Non-Standard Work in the Healthcare Sector in South Asia

INFORMALISATION OF WORK

A REGIONAL OVERVIEW

Ananya Basu

Public Services International, South Asia

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Author: Ananya Basu

Ananya Basu is a researcher with experience in working with rural women's collectives. She is interested in highlighting the gendered dimension of the areas of work she is involved in. She is interested in exploring the role played by the body and sexuality in areas of labour, agriculture, migration and society at large.

This booklet series was made possible thanks to the support of FNV Mondiaal of Netherlands.

First Published, December 2016

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Published by

Public Services International, South Asia
61, I block, sector 10, Faridabad - 121006, Haryana, India
Phone: +91 (0) 129 2261175,
mail: kannan.raman@world-psi.org and susana.barria@world-psi.org

Public Services International
45 Avenue Voltaire, BP 9, 01211 Ferney-Voltaire Cedex, France
Phone: +33 (0) 450 40 64 64, mail: psi@world-psi.org, website: www.world-psi.org

Edited, designed and printed by

Registered Office:
139, Richmond Road, Bangalore - 560025
Executive Office: R7 Hauz Khas Enclave, New Delhi 110017
Phone: +91-11-40640516, Telefax: +91-80-25586284
e-mail: bfc@booksforchange.info

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NON-STANDARD WORK IN THE HEALTHCARE SECTOR IN SOUTH ASIA

The current set of publications under this series include the following:

Informalisation of Work: A Regional Overview covering the trends in informalisation of employment in the public healthcare sector in India, Nepal and Sri Lanka.

Informalisation and Trade Union Movement: A Case Study of Delhi exploring the evolution of the trade union movement in the sector against the backdrop of the continuous neglect of the public health sector.

Non-Standard Work and Quality of Healthcare Services providing a framework to understand the multiple paths through which growing informalisation of employment leads to the deterioration of the quality of services in the public healthcare sector, giving a stern warning against leaving this practice unchecked.

Informalisation of Work and Quality of Healthcare Services: A pilot study in Delhi, which delves into the experience of informalised workers in key public facilities in Delhi to give a compelling insight into the negative impacts of this practice for workers, and open avenues to think and understand how this in turn affects the institutions they work in and the health system more broadly.

Investing in Health: The Emergence of Healthcare Corporates in South Asia which provides a mapping of the nature of the private sector in Bangladesh, India, Nepal and Sri Lanka and its sources of financing.

Employment in Healthcare MNCs: A Case Study of Apollo Hospital, Dhaka which gives a compelling narrative of the exploitative working conditions in the sector, even amongst the most profitable companies in the sector.

Preface

Informalisation of Work: A Regional Overview reveals that the expansion of the private sector in the provision of health-care services and the penetration and normalisation of non-standard forms of employment in the public heath care facilities follow a parallel path of development. In Sri Lanka, where the health system remains dominated by the public sector, informalisation is least entrenched. While in Nepal, where the private sector domination has been established for the longest time, non-standard employment is the norm across institutions and across job categories, including clinical jobs. In India, the picture varies across States as both health-care and labour are legislated by the State administration. In addition, the progression of non-standard employment is also influenced by the level of financial constraint faced by the specific administration in charge of a set of facilities, thus the facilities under the Central ministries are less affected by informalisation than those under the State and Municipal administrations. Yet, the general trend seems to remain consistent in India as well.

While the initial arguments for introducing non-standard forms of employment were of the nature that this would allow ensuring that services remain uninterrupted, or that cutting costs would ensure the efficiency and strengthening of existing services, it appears instead that informalisation of employment is but one more piece in the process of weakening of public health-care institutions and therefore of the role of the public sector in a country's health system.

Thus, informalisation of employment lies at the intersection of the neglect of public health-care facilities (and therefore of compromising access to health-care services for the majority) and the attack on workers and their trade unions. While the manifestation of the challenges facing the health movement and the trade union movement are different and might, sometimes, even seem contradictory sometimes - for instance, when the challenge of providing quality public services might manifest in the form of a contradiction between health care providers and patients, but the roots for both lie in the neglect of and attack on public health-care facilities.

Informalisation increases the burden of work, creates a non-conducive environment that compromises the ability of workers to have a decent life and provide quality services. This also compromises the possibility of workers holding the institutions where they work (their principal employer) responsible for effective service delivery. and as workers are denied the accountability of the institution where they work (their principal employer) to their rights, the accountability of workers to the institution were they work is also compromised quality services. This also compromises the possibility of workers holding the institutions where they work (their principal employer) responsible for effective service delivery. Further, this weakens workers organisations as informalisation divides the workforce, pitches workers against each other: contract workers against permanent workers, professional occupations against non-professional occupations, etc. In such situations, the role of trade unions as social partners in the sector is very much stunted. Trade unions' roles are not limited to maintaining or improving working conditions and ensuring adequate remuneration. trade unions are not able to play their complete role. Because we believe that trade unions' role is not limited to maintaining or improving working conditions. These also include advocacy for the rights of the communities they belong to, or, like in this case, the rights of the communities they serve.

Susana Barria
Public Services International

CHAPTER 1

INTRODUCTION

The Alma-Ata Declaration of 1978, which 'identified primary healthcare as the key to the attainment of the goal of Health for All',[1] was an important step in reinforcing the role of governments in the provision of primary healthcare. This declaration came in the then existing environment of economic reforms, based on the World Bank's Structural Adjustment Programmes (SAP), which were underway in developing countries. However, the economic interventions in developing countries, led by the World Bank and International Monetary Fund, saw a significant restructuring of the health sector in these countries, with an increase in private sector participation in health service provisioning.

In countries like India and Nepal, the reforms in the health sector have concentrated mostly on cost- cutting measures by the government, thereby gradually reducing government health expenditure and, over time, making way for private sector interventions. The stake of the government has been withdrawn significantly and private interests have taken over the provisioning of health services. This has not only had a negative impact on the adequacy of healthcare services (due to lack of accountability) and led to a rise in the out-of-pocket costs, but it has also caused changes in the nature of the labour force employed in the health sector as the combination of budget cuts and private sector participation has resulted in the haphazard growth of employment forms that are not the norm in the public sector. In Sri Lanka, although the economic reforms did not affect the public health system in as harsh a manner, the slow but gradual growing of a parallel private health sector has created a significant cadre of informal workers. The informalization of the health sector labour force has had a negative impact on the quality of healthcare delivery.

