

# WORKSHOP REPORT

## National Workshop on “Informalisation of Employment in the Health Sector”

22-23 April, 2016

Organised by

Public Services International (PSI)

Jan Swasthya Abhiyan (JSA) and

Health Employees Union, Delhi (HEU)

Venue: Indian Social Institute, 10, Institutional Area, Lodi Road, New Delhi, 110003

# National Workshop on

## Informalisation of Employment in the Health Sector

New Delhi, 22-23 April, 2016

Public Services International (PSI), Jan Swasthya Abhiyan (JSA) and Health Employees Union, Delhi (HEU) jointly organized a two day National level workshop on “Informalisation of Employment in the Health Sector” at Indian Social institute, New Delhi. The workshop was an effort to bring together public health activists, trade union representatives and organizations in the health sector to understand the nature and trends of informalisation of employment in the sector, to develop strategies to respond to the challenges posed by these trends and to create a platform for further joint work.

More than 70 participants contributed to the deliberations from a range of unions and federations in the health sector, mostly from the National Capital Region (NCR). Most national trade union centers were represented. Cadres /job categories ranging across nurses, laboratory and other technicians, pharmacists, administrative clerks, multi-purpose staff, housekeeping, auxiliary nurse midwives (ANM), accredited social health activists (ASHAs), and anganwadi workers (AWWs) were present. The unions present represent workers in facilities and schemes/missions under the three levels of government administration (central, state and municipalities), but mostly under the Ministry of Health and Family Welfare and Department of Health. Representation from hospitals under other ministries was scarce. Only one union from the private sector was able to attend.

The deliberations discussed how informal employment for health workers weakens public health institutions and stressed that a struggle for the rights of health workers is also a struggle for a strong public health system and for quality health services. The challenge of an insurance-based model of access to health care was identified as a major emerging issue. The need for unity of the trade union movement and more linkages between trade unions within the health sector was strongly expressed.

The participants to the meeting decided on the following:

- Develop a memorandum and signature campaign highlighting the link between informalisation of employment of the health workforce, weakening of health institutions and of the public health system. This is in order to mobilise larger public support for decent work in the public health system;
- Create a working group on contract work in hospitals (both public and private), to which all the participants will be invited to join;
- Take concrete steps towards the creation of a national coordination of health sector unions.

What follows is a summary of the deliberations.<sup>1</sup>

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<sup>1</sup> This report was prepared with inputs from Allam Ashraf, Deepak Kumar, Devaki Nambiar and VR Raman. PSI thanks all of them for their contribution. For further information, please contact Susana Barria at <susana.barria@world-psi.org>.

## Introduction to the Workshop

The workshop started with an introduction by representatives from JSA, **Vandana Prasad**, and PSI, **Susana Barria**. It was emphasized that the aim of this event was to contribute to building alliances between the health movement and the trade union movement. It was noted that the challenges facing the health movement and the trade union movement are different and might even seem contradictory. Yet, for both, the roots lie in the neglect of and attack on public health facilities, and this is what brings these movements together. Addressing the roots of the problem brings them together. It was stressed that there are multiple ways by which employment is getting informalised, be it through the outsourcing of entire departments such as laundry or, more recently, diagnostics; through keeping posts vacant and hiring nurses on contract instead of filling vacancies; allowing private agencies to offer catering or dialysis services within the premises of the hospital and thereby increasing the cost of the service provided; giving the responsibility of hiring cleaners to a contractor who provides man power without an understanding of the importance of ensuring high standards of cleanliness in the hospital; or simply denying workers their status and rights as workers by calling them volunteers. Clearly, this means that decent work eludes workers, and they are confined to what the ILO calls 'non-standard work', where workers are not directly employed by the primary employer – i.e. the hospital they work in or for, in other words, there is no clear employer-employee relationship; where work agreements, if existent, are informal; and where employment is temporary.

In this context, this meeting was an attempt to contribute to better understanding the common challenges we face and bring together public health activists, trade union representatives and organisers in the health sector to share about:

- a) the trends and patterns of informalisation of employment in the facilities/districts where they organise;
- b) the strategies that have been used to respond to the challenges posed by informalisation of employment and to the needs of informalised workers; and
- c) emerging issues in the health system and the need for social alliances.

