendors: street vending is usually a secondary, seasonal, temporary, or part-time income-generating activity and tends not to be reported in labour force surveys by fear of sanctions.
- **Gender:** Women represent 30%-90% of street vendors, except in countries restricting women's mobility (e.g. India, Tunisia).

Health Issues and Responses

Health Issues

Working Environment

- Harassment from officials (including payoffs) diminish the funds available to address health issues.
- Lack of proper sanitation infrastructure.
- Roadside and fire incidents.

Medical Condition

- Pulmonary, stomach- and liver-related problems.
- Strains and joint pains.
- Headaches, eye infections and stress-related diseases.
- Dehydration and malaria.

Policies and Programs

- Strengthening street vendors' voice and bargaining capacity.
- Implementing street vendor friendly urban policies.
- Micro-insurance (VimoSEWA)
- New concepts introduced in Ghana (SSNIT) on contributions and collaterals.

Landscape Assessment

Key international organizations



Major national & regional organizations

Kenya	South Africa	India
		

Street Vendors: Problem Assessment – Health Issues

Working Conditions

- **Harassment from official forces:** street vendors lead a precarious existence, facing the threat of fines, confiscation of goods, eviction and destruction of their property. In Mumbai, each street vendor pays 15 to 20% of his daily income (that consequently cannot be used for health purposes) as bribes to local police.
- **Lack of proper sanitation infrastructure** such as running water, toilets, and solid waste removal systems. In Johannesburg, 52% of interviewed street vendors reported not to be comfortable with their working environment, for reasons ranging from lack of shelter and dirt (34%), noise (26%) and having to clean the area themselves (24%).
- **Accidents:** Street vendors are exposed to market fires and, when occupying roadsides, to traffic incidents, pollution and exposure to the elements.
- **Long working hours:** frequently 11 hours a day.

Main Diseases and Medical Conditions

Pulmonary problems (bronchitis, asthma):

- Constant exposure to dust and pollution.
- 30% of Indian street workers have chronic respiratory problems.

Eye-related problems:

Blurry vision caused by dust and pollution.

Strains and joint pains:

- Inappropriate work posture and heavy lifting.
- 25% of Indian street workers suffer from backache.

Stress-related diseases

Migraine, hyper acidity, hyper tension and high blood pressure.

Stomach- and liver-related problems:

- Food poisoning: ingestion of food prepared in areas with poor sanitation.
- 38% of Indian street vendors have stomach problems and about 24% have liver problems.

Malaria:

Mosquitoes in stacked sacks of rubbish, blocked gutters and stagnant puddles.

Dehydration:

Exposure to sun and heat.

Chronic headaches:

From car fumes, dust, heat.

Street Workers: Dynamism Assessment

National and International Initiatives

Geared towards formulation of policies allowing informal street vendors to access formalisation in a more inclusive way as street vending is illegal in most countries and perceived as a nuisance.

National initiatives:

India's National Policy on Urban street vendors (2009) aims to:

- Promoting access of street vendors to such services as credit, skill development, housing, social security and capacity building.
- Putting an end to bribery, evictions, harassment .
- Giving street vendors a legal status and vending zones in urban planning.
- Promoting organizations of street vendors and their participation to urban policies (via Town Vending Committees).
- Its implementation since 2004 has been weak and uneven.

Initiatives at international and regional levels:

Street vendors associations are being developed at international, regional and national levels in order to :

- Raise awareness.
- Strengthen the voice and bargaining capacity of informal workers.
- Implement street vendor friendly urban policies.
- Promote solidarity between organizations of street vendors and hawkers.

Health Insurance Initiatives

Failure of governments in implementing an efficient health insurance and social protection to informal workers in general:

Ghana: National Health Insurance Scheme (2003)

- NHIS is a hybrid of the social and community based health insurance models. It extends social protection to informal workers.
- But the World Bank predicts it will go bankrupt in 2013. NHIS premium cannot be afforded by most informal workers and Ghanaian healthcare expenses remain dominated by out-of-pocket payments.

Thailand: Universal Coverage Scheme or "30 baht scheme" (2001)

The service is financed by general tax revenue with minimal co-payment of 30 baht. But it is considered of low quality by its beneficiaries.

Successful initiatives and/or promising ideas:

India: VimoSEWA micro-insurance (1992) implemented by membership-based organization SEWA

- Coverage for life, asset loss, widowhood, personal accident, sickness and maternity benefits is not restricted to SEWA members: it was extended to children and husbands of members in 2002 and 2003.
- Out-of-pocket payments to be later reimbursed by Vimo SEWA.

Ghana: SSNIT Informal Sector Fund (2008) relies on interesting financing concepts for contributions and collaterals

- Voluntary contributory fully funded personal pension scheme designed for 15y-59y informal workers in formal sector establishments.
- Contribution rates are not fixed but based on members' preference and ability, on the occurrence that suits them most.
- Members can use their contributions as partial collateral to secure credit from approved financial institutions.

Transportation Workers: Introduction

Number and Distribution of informal transportation workers

- **Definition:** Informal workers in the transport of passengers, goods and freight, by road, rail, boat, and air. This includes not only workers conducting the transportation, such as drivers and conductors, but also supportive workers, such as mechanics, fuel vendors, packers, loaders, porters, warehouse workers, cleaners, guards, clerks, queue marshals, food vendors, and touts. Some definitions also include fisheries workers.
- **Population:** 37 million in the 32 countries included in the ILO/WIEGO database. Grew substantially over the past two decades; likely to continue growing. (ILO/WIEGO database; Bonner 2006)
- **Gender:** The vast majority are men: 97% in Africa and Asia and 92% in Latin America. (ILO/WIEGO database)
- **Geography:** The majority are in Asia. India has the most with 17.5 million, followed by Pakistan and the Philippines with just over 2 million each. Brazil, Colombia, Mexico, and Vietnam also have more than one million each. (ILO/WIEGO database)

Health Issues

There is significantly more information available about road transport workers than any other group, and much of the following applies to them.

- **Weak lungs, coughs, colds, rhinitis, headaches, and cancer,** from inhalation of pollution including carbon monoxide, sulfur oxide, volatile organic compounds, toluene, and fine airborne particles.
- **Back aches, overall muscle aches and pains, and sprains** from lifting too heavy objects, managing freight without appropriate equipment, and long exposure to whole-body vibration.
- **Hearing damage** from prolonged loud noise exposure
- **Serious injury and death** from traffic collisions.
- **Lack of protection from the elements** including rain, sun, extreme temperatures.
- **Fatigue and sleep deprivation** from long and irregular hours and overnight work, contributing to accident risk and exacerbating other health problems.
- **HIV/AIDS** exposure common among long distance truckers in Africa and parts of Asia.
- **Drug use** common among overnight and long distance drivers.

POPULATION	TOTAL	Asia	Africa	Latin Am.
# of informal transport workers	37 mil	27 mil	2 mil	8 mil
% of all transport workers that are informal	61% (out of 59 mil)	67% (out of 39.7 mil)	38% (out of 6.1 mil)	56% (out of 13.5 mil)
% of all informal workers that are transport workers	9% (out of 399 mil)	9% (out of 292 mil)	16% (out of 14.2 mil)	8% (out of 93 mil)
% of informal transport workers that are female	5% (1.8 million)	4% (1.1 mil)	3% (.06 mil)	8% (.61 mil)

Data from ILO/WIEGO database on Informal workers.

Asia = 8 countries: China, India, Indonesia, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam.

Africa = 8 countries: Cote d'Ivoire, Liberia, Mauritius, Namibia, South Africa, Tanzania, Uganda, Zambia.

Latin America = 16 countries: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela.

Actors in the Space

International bodies: International Transport Workers' Federation; International Transport Forum (within OECD); International Labor Organization (ILO)

National or local transport workers unions that include informal workers: Pakistan Transport Workers' Federation; All-Sindh Private Bus Transport Workers' Union; Bus Driver and Motor Taxis Association of Zambia; Kenya Long Distance Truck Drivers' Union; Jatiya Rickshaw Shramik League; Syndicat National des Travailleurs des Transports Routiers (SNTTRS); Syndicat National des Zomidjan du Benin (Synazebe)

Transportation Workers: Problem Assessment

Urbanization and Privatization Led to Increase in Informal Transport Work

Over the past quarter century, liberal economic policies have pulled workers to urban centers in the global south, requiring transportation for both an expanded urban workforce and increased production and export. Overburdened public systems were then subject to structural adjustment programs pushing deregulation and privatization of public transportation. The inability to meet demand, and fragmentation and outsourcing following privatization caused the state run bus and rail services to effectively collapse in many developing countries. This fueled a transition from formal to informal transportation work, spurred on by rising unemployment and rates of urban poverty, and pushed workers out of social protection and union organization.

Though some work informally to avoid registration or taxation, for increased flexibility, or because of tradition, the vast majority of informal transportation workers do so due to deep poverty and a lack of alternatives, choosing to work informally in order to survive. Informal transport workers are among the poorest of the working poor.

Weak Regulation and Strong Competition Lead to Poor Working Conditions

- **Low wages** – Most net \$1-4 dollars a day. (WIEGO)
- **Irregular income** – often hired by the day or by the job, or pay is contingent on that day's business.
- **Debt** – sometimes half of daily pay given for vehicle lease fee.
- **Long working hours** – 16-20 hours/day commonly reported. (Cervero 2000; Bonner 2006; ILO 1989)
- **Irregular working hours** – often required to work for long stretches, or overnight.
- **No time off or sick days.**
- **Poor maintenance** of vehicles and roads.
- **Crowding of vehicles** with passengers and freight.
- **Lack of adherence to safety regulations.**
- **Inadequate equipment** for lifting and handling freight.
- **Long exposure to whole-body vibration.**
- **Inadequate or absent social protection** – no pensions, healthcare, disability grants, unemployment, maternity benefits, and accident/life insurance coverage.
- **Inhalation of fumes** – exhaust from adulterated fuel and 2-stroke engines causes pollution including carbon monoxide, sulfur oxide, volatile organic compounds, toluene, and fine airborne particles.
- **Lead exposure from fuel.**
- **Exposure to the elements** – lack of protection against rain, sun, heat.
- **Prolonged exposure to loud noise.**

Informal Transportation Work Has Direct and Indirect Impacts on Health

- Workers live in extreme poverty and **cannot afford health care**, or to buy into health insurance schemes.
- **No time to access health care** when needed.
- **Fatigue and sleep deprivation** increase risk of accidents.
- **Drug addiction** common among overnight and long distance drivers.
- **Increased road collisions**
- **Increased injury** when collision occurs.
- **Musculoskeletal injury** including back aches, overall muscle aches and pains, and sprains.
- One incident of ill health or accident can mean disaster for the entire family.
- **Chronic respiratory diseases**, reductions in pulmonary function, lung cancer.
- **Headaches**
- **Circulatory impairments**
- **HIV/AIDS** exposure high amongst long distance truckers.
- **Hearing loss**

Among the poorest of the working poor, transportation workers struggle to survive while facing significant health risks in their work and without social protections.

Transportation Workers: Landscape and Dynamism

Trade Unions and Worker Associations

- A number of trade unions and worker associations have formed for informal workers, or allowed informal workers to join.
- Though their primary purpose is often to maintain or raise levels of income for their members, a number have established basic social protection schemes, such as micro insurance or mutual aid health schemes, as well as campaigning for inclusion in state-administered social protection programs.
 - The Pakistan Transport Workers' Federation, and The All-Sindh Private Bus Transport Workers' Union, maintain small funds collected from union dues, to assist members in times of crisis, such as illness, injury or death.
 - Syndicat National des Zemidjan du Benin-Synazeb (Synazeb) pays drivers a grant in the case of road accidents to cover health care or vehicle repair costs, if the driver is up to date with his union dues. A branch level mutual health savings covers 80% of the cost of treatment at health care centers where the union has an agreement. However, these structures are facing severe financial problems because of the large number of accidents.
 - The Syndicat National des Travailleurs des Transports Routiers (SNTTRS) in West Africa is currently working with the ILO to develop a health scheme for members and their families.
 - In Benin the Social Security Mutual Insurance Fund of the Informal Workers of Cotonou provides informal workers with health coverage, pension, and disability insurance, managed jointly by the state and several unions and workers' organizations. However, it has low membership emphasizing the need for unions to ensure their members are aware of the fund and encourage them to join.
 - The Jatiya Rickshaw Shramik League negotiates with municipal authorities get free access to medical facilities for its members.

Role for Governments

- There is an important role for national and local governments.
- In some cases, as in the Philippines, informal employment is protected legally, but enforcement of the law is weak and often non-existent.
- Government can help workers overcome the barriers to enrollment in existing national social protection.
- Government policy can increased transport worker income by reducing fuel prices; raising fares; reducing government taxes, duties, and permit and registration fees; and curbing extortion and harassment.
- Government regulations can increase worker safety, by paying incentives to scrap older, unsafe vehicles and passing laws requiring helmets for passengers and drivers and other appropriate safety equipment.
- Government may decide to phase out some forms of informal transport, but would need to ensure compensation and alternative livelihoods are provided.

Brazil – Health Family Program – a new strategy of prevention and health promotion that covers informal workers. (Santana and Loomis)

Challenges

- There is a lack of reliable, comparative data. Much of what is available is about road transport workers; far less is available for other subsets.
- The trade unions seem to be the only groups engaged on the issue.
- When social protections are theoretically available, such as voluntary membership in a government scheme, transportation workers are often too poor to access them. In the Philippines, for example, only 42% of families had a member who had joined the social insurance program, and only 28% of the families in the poorest 30% had; in Kingston, Jamaica, only 3% of minibus drivers had health insurance; very few informal transport workers have joined the national pension scheme in Zambia. (Pascual 2006; Cervero 2000; Bonner 2006)
- Root causes such as increasing urbanization and manufacturing, the collapse of public transportation, and poverty, are difficult to address.

Transportation Workers: Impact Assessment

Root causes that drive health vulnerabilities among informal workers suggest **four high-level outcomes** to prioritize for a potential Rockefeller Foundation initiative.

Healthier Workers:

Reduced need by informal workers for health services

- Promote respirator use for drivers exposed to pollution.
- End use of leaded fuel.
- Lower fuel costs to reduce use of adulterated fuel.
- Incentivize removal of old, poorly maintained vehicles.
- Pass and enforce laws promoting worker and passenger safety, such as wearing helmets.
- Crack down on unsafe driving practices.

Greater Access to Care:

Improved access to convenient and quality health care

- Ensure informal workers are eligible for national social protections where available.
- Support trade union and worker association negotiations for member access to affordable health services.
- Provide medical care at transportation hubs, such as ITF/ILO collaboration to run wellness centers with free medical services.

Lower Costs from Illness:

Decreased income lost related to health issues and health care seeking

- Provide accident protection or disability insurance through national schemes or worker groups.
- Underwrite group health insurance schemes provided by worker associations to ensure viability.
- Erase cost of entry for informal workers into national health insurance schemes.

Sustainable Steps:

Improved policies and practices to assure health and safety

- Strengthen public transportation systems to promote shift back to formal transportation work, and ensure public transportation meets the needs of other informal workers who often rely on informal transportation.
- Hold large companies accountable for worker conditions in subcontracted transportation services.

Waste Pickers: Introduction and Landscape

Definition and Overview of Waste Pickers

- **Definition:**
 - Waste pickers are split into different categories and have limited common interests: itinerant waste buyers, street waste pickers, municipal waste collectors, dump pickers, waste recyclers etc. They constitute the lowest social level of society.
 - The informal waste management sector saves cities about 15-20% of waste management budget: it reduces the amount of waste cities would otherwise have to collect and dispose of. Most of the avoided costs concern waste collection: the informal sector performs c. 50-100% of waste collection in most cities in developing countries at no cost to the city budget.
- **Population:**
 - 20 million informal waste pickers (about 1% of the urban population in developing countries) is involved in informal scavenging
 - Children waste pickers (e.g., 45,000 in Brazil) are particularly exposed to health issues.
- **Gender:** Little information is available on gender repartition.

Health Issues and Responses

Health Issues

Working Conditions

Higher vulnerability of informal waste pickers to:

- Waste-related safety hazards and vectors of diseases.
- Accidents and injuries.
- Unhygienic working conditions.

Medical Conditions

- Headaches, pulmonary, eye and stomach-related problems.
- Accidents.
- Lacerations and cuts.
- Strains and joint pains.
- Infections and parasites.

Policies and Programs

- Raising group awareness.
- Legalizing and including informal waste pickers within the formal system (e.g., India and Brazil).
- Suggestions from researchers to improve health conditions.
- Medical insurance initiatives in Pune (India) and the Philippines.