Consequently, labour unions that have in the past successfully organized public healthcare workers to fight for their rights have, in the face of this shift in the

1 'WHO Called to Return to the Declaration of Alma-Alta.' http://www.who.int/social_determinants/tools/multimedia/alma_ata/en.

nature of employment, had to change strategies and respond to the challenges of a growing non-permanent workforce even within the public sector. The current study attempts to document the different forms of non-standard employment existing in Nepal, India and Sri Lanka and to also examine trade union responses to this growing phenomenon. It is hoped that this brief overview will point the way to further analysis.

For Sri Lanka and Nepal the details have been gathered from data collected at two workshops organized by Public Services International (PSI) at Galle on 28th-29th December, 2015 and Kathmandu on 22nd-23rd December, 2015, respectively. Further interviews and informal discussions were held with trade union representatives to corroborate the data. Most unions present at these workshops were organized on a national level; however, participants were mostly from Galle, Colombo and Kathmandu and therefore much of the information on challenges and specific details are restricted to these three cities. In India, the study was located in a single state, the Union Territory of Delhi. This is as, the administrative structure is complex as hospitals are spread across public and private sector, and in the public sector come under central, state and municipal administration. In addition, in India both labour and health are state subjects; therefore, the study aims to capture the specific dynamic at the state level. The data was gathered through unstructured interviews with trade union representatives and from a workshop organized by PSI in New Delhi on 22nd -23rd April, 2016. Additionally for all three countries the data was supplemented by secondary literature review.

This report summarizes the findings of a more extensive study by the same author. It is divided into five chapters. Chapter 1 is the introductory section. Chapter 2 gives an overview of the evolution of the healthcare system in the three counties as well as a comparison of key indicators in order to locate the trends in informalization, which are considered in Chapter 3. Chapter 4 illustrates the different types of trade union responses to informalization in the healthcare sector through short case studies. Chapter 5 presents the challenges faced by the unions and the key strategies that can be considered.

CHAPTER 2

OVERVIEW OF THE HEALTHCARE SYSTEMS

In the region under study, comprising India, Nepal and Sri Lanka, economic reforms have impacted the functioning and dynamics of the healthcare systems and the workforce in them. This section reviews the specific trajectories in India, Nepal and Sri Lanka, and attempts a regional comparison of key health outcomes and health systems indicators. Finally, within this broad picture, the healthcare workforce is described.

REGIONAL TRAJECTORIES

INDIA

The 1990s saw significant changes in healthcare practices in India with the advent of the World Bank Structural Adjustment Programme. Under this programme, the loans provided by the World Bank allegedly aimed to enable recipient countries to honour their debts. These loans came, however, with conditions requiring the recipients to restructure their economies based upon World Bank demands.

In the 1980s, already the growing debate around the inefficiency of the public health sector had led to the questioning of the expenditure on workforce salary. It was estimated that around 80 per cent of the total budget on the health sector was spent on salaries of the workforce.[1] As the public health system had not been able to assure effective service delivery, criticism over the health sector budgeting gained ground. This created a push towards a greater role for private players in the health sector and simultaneously a systematic reduction in the workforce by the government. States reacted to the financial crunch by significant reductions in the healthcare workforce with some states even doing away with certain cadres of workers such as multipurpose health workers.[2]

1 Personal interview with Rama V. Baru, Professor, Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi.

2 Ibid.

The National Health Policy, 1983 states the intent to reduce the government's expenditure on health[3] as well as to expand private sector provision as a way of reducing costs.[4] The larger argument that gained ground was that the private sector would be able to provide better and more efficient delivery of services.

In light of the already existing employment trend in the healthcare sector in India before the 1990s, the adoption of the SAP augmented the trend of inclusion of private players into the public health sector.

The labour force was further reduced and even altered, ostensibly to reduce expenditure. The Eighth (1992–1997) and Ninth (1997–2002) Five Year Plans introduced the system of contracting out of primary level services, and consequently in the Tenth (2002–2007) Plan there were talks of both contracting in and contracting out of clinical and non-clinical services. Public private partnership (PPP) models were created across all the three levels of the sector to draw private players into health service provisioning. At the primary level, these were restricted to interventions like health education, demand generation through social marketing and limited curative services, and included both contracting in and contracting out of services. At the secondary and tertiary levels, these included instances of contracting out of non-clinical services like laundry, catering, cleaning and maintenance to private agencies.[5]

These policy changes shifted the focus from healthcare as a publicly owned system to healthcare as a system made up of parts that could be utilized by multinationals and, more broadly, private sector players, for profit making. The reduced role of the government and greater role of the private sector was encouraged by arguing the more competent nature of private players.

NEPAL

The various Five Year Plans from the 1950s till the 1990s addressed the issue of effective health sector service delivery; however none had been successful in

3 Government of India, 'National Health Policy, 1983', p. 7, With a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professional, increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field.

4 Ibid.
...planned attention would also require to be devoted to the establishment of centres equipped to provide speciality and super-speciality services...To reduce governmental expenditures involved in the establishment of such centres, planned efforts should be made to encourage private investments in such fields so that the majority of such centres, within the governmental set-up, can provide adequate care and treatment to those entitled to free care, the affluent sectors being looked after by the paying clinics.

5 Contracting in' refers to labour force in the hospital hired through labour contractors; therefore contract labour. 'Contracting out' implies outsourcing of a specific task or tasks to an external facility. See Madhurima Nundy and Rama V. Baru, 'Blurring of Boundaries: Public-Private Partnerships in Health Services in India.'

drafting a health policy. One of the first documents dedicated to the health sector planning was the First Long Term Health Plan (FLTH) for the period 1975–1990. The focal point of the document was the expansion of basic healthcare to all, including outreach to rural areas. It was only in 1991, following the Jana Andolan of 1990, that the Nepali Congress brought out the National Health Policy.[6] As well as addressing ways of achieving access to healthcare and strengthening the public health sector, the policy also explicitly gave legitimacy to the building of a parallel private sector that could address the health concerns of the Nepali citizens '.through the establishment of hospitals, health units, nursing homes, without any financial liability to His Majesty's Government[.] [S]uch institutions may be operated after having obtained necessary permission from His Majesty's Government and subject to minimum standards as prescribed'.7

The Health Policy also emphasized on the need to strengthen decentralization processes and the need for greater autonomous functioning of the peripheral health facilities for effective healthcare service delivery.