## Setting the Context: Indian Health System and Challenges to People's Access to Health Care

**Imrana Qadeer**, from the Centre of Social Medicine and Community Health at Jawaharlal Nehru University, provided a historical context of the evolution of the Indian health system. Budgetary allocations for health care have always been low in India. There were many policy recommendations to increase the budget, as well as promises by various political parties and leaders to do so. However, this has simply not happened. Instead, India has seen the rapid and unregulated expansion of the private sector in health. A major chunk of provision in health care is now by the corporate sector and it is growing day by day. This is directly associated with the enfeeblement of public health care institutions.

The privatization agenda started during the 8<sup>th</sup> (1992-1997) and 9<sup>th</sup> (1997-2002) Five Year Plans with the neoliberal turn in India. Shortcomings of the public sector were used as a pretext to increase and encourage the participation of the private sector, especially through public-private partnerships. It was argued that around 70% of the health care budget goes into the salaries of health workers and professionals, who do not perform commensurately. This was used as the basis to promote the informalisation of labour in health. The assumption was that by creating this kind of pressured work environment, services would improve. Not only did this not happen, the basis for any kind of health system strengthening was eroded thereafter.

Following this, the government's next salvo was to promote insurance from private sector by pooling resources and risks. There is a clear strategy of the successive governments to increasingly sell and buy the health care services from the private sector, in accordance with a well-planned policy to facilitate profits by private players. Insurance has allowed the discourse to shift from centering on the responsibility to provide care to assuring coverage and leaving the provision of services out of the government responsibility. The National Health (Assurance) Mission is precisely this.

While health policies were criticized during the 1970s and 1980s, they were certainly better than at present. India's policy during that time had a clearly articulated vision and talked about the need to have integrated services – both of which are sorely lacking at present. Throughout this process, philanthropic organisations, international financial institutions and trans-national corporations have played an important role to support such a move from the government.

**Sakthivel Selvaraj** from the Public Health Foundation of India (PHFI) focused mainly on the sources of financing for health-care and started with a global scenario of health care financing. According to global estimates, most developing countries spend around 7-8% of their Gross Domestic Product (GDP) on health, whereas India spends around 4% of its GDP. This in and of itself is neither good or bad. The issue is that out of this 4%, only about 1.2% is spent by the government. Because of the meager contribution of government, people are major contributors to health-care spending, paying 'out-of-pocket' close to 71% of total health expenditure. Another instance is that of United States of America (USA) where around 17% of the GDP is spent on health, which is the highest in the world. Even then 30% of US citizens lacked insurance coverage (before the implementation of Obamacare). Clearly we have to understand both how health is financed and how the money is spent.

Like other developing countries, India has a tax-based method of health care financing – this is considered appropriate as a large formal economy does not allow for a co-payment model (i.e. where both employer and employee pay). During the 1980s government spending on health was increasing, but soon after the economic reforms of 1991, government spending was curtailed and health spending started coming down again. In addition, data shows that the contribution of the States to health care financing has gone up while the contribution of the central government has come down. There is also a big gap between what is allocated and what is spent in the health sector.

The National Rural Health Mission (now known as National Health Mission) launched in 2005 tried to integrate entire the health system under one umbrella to strengthen it. But NRHM placed extensive

emphasis on Reproductive, Maternal, Neonatal and Child Health (RMNCH). Also, a critique was raised that the health system did not have the capacity to absorb the funds allocated under NRHM. However, the evidence shows that gradually, states did develop the capacity to absorb funds and the scheme has played a role in decreasing out of pocket expenditure on RMNCH.

Shaktivel concluded that some of the policy challenges faced by the health system include: a sharp decline in the central government contribution to health-care, as well as the flow of funds being shifted from the society to the treasury route which he associated with delays.

**Devaki Nambiar** from PHFI described the health system from a gender lens by analyzing the problems of front-line workers, particularly ASHAs. She noted that historically, women were not considered as workers and their work was not counted, like in the Workmen's Compensation Act of India (1923). Gradually, various conventions came about globally and in India that began to recognize the rights of women workers. Various schemes have also been launched that include maternity benefits.