Landscape Assessment

Key International Organizations



Major National and Regional Organizations



Waste Pickers: Problem Assessment – Health issues

Working Conditions

- **Unhygienic and difficult working conditions:** long working hours (12 hours a day) combined with the absence of protective gear, sanitary service, shelter/warehouse to protect from rainwater, health care or social benefits.
- **Accidents and injuries happen 10x more often for solid waste workers** than for the baseline population and as a result, solid waste workers have a up to 30% higher mortality risk. The risks are greater for waste pickers working at open dumps and landfills compared to street waste pickers. They are caused by dog bites, moving trucks and exposure to toxic fumes.
- **Informal waste pickers are faced with greater dangers than formal waste pickers** because their living and working environments often overlap: they live in informal settlements, on the streets or at and on the landfill sites.

Waste-related Safety Hazards

- **Waste is an ideal habitat for disease vectors** (flies, insects, rats) and poses a risk of infection because it is combined with rainwater and contains faecal bacteria/ animal carcasses.
- **Different types of waste** can be hazardous, include toxic materials and expose waste pickers to high concentrations of pollutants (via direct contact, inhalation, consumption of waste food): e.g., Hospital or industrial waste.
- **Sharp objects** (needles, nails, knives, broken glass etc) cause cuts during collection and sorting.

Main Diseases and Medical Conditions

Pulmonary problems (bronchitis, asthma):
1.4- to-2.6-times more frequent for solid waste workers than for the baseline population.

Laceration-related issues can lead to infections, such as tetanus, hepatitis, or HIV.

Strains and joint pains:
twice as frequent for solid waste workers than for baseline population.

Dizziness, headaches and nausea:
Exposure to emissions of methane, carbon dioxide & monoxide.

Stomach-related problems:
acute diarrhoea (linked to consumption of or contact with waste foods) happens 10x more often for solid waste workers than for the baseline population.

Eye-related problems:
conjunctivitis and blurred vision (due to dust and fumes).

Risk of infections and parasites:
3- to 6-times higher for solid waste workers than for the baseline population.

Waste Pickers: Dynamism Assessment

Inclusion and Legalization

International initiatives

IWPAR Project (Project for Informal Waste Pickers And Recyclers organized by Enda) aims to promote the protection and inclusion of popular collectors and recyclers of waste in Colombia, Ethiopia, Madagascar and Vietnam and will last from 2011 to 2013.

National and regional initiatives: raising awareness for legal recognition and integration of informal waste pickers

Recognizing the legal status of informal waste workers

- India: The National Environment Policy (2006) and The National Action Plan for Climate Change (2009) recognize the legal status of the informal sector in waste collection and recycling. They aim at enhancing informal workers' access to institutional finance and relevant technologies.
- Brazil: The National Solid Waste Policy (2010) institutes a number of mechanisms to support cooperatives and municipalities that integrate informal workers into solid waste systems.
- Brazil and Colombia have the largest and best established national movements of waste pickers (MNCR, MNRP) in South America while Peru and Chile are only beginning to organize.

Providing informal waste workers with identity cards to help with social acceptance and recognition.

Many informal waste workers are immigrants or do not have any official identity document. This personal insecurity and subsequent harassment by police or officials can be reduced by the provision of identity cards, e.g. Project for the Empowerment of Waste Pickers by the Women's University in Pune.

Health Initiatives

Researchers' suggestions to improve the health status and working conditions of waste pickers:

- Providing protective equipment (gloves, clothing, boots and face masks), clean drinking water and sanitation facilities near the working place.
- Registering all waste pickers and encourage participation in a regular vaccination and health examination program.
- Establishing micro-insurance as a solution for specific health and pension systems.
- Encouraging the separation of hazardous materials from municipal wastes within the population.

Medical insurance schemes

India: Implementation of a scheme for medical insurance for all registered waste pickers by the Pune Municipal Corporation:

- Payment of health insurance premiums for KKKPK members to New India Assurance Company in recognition of their financial and environmental contribution by the Pune municipality.
- Reimbursement of hospitalisation costs of up to Rs.5000 by the insurance company.

Philippines: The Comprehensive Integrated Delivery of Social Services (CIDSS) is a program of the Department of Social Welfare and Development that provides assistance to informal workers including waste pickers.

Appendix Informal Worker Profile – Africa

Number and Distribution of informal Workers in Africa

Population:

- As many as 152 million informal workers. (R4D calculation)
ILO/WIEGO estimates 32 million informal workers (2% of 1.8 billion global informal workers), 45% of the total workforce, or 53% of the non-agricultural workforce, from the 12 countries reporting.
- In 2002 ILO estimated that the informal economy is 72% of non-agricultural employment in sub-Saharan Africa.
- Benach et al estimate the informal share of Africa's non-agricultural workforce at 80%.
- In 1990, UNDP estimated a total African workforce of 235 million.

Gender:

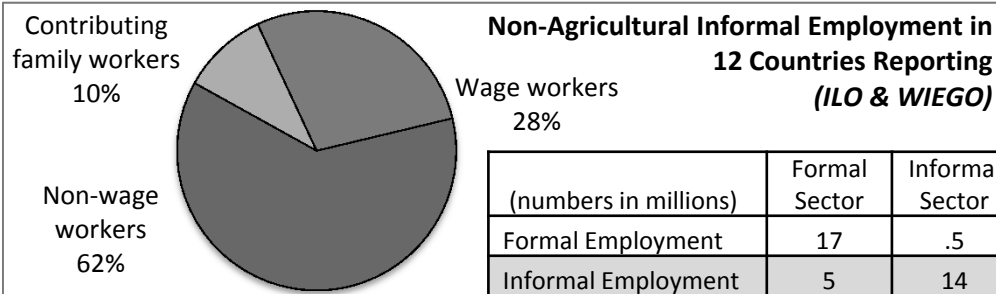
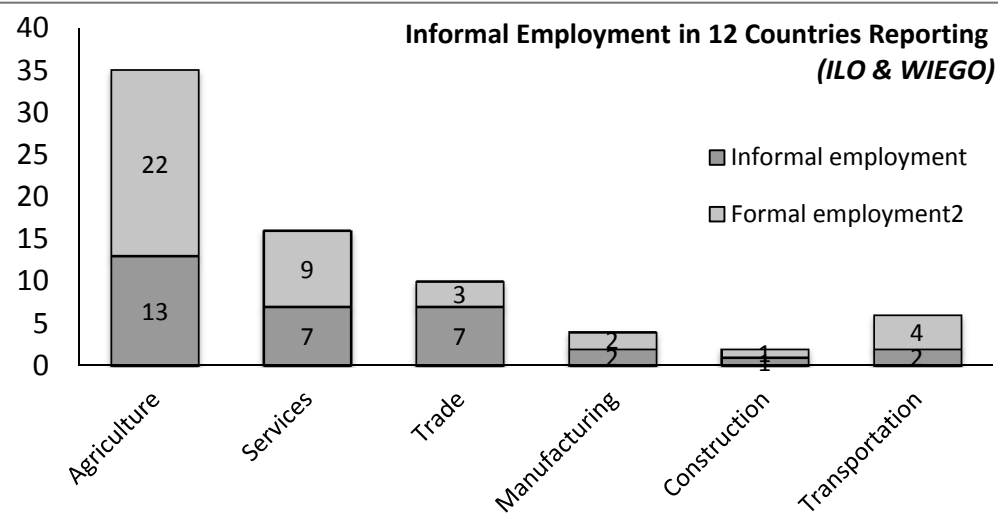
- In ILO/WIEGO reporting countries, women comprise 27-52% of the non-agricultural informal wage workforce and 31-67% of the non-agricultural informal self-employed workforce.
- Informal agricultural wage employment rate is 3-48%; informal agricultural self-employment rate is 25-58%.
- In sub-Saharan Africa 84% of women non-agricultural workers are informally employed compared to 63% of male non-agricultural workers, according to the International Poverty Centre in 2008.
- Most women in the informal economy in Africa are either self-employed or unpaid workers in family enterprises, mostly working as own-account traders and producers or casual and subcontracted workers.
- Women are under-represented in high income activities and over-represented in low income activities such as subcontracted work.

Leading sectors of informal work	# of workers	% of informal work
Agriculture (not including small scale farmers)	13 mil	41%
Domestic workers	5 mil	16%
Home-based workers	Uncertain, but high	

Employment in Millions, 12 Countries* Reporting (ILO & WIEGO)

	Agriculture	Non Agriculture	Combined
Formal employment	22	17	39
Informal employment	13	19	32
Total employment	35	36	71

*Lesotho, Liberia, Madagascar, Mali, South Africa, Tanzania, Uganda, Zambia, Namibia, Côte d'Ivoire, Mauritius, Zimbabwe



The Informal Economy in Africa

Background

- The idea of informal employment developed in context of Africa. It has always been the dominant portion of the economies of most African countries. It remains the main response to Africa's continued weak development and integration into the global economy. In most African countries formal private wage employment accounts for a small fraction of total employment, often well below 10%. (*Heintz 2009; Schurman et al 2012*)
- Though Asia has seen a substantial increase in exports, other world regions have hardly increased their export participation or have not increased it at all. Despite increasing global trade, the benefits have been very unequally distributed with investment flows concentrated in a handful of countries. Most poor countries, including most in sub-Saharan Africa, have been marginalized from investments, resulting in competition for a small share of the market, driving down trade returns and leading to labor market concessions. Increasing debt further reduces development opportunities. (*Benach et al 2007*)
- Though global GDP has increased, incomes have declined in sub-Saharan Africa, and there are widening disparities in wealth and economic opportunity. (*Lowenson 2001*) In all regions, the total number of working poor at the US\$1 level declined between 2001 and 2006 except in Sub-Saharan Africa where it increased by 14 million. In 2006 sub-Saharan Africa had the highest share in working poverty, with 8 out of 10 women and men living on less than \$2 a day with their families. (*Benach et al 2007*)
- A pilot survey in Dar es Salaam found that the common roots of many working and employment conditions problems related to poverty, insecurity of land tenure, poor education, lack of institutional support and weak organization. (*Rinehart 2004*)

Characteristics

- Workers in Africa's informal economy are characterized by having **lower education and literacy levels** compared to the formal sector; by earning **much lower wages (44 to 84 %)**; by working **longer hours**; and by employing **higher proportions of women and children**. (*Schurman et al 2012*)
- **Informal employment accounts for a significantly larger share of total employment than does formal employment.** Though there is notable heterogeneity between African countries, in most, employment is characterized by a relatively small share of private industrial employment, a dominance of agricultural employment, and widespread self-employment is informal, non-agricultural enterprises. (*Heintz 2009*)
- **South Africa is a particular exception;** informal self-employment and agricultural employment are less important than other African countries, it has more wage than self employed agricultural jobs, and more wage jobs are in the private sector than in the public. The unemployed do not enter informal employment very quickly. (*Heintz 2009*)
- **In African countries, earnings are typically lowest and poverty rates are highest in agricultural work.** In non-agricultural informal employment, both wage and self-employment, earnings are higher than in agricultural employment, but lower than in formal employment. (*Heintz 2009*)
- **Child labor remains both pervasive and concentrated in the informal economy of developing countries in Africa.** In some countries more than 50% of children (5 to 14 years old) are workers (Togo, Niger, Guinea-Bissau, Cameroon, Central African Republic, and Chad), and more than 30% in others. (*Benach et al 2007*)
- **Home-based workers in Africa are mainly self-employed in microenterprise,** rather than piece rate workers like their counterparts in Latin America and Asia. (*Hirald 2010; Heintz 2009*)
- **The informal economy in Africa is dominated by retail trade related activities.** Even formal distributors and manufacturers use informal workers to expand their markets to low income groups. The informal economy is estimated as contributing 55% to the GDP of sub-Saharan African countries, including agriculture (60% without South Africa and Botswana). (*Schurman et al 2012*)

The Health of Informal Workers

Health Impacts Common

- World Bank estimates the risk of fatal and non-fatal occupational injury in the Sub-Saharan Africa economic region at five times higher than in Europe and North America (non-fatal: 160/1,000 workers; fatal: 21/100,000 workers). (*Benach et al 2007*) Estimates of the burden of occupational disease suggest that reporting systems in southern Africa probably underestimate the real burden of occupational disease 50 fold. (*Lowenson 2001*)
- Informal-sector risks include poor work organization, poor access to clean water and sanitation, ergonomic hazards, hazardous hand-tools, and exposure to dusts and chemicals. Surveys of informal-sector workers have found occupational injury and mortality rates similar to those in the formal sector, but higher rates of occupational illness. (*Lowenson 2001*)
- The most significant share of nonwage labor is in agriculture. Studies indicate that injury from farm implements and draught animals, musculoskeletal injury from long hours with poor work postures, and agrochemical exposures are common. (*Lowenson 1999*)
- Export Processing Zones (EPZs) have been associated with high levels of machine-related accidents, dusts, noise, poor ventilation, and exposure to toxic chemicals. In the young women who often work in EPZs, the stress can affect reproductive health, leading to miscarriage, problems with pregnancies, and poor fetal health. (*Lowenson 2001*)
- Although new technologies and production processes are benefitting industrialized countries, liberalized trade has led to the transfer to less developed countries of obsolete and hazardous technologies, chemicals, processes and waste, including asbestos and pesticides no longer produced or used in industrialized countries. (*Lowenson 2001*)
- Occupational risks also spill over to non-employed populations, through air and water pollution, and transmission of communicable diseases. Sexually transmitted infections including HIV/AIDS, for example, are more prevalent in communities along transport routes, or surrounding major development projects. (*Lowenson 2001*)
- In sub-Saharan Africa the spread of HIV/ AIDS is linked to the seasonal migration of workers. A recent study of commercial farms in Kenya revealed disproportionately high levels of HIV among agricultural workers. (*ILO 2003, WIEGO, World Bank 2002*). HIV/AIDS exposure is also common among long distance truckers in Africa.

Few Health Protections

- Sub-Saharan Africa has 11% of the world's population and 24% of the global disease burden, but holds only 3% of the world's health workers. (*Benach et al 2007*)
- Few countries in sub-Saharan Africa have free comprehensive health care services available to citizens. In some places, state-funded health care has completely disappeared. In those that offer a limited service, there has been a steady movement back towards a 'user pays' principle. Despite common perceptions to the contrary, the cost of traditional healers is often as expensive as formal medical care. In addition, health care services have been overwhelmed by the high incidence of HIV/AIDS. (*Xaba et al 2002*)
- In most low-income developing countries, such as Tanzania, not more than 5-15% of the working population and their dependents are covered by statutory social insurance, mainly for pensions and health. (*Xaba et al 2002*)
- In Africa unions have never represented a large proportion of the working population, unlike in the developed economies. They have largely focused on defending and advancing wage employment and those employed in the formal economy, rather than securing social protections. (*Schurman et al 2012*)

Current strategies and insights from previous initiatives are shaping the next health interventions for Africa's informal workers.

Lessons Learned So Far

- The African experience has shown that, rather than create new organizations, greater emphasis should be placed on respecting, strengthening and developing organizations to which individuals have freely decided to belong. *(Rinehart 2004)*
- The most successful programs in Africa have occurred when private organizations use, adapt and take ownership of the methodology. *(Rinehart 2004)*
- Health micro-insurance schemes that offer maternity care and/or cash benefits may be ideal groups through which other aspects of working and employment conditions can be promoted, particularly for industries or occupations with high prevalence of chemical exposures or physical stress, which may adversely affect the pregnant mothers and their unborn children. *(Rinehart 2004)*
- There are two fundamental requirements for setting up self-financed social insurance schemes: the existence of an association based on trust; and an administration that is capable of collecting contributions and paying benefits. *(Xaba et al 2002)*
- Rather than compartmentalizing projects by development discipline, such as working conditions, decent work, job quality, social protection, education, poverty, nutrition, etc., all aspects must be addressed in a concerted effort, to have truly significant impact. *(Rinehart 2004; Moghalu 2002)*
- Social protection systems cannot confront all of the health problems from insecure, hazardous and low-quality jobs – instead attention should focus on the source of the hazard. *(Loweson 2001)*

Broadcasting Health

- In Uganda and Ghana, research suggested that radio was by far the most common communication medium used by small enterprise workers, and a large percentage of potential listeners were willing to participate in a call-in radio show if it covered issues central to their business situation. A radio program was developed and aired twice weekly, with caller participation. In part, the program emphasizes the link between a safe and healthy work environment and a competitive and growing business. Featured topics on working conditions have included: safety for people working in restaurants and kitchens; prevention of chemical burns and chemical poisoning when handling paint, fertilizers, pesticides, glues and other hazardous chemical substances; and safety tips for mechanics.

