STATUS of STATES

Insights on health policy across India

Episode 3: Exploring Health and Healthcare in Gujarat

TRANSCRIPTION

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Vivek Divan:

This is Status of States, where we explore health and healthcare across India's diverse regions with a particular focus on policy, programs, and ground realities. The Indian Constitution lists public health as the responsibility of states. Join us as we speak with health experts from different states, understanding the unique contexts, challenges, and innovations shaping public health.

I'm Vivek Diwan, your host for this episode of Status of States, brought to you by the Center for Health Equity Law and Policy at the Indian Law Society in Pune.
Let's dive right in.

In this episode we explore the state of Gujarat. We're pleased to have Mirai Chatterjee from SEWA, the Self-Employed Women's Association, speaking with us today. SEWA is a national union that has organized 2.5 million informal women workers in India. In this context, it has provided work and income security, financial services, childcare, primary healthcare, and insurance, among many other support services.

Mirai's journey with SEWA began in 1984. She would become its General Secretary later, succeeding its founder Ela Bhatt. Today Mirai is the Director of SEWA's Social Security team, overseeing healthcare, childcare, and insurance. She is also the Chairperson of the SEWA Cooperative Federation, which consists of 110 cooperatives of informal women workers.

Mirai also serves as the Chairperson of a global network of informal workers and policy-makers called Women in Informal Employment: Globalizing and Organizing.

In the past she has been an advisor to the National Commission for Enterprises in the Unorganized Sector, a Commissioner in the World Health Organization's Commission on the Social Determinants of Health, and a member of the High-Level Expert Group on Universal Health Coverage set up by the Planning Commission of India in 2010. Currently, she serves on two Lancet Commissions: one on Oral Health and another on Re-Imagining Healthcare in India.

It's a pleasure to have you talk to us today, Mirai, on the state of health in Gujarat. I think it would be best to begin with asking you - describe the state of health in Gujarat, in broad terms. This could of course mean health in the context of healthcare, and it could also mean in relation to the social determinants of health.

Mirai Chatterjee:

Thanks Vivek. Thanks for inviting me to share some experiences and views. So the first thing I'd like to say is I think the state of health in Gujarat actually mirrors the state of health in our country, in India. And in that sense, the state of health in Gujarat is a microcosm of what we see in the rest of the country. And what do we see? We see inequities in health.

I work with women workers of the informal economy and their families, the poorest of Gujaratis, and so my experience is rooted in their experiences. Why do I say inequities? Because on one hand, we have very high quality healthcare. We have people coming from all over the world, private healthcare that I'm referring to, but also public healthcare.

The civil hospital in Ahmedabad caters to not just Gujaratis, but to our neighbouring states, Rajasthan, Madhya Pradesh, even from Maharashtra, people come. And what we hear from them is that they get quality services, of course they still have to pay out of pocket, even in the public health system. And of course, as we all know, in the private system, the payouts are so huge that people sell land, assets, and so on. So that's to just give a little bit of a snapshot on the health services, which is obviously not the same as the state of health.

Coming to the state of health, what we see are a couple of things, concerns. Well, maybe I should start by saying, since I've been a public health worker in my adopted home state of Gujarat for the last four decades, I have seen significant improvement. I must say that, particularly in primary healthcare, in the infrastructure, quality is a whole other ballgame. But overall, there has been forward movement. But having said that, going back to my point on inequity, health inequities, we see great differences. We work in tribal areas, and those are the poorest. Some of the tribal blocks in Gujarat like Dahod, like Poshina in North Gujarat as some of the poorest blocks in the country in a state that is widely considered to be a better off state. So in those states, what do we see? We still see malnutrition among children, among women, and it's not just in the tribal blocks and tribal states. And this is well known from the NFHS (National Family Health Survey) data as well and what we see anecdotally every day, that malnutrition is still a huge issue in our state. And in the tribal blocks I was referring to, we see much greater levels of malnutrition. So this is a concern among children and adolescents and women. And we also see high levels of anaemia. Again, this is not unusual for this state. But what's unusual is that this is a better off state. So we really should have done better in the last 40 years. And as is known, Gujarat is a state that has not invested as much as others like Tamil Nadu and Kerala in social indicators, in programs like healthcare and education. The budgets have always been limited, again, improving over time, but not near where it is required.