The problem with these initiatives is that they run in 'mission' and 'scheme' mode. These schemes and missions legitimize and normalize part time and piece-rate labour. Schemes and missions, and the labour they employ, are always in a tenuous position – missions are temporary in nature and schemes have to be renewed and thus both are constantly insecure. A review of National Sample Survey data suggests that in 2010-11, more than 95% of frontline workers reported being ineligible for a Provident Fund, gratuity, health care and maternity benefits.

In many states, there have been attempts – through sub-schemes and technologies – to improve the productivity and legitimacy of ASHAs. Incentives have been introduced, which on the one hand monetize care and labour and on the other hand invisibilise and de-values activities that can not be priced (like building trust or working with the community). In addition, different States have different structures for these schemes which makes it hard for them to organize and come together to make demands at the national level.

Demands of ASHA workers include government contracts with minimum wages, regularization of NHM, better working conditions for them e.g. transport, lighting etc., scale up and expansion of schemes like Indira Gandhi Matritv Swasthya Sahayog Yojna (IGMSY), opportunities for promotions, and prevention of sexual harassment, among others.

**Rajiv Aggarwal**, supreme court lawyer and HEU president, talked about the history of the union he represents and highlighted that the problem of contract workers in hospitals for class IV workers dates back to the 70s. Human resource appointments in hospitals are fixed and vacant posts are not getting filled as per the requirement. This has led to under-staffing and overload of work for existing staff, in turn affecting the quality of health care. Contract workers have neither job security nor social security, so this makes fighting for rights very difficult. 'How can you organize for better conditions of service if this could cost you your job?' He asked.

In the **discussion**, participants raised that the struggle is against neo-liberal economic policies that have been implemented by various political parties succeeding in government. Participants also stressed that

the private sector, government officials, and politician have all contributed to defaming public services and blame these institutions for decisions that have been taken by governments. For instance, cutting resources for infrastructure and halting recruitments are decisions of the government, but the blame for the consequence is put on workers and public health facilities.

The session concluded that informalisation of work needs to be looked in the broader context of neo-liberal health policies, at the same time that the role of informalisation in further weakening public health institutions and compromising the quality of health services has to be recognised and highlighted. The way forward is to challenge policies that commodify health-care services and advocate for policies that improve the public health system. This requires a collective response from informalised (casual, contract, etc) and permanent workers in the health sector, working in coordination with each other, as well as to work in social alliances that unite different groups and constituencies to challenge the current direction of policies.

### **Informal Employment in Hospitals: Trends, Challenges and Demands**

**Amitava Guha**, from the Centre of Indian Trade Unions (CITU), highlighted the importance of the inclusion of hospitals under the definition of industry (section 2 (j)) of the Industrial Disputes Act as this allows hospital employees to avail the rights provided under India's labour laws. In 1987, the government introduced the Hospitals and other Institutions (Redressal of Grievances of Employees) Bill that would have taken hospital workers out of the ambit of Indian labour law. But the bill was opposed, and lapsed. However, the danger of another such an attempt can not be ruled out.

**Rajender Kumar**, from Hind Mazdoor Sabha (HMS), highlighted the diverse workforce involved in ensuring the provision of health-care. He lamented the fragmentation of cadres into occupation-based trade unions as the trade union movement in the health sector is dis-united with each union struggling for their own cadres' rights in isolation. He also lamented that the trust between hospital institutions and people has eroded. Mistrust and lack of solidarity is further exacerbated by the shrinking of budgetary allocations to the health sector, that further compromises the quality of health-care services in public facilities.

Echoing this point, **Animesh Das**, from the Indian Federation of Trade Unions (IFTU), reflected on the dilemma between working as a health activist or as a trade unionist in the health sector. He stated that this contradiction is fueled by neo-liberal policies that have choked the public health system and the private sector advocates that have actively defamed public hospitals. He also noted that between the 6<sup>th</sup> and 7<sup>th</sup> Central Pay Commission (CPC), 29% of positions have been filled through contract workers. Reflecting on trade union activism in the health sector, he concluded that the struggle around the 7<sup>th</sup> CPC will be limited compared to the organizing that existed around the 4<sup>th</sup> CPC (1986).

