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Informal Workers Co-Producing Social Services in the Global South

Task Shifting or Political Strategy towards a New Social Contract?

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Abstract

This paper is concerned with how organizations of informal workers – as specific type of social movement – are attempting to influence the provision of health services *from below*. The study offers a new perspective for several reasons: firstly, social policy scholarship tends to be dominated by institutionalist approaches which favour top-down explanations of policy development; and secondly, while there has been a growing academic focus on organizing in the informal economy and the interactions between the state and informal workers, very little of this has had an explicit focus on social policy. It focuses at the level where national or local social policies and practices of the state meet the ground, and where these are contested, engaged with, and transformed by informal workers. It looks particularly at how informal workers' organizations have become involved in the provision of social services – something that is often termed “co-production.” Debates on the co-production of services within social policy have been dominated by the debate about task shifting onto poorer women overburdening them with unpaid care work and low paid work. The paper examines the tension between this concern, and a less considered aspect of co-production. The way it is being used by organizations *as a political strategy* – as a means by which to shift relations of power between the state, owners of capital and poorer informal women worker-citizens, to influence the shape and nature of policy, and ultimately to re-imagine a social compact for the 21st century.

Keywords

Health service; social movements; informal workers; co-production; political strategy

Bio

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Introduction

Who should bear the main burden of social service is always a topic of hot debate: is it the state, the private sector, NGOs, communities and/or individuals? While there is widespread consensus that each of these actors have a role, there is much discussion about the allocation of responsibility. It is a debate that has been central to questions of rising inequality and question of the appropriate response to it. This paper is concerned with how informal workers' organizations have become involved in health service provision – something that is often termed “co-production.” Debates on the co-production of services within social policy have been dominated by the debate about task shifting onto poorer women overburdening them with unpaid care work and low paid work. The paper examines the tension between this concern, and a less considered aspect of co-production. The way it is being used by organizations *as a political strategy* – as a means by which to shift relations of power between the state and poorer informal women worker-citizens – to influence the shape and nature of policy, and ultimately to re-imagine a social compact for the 21st century. It focuses at the level where national or local social policies and practices of the state meet the ground, and where these are contested, engaged with, and transformed by informal workers. The study draws from empirical case studies of two organizations of informal workers – the Self Employed Women's Association (SEWA) in Gujarat, India, and HomeNet Thailand. Both organisations are part of the Women in Informal Employment Globalizing and Organizing (WIEGO) global network.

Task Shifting, Informalization & Co-production

In 1989, Caroline Moser posed a differentiation between women's “practical” gender interests and their “strategic” gender interests. She argued that development projects and programmes could only be considered feminist if they went beyond women's pragmatic needs and challenged structural gender inequalities. Similarly, Chant and Sweetman (2012) draw a line between “political action” which challenges gendered social structures through the “transformation of the laws, politics and practices” (and which can truly be defined as women's empowerment) and “pragmatic action” which while often being very welcome to local communities, continues to uphold the gender order of society. While neither of these authors directly address the issue of social service provision, there is an implication that programmes which reinforce women's unpaid (or low paid) care work in the community as a way in which to fill gaps in state provision, would address practical or pragmatic concerns. They would not, however, necessarily be thought of as empowering unless they were simultaneously transforming gendered norms.

When it comes to the provision of social services, this feminist literature has also intersected with a more mainstream political economy critique which focuses on the informalization of public sector work. In the health and care sectors a common response to the roll-back of public provision has been to outsource to the private sector, including to non-governmental organizations. Increasingly there is also a reliance on the work of cadres of (mainly women) “volunteers” – especially in the health and care sectors – whose role is to extend state health or care services into the community, but with no employment contracts and little or no pay or job security. This type of work – which falls outside of the confines of formal employment – is not only argued to increase women's marginalization through intensifying their care responsibilities, but it is also “generally theorized as a key component of a neo-liberal

privatization agenda that erodes both the public sector and the rights of workers employed within it” (Samson 2015:2).

A central argument that has emerged from trade unions (and indeed from many such community workers themselves) is that such work should be formalized. By this it is meant that community health and care workers should become public sector employees, paid at least the minimum wage, and have access to the superior social security provisions that are often attached to employment in the civil service (refs from ITUC/PSI). In this way, it is argued, the relations of power which perpetuate women’s marginalization would be challenged – women’s essential work in the community would be valorised through a decent wage, and the public sector social services bolstered by the creation of decent waged employment (Glenton et al. 2010; Palriwala and Neetha 2009).