So coming back again to the state of health, apart from malnutrition, and of course, malnutrition is not just under nutrition. We are one of the states which has rising obesity and then all the other comorbidities that are associated with rising levels of obesity among children, among adults. And the other major issue we have are the non-communicable diseases. Gujarat is a state which has very high levels of diabetes. We see this among our members. Many of them have no idea that they have high levels of diabetes or high blood pressure, till unfortunately there's an event which may even be fatal. So non-communicable diseases, diabetes, heart disease, of course, cardiovascular disease and we also see cancers. There's a lot of, you know, paan masala chewing. So we do see oral cancer, breast cancer. And as I said, this mirrors also the rest of the country. But what we're also seeing now, and which is a great concern and something we're working on at the grassroots level, is increasing levels of mental health, stress, anxiety, and even more, depression, particularly during COVID, but even in the post-COVID period. Now, whether this is still a COVID effect, which is possible, or whether this was always there, but we're recognizing levels of mental health more particularly in women. Those are questions that remain to be answered by

researchers and others. And we are working with several people, like the BM Institute, like Sangath, and so on.

So those are the two things on health. But health, as we all know, and as you have rightly pointed out, is not just about disease and what are disease levels or nutrition levels. But it's also to be understood as including social determinants of health. So I think one of the things we saw, particularly during COVID and its aftermath, is that a lot of women's livelihoods in particular,and informal workers' livelihoods across the board really, well, crashed, if I may say so. They lost their livelihoods. In studies that we conducted, women said they had high levels of stress and anxiety because they couldn't go out to work and earn, they couldn't pay their children's school fees or buy their school books, et cetera. So I think coming to the social determinants of health, I've spoken about nutrition some, but I think livelihoods, I think it's not widely recognized as much as it should be that if we want to talk about reducing poverty, if we want to talk about improving the health of people in Gujarat and our fellow citizens in the rest of the country, then livelihoods and employment are absolutely critical. You don't have money for food, for medicines, for education, as I've already said, then how are you ever going to come out of poverty, how are you ever going to dream of a better state of health or health and nutrition status? So these are some of the things we see.

Water and sanitation issues are also there, so much inextricably linked to public health and health and state of health in general. Here again, there are some improvements, particularly in cities like Surat, Ahmedabad, Baroda, and we have been working actively with the municipal corporations of these cities. But what of the smaller towns and the rural areas? Garbage collection is a huge problem, you know, waste disposal. So there are huge challenges still on the social determinants of health.

During the Commission on the Social Determinants of Health, early childhood was one that we identified as a critical factor, and one that at SEWA has been, it has been close to our hearts because as we organize informal women workers, the first thing they say is, we want a better future for our children. Do something about that. We can't go out to work if we don't have childcare. And it's not just for women's empowerment and income generation or capacity to earn, but it's also for the wellbeing of our young children. And one campaign that we have been taking up and still have a way to go, is for full day early childhood care. And I believe very strongly that in the state of Gujarat, if we have full day early childhood care, where children are taken care of the whole day while their parents are out at work, and are fed, like the midday meal, not just one hot meal, but throughout the day and then have early childhood education, stimulation, and then of course regular checkups, which is happening, but this kind of holistic approach, then I feel very strongly we'll also be able to tackle the malnutrition issue, at least to a greater extent than is the case now. We will see reduction in wasting and stunting, for example.

So these are some of the things that we see on the ground. There's still gaps. One of the major gaps, again something we're working on with the National Institute of Occupational Health (NIOH) , is that informal workers' occupational health, work -related health status, is really not even on the radar. It's not even part of comprehensive primary health, yet somewhere in the list, but way down. And, you know, informal workers' lives are defined by their constant quest for work and livelihood. So this is a major gap. How can we even think of the state of health, if we don't even pay attention to workers' health. So these are some of

the things I would say. But all in all, again, from the perspective of someone who has been working at the grassroots on public health for the last 40 years, I do see forward movement, whether it's in immunization, digitization. Now, many of the ASHAs and Anganwadi workers and our own health workers and agyavans, as we call them in Gujarati, are grassroots women leaders, they are tech savvy and they are much more aware than the earlier generations.

We are among the third and fourth generation of SEWA members. And it's not just SEWA members, even other frontline workers at the grassroots. So I think there are lots of positive signs, but no doubt we have a long way to go yet. And I haven't even touched on the issue of quality.