Worker Groups and Trade Unions

- The WIEGO database lists at least 190 informal economy associations in Africa, including Member Based Organizations of the Poor (MBOPSs), Community Based Organizations, cooperative, NGOs, and Trade Unions.
- StreetNet, an international street vendor alliance, has a south Africa chapter.
- The Self-Employed Women's Union, in Durban, South Africa, organizes women working in the survivalist sectors of the economy.
- The Syndicat National des Zémidjan du Bénin-Synazeb pays drivers a grant in the case of road accidents to cover health and runs a mutual health savings program that covers 80% of the cost of treatment at health care centers where the union has an agreement.
- The Syndicat National des Travailleurs des Transports Routiers in West Africa is working with the ILO to develop a health scheme for members and their families.
- In Benin the Social Security Mutual Insurance Fund of the Informal Workers of Cotonou provides informal workers with health coverage managed jointly by the state and several unions and workers' organizations.
- Tanzania Association of Informal Construction Workers provides micro insurance.

Approaches to Health Care in Tanzania

Program	Description of Program	Results for Informal Workers
ILO prepaid scheme	<ul style="list-style-type: none"> Registered workers were required to contribute in advance, before they were allowed to receive medical care. 	<ul style="list-style-type: none"> The scheme could not be sustained since, to most Tanzanians, the concept of paying for medical care when one is not yet sick was new – and it still is.
Tanzanian Occupational Health Service (TOHS)	<ul style="list-style-type: none"> This NGO registers workers in the informal sector in member groups and provides health services, helps groups improve occupational health conditions, and form health and safety committee. Forming worker groups give them more voice in making positive changes to their working conditions and family health situations. 	<ul style="list-style-type: none"> There is an increased use of health and safety facilities among participants. Fifty-four per cent of the groups have established health and safety committees . There is an increased availability of community health providers among participating groups.
UMASIDA Health Insurance Scheme	<ul style="list-style-type: none"> Umbrella health insurance organization for the informal economy in Dar es Salaam. It provides health care to all its members and their families on an insurance basis as well as occupational safety and health measures. 	<ul style="list-style-type: none"> This program could be incorporated into state level pilots of the universal coverage program and could help to address the accessibility of primary care.
Interdepartmental Project on the Informal Sector (INTERDEP)	<ul style="list-style-type: none"> Launched by ILO in 1994. The objective of the project was to improve health and safety standards through the introduction of simple low-cost measures for the improvement of informal sector working and living conditions and the reduction of diseases and accidents. 	<ul style="list-style-type: none"> It covered ten business clusters, encouraged the formation and training of safety and health committees within the micro-enterprises in each cluster and the training of one of the members of the committee as a First-Aider.

Within a country, several efforts may need to converge to provide health care for informal workers, particularly to address primary health care needs.

World Bank Social Protection Strategy

The heterogeneity of economies in Africa will require varied approaches.

- In 2012, the World Bank announced a new ten-year strategy to support the development of social protection systems in Africa.
- The vision is to help governments build country-owned national social protection systems. This strategy was informed by numerous consultations with governments and civil society in Africa. It presents a unified vision for social protection and informs the choice of instruments, financing mechanisms and institutional arrangements for social protection. The Strategy will be implemented by leveraging partnerships, knowledge, and the World Bank's financing instruments.

	Safety Nets	Pensions	Insurance	Labor Programs	Targeted Service Delivery
Middle-income countries	National, proxy-means tested social transfer systems	Expand multi-pillar pension system	Expand formal disability & accident insurance	Employment services; job search assistance; labor regulation	Support marginalized groups to access quality services
Low-income countries	Regular seasonal public works; cash transfers to select groups	Reform contributory schemes; promote savings for informal sector	Index-based agricultural insurance; targeted support to extend health insurance poor	Skills development, especially for informal sector	Targeted support to increase access to quality services for the poor
Fragile states	Cash & in-kind safety nets through NGOs or community-based organizations	Social pensions through community-based initiatives	Community-based health insurance	Temporary jobs (public works), demobilization & reintegration	Rebuilding basic infrastructure and services

Appendix Informal Worker Profile – Asia

Number and Distribution of informal worker in Asia

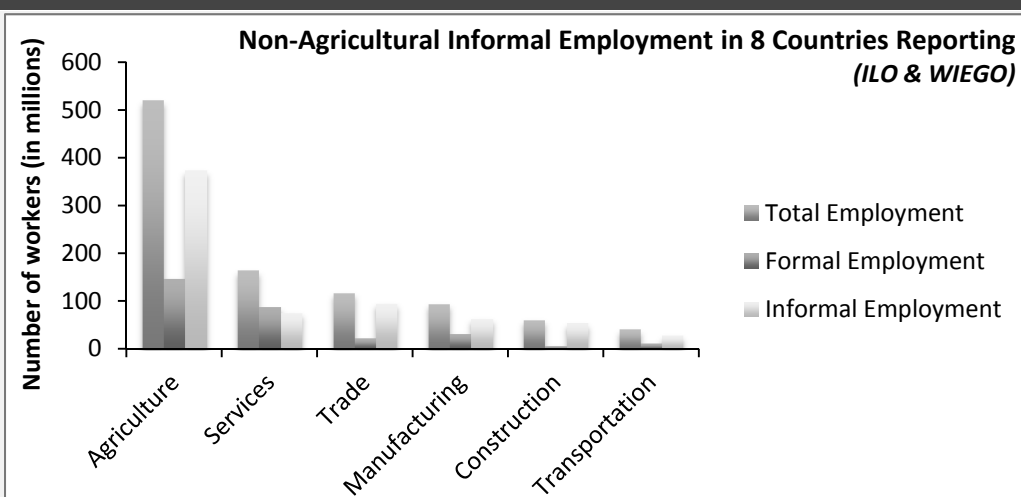
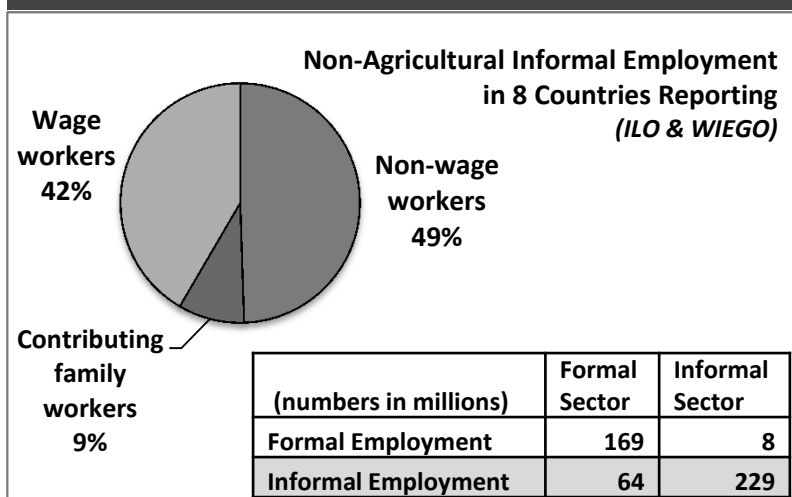
- Population:** Estimated 1.25 billion informal workers (70% of 1.8 billion global informal workers), per World Bank with ILO/WIEGO.
- Gender:** Women comprise 30-50% of the non-agricultural informal workforce, except in India (150 million men, 35 million women or 19%) and Pakistan (20 million men, 2 million women, or 9%). Informal agricultural wage employment rate is 12-40%; informal agricultural self-employment rate is 27-52%.

Employment in Millions, 8 Countries Reporting (ILO & WIEGO)

	Agriculture	Non Agriculture	Combined*
Formal employment	147	177	324
Informal employment	372	292	664
Total employment	519	469	988

* Countries: China, India, Indonesia, Pakistan, Philippines, Sri Lanka, Vietnam, Thailand.

Types of Workers



Actors in the Space – Combining Prevailing Perspectives and Approaches to Promote Health for Informal Workers

Example of Program	The “drive to formalize” approach	The “from the bottom up” approach	The “expanded coverage “ approach
Thailand’s Social Protection Floor	ILO (concept of social protection floor)	HomeNet and 8 other networks	Ministry of Health
India’s Decentralized Oversight	Protection of Livelihood and Regulation of Street Vending Bill	StreetNet, civil society organizations	Local authorities
Indonesia’s Constitutional Plans	National Social Security Law	3% of income from informal workers	Community-level micro insurance

Spotlight on Asia's Programs

Asia has been an active region in developing national-level programs for informal workers' health.

Social Protection Floor in Thailand

Building on policy momentum, Thailand passed the *National Health Security Act* in 2002 to provide health insurance to the 25% of its population that did not qualify for existing health schemes.

- Programs for private employees and civil servants excluded informal workers (about half of the uncovered population).
- Combined two existing schemes targeting the poor.
- Funded through general taxation and free of cost to beneficiaries;
- Provides general health services to individuals not covered by the government's other insurance programs and requires users to register with local primary care units.
- Compulsory participation in the program and national level communication campaigns are important ways to reach informal workers; Thailand has successfully covered 98% of its population.
- The Universal Coverage Scheme moves the country towards establishing what the ILO calls a "social protection floor," which guarantees minimum social services and financial protection.
- Although it does not focus on occupational health risks, it helps address the health needs of informal workers by bringing down barriers to accessing healthcare. Programs that address occupational health risks for informal workers could be added.
- Assessment of effectiveness found it has reduced health-related impoverishment among those employed in the informal sector.
- Pilot initiative: primary care units visited local informal workplaces, assessed the health risks, delivered health education, provided safety equipment, and followed-up with advice and feedback.
- Primary care units refer users working in the informal sector to targeted health programs during registration.

Decentralized Oversight in India

Street vending is a common informal profession; in Delhi alone there are an estimated 200,000 street vendors. The Protection of Livelihood and Regulation of Street Vending Bill has two key health-related components.

- All street vendors register with the local authorities and obtain an identity card, which ensures a dedicated space for their operations and a way the health program can track down the vendor.
- Government authorities can extend credit, insurance, and welfare programs to street vendors. Civil society groups can use this language to advocate for the provision of health care to street vendors.

Constitutional Coverage in Indonesia

The Constitution grants every citizen the right to social security—sets the stage for health coverage for all; National Social Security Law requires insurance and pensions managed by a coordinating entity .

- Rolling out health insurance to cover the entire population, though poor formal sector workers have benefitted the most from expansions;
- In 2006, the Jamsostek program (one of the country's insurance schemes) extended coverage to the informal sector – "self employed" workers:
 - Pilot informal workers program for individuals earning at least minimum wage; user contributions are set at 3% of income.
 - ILO recommends a new scheme for informal workers since program is employer-based and eligibility is linked to number of employees, etc.;
 - Informal workers skeptical of government plans and unwilling to pay premiums; covers work-related injury (hard to verify in informal work).
- ILO recommends a system of micro insurance operating at the community level to reach informal sector.

Approaches to Health Coverage

Community-based Health Insurance Programs

Cambodia: SKY program, which was piloted in 2 districts, expanded to 6; gives poor access to primary care, emergency transportation, RX, etc. Targets populations not covered by schemes for salaried employees; individuals need income to afford the premiums. No unified coverage scheme yet, but the country is moving in this direction and hopes to eventually fully cover informal workers. There are similar community based schemes operating in 18 districts.

Universal Health Services

Sri Lanka: The government provides universal health services for all of its citizens, which includes informal workers, who continue to have significant health needs, especially the elderly who are more likely to work long hours in the informal sector (formal sector mandates retirement at 60). Sri Lanka has a large voluntary public sector insurance scheme for farmers and fishermen, who belong to the informal sector, that focuses on pensions, disability payments, and other non-health social security. One scheme provides up to 1500 rupees a year for hospitalization costs.

Converge Multiple Programs

Laos: Aiming to combine four separate social health protection schemes to reach universal coverage. District-level informal workers reached by community based health insurance (CBHI) schemes, promoted for the informal sector for its affordability for families, capitated payments to local contracted hospitals, and coverage of family members. Donors are helping the Ministry with Health Equity Funds leveraged to buy membership into CBHI programs for poor families. Challenges in scaling up: lack of adequately trained staff at the village level to launch new programs and user contribution requirement is voluntary but deters informal workers.

Municipal Government Role

China: 140 million informal sector workers largely lack health insurance. The central government allows municipal governments to grant informal workers access to the basic health insurance program but does not require it; many municipalities do not offer or have high eligibility criteria (e.g., residence in a permanent registered household). Studies suggest informal workers are willing to pay to join the basic health scheme, but subsidies are needed to cover costs. There is room for policy action on the health of informal workers, similar to China's mandated informal worker sign up for the central public or collective pension scheme.

Countries often can expand existing policies or consolidate existing programs to provide health coverage or services to informal worker communities.

Challenge of Health Care in India

Program	Description of Program	Goals and Results for Informal Workers
In 2008 India's Ministry of Labor launched <i>Rashtriya Swasthya Bima Yojana (RSBY)</i> for families living below the poverty line	<ul style="list-style-type: none"> Central and state governments cover the majority of beneficiary premium costs. User pays 30 rupees for 30,000 rupees of hospital coverage annually. Insurance companies and state level ministries of labor and employment implement village level enrollment campaigns. Emphasis on the poor makes it a potential resource for workers in the informal sector. 	<ul style="list-style-type: none"> Increased health care use across all poor groups, incl. informal workers. Significant flaws in suitability. Overemphasizes hospital care, under-emphasizes preventative care and occupational health and safety. Informal workers have a greater need for frequent outpatient care visits to (work-related chronic conditions).
In 1992, Self Employed Women's Association (SEWA) launched <i>SEWAVimo</i> for members	<ul style="list-style-type: none"> Provide more basic health programs to informal workers who are SEWA members. An insurance program covering life, assets, and some health benefits including primary and maternity care. In 2008 the scheme covered 194,000 people. 	<ul style="list-style-type: none"> Similar programs starting that use similar model: on a smaller scale a waste pickers' union in Pune, Maharashtra has launched a health insurance scheme for its members.
(New) Ministry of Health and Family Welfare and the Planning Commission of India	<ul style="list-style-type: none"> Develop and implement own agenda to reach universal health coverage. Emphasizes primary care, access to free medicines, and public provision of services. Strong and targeted advocacy considerations around effective outreach to informal workers 	<ul style="list-style-type: none"> This program could be incorporated into state level pilots of the universal coverage program and could help to address the accessibility of primary care.

Within a country, several efforts may need to converge to provide health care for informal workers, particularly to address primary health care needs.

Appendix

Informal Worker Profile – Latin America

Number and Distribution of informal workers in Latin America

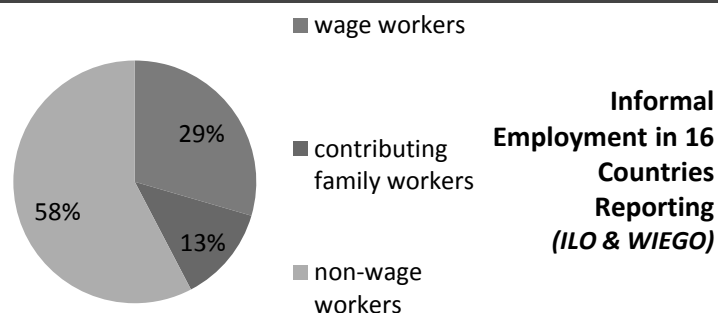
- Population:** Estimated 178 million informal workers (R4D calculation). ILO/WIEGO reports 145 million informal workers (over 60% of total employment in Latin America), in 16 countries reporting.
- Gender:** : More women (53.7%) than men (47.8%) work in the informal sector. Domestic workers alone account for 17.4% (18 million) of total female employment. The percentage of women employed in the informal sector increases dramatically as income bracket decreases. (ILO/ WIEGO database, OIT 2011)

Employment in Millions, 16 Countries Reporting (ILO & WIEGO database)

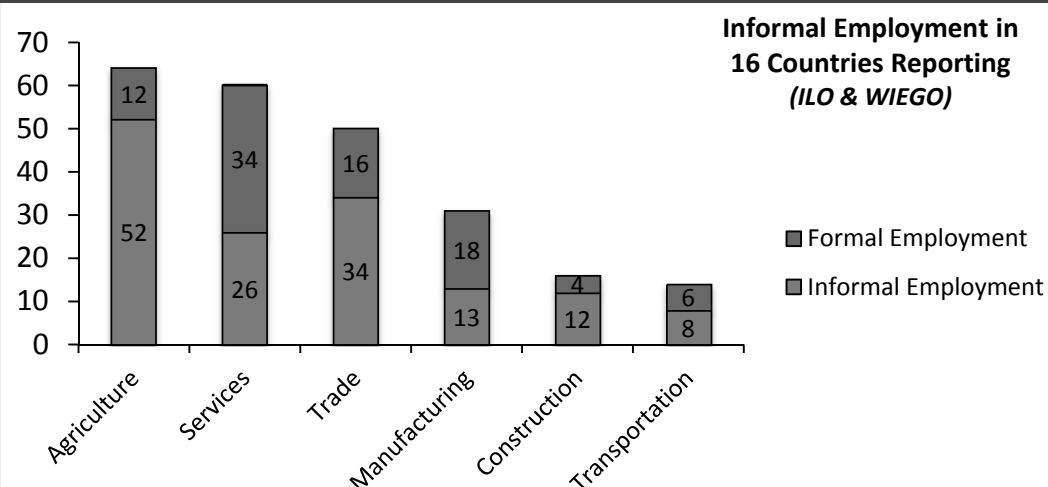
	Agriculture	Non Agriculture	Combined*
Formal employment	12	72	84
Informal employment	52	93	145
Total employment	63	165	228

* Countries: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela.

