Combating hazardous and exploitative child labour in surgical instruments manufacturing through prevention, withdrawal and rehabilitation – Phase II

Quick Facts

Countries: Pakistan

Final Evaluation: February 2009

Mode of Evaluation: Independent

Technical Area: Child Labour

Evaluation Management: ILO-IPEC's Design, Evaluation and Documentation Section (DED)

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Background & Context

Summary of the project purpose, logic and structure

Since the mid-1990s, the Government of Pakistan and the private sector had come under intense international pressure to take steps for the elimination of child labour, particularly in the country's export industries.

Both the surgical and soccer ball industries in Sialkot were seriously affected by the withdrawal of the Grant for Social Protection (GSP) by the US in mid 1996. Pakistan was also suspended from the list of countries eligible for the Generalized System of Preferences (GSP) for handicraft textiles in June 1996 by the US. To address this problem, International Labour Organization (ILO), Sialkot Chamber of Commerce and Industry (SCCI) and UNICEF signed the Atlanta Agreement in 1997, which initiated a multi-pronged programme in 1998 to address the child labour problem in the soccer ball industry in Sialkot. This was the first major child labour programme initiated by ILO-IPEC in Pakistan. This was followed by another initiative taken by the Italian Social Partners in collaboration with ILO-IPEC and the surgical instruments manufacturers (the Surgical Instruments Manufacturers Association of Pakistan, (SIMAP) for combating child labour in the surgical instruments industry in Sialkot district.

The first phase of this project, entitled 'Combating Hazardous and Exploitative Child Labour in Surgical Instruments Manufacturing through Prevention, Withdrawal and Rehabilitation', was launched in 1999. The surgical project built on, and became an integral part of the ILO-IPEC country programme in Pakistan. It focused on the provision of education and other support services to a large number of children and the need to address the health and safety problems in the workplaces by removing, or at least reducing, the hazardous working conditions in surgical instruments production. An internal evaluation conducted in March 2002 for Phase

I, despite identifying positive impacts, indicated that the government, employers, workers groups, community, parents, as well as children, were unanimous in asserting that more needed to be done to achieve the goal of eliminating child labour in the surgical instruments industry. The project was thus extended into a second phase which commenced in 2003. The second phase of the surgical project pursued an expansion of the programme to cover larger numbers of children and to promote the sustainability of action.

The second phase of the project had the following objectives:

> Child labour in surgical instruments manufacturing (including underage workers, hazardous situations and exploitative working conditions) reduced by 50% in the targeted areas of Sialkot district through the provision of education and other support services to children.
> Awareness of child labour issues raised among stakeholders and partners and action initiated to address health and safety problems in the workplace.

Present situation of project
The planned pre-vocational component was delayed due to SIMAP seeming concern about the quality of training providers/institutions available in Sialkot.

Project personnel did however negotiate with different institutions, especially with Technical Education & Vocational Training Authority (TEVTA), which is a government operated training agency to initiate this training activity. Relevant teaching materials (for a three-months training course) were also prepared by TEVTA in August 2007.

However, the actual training did not commence since TEVTA itself was keener to have both an age and qualifications criteria which was not very appropriate for children working in the surgical project. During the bridging phase, the district government has proposed to provide vocational skills training within literacy centres being established at the union council level under the District Child Labour Elimination Plan of Action (DCLEPA). When this activity will actually unfold on ground remains to be seen.

Purpose, scope and clients of the evaluation
The independent evaluation focuses on the Phase II of the 'Combating Hazardous and Exploitative Child Labour in Surgical Instruments Manufacturing through Prevention, Withdrawal and Rehabilitation' project. The scope of this evaluation is the initial project design, as well as assessing the strategies and models of intervention used within the project, and whether and how these can be integrated into planning processes and implementation for future ILO-IPEC support to address child labour in Pakistan.

Besides considering broader evaluation imperatives including relevance, effectiveness, efficiency and sustainability, this evaluation report will aim to ascertain whether specific project objectives were achieved at the policy level, as well as at the organizational (partner) and beneficiaries' levels.