Vivek Divan:

Okay, there's a lot to chew on there. Mirai, I'd like to know a bit more about a few things you mentioned. You spoke about the issue of livelihoods. I was wondering - what is the effectiveness of implementation of social sector legislations like NREGA in Gujarat to respond to this issue?

Mirai Chatterjee:

So, Gujarat is a state of contrast, as you may be aware. So, in some areas, like the peri-urban areas and also, you know, like Ahmedabad district, Mehsana district, these are all areas which have quite a lot of industry, particularly the pharma and other types of industry, you know, textile and so on, and there is employment, but it's precarious employment.

The other areas that I was referring to, particularly the tribal areas, parts of Saurashtra, which are the poorer parts of our state, there, MNREGA is made use of, if I may use that. I mean, our members and others also do start working on sites or in the case of tribal areas, they can also work on their own lands that's permissible. But they do that for, of course, a handful of months of the year. But when I say precarious, you know, it's still the mass of workers and the informal economy. They are street vendors and in the urban areas, of course, all street vending came under severe restriction during COVID. But even after that, it's taken a long time to recover. And in the new beautification of our towns and cities, somehow street vendors find little or no place. So here is a group of people, I always feel particularly incensed about this, who are not asking anything from the state, except as we say, 'do tokari ni jagya', two basket works of space in the market, and even that they are denied. Of course, during COVID there were those loans, 10,000 rupee loans for street vendors and many of them did avail of that. So it's not all a dismal scenario. But what they want is space in urban planning. I'm just giving you one example.

Then of course, the mass of Gujarati citizens are still farmers and there are a whole lot of issues to do with that, particularly now we see with climate change in the last couple of years, agriculture has even become more precarious. So they can no longer depend on that livelihood. Many of the women farmers come to the cities and have become domestic workers. So I'm just saying that the precarity of life, their work, their livelihoods has increased, I believe, particularly since COVID. And what we hear from our members, or all

informal workers as you know, but even others is that even after COVID, it was men who were able to get back to work. But it's been a struggle for women to get back to work for a whole host of reasons. A lot of the work that was available to them just folded up. They also got back to work much later because the schools didn't open, the Anganwadis didn't open, so you know. They were still at home for much longer than the menfolk. So these are some of the issues. And of course, maybe I needed to clarify that livelihood for the mass of Indian citizens, including in Gujarat, is the lifeline to survival. You have work and income. That's what we hear all the time. 'mane kam apo', give us some work so that we can feed our kids and have a better future for them and better health too. I hope that answers your question.

Vivek Divan:

Yes, absolutely. It certainly gives some idea to us in the short time we have about precarity. But I'm also curious then, what does a program like, for instance, the PMJAY (Pradhan Mantri Jan Arogya Yojana) or you have these state level programs, the Mukhyamantri Amrutam Yojana, so health related insurance schemes, for people in precarity, do they come to the help of people seeking to access the health system?

Mirai Chatterjee:

Indeed, they do, and these programs have been very popular, widely appreciated. But having said that, I must say that not just for PMJ, Pradhan Mantri, Janarogya Yojana and other Yojanas of our state, what we have learned all these years is that a lot of support and handholding is required to not only access these programs in terms of enrollment, but also to navigate all the processes, particularly the documentation. Somehow in our country, we are so much focused on this document, that document, whatever the Supreme Court says, Aadhaar card is required.

You'll be surprised to know that a lot of our time goes helping our members and others to obtain Aadhaar cards. Because without an Aadhaar card, you know, so many of the schemes you cannot access. There are all these micro level issues, which I wonder whether policy makers in New Delhi have a handle on or maybe they don't know about them. Even things like names, names change. When women get married, the names change and they don't match on the Aadhaar card, or the ration card then it means several trips to change all this. So, yes, they have access to these schemes, but with a lot of support and hand-holding. And that's something we have been saying to the government of Gujarat.

We have set up what we call SEWA Shakti Kendras, wherever our members are, which are basically hubs for information on all these schemes and entitlements and services. And also we help our members, we have agyavans, the local women leaders who are trained in all these schemes and what's required, what's not required. And they help women and their families access all these entitlements in a transparent manner without any graft or greasing anybody's palms. So yes, those have gone well. And of course it's win-win because the government folks, local authorities also are pleased because these are hubs where they can come then and immunize kids, discuss with women, disperse certain entitlements.

We've been saying that this kind of decentralised approach, taking the schemes to people rather than people running around trying to access schemes is what really works for local people.

