HEALTHIER PROCUREMENT

Improvements to working conditions for surgical instrument manufacture in Pakistan

Report #73

SWEDWATCH

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Swedwatch is a religiously and politically independent organisation that examines Swedish companies' business operations abroad. The organisation's purpose is to reduce adverse social and environmental impacts, encourage best practice, share knowledge and hold an open dialogue with Swedish companies so that the business community pays greater attention to these issues. Swedwatch has six member organisations: the Church of Sweden, Diakonia, the Swedish Society for Nature Conservation, Fair Trade Center, Solidarity Sweden-Latin America and Africa Groups of Sweden.

The BMA is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 154,000 which continues to grow each year.

The Medical Fair and Ethical Trade Group was established in August 2007 by the British Medical Association to investigate, promote and facilitate fair and ethical trade in the production and supply of commodities to the healthcare industry.

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Contents

Executive Summary 4

1. Introduction 8

2. Methodology 9

3. Background 11
   - 3.1 Surgical instrument manufacturing in Sialkot 11
   - 3.2 Labour rights and legislation in Pakistan 14
   - 3.2.1 The Constitution of Pakistan 14
   - 3.3 Minimun wage 15
   - 3.3.1 Union activities 15
   - 3.3.2 Protection of young workers 16

4. Swedish and UK buyers 16
   - 4.1 The Swedish county councils 16
   - 4.2 The UK National Health Service 20

5. Suppliers to Sweden and the UK 21
   - 5.1 Swedish suppliers 21
   - 5.2 UK suppliers 23

6. Back to Pakistan – findings on the ground 24
   - 6.1 Sialkot – a change in attitude in exporting factories 25
   - 6.1.1 Provision of minimum wage, contracts and benefits 26
   - 6.1.2 A lack of unions 27
   - 6.1.3 "No child labour" policies at all factories 28
   - 6.1.4 Lack of health & safety measures 29
   - 6.1.5 Gender inequality 30
   - 6.1.6 The challenge of price 30
   - 6.1.7 Dialogue with buyers 34
   - 6.2 Further down the supply chain 35
   - 6.2.1 Sub-contractors in Sialkot - improvements, but challenges remain 35
   - 6.2.2 Forges in Daska – noisy, with risk of injury 39
   - 6.2.3 General vendors – child labour still prevalent 40

7. New EU Directives on public procurement 42

8. Conclusions 44

9. Recommendations 48

10. Bibliography 50

Executive Summary

The buying power of public authorities is significant. In the EU annual spending through public procurement amounts to hundreds of billions of Euros. A substantial proportion of goods procured by public buyers are produced in developing countries, where working conditions and respect for human rights may not be enforced. Integration of social criteria in public contracts can be a key mechanism to counter these deficiencies, and promote ethical trade.

One category of goods with significant human rights risk is the production of surgical instruments. Thousands of surgical instruments are used every day in operations throughout Sweden and the UK, and a proportion of these instruments are produced in the city of Sialkot, in north-eastern Pakistan. Although Pakistan has ratified all eight International Labour Organisation Core Conventions, labour rights abuse in the country is still widespread.

In Sweden, the Swedish county councils, responsible for health care in each region, are the procurers of surgical instruments. Instruments are supplied through Swedish importers, buying from manufacturers in Pakistan. In the UK, the National Health Service (NHS) procures surgical instruments. The procurement of goods and services within the NHS is complex and may occur by direct supply to end-users, or through a number of local, regional or national procurement hubs. Procurement is also divided between England, Scotland, Wales and Northern Ireland. This report is limited to procurement within the NHS in England. The organisation NHS Supply Chain is the largest procurement hub for goods in England, and has awarded contracts to UK suppliers importing instruments from factories in Pakistan.

Swedwatch and the BMA have produced reports on labour rights in the Pakistani surgical instruments industry since 2007, which have documented anti-union policies, a lack of health and safety measures, violations of local labour laws with regard to minimum wage and excessive overtime, and widespread child labour. Social criteria are now, since 2010, included in public contracts for surgical instruments in Sweden, and have also been introduced to some sectors in England. In October 2014 Swedwatch and the BMA undertook research to ascertain any improvements in working conditions and labour rights in Pakistan following the inclusion of social criteria in procurement contracts.

Overall our findings are that conditions at the visited factories (supplying Sweden and England) have improved. Conditions at the sub-contractors working for exporting factories have also improved. The prohibition of child labour is now strictly enforced, wages are paid in accordance with the minimum wage, and employees are not forced to work overtime. Challenges remain in health and safety, with workers still operating machinery without personal protective equipment, as well as insufficient wage levels. Capacity building in unionisation and collective bargaining is also needed. Management and employees state that unions are redundant because of good working relationships, but such statements fail to recognise the value of a union in giving workers a collective voice and in levelling the playing field between management and employees.

Evaluation of workshops (general vendors) outside of Swedish and English supply chains, where no social requirements are mandated, reveals little change since 2007. Employees work in cramped, poorly lit workshops with no ventilation. They are paid a piece rate, have little safety equipment, and child labour is still common practice. Much remains to be done to improve working conditions in the industry as a whole.

A challenge emphasized by Pakistani manufacturers is the issue of pricing. In some cases prices have not increased since 2007, despite costs incurred through improving working conditions and rising energy prices. Management at exporting factories feel that without increased remuneration, they will be unable to continue improvements in working conditions for their employees. Swedish suppliers buying from Pakistan state that they cannot increase prices and remain competitive, because procurement tenders award contracts heavily based on price. These suppliers call for a model where efforts towards improving labour standards are evaluated together with price in the award criteria for contracts. The Swedish county councils state that social criteria are stipulated in the performance of a contract and are mandatory requirements for each supplier. They expect suppliers to include the costs for adhering to these requirements in the prices they tender.

In England, NHS Supply Chain has developed a good model to ensure labour standards are respected through the product supply chain. There is, however, a lack of engagement from the UK government with no clear requirement regarding social criteria in healthcare or other public procurement. At present it is NHS Supply Chain, a corporate entity, driving these issues forward in the UK. Other public buyers in the UK should also include social criteria in their contracts.

It is critical to resolve the issue of pricing to maximise the impact of social criteria in manufacturing countries. Improvements in labour standards incur costs for manufacturers, which both suppliers and public procurers must consider. A proposed model to deal with the issue of pricing is for procurement authorities to explore possibilities to integrate social criteria into award criteria, rather than only as contract performance clauses. Recent changes to the EU directives on public procurement may enable this. This strategy should not exclude suppliers unable to demonstrate commitment to better labour standards at the time of award, but may place them at a relative competitive disadvantage.

Overall, this report shows that introducing social criteria in the performance of public contracts to supply surgical instruments to Sweden and England are having tangible effects on the ground in Pakistan. New EU directives and the buying power of public authorities offer strong opportunities for EU member states to expand this work, and further promote labour rights in a range of goods procured by public buyers. Continued evaluation of policies and strategies will be a necessary part of future development. This also aligns with the UN Post-2015 Development Agenda, which highlights public procurement as one of many key drivers for sustainable development.

This report therefore recommends public authorities to exploit the full range of tools presented in the new EU directives with regards to setting social criteria in public contracts, as well as allocate adequate resources within the authorities for follow up, such as conducting audits, of social criteria in public contracts.

Personal protective equipment such as ear defenders are often missing. Some workers use earphones instead.

1. Introduction

Thousands of surgical instruments are used every day in operations throughout Sweden and the UK. The global market for surgical equipment was estimated at € 4.4 billion in 2013.[1] A growing proportion of the simple surgical instruments that reach healthcare providers are manufactured in Sialkot, Pakistan. Forming a cluster, the surgical instrument producers in this area are an established industry, producing more than 150 million surgical instruments every year, with a global market value of € 277 million in 2013-2014.[2]

Swedwatch and the British Medical Association (BMA) have separately conducted primary research and previously published several reports on the surgical manufacturing industry in Pakistan since 2007. The manufacturing conditions within the industry were first reported on by Dr Mahmood Bhutta in 2006[3] (who subsequently founded the Medical Fair and Ethical Trade Group at the BMA). The article, published in the British Medical Journal, exposed hazardous working environments and widespread use of child labour. A subsequent report by Swedwatch in 2007, reinforced these findings and uncovered several labour standard violations including poor remuneration and unfair contractual obligations. The reports called for fair and ethical trade policies to be instigated in healthcare procurement. The BMA has since then followed developments within the industry, publishing a further report in 2008. In a follow-up study, initiated by the Stockholm county council and conducted by Swedwatch in 2009 (published in 2010), improvements were reported as a result of increased social requirements from public buyers in Sweden. Improvements documented were mainly; prohibiting child labour and allowing the formation of unions to protect workers, but health and safety concerns, as well as excessive overtime and inadequate pay were still prevalent.

The findings from both Swedwatch and the BMA, highlighted the need for social criteria to be specified within public procurement contracts, and exposed the lack of requirements from public buyers in Sweden and the UK. As a result, social criteria relating to ethical procurement are now part of the procurement contracts of surgical instruments in Sweden, and have been introduced in some contracts in the UK. Recent developments in the legislative environment, with the adoption of new EU directives on public procurement, have also triggered a shift in focus towards labour standards in global supply chains. Social requirements are commonly becoming contractual obligations for global suppliers. The Swedish county councils' have initiated a national coordination programme on setting social criteria in contracts, whilst in the UK, distribution centres such as the NHS Supply Chain in England, have developed programmes to address labour standards issues.

According to the new EU directives on public procurement member states shall take appropriate measures to ensure that in the performance of public contracts economic operators comply with applicable obligations in the fields of environmental, social, and labour law. Public procurers will therefore have a responsibility to

1 PR Newswire, *Surgical Equipment: Technologies and Global Markets,* October 15, 2014.
2 The Surgical Instruments Manufacturers Association of Pakistan, http://www.simap.org.pk/.
3 Bhutta, MF, *Fair Trade for Surgical Instruments,* British Medical Journal, August 2006.

ensure that goods and services they procure are produced with respect for labour rights. Now that such demands are increasingly put forward in procurement contracts, the question is whether or not they have any actual effects for workers on the ground.