Speaking of their experience in Delhi, **GK Khurana**, from All India Government Nurses Federation (AIGNF) and Delhi Nurses Union (DNU), described the struggle of nurses unions to improve the conditions of work of nurses in government hospitals. In 1990, DNU forced the Health Ministry to make

an order to regulate the working days and leaves of nursing personnel. The DNU forced the Ministry of Finance to get its Staff Inspection Unit (SIU) to set up norms for nurse staffing (nurse patient ratios among others), published in 1992. DNU also fought for the government to review nurses pay scales in-between Central Pay Commissions (CPCs) revisions as well as successfully fought for a nursing allowance. The 6<sup>th</sup> CPC (2006) recommended a higher entry level pay scales for nurses effectively upgrading these cadres vis-à-vis other paramedical staff. However, the 7<sup>th</sup> CPC (2016) nullified the upgrading.

**Umesh Sharma**, from All India Health Employees and Workers' Confederation (AIHEWC) and Safdarjung Hospital Karmchari Sangharsh Union, described the strategies that the management of the Safdarjung Hospital had used to fight his union. The Essential Services Maintenance Act (ESMA) was misused to dissuade workers to be active in the union, and some of the members even went to jail. Then, the union was active and strong and held several negotiations with the Health Minister. Today the union stands scattered and has not been able to intervene to maintain the standards of health-care provision in the hospital. The prestige of the hospital has been adversely affected. **Ram Kishan**, from AIHEWC, reminded that ESMA was again used against junior doctors from Safdarjung Hospital in 2009.

Speaking of the situation at the Lala Ram Swarup (LRS) T.B. Hospital in Mehrauli, **Shambhu Kumar Singh**, from LRS Hospital Group C & D workers union, said that there are currently 200 contract workers in the hospital, and they are not getting Providence Fund or any other social security benefits. The union had successfully agitated against the hospital Director and had him removed from his post, but in a recent strike the union got exhausted and is now relatively inactive.

**Suresh Kumar**, from Multi-purpose Health Employees Association of Haryana, shared that the ratio of permanent and contractual employees in health sector in Haryana is 60:40, and ASHAs are not even considered a part of the health system. He stressed that not only do occupation based unions focus on the issues of their own cadres but there are also antagonistic relation between certain cadres, such as between ASHAs and ANMs. In addition, in the case of Haryana, a comment was made that workers have started to form unions along caste identities, such as the Dalit Nursing Union, which is important to reach out to this workforce but also furthers the fragmentation of unions. Suresh Kumar shared his attempts to bring all of them under one umbrella, which has not concluded as yet and called for creating spaces for discussions and debates in order to deal with these issues and work towards a united movement of health unions.

Talking of their experience in other states in India, **H.N. Nanjundaswamy**, from the Karnataka State Government Employee Association (KSGEA), stressed on the blame game between Centre and State governments with regard to the responsibility to ensure the provision of health services and called for a holistic health system approach in response. **Prakash Devdas**, from the Mumbai Mahanagarpalika Karmachari Mahasangh (MMKM), emphasized that the government has gradually disregarded the responsibility of providing health-care resulting in an increase of contractual labour and work overload. He shared that when a contract labor union was formed the contractor immediately removed the organizer from his job and quelled the union.

## Front-line Health Workers: Challenges for Organizing

### Working in Primary Health Care

**Jayalakshmi**, from Karnataka State Health Assistant and Supervisor Union, noted that despite Indian Public Health Standards (IPHS) guidelines stating that 10,000 population should have one Primary Health Centre (PHC), her experience is that one PHC covers up to 32,000 people. In addition, health workers in the PHCs are doing a broad range of tasks such as on-line reporting, Health Management Information System (HMIS) data recording, etc. The work load and expectations are disproportionate to the staff available, she concluded.

**V R Raman**, from Public Health Foundation of India (PHFI) and JSA, noted that with the introduction of NRHM, new positions of 'coordinators' were created at district, block and state level, in the ASHA resource centers and State Health Resource Centers. These positions are for technicians/professional category who are mostly employed on contracts and as consultants. These institutions don't have permanent structures and salaries vary across States. Raman stressed that while these workers have been brought in the system to quell corruption in the public health system, their employment and work conditions are inadequate and insecure. This then provides a platform for organized abuses within NRHM. He lamented that this workforce has been neglected and is less organised, and welcomed that in Madhya Pradesh, these workers have successfully organised themselves and are currently agitating for standard working conditions.