Types of Workers



(numbers in millions- not including agriculture)	Formal Sector	Informal Sector
Formal Employment	71	1
Informal Employment	33	60



The distribution of informal employment in Latin America varies across countries. (Tokman 2008)

Relatively Low Incidence (Below 50%)

Uruguay, Panama, Costa Rica, Chile (below 40%)

Average Incidence (55%-65%)

Brazil, Mexico, Argentina

High Incidence (over 65%)

Venezuela, El Salvador, Guatemala, Nicaragua, Ecuador, Paraguay, Peru, Bolivia

Health Coverage of Latin America's Informal Sector

40% of workers in Latin America do not receive health services as a result of their employment relationship.

Informal workers are most covered by UHC schemes in Costa Rica, Cuba (publicly funded), and a mix of public and private institutions in Uruguay, Brazil, and Chile. (Tokman 2008)

Brazil Family Health Teams- government funded FHTs consist of a general doctor, nurse, dentist, and community health agent. Each team is responsible for covering primary health as well as OSH services for 800-1000 families- specifically targeting informal sector workers who lack insurance. (WHO 2011)

Chile's Dual System- coverage of primary health is high due to a public/ private network of insurance. The National Health Insurance Fund (covers 68% of the population), private insurance (18%), and non-profits all provide options for health coverage. A public health program is being developed to integrate OSH and PHC in order to better serve the informal sector. (WHO 2011)

- **Over half of wage workers are employed either without contracts or under atypical contracts**, ranging from 21% in Argentina to 74% in Bolivia. (Tokman 2008)
- **19% of workers without contracts are covered by social security**, compared to 80.4% of workers with written contracts. (Tokman 2008)
- **In 2005, average income in the formal sector was 80% higher than the informal sector.** Employers in formal firms with more than 5 employees earn 2.2 times more than employers of micro enterprises and 7 times more than the self-employed. (Tokman 2008)

Informal Prone Categories Have the Fewest Workers with Health insurance

Survey of Latin American working urban population with health insurance (2010, 12 countries):



Data From: Presentation by FLACSO Chile and the Rockefeller Foundation: March 11, 2013

- **35% of workers in categories which are generally informal have access to health systems compared to 60% of workers on average.**
- **Ecuador, Mexico, Panama, and Peru (2009)-** Found in companies with 100 workers or more the health insurance coverage is about **90%** vs. in organizations with between 1 and 5 workers it is **15%**.
- **Poverty tied to informality produces even lower levels of coverage-** Among heads of households in the lowest income brackets (1st and 2nd quintiles), informal workers are least likely to have access to social protection (**81.6% lack insurance**). Informal workers in quintile 5 are **seven times** more likely to have social security than those in quintile 1.

Latin America: Enforcing Labor Rights and Health Standards

Examples of Interventions by Sector

Domestic Workers

More Latin American countries are granting domestic workers' basic labor rights and legal protections via national legislation. In **Argentina** a new law will give domestic workers fairer wage terms, a maximum 48 hour work week, and maternity leave. In **Brazil** a recently passed amendment ensures DWs receive the same benefits as other workers. Since the ILO Convention on Decent Work for Domestic Workers was adopted, **Venezuela** and **Uruguay** (the first country to ratify the convention) have also passed new laws improving domestic workers' labor and social rights. Legislative reforms have begun in **Chile** as well. (*The Argentina Independent, WIEGO, HRW, IDWN*)

In **Uruguay** where employers are legally required to register their workers with the Banco de Prevision Social (BPS Social Welfare Bank), their employees are provided with health insurance, social security, maternity and sick leave. The BPS recorded a 110% increase in domestic workers receiving sick leave between 2004 and 2010. A similar mandate in **Argentina** relied on an intense outreach campaign and income tax deduction to garner employers' support. One year after the program began, the number of domestic workers covered under social security increased from 5.5% to 12%. **Pros:** Because these programs are mandatory and subsidized by the state, employers have an incentive to actually make contributions. **Cons:** For informal-prone sectors, it is easy for employers to evade even mandatory contributions. Of the 43% of evaders, which the BPS deemed "difficult to capture," 70% were in the domestic sector. (*BPS, El Pais, ILO 2011*)

Miners

Although affecting a smaller share of the population, informal small-scale and illegal mining has a long history of hazardous working conditions and extortion in Latin America. **Peru's** informal miners' union Fenamarpe estimates up to 300,000 informal miners exist nationwide. Large informal mining populations appear throughout the Andes in **Colombia**,

Bolivia, Venezuela, and Brazil. Along with violent political clashes over extraction rights, indigenous land rights, and pollution, mining in itself is one of the top three most dangerous occupations. The working conditions of informal miners are very poor – there is a high incidence of respiratory disease, mercury poisonings, and injuries. Treatment for occupational related injuries is limited because of lack of access to health facilities. During the 1980s and 1990s, UNESCO, UNEP, and the World Bank invested heavily in the informal mining sector. However, after finding little could be done to formalize the sector, development agencies reduced funding in the 2000s.

(*World Politics Review 2010, ELLA*)

Agricultural Workers

Chile's Plan Nacional helps small-holder raspberry farmers comply with global labor standards. Chile requires employers to issue written labor contracts for temporary workers and make payroll contributions to social insurance programs when workers are employed through third-party contractors. **Argentina** – inclusion of informal agricultural workers into public health insurance plans was facilitated by pressure from local unions. In Argentina, the farmers' union UATRE worked with government to create the National Registry for Agricultural Workers and Employers (RENATRE) that included informal temporary workers and migrants. The Chiquita Code of Conduct, established minimum labor standards and freedom of association for all company owned farms in **Central America and Colombia**. The code resulted from negotiations among Chiquita, the IUF, and the regional banana union. (*ILO 2003*)

Waste Pickers

Brazil and Colombia have the largest and best established national movements of waste pickers (MNCR, MNRP) in South America while Peru and Chile are only beginning to organize. In Brazil, The National Solid Waste Policy (2010) institutes a number of mechanisms to support cooperatives and municipalities that integrate informal workers into solid waste disposal systems. (*Information from appendix: Worker Profile slides*)

Latin America: Approaches for Extending Health Coverage to the Informal Sector

Interventions to increase health coverage among Latin America's informal sector fall into two categories: Public Policies and Worker-led Initiatives.

Extension of Public Health Coverage to Informal Workers

The passage of public health schemes by governments has been linked to pressure from workers' organizations, but many laws extending rights to informal workers do not translate to increased coverage in practice. The low level of expectations about health and insurance among Latin America's informal sector act as a strong barrier. **Ex:** Caja de Seguro Social (**Costa Rica**) and **EsSalud (Peru)**: Contributory national initiative created in 2010 offering health coverage for independent workers and their families, includes benefits such as outpatient care, hospitalization, emergencies, medications, and co-pays for exams. Financed by voluntary contributions from workers based on number of dependents. **Results:** Has 23,000 members so far and unlike the free public insurance model (SIS), EsSalud provides better quality and access to healthcare. In 2009, 70.5% of formal workers were covered by EsSalud compared to 9.3% of informal workers. 35.9% of informal workers were covered by SIS. (FLACSO 2013, ECLAC 2013)

Microinsurance

Health insurance linked to private companies, in which members of a particular working group define their priority needs. **Ex: Seguro Facultativo de Salud (Nicaragua)**: In 2007, the government extended its national health insurance plan to informal workers via MFIs through a pilot among street-vendors. Financed by voluntary contributions as flat monthly installments of \$15, with a two month premium of \$171. **Results:** Subsidies brought informal sector workers into the program but did not contribute to long term retention; deterrents included the high premium relative to low income levels, time/ convenience costs, and lack of information. In Nicaragua, those with higher income and education levels were more likely to buy into the plan. (FLACSO 2013, CHMI Profile, Poverty Action Lab)

Mutuelles

Mechanisms of collective savings, whereby funds are managed autonomously by a community of workers, oftentimes through unions or collectives. **Ex:** Mutua de Salud Urbana Nicaragua, AMUTRABA- Asociacion Mutual para los trabajadores de Bateyes (sugar refinery workers), **Asociacion Mutua del Campo Nicaragua**: Created in 2000 to assist agricultural workers and their families; includes a health plan covering dentist visits and family co-pays for medication. The fund is financed through shared contributions between employers and workers. **Results:** As of 2009, 4,565 workers are affiliated and 6,009 have benefitted. (FLACSO 2013)

Community-based Health Insurance

Through CBHI, workers' organizations are associated with a particular micro-insurance model and membership is voluntary. The workers' organization acts as mediator of the private insurance company, with municipalities sometimes playing a regulatory role. **Ex:** Obra Social de Vendedores Ambulantes de la Republica de **Argentina** (street vendors), **OSMU Trenque Lauquen (Argentina)**: Created in 1992 at the municipal level to benefit community members without health coverage; includes hospitalizations, exams, and medications. OSMU is financed through a combination of contributions from members, the municipality, and worker organizations representing its beneficiaries. **Results:** 18,000 members are affiliated. (FLACSO 2013)

OVERVIEW

- Benach, Joan, Carles Muntaner, Vilma Santana, and F. Chairs. "Employment Conditions and Health Inequalities." *Final Report to the WHO Commission on Social Determinants of Health (CSDH) Employment Conditions Knowledge Network (EMCONET)*. Geneva: WHO (2007). http://cdrwww.who.int/entity/social_determinants/resources/articles/emconet_who_report.pdf.
- Carr, Marilyn, and Martha Alter Chen. *Globalization and the Informal Economy: How Global Trade and Investment Impact on the Working Poor*. Working paper on the informal economy. Geneva: International Labour Organisation, 2002. http://www.oit.org/wcmsp5/groups/public/@ed_emp/documents/publication/wcms_122064.pdf.
- Chen, Martha Alter, Renana Jhabvala, and Frances Lund. *Supporting Workers in the Informal Economy : a Policy Framework*. Working Paper. Working Paper on the Informal Economy. International Labor Office, 2002. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122055.pdf.
- *Decent Work and the Informal Economy: Sixth Item on the Agenda*. 90th Session International Labour Conference. Geneva: International Labour Office, 2002. http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/---reloff/documents/meetingdocument/wcms_078849.pdf.
- "Fact Sheet No. 11: Work Insecurity Work-related Ill Health - a Global Sickness." International Labor Organization. Accessed February 13, 2013. http://www.ilo.org/public/english/protection/secsoc/downloads/stat/ses/docs/sheet_no11.pdf.
- "Is Informal Normal? Messages, Figures and Data." *OECD*. Accessed May 1, 2013. <http://www.oecd.org/dev/poverty/isinformalnormalmessagesfiguresanddata.htm>.
- "Labor Markets - Workers in the Informal Economy." *The World Bank*. Accessed May 1, 2013. <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTLM/0,,contentMDK:20224904~menuPK:584866~pagePK:148956~piPK:216618~theSitePK:390615,00.html>.
- Lund, Francie, and Anna Marriot. *Occupational Health and Safety of the Poorest*. Research Report. School of Development Studies Research Report. Durban: University of KwaZulu-Natal, April 2011. www.sds.ukzn.ac.za/files/RR%2088%20Lund.pdf.
- Rani, Uma. *Impact of Changing Work Patterns on Income Inequality*. Discussion Paper. International Labour Organization, September 9, 2008. http://www.ilo.org/inst/publication/discussion-papers/WCMS_193166/lang--en/index.htm.
- Rinehart, Richard D. *Designing Programmes to Improve Working and Employment Conditions in the Informal Economy: A Literature Review*. International Labour Organization, 2004. http://www.oit.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_travail_pub_10.pdf.
- "The Informal Economy and Decent Work: A Policy Resource Guide Supporting Transitions to Formality." Book, March 19, 2013. http://www.ilo.org/emppolicy/pubs/WCMS_207727/lang--en/index.htm.
- Vanek, Joann, and Martha Chen. *Women and Men in the Informal Economy: A Statistical Picture*. International Labour Organization and WIEGO, 2012. <http://www.ilo.org/dyn/infoecon/docs/441/F596332090/women%20and%20men%20stat%20picture.pdf>.

EXECUTIVE SUMMARY

- “Is Informal Normal? Messages, Figures and Data.” *OECD*. Accessed May 1, 2013. <http://www.oecd.org/dev/poverty/isinformalnormalmessagesfiguresanddata.htm>.
- Mathauer, Inke, Jean-Olivier Schmidt, and Maurice Wenyaa. “Extending Social Health Insurance to the Informal Sector in Kenya. An Assessment of Factors Affecting Demand.” *The International Journal of Health Planning and Management* 23, no. 1 (March 2008): 51–68. doi:10.1002/hpm.914.
- Rani, Uma. *Impact of Changing Work Patterns on Income Inequality*. Discussion Paper. International Labour Organization, September 9, 2008. http://www.ilo.org/inst/publication/discussion-papers/WCMS_193166/lang--en/index.htm.
- Rosenstock, Linda, Mark Cullen, and Marilyn Fingerhut. “Occupational Health.” In *Disease Control Priorities in Developing Countries*, 1127–1145. 2nd ed. Washington, DC: The World Bank, 2006.
- The World Bank. (2013). World Development Indicators: Labor Force - total [Data file]. Retrieved from <http://data.worldbank.org/indicator/SL.TLF.TOTL.IN>.
- International Labor Organization and Women in Informal Employment: Globalizing and Organizing. (2012). Women and men in the informal economy - A statistical picture. [Data file]. Retrieved from http://www.ilo.org/global/statistics-and-databases/WCMS_179795/lang--en/index.htm.

PROBLEM ASSESSMENT

- “Asiye Etafuleni |.” Accessed May 4, 2013. <http://www.aet.org.za/>.
- Barrientos, Stephanie. *The ETI Code of Labor Practice: Do Workers Really Benefit? (South Africa)*. University of Sussex, United Kingdom: Institute of Development Studies, 2006. <http://www.ethicaltrade.org/sites/default/files/resources/Impact%20assessment%20c%20safrica.pdf>.
- Benach, Joan, Carles Muntaner, Vilma Santana, and F. Chairs. “Employment Conditions and Health Inequalities.” *Final Report to the WHO Commission on Social Determinants of Health (CSDH) Employment Conditions Knowledge Network (EMCONET)*. Geneva: WHO (2007). http://cdrwww.who.int/entity/social_determinants/resources/articles/emconet_who_report.pdf.
- Chen, Martha Alter, Renana Jhabvala, and Frances Lund. *Supporting Workers in the Informal Economy : a Policy Framework*. Working Paper. Working Paper on the Informal Economy. International Labor Office, 2002. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122055.pdf.
- “Domestic Workers in the Informal Economy | WIEGO.” *WIEGO*. Accessed May 3, 2013. <http://wiego.org/informal-economy/occupational-groups/domestic-workers#size>.
- Dror, David, Van Putten-Rademakers, and Ruth Koren. “Cost of Illness: Evidence from a Study in Five Resource-poor Locations in India.” *Available at SSRN 1016701* (2008). http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1016701.