The restructuring of the health sector was influenced by the Structural Adjustment Programme policies dictated by the World Bank, which Nepal had adopted in 1986. And hence it followed a pattern similar to its neighbouring country India, of cutting down costs incurred by the government so as to improve efficiency. This policy resulted in the mushrooming of autonomous institutions. At the same time, the workforce in the public health sector was reorganized to bring in competency, leading to the retrenchment of workers on temporary contracts and the subsequent re-hiring of a few tertiary care staff on new two-year contracts.[8]

The Second Long Term Health Plan (SLTHP) for the period 1997–2017 has as its vision statement the building of an 'integrated health system', which includes NGOs and private for-profit companies working with the public sector in realizing the health goals of the country.9 The way forward for the country's healthcare system clearly appears to involve the private sector. Over the last two decades of a tumultuous political environment, Nepal's public healthcare sector has been functioning on the principles of decentralization and the increasing role of private players through PPPs.

6 The 1990 People's Movement (Jana Andolan) was a multiparty movement in Nepal that brought an end to absolute monarchy and the beginning of constitutional democracy.

7 Government of Nepal, 'National Health Policy, 1991,' Section 4, p. 4.

8 See Hemang Dixit, Nepal's Quest for Health, Chapter 5.

9 Government of Nepal, 'Second Long Term Health Plan.'

SRI LANKA

Sri Lanka has an extensive public healthcare system that dates back to the 1930s. In 1951, in possibly the most significant step taken towards upholding the principles of a welfare state, the ruling government abolished user-fees for health services.[10] From this point on and until the 1970s, ruling governments gave priority to providing free health services for all.

Conforming to the World Bank's SAP demands in 1977, Sri Lanka facilitated the entry of private players in a series of sectors, including the public service sector. Accordingly, the healthcare sector began to include more private companies. Along with the emergence of private participation, the government began to allow state health officers, including medical and technical staff, to practice privately outside their working hours.[11]

The adoption of the SAP and a range of pro-private sector policies prompted the establishment of private hospitals and a corresponding government withdrawal from health sector responsibilities. Government subsidies included incentives to purchase state lands for private hospital construction, loans for the expansion of private facilities, duty free facilities for importing biomedical equipment and the grant of permission to public health sector professionals to work part-time in private facilities.[12] As a result, budget allocations for health have decreased since the 1980s. As budget allocations for health decreased, private health facilities increased between 1981 and 2000.

Despite this trend, the involvement of the private sector in healthcare provision by the private sector is less extensive in Sri Lanka than in other countries in the region. Sri Lanka has a history of devoting considerable time and budget to the creation of a robust health system based on an extensive primary healthcare network. 'On average, a public health care facility is located less than five kilometres from a person's residence, and ranges from primary medical care units that provide only outpatient services to tertiary-level and specialized hospitals.'[13].This already existing efficient public health system seems to have delayed the worst of the disastrous effects of privatization in Sri Lanka, which have been experienced by its South Asian neighbours.

10 Ravi P. Rannan-Eliya and Nishan de Mel et al., 'Resource Mobilization in Sri Lanka's Health Sector.'
11 See Rama V. Baru, 'Health Sector Reform in South Asia,' p. 5–6.
12 See Ramya Kumar, 'Preserving "Free Health".'
13 See Shanti Dalpatadu et al., 'Public Hospital Governance in Sri Lanka.'

Table 2.1: Data on Health Sector Financing

2014 Data on health sector financing	India	Nepal	Sri Lanka
Total health expenditure (THE) as a % of GDP	4.7	5.8	3.5
Government expenditure on health as a % of GDP	1.4	2.3	2.0
Government expenditure on health as a % of THE	30	40.3	56.1
Out-of-pocket expenditure as a % of THE	62.4	47.7	42.1

Source: The World Bank. Total Health Expenditure as % of GDP <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>, Government expenditure on health as % of GDP <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>, Governmnet Expenditure on Health as % of Total Health Expenditure < http://data.worldbank.org/indicator/SH.XPD.PUBL>, Out-of-pocket expenditure as a % of THE < http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS>

Table 2.2 Health Expenditure as a % of GDP

Country	1995	2014
India	1.1	1.4
Nepal	1.4	2.3
Sri Lanka	1.6	2.0

Source: The World Bank. Total Health Expenditure as % of GDP <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

REGIONAL COMPARISON

The experiences in the three countries reinforce the argument that privatization erodes the robustness of the healthcare system.

It is imperative for the government to invest in the healthcare sector to both create and sustain a well- functioning system. This is corroborated in the Indian Draft National Health Policy, 2015, which states that 'Global evidence on health spending shows that unless a country spends at least 5–6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met.' However, none of the three countries has brought up the investment in the health sector to 5 per cent of its GDP. As the data in Tables 2.1 and 2.2 suggests, this has led to the burden of expenditure falling largely on patients (through out-of-pocket costs). India's out-of-pocket expenditure accounts for more than half the total healthcare expenditure while for both Nepal and Sri Lanka the share is just less than half.

Among the three countries, India has invested the least in the health sector. Although all three countries have significantly low public health expenditures, for India the percentage share as part of the GDP is the lowest at 1.4 per cent.

HEALTH OUTCOMES INDICATORS

Sri Lanka is ahead of both Nepal and India in both maternal mortality rate (MMR) and infant mortality rate (IMR). Sri Lanka has managed to bring down the infant mortality rate to almost a tenth of what it was in the 1960s. Nepal too has almost brought the number down to a tenth of what it was. However India is yet to achieve this (Table 2.3). Maternal mortality rate remains a more daunting challenge; however in terms of absolute numbers, Sri Lanka still has the lowest figures among the three countries (Table 2.4).

As mentioned earlier, Sri Lanka has the most robust public heatlhcare system in the region, which contributes to better health outcomes. It is also interesting to note that in spite of having a better functioning healthcare system, Sri Lanka's total health expenditure as a share of GDP is lower than that of India and Nepal. Further, it is only in Sri Lankan that the public investment is higher than out-of-pocket expenditure, unlike in India and Nepal. This further validates the necessity of the health sector to remain in the public domain and for private players to have a secondary role, if at all, in the provisioning of services.

ORGANIZATIONAL STRUCTURE

The public health sector in each of the three countries has broadly similar organizational systems in terms of having hospitals under the central health ministry and state level/provincial health ministry.