This approach does, however, sit in tension with alternative currents of left and progressive thinking about public provision in the global south, something that could perhaps be thought to draw more strongly on a post-colonial vision of both work and public sector provision, and even ideas implicated in what is commonly referred to as the solidarity economy. Two scholars – both largely engaged in urban policy debates – in particular have attempted to complicate the narrative discussed above.

The first of these is Diana Mitlin (2008) who discusses the issue of co-production in the context of urban service delivery. Co-production here is defined as the joint production of services by citizens and the state, something which has long been a subject of academic interest in both the global north and south. Much attention has been paid to co-production in terms of its effectiveness in promoting citizen participation and improving service provision. While there are justifiable concerns about whether this is a form of task-shifting from state to communities, it has also been shown that co-produced services are not necessarily less expensive for the state, and may be a more effective form of provision particularly in relation to services which require behaviour change – something which state bureaucracies are not best equipped to deal with (Mitlin 2008). Mitlin’s key point, however, is that there is a form of co-production of urban services (housing, water, sanitation) that has emerged in the global south which has been driven largely by organized groups of the urban poor. She argues that to see this as a purely pragmatic activity is to miss the point that co-production is also as a form of political action “through which the organized poor may...consolidate their local organizational base and augment their capacity to negotiate successfully with the state” (Mitlin 2008:2). Using examples from the international movement Shack/Slum Dwellers International, Mitlin (2008) shows that in the context of weak states and inaccessible private provision, grassroots organizations are managing to build relationships with more powerful institutions, and through their work with the state, shift the relations of power and influence state policy and practice in their own interests. In these terms co-production can be thought of as both pragmatic/practical and political/strategic action.

Melanie Samson (2015) is the second scholar who has provided a somewhat different perspective on the role of informal workers in urban service provision. Her concern is with the inclusion of waste pickers into urban solid waste management. Samson (2015) argues that while the inclusion of informal waste workers into urban systems may be a consequence of the informalization and privatization of the local state, it cannot always be thought to be so. For example, in India, Brazil and Colombia, cooperatives of waste pickers have negotiated their

own inclusion into waste management systems in a way that has improved their working conditions and stabilized and/or improved their incomes (Samson 2015). In these cases, the inclusion of waste pickers into urban systems cannot be thought of as a withdrawal of public provision, but rather as a broadening of the conception of public provision in a way that responds to the context of the global south.

Both Mitlin and Samson are, however, clear that not all of these processes can be thought of as progressive as opposed to regressive task shifting and state withdrawal. For Mitlin, the key conditions under which co-production is progressive are: i) when it is driven and initiated by grassroots movements themselves (i.e. it is not a top-down process); ii) when it is not motivated by income generation so that co-production becomes akin to a public-private partnership; iii) the grassroots organizations are able to maintain autonomy from the state – “the objective is not to develop a model to be passed over to state employees”; and iv) the grassroots organization maintains a political objective of increasing citizen control of the state. For Samson, what differentiates the inclusion of waste pickers into solid waste management systems (which does have an income earning element) from a standard public-private partnership is i) the fact that waste pickers are providing a service (recycling) which has generally not been provided by municipalities in the global south before (hence this is not the informalization of previously formal jobs); ii) inclusion is driven by grassroots organizations of waste pickers themselves; iii) their motivation is not only to improve incomes, but to transform the nature of the state; iv) their working conditions and incomes improve rather than worsen through inclusion.

Lok Swasthya SEWA Mandali and the Shakti Kendras

The Lok Swasthya SEWA Mandali (LSSM) was founded as a cooperative in 1990 in order to provide health services to the members of India’s Self Employed Women’s Association (SEWA) – a trade union of almost two million informally employed women based in Ahmedabad, Gujarat. Aside from the provision of health services, LSSM also aims to provide greater economic security to the community health workers who make up the cooperative. In 2016 it had close to two thousand shareholders managed by a board of 15 elected directors (Desai and Chatterjee 2018). As a cooperative, LSSM is unique in its focus on the provision of a social service rather than on market-based production. The fact that it is owned and operated by the health workers and generates its own income, also distinguishes it from the majority of non-governmental public health service provision in India which either relies on voluntary work or is subsidised by grants from external donors (Desai and Chatterjee 2018).