The evaluation will also review levels of complementarities and synergy existing between activities carried out by various implementing partners and the local government of Sialkot, as well as highlighting any linkages created by the project with the IPEC project of support of the Time Bound Programme and the Decent Work Country Programme

Methodology of evaluation
In view of the above stated purposes and scope of the evaluation, which had been outlined in more detail in the terms of reference (TORs) prepared for the evaluation (see Annex I), the consultant commenced the twenty days assignment by undertaking a desk review of relevant project documents.

This desk review focused on numerous project documents including the project proposal, its

logical framework of analysis (LFA), the annual and quarterly progress reports, and the information, education and communication (IEC) materials produced by the project.

Based on the suggested aspects to be addressed section of the TORs, which identifies a range of issues identified by key stakeholders in the consultative process, (see 'suggested aspects to be addressed' at the end of the annexed TORs), some further queries were prepared by the evaluator for specific project stakeholders including the implementing partners, line departments, the Pakistan Workers Federation and the Surgical Instrument Manufacturers Association of Pakistan (see Annex II).

Then, the evaluator conducted a five-day field visit to various project sites in Sialkot so as to interview project staff and project partners and beneficiaries, as well as other key stakeholders including local government officials. Relevant stakeholders were also consulted in Lahore and in Islamabad (see Annex III for a list of interviewees).

The rest of the allocated time for the evaluation was time preparing field notes and the evaluation report (see Annex IV detailing evaluation activities).

Main Findings & Conclusions

The project design for Phase II of the surgical project was logical and coherent. It tried to take into account the relevant institutional arrangements and also specified potential roles of concerned stakeholders in order to achieve its specific objectives. For instance, the project design aimed to create linkages with the local government, as well as with concerned stakeholders like SIMAP, and tried to involve them in registering vendors, and to take responsibility for monitoring the vendor workshops with regards to child labour.

However, the project design did not take into account the capacity and commitment of stakeholders like SIMAP, as well as the manufacturers and vendors to eliminate child labour in the surgical sector. Therefore, while the project design was internally logical, it was not accurate in terms of specifying roles of concerned stakeholders based on ground realities which in this case implied designing interventions based on the real capacity and commitment of the concerned stakeholders, and supplementing any shortcomings with supplemental activities to ensure achievement of specific objectives.

Although survey research had been conducted on the surgical sector prior to launching Phase II of the project, more in-depth analysis of the informal actors (vendors) and their interaction with manufacturers and their larger association SIMAP could have been taken into consideration at the time of the design to identify alternative strategies, and/or supplemental inputs.

Due to the unforeseen problems faced by the project with regards to interacting with these key stakeholders, despite implementation of activities such as registration of vendors, the desired objectives of the project with regards to adoption of OSH at vendor workshops, or monitoring child labour at these vendor workshops were hindered. Phase II built on the existing capacity and local efforts of project partners which were already underway in Phase I to address child labour and promote educational opportunities for targeted children. These same partner organizations (Sudhaar and BLCC) and relevant line departments were also subsequently involved in the project of support to the TBP.

A series of useful direct interventions covering the targeted beneficiaries (children and their families involved in the surgical sector) have been introduced under the surgical project. The project has also managed to create liaison with the most relevant stakeholders concerning this issue, however, the fact of the matter remains that the surgical sector is still not child labour free after several years of ILOIPEC support (under Phase I and II as well as the TBP support project). SIMAP, and the

concerned manufacturers and vendors registered by the project were not keen to facilitate monitoring of the withdrawal process.

Moreover, while the 2001 survey commissioned by the ILO-IPEC Surgical Project found a majority of surgical children lived in homes owned by their parents, which is indicative of the fact that these children do not belong to the poorest of the poor households, project personnel and partners argued that children working in the surgical goods industry required strong rehabilitative efforts to ensure complete withdraw from the profession (in comparison to children working in the carpet and soccer industry, who are less skilled and receive less remuneration, and therefore require lesser efforts to stop working).

Yet, the surgical project could not offer much more to children working in the surgical sector other than NFE education. The micro-credit initiative included in the project was too modest in scope to enable families of these children to engage themselves and their children (over 14 years of age) in alternate livelihood opportunities.

Finally, while the implementing partners did manage to involve local communities in a range of activities during the time that the project was being implemented, these on-ground actors at the community level were not strengthened to plan, initiate, implement and evaluate actions to prevent and eliminate child labour. Besides some awareness-raising, the project was therefore not able to provide tangible opportunities to curb the supply of child labour.