PROBLEM ASSESSMENT CONT'D

- Dung, Nghiem, Social Health Insurance in Vietnam. Ministry of Health, 2010; World Health Organization. Country Cooperation Strategy – Thailand, 2012. Global Extension of Social Security, Indonesia webpage. <http://www.social-protection.org/gimi/gess/ShowWiki.do?wid=869>.
- “Ethical Trading Initiative- About ETI.” *Ethical Trading Initiative- Respect for Workers Worldwide*, 2013. <http://www.ethicaltrade.org/about-eti>.
- “Fact Sheet No. 11: Work Insecurity Work-related Ill Health - a Global Sickness.” International Labor Organization. Accessed February 13, 2013. http://www.ilo.org/public/english/protection/secsoc/downloads/stat/ses/docs/sheet_no11.pdf.
- Forgia, Gerard La, Nagpal, Somil, Government-Sponsored Health Insurance in India: Are You Covered?. The World Bank, 2012.
- Ghosh, Ruma. *Health Insecurities of Workers in Informal Employment: A Study of Existing and Possible Interventions*. V.V. Giri National Labour Institute, 2010.
- “Home-Based Workers | WIEGO.” Accessed April 22, 2013. <http://wiego.org/informal-economy/occupational-groups/home-based-workers>.
- Hussmanns, Ralf. “Defining and Measuring Informal Employment.” *Bureau of Statistics Paper, ILO, Geneva, February* (<http://www.ilo.org/public/english/bureau/stat/download/papers/meas.Pdf>) (2004). <http://ilo.org/public/english/bureau/stat/download/papers/meas.pdf>.
- “Is Informal Normal? Messages, Figures and Data.” *OECD*. Accessed May 1, 2013. <http://www.oecd.org/dev/poverty/isinformalnormalmessagesfiguresanddata.htm>.
- International Labour Organization, Social Security for Informal Workers: Looking for Flexible and Highly Targeted Programs, 2010.
- International Social Security Association, The extension of social security coverage to informal labour: Thailand’s experience, 2012.
- “Kagad Kach Patra Kachtakari Panchayat.” Accessed May 4, 2013. <http://www.wastepickerscollective.org/>.
- Loewenson, R H. “Health impact of occupational risks in the informal sector in Zimbabwe.” *International journal of occupational and environmental health* 4, no. 4 (December 1998): 264–274.
- Lund, Francie. “Work-related Social Protection for Informal Workers.” *International Social Security Review* 65, no. 4 (2012): 9–30. doi:10.1111/j.1468-246X.2012.01445.x.
- Rahman, Mahjabeen and Ahmed, Syed, Morbidity and Poverty: Measuring Economic Burden of Illness Requiring In Patient Services, 2006
- Rani, Uma. *Impact of Changing Work Patterns on Income Inequality*. Discussion Paper. International Labour Organization, September 9, 2008. http://www.ilo.org/inst/publication/discussion-papers/WCMS_193166/lang-en/index.htm.
- Ross, MH, WM Pick, and Y Dada. “The Reproductive and Occupational Health of Women Street Vendors in Johannesburg, South Africa.” *Department of Community Health and WHO Collaborating Centre for Urban Health, University of the Witwatersrand (Parktown, South Africa)* (n.d.). <http://www.ncbi.nlm.nih.gov/pubmed/11824925>.

PROBLEM ASSESSMENT CONT'D

- “RSBY: Rashtriya Swasthya Bima Yojna.” Accessed May 4, 2013. <http://www.rsby.gov.in/>.
- Smith, Peggie. “The Pitfalls of Home: Protecting the Health and Safety of Paid Domestics.” *Canadian Journal of Women & the Law* Washington University in St. Louis Legal Studies Research Paper No. 11–03–03 (March 1, 2011): 40.
- “Statistical Picture | WIEGO.” *WIEGO*. Accessed May 1, 2013. <http://wiego.org/informal-economy/statistical-picture>.
- Taswell, K. 2001. “Using household surveys to collect basic information on occupational injuries.” *Asian-Pacific Newsletter on Occupational Health and Safety*, 8:34-37.
- “Universal Coverage Scheme | Joint Learning Network for Universal Health Coverage.” Accessed May 4, 2013. <http://jointlearningnetwork.org/content/universal-coverage-scheme>.
- van Niftrik, M., Reijnierse, J., Bogaard, A. and Lumens, M. (2003) ‘Occupational health and safety in the urban informal economy in Delft, South Africa’ *African Newsletter on Occupational Health and Safety* 13:13-15
- Vanek, Joann, and Martha Chen. *Women and Men in the Informal Economy: A Statistical Picture*. International Labour Organization and WIEGO, 2012. <http://www.ilo.org/dyn/infoecon/docs/441/F596332090/women%20and%20men%20stat%20picture.pdf>.

SCALE AND SCOPE

- Asian Development Bank, *Informal Sector and Informal Employment in Bangladesh*, 2010
- Asian Development Bank, *The Informal Sector and Informal Employment in Indonesia*, 2010
- Jacques Charmes, *On Measuring Place of Work*, Working paper, January 1, 2002, http://www.ilo.org/global/statistics-and-databases/WCMS_087887/lang-en/index.htm.
- *Domestic Workers Across the World: Global and Regional Statistics and the Extent of Legal Protection* (Geneva: International Labour Office, January 2013), http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_173363.pdf.
- Kalpana Hiralal, “The ‘Invisible’ Workers of the Informal Economy—A Case Study of Home-based Workers in Kwazulu/Natal, South Africa,” *J Soc Sci* 23, no. 1 (2010): 29–37.
- “Is Informal Normal? Messages, Figures and Data.” *OECD*. Accessed May 1, 2013. <http://www.oecd.org/dev/poverty/isinformalnormalmessagesfiguresanddata.htm>.
- International Labor Organization and Women in Informal Employment: Globalizing and Organizing. (2012). *Women and men in the informal economy - A statistical picture*. [Data file]. Retrieved from http://www.ilo.org/global/statistics-and-databases/WCMS_179795/lang-en/index.htm.

SCALE AND SCOPE CONT'D

- International Labour Organization, Decent Work for Women and Men in the Informal Economy: Profile and Good Practices in Cambodia, 2006
- International Labour Organization, Research on informal employment in Vietnam: current situation and solution, 2011.
- International Labour Organization, Vision for Asia's Decent Work Decade: Sustainable Growth and Jobs to 2015, 2007.
- "Labor Markets - Workers in the Informal Economy." *The World Bank*. Accessed May 1, 2013.
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTLM/0,,contentMDK:20224904~menuPK:584866~pagePK:148956~piPK:216618~theSitePK:390615,00.html>.
- Mohapatra, Kamala, Women Workers in Informal Sector in India: Understanding the Occupational Vulnerability. *International Journal of Humanities and Social Science*, 2012.
- "MPI Data Hub Graph." *Migration Policy Institute Data Hub*. Accessed May 1, 2013.
http://www.migrationinformation.org/DataHub/charts/worldstats_1.cfm.
- Naik, Ajaya, Informal Sector and Informal Workers in India, 2009.
- National Commission for Enterprises in the Unorganised Sector, Contribution of the Unorganised sector to GDP Report of the Sub Committee of a NCEUS Task Force, 2008.
- Ratna M. Sudarshan and Renana Jhabvala, "Social Protection for Home-Based Women Workers in South Asia: Learning from Action and Research" (2009), <http://dspace.cigilibrary.org/jspui/handle/123456789/21078>.
- Ratna M. Sudarshan and Shalini Sinha, "Making Home-Based Work Visible: A Review of Evidence from South Asia" (2011), http://wiego.org/sites/wiego.org/files/publications/files/Sudarshan_WIEGO_WP19.pdf.
- Rockefeller Foundation, Informal City Dialogues: Bangkok's webpage, <http://nextcity.org/informalcity/city/bangkok>.
- Shalini Sinha, *Rights of Home-based Workers* (New Delhi, India: National Human Rights Commission, 2006), <http://www.bhrc.bih.nic.in/Docs/Home-based-Workers.pdf>.
- Thai Health, 12 Health Indicators of Thailand's Workforce: Informal Sector, 2010.
- UN Women and Baidari ILO, "Report on Experience Sharing and Advocacy Workshop: Integrated Support Programme to Home Based Workers," Book, April 15, 2011, http://www.ilo.org/islamabad/whatwedo/publications/WCMS_155223/lang--en/index.htm.
- The World Bank. (2013). World Development Indicators: Labor Force - total [Data file]. Retrieved from <http://data.worldbank.org/indicator/SL.TLF.TOTL.IN>.

DYNAMISM

- Acharya, Arnab, Sukumar Vellakkal, Fiona Taylor, Edoardo Masset, Ambika Satija, Margaret Burke, and Shah Ebrahim. *The Impact of Health Insurance Schemes for the Informal Sector in Low- and Middle-Income Countries: A Systemic Review*. Development Economics Vice Presidency Partnerships Capacity Building Unit. The World Bank, January 2013. <http://saludtrabajoyequidad.cl/wp-content/uploads/2013/03/World-Bank-2013.-The-impact-of-health-insurance-schemes-for-the-informal-sector-in-low-and-middle-income-countries.pdf>.
- CGAP Working Group on Microinsurance, and Denis Garand. *Good and Bad Practices in Microinsurance*. VimoSEWA (India), 2005. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122472.pdf.
- Chen, Martha Alter, Renana Jhabvala, and Frances Lund. *Supporting Workers in the Informal Economy : a Policy Framework*. Working Paper. Working Paper on the Informal Economy. International Labor Office, 2002. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122055.pdf.
- *Combating Poverty and Inequality*. UNRISD Flagship Report. Geneva: UNRISD, March 9, 2010. [http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/DBE2AA3391D52DEDC125778900317806/\\$file/PovRepCh1.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/DBE2AA3391D52DEDC125778900317806/$file/PovRepCh1.pdf).
- Dimovska, Donika. *Innovative pro-poor healthcare financing and delivery models landscaping from the Rockefeller foundation-sponsored initiative on the role of the private sector in health systems in developing countries*. Washington, DC: Results for Development Institute, 2009. <http://www.rockefellerfoundation.org/uploads/files/58b820ed-8263-49c4-a89e-7c25beac17eb-innovative.pdf>.
- Forastieri, Valentina. "Improvement of Working Conditions and Environment in the Informal Sector Through Safety and Health Measures." *Occupational Safety and Health Branch Working Paper, OH/9907/08 (Geneva, ILO (1999))*. <http://www.ifwea.org/@Bin/148785/1999ImproveConditionsThroughHS.pdf>.
- Frye, Isobel. *Extending Social Security to Developing Countries: Particular Emphasis on Healthcare and Informal Economy Workers*. Literature Review. Discussion Paper. Global Union Research Network, October 2005. <http://www.gurn.info/en/discussion-papers/healthcare05.pdf>.
- Van Ginneken, ed. "Social Security for the Informal Sector: Investigating the Feasibility of Pilot Projects in Benin, India, El Salvador and Tanzania." International Labor Office, 1997. <http://www.ilo.org/public/french//protection/socsec/pol/publ/discus5.htm>.
- Van Ginneken, Wouter. "Social Security for the Informal Sector: A New Challenge for the Developing Countries." *International Social Security Review* 52, no. 1 (1999): 49–69. doi:10.1111/1468-246X.00033.
- Ivanov, Ivan D. "Scaling Up Access to Essential Interventions And Basic Services For Occupational Health Through Integrated Primary Health Care." In *Background Document*. The Hague, Netherlands: World Health Organization, 2011.

DYNAMISM CONT'D

- Jakab, Melitta, and Chitra Krishnan. *Community Involvement in Health Care Financing: Impact, Strengths and Weaknesses, A Synthesis of the Literature*. World Bank, April 15, 2013. <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20190566~FirstTime:True~menuPK:431645~pagePK:148956~piPK:216618~theSitePK:376793,00.html>.
- Kawakami, Tsuyoshi. "Networking Grassroots Efforts to Improve Safety and Health in Informal Economy Workplaces in Asia." *Industrial Health* 44, no. 1 (2006): 42–47.
- Kawakami, Tsuyoshi (ed). "Good Practices in Safety, Health and Working Conditions: Home Workers, Farmers and Construction Workers in Cambodia, Mongolia, and Thailand." Publication, January 1, 2006. http://www.ilo.org/asia/whatwedo/publications/WCMS_BK_PB_311_EN/lang--en/index.htm.
- Lund, Francie. "Social Protection and the Informal Economy: Linkages and Good Practices for Poverty Reduction and Empowerment *." In *Promoting Pro-Poor Growth: Social Protection*, 69–88. OECD, 2009. <http://wiego.org/sites/wiego.org/files/publications/files/Lund-Soc-Protection-Linkages.pdf>.
- ———. "Work-related Social Protection for Informal Workers." *International Social Security Review* 65, no. 4 (2012): 9–30. doi:10.1111/j.1468-246X.2012.01445.x.
- Pereira, Javier. *Decent Work and the Millennium Development Goals: A Promising Partnership*. SOLIDAR, September 2010. http://www.solidar.org/IMG/pdf/gn2010report_dw_mdg.pdf.
- *Promoting Pro-Poor Growth: Social Protection*. Organisation for Economic Cooperation and Development, n.d.
- Ranson, Kent, Tara Sina, Mirai Chatterjee, Akash Acharya, Ami Bhavsar, Saul S. Morris, and Anne J. Mills. "Making Health Insurance Work for the Poor: Learning from the Self-Employed Women's Association's (SEWA) Community-based Health Insurance Scheme in India." *Elsevier. Social Science & Medicine* (2005): 14.
- Rinehart, Richard D. *Designing Programmes to Improve Working and Employment Conditions in the Informal Economy: A Literature Review*. International Labour Organization, 2004. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_travail_pub_10.pdf.
- De la Rosa, Jennifer, and Xenia Scheil-Adlung. *Enabling Transition to Formalization Through Providing Access to Health Care: The Examples of Thailand and Ghana*. ILO, 2007. http://www.ilo.int/wcmsp5/groups/public/---ed_emp/---emp_policy/documents/meetingdocument/wcms_125994.pdf.
- "The Informal Economy and Decent Work: A Policy Resource Guide Supporting Transitions to Formality." Book, March 19, 2013. http://www.ilo.org/emppolicy/pubs/WCMS_207727/lang--en/index.htm.
- Unni, Jeemol, and Uma Rani. *Social Protection for Informal Workers: Insecurities, Instruments and Institutional Mechanisms*. Working Paper. eSocialSciences, 2009. <http://ideas.repec.org/p/ess/wpaper/id1920.html>.

Works Cited in Main Deck (8/15)

DYNAMISM CONT'D

- <http://wiego.org/>
- http://www.sewa.org/About_Us.asp
- <http://www.streetnet.org.za/>
- <http://www.homenetsouthasia.net/>; <http://www.homenetseasia.org/>
- <http://www.ilo.org/public/english/bureau/program/dwcp/>
- <http://www.worldbank.org/>
- <http://www.sida.se/English/>
- <https://www.gov.uk/government/organisations/department-for-international-development>
- <http://www.who.int/en/>
- <http://www.oecd.org/>
- <http://www.gatesfoundation.org/>
- <http://www.mhealthalliance.org/>
- <http://www.un.org/millenniumgoals/>

Works Cited in Main Deck (9/15)

LANDSCAPE

- “2005 World Summit Outcome: Resolution Adopted by the General Assembly.” In *2005 World Summit Outcome*, Sixtieth Session:38. Agenda Items 46 and 120. New York, 2005. <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement>.
- *2007 Annual Report*. Annual Report. Cambridge, MA: WIEGO, 2007. http://wiego.org/sites/wiego.org/files/reports/files/WIEGO_Annual_Report_2011-2012.pdf.
- “A Handbook on HIV/AIDS for Labour and Factory Inspectors.” International Labour Organization, February 2005. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_110151.pdf.
- Acharya, Arnab, and Sukumar Vellakkal. *Impact of National Health Insurance for the Poor and the Informal Sector in Low- and Middle-income Countries*, n.d.
- Acharya, Arnab, Sukumar Vellakkal, Fiona Taylor, Edoardo Masset, Ambika Satija, Margaret Burke, and Shah Ebrahim. *Impact of National Health Insurance for the Poor and the Informal Sector in Low- and Middle-income Countries*. Systematic Review. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, n.d. <http://www.dfid.gov.uk/r4d/PDF/Outputs/SystematicReviews/Health-insurance-2012Acharya-report.pdf>.
- “Action for Health Initiatives, Inc. (ACHIEVE).” *Action for Health Initiatives, Inc. (ACHIEVE)*, 2013. <http://www.achieve.org.ph/>.
- Aggarwal, Surinder. *Tackling Social and Economic Determinants of Health Through Women Empowerment The SEWA Case Study*. Draft. New Delhi: WHO-SEARO. Accessed May 9, 2013. http://www.who.int/social_determinants/resources/isa_sewa_ind.pdf.
- *Annual Report April 2010 – March 2011*. Annual Report. Cambridge, MA: WIEGO, 2011. http://wiego.org/sites/wiego.org/files/reports/files/WIEGO_Annual_Report_2011-2012.pdf.
- *Annual Report April 2009 – March 2010*. Annual Report. Cambridge, MA: WIEGO, 2010. http://wiego.org/sites/wiego.org/files/reports/files/WIEGO_Annual_Report_2011-2012.pdf.
- *Annual Report January 08 – March 09*. Annual Report. Cambridge, MA: WIEGO, 2009. http://wiego.org/sites/wiego.org/files/reports/files/WIEGO_Annual_Report_2011-2012.pdf.
- Bacchetta, Marc, Ekkehard Ernst, and Juana P. Bustamante. *Globalization and Informal Jobs in Developing Countries*. Switzerland: Joint WTO and ILO publication, 2009.
- Behrman, Jere, David Robalino, and Rita Almeida. *The Right Skills for the Job? Rethinking Training Policies for Workers*. The World Bank, January 1, 2012. <http://documents.worldbank.org/curated/en/2012/01/16489532/right-skills-job-rethinking-training-policies-workers>.
- “Bicao Investment Care Administration Organization (BICAO) | Center for Health Market Innovations (CHMI).” *Center for Health Market Innovations (CHMI)*, September 27, 2011. <http://healthmarketinnovations.org/program/bicao-investment-care-administration-organization-bicao>.