For many years, India’s public health system was infamous for its lack of resources (with government spending of less than 1 percent of GDP), poor quality of care, lack of frontline health workers and bureaucratic mode of operation. Poorer citizens, including informal workers, have learned to distrust the system, often preferring to bankrupt themselves seeking private health care as an alternative. It was in this context that the LSSM first began to operate – attempting to bring affordable health care closer to SEWA’s members by providing basic preventive and promotive health services, organizing diagnostic health camps suited to the working hours of informal workers, and linking workers to any entitlements that did exist (health insurances for the poor for example). Since the implementation of the National Rural Health Mission in 2005, public health provision has expanded and improved, particularly in

rural areas. Primary health care services were bolstered and the position of Accredited Social Health Activist (ASHA) was instituted in order to strengthen the frontline provision of sexual and reproductive health services (Saprii et al. 2015).

As the role of the state has expanded under subsequent health missions, LSSM has developed new ways of working in its mission not to replace public health services, but to continue to fill the gaps in provision. While continuing its basic health promotion and prevention services, there is now also a much stronger focus on working with the state to ensure that the public health services which are on offer, actually reach informal workers. In 2015, SEWA's Social Security Team in Gujarat began to adapt a model of working originally developed by SEWA in Delhi and Madhya Pradesh, called the SEWA Shakti Kendras (SSKs). Whereas before health workers would give out information about public services and schemes, now they adopt an approach called "follow the worker" (Interview with SSK Team Leader, Ahmedabad, April 2018). This entails accompanying workers throughout the entire process of accessing public entitlements – providing information, filling out forms, helping workers to get documentation ready, accompanying workers when they submit forms, collect cash benefits and/or access health services. Only once an entitlement or treatment has been received successfully by the worker, do the health workers consider their own efforts to have succeeded. Data on the impact of the SSKs in Gujarat is not yet available. However, evaluations of the SSKs operating in Delhi and Madhya Pradesh suggest that they can help large numbers of poor workers to better access health services. There are now 23 SSKs operating in 5 states of India (Gujarat, Uttarkhand, Rajasthan, Bihar and Murshidabad). In Delhi, during the year 2015/2016, 69 000 workers visited the SSKs, and nearly 67 percent of those people received benefits as a result. It is estimated that the 5023 referrals to the public health system that year saved poor families Rs 411520 (just over \$6000) in costs that would otherwise have been spent on private health care providers.¹

In order to "follow the worker" and ensure that either benefits or treatment is received, it is necessary that community health workers are empowered to engage with the state effectively. One way in which LSSM has consistently approached a basic level of empowerment, is through its cooperative structure. Within the public health system, community health workers – all of whom are women – are firmly situated at the bottom of a heavily bureaucratized hierarchy which pays poorly and demands much. "If you want anything done at grassroots level, from data collection through to vaccinations, you just grab an ASHA and make them do it", says Mirai Chatterjee, Director of SEWA's Social Security Team. In this context, as Chatterjee and her co-author Sapna Desai (2018) point out, community health workers effectively become employees with no rights or decision-making power. The cooperative structure, on the other hand, is based on the idea of community health work as collective action – decisions about priorities, workplans and activities are taken jointly by the cooperative members. This is an empowering process for the community health workers, who are drawn from SEWA's membership (LSSM 2018), and it is not surprising to hear that SEWA's health workers regularly turn down coveted government jobs so that they can remain with the cooperative:

I wouldn't take a job from the government instead of SEWA...we've all been offered opportunities, but I never would...I've have learned so much here...there just isn't any way my self-confidence would be the same. (SSK Leader, Jalalpur, April 2018)

¹ Data provided by SEWA Delhi and SEWA Madhya Pradesh, 2017.

Key to the work of the SSKs, however, is that they are not only about the individual empowerment of health workers. They also serve as a platform to develop a relationship between LSSM and the state. Establishing this relationship has been far from easy, mainly because of the power differentials that exist between the Indian state and its poorer citizens (Gupta 2012). An important part of establishing this relationship has therefore been about evening out the terms of engagement. Within this process, the generation and uptake of knowledge has played a central role.