However, there are certain distinguishing characteristics. For example, India also has hospitals under other ministries and in municipalities. For example, the Labour Department, Railway, and the Defence services have each their own medical facilities. The multiple structures and jurisdictions create segmentation in the total healthcare workforce. Thus it is necessary to understand the structure of the public health system in each country to analyse the effect of differing administrative set-ups on employment patterns. The idea of a united healthcare workforce gets complicated on account of workers being divided along types of health work, level of skill, socio-economic background and, additionally, administrative differentiation..

INDIA

In India public healthcare facilities are divided into central facilities under the Ministry of Health and Family Welfare and state-owned facilities under the

Table 2.3 Infant Mortality Rate (per 1000 live births)

Country	1960	2015
India	165	38
Nepal	220	29
Sri Lanka	73	8

Source: The World Bank, Mortality Rate, Infant (per 1,000 Live Births) <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN.'>

Table 2.4 Maternal Mortality Ratio (modelled estimate, per 100,000 live births)

Country	1990	2015
India	556	174
Nepal	901	258

Source: The World Bank, 'Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births)
<http://data.worldbank.org/indicator/SH.STA.MMRT.'>

various state Departments of Health and Family Welfare. Further, there are facilities are owned by municipalities, which are often given administrative and financial autonomy under the decentralization policies.

Apart from the Ministry of Health and Family Welfare, other ministries also have their own facilities in different parts of the country.

- Ministry of Labour and Employment–Employee State Insurance (ESI) hospitals built by the Employees' State Insurance Corporation (ESIC), established by the ESI Act. At present there are 151 such hospitals[14] across the country.
- Ministry of Railways–Indian Railway hospitals under the Ministry of Railways. At present there are 125 hospitals[15] across the country.
- Ministry of Defence–Health service facilities in cantonment areas are run by the Cantonment Boards set up under the Cantonments Act of 2006.

NEPAL

The administrative structure of the public health system in Nepal is relatively more straightforward, with all its health facilities coming under the Department of Health Services of the Ministry of Health. The five Regional Health Services Directorates (organized on a east–west axis) are in charge of facilities in each of the three ecological zones –terai, hill and mountain (see Table 2.5). Each region faces its own challenges on account of kind of terrain, accessibility and climate

14 Government of India, '151 ESI Hopsitals in India.'
15 Ministry of Railways, 'Health Directorate.'

Table 2.5 Organizational Structure in Nepal

Primary Health Care Facilities	Secondary and Tertiary Care Facilities
Primary health care centre	Central
Health post	Regional
Sub-health post	Zonal
	District

Table 2.6 Organizational Structure in Sri Lanka

Central Ministry	Provincial Ministry
National hospital of Sri Lanka	District base hospital (A/B)
Provincial (teaching) general hospital	Divisional hospital
District general hospital	Primary care units

Table 2.7 Worker Categories Across South Asia

Skill Level	Medical	Non-medical
Skilled	Nurses	–
Semi-skilled	Technical staff–diagnostic personnel, pharmacists	Ward boys/attendants, cooks/ kitchen staff, clerks, drivers, security personnel
Un-skilled		Sweepers, washermen/ washerwomen

SRI LANKA

In Sri Lanka the facilities under the Ministry of Health and eight provincial Departments of Health form a dense, integrated network with more than a thousand institutions (Table 2.6). According to government data, most Sri Lankans live within 3 km of a public facility.

PUBLIC HEALTHCARE WORKFORCE

The present study has categorized workers based on where they work: (i) facilities with more than five beds, such as hospitals in secondary and tertiary healthcare and (ii) non-hospital set-ups. The, latter includes, among others, community health workers (CHW). Within the second category, only CHW have been studied. The study tried to document very briefly some of the challenges of working as CHWs, for example, the Female Community Health Volunteers in Nepal.

The study has grouped occupational categories according to medical- and non-medical-based skills required for work (Table 2.7). The study did not cover doctors and administrative staff. Table 2.7 shows the categories of workers in hospitals.

CHAPTER 3

NON-STANDARD FORMS OF EMPLOYMENT IN PUBLIC HEALTHCARE SECTOR

Labour market segmentation arising out of contractual agreements divides the workforce into permanent and non-permanent workers. Traditionally, the 'norm' in the public sector has been that of permanent work. Due to the rise in contractual agreements with varying terms of employment, the cadre of non-permanent workforce has increased substantially.

Non-standard work is the term used to define work that falls outside the pattern of permanent work. The ILO defines non-standard forms of employment (NSFE) as 'work that falls outside the scope of a standard employment relationship, which itself is understood as being work that is full-time, indefinite employment in a subordinate employment relationship.'[1]

In this study, data from the three countries has been used to broadly group non-permanent types of employment into five categories. However, given the frequent and unregulated changes in employment patterns, there are non-uniform characteristics, depending on, among other factors, the country, administrative structure of the healthcare system, particular facility and model of public–private partnership. Some of these variations have been explored.

1 Direct fixed duration contracts–workers who are hired directly by the hospital management through fixed duration contracts (FDCs). These contracts establish a direct employer–employee relationship but are for a short duration of employment. The workers receive their salaries directly from the hospital management. Under the ILO classification, they would fall under 'temporary employment' with possibly 'ambiguous employment relationships'.

1 International Labour Organization,'Non-standard Forms of Employment.'

2 Contract work–workers supplied to the hospital management by contractors. These workers maybe hired through the labour contractor by the management for varying lengths of time, depending on the workload. The payment of wages may be made to them by the contractor who may receive it directly from the hospital management. In the ILO's nomenclature, they would fall under 'temporary employment' with 'ambiguous employment relationships'.

3 Daily wagers–workers hired for a day's work. They have no formal relationship with the management. An example would be those called into the medical facility for maintenance work. This study did not delve into the working conditions of daily wage workers.[2]

4 Outsourced departments–third party agencies that take over entire departments in the hospital. This has been an emerging trend over the last few years. The said agency is given complete autonomy over the running of the department, including fixing and payment of wages and work hours. Thus the workers here are in a direct relationship with the third party agency even though they might work within the hospital premises.

5 'Volunteerised' workers–workers not formally recognised by the government as being part of the health workforce despite the expectation that they would provide their time and skill regularly towards certain tasks and jobs. They might not have regular and fixed working hours or wages. In some instances, though, there might be a more structured remuneration and work profile. Although a work relationship exists, it is not of the nature of an employee-employer relationship.