The project design itself did not contain any provisions for ensuring sustainability of project accomplishments like community mobilization.

Recommendations, Lessons Learned and Good Practices

Main recommendations and follow-up

1. The proposed 'vendor friendly policy' to be adopted by SIMAP must also be based on the principle of cost effectiveness, quality assurance, and vendor reliability, besides promoting notions of OSH and prevention of child labour

2. While IEC materials were developed and awareness workshops arranged by the CIWC&E, partner NGOs could also have been used for creating OSH awareness amongst a larger audience. Focus group discussions with relevant communities, or even the use of street theatre conducted just outside the vendor shops would have provided an effective medium for creating awareness concerning health hazards of metal dust, for instance, which workers at vendor shops currently seem oblivious to.

3. Request PWF mobilizers to wear masks while registering more vendors

4. If BLCC is linking any more workers at vendor workshops to the Kushali Bank under the briding phase, an effort should be made to expose these loan recipients to relevant OSH practices, by visiting the best five model workshops (if nothing else is possible at this late stage of project implementation)

5. The monitoring mechanism within the project which has already become dormant needs to be revived, and redesigned if required during the bridging phase. There is a possibility of using the precedent set by the Decent Work Programme which led to articulation of the Sialkot Initiative to monitor vendors in the soccer industry (Independent Monitoring Association on Child Labour; IMAC, is the independent monitoring mechanism established with ILO support for the soccer ball industry). Besides IMAC, EFP may be able to push the idea of adopting a vendor friendly policy to SIMAP and perhaps accentuate the short term benefits of this

policy to the vendors themselves, as well as its long term benefits to SIMAP.

6. The ILO and the (local) government need to ensure serious commitment of the vendors/manufactures and SIMAP to make the surgical sector child labour free and to ensure that SIMAP takes a more proactive role in ensuring utilization of OSH equipments at the vendor workshops by in turn convincing manufacturers to take the responsibility of ensuring this compliance. Social mobilization though NGOs and relevant platforms like PWF to apply pressure on these stakeholders to eliminate child labour and adopt OSH practices in the surgical sector is another possibility which the ILO may further explore, in addition to working with the government and the stakeholders themselves.

7. There is a possibility of forming another coalition of small surgical producers/exporters; SIMAP II (a precedent to this effect exists in the tanneries industry in Kasur), which may then work with implanting partner NGOs and the PWF to monitor vendor shops.

8. While either of the above options could be used to revive monitoring, and linking it with the district based monitoring system, the eventual scope of the latter option (option 2) will be limited and also more risky as it may fuel a sense of alienation of SIMAP.

9. Now the District Assembly has the "Child Labour Free Sialkot" resolution and a notification to this effect has also been issued for compliance with the "minimum wage" and "child labour" standards. The District Government has also developed the "District Child Labour Elimination Plan of Action (DCLEPA") and thus it is recommended that SIMAP should work very closely with the DCO to eliminate CL from the surgical sector, rather than waiting for another ILO project to address this problem.

Important lessons learned

> Perhaps allowing CWIC&E to select the locations of the OSH model workshops may have improved their quality. The existing quality of OSH practices adopted within the model workshops itself diminishes the possibility of them being replicated.

> Moreover, it must be realized that the concept of OSH is itself only one aspect of a decent working environment, which requires not only OSH standards but also a range of other labour standards like working hours, minimum wage and observance of employment contracts. Such issues have been addressed in parallel ILO-IPEC activities like the Sialkot Initiative, and their resonance within Phase II of the surgical project could also have been sought.

> PWF has very limited capacity to act as a watchdog or access to vendors given the fact that it has not yet been able to unionize many workers working.

> Vendors themselves are hard to motivate given that they have no obligation to the outside world, and are primarily linked to their manufacturers, with the exception of some mid-sized vendors who have direct access to exporters, even the exact number of whom is also not known with any certainty.

> Since vendor registration is not yet comprehensive, it does not provide baseline information concerning child labour or occupational safety and hazard concerns in vendor workshops as a whole. The Ministry of Labour is however planning to initiate a labour survey, which is meant to be mapping labour in different sectors, whether this exercise will produce a reliable source of information concerning the situation in surgical vendor workshops remains to be seen. The ILOIPEC project should at least try to compare its existing data on registered vendors with the findings emerging from the labour survey within Sialkot.