Multiple departments are involved in the provision of both social security and social services – both of which impact on access to health care. In order to “follow the worker” through the system, SEWA’s health workers have had to study and understand the system better. They have had to learn which departments are responsible for what services, which forms and documents are necessary to apply for which benefits², and who in each department should be contacted to ensure the best services for the workers. Mapping that information – a time consuming job because very little of this information is official, written down or accessible in any way – was the first step in the process.

Community health workers then had to be empowered to use the information collected during the mapping. Initially, health workers were accompanied by their supervisors on “exposure visits” to government departments and public health services so that they could establish personal contacts with officials. This was not something that came easily to many of the women who were comfortable interacting with their own community members, but found it difficult to interact with state authorities. “I cried the first time I had to go and talk to a government official”, said Ranjanben, who worked as a health worker on the first pilot round of the SSKs in Gujarat. Slowly relationships were built through repeated exposure visits and the confidence of the health workers to communicate with officials has improved to the point where they are able to operate independently.

Our community health workers now understand the public health system...All these lower caste women are not scared anymore – they can just march into a health centre and sit down as if they own the place, rather than waiting outside to be told to come in.
(Mirai Chatterjee, Director, SEWA Social Security, April 2018)

The SSK model builds on the improved confidence of the health workers to engage in a number of strategies which are aimed at influencing the operation of public health services on the ground. With their greater confidence and ability to engage with the state, many of the health workers have become respected members of their communities. This means they are regularly nominated onto local health committees. For example, SEWA now has several representatives sitting on the *Rogi Kalyan Samiti* (patient welfare committees), which are given a small lump sum each year by the government to spend on community health activities. Their positions on the RKS has meant that the SEWA health workers are able to influence the way this money is spent, and to ensure it does in fact directly benefit community members.

² The number of documents needed to access benefits in India is astounding. In some cases, a person seeking to access a benefit could be asked to produce the following: an aadhar card, election card, ration card, Below Poverty Line (BPL) certificate (and there are 3 different grades of BPL), income certificate, caste certificate, birth certificate, marriage certificate and proof of age certificate. If the benefit is a cash grant, evidence of a bank account is needed. Understandably, documents have themselves become a barrier to access for many poorer Indians.

The health workers also make a concerted effort to maintain the relationships they develop with government officials, which can be challenging because of the high staff turnover rate. Nevertheless, whenever a new official arrives, the health workers move in to introduce themselves, providing regular reports of their activities to the medical officers who staff primary health care centres, following this up with consistent personal contact. “We used to give the medical officers our reports in the old days, but they never read them”, says a SSK Supervisor in Pathan-ni-Chali in Ahmedabad. “I think that’s changed because now we’re always around, always talking about what we do.” The SEWA team is also careful to point out the mutual benefits that can come from working together.

When we first started working we got no support from the ASHAs...but after a year we’ve started to build a relationship with them. We told them we weren’t going to complain about them – that we wanted the same things as them, that we could help them, and that they could also help us. (SSK Supervisor, Pathan-ni-Chali, April 2018).

The result is that SEWA community health workers increasingly find themselves being called in to provide assistance to public health officials – from MOs down to frontline health workers. This allows them influence over the process of implementation and delivery of health services and activities and means that their members are more likely to benefit from what is on offer. “Often I have to call in [a SEWA health worker] to help us run our health and nutrition days”, said the manager of an urban health centre in Rajiv Nagar in Ahmedabad. “Government needs help to reach people. Truthfully, we really don’t have any idea how to do this and the SEWA workers really help us there.” On the other hand, ASHAs in this area have also started to help make connections between SEWA’s health workers and the public health system, aiding the types of relationships which further enable SEWA to influence the process of public health implementation.

SEWA also continues to offer its own health promotion and prevention services, as well as running health camps where workers can access basic diagnostic services before being referred onwards to the health system. This provides a service to workers, but it also has another motivation.

This is about instilling a different health behaviour. It’s about getting members to understand the importance of check-ups, and to actually use the public health system to do this. We’re trying to counter the negative view people have of the public system. (SSK Supervisor, Shiheshwari Nagar, Ahmedabad)

Building trust with the public health system isn’t always easy, particularly if people are then let down by poor care or medicine stock-outs, but SEWA see this process as important. “The more people start to use the public system, the more they are able to start demanding things from it” (SSK Supervisor, Shiheshwari Nagar, Ahmedabad).