INDIA

In India, the Delhi state government initiated an increase in the non-permanent staff in its facilities around early 2000. Amongst the skilled workforce such as nurses, the hiring of temporary staff was justified on the grounds that healthcare work was being compromised due to the time-taking process of hiring regular staff. This, however, did not remain a short-term measure and, now, even central government facilities have begun hiring nurses on fixed duration contracts. In the the semi-skilled and unskilled jobs, the central government has entirely eliminated regular posts. Thus the ban on hiring workers on regular posts was

2 However, in many cases it was seen that workers such as attendants and ward boys were also hired on daily wages by the hospital management while being paid at the end of the month.

implemented for Group C (2000–2005)[3] and D workers (2000–2015).[4] The period 2000 to 2015 saw the rise of a large cadre of non-permanent workers, with the absence of any contractual arrangement directly with the hospital management. The workers were hired through either an individual small contractor or an agency supplying labour, such as agencies providing security personnel. It is important to note that the informal workforce increased with the privatization of public hospitals and the entry of large corporate private hospitals.

SKILL LEVEL AND INFORMALIZATION

Differences in the employment terms even within the non-permanent workforce are seen to be based on skill level. Whereas nurses with a certain level of medical knowledge have not yet been subjected to the more precarious forms of irregular employment, other semi-skilled and unskilled workers have been employed on much more whimsical terms. In early 2000's as a reaction to the ban on hiring permanent workers in the Group C category, technicians took action by emphasizing the need for skilled employees in the profession. Thus the level of skill has played an important role in shaping the terms of employment across the workforce. With increased skill levels it seems that it is easier to resist unfair terms and negotiate with the management. The impact is the severest on low skill workers.

Workers hired through contractors are largely found in the Group D workforce. The contractor enters into an agreement with the hospital management, which provides the former with the number of workers it requires for a certain task. The agreement is generally for a duration of one year after which it is either renewed or a new contractor is hired. Out of a total of 150 posts for ayahs, in Ram Manohar Lohia (RML) hospital, New Delhi, in 2016 only 25 ayahs were on the permanent pay roll, while there are around 150 employed through a contractor. In Lala Ram Swarup (LRS) T B. Hospital, New Delhi, out of a total Group C and D workforce of 500, 200 are employed through a contractor.[5]

DECENTRALIZATION POLICIES

'When … [decentralization] is linked to reduced resource allocation from government with no balancing powers of local taxation, the result is often a reduc-

3 The classification of government employees under the Central Civil Services (Classification, Control & Appeal) Rules, 1965 is as follows: Group C–A central civil post carrying a pay or a scale of pay with a maximum of over Rs 4,000 but less than Rs 9,000; Group D–A central civil post carrying a pay or a scale of pay the maximum of which is Rs 4,000 or less. See Government of India, 'Central Civil Services (Classification, Control & Appeal) Rules, 1965.'

4 Personal Interview with Ram Kishan Tripathi, General Secretary, All India Health Employees and Workers' Confederation (AIHWEC).

5 Ayahs employed through contractors in RML hospital receive Rs 7,000–Rs 8,000 as opposed to the Rs 11,000 that the hospital pays the contractor per worker (information obtained from informal discussion with an ayah from RML Hospital on 10 March2016).

tion in resources, leading to cuts in services.'[6] In the case of India, this is an apt description of the situation. Decentralization of health services in order to shift the administrative and financial responsibility to the states, with the intention of increasing efficiency, has yet to fulfill its aim of better access to healthcare services. Instead, in a liberalized economy, the limited central funding has resulted in increased partnerships with the private sector for health service provisioning and simultaneously in an increase in the irregular healthcare workforce of the country. The variation in resources across states has also resulted in differences in the quality of healthcare services as well as the access to these services.

OUTSOURCING AND MARKET CONSOLIDATION OF MEDICAL SERVICES

Outsourcing of services that are considered non-essential, such as laundry, has been a regular practice in hospitals. Outsourced services later expanded when the Delhi government passed orders to all facilities for outsourcing security and cleaning services.[7] However, more recently, the trend has extended to essential medical services as well, such as diagnostics and laboratory testing.[8] The hospital management here provides infrastructure to a third party private agency that is responsible for running these departments, including labour and maintenance of the equipment. The incidence of outsourcing of departments seems to coincide with the rise in the number of private companies that offer these different services. The ready availability of such services in the market might be a reason for the increase in outsourcing in government facilities. However, the obvious implication of this, which is the withdrawing of the government from responsibility towards its workforce, is a matter of concern.

NEPAL

In Nepal the experiences of non-formal employment have been similar to India, with an even larger proportion of workers falling in this category. The health sector in Nepal faces the challenge of a highly informalized labour force, ranging from unskilled to skilled workers in non-medical and medical occupations. Among the non-permanent workers, ad-hoc practices of hiring have led to the present situation of a highly complex workforce in terms of employment. This, coupled with the existing challenge of building a competent health system, has

6 Jane Lethbridge, 'Health Care Reforms and the Rise of Global Multinational Health Care Companies.'
7 Personal interview with Ram Kishan Tripathi, General Secretary, All India Health Employees and Workers' Confederation (AIHWEC).
8 In 2015 the Delhi government advertised for outsourcing of maintenance of medical equipment. See 'Delhi Govt Plans to Outsource Maintenance of Hospital Equipment.' <http://indianexpress.com/article/cities/delhi/delhi-govt-plans-to-outsource-maintenance-of-hospital-equipment/>

been a key struggle against the backdrop of political turmoil that Nepal has witnessed. In Nepal, nurses too are subject to a high degree of informality in their employment. A comparison of the terms of employment between nurses and doctors shows that in the case of the former, wages are disproportionately lower and contract duration is generally as short as even six months. In the aftermath of the earthquake in April 2015 there were many instances of ad-hoc hiring of nurses without proper contracts, leading to a lack of compliance with labour laws and basic benefits for the worker. Many nurses were hired on three months contract, which were not renewed.[9]

CORPORATIZATION AND ATOMIZATION OF THE HEALTH SYSTEM

The introduction of market principles to the working of public sector hospitals has been instrumental in the process of labour irregularization. In Nepal, the reduced funding from the government in the guise of decentralization policies has resulted in hospitals resorting to seeking new avenues for funding and income generation. This has led to the mushrooming of autonomous public facilities. According to Lethbridge this changes the ethos of the institution, whereby '[H]ospitals become more concerned with reducing the costs of service delivery than with delivering improved quality of care.' Hospitals are then focused only on cost and income generation and will readily resort to practices that compromise labour rights. In addition, instead of an integrated health system, the different facilities in the country work as independent units with little coordination and minimal accountability to the central government.