As a result of a joint research trip, and in order to compare buying strategies in Sweden and England, Swedwatch and the BMA have produced this joint report. The issue of ethical public procurement concerns all EU member states. This report aims to raise awareness among public buyers not only in Sweden and the UK, but all other member states, to encourage widespread incorporation of social criteria in EU public contracts.

2. Methodology

This report is the result of a joint research trip to Sialkot, Pakistan undertaken in October 2014 by Swedwatch and the BMA, as a follow up to these organisations' previous studies on the surgical manufacturing industry in Pakistan. This study does not evaluate the industry as a whole, but rather aims to look at selected surgical instrument manufacturers who export to Sweden and to NHS suppliers, to ascertain if improvements in working conditions and labour rights have been instigated since social criteria were embedded into procurement contracts. For more in depth background information to the industry, we refer to our previous reports.[4]

The aim of this trip was to increase understanding of the challenges that exist in relation to ethical procurement and of the multi-faceted problems in the surgical manufacturing industry. Specifically, the objectives of the trip were to:

- Follow up on previous studies by observing practice in factories and sub-contractors to assess for improvements in working conditions;
- Interview local manufacturers about the issue of fair and ethical trade, to discuss their role and perceived challenges in strengthening the respect of labour rights;
- Interview key informants within the industry to discuss their views on current problems regarding employment and working conditions.

The issue of ethical public procurement is relevant to all EU member states. This report therefore also aims to raise awareness among public buyers in EU member states other than Sweden and the UK.

In the case of the two factories supplying to Sweden, both have been visited by Swedwatch before – firstly in 2006, and again in 2009. A formal audit was conducted of

4 Swedwatch, *Vita rockar vassa saxar – en rapport om landstingens brist på etiska inköp,* 2007, Swedwatch, *Skärpta krav och villkor efter Swedwatchs avslöjande,* 2008, , Swedwatch, *Compliance Report on a Procurement of Simple Surgical Instruments,* 2010, BMA, *Visit to Surgical Instrument Manufacturing Zone Sialkot, Pakistan,* 2008.

the factory and their sub-contractors visited in 2009. The sub-contractors to that factory are the same as the ones visited for this report. The factories supplying to England were visited for the first time for this report.

In preparation for this report, the Swedish county councils provided Swedwatch with a list of suppliers for their surgical instruments contract. At the time of this research, there were eight companies supplying surgical instruments to the Swedish county councils, two of whom are supplying instruments manufactured in Pakistan; IM-Medico and Instrumenta. At our request, these two suppliers released information on their suppliers (exporting factories) in Pakistan. Swedwatch commissioned the Pakistani NGO, *Backwards Rehabilitation and Improvement Commission* (BRIC), to map the supply chain of sub-contractors supplying these exporting factories, and to conduct interviews with workers at these sub-contractors, in preparation for Swedwatch and the BMA's visit. BRIC visited a total of twelve sub-contracting units and interviewed 3-4 workers at each unit. The visits were unannounced and the workers were interviewed outside of the work place to ensure they were able to speak freely.

The procurement landscape for the UK National Health Service (NHS) is complex, and involves an array of direct and indirect routes for supply. For the purpose of this research trip, the BMA contacted suppliers that enter the NHS through local routes, i.e. provide directly to NHS providers, or through a distribution hub, namely NHS Supply Chain. In the UK, the NHS has separate organisations for England, Scotland, Wales, and Northern Ireland. This report focuses on suppliers to, and the procurement policies of, the NHS in England.

For the purpose of this visit, the BMA asked NHS supply chain to invite any companies currently under contract to supply surgical instruments to participate in this research project. We invited participation only from suppliers who manufacture in Sialkot, and participation was voluntary (under the current contractual regulations, neither the BMA nor NHS Supply Chain can mandate visits of manufacturing units by external parties). Two companies responded to this request: The Dental Directory, and Disposable Medical Instruments Ltd. Both of these companies source their products from Sialkot, and were happy to make direct contact with their suppliers to arrange site visits. Due to logistical difficulties, we were unable to visit the Sialkot supplier to Disposable Medical Instruments Ltd (Nawaz surgical) as part of this research project.

The BMA Medical Fair and Ethical Trade Group has also had previous contact with senior management in a relatively new surgical instrument manufacturer called Abarut Industries. This manufacturer has a factory in Sialkot, and the company was instigated with the explicit ethos of protecting labour rights for its workers. We were aware that this factory supplies a distributor to the NHS called DTR Medical, who supply direct to the NHS rather than through NHS Supply Chain. At our request, both Abarut Industries and DTR Medical agreed to also participate in this project.

Swedwatch and the BMA visited four surgical instrument manufacturing companies and seven sub-contracting units. Visits to factories were scheduled, but three of the

seven sub-contractors were visits were unannounced. Sub-contracting units were selected from the ones visited in advance by BRIC. Approximately 3-4 workers were individually interviewed at each location, within a private setting. Interviews were semi-structured, focusing on health and safety, working hours and remuneration, and freedom of association. All interviewees were given the option of remaining anonymous. Interviewees were chosen by Swedwatch and the BMA, aimed at representing workers at different stages of the production process. To protect the identity of those interviewed, names of the workers in this report have been changed.

It is important to emphasize that the visited factories and sub-contractors were not fully audited. The findings in this report are based on selected interviews and should therefore be regarded only as indicators for possible improvements. Written documentation was not verified in all cases, and this report cannot consequently guarantee that deviations from what is documented have not occurred.

Other relevant actors in the industry were also interviewed, including the Metal Industries Development Center (MIDC), a former International Labour Organisation (ILO) employee and forge workers in the city of Daska. Subsequent interviews by teleconference were conducted with the Surgical Instruments Manufacturers Association of Pakistan (SIMAP). Interviews have also been conducted with Swedish and UK based suppliers, and the Swedish County Council.

3. Background

When Swedwatch first looked at surgical instruments manufacturing in Sialkot in 2006, the Swedish county councils, procuring for the health care sector, had no social criteria what so ever in their contracts. The Swedwatch report *Vita rockar, vassa saxar,* from 2007 exposed the appalling working conditions in the workshops in Sialkot, and received widespread media attention. Shortly after this report the Swedish county councils started implementing social criteria, and do so today in the procurement of surgical instruments, as well as in seven other high-risk categories of goods.

In response to the initial findings by Bhutta in 2006, the BMA Medical Fair and Ethical Trade Group was established in 2007. Its purpose is to investigate, promote and facilitate fair and ethical trade in the production and supply of commodities to the healthcare industry. The work includes both development of national institutional and international policy, and supports those wishing to develop product lines that represent good practice in terms of social criteria.

3.1 Surgical instrument manufacturing in Sialkot

The surgical instruments manufacturing industry in Sialkot caters to the needs of both the national and international health industry. Figures from the Trade Development Authority of Pakistan, estimate around 2 300 companies engaged in this

FACTS

Pakistan

Population: 196 million (2014)
GDP: € 506 billion (2013)
GDP per capita: € 2 735 (2013)
GDP growth: 3.6% (2013)
Inflation rate: 7.7% (2013)
Unemployment rate: 6.6% (2013)
Youth unemployment rate: 7.7% (2013)
Population below poverty line: 21% (2013)
Literacy rate: 58% (2013)
Life expectancy at birth: 65.7 (2013)
Infant mortality rate: 57.48 deaths/1,000 live births (2014)
Female Labour Force Participation Rate: 22.7% (2013)

Pakistan is ranked 146 out of 187 countries in the UNDP Human Development Index 2014 and 126 out of 175 countries in the Transparency International Corruption Perception Index.

Sources: UNDP Pakistan, UNDP Human Development Index 2014, the CIA World Factbook, Transparency International Corruption Perception Index 2014.

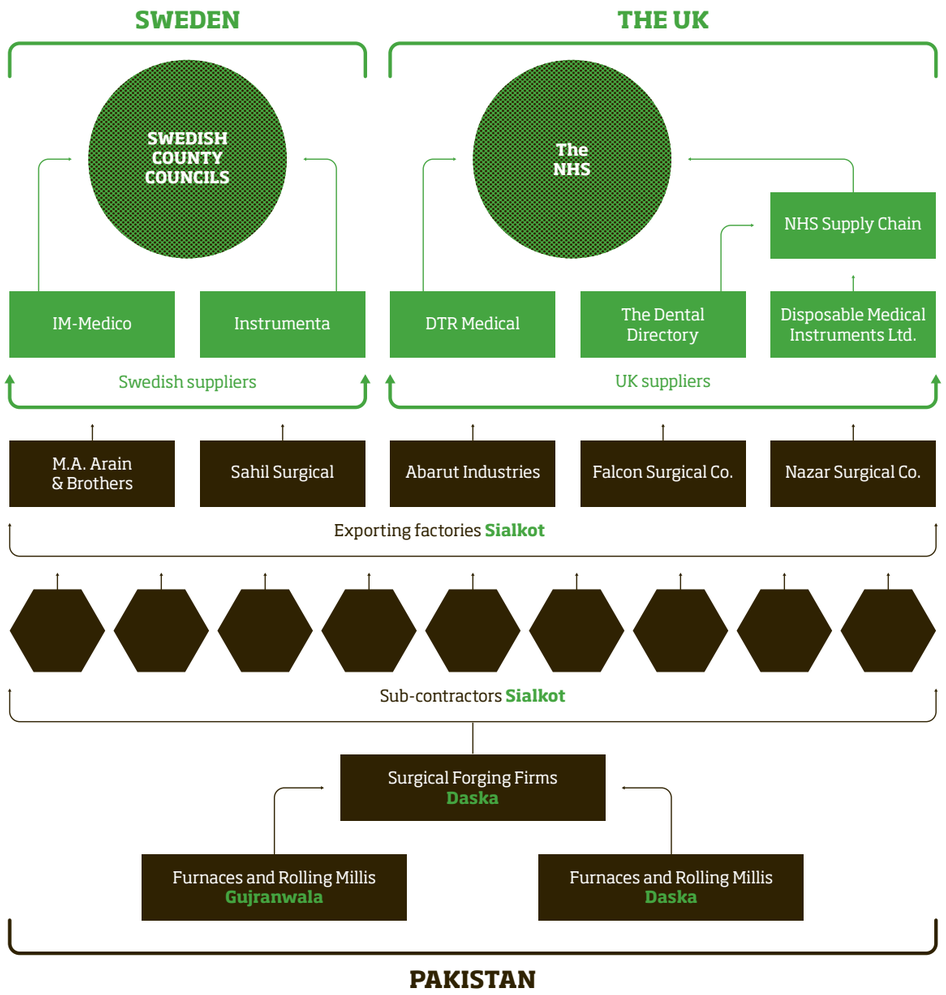
industry.[5] Almost 95% of the products are exported, and most of the firms are working as sub-contractors to international brands of European and USA origin. The instruments produced are of a wide range and variety including, retractors, scissors and forceps.