HomeNet Thailand and the Local Health Funds

Founded in 1997, HomeNet Thailand (HNT) has worked across the country to organize workers, mainly women, engaged in the homebased production of goods, and now has a membership of approximately six thousand informal workers. One of HNT’s main concerns

around which it has organized workers is health, and they were one of nine civil society networks in Thailand who joined forces with public health professionals in the early 2000s to push for the implementation of the well-known “30-Baht” and later Universal Coverage (UC) Scheme³ (Nitayarumphong 2006). The UC scheme is in many respects a model of inclusiveness (see Alferts and Lund 2012), and HNT plays an active role in the many mechanisms for public participation which characterise the scheme, including being represented on the National Health Security Office (NHSO) Board. Many of its members also serve as volunteer health workers, of which there are about 800 000 active across the country (Kowitt et al. 2015).

One aspect of the UC scheme which HNT has been unsatisfied with, however, is the operation which is known as Local Health Funds (LHFs). The LHFs operate at local level, are part funded by the NHSO and municipalities, and are governed by a board which includes representatives from the health system, the municipality, and the community. They have been set up to fund community health services across four dimensions – health promotion, preventive health, rehabilitation, and out-of-hospital progressive treatment. One of the key goals of the LHFs is to foster a form of co-production between grassroots “people’s organizations” and the primary health care system. Organizations can put in a proposal to the LHF for a health-related activity, which they then carry out with the assistance of the local primary health care (PHC) unit and the health volunteers. “While rehabilitation and progressive treatment are best handled by PHCs, we realised that people’s organizations do much better than the government health system when it comes to promoting the behavioural changes that are needed for preventive health” (NHSO District Director).

The problem is that people’s organizations – including organizations of informal workers – have not been accessing the LHFs, to the extent that the NHSO is now considering cutting the LHF budget. Where the money is claimed, it is largely through proposals submitted by PHC units, often with little real input from community members. “In 2016 the Director of the PHC Unit, who is very respected here, decided that a good health intervention would be to get the community to grow its own organic vegetables,” said an HNT member.

We had the training, and we also had a follow up training...they even bought in trainers from the Department of Agriculture. But after the end of the activity nobody went on to grow organic vegetables. (Toddy Palm Growers in Song Khla Province, August 2018)

“This story shows the problem,” says Suntaree Saeng-Ging from HNT:

The PHC Director thinks it’s a good project. He proposes it and calls for comment, but no one is really empowered to give a proper comment, and he has already set out the terms of engagement. The project is not coming from the people themselves. And people give up on things when they haven’t initiated it themselves.

The question then is: why haven’t people’s organizations been accessing funds which are intended for them? “There are several problems”, says Saeng-Ging. Firstly, many people’s organizations do not actually know about the LHFs, and quite often this serves local political interests who can then direct the funds towards their own interests and patronage networks.

³ The 30-Baht Health scheme allowed all Thai citizens to access a basic package of health services for a payment of 30 Bhat (approx. 1USD). The 30 Bhat payment was later scrapped in favour of a fully free public health service, now known as the Universal Coverage Scheme.

Secondly, even when people's organizations know about the funds, they are both afraid of interacting with government officials, and intimidated by the idea of writing and submitting a proposal. "The biggest problem for us is that we are so afraid of approaching the municipality", said a garment producer from Pattani Province. "I honestly thought that if we submitted a proposal, they would just throw it in the bin." Thirdly, there is a feeling – related to the process of writing the proposal – that health issues should be left to health experts.

I am really unconfident in writing issues, and in academic issues. This makes me think the proposal should be left to the experts like the PHC Director. Health issues need experts, not ordinary people. (Toddy Palm Grower, Song Khla Province).

Often this idea is reinforced by health professionals themselves.

The PHC staff tell us it's better for them to design the health activities – we shouldn't be coming up with any ideas ourselves. As health volunteers we should just be the implementers and as informal workers we should just be the beneficiaries. (Toddy Palm Grower, Song Khla Province).

Through its project on improving access to LHF's, HomeNet Thailand has been working to change this situation. They have provided information, training and proposal writing support to 26 informal worker organizations across the country. The project came about because of HNT's frustration with the way the funds were being managed.

