International Labour Organization

BetterWork

Assessment of Health Care Services Provided to Workers in the Garment Sector in Jordan

October 2022

Better Work Jordan: Better Work Jordan was created in 2009 as a partnership between the UN's International Labour Organization (ILO) and the International Finance Corporation (IFC), a member of the World Bank Group. The programme engages with workers, employers, and governments to improve working conditions and boost the competitiveness of the garment industry. For more information, see:

https://betterwork.org/where-we-work/jordan/

Phenix Center for Economics & Informatics Studies: is a non-governmental organization dedicated to independent policy research and measuring public opinions on impactful current and emerging issues in areas of economics, society, and its legislative environment in Jordan. The Center was founded in Amman, Jordan in 2003 under the registration number 142203. Phenix Center works to promote a sustainable developmental paradigm in Jordan, rooted in human rights and the principles of democratic governance by focusing on reforming labor policies, lifting restrictions on freedom of association, and strengthening social protection policies. The Center specializes in promoting inclusivity in development processes by compiling databases of relevant actors and stakeholders, developing research, studies, papers, and reports, conducting conferences and advocacy campaigns and empowering several actors to take part in steering development through capacity-building.

https://en.phenixcenter.net/

Funding is provided by the United States Department of Labor under cooperative agreement number IL-21187-10-75-K. 100 percentage of the total costs of the project is financed with Federal funds, for a total of 1,550,000 dollars. This material does not necessarily reflect the views or policies of the United States Department of Labor, nor does mention of trade names, commercial products, or organizations imply endorsement by the United States Government.

This research would not have been possible without the workers and stakeholders who generously offered their insights and shared their experiences.

Printed in Jordan

Table of Contents

Acronyms

CBA	Collective Bargaining Agreement
Better Work	Better Work Jordan
ILO	International Labour Organisation
MoL	Ministry of Labour
MoH	Ministry of Health
BWJ	Better Work Jordan
SSC	Social Security Corporation
FTA	Free Trade Agreement
J-GATE	The Jordan Garments, Accessories & Textiles Exporter's Association
Trade Union / Union	The General Trade Union of Workers in Textile, Garment and Clothing

Foreword

Better Work Jordan (BWJ), a partnership between the International Labour Organisation (ILO) and the International Finance Cooperation (IFC), aims at improving working conditions, enhancing respect for labor rights, and boosting competitiveness. Approximately 63,000 workers in Jordan are covered by BWJ, most of whom are women (74%) and migrants (also 74%). Accoording to applicable legislation as well as the Collective Bargaining Agreement (CBA), employers have to provide health care services to their workers.

However, the quality of healthcare[1] provided by employers to employees in the garment sector has so far not been comprehensively assessed. The present study conducted by Phenix Center for Economics & Informatics Studies to assess the needs of workers in the garment sector in Jordan concerning health care services, the current situation of health services as provided by factory clinics, as well as legal gaps, and recommendations moving forward. It is the first comprehensive study of its kind.

This study relies mainly on existing secondary data as well as qualitative primary data from within the factories and involved stakeholders. Therefore, the authors of this study would like to thank the staff of BetterWork for granting access to their databases, facilitating contacts with factory management and for their great support throughout the data collection process. In addition, thanks go out to the General Trade Union of Garment Workers for supporting the organization of Focus Group Discussions as well as to factory management staff for granting access to their factories to facilitate the data collection for this study. Lastly, the authors would like to thank all workers who took part in the Focus Group Discussions, medical staff in the clinics, and all stakeholders who contributed their time and expertise during Key Informant Interviews.

Without the support of all parties, this study would not have been possible.

1 As defined by the WHO as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”

Executive Summary

During the last twenty years, Jordan has established itself as a garment exporting country. The industry is now one of Jordan's leading export sectors due to preferential treatment to export to the US Market under a Free Trade Agreement (FTA). In order to export under the FTA, Jordan's garment factories have to take part in the Better Work Program brokered by the International Labor Organisation (ILO). According to Better Work's Annual Report 2022, approximately 63,000 workers are covered by the program, of whom 74% are migrants, and 74% are women. According Jordanian legal framework and the Collective Bargaining Agreement, factories have to provide medical care to both migrant and Jordanian workers including the provision of health care clinics on-site at factories.This comes as the garment sector is characterized by a high number of migrant workers, who come to Jordan to work and do not have health insurance from their countries covering their health care needs. The quality of healthcare provided had so far not been comprehensively assessed. The present study, therefore, aimed to evaluate the quality of care provided at the health clinics and identify workers' health care needs as well as legal gaps. The ultimate aim of the study is to provide recommendations for the way forward for health care services in Jordan's garment sector.

In order to reach the study's findings, researchers used a mainly qualitative descriptive approach. To that extent, researchers, medical and legal experts conducted a comprehensive desk review identifying international health care standards. Based on this desk review, research tools were developed consisting of Focus Group Discussion Guides, a Quality Assurance Checklist for Health Clinics in Factories, and Key Informant Interview (KII) Guides. The team conducted five quality assurance visits to health clinics, conducted 9 Focus Group Discussions with workers representing the demographics of the overall workforce and 13 Key Informant Interviews. These interviews included representatives from the Ministry of Health, medical staff from a Trade Union clinic, representatives of factory managements and medical staff, as well as with a representative of the Trade Union, employers' organisations and international buyers.