Works Cited in Main Deck (10/15)

LANDSCAPE CONT'D

- *Building and strengthening health and wellness activities for the Sustainable Tree Crops Program (STCP) in Ghana and Côte d'Ivoire*. Final Report. Ghana: Family Health International, January 30, 2009. http://www.candyusa.com/files/FHI_Final_Report_Sept_2008.pdf.
- *Building Better Lives Together: 2011 Annual Report*. Annual Report. Seattle, WA: Bill and Melinda Gates Foundation. Accessed May 9, 2013. <http://www.gatesfoundation.org/~media/gfo/documents/annual%20reports/2011gates%20foundation%20annual%20report.pdf>.
- "Canadian International Development Agency." *Project Browser*. Accessed May 9, 2013. <http://www.acdi-cida.gc.ca/home>.
- CGAP Working Group on Microinsurance, and Denis Garand. *Good and Bad Practices in Microinsurance*. VimoSEWA (India), 2005. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122472.pdf.
- Cho, Yoonyoung. *Informality and Protection from Health Shocks: Lessons from Yemen*. World Bank, December 2010. http://www.iza.org/conference_files/worldb2011/cho_y2150.pdf.
- Clark, Phoebe. *Assessment of Social Accountability Standards: Light Manufacturing Small and Medium-sized Enterprises*, November 2007. http://pdf.usaid.gov/pdf_docs/PNADP612.pdf.
- *Decent Work and the Informal Economy: Sixth Item on the Agenda*. 90th Session International Labour Conference. Geneva: International Labour Office, 2002. http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/---reloff/documents/meetingdocument/wcms_078849.pdf.
- Deshingkar, Priya. *Extending Labour Inspections to the Informal Sector and Agriculture*. Working Paper. Chronic Poverty Research Centre. London: Overseas Development Institute, November 2009. http://www.dfid.gov.uk/r4d/PDF/Outputs/ChronicPoverty_RC/WP154-Deshingkar.pdf.
- "DFID Projects Database." Bilateral Agency. *DFID*. Accessed May 9, 2013. <http://projects.dfid.gov.uk/>.
- "Dutch Foreign Ministry." *Documents and Grants*. Accessed March 13, 2013. <http://www.government.nl/issues/development-cooperation/documents-and-publications/parliamentary-documents/2012/01/12/new-focus-of-dutch-development-policy.html>.
- "Educating Cocoa Farmers Through Mobile Phones." *NCA Journal* 1, no. Fall 2011 (2011). <http://www.candyusa.com/files/NCAJSustainabilityHershey.pdf>.
- "Fact Sheet No. 11: Work Insecurity Work-related Ill Health - a Global Sickness." International Labor Organization. Accessed February 13, 2013. http://www.ilo.org/public/english/protection/secsoc/downloads/stat/ses/docs/sheet_no11.pdf.
- *Fact Sheet on Youth Reproductive Health Policy - Sustainable Livelihood Programs and HIV/AIDS*. Fact Sheet. Washington, DC: Health Policy Initiative, Task Order 1, Futures Group, November 2009. http://pdf.usaid.gov/pdf_docs/PNADR399.pdf.
- Frye, Isobel. *Extending Social Security to Developing Countries: Particular Emphasis on Healthcare and Informal Economy Workers*. Literature Review. Discussion Paper. Global Union Research Network, October 2005. <http://www.gurn.info/en/discussion-papers/healthcare05.pdf>.

Works Cited in Main Deck (11/15)

LANDSCAPE CONT'D

- “Fundacion FACES | Center for Health Market Innovations (CHMI).” *Center for Health Market Innovations (CHMI)*, September 27, 2011. <http://healthmarketinnovations.org/program/fundacion-faces>.
- Van Ginneken, Wouter. “Social Security for the Informal Sector: A New Challenge for the Developing Countries.” *International Social Security Review* 52, no. 1 (1999): 49–69. doi:10.1111/1468-246X.00033.
- “GIZ.” AID Agency website. *Deutsche Gesellschaft Für Internationale Zusammenarbeit (GIZ)*. Accessed May 9, 2013. <http://www.giz.de/en/aboutgiz/profile.html>.
- “Globalising Decent Work.” Accessed May 9, 2013. <http://www.solidar.org/Globalising-Decent-Work.html>.
- Heintz, James. *Employment, Poverty, and Inclusive Development in Africa: Policy Choices in the Context of Widespread Informality*. Revised Draft. Political Economy Research Institute University of Massachusetts, Amherst, March 2009. http://www.peri.umass.edu/fileadmin/pdf/conference_papers/khan/Heintz_chapter_PEA_volume_Mar_5.doc.
- “Helping smallholder farmers | Sustainable living | Unilever Global.” *Unilever*, 2013. <http://www.unilever.com/sustainable-living/betterlivelihoods/farmers/>.
- “Hershey’s CocoaLink Mobile Phone Program Delivers 100,000 Farmer and Family Messages During First Year in Ghana | Reuters.” *Reuters*, August 6, 2012. <http://www.reuters.com/article/2012/08/06/idUS137424+06-Aug-2012+BW20120806>.
- *HIV/AIDS Mainstreaming Guideline into Rural Capacity Building Project*. Ethiopia: Ethiopian Ministry of Health, February 2009. <http://www.moa.gov.et/sites/default/files/HIV%20AIDS%20mainstreaming%20guideline.doc>.
- “ILO and Today’s Global Challenges (Part 2: 1999–) 1999.” UN Agency Website. *International Labour Organization*. Accessed May 9, 2013. <http://www.ilo.org/public/english/support/lib/century/index6.htm>.
- “Improving Access of Migrant and Mobile Populations to HIV Services in the Caribbean.” *Pan Caribbean Partnership Against HIV and AIDS*, 2012. <http://www.pancap.org/en/migrant-population.html>.
- “Institute for the Study of Labour.” Research Institute. Accessed May 9, 2013. http://www.iza.org/en/webcontent/index_html.
- International Labor Organization. *Statistical Update on Employment in the Informal Economy*. Department of Statistics. Geneva: International Labor Organization, June 2011. http://www.ilo.org/wcmsp5/groups/public/---dgreports/---stat/documents/presentation/wcms_157467.pdf.
- *Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Study*. Case Study. Reducing Intimate Partner Violence. Global Violence Prevention, 2011. http://www.aidstar-one.com/promising_practices_database/g3ps/intervention_microfinance_aids_and_gender_equity_image_study.

Works Cited in Main Deck (12/15)

LANDSCAPE CONT'D

- Jain, Saranga, Margaret Greene, Zayid Douglas, Myra Betron, and Katherine Fritz. *Earning Their Way to Healthier Lives—Mulheres Primero (Women First): Health and Legal Training Combined with Income Opportunities Helps Rural Mozambican Women Mitigate HIV Risk*. Case Study Series. Arlington, VA: AIDSTAR-One, October 2011. http://www.aidstar-one.com/focus_areas/gender/resources/case_study_series/mozambique_women_first.
- Kawakami, T. "Networking Grassroots Efforts to Improve Safety and Health in Informal Economy Workplaces in Asia." *Industrial Health* 44, no. 1 (January 2006): 42–7.
- Kogi, K. "Advances in Participatory Occupational Health Aimed at Good Practices in Small Enterprises and the Informal Sector." *Industrial Health* 44, no. 1 (January 2006): 31–4.
- *Labor Market Programs*. Africa Social Protection Policy Briefs. World Bank, December 2012. <http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-policy-brief-labor-EN-2012.pdf>.
- Lund, Francie. "Social Protection and the Informal Economy: Linkages and Good Practices for Poverty Reduction and Empowerment *." In *Promoting Pro-Poor Growth: Social Protection*, 69–88. OECD, 2009. <http://wiego.org/sites/wiego.org/files/publications/files/Lund-Soc-Protection-Linkages.pdf>.
- Lund, Francie, and Anna Marriot. *Occupational Health and Safety of the Poorest*. Research Report. School of Development Studies Research Report. Durban: University of KwaZulu-Natal, April 2011. www.sds.ukzn.ac.za/files/RR%2088%20Lund.pdf.
- *Mahatma Gandhi National Rural Employment Guarantee Act*. Accessed February 13, 2013. <http://nrega.nic.in/netnrega/home.aspx>.
- *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*. World Bank, September 9, 2011. http://www.who.int/providingforhealth/countries/WB_TanzaniaHealthFinancingPolicyNoteFinal.pdf.
- *MANAGING RISK, PROMOTING GROWTH Developing Systems for Social Protection in Africa*. The World Bank. Accessed April 24, 2013. <http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-strategy-summary-2012.pdf>.
- *Managing Risk, Promoting Growth: Developing Systems for Social Protection in Africa*. The World Bank, June 2012. <http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-full-report-EN-2012.pdf>.
- "Market Vendors AIDS Project (MAVAP) | Center for Health Market Innovations (CHMI)." *Center for Health Market Innovations (CHMI)*, July 11, 2012. <http://healthmarketinnovations.org/program/market-vendors-aids-project-mavap>.
- *Mars Partnership for African Cocoa-Communities of Tomorrow (iMFACT)*. Ghana: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), 2011. <http://hespa.net/sites/hespa.net/files/mars-gtz-impact-en.pdf>.
- "MicroInsurance Innovation Facility." *International Labour Organization*. Accessed May 9, 2013. <http://www.ilo.org/public/english/employment/mifacility/>.

LANDSCAPE CONT'D

- *Microinsurance Innovation Facility: Protecting the Working Poor*. Annual Report 2012. Geneva: Microinsurance Innovation Facility, Social Finance Programme – Employment Sector, International Labour Office, 2013.
http://www.ilo.org/public/english/employment/mifacility/download/annual/annualreport2012_en.pdf.
- *MILES to Go: A Quest for An Operational Labor Market Paradigm for Developing Countries*. Draft. Social Protection & Labor Sector, The World Bank, January 21, 2008. http://siteresources.worldbank.org/INTLM/Resources/390041-1212776476091/5078455-1267646113835/MILESThequestoperationalLMparadigm_Jan212008.pdf.
- “Ministry of Foreign Affairs, Norway.” *Ministry of Foreign Affairs*. Accessed March 13, 2013. http://www.regjeringen.no/en/dep/ud/selected-topics/development_cooperation.html?id=1159.
- “Multi Donor Trust Fund: Labour Markets, Job-Creation and Economic Growth.” *World Bank*. Accessed May 9, 2013.
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTLM/0,,contentMDK:22512466~menuPK:7010971~pagePK:148956~piPK:216618~theSitePK:390615,00.html>.
- “Multi Donor Trust Fund: MILES Framework.” *World Bank*. Accessed May 9, 2013.
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTLM/0,,contentMDK:22512466~menuPK:7010971~pagePK:148956~piPK:216618~theSitePK:390615,00.html>.
- “Munich Re Foundation.” *Microinsurance*. Accessed May 9, 2013. <http://www.munichre-foundation.org/home.html>.
- Munshi, Kaivan. “Networks in the Modern Economy: Mexican Migrants in the U. S. Labor Market.” *The Quarterly Journal of Economics* 118, no. 2 (May 1, 2003): 549–599. doi:10.1162/00335530321675455.
- “Network of WHO Collaborating Centres in Occupational Health.” WHO collaborating centres database. *World Health Organization*. Accessed May 9, 2013.
http://www.who.int/occupational_health/network/en/.
- “NRSP Microfinance Bank Limited.” *NRSP Bank*. Accessed May 9, 2013. <http://www.nrspbank.com/>.
- “OECD.StatExtracts: Creditor Reporting System.” Database query system. Accessed May 9, 2013. <http://stats.oecd.org/Index.aspx?datasetcode=CRS1>.
- Okello, Francis O., and Juliet Ighure. *HIV/AIDS and the Workplace: A Qualitative Assessment of the Ghana Port and Harbor Communities for an HIV/AIDS Workplace Program*. Ghana: Commercial Market Strategies, Abt Associates, February 2004.
http://www.abtassociates.com/reports/ES_Ghana_PH_Research_Report.pdf.
- Park, H., E. Ha, J. Kim, H. Jung, and D. Paek. “Occupational Health Services for Small-scale Enterprises in Korea.” *Ind Health* 40, no. 1 (2002): 1–6.
- “Pathfinder International: Bangladesh NGO Service Delivery Program.” *Pathfinder International*, 2012. <http://www.pathfind.org/our-work/projects/ngo-service-delivery-program-bangladesh.html>.

Works Cited in Main Deck (14/15)

LANDSCAPE CONT'D

- Pereira, Javier. *Decent Work and the Millennium Development Goals: A Promising Partnership*. SOLIDAR, September 2010. http://www.solidar.org/IMG/pdf/gn2010report_dw_mdg.pdf.
- “PhilHealth KaSAPI (Kalusugang Sigurado at Abot-Kaya sa PhilHealth Insurance) | Center for Health Market Innovations (CHMI).” *Center for Health Market Innovations (CHMI)*, May 30, 2012. <http://healthmarketinnovations.org/program/philhealth-kasapi-kalusugang-sigurado-at-abot-kaya-sa-philhealth-insurance>.
- Pierre, Jennifer, and Soniaa David. *A Case Study of CSR Fueling Health Service Provision in Ghana*. Ghana: International Institute of Tropical Agriculture-Sustainable Tree Crops Program, 2010. <http://www.ilcafrica.com/directory/documents/Health%20Increased%20access%20to%20health.pdf>.
- Preker, Alexander S., Guy Carrin, David Dror, Jakab Melitta, William Hsiao, and Dyna Arhin-Tenkorand. *Effectiveness of Community Health Financing in Meeting the Cost of Illness*. Health, Nutrition and Population (HNP) Discussion Paper. Washington D.C.: World Bank, February 2002.
- “Realising Social Protection and Decent Work for All.” *Global Network*. Accessed May 9, 2013. http://www.theglobalnetwork.net/uploads/files/en/GN-Materials/GN_DFID%20Project%20leaflet_Oct2010.pdf.
- “Rockefeller Foundation.” Foundation Website with searchable database of grants. *Recent Grants*. Accessed May 9, 2013. <http://www.rockefellerfoundation.org/>.
- “Rural Capacity Building Project.” *World Bank*, 2013. <http://www.worldbank.org/projects/P079275?lang=en>.
- “Safety Nets: Public Works.” Policy Brief. *Africa Social Protection Policy Briefs*. Accessed May 9, 2013. <http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-policy-brief-safety-nets-public-EN-2012.pdf>.
- Sankaran, Kamala, and Roopa Madhav. *Informal Economy: Law and Policy Demands Lessons from the WIEGO India Pilot Study*. USAID, February 2012. http://www.solidaritycenter.org/files/infekon_wiego_law_and_informal_economy.pdf.
- Santana, V. S., and Ribeiro, F. S. N. “Occupational Cancer Burden in Developing Countries and the Problem of Informal Workers.” *Environmental Health: A Global Access Science Source* 10, no. 1 (2011).
- *SEWA Joins Forces with the ILO to Help Informal Sector Workers Move Out of Poverty*. Stories of Empowerment. Geneva, Switzerland: ILO-SEWA-OECD. Accessed May 9, 2013. <http://www.oecd.org/dac/povertyreduction/48869455.pdf>.
- “Smallholder Farmers Rural Radio.” *SmallHolders Foundation*, 2012. <http://smallholdersfoundation.org/sfrf.php>.
- “Social Protection Floors for Social Justice and a Fair Globalization.” Vol. ILC.101/IV/1. Geneva: International Labour Office, 2012.
- “The Informal Economy and Decent Work: A Policy Resource Guide Supporting Transitions to Formality.” Book, March 19, 2013. http://www.ilo.org/emppolicy/pubs/WCMS_207727/lang--en/index.htm.