Vivek Divan:

I want to come back to that actually in a second about the role of government. But while we're on the initiatives that SEWA has taken like the Shakti Kendra as you mentioned, could you tell us a little bit about the work that SEWA does with women in the informal sector historically and what's the essence of SEWA's efforts, especially in the recent past as it relates to health?

Mirai Chatterjee:

Sure, I'd be happy to. As you may know, SEWA, the Self -Employed Women's Association, now a 52 -year -old organisation, is registered as a trade union and it grew out of the labour movement in Gujarat. Actually, the labour movement was led by Mahatma Gandhi and Anusyabehn Sarabhai many, many years ago before even our independence.

So we are continuing in that tradition, the tradition of organizing, which is bringing workers of all castes, communities, religions together, building the solidarity and the sisterhood, and supporting them to create their own membership-based organizations, democratic organizations like unions and cooperatives, and other collective forms which are based on cooperatives principles and solidarity principles. And so a lot of our work has focused on what ElaBen Bhatt, our late founder, called full employment, which we see as a composite concept, actually a social determinants concept, if I may say so, which is work and income security, food security, and social security. So full employment in our experience from the ground, If we want people to come out of poverty, has to include these four. Not one before the other. All simultaneously.

Work and income security, food security, and social security. And by social security in SEWA's experience, we mean at least healthcare, childcare, insurance, pension, and housing with basic amenities, like at least a tap and toilet in every home. And then of course, a source of energy, electricity, solar, and so on.

So in our experience, if at the micro level, at the household level, families, workers have access to this full employment, then they can come out of poverty and move towards self-reliance, both financially speaking and also in terms of autonomous decision making and control, which is of course especially important for women. So you could say social determinants of health is wired into our DNA because we have seen that this comprehensive integrated approach is what leads to women's economic empowerment. So because our health work and more broadly our social security, social protection work is embedded in the SEWA ethos of organizing, our approach from the beginning has not been to set up hospitals and clinics, but rather to organize women around health issues and use our collective strength to make sure that services actually reach where they are supposed to reach. All families, no exclusion, all inclusion, clearly the poorest and most vulnerable like Dalits and

Adivasis and other working class communities. And also to throw up new ideas based on what are the needs and demands of our members.

I mentioned occupational health, mentioned mental health. I remember once we took up an issue with the Health Commissioner of Gujarat on the prolapse of the uterus. You know, the government has traditionally been so focused, the Indian government and Gujarat government, on controlling women's fertility that they forgot to look at those who are unable to have children or who have other kinds of issues, including prolapse. So when we brought this to the attention of the Health Commissioner of Gujarat, to his credit, immediately he took action. And those women also got operated on and so on and so forth.

So it's both the organizing approach, using our collective strength as a union to make sure that last-mile delivery happens in a transparent and fair manner without greasing anyone's palms, without, you know, chai-pani, those kinds of things. But also coming up with creative workable solutions which we learn from the ground, and that includes setting up of a health cooperative, which I believe is the first of its kind in our country, which is Lok Swasthya SEWA, which I've been very privileged to be a part of from its very inception, and this cooperative provides primary healthcare, rather fills in the gaps. They don't duplicate, but for example, health literacy is a major gap, health education is a major gap. Bringing up occupational health and mental health issues is a major gap. So we tried to demonstrate on the ground how actually this can be done. Then I mentioned the SEWA Shakti Kendras. We have all these yojanas, how to improve access, how to make the life of our sisters, SEWA sisters and other informal workers easier by reducing the number of trips for documentation of this and that.

So those are some of the approaches that we've taken. Our health cooperative also runs a chain of low-cost pharmacies, which then brings up revenues, which then we use for non-revenue work like health literacy. We also, from the modest profits of our chain of low-cost pharmacies, have an Ayurvedic business, which, thanks to the government's current focus on AYUSH, is doing very well. And that further supports, as I said, the non-revenue stream of our primary healthcare work. And of course, we also work on childcare. We have a childcare cooperative which provides early childhood care, an insurance cooperative, again, and both of these are also first of their kind.