CAPITAL CONSOLIDATION IN NON-MEDICAL SECTOR

A trend seen in Nepal is the hiring of one particular agency to supply workers for a particular occupation. The security personnel, for example, in many publicly owned hospitals are hired from one agency across Kathmandu. This shift from numerous petty contractors providing labour to a takeover by one big contractor in the form of an agency could point to a trend towards greater corporate consolidation.

SRI LANKA

Unlike the other two countries, in Sri Lanka nurses are not yet subjected to non-permanent employment. The only difference is a law that allows retired nurses to

9 Personal interview with Ms Janaki K. C., President, Nursing Union of Nepal.

be hired on a three year contract. Thus any form of non-permanent employment in the public sector is found among workers of the semi-skilled and unskilled categories, like security personnel, ward boys, ayahs, ambulance drivers, cleaning staff, laundry staff, among others. In Sri Lanka the forms of non-permanent employment that have emerged include hiring of workers through contractors (known as manpower agencies) and direct fixed duration contracts. The security services department seems most prone to hiring through manpower agencies, followed by the cleaning and laundry departments. Respondents reported that maintenance staff is also mostly hired through contractors. The conditions of work and benefits (such as medical insurance for self and leave) for fixed duration healthcare workers are better than for their counterparts in the neighbouring countries. Additionally their contract is drawn for two years as opposed to contracts as short as three months in Nepal and India.[10]

EFFECT OF INCREASED PRIVATISATION

Unlike Sri Lanka where public health facilities are accessible to all, India and Nepal both have a system wherein those who are well off access private healthcare services and those who are poor access the public facilities. With the various public–private models providing access to private players for profit generation, health services have become expensive and additionally public healthcare investment has reduced. Thus not only are the economically vulnerable sections of society not able to afford private services, affordable public health services are either lacking in quality or not available at all. Another fallout of the increased participation of private players in healthcare provisioning is the change in the ethos of the health sector, which instead of working with accountability towards the public and public health is now increasingly being driven by market logic.

10 For example in India, Ram Manohar Lohia Hospital (a central government hospital in Delhi) hired its first batch of fixed duration contract nurses for a term of six months in December 2015.

CHAPTER 4

TRADE UNION RESPONSES

In all the three countries studied, trade unions, which had hitherto been active in the health sector and had established themselves in terms of membership and negotiating skills are grappling with the changing nature of the workforce brought on by the sharp rise in the percentage of non-permanent workers. In many instances, when the move towards building a non-permanent workforce started, unions were unable to fully grasp the extent of the problem and had therefore not opposed it. However, now with the continued increase in the numbers of non-permanent workers the need to engage with this workforce is pressing.

As the issues surfacing are varied and not uniform due to the complicated reshaping of the workforce, there are a number of challenges confronting health sector unions. The engagement with irregular workers is at a nascent stage and strategies to combat the trend of informal work in the health sector are being developed mostly on a case by case basis. Based on interviews with union representatives and data gathered from the various workshops, the engagement of unions with non-permanent workers is divided into the following categories.[1]

- Public sector unions that work with non-permanent workers directly, taking up their issues–*All India Government Nurses Federation (AIGNF)in India*
- Public sector unions that organize separate unions of non-permanent workers in both public and private sector facilities, which then take up their own issues–*Health Professionals Organization of Nepal (HEPON); Confederation of Public Services Independent Trade Union (COPSITU) in Sri Lanka*
- A single union of permanent and non-permanent workers–*Hospital Employees Union (HEU) in India*

1 The case studies presented in this section have been chosen from among the trade unions that participated to the meetings held between December 2015 and April 2016. They are merely meant to illustrate the categories proposed.

- Non-permanent or informal workers' unions that are formed independently–*National Health Volunteers Association (NHVA) in Nepal*

ALL INDIA GOVERNMENT NURSES FEDERATION

In India, nurses, although significant in number, were rarely part of unions in the 1960s. During early and mid-1970s nurses started joining the existing workers' unions in their place of work; nurses from RML hospital, New Delhi joined the existing workers' union (comprising of Group C and D workers. However, the specific issues of the nursing staff were not being satisfactorily addressed within the larger workers' union. Therefore, after a few years, a separate nurses union was formed within RML hospital with more than half of the existing nursing workforce. This was the trajectory followed by nurses in other hospitals too.

The precursor to the AIGNF was the formation of the Delhi Nurses Union. To protest against the recommendations of the 4th Pay Commission, 1986, healthcare workers, including nurses, from all facilities went on an indefinite strike. While the other workers continued the strike, the nurses called off the strike after negotiating with the government for the payment of nursing allowance. In 1988, the nurses from Delhi facilities, led by the central facility nurses formed the Delhi Nurses Union. The AIGNF was formed in May 1988 at a national conference in Delhi, with a push from nurses from Maharashtra and Rajasthan, among others states ,uniting nurses throughout public health facilities across the country.

The AIGNF has under it unions from different administrative facilities; however the health facilities under the Indian Railways and ESI have also created a separate national platform for nurses from these specific facilities. As mentioned earlier, due to the many different administrative structures under which health facilities fall in India, the conditions of work differ for the same category of staff between facilities, and in certain cases within facilities too. Also as health is a state subject, these conditions vary across states. However the nature of work and the workload remain similar. National platforms aim to work to create parity in the terms of employment and conditions of work across the country.

ENGAGEMENT WITH NON-PERMANENT WORKERS

The Delhi Nurses Union (DNU) was actively engaged on the issue of 'contract nurses' (those on fixed duration contracts hired by the management) in central government hospitals between December 2015 and early 2016. Nurses on FDCs were hired on six-month contracts as a stopgap measure till regular posts were

filled. The delay in filling up regular posts was due to the conflict between the union and the Ministry of Health over changes in recruitment rules. Having agreed to hire nurses on FDCs, the DNU negotiated the terms of hiring with the ministry. Some of the key points were

- Only hospital management would conduct the interview; no middle men would be allowed.
- There was opposition to the proposed meagre salary of Rs 18,000 and the demand was made for 'same work same pay' This was later re-negotiated to Rs 37,500, which is on par with the basic salary and DA for regular nurses.
- Leave entitlement would be the same as for permanent nurses.
- The term of contract would only be for six months.