LANDSCAPE CONT'D

- *The World Bank's Africa Social Protection Strategy 2012-2022*. Overview. Human Development Africa, The World Bank, 2012.
<http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-strategy-summary-2012.pdf>.
- Thomas, Duncan, and Elizabeth Frankenberg. "Health, Nutrition and Prosperity: a Microeconomic Perspective." *Bulletin of the World Health Organization* 80, no. 2 (2002): 106–113.
- Thornton, Rebecca, L., Laurel E. Hatt, Erica M. Field, Mursaleena Islam, Freddy Solis Diaz, and Martha Azucena Gonzalez. "Social Security Health Insurance for the Informal Sector in Nicaragua: A Randomized Evaluation." *Health Economics* 19 (June 2010): 181–206.
- "UN Women." UN Website. *United Nations Entity for Gender Equality and the Empowerment of Women*. Accessed May 9, 2013.
<http://www.unwomen.org/>.
- Utting, Peter. "Regulating Business Via Multistakeholder Initiatives: A Preliminary Assessment." In *Voluntary Approaches to Corporate Responsibility: Readings and a Resource Guide*. Geneva, Switzerland: UN Non-Governmental Liaison Service (NGLS) and UNRISD, 2002.
[http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/35F2BD0379CB6647C1256CE6002B70AA/\\$file/uttngls.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/35F2BD0379CB6647C1256CE6002B70AA/$file/uttngls.pdf).
- *WIEGO Annual Report 2011-2012*. Annual Report. Cambridge, MA: WIEGO, 2012.
http://wiego.org/sites/wiego.org/files/reports/files/WIEGO_Annual_Report_2011-2012.pdf.
- *Workers' Health: Global Plan of Action*. Agenda Item 12.13. Sixtieth World Health Assembly: WHO, May 23, 2007.
http://www.who.int/occupational_health/WHO_health_assembly_en_web.pdf.
- <http://www.ilo.org/public/english/employment/mifacility/>
- http://www.engineersagainstopoverty.org/viewitem.cfm?cit_id=382658
- <http://nrsp.org.pk/>

UNIVERSAL HEALTH COVERAGE

- Dimovska, Donika. *Innovative pro-poor healthcare financing and delivery models landscaping from the Rockefeller foundation-sponsored initiative on the role of the private sector in health systems in developing countries*. Washington, DC: Results for Development Institute, 2009. <http://www.rockefellerfoundation.org/uploads/files/58b820ed-8263-49c4-a89e-7c25beac17eb-innovative.pdf>.
- Giedion, Ursula, Eduardo Andrés Alfonso, and Yadira Díaz. *The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence*. UNICO Studies Series No. 25. Universal Health Coverage Studies Series (UNICO). Washington DC: World Bank, January 2013. <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Images/IMPACTofUHCSchemesinDevelopingCountries-AReviewofExistingEvidence.pdf>.
- Hatt, Laurel, Rebecca Thornton, Barbara Magnoni, and Mursaleena Islam. *Extending Social Insurance to Informal Sector Workers in Nicaragua via Microfinance Institutions: Results from a Randomized Evaluation*. Country Report Series. Bethesda, MD: Private Sector Partnerships-One Project, Abt Associates, October 2009. http://pdf.usaid.gov/pdf_docs/PDACP309.pdf.
- Hennig, Jennifer. *Using Private Companies to Extend Health Insurance to the Informal Sector*. Discussion Paper. Discussion Papers on Social Protection. Eschborn, Germany: GTZ Discussion Papers on Social Protection, December 2010. <http://www.giz.de/Themen/de/dokumente/2010gtz-en-private-companies-to-expand-insurance.pdf>.
- Jakab, Melitta, and Chitra Krishnan. *Community Involvement in Health Care Financing: Impact, Strengths and Weaknesses, A Synthesis of the Literature*. World Bank, April 15, 2013. <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20190566~FirstTime:True~menuPK:431645~pagePK:148956~piPK:216618~theSitePK:376793,00.html>.
- Khan, Jahangir A. M. *Impact of Education on Informal Workers Willingness-to-Pay and Knowledge of Health Insurance*. Research Paper. Geneva: ILO, March 2012. <http://www.ilo.org/public/english/employment/mifacility/download/repaper16.pdf>.
- Lagomarsino, Gina, Alice Garabrant, Atikah Adyas, Richard Muga, and Nathaniel Otoo. "Moving Towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia." *Lancet* 380 (2012): 933–43.
- Leatherman, Sheila, Lisa Jones Christensen, and Jeanna Holtz. *Innovations and Barriers in Health Microinsurance*. Microinsurance Paper. Geneva: International Labour Organization, Spe. http://www.ilo.org/public/english/employment/mifacility/download/mpaper6_health_en.pdf.
- Thornton, Rebecca, L., Laurel E. Hatt, Erica M. Field, Mursaleena Islam, Freddy Solis Diaz, and Martha Azucena Gonzalez. "Social Security Health Insurance for the Informal Sector in Nicaragua: A Randomized Evaluation." *Health Economics* 19 (June 2010): 181–206.
- Townsend, R. "Risk and Insurance in Village India." *Econometrica* 62, no. 3 (May 1994): 539–91.

PROFILES: AGRICULTURE WORKERS

- Barrientos, Armando, and Stephanie Ware Barrientos. *Extending Social Protection to Informal Workers in the Horticulture Global Value Chain*. Discussion Paper. Social Protection Discussion Paper Series. World Bank, June 2002. <http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-papers/Labor-Market-DP/0216.pdf>.
- Barrientos, S., J. Anarfi, N. Lamhauge, A. Castaldo, and N. Akua Anyidoho. *Social Protection for Migrant Labour in the Ghanaian Pineapple Sector*. Brighton: Development Research Centre on Migration, Globalisation and Poverty, University of Sussex., 2009. <http://www.dfid.gov.uk/r4d/PDF/Outputs/MigrationGlobPov/WP-T30.pdf>.
- Barrientos, S., and S. Smith. *The ETI Code of Labour Practice: Do Workers Really Benefit? Part 1: Main Findings and Recommendations from an Independent Assessment for the Ethical Trading Initiative..* Brighton: Institute of Development Studies, University of Sussex., 2006. www.ethicaltrade.org/sites/default/files/resources/Impact%20assessment%20Part%201,%20main%20findings_0.pdf.
- Barrientos, Stephanie. *The ETI Code of Labor Practice: Do Workers Really Benefit? (South Africa)*. University of Sussex, United Kingdom: Institute of Development Studies, 2006. <http://www.ethicaltrade.org/sites/default/files/resources/Impact%20assessment%20c%20safrica.pdf>.
- Barrientos, Stephanie, A. Kritzinger, G. Muller, P. Rossouw, N. Termine, N. Tregurtha, and N. Vink. *The Global Value Chain and Changing Employment Relations in South African Fruit: Summary of Findings.*, 2003. <http://www.inti.gov.ar/cadenasdevalor/Draft4summaryofreport.pdf>.
- Chan, Man - Kwun. *Review of Value Chain Analyses in the Commodities and Horticulture Sectors Roles, Constraints and Opportunities for Informal Workers*. WIEGO: Women In Informal Employment: Globalizing and Organizing (WIEGO), July 2011. http://wiego.org/sites/wiego.org/files/resources/files/Chan_Value_Chain_Analyses_Report.pdf.
- "Database On Informal Employment." *New Enhanced Database on Informal Employment Produced by the ILO in Partnership with WIEGO*, April 30, 2012. http://www.ilo.org/global/statistics-and-databases/WCMS_179795/lang--en/index.htm.
- "Decent Work in Agriculture." In *Background Paper*. Geneva, Switzerland: International Labor Organization, 2003. http://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/publication/wcms_161567.pdf.
- "Ethical Trading Initiative- About ETI." *Ethical Trading Initiative- Respect for Workers Worldwide*, 2013. <http://www.ethicaltrade.org/about-eti>.
- "Helping smallholder farmers | Sustainable living | Unilever Global." *Unilever*, 2013. <http://www.unilever.com/sustainable-living/betterlivelihoods/farmers/>.
- *Mars Partnership for African Cocoa-Communities of Tomorrow (iIMPACT)*. Ghana: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), 2011. <http://hespa.net/sites/hespa.net/files/mars-gtz-impact-en.pdf>.
- "Occupational Groups- Smallholder Farmers." *Women in Informal Employment: Globalizing and Organizing (WIEGO)*, n.d. <http://wiego.org/informal-economy/occupational-groups/smallholder-farmers>.

PROFILES: AGRICULTURE WORKERS CONT'D

- *Trading Away Our Rights: Women Working in Global Supply Chains*. Oxford: Oxfam International. Oxford: Oxfam International: Oxfam, 2004. www.oxfam.org.uk/resources/papers/downloads/trading_rights.pdf.

PROFILES: CONSTRUCTION WORKERS

- "ACIW - Association of Construction and Informal Workers." Accessed April 12, 2013. http://www.aciw.org.ph/services_damayan.html.
- Benach, Joan, Carles Muntaner, Vilma Santana, and F. Chairs. "Employment Conditions and Health Inequalities." *Final Report to the WHO Commission on Social Determinants of Health (CSDH) Employment Conditions Knowledge Network (EMCONET)*. Geneva: WHO (2007). http://cdrwww.who.int/entity/social_determinants/resources/articles/emconet_who_report.pdf.
- "Construction Workers in the Informal Economy | WIEGO." Accessed April 12, 2013. <http://wiego.org/informal-economy/occupational-groups/construction-workers>.
- International Labor Organization. *Note on the Proceedings of the Tripartite Meeting on The Construction Industry in the Twenty-First Century: Its Image, Employment Prospects and Skill Requirements*, 2001. <http://wiego.org/publications/note-proceedings-tripartite-meeting-construction-industry-twenty-first-century-its-imag>.
- Jason, Arthur. *Informal Construction Workers in Dar Es Salaam, Tanzania*. Working paper, February 1, 2007. http://www.ilo.org/sector/Resources/publications/WCMS_160790/lang--en/index.htm.
- Jha, Kishore K. "Informal Labour in the Construction Industry in Nepal." *ILO Sectoral Activities Programme Working Paper* 187 (September 2002).
- Jhabvala, Renana, and Ravi Kanbur. "12 Globalization and Economic Reform as Seen from the Ground: SEWA's Experience in India." *India's Emerging Economy: Performance and Prospects in the 1990s and Beyond* (2004): 293.
- Kawakami, Tsuyoshi (ed). "Good Practices in Safety, Health and Working Conditions: Home Workers, Farmers and Construction Workers in Cambodia, Mongolia, and Thailand." Publication, January 1, 2006. http://www.ilo.org/asia/whatwedo/publications/WCMS_BK_PB_311_EN/lang--en/index.htm.
- Mitullah, Winnie V., and Isabella Njeri Wachira. "Informal Labour in the Construction Industry in Kenya: A Case Study of Nairobi." *ILO Sectoral Activities Programme Working Paper* 204 (2003).
- Pais, Jesim. "Casualisation of Urban Labour Force." *Economic and Political Weekly* (February 16, 2002). <http://www.epw.in/special-articles/casualisation-urban-labour-force.html>.
- *Research on Skill Formation, Enhancement and Refinement of Informal Sector Workers*. CHF International. Accessed April 9, 2013. <http://www.graam.org.in/sites/graam.org.in/files/Report%20on%20Construction%20workers-final1.pdf>.

PROFILES: CONSTRUCTION WORKERS CONT'D

- Rinehart, Richard D. *Designing Programmes to Improve Working and Employment Conditions in the Informal Economy: A Literature Review*. International Labour Organization, 2004. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_travail_pub_10.pdf.
- Unni, Jeemol, and Uma Rani. *Social Protection for Informal Workers: Insecurities, Instruments and Institutional Mechanisms*. Working Paper. eSocialSciences, 2009. <http://ideas.repec.org/p/ess/wpaper/id1920.html>.
- Wells, Jill. "Informality in the Construction Sector in Developing Countries." *Construction Management & Economics* 25, no. 1 (2007): 87–93.
- ———. *The Construction Industry in the Twenty-first Century: Its Image, Employment Prospects and Skill Requirements*. Geneva: International Labor Organization, 2001. <http://www.ilo.org/public/english/standards/relm/gb/docs/gb283/pdf/tmcitn.pdf>.
- Wells, Jill, and Arthur Jason. "Employment Relationships and Organizing Strategies in the Informal Construction Sector." *African Studies Quarterly* 11, no. 2 & 3 (Spring 2010): 107–124.

PROFILES: DOMESTIC WORKERS

- "100th ILO Annual Conference Decides to Bring an Estimated 53 to 100 Million Domestic Workers Worldwide Under the Realm of Labour Standards." *International Labor Organization Press Release*. June 16, 2011. http://www.ilo.org/ilc/ILCSessions/100thSession/media-centre/press-releases/WCMS_157891/lang--en/index.htm.
- Bonner, Chris. "Domestic Workers Around the World: Organising for Empowerment." Cape Town, South Africa: Women In Informal Employment: Globalizing and Organizing (WIEGO), 2010. http://www.dwrp.org.za/images/stories/DWRP_Research/chris_bonner.pdf.
- Burnham, Linda, and Nik Theodore. *Home Economics: The Invisible and Unregulated World of Domestic Work*. New York, NY: National Domestic Workers Alliance, 2012. <http://www.domesticworkers.org/pdfs/HomeEconomicsEnglish.pdf>.
- "Decent Work for Domestic Workers." Report IV:119. Geneva, Switzerland: International Labor Organization, 2010. http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_104700.pdf.
- *Domestic Workers Across the World: Global and Regional Statistics and the Extent of Legal Protection*. Geneva: International Labour Office, January 2013. http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_173363.pdf.
- "Domestic Workers in the Informal Economy | WIEGO." *WIEGO*. Accessed May 3, 2013. <http://wiego.org/informal-economy/occupational-groups/domestic-workers#size>.

PROFILES: DOMESTIC WORKERS CONT'D

- “Informal Economy Occupational Groups: Domestic Workers.” *WIEGO*, n.d. <http://wiego.org/informal-economy/occupational-groups/domestic-workers>.
- Mkize, Vuyo. “Cheap Health Care for Domestic Workers.” *IOL News*. February 26, 2013. <http://www.iol.co.za/news/south-africa/cheap-health-care-for-domestic-workers-1.1476918#UYBow6kpv1q>.
- “Naya Jeevan- Lessons from the Project.” *Microinsurance Innovation Facility*, n.d. <http://www.microinsurancefacility.org/en/grantee/ig/naya-jeevan#group-lessons-from-the-project>.
- Neisloss, Liz. “Call for Action as Singapore Maids Fall to Their Deaths.” *CNN*, May 24, 2012. <http://edition.cnn.com/2012/05/23/world/asia/singapore-maids-deaths/index.html>.
- “Partners of Domestic Worker Organizations.” *International Domestic Workers’ Network*, n.d. <http://www.idwn.info/content/partners-domestic-worker-organizations>.
- “Programs- Naya Jeevan.” *Center for Health Market Innovations (CHMI)*, March 15, 2013. <http://healthmarketinnovations.org/program/naya-jeevan>.
- Smith, Peggie. “The Pitfalls of Home: Protecting the Health and Safety of Paid Domestics.” *Canadian Journal of Women & the Law* Washington University in St. Louis Legal Studies Research Paper No. 11-03-03 (March 1, 2011): 40.
- Varia, Nisha. “A Victory Against Modern Day Slavery.” Article. *Human Rights Watch*, December 1, 2012. <http://www.hrw.org/news/2012/12/01/victory-against-modern-day-slavery>.
- “Violence Against Women- Intimate Partner and Sexual Violence Against Women.” World Health Organization, November 2012. <http://www.who.int/mediacentre/factsheets/fs239/en/index.html>.

PROFILES: HOME-BASED WORKERS

- Benach, Joan, Carles Muntaner, Vilma Santana, and F. Chairs. “Employment Conditions and Health Inequalities.” *Final Report to the WHO Commission on Social Determinants of Health (CSDH) Employment Conditions Knowledge Network (EMCONET)*. Geneva: WHO (2007). http://cdrwww.who.int/entity/social_determinants/resources/articles/emconet_who_report.pdf.
- Chen, Martha Alter, Renana Jhabvala, and Frances Lund. *Supporting Workers in the Informal Economy : a Policy Framework*. Working Paper. Working Paper on the Informal Economy. International Labor Office, 2002. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122055.pdf.