Data collection covered three industrial zones and factories in Dulail, Irbid, Jerash, Sahab, South of Jordan, the Northern Jordan Valley and thereby included both main factories as well as satellite factories. In analyzing the data, the team-oriented itself along the standards stipulated by the World Health Organisation (WHO) on the Right to Health, namely that health care should be effective and efficient, safe, people-centered, timely and integrated, as well as equitable. In addition, the requirements of the Jordanian legal framework and the and the CBA guided the research.

In general, the study finds that compliance with international standards, the legal framework and the Collective Bargaining Agreement is generally quite weak. In addition, workers' satisfaction with the services differ on a variety of levels – depending on the factory location and its management, the nationality of workers and to some extent the gender of workers.

With regards to the effectiveness and efficiency of health care, the study finds that there is no standard minimum care package that needs to be provided, also because the CBA and other agreements are sufficiently vague or subject to legal misinterpretation. Workers in most factories reported that health clinics are not sufficiently prepared to deal with emergency situations and that serious conditions are

often referred to a nearby hospital without the health clinics being able to provide necessary first aid. Despite clinics not being allowed to have medication at the clinics due to legal restrictions for health care services at work places, medication was available. Quality assurance visits showed that on average, health clinics only had 10-30% of the medications deemed essential by the medical experts on stock, while only one health clinic had more than 50% of essential medication on hand. The observation team also noted that in most cases no records were kept on equipment and medication used or given out to patients. In most cases, a lack of equipment was reported by workers and observed during visits by medical experts. For example not all clinics had refrigeration facilities or blood pressure monitors: One female FGD participant reported that a diabetes patient stored her diabetes medicine in a water bottle to keep it from spoiling due to the absence of a refrigerator in her factory. In addition, medical experts observed a lack of health assessment forms and concluded that sometimes treatment and medication is given without a complete examination of workers. This matches workers' reports who stated that they would often receive treatment without examination. In general however, migrant workers reported a higher satisfaction with the health care services than Jordanian workers.

The latter reported issues also tie into the safety of health care services provided. In addition to the absence of health assessment forms and – sometimes –-incomplete examination of patients, workers also noted that on occasion they had received medication that would not match their illness or health concerns. Concerning sanitation issues, nearly all of the workers stated that the clinics had proper lighting and ventilation systems in place, however, when it came to hand washing facilities for staff and workers, improvements needed to be made in several clinics. Interestingly, while one clinic did not have running water at the clinic, nor drinking water for patients, the nurse present and the factory management assessed the facilities as "sufficient".

Concerning the people-centered aspect of the health care provided, variations were observed between factories, even though in all factories considered in the study workers felt comfortable speaking to medical staff. For one factory, workers even reported the ability of medical staff to address all their needs as sufficient and did not see any room for improvement. Nevertheless, dental and oral care was offered in no factory, and neither were maternal or prenatal services. In some factories, it was apparent that medical staff were not able to address workers' needs, which, at least as workers stated was due to the factory management. Researchers and the medical team observed and were told about violations with regard to sick leave allowances for workers. While workers across the board were aware of their rights, they reported that sometimes doctors at the factory health clinic, but also outside the clinic at hospitals were instructed not to give sick leave to workers. At one factory, the management would not accept a sick leave letter from a doctor outside the factory health clinic. Sick leave problems and illegal deductions for "unauthorized" sick leave even extended to patients with chronic diseases, and in one case a cancer patient.

Health care services provided at the factories were generally perceived as timely and efficient. Workers stated that going to the clinic was easy and even in cases where permission was required that was easy to obtain. However, the availability of medical staff varied from once per week to 24/7 in different factories. Similar variations were found with regards to the health care being equitable. In some cases, factories hired native speakers speaking the languages of migrant workers at the health clinics, while others did not have these facilities. Nevertheless, migrant workers were overall more likely to report positive experiences with the care provided, as more services were covered for them, including the

referral to an outside hospital. This however was not the case for most Jordanian workers, who in the absence of health insurance could not access the same level of care as their migrant worker colleagues. None of the clinics provides prenatal or maternal care or feminine hygiene products. In addition, some women reported that their request for sick leave based on menstrual pain was dismissed.

As a result of the above, they study finds that the international standards of care are mostly not adhered to. These are however, not legally enforceable but rather recommendations when designing and improving health systems. However, also when it comes to the requirements in the CBA, most factories are non-compliant or only partially compliant, or conclusions could not be drawn to due ambiguity of the CBA, in particular with regards to the quality of care provided in the health clinic. The CBA under Article 11 A states that garment factories are committing to: "Providing a health clinic at the workplace appropriately equipped with medical staff approved by the Ministry, including a general physician, and at least one nurse (male or female) certified by the Ministry of Health to provide adequate healthcare and required treatments." [2]

Finally, the study found that none of the factories studied could produce the licence by the Ministry of Health to prove their licenced status, and the observation team stated that most clinics would also not fulfill the requirements for licencing. An unlicenced status would also preclude any inspection visits by Ministry of Health staff to assess compliance with Ministry of Health standards.