**Shakuntala Devi**, from the Lady Health Visitor and ANM Association, Delhi, noted that in a PHC, a great deal of the responsibility lies with ANMs. For instance, the whole "Indradhanush" campaign was under the responsibility of ANMs. There was again a shared feeling that the expectations and workload is too high and compromises the quality of the services provided.

### Anganwadi Workers

*Anganwadis started in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition, as a part of the public health-care system. Anganwadis provide basic health care such as contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school education, immunization, health check-up and referral services.*

**Pushpa Rani**, from an Anganwadi Workers' (AWWs') union affiliated to Bharatiya Mazdoor Sangh (BMS), shared that while her appointment letter calls her a "Swayamsevika" (volunteer) the government asks her to work like a regular employee. For instance, the SABLA scheme (Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls) requires AWW to work from 9am to 6pm. **Shakuntala Shukla**, from the AWW Karmachari Sangh of Delhi, shared that in the city AWW only get Rs. 5000/- for work performed from 9 am to 6 pm. Echoing this feeling, **Usha Sharma**, from the All India Trade Union Coalition (AITUC) in Uttar Pradesh, stated that 'there is too much work and too little compensation' and pointed to the fact that even as the need for AWWs services is growing, the Government is curtailing the budget day by day.

Not only is the pay too little and the expectations high, AWW lack social security, timely payment, and the required infrastructure for their work. In Uttar Pradesh, earlier, AWWs used to get 2 *sarees* as their uniform but are now receiving only one. In addition, AWW get frequent additional work requests from the government. There was a shared feeling of working under tremendous pressure. Another major issue frequent harassment from other functionaries in the health system as well as in communities.

Adding insult to injury, the AWWs work is not recognized. There was a shared feeling of loss of dignity attached to the conditions of work AWWs face. Their demands are to be recognized as workers, ESI cards, appreciation (an honorarium or letter) when they retire, with the option of work after retirement.

### **Accredited Social Health Activists**

*ASHAs are women trained as health educators and promoters in their communities as part of the National Rural Health Mission (NRHM) that began in 2005. Their tasks include motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning, treating basic illness and injury with first aid, keeping demographic records, and improving village sanitation. ASHAs are also a communication mechanism between the health-care system and the community served by it.*

**Sunita and Kiran Devi**, from an ASHA Workers Union in Haryana shared the exploitative conditions under which ASHAs work. ASHAs do not have fixed work times, and might have to go out at midnight for a delivery. They do not receive a salary but incentives after their tasks are fully completed, and they will, for instance, need to complete all antenatal care visits before being paid. They are required to fill out 9 registers, notwithstanding that in some cases ASHAs may not be literate. Their working conditions are not safe and they face conflict with co-health workers, the community and medical officials. In some cases they might not even get support from their families to continue their work.

One of the issues that arose was the contradiction between ANMs and ASHAs, wherein ASHAs have excessive dependence and reporting requirements towards ANMs. For instance, ASHAs appraisal will be dependent on the ANM she is reporting to, who is herself overworked and under pressure. Initially, there was a provision for an ASHA facilitator at every PHC, but this was abandoned due to budgetary constraints. However, both ANMs and AWW underscored the importance for ANMs and ASHAs to struggle together.

Sunita and Kiran also expressed the lack of motivation. When any program becomes successful, every official including ministers beat the drum and celebrate but nobody mentions the ASHAs based on whose labour these achievements can be made, they said.

After the formation of their union, working conditions have improved, and ASHAs are feeling more confident. The union demand is fixed work and fixed wages for ASHAs.

Adding to the discussion on health system privatisation, **A. R. Sindhu**, from CITU, noted that the government perceives Public Private Partnership (PPP) as the solution to any problem. The privatization agenda has been introduced into ICDS with the entry of corporate players. Recently, there was an agreement between Vedanta and government to construct 4,000 Anganwadi centers with an investment of Rs. 400 crores. Vedanta has tax money pending with the government, which could be utilized for public spending for health-care, she concluded.