Surgical instrument manufacture is a multi-stage process. The final stages and quality control happens within exporting units. Earlier stages in the production may also happen in these units, and indeed the larger factories may undertake most or all of the manufacturing process in-house. Others will use sub-contractors for some or many of these stages, although larger factories may also use sub-contractors on demand, to meet temporary increases in production requirements. However, only a handful of units will undertake the initial forging of instruments in-house; many will sub-contract this stage to specialised forging units, especially in Daska, a town adjacent to Sialkot.[6]

Most of the subcontracted units work to order, being paid a piece rate rather than a regular income. The manufacturing process is labour intensive, and although mechanisation (with imported machinery) has been introduced in some of the larger factories, the majority of production is still manual.

5 Trade Development Authority of Pakistan, 2014 statistics, http://www.rcci.org.pk/wp-content/uploads/2012/12/SurgicalIndustry.pdf.
6 The Surgical Instruments Manufacturers Association of Pakistan, http://www.simap.org.pk/facts.php.

SUPPLY CHAIN OF SURGICAL INSTRUMENTS



The supply chain of surgical instruments contains several tiers before reaching the end-users in hospitals and clinics. This figure shows the different stages in the supply chains researched for this report.

3.2 Labour rights and legislation in Pakistan

Pakistan has ratified all eight ILO Core Conventions. The last one, ratified in 2006, was ILO Convention C138 concerning child labour and minimum age of work.[7] Nevertheless, Pakistan still remains a high-risk country concerning labour rights.

3.2.1 The Constitution of Pakistan

The Constitution of Pakistan, ratified in 1973, contains a range of provisions with regards to labour rights. The Constitution is the responsibility of both the Federal and Provincial governments.[8]

- Article 11; prohibits all forms of slavery, forced labour and child labour.
- Article 17; provides for a fundamental right to exercise freedom of association and the right to form unions.
- Article 18; proscribes the right of its citizens to enter upon any lawful profession or occupation and to conduct any lawful trade or business.
- Article 25; lays down the right to equality before the law and prohibition of discrimination on the grounds of sex alone.
- Article 37 (e); makes provisions for securing just and humane conditions of work, ensuring that children and women are not employed in vocations unsuited to their age or sex.

7 ILO, *Ratifications of fundamental Conventions and Protocols by country*.
8 Laws are enacted by the Federal Government, stipulating that Provincial Governments may make rules and regulations of their own according to the conditions prevailing in or for the specific requirements of the Provinces.

3.3 Minimum wage

In June 2014, the Federal Government raised the minimum wage from PKR 10 000 (€ 87) to PKR 12,000 (€ 104) per month for unskilled workers. This decision was replicated by the Punjab Government, governing Sialkot, and applicable from 1 July 2014.[9] The average household in Pakistan spends 42.6 % of its income on food.[10] Whereas the minimum wage has increased, so have living costs. Food prices have increased by 217 % since 2001, and in the same period the cost of petrol has increased 153 %, the cost of power 179 % and the cost of transport by 166 %. Most of these price increases have occurred in the last 5-6 years. Since 2007, the minimum wage has increased by only 93 %.[11]

3.3.1 Union activities

The Pakistan Workers' Federation (PWF) is the single largest national trade union centre in Pakistan. It currently has eight regional offices in the four provinces of Pakistan with an affiliation of 419 unions and a membership of more than 880 000 workers nationwide, representing the majority of unionized workers. PWF is a conglomeration of three previously existing bodies: All Pakistan Federation of Trade Unions, All Pakistan Federation of Labour, and the Pakistan National Federation of Trade Unions.[12] Although there are approximately 8 000 local unions in Pakistan today, only five % of the workforce are union members.[13]

The International Trade Union Confederation (ITUC) reports that in practice there are legal barriers to fully realizing freedom of association in Pakistan. Formal requirements for registering a union are complex and cumbersome. The power of authorities to dissolve a union is also reportedly misused, and employers often resist unionization, resorting to intimidation, dismissal and backlashing.[14]

9 The Punjab Gazette, Government of the Punjab Labour & Human Resource Department, *Notification on Minimum Wages Rates*, http://www.glxspace.com/2013/12/04/notification-minimum-wages-rates-labour-human-resource-department-punjab/.
10 Government of Pakistan Statistics Division Pakistan Bureau of Statistics Islamabad, *Household Integrated economic Survey 2011-12,* May 2013.
11 Harvard International Review, *Poverty and Poor Health in Pakistan: Exploring the Effects of Privatizing Healthcare*, June 15, 2014.
12 Pakistan Workers' Federation, http://www.pwf.org.pk/.
13 LO-TCO Biståndsnämnd, http://www.lotcobistand.org/pakistan#statsskick-och-politik.
14 ITUC, *Survey of Violations of Trade Union Rights.*

3.3.2 Protection of young workers

Article 11 (3) of Pakistan's Constitution prohibits the employment of children below the age of 14 in any factory, mine, or other hazardous employment. In addition, the Constitution makes it a principle of policy of the State of Pakistan to protect the child, to eliminate illiteracy and provide free and compulsory education. Despite child labour being criminalized by national law, an estimated 3.6 million children under the age of 14 work in Pakistan, mostly in exploitative and hazardous labour.[15]

4. Swedish and UK buyers

4.1 The Swedish county councils

There are 21 county councils in Sweden, responsible for the health care in each region. Together, they procure simple surgical instruments for approximately € 267 000 annually. The county councils started their work on social criteria in public procurement in 2007. This work was led by the three largest regions; Stockholm, Västra Götaland and Skåne. In 2008, the three county councils established a common code of conduct for suppliers and in 2009 a set of 11 questions for follow up of suppliers' compliance with the code of conduct was introduced. Cooperation between all of the county councils started in 2010, and since 2012 there is a formalized structure with a National Coordinator for social responsibility. The cooperation consists of a Steering Committee, a National Coordinator, an Expert Group, and point of contact at each county council.[16] Discussions with other Nordic countries have also been initiated in order to explore possibilities for joint efforts regarding social criteria in public procurement.[17]

The county councils have prioritized seven categories of goods for social criteria in public procurement, of which "surgical instruments and stainless steel medical products" is one.[18]

The categories are chosen due to high risk for adverse human rights and environmental impacts, as well as high procurement volumes. When buying these goods, integration of social criteria is a requirement of the procurement process. In 2015 the county councils plan on expanding the list with several more goods and service categories.

The county councils' code of conduct refers to the UN Universal Declaration of Human Rights, the eight ILO core conventions, the UN Convention on the Rights of the Child, national legislation regarding labour rights and environmental protection, as well as the UN Convention against Corruption. The requirements of the code of conduct are implemented through contract performance clauses. The ethos underlying this is that the county councils do not want requirements to be optional, but at the same time they do not wish to exclude suppliers not meeting criteria at the time of the bidding process. Contract performance clauses require suppliers to demonstrate compliance during the contract period, after the contract has been awarded.[19]

The contract performance clauses require suppliers to have procedures in place to ensure that the production of goods and/or services delivered during the term of the contract occurs under conditions that are compatible with the code of conduct. The procedures include:

- Clear responsibilities at the supplier regarding social responsibility in the supply chain;
- A description of how subcontractors used for production are assessed based on social criteria;
- The actual requirements demanded of sub-contractors in terms of social responsibility;
- A description of follow up procedures, verification and dialogue;
- Procedures for monitoring and maintaining dialogue with subcontractors;
- A process to address deviations.[20]

Suppliers who are awarded the contract need to account for how these requirements are met by answering a self-assessment questionnaire (SAQ). This consists of 15 questions regarding processes to identify and mitigate risk relating to the code of conduct, with responses uploaded to a shared database. Each year appointed county councils undertake an annual appraisal of social criteria within relevant contracts, with evaluation for different categories using a standardised template, and with results shared between all county councils[21] An expert group is also involved in the evaluation and follow up process. county councils reserve the right to perform audits further up the supply chain. If deviations to the code of conduct are identified, the supplier is required to address these within a set time frame. Repeated deviation or non-cooperation from a supplier is deemed a breach of contract, and may lead to contract termination.[22]

15 UNICEF, http://www.unicef.org/pakistan/overview.html.
16 Göthberg, Pauline, National Coordinator, Stockholm County Council, Interview October 7th 2014.
17 Statskontoret, *Förstudie om nordiskt samarbete rörande socialt och miljömässigt hållbar upphandling*, Dnr 2013/2012-5.
18 The other categories are: gloves, syringes and needles, first aid supplies, textiles, pharmaceuticals and IT.
19 Göthberg, P.
20 Socialt ansvarstagande i offentlig upphandling – Ett samarbete mellan Sveriges andsting och regioner, *Uppföljningsfrågor och förklaringstexter*.
21 Swedwatch developed the SAQ and evaluation template for the county councils in 2013.
22 Hållbarupphandling, http://xn--hllbarupphandling-8qb.se/index.php/dokument/category/3-hallbar-upphandling.

Even though chairs and workbenches were introduced at some factories and workshops, the workers still prefer to sit and work in the traditional way.

4.2 The UK National Health Service

In the UK, the National Health Service (NHS) is the fifth largest employer in the world, and spends in excess of € 53.4 billion annually on the procurement of goods and services. [23]

The BMA, through its Medical Fair and Ethical Trade Group, has been instrumental in promoting and supporting the development of ethical trade in healthcare products purchased in the NHS (as well as in collaboration with partners involved in procurement in other European countries). This is both through its work in highlighting labour rights abuse in the manufacture and supply of healthcare products, and through cooperation with relevant stakeholders to develop policy, tools and practice to support ethical trade. In 2011, in partnership with the UK Ethical Trading Initiative (ETI), the BMA released *Ethical Procurement for Health - a workbook for those procuring for health*[24], detailing a stepwise approach to developing a system to protect labour rights in supply chains.