So we try to take care of all the bases that are important to the lives of poor women in our country and in Gujarat, and of course, our efforts are not limited to Gujarat. Now, learning from the Gujarat experience, our sisters in Madhya Pradesh, Bihar, and in another total of 18 states, some of our health work and lessons, of course, they adapt and tweak, are being carried across the country. But as far as Gujarat is concerned, just to recap, working on primary healthcare with women and children's health in the centre, and with an informal worker lens, so the occupational part is not left out. Then also working on nutrition. These SEWA shakti kendras I mentioned are very active in making sure that our members get the entitlements that are their due under PDS (Public Distribution System), otherwise what will they eat. Childcare I've already spoken about and another effort we are engaged in, experimental effort, the government of Gujarat in two tribal areas is to see what happens if you extend the hours of ICDS (Integrated Child Development Scheme) so that women can go out to work? What would be the impact of that? What's the impact of that on children, on malnutrition? And we're seeing good results and good partnership, I must say, with the

government of Gujarat, local authorities. And we're going to scale it up. They want us to scale it up, the other Anganwadis. Of course, we can't run all the Anganwadis of Gujarat, but we could show what is possible, which is actually very much part of our approach.

And now we have in SEWA an entire organization called Mahila Housing SEWA with engineers and other technical experts who are focused just on water and sanitation and housing issues. So all of these different streams work in tandem. All of these are the social determinants, but the bedrock is organizing. Because what we have learned all these years is without collective strength and bargaining power, we are nowhere. And it's that collective strength and bargaining power and building a grassroots movement of informal women workers that has given them voice, representation, visibility and validity, not only in health, but in all spheres of their lives.

Vivek Divan:

Frankly, I'll tell you, it's really inspiring to listen to this because the idea of collectivization and this sort of bottom-up description you've given is an aspect which resonates so much with me. I've been part of in a much smaller kind of more modest ways movements and I think there's so much strength in the way you've described how things emerged and how they've actually had impact. I do want to ask though about scale. What is the scale at which SEWS does the work it does? And like you mentioned, you can't do the work for all Anganwadis, et cetera, in Gujarat. But what is then the actual need in Gujarat which really needs to sort of multiply SEWA's efforts?

Mirai Chatterjee:

Your question is a good one and we get asked about it a lot in general about SEWA's work, but also our health and social protection work. And you know we started out by, if I speak of our primary healthcare work 40 years ago, providing services in a situation where as you know there were almost none. I mean there were some mother and child, maternal and child care services. The kind of comprehensive primary healthcare that we see under the National Health Mission, both at the centre and in Gujarat, was just not there.

I think that's a major change and, just diverting for a second, but I think for me with a real aha moment and an inspiring moment was the Cairo Conference. And I think that was a major game changer, even for India, and that led to the NRHM, the National Rural Health Mission, National Health Mission, and so on and so forth.

Now, coming back to scaling, you know, we are an organization and a movement, so scaling for us is very important. I mean, the numbers are important, not just simply grabbing women and saying, 'let's become a member', not that way, but really understanding the values, the ethics, principles behind the movement, why we organize for voice and representation, why it is the working class women who are the agyavans, the local leaders, how to build their capacity, those kinds of issues. And by the way, all this takes time. It takes time, it takes resources, both financial and human. And as I said earlier, we are not the government of India or the government of Gujarat even. But what we can do is to show how this can be done. So apart from increasing our membership, which is a scaling, I think our approach to

scaling up has been more like, see, these are some basic principles. This is what has worked. And perhaps with tweaking in other states to local contexts, these basic principles can be applied.

What are these basic principles? They are organizing, first of all, to build collective strength, because we don't believe you can improve people's health unless people are organized and united and you build solidarity in communities. And we've seen that once that is there, what impact happens in COVID and beyond. So that's the first thing, principle.

The second principle is having faith in local people so that you entrust local people to take care of their own health. And the government is the facilitator, the stewardship, the investor, but you leave it to local people's good sense. They know what they want. They know their priorities. They know their needs. And they'll speak up if you give them an opportunity, if you give them voice and representation. So the second principle, if you will, is this bottom-up approach where people themselves take charge of their own health. And I must say, this is also very much connected to the way Gandhiji saw things. He didn't think that it's just up to the government to do everything. And we know now from our country that the government can do a lot, but they also have their limitations. And we have faith in local people. So we feel that scaling up should, and can happen if local people take charge. But then you have to put your faith in them, which I'm afraid is not the case. Many government authorities understand, and many are like, 'nahi, nahi (no-no), what do they know? They're illiterate people.'
So our scaling up is, I think, more culling out the lessons and encouraging others to do the organizing in their own way, in their own states, in their own districts in Gujarat. One size does not fit all. So it's not copying or replication in that sense, but scaling up through encouraging others to also take up this kind of work, and also sharing the lessons with the government so that we don't keep on making the same mistakes.