Really it isn't good enough what the local state is doing. You can't just tell people that a fund exists – you have to be proactive especially when you know that people are going to struggle to write the proposals. (Suntaree Saeng-Ging, HomeNet Thailand, August 2018).

The project has also tried to disrupt the idea that it is only health professionals – not health volunteers or informal workers – can develop health interventions.

Our work is to try and change what is normal. By supporting worker organizations to make their own applications, it's not the PHC writing the proposal and informal workers being the target group anymore. Now informal workers who are able to write the proposals themselves. (Suntaree Saeng-Ging, HomeNet Thailand, August 2018).

The training sessions developed by HNT have involved technical information and support, but they have simultaneously also involved training on political strategy. "Good technical proposal writing is important, but it is not enough. The workers also have to understand how power works so that they can be powerful too" (HNT Southern Provinces Regional Coordinator). The power dynamics around the LHF's operate on several different levels, and informal workers are trained in how to engage on multiple levels. The fact that the LHF funds come under the purview of elected figures such as the Mayor and Deputy Mayor means that informal worker groups have had to use the electoral system to demand the fair implementation of the LHF's. But they have also had to learn to develop relationships with the LHF's and engage in politics in less overt ways. "It is really important for the worker organizations to develop personal connections with the LHF committee members. We teach them how to develop these relationships, to get in touch with these people, to let them know who they are" (HNT Southern Provinces Regional

Coordinator). This has certainly been beneficial for the informal worker organizations in Pattani Province. “This was the first time we’d heard anything about informal workers,” said the local Mayor.

It’s now a lot clearer to us that their work and their health are closely related...I want to see how far they can go with this, and then perhaps we can start extending to other informal worker communities in the province.

The process of training and proposal development has had an important impact on the informal worker organizations. Fifty percent of the organizations which have gone through the HNT trainings have received (or will receive) government funding to carry out health activities designed by themselves for their communities and organizations. This has resulted in both personal and collective empowerment. “After going through this process, it feels like we are able to have good ideas and to achieve our goals” said one of the garment workers from Pattani Province. She pointed out as well that the process had had a beneficial impact on her organization, which had served as a very concrete concern around which to organize. “This process has really helped strengthen the garment workers. Every time we had a meeting about the health project, most of the members would actually come – they really care about it.”

However, not all the organizations have been able to take advantage of the situation, illustrating some of the more difficult aspects of co-production. The organization of rice millers in Song Khla decided after the training not to submit a proposal. “After we developed the proposal we just got so busy with work,” said the leader of the organization. “Actually, the grant would feel like a bit of a burden...if we were successful it would take all of our time to organize this activity, and it takes us away from work.”

Co-producing Social Services: Challenging Power in the Interests of a More Equal World?

“Our bodies are our only asset” say SEWA’s members, and for this reason good health is essential to maintaining income security (LSSM 2018). The two case studies presented above give a brief overview of how two membership-based organizations (MBOs) of informal workers are involved – to a greater or lesser degree – in the co-production of health services. Both organizations are working with public health services to extend the provision of the all-important preventive and promotive health services to their members by their members, in the hope that this will ensure not only good health, but more stable incomes. This is intensive work for both SEWA and HNT. Leveling the playing field between state and citizen takes up a large amount of resources, both human and financial, and it relies heavily on the work of women in the community which, as the HNT example showed, can sometimes be a real problem. Is it really sustainable to expect MBOs to take on this role? Is this strategic action or is it serving pragmatic needs? In Samson’s terms, is this a narrowing of the public sphere through a reliance on social movement action, or is this potentially a redefinition of the public?

To answer these questions it may be useful to think through the work being done by these organizations through the criteria laid out by both Mitlin (2008) and Samson (2015) for determining whether co-production can be thought of as progressive. Merging the two sets of criteria leaves us with the following:

In order for co-production to be thought of as progressive, it must:

1. Provide a service not yet provided by the state (or not best provided by the state), so that it is not a withdrawal of the state;
2. Be driven by grassroots organizations from the bottom-up, not top-down;
3. Be engaging in a political process to transform the nature of the state/have an objective to increase citizen control of the state;
4. Working conditions for informal workers improve, rather than worsen, through the process of co-production.