Ethical trade in the NHS was also supported by the 2008-2013 UK government strategy *Health Is Global*[25], which recognised that free and ethical trade can support global development. In 2014, the NHS Sustainable Development Unit, accountable to NHS England and Public Health England, released a *Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020*[26] This envisages a sustainable health and social care system through the reduction of carbon emissions, protecting natural resources, preparing communities for extreme weather events, and promoting healthy lifestyles and environments. A commissioning and procurement[27] arm is contained within this strategy, and where this does not oppose ethical procurement, it fails to detail or mandate the protection of labour rights in supply chains to the NHS.

The UK National Action Plan on implementation of the UN Guiding Principles on Business and Human rights, states that the UK government is committed to ensuring that in procurement human rights related matters are reflected appropriately when purchasing goods, works and services.[28]

The procurement of goods and services within the NHS, is complex and may occur by direct supply to end-users, or through a number of local, regional or national procurement hubs. Contracts can range from a small-scale single purchase, to a large-scale contract awarded to run over several years.

23 NHS England, Sustainable Development Unit, *Commissioning and procurement*, http://www.sduhealth.org.uk/areas-of-focus/commissioning-and-procurement.aspx.
24 ETI, MFETG, BMA, *Ethical Procurement for Health: Workbook,* 2011,
25 Department of Health, *Health is Global – A UK Government Strategy 2008-13,* London, 2008.
26 NHS England, Sustainable Development Unit, *Sustainable Development Strategy for the Health and Care System 2014 – 2020*, http://www.sduhealth.org.uk/policy-strategy/engagement-resources.aspx.
27 NHS England, Sustainable Development Unit, *Commissioning and procurement*.
28 *Good Business – Implementing the UN Guiding Principles on Business and Human Rights,* CM 8695, September 2013.

The organisation NHS Supply Chain is the largest procurement hub for goods for the NHS in England. It procures around £2 billion worth of goods annually; around 40% of the total NHS spend on goods in England[29]. NHS Supply Chain also delivers these goods (effectively working as a logistics agency), which amounts to the annual distribution of around 600 000 products to over 600 healthcare organisations across England. It is run by a private company (at present DHL), under a contract awarded through an executive agency of the government (NHS Business Authority working for NHS England).

NHS Supply Chain has worked closely with the BMA's Medical Fair and Ethical Trade Group and with the UK Ethical Trading Initiative to develop systems to support ethical trade in its procurement. This includes the release in 2008 of a code of conduct[30] for all its suppliers and in 2012 the development of a Labour Standards Assurance System (LSAS). LSAS is a tool to develop and embed processes to protect labour rights into supply chains for contracts awarded by NHS Supply Chain, and is currently being applied to certain product categories deemed at risk of labour rights abuse.

Within LSAS there are four levels of maturity: foundation (level 1), implementation (level 2), established (level 3), and progressive (level 4). As a condition of contract, suppliers are obliged to achieve foundation status within six months of award of contract, and to then move towards higher stages, thus embedding continual improvement in systems designed to protect and promote good labour standards in supply chains. Restrictions are in place on product sales for all awarded suppliers until at least foundation level is reached. At present the system relies on self-assessment and self-reporting. Failure to achieve contractually defined goals invokes remedial action plans, with termination of contract seen as a last resort.

The LSAS was pioneered on the NHS Supply Chain Framework Agreement for Surgical Instruments in September 2012 (awarded in 2013), and is now being applied to contracts for other product categories.

5. Suppliers to Sweden and the UK

5.1 Swedish suppliers

The Swedish county councils report that overall, suppliers have had a positive approach to the new social requirements in Swedish procurement. However, the information in the self-assessment questionnaires has been inadequate. According to Pauline Göthberg, National Coordinator at the county councils, this may be due to a lack of CSR-expertise within companies. The county councils have therefore also been supporting suppliers with training and dialogue, but in order to increase the strength

29 Department of Health, *Better Procurement, Better Value, Better Care: A procurement Development Programme for the NHS*, 2013.
30 NHS Supply Chain, *Supplier Code of Conduct*.

and effectiveness of this and their other work, further resources and organizational commitment may be needed.

- This work is not done by itself. All county councils need to allocate staff, with the right qualifications, and financial resources. When we have a strong commitment matched with adequate resources we will see clear results of our work, says Pauline Göthberg.

The Swedish suppliers to the county councils also acknowledge that social requirements in public contracts have pushed them towards strengthening their work on social and labour rights in their supply chains.

FACTS

IM-Medico

IM-Medico is a Swedish company and part of the ADDvise Group. They provide lab equipment and technologies, surgical instruments and other health care products, as well as scales for use in research and industrial use. The company was founded in 1987, has an annual turnover of € 4.5 million, and a total of seven employees. The annual turnover related to surgical instruments from Pakistan is € 38 000. In January 2014 Tillquist Medical became part of IM-Medico. Tillquist Medical was the company supplying surgical instruments to the county councils in 2007, when Swedwatch published its first report on the surgical instruments manufacturing industry in Pakistan. IM-Medico uses M.A. Arain as their supplier in Pakistan, who was also the supplier to Tillquist in 2007. As a result of the Swedwatch report from 2007, Tillquist, and now IM-Medico, developed their own code of conduct which suppliers are required to adhere to. The code of conduct refers to national legislation in the countries of operation, ILO core conventions, fundamental human rights as defined by the UN, environmental standards and anti-corruption. Suppliers are also required to demand the same standards and respect of the code of conduct from their sub-contractors.[1]

Instrumenta

Instrumenta is a Swedish company distributing and marketing surgical and diagnostics instruments and medical-technical equipment. It was founded in 1989, has an annual turnover of € 3.6 million, and a total of ten employees. The annual turnover related to surgical instruments from Pakistan is € 143 000. Instrumenta's Pakistani supplier, Sahil Surgical, and their sub-contractors were audited by Swedwatch in 2009. Instrumenta has implemented social requirements regarding their products since 2004. The company's code of conduct refers to national legislation in the countries of operation, ILO core conventions, fundamental human rights as defined by the UN, environmental standards and anti-corruption. Suppliers are also required to demand the same standards and respect of the code of conduct from their sub-contractors. Instrumenta states that the requirements from the county councils has pushed forward their work on respecting social and labour rights in the supply chain.[2]

1 Akhtarzand, Rikard, CEO IM-Medico, Interview via mail, October 22nd 2014, IM-Medico, http://www.im-medico.se/om-im-medico/var-historia/.
2 Juhlin, Lars, Sales Manager Instrumenta, Interview via mail, October 24th 2014, Instrumenta, http://www.instrumenta.se/htm/omoss.htm.

5.2 UK suppliers

Initial engagement from surgical instrument suppliers to NHS Supply Chain's LSAS system was slow, but is now gathering momentum. Of the 29 surgical instruments suppliers awarded a contract by NHS Supply Chain in 2013, 28 have achieved foundation status on the LSAS (one supplier is in remedial action at the time of writing, but may have their contract terminated). Some surgical instrument suppliers have moved to higher levels within the LSAS system.

In discussions with The Dental Directory[31], they candidly stated that at the start of their contract they had considerable uncertainty over the content or extent of labour protection requirements stipulated by NHS Supply Chain. An initial audit was scheduled to help define the nature of these requirements, however the management team responsible for implementing LSAS were misinformed by the auditing firm, and set unrealistic initial objectives, including mapping the entire supply chain down to the mining of raw materials (this is better considered an aspiration on progressing through the LSAS programme, rather than an initial step). The Dental Directory have subsequently hired a part-time consultant to work on this programme, and now feel they are progressing[32]. The team expressed that they have invested substantial time and money into this process consequent to their uncertainty over the requirements or process of the LSAS system.

Disposable Medical Instruments Limited have also expressed uncertainty over the content or extent of labour protection requirements stipulated through their contract with NHS Supply Chain, and also wished for further clarity.

NHS Supply Chain provide webinars and other training to surgical instrument suppliers. However, it appears that this is insufficient for the needs of some of these suppliers. Further training may need to be provided by NHS Supply Chain, or by partners who could provide this service, with these partners identified and highlighted to suppliers.

31 Teleconference with Kevin Perry, Safety Manager, The Dental Directory, 21st October 2014.
32 Interview with Bob King, Consultant, The Dental Directory, 25 November 2014.

FACTS

The Dental Directory

The Dental Directory is a UK company supplying dentistry instruments nationwide. The company is looking to enter the surgical instruments industry, and was awarded a surgical instruments framework agreement through NHS Supply Chain in 2013. The company was founded in 1971, initially as Dental Supply Company, and later renamed in 1983 to Dental Directory. It employs over 250 people across its UK sites. Their manufacturing supplier in Sialkot is Falcon Surgical.[1] In an interview with the management team, Dental Directory admitted they had no experience or knowledge of fair or ethical principles in business prior to being subject to NHS Supply Chain's LSAS.

DTR Medical

This UK based supplier is a single use surgical instruments supplier, supplying several NHS providers directly. One of their primary suppliers from Sialkot is Abarut Industries. Through conversations with Abarut Industries, the BMA has been informed that compliance with the ETI base code of conduct[2] is embedded within quality control contracts with DTR Medical Ltd.[3]

Disposable Medical Instruments Limited

Disposable Medical Instruments Ltd (DMI), are an approved supplier to NHS Supply Chain. In 2013 they recruited a new member of staff whose portfolio includes management of the LSAS programme, and at present they are in the implementation phase (phase 2). DMI import products from three manufacturing sites in Sialkot, with the majority sourced from Nawaz Surgical Co. It was, however, not possible to visit the Nawaz Surgical Co. unit during the research visit to Sialkot.

1 The Dental Directory, https://www.dental-directory.co.uk/home/CompanyAndInfo/.
2 The ETI Base Code.
3 DTR Medical, http://www.dtrmedical.com/about/.