I remember saying to the government when they started the Rashtriya Swasthya Bima Yojana (RSBY), which by the way was modelled on VimoSEWA, SEWA's insurance cooperative. So this is how the scaling up happens. We had the labour department come, they spent several days with us, understood. One of the essential elements they left out, which is educating people on what is RSBY, how do you get enrolled, all that hand-holding that I spoke of earlier in the context of SEWA Shakti Kendras, that was left out. You know, and we told them and told them and told them that they just wouldn't. And so as a result, that program had limited outreach. People simply didn't know what is going on and what is this program. And the same with PMJAY. We have been telling the authorities that you must also have much more. And it's not just putting ads on television or billboards. You have to do the hard work of going door to door, village to village, mohalla to mohalla. So scaling up through the government, through encouraging others to chart their own path based on some basic principles- Women, work, peace, faith in local people, are also some of the ways that we are scaling up.

Vivek Divan:

Listening to you, I'm getting a sense that at some level this is inherently the effort of communities, right? I mean, at a fundamental level, while one can try and advocate for change within bureaucratic systems, etc., it has to lie within communities to put the pressure

on governments to actually deliver services, change systems, and be more receptive to the needs of people. I'm also wondering then what is the role of government in issues like you mentioned earlier, you know, water and sanitation is improved in larger cities in Gujarat, but in smaller towns it remains a challenge. Garbage collection is a big issue with increased urbanization.

What do you think are the capacities of government to actually kind of respond to this? And do you see, you know, the role of civil society in educating the government on what they've learned even outside what you've described that SEWA does in terms of issues like water, sanitation, etc.

Mirai Chatterjee:

So you're absolutely right. You very much understood what I was saying, Vivek. And in no way am I saying the government doesn't have a role. Coming to the health sector, I think the government has a role to invest much more. Many of us have been hanging on the doors of government, the last government, this government. Well, this kind of investment in health, and when I say health, I mean, you know, health and its social determinants. The levels we have, clearly inadequate. And some states just don't have the resources. So there's that issue too, particularly the poorer states. And we all know that. And secondly, stewardship. Government has to take the lead on policy, laws, and be an enabler.

But I think finally we have to leave it up to the states. I mean, health is a state subject, as I said, to tweak some of these policies, to give them more space and leeway to innovate, experiment. And then from the states like the state of Gujarat, I would say that we would as SEWA demand that you work more closely with us. Wherever we work closely, it has worked. I mentioned the case of the ICDS where we are working closely with local authorities, local district authorities. And it's been really enriching for both, because the government is never going to have the kind of reach that civil society, that the SEWAs, that the cooperatives and the unions and others have and the faith and trust they enjoy. Sometimes they may, but oftentimes they don't. There's a mistrust, particularly in the poorest and most vulnerable communities like the tribal communities of India. So that's where we can come in.

We partner, it's their resources, but we can show how it can be done, and it can be done in an inclusive and participatory manner, in a manner that strengthens the democracy of our country and that leaves no one behind. So that's where we come in. And particularly, speaking of SEWA, other civil society too, I guess. How women can be in the lead. Because again and again we see when women are in the lead, whether it's for livelihood, whether it's for childcare, whether it's for the health and well-being of their communities, they're second to none. They really bloom, they really do well, they make sure no one is left behind. And, you know, it was really touching to see this during COVID also.

So these are things that we as civil society can bring to the table. But unfortunately, you know, gaps remain as we are all well aware between the government and civil society. One example I remember from 10 years ago, when we were trying to bring tuberculosis care and control and services to the community, And we said, rather than waiting for TB patients to

come to the hospital, let's take the lab, let's take the services right where they are. It took two years for us to convince the government at that time. More than 10 years ago, I think 15 or maybe even 20 years ago this was.

The World Health Organization was convinced, everybody was convinced. But anyway, we waited and after those two years, there was such a fruitful partnership and now that model has been mainstreamed by the Ahmedabad Municipal Corporation because they saw that there was greater case holding and better results as per WHO standards. So there's a lot to be gained from each other and also working together at the grassroots, particularly with local authorities, local public authorities. What do I mean? I mean the medical officers, the nurses, CDHOs (Chief District Health Officer), the in-charges of the district, the block health incharges has been really a win-win experience. We have learned a lot. And what they tell us is that, they wouldn't have been able to do a lot without this kind of support. But they have to be based on mutual trust, respect, and it takes time as it does in building any relationship and partnership.