Criterion No. 2 is easy to judge – in both cases this has been driven by grassroots organizations from the bottom-up. It can also be argued in relation to criterion No. 1 that in both cases the organizations are either providing services which are not offered by the state, or are not best offered by the state. In India, the ASHAs link workers with the grassroots and the public health system, but only in relation to sexual and reproductive health. LSSM's health workers attempt to "fill the gaps" by providing linkages and services in other areas that are important to informal workers: non-communicable diseases, occupational health and safety, and mental health. Similarly, HNT's specific focus has been to encourage their members to apply to the LHF's to fund occupational health and safety activities.

In both cases as well, state officials themselves have made the case that social movements are better equipped than the government to do the work of reaching out effectively to the grassroots than the government. There are differences. Thailand has a relatively well-resourced and effective primary health care system. The feeling is still though that to promote health behaviour change, it is necessary to work with communities themselves – it cannot only be the state involved. In India, however, Akhil Gupta's (2012) ethnographic account of the workings of state bureaucracy shows how state-run social services provide very different outcomes than the Weberian ideal would suggest.⁴ In this case it is perhaps related to the idea that it is only organizations which can somehow subvert that bureaucracy (and allow state officials to do the same) which can ensure that a more consistent standard of care reaches the ground.

Criterion No. 3 links the feminist debates highlighted earlier in the paper regarding pragmatic versus strategic or political work. While both SEWA and HNT engage in more traditional forms of policy advocacy, their work on the ground could easily be classified as a pragmatic form of service delivery. This would, however, miss the point that while, for example, the SSKs do indeed have very pragmatic aims, the *ways* in which they achieve these aims is profoundly political. They challenge established and often gendered relations of power between poor workers and the state from the bottom up. In doing so, they are attempting to transform the nature of the state and citizen's control over it. There are a number of ways in which this is true.

Firstly, as Michael Lipsky (1980) observed in his work on what he called "street-level bureaucrats", state policy is not only made in formal policy making settings. Lipsky argued that it is often frontline public employees who are tasked with the implementation of public policies who in effect make policy. They are often under-resourced, subject to public pressure, and the structure of their work makes it impossible for them to carry out policies as officially mandated. The solutions they develop in this context become the real policy, argues Lipsky, and thereby,

⁴ Weber argued that bureaucracies were a superior way of organizing the state because they ensure a basic standardization of service provision. In the Indian context, Gupta shows that it is the bureaucracy of the state itself which creates the conditions for highly uneven service provision outcomes.

street level bureaucrats become policy formers rather than just implementers (Hupe and Hill 2007). The fact that both LSSM and HNT have worked to develop relationships with frontline government workers and used those relationships to shift the way in which health programmes are implemented, can therefore be thought of as a form of strategic action to shift policy as well as ensuring service delivery. Here the line drawn by Moser between pragmatic and strategic action is blurred.

Secondly, both organizations are engaged in processes to transform ideas about community health workers/volunteers. Hierarchies within the public health system often reinforce the class and gender structure of society, allowing poor women workers little decision-making power and/or autonomy in their work. LSSM have been working to change this idea through their cooperative structure and empowering their health workers to engage more confidently with the health system. Through their training courses HNT are trying to shift the idea of health volunteers as only implementers of ideas developed by PHC staff, by encouraging them to develop their own ideas for health activities.

Thirdly, by bringing poorer workers into closer contact with the health system and even providing their own health services, both LSSM and HNT are engaging in a process to conscientize workers to the idea of health provision. In a recent article, Holland (2018: 556) argues that “in many unequal societies important welfare programmes exclude the poor, which dampens the poor’s support for redistribution.” The corollary to this is that in order to develop the widespread support necessary to expand public provision, it is necessary to ensure that people are coming into contact with social programmes. In this case, programmes which serve practical needs by bringing public health services closer to the previously excluded may also be doing political work to increase support for public provision.

Criterion No. 4 is more complicated, and here the differences in context are important. In Thailand, health volunteers are paid a small stipend of 600 Baht⁵ per month by the state to cover transport costs, but are considered volunteers, not paid workers. In general, informal workers who become health volunteers do the work for non-monetary reasons. It is considered to be part of the “service minded” tradition, rooted in Buddhist philosophy, and the reward is respect and a higher status within the community (Kowitt et al. 2015). However, it is largely women who take on this role, and as the example of the rice millers showed, this can add to their burden of care and detract from their income earning work. Overall, while the Thai volunteer programme is considered by the WHO to be a model of community health provision, it may not be the best example in situations where community health work is being thought of as a way to enhance women’s income security.