6. Back to Pakistan - findings on the ground

As stated previously, Swedwatch and the BMA have conducted research on working conditions in the surgical instruments manufacturing industry in Pakistan since 2007. An apparent lack of respect for human and labour rights in the industry exposed by these previous reports prompted public buyers in Sweden and the UK to act. The audit conducted by Swedwatch in 2009, commissioned by the Swedish county councils, was of Sahil Surgical (presented below) and their sub-contractors. Whereas improvements were reported, mainly with regard to strict prohibition of child labour and the respect for freedom of association, much was still lacking with regards to health and safety, excessive overtime, and inadequate pay – identified both at factory and sub-contractor level. Although the audit did not reveal anti-union activities, in contrast to the first study from 2006, several interviewed workers still stated that unions were not allowed in the industry, and they felt that if someone tried to form a union they would lose their jobs.[33]

The following section presents findings from the recent trip to Sialkot in October 2014.

6.1 Sialkot - a change in attitude in exporting factories

The city of Sialkot relies heavily on its surgical manufacturing industry. Throughout the city you can see workers in small workshops grinding, filing and polishing surgical instruments for one of the many exporting companies in the city. Workshops differ in size but often consist of no more than one or two rooms. Some are located in more quite, residential areas outside of the city centre, and others open to busy, dusty streets with heavy traffic.

The four factories visited during our trip to Pakistan differed in size and in how advanced their production facilities were, but in all four cases the impression overall was that they provided a clean working environment and that working conditions and labour rights were prioritized by management. There was a clear realisation by the management that these issues need to be addressed, due to increasing demands from buyers, but also to attract the best skilled workers.

– Workers are powerful. They are sought after, so you have to look after them well, explains Khizer Hayat, CEO of Falcon Surgical.

The workers interviewed also seemed, overall, satisfied with their work, with no major complaints expressed. These results confirm the findings from the preparatory interviews conducted by BRIC, where workers also consistently answered that they are satisfied with their work and that their situation has improved over the last years. BRIC themselves also underline that they could see improvements during this study as compared to before.

– We have been following the issues related to labour rights in the industry since 2006. What we saw this time around is far away from 2006 and 2009. Clear efforts towards improving labour standards were identified, says Liaqat Javed, Director, BRIC.

Despite the overall positive attitude of employees, several issues of non-compliance with labour standards were noticed during factory visits, as well as at sub-contractor level. These are described in the following chapter.

33 Swedwatch, 2010.

FACTS

M.A. Arain & Brothers

M.A. Arain & Brothers is a surgical manufacturing company exporting instruments all over the world, including to Sweden and a small proportion to the UK (details of the UK supply route were not provided). The company was founded in 1972 and has today over 300 employees. The factory in Sialkot undertakes the majority of stages within the production process, except forging. M.A. Arain has a total of 13 sub-contractors providing different services within the production process. Their Swedish buyer is IM-Medico. The Swedwatch report from 2007 looked at M.A. Arain and its sub-contractors.

Sahil Surgical

Sahil Surgical is a family owned business founded in 1982 in Sialkot. Currently they employ 15 workers and produce instruments for export. Their main market is China but Sweden is also a large buyer, comprising 25-30 % of their business. Sahil Surgical have supplied to the Swedish company Instrumenta since 1992. The factory has grinding, fixing polishing, checking and packaging departments. Over the last five years, they have developed a close relationship with three sub-contractors, who provide different services within the production process. Sahil Surgical, and their sub-contractors, were audited by Swedwatch in 2009.

Falcon Surgical Co.

Falcon Surgical Co. is one of the larger exporting factories in Sialkot with 450 employees. The company was founded in 1975 and exports all over the world, including to the UK. Most of the stages in the production process are undertaken in-house, with the exception of heat treatment which is outsourced to a sub-contractor. Their main UK buyer is The Dental Directory, with whom they have had a relationship over several years.

Abarut Industries

Abarut Industries was established in 2011 with the aim of being an “ethical factory”, to promote good working conditions for labourers in the industry. The factory has approximately 20 employees and provides facilities for grinding, polishing, chemical treatment, fixing, checking and packaging. DTR medical is their largest buyer.

6.1.1 Provision of minimum wage, contracts and benefits

The workers interviewed at all four factories were paid the minimum wage of PKR 12 000 (€ 104) per month, and a double rate for overtime. No workers stated that they exceeded the legal limit of overtime per week. We were shown written contracts for the workers but there still was an issue of recent employees not becoming permanently employed after a year, as prescribed by national law. Compared to previous reports there is a clear improvement with regard to all workers being paid a monthly salary in compliance with the minimum wage level.

All of the four factories provided medical treatment if needed, contributed to a pension fund, as well as social security plans for their employees, as required by Pakistani law. All four factories also usually offered financial support to employees to cover the cost of weddings, renovations etc. if requested to do so. M.A. Arain, Sahil Surgical and Falcon Surgical all covered employees’ tuition fees for their children. Abarut Industries had ambitions to do the same in the near future. Falcon Surgical furthermore offered all employees seasonal food grains throughout the year, at a fixed price, and provided subsidised residential housing for six employees (available through a lottery system). Abarut Industries routinely provided lunch to their employees at no cost.

6.1.2 A lack of unions

None of the factories visited had an established union of workers. The management, in all four cases, stated that they would welcome the establishment of a union, but they claimed that workers were simply not interested in forming one. The factory managers told us that they have a good relationship with their employees and have an open door policy, encouraging workers to voice grievances directly. Management also informed us that there is no tradition of solving work related issues through a union and therefor there is no need for one. M.A. Arain has had a worker council since 2011 with three seats for worker representatives comprising two men and one woman. The employees elect their representatives and the council is responsible for discussing worker related issues with the management. But according to Tariq Mahmood, Administration and Export Director for M.A. Arain, the workers still prefer to come to him directly. When asked what kind of grievances the workers file, we were shown applications asking for financial support for weddings, renovations, tuition fees, etc. In the case of Sahil Surgical the management provides a suggestion box that the workers can use if they have any grievances, but it is rarely used.

The Swedish county councils require information from suppliers with regard to the type of training exercises and grievance mechanisms provided in their supply chain. Clearly, further efforts in this regard are needed, and could maybe form a specific question raised by county councils during their follow up of suppliers.

While the management at the factories might see the open door policy as effective, applications for financial support do not constitute work related grievances. Rather, the lack of complaints is an indication of a non-functional process. The same can be said of the empty suggestion box, and in that case employee illiteracy might also be a factor.

The good relationship with management was nevertheless confirmed at all four factories when we interviewed workers. In all cases the workers stated that they did not need a union, because they were satisfied with their work, and they can talk to the management, and that they do listen.

– I have friends working at other factories, this one is special. Ours is better, says Ali Rashid, a worker at Sahil Surgical.

Prohibition of child labour is now strictly enforced at the exporting factories and their sub-contractors.

The lack of unions in the industry still indicates that freedom of association is not respected. The difference compared to previous reports is that the workers now say that they do not see the need for a union, whereas workers previously felt that starting a union would lead to dismissal. The workers appear no longer to think that unions might get them fired, but they may lack awareness regarding the role of a union as well as awareness regarding their rights. In order to fully realize freedom of association, employees need to be trained on labour rights and the role of unions. However, such efforts may be hampered by legal barriers to the formation of unions in Pakistan, and by the strong resistance to unionisation by many employers.

6.1.3 "No child labour" policies at all factories

A strict no child labour policy is applied at all four factories, as well as being a requirement of their sub-contractors. It was clear that preventing child labour was the first and foremost priority of the factory management when talking about ethical trade. M.A. Arain and Sahil stated that if a sub-contractor was found to be using child labour, the company would work towards ensuring the child returns to full time education.

The ILO has previously worked on projects to eliminate child labour in Pakistan. During our trip, we secured a teleconference with a former employee of the ILO Pakistan County Office. The representative (who wishes to remain anonymous) led a program of work in Pakistan that focused on the elimination of child labour.

The former representative informed us that interest from local partners to act was largely driven by global media exposure of child labour in these regions. In the soccer ball industry (another major industry in Sialkot) 5 383 children previously employed in the sector had been mainstreamed into formal schools, and a further 10 572 provided with non-formal education, through a programme in part instigated following media reports.

In 2000 the ILO sought to replicate and expand this approach to the surgical instruments manufacturing industry, and partnered with the Surgical Instruments Manufacturers Association of Pakistan (SIMAP). The partnership however failed to secure financial contribution from the industry to support the prevention, withdrawal, and rehabilitation efforts proposed. Cooperation and ownership from industry stakeholders was deemed pivotal to ensure that an internal monitoring system was established, but was not forthcoming according to the former ILO representative. We were told the relationship with SIMAP soon disbanded.

6.1.4 Lack of health & safety measures

The main issue that still needs improvement is poor personal protective equipment (PPE) at all four factories. Several stages of the manufacturing process can result in injury, and workers are exposed to metal dust and deafening noise levels in the grinding rooms.

The workers we saw did not use ear defenders. When questioned, workers stated that they had received training and that personal protective equipment was available, but they do not want to use ear defenders because they are uncomfortable. At M.A. Arain a worker handling chemicals only had cotton gloves and a cotton face mask, which affords insufficient protection against chemical hazard. The chemical processing room at Falcon Surgical was in a tight space with poor ventilation and only fans kept potentially toxic fumes from filling the room. When we visited Sahil Surgical all workers operating machinery were wearing face masks, but the masks were impeccably clean implying that this was done for our visit and is not standard practice. Lack of safety equipment such as guards and proper grinding tools were also a serious issue at all of the factories. When asked about this, the management at Abarut Industries explained that during maintenance the workers sometimes remove guards installed on machinery, and then do not put them back on because they find them inconvenient.

In all four factories management stated that they provide regular health and safety training for their employees as well as for sub-contractors, which was confirmed by the interviewed workers. Nevertheless, a lack of awareness amongst the workers and a lack of enforcement of standards by management was apparent.

Although health and safety remains an unresolved and crucial issue, some improvements with regards to the working environment were noticed since the last report, including in lighting, cleanliness, and in some cases better equipment.