However the engagement is still nascent and Mrs G. K. Khurana, President, AIGNF feels that they have not yet been able to fully grasp the issues plaguing non-permanent employees and thus have not been able to organize them effectively. However, in February 2016 at the relay hunger strike called by AIGNF in protest against the recommendations of the 7th Pay Commission, the DNU managed to amass the support of a large number of contract nurses. The union leadership feels that it is important to organize contract nurses as they have now become a significant part of the workforce and cannot be ignored. What the nature of engagement will be with non-permanent nurses and to what extent the present union of permanent nurses can influence conditions of employment and work are the questions that need to be answered.

HEALTH PROFESSIONALS' ORGANIZATION OF NEPAL

The Health Professionals' Organization of Nepal (HEPON), formed in 1991 initially comprised only permanent workers in the public sector. In the last eight years with the expansion of the private sector, it has extended to organizing workers from private sector facilities as well. Mr Ghimire, president of HEPON feels that a union is as strong as its membership; hence increasing HEPON's reach to different sectors and facilities would enable HEPON to grow in strength.

The challenge however is that private sector workers are not legally registered members of the union as only permanent public sector workers can become registered members of a recognized union in the public sector.

Workers who do not belong to the 'permanent' category are not allowed to register in the Labour Department of Nepal. The Health Service Act of Nepal on the other hand does not allow unions to issue membership to workers who are not registered in the Labour Department. To register, workers need an identity number, which is a number issued only to permanent workers.[2] Thus a legal loophole prevents the formal membership of non-standard workers into unions in the health sector. Union representatives see this as a bid to weaken unions; especially as there is a rise in the number of workers that are now employed as temporary staff and consequently a decline in the permanent workforce.

Though HEPON does not have the legal status of a federation, it works like one in bringing together different unions under a collective agenda to fight to protect workers against labour rights violations.

CONFEDERATION OF PUBLIC SERVICES INDEPENDENT TRADE UNION

The Confederation of Public Services Independent Trade Union (COPSITU), Sri Lanka, which was formed in 1981, has 700 members from the public health sector, all of whom are professionals and permanent employees. The history of the union is a tumultuous one, involving a setback the union suffered in the 1990s. From a federation of around 64 trade unions of which the health sector formed a major chunk, the union now has a membership of 2,000 with around 35 per cent from the health sector workforce. COPSITU's strategy is to influence policies through evidence-based research and documentation. COPSITU stresses on a research-based approach towards influencing government policies.

The union began efforts to unionize workers in the private sector after a meeting with the PSI in 2015, The Private Sector Health Professional Independent Trade Union (PSHPITU) is a private sector non- permanent healthcare workers union of nurses and pharmacists organized by COPSITU in late 2015. The union is at a very nascent stage and the strategies to move it forward are yet to be formulated. Unionizing workers in the private sector is fraught with challenges, including the

2 Data gathered at the 'National Mapping Workshop in Nepal on Precarious Work in the Health Sector and Trade Union Responses,' held in Kathmandu on 22 and 23 December 2015.

A participant at the workshop recounted the difficulties faced by volunteer workers in getting registered. An application at the Labour Department for the registration of a volunteers' trade union was rejected despite the application form having been signed by the head of the District Public Health Office. The Labour Department rejected the form stating that only employees of the Health Department of the government were eligible for registration. Registration could be considered if the secretary of the Village Development Committee (VDC) or an authorized official of the municipality approved the form for registration, but such approval was very hard to come by.

dismissal of workers, a most common union-busting tactic employed by the management. However, COPSITU is one of the few unions in Sri Lanka that has taken up the challenge to enter the private sector. It hopes also to regain its strength through this effort while also expanding its influence beyond the public health sector.

NATIONAL HEALTH VOLUNTEERS ASSOCIATION

At present the only registered union of health volunteers is the National Health Volunteers' Association (NHVA), Nepal formed in 2009.[3] This is a big victory for volunteers as a key challenge to organizing volunteers is the problem of registration of the union. With a current membership of 10,000 volunteers, they had an initial outreach of 4,000 volunteers across 22 districts. Through its members the union started a signature campaign to reach out to others working in the same districts in different villages. Apart from NHVA, there are other unregistered health volunteers' associations such as those affiliated with HEPON and the All Nepal Women Health Volunteer Workers' Union."

Health volunteers get paid NPR 400 per day for four days of work in a year, and a yearly dress allowance of NPR 7,000. The increase in remuneration (fromm 200 NPR pe day) and dress allowance came about in 2012/2013. After a long struggle that started in 1999, health volunteers also won the right to be issued identity cards and thereby won recognition by the Health Ministry. The expectation was that with the issuing of identity cards, volunteer workers would be also entitled to certain benefits. But this did not happen. The government continued to argue arguing that volunteers did not have the rights to benefits or entitlements on par with any other healthcare workers.

Further, there is much disparity in the work conditions of volunteers based on location. In rural areas volunteers are given a meagre allowance for travel-related expenses, whereas in urban areas volunteers do not get this allowance as their work supposedly does not entail much travel. There is a lack of robust capacity and skill building programmes for volunteers. The NHVA has done many demonstrations in front of the Ministry of Health and Population as well as the Labour Ministry. The primary demand is for health volunteers to be recognized as being part of the healthcare workforce; the basic right to be recognized as a worker, workshop participants pointed out, is what needs to be upheld first.

3 Personal interview with Gita Thang, General Secretary, NHVA.

Finally in 2014 under pressure from the union, the government agreed to form a working team comprising health volunteer representatives from the NHVA and members of the Ministry of Health and Population. The mandate of the working team is to work towards securing the rights of volunteers and ensuring fair working conditions. Currently unions of health volunteers together have submitted a 14-point letter of demand to the Ministry of Health demanding recognition and better conditions of work. The main demand is that the 50,000 odd health volunteers across the country should be allowed to form a separate recognized trade union.

CHAPTER 5

CHALLENGES AND KEY STRATEGIES

CHALLENGES FACED BY UNIONS IN ORGANIZING NON-PERMANENT WORKFORCE

JOB INSECURITY IN THE PRIVATE SECTOR

A key challenge that emerged through engaging with non-permanent workers is the need for separate ways for unions to address the issue in the public and private sectors. Due to the already existing unions of permanent workers across public health facilities in all three countries, there is at least a sense of awareness among even the non-permanent workers about the necessity of a union to protect their rights. This, as was clear during the study, is mostly absent amongst workers in the private sector facilities. The challenge of organizing irregular workers is intensified due to the insecure nature of their jobs. In the absence of regulatory mechanisms, the management hires and fires workers capriciously. The element of precariousness is spread across facilities that work for profit as well as non-profit facilities and trusts. In this context, Mr Ghimire of HEPON stated that collective bargaining would be a powerful tool.