Further, showing how privatisation and informalisation go hand in hand, **Rajeev Kumar**, from National Centre for Disease Control (NCDC), stated that even in a premier organization such as the NCDC (which does research on new emerging diseases like Ebola, Zika etc) privatization and outsourcing is rampant, despite the negative effects on quality of services. He denounced the strong nexus between the top level bureaucrats and private contractors. He also denounced the forgery going on in the name of insurance and Provident Funds. **Ram Kishan** shared that in response to an RTI about why contract work is used in Hospital facilities, the government responded that it is cost-effective and efficient. He and criticized this as a blatant lie.

Speaking of the systemic attack on labour laws, **Rajbala**, from the Satyawadi Raja Harish Chandra (SRHC) Hospital Hospital Workers Union in Narela, gave the instance of Gujarat where strikes in public utility services are prohibited. **Sandeep Singh**, from the Democratic Youth Federation of India in Haryana, pointed out that the government uses unemployment to break the unity of people. He gave the instance of the close to 18,000 annual graduates from ANM and General Nursing and Midwifery (GNM) courses in Haryana who find no job opportunities.

There was a shared feeling that there is a need for a broad based and united struggle. An illustration of the fragmentation of health sector unions was given by **Ram Kishan**, from the AIHEWC, who stated that 1270 memoranda have been submitted by health sector unions and that there are 1100 categories of workers in the health sector. **Sindhu** noted that despite the government trust in neo-liberal policies, people's movements have successfully fought for and secured the right to education, right to food and right to information, and stressed that these achievements were only possible because of unified efforts and social alliances. **GK Khurana**, from AIGNF and DNU, echoed the call for a united struggle that would bring unions together. Joining unions should be a major emphasis as only collective strength will succeed in pressurizing the government. **Ram Kishan** also stressed that when permanent nurses called for mass casual leave earlier this year, contract nurses supported them and this proved decisive in their impact. **Rajeev Kumar** also added that to break and challenge the nexus between government and corporates, a strong organization with mass public support is needed. Further, **Sandeep Singh** reminded participants about the junior doctors who went on strike in Haryana not for their salaries but to express people's anger and protest poor quality of services. He concluded that health union activists have a role to play as advocates for an adequate health systems and quality public services.

## Way Forward

**V Lakshmi**, from PSI, and **Ashim Roy**, from the New Trade Union Initiative, chaired the discussion and proposed three tracks of work for the way forward: *a union alliance* to address the problems and challenges of health workers in the public and the private sector, *a social alliance* between health workers and public health activists for strengthening the public health system; and *a national coordination* to engage with labour issues at the national level.

The participants discussed that India is seeing a fierce attack on the working class which is long standing and has increased in intensity with the current government. The 2 September strike is an expression of the coordinated response of the trade union movement to this attack. It was recognised that public sector workers, including health workers, have been patly insulated from this attack. As an instance, employment in the public sector is more formal than in the rest of the economy. Though the impacts are increasingly being felt in the public sector too. It was stressed that trade union activists need to remind the newer workforce that today's labour rights and entitlements were won through trade union struggles.

Informalisation has been driven by the intent to make space for the private sector in health-care, which has in turn fueled the fragmentation of the health workforce. In the process, trade unions lost bargaining strength, and the public sector is loosing its 'public ethos'. Public services are not simply services provided by government-owned facilities, but the expression of a responsibility of the government towards the public that is expressed through the provision of these services. Maintaining the public ethos is the core of the joint agenda of health union activists and public health activists.

It was recognised that despite that strengthening the health system requires strengthening its workforce, the public health movement has put most emphasis on the right to health and not enough on the right of health workers. The instance of the struggle to keep the Central Government Health Scheme (CGHS) in Pondicherry - which brought together patients, freedom fighters, Members of Parliament, along with trade unions and ultimately led the government to withdraw the decision to terminate this scheme, shows that social alliances are fundamental to win battles to strengthen the public health sector.

It was argued that in health organising, a national level approach is inadequate and organising should be intensified at the State level, with a national level coordination. In order to regain bargaining strength trade union density has to be increased, either within a facility or set of facilities brining all categories of workers together, or by brining one category of workers together across the State. In this process, reaching out to workers in private facilities will be fundamental.

The participants to the meeting decided on the following concrete outcomes:

- Trade union alliance: Create a working group on contract work in public and private hospitals;
- Social alliance: Develop a memorandum and signature campaign highlighting the link between informalisation of employment of the health workforce, weakening of public health institutions and weakening of the health system;
- National coordination: Take concrete steps towards a national coordination of health sector unions.