> Phase II of the surgical project has built upon findings emerging from Phase I. One of these findings was the need to further involve workshop vendors within the project, while the

other was to have a more explicit strategy in place to mainstream children after providing them non-formal education.

> Furthermore, Phase II of the project can also be considered part of a continuum which subsequently facilitated implementation of the TBP support project in Sialkot. Building on the sequential experience of both phases of the surgical project, the TBP support project made a more concerted effort to involve local government stakeholders in its activities, and bolster mechanisms like the project advisory committee to take a more active part in TBP support project activities in the form of a district coordination committee, headed by the District Coordination Officer.

> It was also in retrospect of demands emerging from the surgical projects that the project of support to TBP realized the necessity to offer literacy and vocational trainings instead of focusing on NFE alone.

> The utility of forming mother groups within the TBP support project was also based on the encouraging experience of working with mothers within the community mobilization component of the surgical project. Based on success with mainstreaming children under Phase II of the surgical project, this target was increased for the TBP support project. Also, the age of children working in child labour was also extended to focus on the 14 to 18 year old age group in the TBP support project which was not being given due attention in the surgical projects.

Good Practices

> Realising the need for ownership of the project interventions by the stakeholders, 90 Community Education Committees were organized by the project. The project also managed to mobilize 160 allied community groups comprising of mothers, vendors and children. 83 teachers' training workshops were conducted by the implementing agencies, to provide teachers modern techniques of teaching, joyful learning, multigrade system and psychology of the working children. The community had in turn contributed more than 100,000 rupees for children activities in different NFE centres. The community had paid electricity bills, provided encouragement awards, sport kits, drawing books and colour pencils to NFE children. Subsequently, some of these interventions like the community based schools established by NFE teachers (mentioned in detail in the sub-sections above) are still operational on ground to date.

> Although the implementing partners of the project were meant to organize communities of the target groups for support in further activities whereby they could potentially have secured access to government funds for educational and other welfare schemes during the phasing out of the ILO-IPEC project, this did not happen. The implementing Non-government Organizations (NGOs) pointed out that some project funding should have been set aside for ensuring the sustainability of project interventions or capitalizing on emergent opportunities, like creating a common platform or vendors (a possibility mentioned by Sudhar). Project partners themselves were however also supposed to try to help children within their NFEs secure scholarships, and to provide poor families access to other government offered social safety nets. While some instances of this may exist on ground, they do not seem to be statistically significant. The bridging phase has thus particularly aimed to provide microcredits.

> While the surgical project has not yielded replicable models, some of its achievements can be built upon within the context of the Sialkot Initiative and by the National Time Bound Programme which is to be implemented from 2008 to 2016, whereby the Ministry of Labour has envisioned creation of a federal and provincial level coordination committees, which would also be replicated at the district level and involve public private partnerships to focus on labour within the formal as well as informal sectors. ILO has expressed its willingness to work with the government in Sialkot, since it has already put in place a

mechanism to this effect under the TBP support project. The intention to pilot labour inspections would be undertaken within the context.

> Phase II of the surgical project did adopt a flexible and process-based approach for eradication of child labour by means of identifying age cohorts and identifying corresponding actions for these cohorts. Implementing partners mentioned for instance that they had adopted a zero tolerance for children under nine years of age working at all and insisted that these children be sent to NFE and then be mainstreamed. Conversely, the project operated NFEs remained willing to enrol older children into its NFE centres even if they were still working at the vendor workshops. As the surgical industry was declared 'hazardous', it is not admissible even for children over 14 to be working in it, albeit some processes are more hazardous than others, which enabled identification of numerous areas within the vendor workshops where children over 14 to work under approved conditions like strict adult supervision, work for not more than four hours, provided they are also getting an education.

> Prior to the ILO-IPEC project intervention, there was not much authentic information available on the volume and related issues concerning child labour in the surgical industry in Sialkot. ILO-IPEC commissioned surveys for Phase I and II of the project have provided a greater understanding of the scope of the problem. Other project activities have added to the knowledge base concerning child labour and OSH issues in the surgical instruments industry. A comprehensive child profile, on the approved format devised by ILO-IPEC in Geneva was also computerized (it was this same format which should have been used to ensure duplication being prevented under the TBP support project).