SEGMENTATION OF WORKFORCE

The complicated segmentation of the workforce along different axes is another challenge. For example, in India the labour force is segmented along multiple lines: among others, the public and private sectors; within the public sector, the different ministries and the facilities run by them; medical and non-medical workers; within the non-medical category, those who work directly with patients and those who do not.

LAWS FAIL TO REFLECT THE CHANGING NATURE OF THE WORKFORCE

Trade unions and associations have not kept pace with the changing nature of the workforce, nor have the laws governing have not been revised in keeping with the changes. Legal membership of non-permanent in registered unions is an issue

in Nepal due to a loophole in the law that allows only workers with identity proof provided by the government to be part of a recognized union. This proof is provided to only permanent workers. Similarly in India the Central Civil Services (Recognition of Service Association) Rules, 1993 allows only for regular employees to be part of a recognized union by restricting membership to 'government servants' who by definition are those 'to whom the Central Civil Services (Conduct) Rules, 1964, apply'.[1] Thus, in medical facilities, legal membership of contractual workers is not possible in the existing workers' union. In addition, a trend towards occupation-based unions also causes fragmentation of unions, affecting negatively their bargaining capacity.

As the massive irregularization of the workforce is a relatively new phenomenon, understanding its impact and the ways of combating the fallout are still at a nascent stage for the unions. Trade unions do not yet have a strategy for dealing with the issues arising out of organizing irregular workers, including tackling insecurity of tenure, which is used as a union-busting technique. Thus the permanent workers' unions are still grappling with the issues of non-permanent workers and success has been rare and isolated.

THE WAY FORWARD

The criticality of the role of the government in health service provisioning therefore cannot be overemphasized. However from the experiences of restructuring of the public health system in both India and Nepal, it is evident that the government is withdrawing from investing in the health sector. For-profit enterprises have been allowed to take over certain parts of the health sector provisioning both independently as well as in partnership with the government.

The study has identified four possible ways to deal with changing nature of the workforce.

1 Addressing policy issues: A big challenge to organizing non-permanent workers is the insecurity of tenure that the workers face. It may be helpful to devise a legal strategy to make a policy change with regard to ensuring security of tenure for non-standard forms of employment.

2 Collective bargaining: Collective bargaining is of utmost necessity to address issues across a currently divided healthcare workforce. A scaling up of the

1 See Government of India. Department of Personnel & Training. 'Office Memo, Sub: Central Civil Services (Recognition of Service Association) Rules, 1993.'

collective of healthcare workers will aid in the struggle. The original idea of a workers' union where all non-permanent workers irrespective of skill level and occupation type can come together on one platform to negotiate with the management should be revived in all facilities.

3 Alliance building–It would be helpful to conduct a campaign where healthcare providers and patients can cooperate and mutually agree that quality healthcare can only be provided by a healthcare workforce working under decent conditions.

4 Research in the following areas:

- Private sector where unionizing is at the lowest level and information is scarce; detailed understanding of the kinds of workforce employed in the private sector as well as employment practices across occupations, genders and caste/social groups.
- Public–private partnership models, impact on workforce, and the division of power between the public authorities and the private sector, both administratively as well as financially.
- Specific occupational groups and the terms of employment of each group to understand the different divisions in conditions of employment.

Annexure

Details of Interviews and Discussions Held

FOCUS GROUP DISCUSSIONS

- National mapping workshop in Nepal on 'Precarious Work in the Health Sector and Trade Union Responses' held in Kathmandu on 22 and 23 December, 2015 (PSI)
- National mapping workshop in Sri Lanka on 'Precarious Work in the Health Sector and Trade Union Responses' on 28 and 29 December 2015 in Galle, Sri Lanka (PSI)
- National workshop in India on 'Informal Work in the Health Sector' held in Delhi on 22 and 23 April 2016 (PSI)
- Sub-regional conference in Nepal on 'Confronting Precarious Work in the Health Sector in South Asia, 2–3 June 2016, Kathmandu (PSI)

INTERVIEWS

SRI LANKA

Date	Name	Union
29.12.2015	Ms S. Jayaratne, Committee Member	Public Service National Trade Union Federation (PSNTUF)
29.12.2015	Ms K. Jayanthi, Research Secretary	Confederation of Public Services Independent Trade Union
31.12.2015	Ms Vimala Ratna, President	Private Sector Health Professional Independent Trade Union
04.01.2016	Two members	PSNTUF

NEPAL

Date	Name	Union
20.12.2015	Mr Ramji Ghimire, President	Health Professionals' Organisation of Nepal
21.12.2015	Mr Chandra Thapa, President	National Health Volunteers Association
22.12.2015	Ms Gita Thang, General Secretary	National Health Volunteers Association
23.12.2015	Ms Janaki K.C., President	Nursing Union of Nepal

INDIA

Date	Name	Union/Organization	Location
02.09.2015	Ms Bhawna, President	Delhi National Rural health Mission/ Reproductive Child Health Contract Workers and Employers Welfare Society	Guru Gobind Hospital
06.05.2016	Ms Rama Baru, Professor Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University	Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University	Jawaharlal Nehru University
09.05.2016	Ms Bijoya Roy, Assistant Professor Centre for Women's Development Studies	Center for Women's Development Studies	Telephonic interview
10.05.2016	Ms Khurana, General Secretary	All India Government Nurses Federation (AIGNF)	Ram Manohar Lohia Hospital
16.05.2016	Mr Rajiv Agarwal, President	Hospital Employees Union	Jorbagh
17.05.2016	Mr Ram Kishan Tripathi, General Secretary	All India Health Employees and Workers' Confederation (AIHWEC)	RAK College of Nursing
10.06.2016	Mr Swambhu	AIHWEC	Telephonic talk

OTHER INFORMAL DISCUSSIONS/GROUP DISCUSSIONS

	Dates	Location
AIGNF Strike	21.02.2016	Jantar Mantar, New Delhi
AIGNF Strike	23.02.2016	Jantar Mantar, New Delhi
AIHWEC Strike	10.03.2016	RML Hospital, New Delhi.

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Public Services International, South Asia
61, I block, Sector 10, Faridabad - 121006, Haryana, India
website: www.world-psi.org