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**AGENDA**

<b>Day 1</b>	<b>Friday 22 April 2016</b>
10 am to 10.30 am	Session 1: <b>Welcome and Introduction</b> <i>Susana Barria, Public Services International (PSI)</i> <i>VR Raman, Jan Swasthya Abhiyan (JSA)</i>
10.30 am to 1 pm	Session 2: <b>Setting the Context: The Indian Health System and Challenges to People's Access to Healthcare</b> <i>Chair: Vandana Prasad, Public Health Resource Network (PHRN)</i> <ul style="list-style-type: none"> <li>• <i>Sakthivel Selvaraj, Public Health Foundation of India (PHFI)</i></li> <li>• <i>Imrana Qadeer, Council for Social Development (CSD)</i></li> <li>• <i>Rajiv Agarwal, Hospital Employees Union (HEU)</i></li> <li>• <i>Devaki Nambiar, JSA</i></li> </ul>
Lunch	
2pm to 4 pm	Session 3: <b>Informal Employment in Hospitals: Trends, Challenges and Demands</b> <i>Chair: CITU and HMS</i> <ul style="list-style-type: none"> <li>• <i>Nurses unions</i></li> <li>• <i>Technical staff unions</i></li> <li>• <i>Class IV employees unions</i></li> <li>• <i>Hospital specific unions</i></li> </ul>
4 pm to 5.30 pm	Session 4: <b>Frontline Health Workers: Challenges for Organising</b> <i>Chair: AICCTU and AIUTUC</i> <ul style="list-style-type: none"> <li>• <i>ANM unions</i></li> <li>• <i>ASHA unions</i></li> <li>• <i>Anganwadi workers unions</i></li> </ul>
<b>Day 2</b>	<b>Saturday 23 April 2016</b>
10 am	Summing up from the previous day: Rapporteur
10.30 am to 1 pm	Session 5: <b>Strategies for Organising Informal Workers in the Health Sector</b> <i>Chair: AITUC and IFTU</i>
Lunch	
2 to 4 pm	Session 7: <b>Way Forward</b> <i>Moderated by V Lakshmi, PSI, and Ashim Roy, NTUI</i>
4 pm	<b>Vote of Thanks:</b> <i>VR Raman, JSA</i>

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**PARTICIPANTS LIST**

<b>Participant Name</b>		<b>Name of the Union/Association/Federation</b>
1 Aatam Singh	M	All India United Trade Union Centre (AIUTUC)
2 Abhilash	M	La Via Campesina
3 Adsa Fatima	F	Jan Swasthya Abhiyan (JSA)
4 Alam Ashraf	M	Public Health Resource Network (PHRN)
5 Amarjeet Kaur	F	All India Trade Union Congress (AITUC)
6 Amitava Guha	M	Center of Indian Trade Unions (CITU)
7 Amrita Gupta	F	Jan Swasthya Abhiyan (JSA)
8 Ananya Basu	F	Society for Labour and Development (SLD)
9 Animesh Das	M	Indian Federation of Trade Unions (IFTU)
10 Anita Panwar	F	ASHA Workers Union Haryana
11 AR Sndhu	F	Center of Indian Trade Unions (CITU)
12 Aruna	F	All India Asha Workers Coordinating committee / CITU
13 Asha Devi	F	ASHA workers union, Mathura UP
14 Ashim Roy	M	New Trade Union Initiative (NTUI)
15 Azhar Ali Khan	M	Jamia Hamdard employees union / AITUC
16 B. Jayalakshmi	F	Karnataka State Government Employees Association (KSGEA)
17 Bhagirath Prasad	M	SRHC Hospital Workers Union group C&D
18 Bharat Pandita	M	Public Services International (PSI)
19 Bijoya Roy	F	Centre for Womens Development Studies (CWDS)
20 Chanahal Lata	F	CITV
21 Deepak Kumar	M	Center for Health and Social Justice (CHSJ)
22 Devaki Nambiar	F	Public Health Foundation of India (PHFI)
23 Dily Badwar	F	Nazareth Hospital Workers Union
24 G.K.Khurana	F	All India Government Nurses Federation (AIGNF)
25 Geeta Rani	F	All India Government Nurses Federation (AIGNF)
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