PROFILES: HOME-BASED WORKERS CONT'D

- “Convention C177 - Home Work Convention, 1996 (No. 177).” Accessed April 22, 2013. http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID:312322.
- Hiralal, Kalpana. “The ‘Invisible’ Workers of the Informal Economy—A Case Study of Home-based Workers in Kwazulu/Natal, South Africa.” *J Soc Sci* 23, no. 1 (2010): 29–37.
- “Home-Based Workers | WIEGO.” Accessed April 22, 2013. <http://wiego.org/informal-economy/occupational-groups/home-based-workers>.
- ILO, UN Women and Baidari. “Report on Experience Sharing and Advocacy Workshop: Integrated Support Programme to Home Based Workers.” Book, April 15, 2011. http://www.ilo.org/islamabad/whatwedo/publications/WCMS_155223/lang--en/index.htm.
- Manothum, Aniruth, and Jittra Rukijkanpanich. “A Participatory Approach to Health Promotion for Informal Sector Workers in Thailand.” *Journal of Injury and Violence Research* 2, no. 2 (July 1, 2010): 111–120. doi:10.5249/jivr.v2i2.36.
- Rinehart, Richard D. *Designing Programmes to Improve Working and Employment Conditions in the Informal Economy: A Literature Review*. International Labour Organization, 2004. http://www.oit.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_travail_pub_10.pdf.
- Sinha, Shalini. *Rights of Home-based Workers*. New Delhi, India: National Human Rights Commission, 2006. <http://www.bhrc.bih.nic.in/Docs/Home-based-Workers.pdf>.
- Sudarshan, Ratna M., and Renana Jhabvala. “Social Protection for Home-Based Women Workers in South Asia: Learning from Action and Research” (2009). <http://dspace.cigilibrary.org/jspui/handle/123456789/21078>.
- Sudarshan, Ratna M., and Shalini Sinha. “Making Home-Based Work Visible: A Review of Evidence from South Asia” (2011). http://wiego.org/sites/wiego.org/files/publications/files/Sudarshan_WIEGO_WP19.pdf.
- “The Informal Economy and Decent Work: A Policy Resource Guide Supporting Transitions to Formality.” Book, March 19, 2013. http://www.ilo.org/emppolicy/pubs/WCMS_207727/lang--en/index.htm.

PROFILE: MANUFACTURING WORKERS

- Benach, Joan, Carles Muntaner, Vilma Santana, and F. Chairs. “Employment Conditions and Health Inequalities.” *Final Report to the WHO Commission on Social Determinants of Health (CSDH) Employment Conditions Knowledge Network (EMCONET)*. Geneva: WHO (2007). http://cdrwww.who.int/entity/social_determinants/resources/articles/emconet_who_report.pdf.

PROFILE: MANUFACTURING WORKERS CONT'D

- “Garment Workers - Conditions, Statistics, Challenges and Research | WIEGO.” Accessed April 15, 2013. <http://wiego.org/informal-economy/occupational-groups/garment-workers>.
- Goldman, Marlene B., and Maureen C. Hatch. *Women & Health*. Gulf Professional Publishing, 2000.
- Manik, Julfikar Ali, and Jim Yardley. “Bangladesh Factory, Site of Fatal Fire, Made Western Brands.” *The New York Times*, January 27, 2013, sec. World / Asia Pacific. <http://www.nytimes.com/2013/01/28/world/asia/bangladesh-factory-site-of-fatal-fire-made-western-brands.html>.
- Mehrotra, Santosh, and Mario Biggeri. *Social Protection in the Informal Economy: Home Based Women Workers and Outsourced Manufacturing in Asia*. Innocenti Working Paper No.97. Florence: UNICEF Innocenti Research Centre, December 2002. http://www.researchgate.net/publication/24139993_Is_EFA_Affordable_Estimating_the_Global_Minimum_Cost_of_'Education_for_All'/file/79e415122362a9441e.pdf.
- Merk, Jeroen. *10 Years of the Better Factories Cambodia Project*. Clean Clothes Campaign and Community Legal Education Centre, 2012. http://www.clec.org.kh/web/images/Resources/Res_CCC-CLEC-BetterFactories-Eng-Final1346726534.pdf.
- Messing, Karen, and Pirooska Ostlin. “Gender Equality, Work and Health: A Review of the Evidence.” World Health Organization, 2006.
- “Wal-Mart And Sears Don’t Plan To Pay Victims Of A Bangladesh Factory Fire That Killed 120.” *Business Insider*. Accessed April 18, 2013. <http://www.businessinsider.com/wal-marts-bangladesh-factory-fire-2013-4>.

PROFILE: STREET VENDORS

- Alfes, Laura. *Occupational Health & Safety for Market and Street Traders in Accra and Takoradi, Ghana*. WIEGO, 2009. http://www.inclusivecities.org/wp-content/uploads/2012/07/OHS_Street_Traders_Final.pdf.
- CGAP Working Group on Microinsurance, and Denis Garand. *Good and Bad Practices in Microinsurance*. VimoSEWA (India), 2005. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122472.pdf.
- Ross, MH, WM Pick, and Y Dada. “The Reproductive and Occupational Health of Women Street Vendors in Johannesburg, South Africa.” *Department of Community Health and WHO Collaborating Centre for Urban Health, University of the Witwatersrand (Parktown, South Africa)* (n.d.). <http://www.ncbi.nlm.nih.gov/pubmed/11824925>.
- Saha, Debdulal. *Conditions of “Decent Working Life” of Street Vendors in Mumbai*. Tata Institute of Social Sciences, n.d. <http://www.ilo.org/legacy/english/protection/travail/pdf/rdwpaper27c.pdf>.

PROFILE: STREET VENDORS CONT'D

- Sekar, Helen. *Vulnerabilities and Insecurities of Informal Sector Workers - A Study of Street Vendors*. V.V Giri National Labour Institute, NOIDA, n.d. http://www.vvgnli.org/sites/default/files/publication_files/Vulnerabilities%20and%20Insecurities%20of%20Informal%20Sector%20Workers%20A%20Study%20of%20Street%20Vendors.pdf.
- Sinha, Shalini, and Sally Roever. *India's National Policy on Urban Street Vendors*. WIEGO, 2011. http://wiego.org/sites/wiego.org/files/publications/files/Sinha_WIEGO_PB2.pdf.
- Skinner, Caroline. *Street Trade in Africa: A Review*. WIEGO, 2008. http://wiego.org/sites/wiego.org/files/publications/files/Skinner_WIEGO_WP5.pdf.
- Vanek, Joann, and Martha Chen. *Women and Men in the Informal Economy: A Statistical Picture*. International Labour Organization and WIEGO, 2012. <http://www.ilo.org/dyn/infoecon/docs/441/F596332090/women%20and%20men%20stat%20picture.pdf>.

PROFILE: TRANSPORTATION WORKERS

- Bonner, Chris. *Organising Informal Transport Workers. Overview Report*. International Transport Workers' Federation, 2006. <http://wiego.org/publications/organising-informal-transport-workers>.
- Cervero, Robert. *Informal Transport in the Developing World*. UN Habitat, 2000.
- Hisam, Zeenat. "Collective Care Arrangements in the Informal Labour Market: Road Transport Workers in Pakistan." *Economic and Political Weekly* (2006): 2099–2106.
- Krueger, Gerald P. *Health and Wellness Programs for Commercial Drivers*. Vol. 15. Transportation Research Board National Research, 2007. [http://books.google.com/books?hl=en&lr=&id=oXkZwE8lCHgC&oi=fnd&pg=PA1&dq=%22Edward+Johnson,+Director,+Applied+Science+Directorate,+National+Aeronautics+and+Space+Administration,+John+C.+Stennis+Space+Center,%22+%22and+Wellness%22+%22\(FMCSA\)+was+established+within+the+Department+of+Transportation+on%22+&ots=3hqRU2p3mF&sig=EjWtnMc3LO4eYjwFG1AYpeThUWM](http://books.google.com/books?hl=en&lr=&id=oXkZwE8lCHgC&oi=fnd&pg=PA1&dq=%22Edward+Johnson,+Director,+Applied+Science+Directorate,+National+Aeronautics+and+Space+Administration,+John+C.+Stennis+Space+Center,%22+%22and+Wellness%22+%22(FMCSA)+was+established+within+the+Department+of+Transportation+on%22+&ots=3hqRU2p3mF&sig=EjWtnMc3LO4eYjwFG1AYpeThUWM).
- *Making a Difference - Women Transport Workers in the 21st Century*. International Transport Workers' Federation. Accessed April 4, 2013. http://www.itfcongress2010.org/files/extranet/-2/24694/10Eng-%2042C_14_WTWC_2_Annex%20%20%5BITF%20Women%20-%20Making%20a%20Differe..pdf.
- Pascual, Clarence. *Organising Informal Transport Workers: A Case Study of the National Transport Workers' Union Philippines | WIEGO*. International Transport Workers' Federation, 2006. <http://wiego.org/publications/organising-informal-transport-workers-case-study-national-transport-workers%E2%80%99union-phil>.
- Schurman, Susan, Adrienne Eaton, Rebecca Gumbrell-McCormick, Richard Hyman, Camille DiLeo, Gilma Madrid Berroterán, Sahra Ryklief, Mihai Varga, and Verna Viajar. *Organizing Workers in the Informal Economy*. Cape Town, South Africa: Solidarity Center, December 2011.

PROFILE: TRANSPORTATION WORKERS CONT'D

- “Transport Workers | WIEGO.” Accessed April 22, 2013. <http://wiego.org/informal-economy/occupational-groups/transport-workers>.

PROFILE: WASTE PICKERS

- Dias, Sonia Maria. *Waste & Citizenship Forums - Achievements and Limitations*. Solid waste, health and the Millennium Development Goals. Kolkata, India, 2006. <http://www.cwgn.net/prarticle.2006-01-27.9445210332/prarticle.2006-01-27.0949657238/prarticleblocklist.2006-01-27.1370579427/skatdocumentation.2006-01-27.0903224148/file>.
- Poschen, Peter, Ana Lucía Iturriza, and Xinxing Li. *Working Towards Sustainable Development: Opportunities for Decent Work and Social Inclusion in a Green Economy*. ILO, 2012. http://www.oitcinterfor.org/sites/default/files/file_publicacion/wcms_181836.pdf.
- Samarth, Ujwala. *Occupational Health of Waste Pickers in Pune: KKPKP and SWaCH Members Push for Health Rights*. KKPKP, n.d. <http://www.mfcindia.org/main/bgpapers/bgpapers2013/am/bgpap2013Vv.pdf>.
- *Solid Waste Management in the World's Cities*. UN Habitat, 2010. <http://www.wsscc.org/resources/resource-publications/solid-waste-management-worlds-cities-2010>.

PROFILES: AFRICA

- Benach, Joan, Carles Muntaner, Vilma Santana, and F. Chairs. “Employment Conditions and Health Inequalities.” *Final Report to the WHO Commission on Social Determinants of Health (CSDH) Employment Conditions Knowledge Network (EMCONET)*. Geneva: WHO (2007). http://cdrwww.who.int/entity/social_determinants/resources/articles/emconet_who_report.pdf.
- Heintz, James. *Employment, Poverty, and Inclusive Development in Africa: Policy Choices in the Context of Widespread Informality*. Revised Draft. Political Economy Research Institute University of Massachusetts, Amherst, March 5, 2009. http://www.peri.umass.edu/fileadmin/pdf/conference_papers/khan/Heintz_chapter_PEA_volume_Mar_5.doc.
- Hiralal, Kalpana. “The ‘Invisible’ Workers of the Informal Economy—A Case Study of Home-based Workers in Kwazulu/Natal, South Africa.” *J Soc Sci* 23, no. 1 (2010): 29–37.
- Loewenson, Rene. “Assessment of the Health Impact of Occupational Risk in Africa: Current Situation and Methodological Issues.” *Epidemiology* 10, no. 5 (1999): 632.
- Loewenson, Rene. “Globalization and Occupational Health: a Perspective from Southern Africa.” *Bulletin of the World Health Organization* 79, no. 9 (2001): 863–868.

PROFILES: AFRICA CONT'D

- *MANAGING RISK, PROMOTING GROWTH Developing Systems for Social Protection in Africa*. The World Bank. Accessed April 24, 2013. <http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-strategy-summary-2012.pdf>.
- Rinehart, Richard D. *Designing Programmes to Improve Working and Employment Conditions in the Informal Economy: A Literature Review*. International Labour Organization, 2004. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_travail_pub_10.pdf.
- Schurman, Susan, Adrienne Eaton, Rebecca Gumbrell-McCormick, Richard Hyman, Camille DiLeo, Gilma Madrid Berroterán, Sahra Ryklief, Mihai Varga, and Verna Viajar. *Organizing Workers in the Informal Economy*. Cape Town, South Africa: Solidarity Center, December 2011.
- "The Informal Economy and Decent Work: A Policy Resource Guide Supporting Transitions to Formality." Book, March 19, 2013. http://www.ilo.org/emppolicy/pubs/WCMS_207727/lang--en/index.htm.
- Xaba, Jantjie, Pat Horn, and Shirin Motala. *The Informal Sector in Sub-Saharan Africa*. Working Paper on the Informal Economy. Geneva: International Labor Office, 2002. http://www.ilo.int/wcmsp5/groups/public/@ed_emp/documents/publication/wcms_122204.pdf.

PROFILES: ASIA

- Casanova-Dorotan, Florencia G. *Informal Economy Budget Analysis in Philippines and Quezon City*. WIEGO, 2010. http://wiego.org/sites/wiego.org/files/publications/files/Casanova-Dorotan_WIEGO_WP12.pdf.
- Nirathron, Narumol, and Kamolthip Chamkajang. *A Review of Barriers in Access to Health Services for Selected Vulnerable Groups: Case Studies from Thailand*. Thammasat University, Thailand, n.d. <http://cop.mdgasiapacific.org/files/cop/7/Thailand.pdf>.
- Pina, Patricia, Tim Kotin, Vicky Hausman, and Edwin Macharia. *Skills for Employability: The Informal Economy*. Innovative Secondary Education for Skill Enhancement (ISESE). Results For Development, May 7, 2012. <http://www.resultsfordevelopment.org/sites/resultsfordevelopment.org/files/resources/Skills%20for%20Employability%20in%20the%20Informal%20Economy.pdf>.
- *Profile of the Informal Sector*. Congressional Planning and Budget Department House of Representatives (Philippines), November 2009. http://www.congress.gov.ph/download/cpbd/fnf_112008_profsector.pdf.
- Ranson, Kent, Tara Sina, Mirai Chatterjee, Akash Acharya, Ami Bhavsar, Saul S. Morris, and Anne J. Mills. "Making Health Insurance Work for the Poor: Learning from the Self-Employed Women's Association's (SEWA) Community-based Health Insurance Scheme in India." *Elsevier. Social Science & Medicine* (2005): 14.
- De la Rosa, Jennifer, and Xenia Scheil-Adlung. *Enabling Transition to Formalization Through Providing Access to Health Care: The Examples of Thailand*. 128

PROFILES: ASIA CONT'D

- Saha, Debdulal. *Conditions of "Decent Working Life" of Street Vendors in Mumbai*. Tata Institute of Social Sciences, n.d. <http://www.ilo.org/legacy/english/protection/travail/pdf/rdwpaper27c.pdf>.

PROFILES: LATIN AMERICA

- Chen, Marty. "THE INFORMAL ECONOMY IN LATIN AMERICA: A GLOBAL PERSPECTIVE." Monterrey, Mexico, May 22, 2008. http://wiego.org/sites/wiego.org/files/resources/files/Chen_Presentation_Monterrey%20Conference_May_16_08.pdf.
- Ivanov, Ivan D. "Scaling Up Access to Essential Interventions And Basic Services For Occupational Health Through Integrated Primary Health Care." In *Background Document*. The Hague, Netherlands: World Health Organization, 2011.
- Lavigne, Milena. *Social Protection Systems in Latin America and the Caribbean- Peru*. Project Documents Collection. Santiago, Chile: Economic Commission for Latin America and the Caribbean (ECLAC), January 2013. http://www.eclac.cl/publicaciones/xml/5/49105/SPS_Peru_ing.pdf.
- *SMALL-SCALE AND INFORMAL MINING: A BIG PROBLEM FOR LATIN AMERICAN STATES*. Policy Brief- Economic Development. Evidence and Lessons from Latin America (ELLA). GRADE, Practical Action Consulting, UK Aid, n.d. http://ella.practicalaction.org/sites/default/files/121129_ECO_ExtIndConMan_BRIEF4.pdf.

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