Vivek Divan:

Right. I imagine that this is a constant effort for SEWA and other civil society groups because the bureaucracy is constantly changing. It’s never-ending at some level because it's not like you're going to get a new administration at the block level which is suddenly attuned to issues of gender or caste or inequality etc.

I'm curious about the issue of documentation that you mentioned. Surely this is something the authorities understand as a huge obstacle for people to smoothly access services, especially health insurance. Do you see any change around this issue?

And on that note, you mentioned the issue of holistic full-day childcare and the huge gap responding to occupational health of informal workers. Are you seeing any momentum towards change on these aspects? Or are these early days in terms of convincing government or policymakers to respond to these needs?

Mirai Chatterjee:

I just wanted to say one more thing on working with the government and the issue of partnerships is that one thing that we found useful is the use of various platforms for community action and engagement like Gram Sabhas, earlier women were not attending Gram Sabhas at all. So, you know, we organized women in SEWA and now in large numbers they attend, they put up their health demands and so on over there. And we also get the local health authorities and other development authorities to come and speak at the Gram Sabhas, Mohalla Sabhas, then Jan Samvad and all that. And all of that builds dialogue and trust. Slowly, slowly, but it happens.

And linked with the documentation issue, in these kinds of open forums where issues and grievances are raised with the authorities present listening, noting down things. One of the things that comes up is documentation. And I'm afraid we have a long way to go as far as reducing documentation and streamlining and making it easier.

Digitalization has helped to some extent, but I feel like the whole system is predicated on mistrust. We don't trust our own citizens, you know. It's like they're going to game the system. They're going to cheat. So we have to create all these hurdles before they actually get the services and entitlements that are their due.

So one of the things in these Jan Samvads and dialogues that we have at local level, then also revitalizing the village health sanitation committees, and the Urban Mahila Arogya Samiti, Rogi Kalyan Samiti, all these platforms that are created under NHM, National Health Mission, is that we have these officers there and we tell them, you know, look, these are the barriers. You also want to show results. We want to make sure the entitlements reach. Let's work it out. Why do we have to go round and round and round like this? Why so many trips to the Taluka office? 'Dhakka khavanu', as our members say. You know, again and again going there, wasting time and money.

I remember one woman, I met a woman in a village. I've even written about her, Jaya Ben. It took her two years to change the name on her Aadhaar card. And then also it had to match with her ration card so that she started getting her old age pension. Cost two years. And the reason was that she didn't have the death certificate of her husband. So that's required. Of course, now people are more savvy, but you don't think of all these things. Her husband passed away 40 years ago. She was a young widow. She was hardly in a position to run around getting death certificates. And the only reason we were able to help her was miraculously, she recalled that there was a child who was born on the same day in her village that her husband died. So we were able to use that now grown adult man's birth certificate to kind of do an affidavit, which of course means more money, more legal fees, so that she could state that this is the date my husband died.

I'm just giving you one example. There are hundreds of these, thousands that we see over the years. Why can't we make it simple for people? Put the checks and balances? But why do we give poor people such a runaround?

Now coming to the childcare issue. I think we've made headway on that. And that's not just because of SEWA, it's because, when Elaben chaired the Shram Shakti Commission, the Commission on Informal Workers and Self -Employed Workers, and came out with a seminal Shram Shakti report way back in 1988, one of the strong recommendations was full-day childcare. It's not a new issue. It's not some eureka moment that we've had. We've been with this issue for a long, long time, and Elaben and others, and SEWA was a founder of a national network called Forces, which has been pushing for full day early childhood care. And some states have, as a result, I think of this grassroot push, extended the hours like Tamil Nadu, Kerala, to some extent in Odisha and so on. Haryana is also coming up with new models. But we still have a way to go.

When I say we have ways to go, the major issue is investment. No, it's not a huge investment. We've documented that it's maybe about 20-25,000 rupees more per month per ICDS center. That's not a huge ask. So these are the kinds of things we're taking to NITI Aayog and hopefully to the new Minister of Women and Child and Labor. I'm quite satisfied with this journey. But as far as occupational health is concerned, I think we have a long way to go.