Here the Indian example may be more relevant. One of LSSM’s central goals has been to provide a more steady income to its health workers. For their work they not only earn an income from SEWA, but they also supplement this through selling the co-operatives products – health insurance cover and ayurvedic medicines. In 2016, the ILO released its global research about cooperatives providing care services. It found that the co-production of care services through cooperatives can be both an effective way to create decent work opportunities for women and provide responsive community-based care (Matthew et al. 2016). Financing the incomes of the health workers is a challenge for SEWA, however (ILO/WIEGO 2018), and it is here that the

⁵ Approximately USD20.

state could play an important role in providing public financing. Mirai Chatterjee from SEWA believes that in the Indian context, where cooperatives are common, co-producing health services in this way would be a solution to current human resource challenges within the health system (Interview with Mirai Chatterjee, August 2018). This is not a cheap option, she insists – cooperatives would need to receive financing from the state, as well as generating their own resources – but it would be a cheaper, more realistic, and more effective option than training doctors to perform the grassroots community health functions which they are ill-suited to perform.

Bibliography

Alfers, L, and F. Lund. 2012. "Participatory Policy Making: Lessons from Thailand's Universal Coverage Scheme." WIEGO Policy Brief No. 9. Cambridge, MA: WIEGO.

Chant, S, and C Sweetman. 2012. "Fixing women or fixing the world? 'Smart economics,' efficiency approaches and gender equality in development." *Gender & Development*, 20(3):517-529.

Desai, S, and M Chatterjee. 2018. "The SEWA Lok Swasthya Mandali: a dual experiment in organizing and service provision in Gujarat." In *Redefined Labour Spaces: Organising Workers in Post-Liberalised India*, edited by S. George and S. Sinha. London and New York: Routledge.

Glenton, C, I.B Scheel, S Pradhan, S Lewin, S Hodgins, and V Shrestha. 2010. "The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives." *Social Science and Medicine*, 70:1920-1927.

Gupta, A. 2012. *Red Tape: Bureaucracy, Structural Violence and Poverty in India*. Durham and London: Duke University Press.

Holland, A. 2018. "Diminished Expectations: Redistributive Preferences in Truncated Welfare States." *World Politics*, 70(4):555-94.

Hupe, P, and M Hill. 2007. "Street-Level Bureaucracy and Public Accountability." *Public Administration*, 85(2):279-299.

ILO/WIEGO. 2018. *Cooperatives Meeting Informal Economy Workers' Child Care Needs*. Geneva: ILO.

Kowitt, S.D, D Emmerling, E.B. Fisher, and Cs Tanasugarn. 2015. "Community Health Workers as Agents of Health Promotion: Analyzing Thailand's Village Health Volunteer Programme." *Journal of Community Health*, 40:780-788.

Lipsky, M. 1980. *Street Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

LSSM. 2018. *Our Bodies Are Our Only Asset: The Story of the Lok Swasthya SEWA Mandali*. Ahmedabad, Gujarat: Lok Swasthya SEWA Mandali.

Matthew, L, S Esim, S Maybud, and S Horiuchi. 2016. *Providing Care through Cooperatives: Survey and Interview Findings*. Geneva: ILO.

Mitlin, D. 2008. "With and beyond the state - co-production as a route to political influence, power and transformation for grassroots organizations." *Environment and Urbanization*, 20(2):339-360.

Moser, C. 1989. "Gender Planning in the Third World: Meeting Practical and Strategic Gender Needs." *World Development*, 17(11):1799-1825.

Nitayarumphong, S. 2006. *Struggling Along the Path to Universal Care for All*. Nonthaburi: National Health Security Office.

Palriwala, R, and N Neetha. 2009. Paid Care Workers in India: Domestic Workers and Anganwadi Workers. In *UNRISD Research Report 4*. Geneva: UNRISD.

Samson, M. 2015. Forging a New Conceptualization of "The Public" in Waste Management. In *WIEGO Working Paper No. 32*. Cambridge, MA: WIEGO.

SEWA. 2017. Unpublished data on Impact of Shakti Kendra's in Delhi and Madhya Pradesh.

Saprii, L, E Richards, P Kokho, and S Theobald. 2015. "Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles." *Human Resources for Health*, 13 (95).