6.1.5 Gender inequality

Of the four factories visited only M.A. Arain employed female workers, mostly in the packaging and checking departments, where they work separately from male employees, due to cultural norms.

– It is important for us not to discriminate in any way due to gender, race or religion. We therefore have a diversified workforce, says Tariq Mahmood, Administration and Export Director M.A. Arain.

At the other factories the management explained that women simply do not apply for jobs. Whereas Sahil Surgical and Abarut Industries stated that they do not have a policy against employing women, the CEO of Falcon Surgical told us that they do not employ women because it would cause trouble if men and women work together. Although cultural norms in Pakistan may be a factor in such discrimination, a policy of not employing women is in violation of ILO standards, and unacceptable. M.A. Arain has demonstrated ways of offering equal opportunities consistent with local cultural norms, and this approach should be adopted by other factories.

– I like working here. As a woman it is not easy to get a job, says Aisha Rana, a female worker at M.A. Arain.

6.1.6 The challenge of price

When asked about challenges within the industry and what is needed to further improve labour standards, a recurring answer from factory management at all four sites was the issue of pricing and rising utility costs. Sameer Ahmed, Deputy Director of Metals Industries Development Center (MIDC)[34], a government institute in Sialkot, agrees.

– Change happens slowly in Pakistan, but we (MIDC) have contributed to moving the industry forward and improving manufacturing technics. The main challenges, and areas which need improvement, are satisfactory wage levels and high energy prices.

Tariq Mahmood at M.A. Arain says that the social requirements from IM-Medico are more extensive than other buyers, but at the same time they have barely increased

34 MIDC is a government institute in Sialkot, providing high end machinery and processes for small and medium sized companies to use in their manufacturing. MIDC was established in 1942, then under a different name, and aims towards pushing the industry forward through providing advanced manufacturing solutions, training and advisory services. The Center is non-profit, only charging for use of machinery.

Of all visited factories only M.A. Arain employed women, which indicates that gender inequality is an area for improvement.

their prices since 2007. During this period the cost of electricity has increased, and almost doubled over the last year.

- We want to improve the situation for workers, but the buyers need to understand the costs. They do not want to pay much but have lots of demands. Without suitable prices how is it possible for us to improve? asks Tariq Mahmood.

When Swedwatch asked Rikard Akhtarzand, CEO of IM-Medico, about the pricing issue he stated they are currently negotiating pricing with M.A. Arain. He emphasised that it is not possible for them to increase prices significantly due to strong competition from other Swedish surgical instrument suppliers, and because the award of procurement contracts by Swedish county councils is heavily based on price.

In the case of Sahil Surgical and Instrumenta, the two companies have agreed on several price increases since 2010, partly as a result of regular annual increases, and partly due to better compliance with labour standards. Overall, the price has increased approximately 14 % over four years. Lars Juhlin, Sales Manager at Instrumenta, also points out that now, when price is the decisive factor in awarding contracts, they do not feel able to continue increasing prices for their suppliers in Pakistan and still remain competitive. He calls for a procurement model where suppliers showing commitment to human and labour rights at the time of the tender are prioritized when awarding the contract.

Early stages of production at a sub-contracting unit. The worker lacks personal protective equipment.

A comparison of the prices of IM-Medico and Instrumenta, to the county councils, shows that they are more or less the same, although IM-Medico generally sells for a marginally higher price. Although IM-Medico has not increased their prices since 2007, this shows that the 14 % increase by Instrumenta still puts the companies at almost the same price level today.[35]

Pauline Göthberg, National Coordinator at the Swedish county councils, explains however that not only price is evaluated in the contracts.

– Our code of conduct contains mandatory social and environmental criteria. We therefore expect suppliers to include costs relating to adhering to these standards when setting their prices.

The challenge for suppliers to the county councils is that although respect for the code of conduct is mandatory, the suppliers are evaluated on this criterion only after the contract is awarded. The work and costs that suppliers allocate to ethical buying practices is not considered when awarding the contract. A potential supplier with a higher price can therefore be excluded even though they may include costs for improving

35 Stockholms läns landsting, *Upphandling sammanställning,* SLL480, Instrument och sjukvårdsartiklar.

labour standards. Failure to consider increased costs as a result of improved working conditions may limit the effectiveness of social criteria in public contracts. Regardless of the model used to set social criteria in public contracts, it is essential for public authorities to allocate sufficient resources to follow up on contracts, and ensure requirements are adhered to.

The senior management team at Falcon Surgical had a good attitude towards, and understanding of, ethical principles and practices. This was evident through the array of employee incentives offered demonstrating the company's awareness of the national socioeconomic environment. The management team were supportive of labour rights, and showed a willingness and commitment to implement remedial actions if, and where, necessary. Policies on child labour have been enforced due to increasing pressure from purchasers – which included UN agencies. The main concern highlighted, was price. Despite the price increase of stainless steel and sharp increases in the price of utilities, exporting companies are unable to raise their prices at the risk of becoming uncompetitive. We were shown a purchasing catalogue from 1995 where we could clearly see that the cost unit price had not changed, and remained fixed for nearly ten years.

The issue of pricing remains a challenge, without an obvious solution. Setting a minimum price may be appropriate, if the revenue is shared appropriately throughout the supply chain. However, an agreed pricing structure may be difficult to achieve in a price-sensitive competitive environment, and it is not easy to ascertain which actors within the supply and procurement process can engender this change.

When discussing the issue of pricing with UK and Swedish suppliers, they explained that a possible means to rectify this could be for companies to work together collaboratively as an industry, as it is unlikely that each individual company imports from different manufacturing sites in Pakistan. This is to ensure that there is no duplication of efforts, and that there is a consistent demand that is manageable for exporting companies in Pakistan. We heard that while this is desirable, the industry environment at present will not allow for it because of lack of transparency and competition. More research is required to identify a pre-competitive space that will allow for such collaborative discussions to take place. Due to regulations in EU competition law an agreed minimum price among UK or Swedish buyers might not be legal.

An alternative is for minimum pricing to be agreed through a collaboration of manufacturers in Pakistan. Given Sialkot's domination of the world market for surgical instruments, such a strategy would seem unlikely to damage the industry by sending business elsewhere. However, such strategies have previously been tried. Our discussions with the General Secretary and Chairman of the Surgical Instruments Manufacturers Association of Pakistan (SIMAP) revealed that the industry has previously set a minimum exporting price for steel instruments, determined by the type and specification of the instrument (e.g. surgical grade, dental grade, or beauty grade). Minimum exporting price was introduced in 2011, as a collaboration of the Pakistani government and SIMAP, but we were advised that this pricing structure was not

respected by all exporting units, and is now effectively defunct.[36] This idea could be reignited, with stronger systems to ensure that any locally agreed pricing structure in Pakistan is respected, or enforced, either through SIMAP, the government, or a new player.

- We can only do so much, but there are still problems in the industry which are outside of our control. The government needs to take responsibility, says Muhammad Safdar, CEO of Sahil Surgical.

6.1.7 Dialogue with buyers

There was a difference in the extent of communication and contact between exporting factories and their buyers in Sweden and the UK.

Muhammad Safdar at Sahil Surgical emphasized the close and long lasting relationship the factory has with Instrumenta in Sweden, and the support they have been given towards improvements. Since Swedwatch's audit in 2009 of Sahil Surgical and their sub-suppliers, Instrumenta has conducted four audits. After each audit an improvement plan was agreed and later followed up. In interviews with Instrumenta they state that the most apparent risks in their supply chain are related to health and safety and compensation levels for unskilled workers.

Tariq Mahmood at M.A. Arain states that IM-Medico has not conducted any audits or visited the factory since 2007. Rikard Akhtarzand at IM-Medico confirms this, but states that they have not identified any risks in their supply chain, and that M.A. Arain have signed an agreement to respect the company's code of conduct. Not conducting any audits and relying solely on a commitment from suppliers to respect the code of conduct is not sufficient. Stronger engagement is needed from IM-Medico. Clearly, potential violations of the code of conduct are still present in their supply chain. According to IM-Medico, an audit of M.A. Arain is planned for 2015.

Dental Directory, DTR Medical and DMI state that they have good long-standing relationships with their manufacturers in Sialkot. The Chairman of Falcon Surgical confirmed he is in regular communication with the Dental Directory, and is aware of the content and requirements of NHS Supply Chain's LSAS. The company operates a strict vendor approval system, which include policies on child labour, and ISO certification requirements.

Similarly, Abarut Industries stated a good relationship with DTR medical, although this is a relatively new relationship.

DMI Ltd will be visiting Pakistani suppliers in mid 2015 with the explicit purpose of evaluating how imposed labour standards requirements are translating to real change, and what further support is required.

36 Interview, teleconference, with Tahir Ashfaque, General Secretary SIMAP, and Muhammad Amjad, Chairman SIMAP, November 25th 2014.

6.2 Further down the supply chain

6.2.1 Sub-contractors in Sialkot - improvements, but challenges remain

Requirements from the Swedish county councils state that suppliers are obliged to ensure that their code of conduct is adhered to throughout the supply chain. During the trip to Sialkot a total of seven sub-contractors were visited, four supplying M.A. Arain and three supplying Sahil Surgical. The three supplying Sahil Surgical were also visited by Swedwatch in 2009. These sub-contractors were identified by BRIC in preparation of our trip. Falcon Surgical rarely use subcontractors, and said that they did not see it as their responsibility to enquire about sub-contractor activities. No sub-contractors supplying to Falcon Surgical or Abarut Industries were visited.

Both M.A. Arain and Sahil Surgical stated that they have strict control over their supply chain, only sourcing from approved sub-contractors. Sub-contractors are expected to follow the same labour standards as the exporting factories and are audited on a regular basis by the exporting factories. The exporting factories also provide training on health and safety for their sub-contracted units. Instrumenta had translated their code of conduct to Urdu, and Sahil Surgical has distributed it to their sub-contractors. These changes are a significant improvement from the previous Swedwatch report, in that the exporting factories now only source from approved sub-contractors, in that they provide training, and in that they conduct regular audits. This was also verified by BRIC when they conducted their preparatory research and mapped the supply chains of the exporting factories.