You know, a lot of it is to do with leadership, presenting the evidence, who presents the evidence. Many a time, even though SEWA has evidence, they feel we are not an objective party, which we are not. We never said we were, but we have credible evidence. But for example, currently, the current director of the National Institute of Occupational Health (NIOH) is very keen to join hands. And there have been several people over the years like this, directors in the NIOH and ICMR.

We're keen to join hands and keen to make a difference. In fact, even as we speak, we've just started a joint program with the National Institute of Occupational Health to work together to generate evidence on work-related health and to see how it can be integrated into comprehensive primary healthcare under the National Health Mission. So for occupational health, we have a way to go.

Vivek Divan:

Oh but that's really hopeful to hear because as a lawyer I've looked at the issue of occupational health and you know very recently the labour courts were amended during COVID and unfortunately they were pretty much a copy-paste job of what existed all these years so there's such lacunae in the law as far as I can tell on these issues that I'm glad that there's some momentum. It takes me to another question and I'm probably winding up shortly. The question of law.

What do you see the role of law being in the context of some of the work you've described, some of the issues and demands that you've spoken about and some of the aspects of participation and empowerment that you've also alluded to?

I'm curious in the context of every state really, but also in the context of Gujarat, whether some of this is framed as a right to health or a right to livelihoods, etc. And is it from that sort of framework that there is a receptivity from the government or that there is a better ability of civil society and communities to organize?

Mirai Chatterjee:

Thanks, Vivek. And at the outset, I should say, I'm quite ambivalent about the law. We have had very mixed experiences with the law, and that may not sound good to a lawyer. And why I say that is, you know, who could say no to a right to health? Obviously, as a union, as an organization that works for workers' rights and people's rights more generally, we are strongly supportive of the right to help. But we've also seen that the law becomes in some ways like a toothless tiger if it's not implemented, if there's no pressure from unions, cooperatives, grassroots groups, and civil society to actually make it work. And it's, as you had earlier remarked, not a one-time thing. It's a constant continuous pressure from below. And why do I say this? You know, we worked so hard. It took us 40 years, a campaign of street vendors, and a proud moment when the Indian Parliament passed the street vendors law. That was in 2014, just before the elections and the current government came in. But still, town-vending committees have not been set up, as you may be aware.

We have the law which has set a standard which we are proud of and the law helps us set basic standards and enshrine our rights. But then what? I feel like the same thing with the Unorganized Sector Social Security Act (2008). So many of us unions got together and pushed for that. Few schemes have come out of that. But social protection is a right for all informal workers. Still far from that. So I think it's a mixed bag. That's why I say I'm ambivalent.

Obviously, we support the right to health, the right to work, these kinds of rights. Elaben had also brought that up long ago. But you know, we have to create the pressure so that there's political will to implement this. And of course, some states do. We do see that in some states. I know that the Rajasthan government has the right to health, but we also saw what happens. It's usually these vested interests who then you know, try to nix everything. We saw the same here in Gujarat. The government, the assembly wanted to pass the Clinical Establishments Act. And you know, the doctors and their associations basically killed it. They said, this is Nazi, if you please.

So I think people's groups, movements have to come together and really stand firm. And the farmers movement showed us what that means. It means sacrifice. It means being there for the long haul. It means a marathon. It means good strategies, and it means resources, both financial and human. These are not easy things. But of course, you know, we are proud of our constitution. We are proud of the laws of this land. And they also give us hope. We still have a lot to do to make them truly workable on the ground and make them a reality for the mass of Gujaratis and Indian citizens

Vivek Divan:

Okay, Mirai, thank you so much for those incredible insights. I certainly learned so much just listening to you. But I am left wanting more, with so much more there to unpack. Your skepticism of the law is something that does exist in myself as a lawyer too, but I do see the value of having a legal framework, based on which one can mobilize.

I also greatly appreciate your remarks on the guiding principles of democracy and the Constitution. What I'm left with is the fact that SEWA's model, like you mentioned earlier, is being used elsewhere by informal workers and women's collectives and others. And I'm hopeful that these collective forces really create change within systems, be they health or other aspects of governance. Thank you so much for your time and more strength to the work.

Mirai Chatterjee:

Thank you very much, most welcome. And I hope these words and experiences will be of some use to others.

Vivek Divan:

Thanks for joining us for this episode of Status of States. Stay tuned for more such conversations. This is your host, Vivek Divan, signing off.