The standard at the premises of the sub-contractors was lower than that of the exporting factories. Spaces were often cramped, poorly lit and with inadequate ventilation. Sub-contractors usually consist of small workshops focusing on specific, less advanced, stages of the production process. The number of workers varied from ten to twenty.

The owners of all the visited sub-contractors assured us that they do not further subcontract any part of the orders they receive from the exporting factories, but some of Sahil Surgical's sub-contractors do work for other factories. This information, however, has not been verified. When asked about the different companies' approach to worker related issues and labour rights, their view was that Sahil Surgical helps them more than others, in terms of training. One manager stated that Sahil Surgical was better because they placed more orders than the other factories, so the positive attitude might simply reflect more business loyalty.

All of the interviewed workers stated that they earned at least the legal minimum wage and that they were paid on time. If correct, this is an improvement over previous reports, where employees at sub-contracted units often were paid a piece rate, and the factories did not always pay on time. Some workers answered that they exceed the legal overtime limit, but they do so by choice. Even though it was clear that child labour was not allowed at the sub-contractors, many of the workers started working as children themselves, over ten years ago. The risk of child labour is still present in the supply chain, but the commitment towards prohibiting children from working at the workshops is stronger today than in previous studies.

The workers had an overall positive attitude towards their work and emphasized that things had improved. Both workers and management also spoke of skilled workers being sought after, and that the employers could therefore not afford to mistreat their workers.

- We have no problems here and the management treats us well. They know that if we are dissatisfied we can change to another workshop, says Abdul Naveed, a worker at one of the sub-contractors.

When asked what improvements are needed, the workers consistently answered that they hope for more orders so that they can earn more. This indicates that salary levels for many may still be insufficient. Some also mentioned better machines and facilities. There were no unions at the sub-contractors, and the workers did not feel the need for one.

- The management listens to us. We do not have to fight with them, explains Haqi Abbas, a worker at one of the sub-contractors.

It is important however to highlight that many businesses are family owned, and it is not uncommon that the workers are related to the management, which might influence their attitude towards their work. Here the same can also be said as previously regarding the need for unions; workers should be trained regarding their rights, and the role of unions.

Lack of proper health and safety measures was identified as the main issue at all sub-contracting units. Several used power generators with deafening noise levels, and the grinding machines added to that. Workers did not use ear defenders, but some used earphones to listen to music instead. Guards on the machines were missing and workers stated that they do sometimes get injured, but that management always takes care of injuries and pays hospital bills if necessary.

Although much work remains with regards to raising health and safety standards at the workshops to an acceptable level, clear improvements in the working environment were noticed compared to previous visits, mainly with regards to cleanliness and the work spaces.

A worker we interviewed outside of the workshop premises, at his home, told us that the situation for him as a worker had improved, due in a large part to a change in approach from the owners, and a more cooperative attitude from the management. He has worked in the industry for 25 years and started himself at the age of 15.

- Things were much worse then, step by step it is getting better. But I still wish I could leave this place for a better life for me and my family. I earn 14 000 rupees per month, without overtime. I have to pay 5 000 rupees per month for each of my three children for them to go to school. So I have to work overtime every day, says Abu Mianriaz.

6.2.2 Forges in Daska - noisy, with risk of injury

Forging is the process for shaping metal parts through compressive forces (either hot or cold) and is the first stage of manufacture of surgical instruments. We visited the main area for forging in Daska, a town adjacent to Sialkot. Forges in Daska supply casts of millions of surgical, medical, beauty, and veterinary instruments. Stainless steel furnaces and rolling mills are also located in Daska and a neighbouring town Gujranwala.

Of the units we visited in Sialkot, the majority sourced from surgical forging firms in Daska. We visited a medium sized firm, Najam Surgical Forging Works. This forge has operated since 1985 and currently employs approximately 50 workers. This firm houses furnaces, rolling mills, forging machines, as well as the tools for the finer process of trimming and filing, using steel sourced from Japan.

The work space was noisy, cramped and with poor lighting and ventilation. We were told by the senior management team that whilst the infrastructure and working environment are not adequate for the needs of the firm, they do support labour rights and have implemented policies to demonstrate this. Workers receive the minimum wage as an initial salary, but have the opportunity to earn more as they develop skills. They operate a strict ban on child labour, but the management team did allude to the existence of child labour in smaller backstreet workshops in the area (they estimated 250 workshops of this nature). We were unable to investigate this because most surgical forging firms and units are closed to the public. When we asked what prompted this particular firm to operate a no child labour policy, we were told that the demand came from larger clients who actively included this requirement within their contract. Whereas the manufacturers acknowledged short-comings in labour conditions, they highlighted the concern of price. We were told that with a continual “race to the bottom” on price, and the need to remain competitive, there are insufficient financial resources to remedy these issues without further support.

We were able to interview an employee from the firm, who reinforced that the situation outside of regulated firms is dismal. The worker reported that outside of his unit there is no formal accountability, pay is significantly below minimum wage, the working environment is dirty, and safety measures are extremely poor. When asked about unionization within the firm, the worker stated there was no need, as any concerns a member of staff may have can be directly taken to management. This situation is different in other parts of the industry.

– There is no union here, but they need it outside (referring to the smaller unregulated workshops), says Imran Muhammad, a worker at the forge.

The use of health and safety equipment was inadequate, and again the workers stated that they chose not to use the protective equipment provided.

– Yes, we have been given defenders and masks, but we do not need to wear them. It slows down our work, says Ali Hamza, a worker at the forge.

Child labour is still common practice at the general vendors and a risk buyers need to consider and mitigate.

In the event of an injury, which the workers agreed did happen frequently, all medical costs are covered by the firm.

6.2.3 General vendors - child labour still prevalent

In Sialkot there are thousands of small workshops undertaking work for whoever places orders. These workshops are called general vendors. These workshops do not knowingly supply the factories named in this report, but we report on them in order to give a picture of the industry as a whole. We cannot guarantee that these general vendors are not part of the supply chain of instruments exported to Sweden or the UK, even if exporting factories and their sub-contractors stated that that is not the case.

The general vendors we visited were chosen at random and visits were unprepared. Working conditions at the vendors were much worse than at the factories or sub-contractors. Rooms were dirty, cramped and with poor or no ventilation. It did not take long for us to find children working at the workshops. At one of the workshops we saw a young boy sorting and packing instruments. The owner emphasized that this was just a boy from the neighbourhood who was interested in the work and liked spending time at the workshops. However, the boy clearly knew what he was doing

and did it systematically. At another workshop the manager admitted that the boy we saw was his seven year old son who worked there.

- My two eldest sons, seven and ten years old, have to work so that I can send my two youngest children to school, says Sajid Aznar, the manager of the workshop.

The boy operated the grinding wheels and did some polishing work. He worked six days a week, 10-11 hours per day and earned PK 4 000 (€ 35) per month, well below the minimum wage. He stated that he did not enjoy his work.

The workers we talked to at the general vendors all said that the piece rate they are paid has been lowered and that they have to negotiate the price for every order.

- We small vendors have no voice and no say. We need a makers union and leaders who are experienced to look out for our interests. But we need education and support for this, says Abdul Abbas, a worker at a general vendor.

When asked about child labour, some workers were reluctant to admit that children did work at the workshops. Others spoke openly about it, but saw it as a necessity.

- Children have to work. What we get paid is not enough to support a family and send the children to school, adds Abdul Abbas.

Health and safety safeguards at the general vendors were absent, with no safety equipment at all. Workers informed us that injuries do happen, and that the management does not cover costs. A recurring event mentioned by workers was the grinding wheel coming free at full speed, due to dismantled safety guards on machines. One worker recounted a friend of his being hit in the head by a grinding wheel. He survived but is permanently disabled and unable to work again.

The contrast between the working environment at the general vendors and the approved sub-contractors supplying the factories exporting to Sweden clearly shows improvements made in parts of the industry subject to labour rights safeguards. However, working conditions at the general vendors are at the same low standards documented in 2006. A risk of adverse labour rights when sourcing from Pakistan is still present. Swedish and UK buyers need to actively and continuously check their supply chains to ensure that instruments they are buying are produced in accordance with the social criteria of public contracts. It is insufficient to simply have manufacturers in Pakistan sign a code of conduct.

7. New EU Directives on public procurement

In December 2011 the Commission proposed the revision of Directives 2004/17/EC (procurement in the water, energy, transport and postal services sectors) and 2004/18/EC (public works, supply and service contracts), as well as the adoption of a directive on concession contracts. The directives were voted on by the European Parliament on 15 January 2014 and adopted by the Council on 11 February 2014. EU Member States have until April 2016 to transpose the new directives into national law.[37]

One of the main focuses of the new directives is on social and environmental criteria. In the preamble the directives clearly state that:

"Public procurement plays a key role in the Europe 2020 Strategy (...) as one of the market-based instruments to be used to achieve smart, sustainable and inclusive growth while ensuring the most efficient use of public funds."[38]

This statement signals that social criteria are now a priority. Furthermore, a new article under *Principles of Procurement*, Article 18.2 has been added, promoting compliance with social and labour requirements in the performance of public contracts:

"Member States shall take appropriate measures to ensure that in the performance of public contracts economic operators comply with applicable obligations in the fields of environmental, social and labour law established by Union law, national law, collective agreements or by the international environmental, social and labour law provisions listed in Annex X."[39]

Setting social criteria is no longer just a possibility for procurers, but a requirement. Indeed the new directives also include an option for contracting authorities to exclude suppliers deemed to be in violation of social and labour related standards, Article 57.4 (a).

37 Council of the European Union, *Council adopts directives for the reform of public procurement,* February 11th 2014.

38 Directive 2004/18/EC, preamble 2), http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014L0024&from=EN.

39 Annex X includes: ILO Convention 87 on Freedom of Association and the Protection of the Right to Organise; ILO Convention 98 on the Right to Organise and Collective Bargaining; ILO Convention 29 on Forced Labour; ILO Convention 105 on the Abolition of Forced Labour; ILO Convention 138 on Minimum Age; ILO Convention 111 on Discrimination (Employment and Occupation); ILO Convention 100 on Equal Remuneration; ILO Convention 182 on Worst Forms of Child Labour; Vienna Convention for the protection of the Ozone Layer and its Montreal Protocol on substances that deplete the Ozone Layer; Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal (Basel Convention); Stockholm Convention on Persistent Organic Pollutants (Stockholm POPs Convention); Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (UNEP/FAO) (The PIC Convention) Rotterdam, 10 September 1998, and its three regional protocols.

Support for sustainable procurement is further emphasized in Article 68 which encourages public authorities to consider the full life-cycle of products in their purchasing decisions, not only the immediate price. Contracting authorities may consider criteria related to production of the works, services or supplies to be purchased, hence incorporating costs of improving labour standards in manufacturing countries in tender evaluations.

A further important development in the new directives is Article 46; division of contracts into lots. The "apply or explain" principle, allows contracting authorities to divide contracts into lots, or provide an indication of the main reasons for their decision not to do so. This division of contracts facilitates small and medium enterprises to participate in bidding processes by allowing them to bid on the number of lots within their capacity. This could make it easier for producers in Pakistan to supply directly to purchasing authorities.

Besides the strong commitment to social criteria in the new directive, public procurement is also emphasised as an important tool in implementing the UN Post-2015 Development Agenda.[40]

The new directives provide a set of tools to incorporate social criteria and considerations into public procurement. By combining mandatory requirements in the form of contract performance clauses with optional requirements in the form of award criteria, public authorities could support suppliers that demonstrate ethical manufacturing practices at the time of bidding. Award criteria could focus on more progressive processes, for example whether a supplier demonstrates active involvement in labour rights training down the supply chain, or how a supplier ensures a living wage to factory workers. Such criteria could allow a higher immediate cost price. Suppliers unable to demonstrate such processes could still be awarded the contract, but without any compensation on price. Thus, no suppliers would be excluded, but those with relevant processes in place gain a competitive advantage. Any supplier awarded the contract will nevertheless need to adhere to a code of conduct for protecting labour rights, as detailed in contract performance clauses.

In 2014, and in response to the new EU Directives, the UK Cabinet Office undertook public consultation on a draft of new public procurement regulations[41]. The UK government are looking to transpose the directives by spring 2015. In Sweden, a first draft of a new legislative proposal has been under public consultation.[42] A final draft of the legislative proposal is scheduled during 2015, in order to transpose the directive in Sweden by spring 2016.

40 United Nations, *The Road to Dignity by 2030: Ending Poverty, Transforming All Lives and Protecting the Planet – Synthesis Report of the Secretary-General On the Post-2015 Agenda,* New York, December 2014.

41 UK Cabinet Office, *Transposing the 2014 EU Procurement Directives,* 30 January 2015.

42 SOU 2014:51 *Nya regler om upphandling – Delbetänkande av Genomförandeutredningen,* Stockholm 2014.

8. Conclusions

This report demonstrates that contractual obligations imposed by purchasing authorities in Sweden and the UK have had a demonstrable effect on improvements in labour rights for employees subject to these contractual obligations in the surgical instruments manufacturing sector in Pakistan. This should encourage an expansion of this programme, to include further improvements in working conditions in this industry, to expand into other at risk product categories, to consider pricing and procurement initiatives to give competitive advantage to suppliers improving labour rights in their supply chains, and to expand this programme to other purchasing authorities in Europe.

Despite improvements there is still much work to be done. Health and safety awareness and practice needs to be better. In almost every factory or workshop we visited employees did not use proper personal protective equipment, due to a lack of understanding why they should, despite health and safety training. A lack of awareness amongst the workers and a lack of enforcement of standards by management were apparent. Factory management needs to re-evaluate the health and safety training they provide, and need to better enforce health and safety regulations to prevent employees operating machinery without guards, ear defenders or goggles.

Child labour is still a widespread problem in the industry, and a risk which needs to be recognised and mitigated when sourcing from Pakistan. Unions and collective bargaining also need strengthening. Both management and workers told us that unions are not needed because they have good relations with each other. But even in the circumstance of good relations between workers and management, a union can be beneficial to give workers a collective voice and level the playing field between management and employees. Most workers could not say what improvements with regards to labour rights they saw as necessary, which signifies a need for education on labour rights and collective bargaining, a role that unions could fulfil.

A union or organization for small vendors and sub-contractors is also needed. SIMAP somewhat represents the interest of exporting factories, but smaller vendors have no collective voice to strengthen their position in the industry or to improve working conditions. Working conditions are still very poor at the general vendor and small workshop levels, and also at the forges in Daska.

Respect for national legislation regarding wages and working hours has improved, workers at sub-contracted units however still view overtime as a necessity in order to earn a wage to live on. Furthermore, women are employed at only one factory, indicating that gender inequality is an area for improvement.

Demands from international buyers have, nevertheless, had real effects on the ground. Increased social requirements have initiated an active approach towards improving working conditions from managers in supplying factories. We found that management prioritized these issues, and wanted to work towards continued improvements. This is driven not only by requirements from buyers, but also because managers realise other advantages, such as employee loyalty, from promoting a good work environment and satisfied employees.

Buyers do however need to look further than direct suppliers. The most severe risks of adverse human rights impacts are usually found further down the supply chain. To enable effective follow up of social criteria in awarded contracts, resources need to be allocated to identify risk in the entire supply chain, and to push suppliers and manufacturers to continual improvement.

One persisting challenge to progress is the issue of price. We have heard from manufactures in Pakistan that the market is price driven, and they receive no compensation for improvements in policy and practice with regard to social and labour rights. The increased costs incurred with improving working conditions need to be reflected in pricing. There is an opportunity for suppliers, contracting authorities, or manufacturers to explore options for minimum fair pricing.

The Swedish county councils have noticeably improved their processes since Swedwatch first looked at their buying practices in 2007. The model the Swedish county councils have developed could be adapted on a larger scale. The joint code of conduct, follow up procedures, and sharing of information is cost effective for contracting authorities, and also facilitates the work of suppliers who are required to answer basically the same set of questions in their contract with a potential range of public buyers in Sweden. Manufacturers in producing countries also benefit, as they do not need to anticipate constant audits. This model could be scaled up to include other buyers in Sweden.

In the UK healthcare purchasing is more complex and fragmented, and there is still a long way to go, with many actors to influence. NHS Supply Chain has developed a good model to ensure labour standards are respected through their supply chain, and have been influential in triggering action within the industry. There is, however, a lack of engagement from the UK government with no clear requirement regarding social criteria in healthcare or other public procurement. At present it is NHS Supply Chain, a corporate entity, driving these issues forward in the UK. Other public buyers in the UK should also include social criteria in their contracts.

We also see an opportunity for coordination with other EU member states, for example by expanding the Swedish model across Europe. A collaborative model to promote ethical principles and practices in medical supply chains would seem effective for both purchasing authorities and for suppliers.

Contracting authorities need to consider how they can better support suppliers able to demonstrate commitment to respecting labour rights. The argument for setting social criteria as contract performance clauses is to instigate mandatory requirements, whilst not excluding suppliers from the tender. This report shows that suppliers of surgical instruments are already working with these issues, and are even themselves requesting stricter requirements from public authorities. It is therefore time to explore possibilities for combining contract performance clauses with award criteria to give competitive advantage to suppliers showing commitment to protecting labour rights at the time of award. This should not exclude suppliers unable to show such commitment at the time of award, but could place them at a relative competitive disadvantage. Obviously, this is not a one size fits all solution but needs to be adapted to different sectors and categories of goods and services.

Compared to the smaller workshops, M.A. Arain provides adequate lighting and ventilation at the workstations.

Support is also needed in terms of identifying the training needs of suppliers under these new tendering and contractual frameworks. Many suppliers will be inexperienced in the processes required to protect labour rights in their supply chains. In addition public authorities need resources to effectively follow up on social criteria in public contracts, regardless of the model being used.

The public sector in Europe has significant collective spending power, and an expansion of social criteria in public contracts could significantly impact upon poverty reduction, improvements in working conditions and empowerment of employees in source nations.

9. Recommendations

To the Swedish county councils

- Evaluate a model where the decisive factor in awarding contracts is not only price, but can include a suppliers' sustainability performance;
- Exploit the full range of tools presented in the new EU directives with regards to setting social criteria in public contracts;
- Continue dialogue with other contracting authorities to coordinate efforts in social criteria in public procurement and look into possibilities for further collaborations;
- Allocate adequate resources within the county councils for follow up of social criteria, such as conducting audits;
- Identify additional needs and resources to support suppliers in implementing contractual requirements with regards to labour rights.

To NHS Supply Chain

- Evaluate a model where the decisive factor in awarding contracts is not only price, but can include a suppliers' sustainability performance;
- Exploit the full range of tools presented in the new EU directives with regards to setting social criteria in public contracts;
- Further develop the Labour Standards Assurance System (LSAS) to require all suppliers to continually report on progress and to allow audit of any approved supplier;
- Encourage other procurement organisations to follow the LSAS model by sharing best practice;

- Identify additional needs and resources to support suppliers in implementing contractual requirements with regards to labour rights.

To suppliers to the Swedish county councils and the NHS

- Clearly communicate demands and expectations, as well as cooperate closely with the suppliers in Pakistan by regularly following up on improvements;
- Acknowledge that improved working conditions need to be reflected in pricing and explore how fair pricing can be achieved;
- Focus on awareness raising and training for employees regarding their rights;
- Approach procurement organisations as an industry in order to improve the model for awarding contracts.

To the Swedish Government

- In the transposition of the EU directives, exploit the full range of tools presented in these directives with regard to setting social criteria in public contracts;
- Include commitment in the National Action Plan on implementation of the UN Guiding Principles on Business and Human Rights to ensure that goods and services procured are produced and delivered in accordance with human rights and labour standards;
- Act at EU-level to increase cooperation between member states in developing standards for social criteria in public procurement.

To the UK Government

- In the transposition of the EU directives, exploit the full range of tools presented in these directives with regards to setting social criteria in public contracts;
- Provide explicit policy to support or mandate the protection of labour rights in those procuring on behalf of the NHS or other public bodies;
- Provide appropriate resources to enable the adoption of such policies in practice;
- Act at EU-level to increase cooperation between member states in developing standards for social criteria in public procurement.

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