The researchers have therefore developed the following concluding recommendations for stakeholders

- **Ministry of Labor :** Address the labor violations occurring in some factories through inspection
- **Ministry of Health :** Inspect and ensure licencing of health clinics
- **Ministry of Labor , International Labor Organization/ Better Work, Trade Union, Factory Management:** Ensure health and safety in clinics and factories
- **Ministry of Labor andThe General Trade Union of Workers in Textile, Garment and Clothing:** Conduct in-depth legal inquiry into the practice of preventing workers from taking medical leave for all factories
- **Factory Management:** Address "quick fix" challenges such as hygiene and cleanliness of bathrooms at factories
- **Factory Management:** Expand health services offered to women
- **All stakeholders:** Encourage knowledge sharing across factories within the garment sector
- **All stakeholders:** Conduct consultations among all stakeholders on the way forward

In addition, the following long-term recommendations are made:

- **Parties to CBA (The Jordan Garments, Accessories & Textiles Exporter's Association (JGATE), The General Trade Union of Workers in Textile, Garment and Clothing, Ministry of Labor):** Amend the collective bargaining agreement to ensure that specific requirements for the provision of health services are included and leave no room for different interpretations

2 First clause of the CBA, own emphasis

- **MoH:** Build the capacity of health clinic staff regarding the minimum package, quality assurance, mental health, etc.
- **Trade Union:** Enhance the effectiveness of monitoring the working conditions in the factories by a proactive approach
- **MoH in cooperation with CBA parties and ILO/Better Work:** Develop a minimum service package for clinics to ensure that minimum basic services are provided
- **MoL and Social Security Corporation:** Review the health insurance coverage/ proposed by SSC a few days ago to be fairer and more affordable for Jordanians
- **MoL:** End discrimination between Jordanian and migrant workers on the level of health services provided to workers
- **All stakeholders:** Create consensus amongst workers, buyers, and management regarding the role of factory clinics

1. Introduction and Methodology

1. Introduction and Methodology

1.1. Background and Purpose

During the last twenty years, Jordan has established itself as a garment exporting country. The industry is now one of Jordan's leading export sectors due to preferential treatment to export to the US Market under a Free Trade Agreement (FTA). In order to export under the FTA, Jordan's garment factories have to take part in the Better Work Program brokered by the International Labor Organisation (ILO). According to Better Work's Annual Report 2022, approximately 63,000 workers are covered by the program, of whom 74% are migrants, and 74% are women. Under the Jordanian legal framework and the Collective Bargaining Agreement, factories have to provide medical care to both migrant and Jordanian workers including the provision of health care clinics on-site at factories. The quality of healthcare provided had so far not been comprehensively assessed. The present study therefore aimed to evaluate the situation at and the quality of care provided at the health clinics, identify workers' health care needs as well as legal gaps. The ultimate aim of the study is to provide recommendations for the way forward for health care services in Jordan's garment sector.

This research assesses the availability and quality of health care services provided at garment factories and identify current regulations governing the provision of healthcare within garment factories. The purpose of this study is to assess and identify the needs of workers in the garments sector in Jordan concerning health care services, the current situation of health services as provided by factory clinics, as well as legal gaps, and recommendations moving forward. The objective of the study is to contribute to helping national stakeholders (the Trade Union, the Jordan Garments, Accessories and Textiles Exporters Association, the Syndicate, the Ministry of Health, and the Ministry of Labour) to define the objectives and prioritize activities for the forthcoming years. The objectives of this study are as follows.

Output 1: Collect and review national and international healthcare quality assurance standards and legal framework

Output 2: Understand the current situation of the health care services provided by medical staff within garment factories and legal aspects/challenges

Output 3: Present the results and outcomes to the national stakeholders and modify them accordingly.

The study is structured as follows. The following section outlines the methodology of this present study, while Chapter 2 provides an overview of the legal framework governing the provision of health care services to the workers in the garment sector in Jordan and relies on a comprehensive desk review and legal analysis. Chapter 3 then proceeds to assess the quality of care provided in the health care clinics in the garment factories that were part of this study.

1.2. Methodology

This research relies on a mixed-methods study methodology, consisting of desk review and analysis of existing quantitative data, as well as quality assurance visits using a check-list, as well as qualitative tools.

This research assessed the quality of health services offered in the garment factories in the three industrial zones studied in this assessment – Irbid, Sahab and Al Dhleil – as well as in Satellite sites in the Northern Jordan Valley and South of Jordan. This assessment was based on international standards relating to the right to health, such as the WHO, as well as the Agenda 2030 (Sustainable Development Goal 3.8.) and other international treaties and national legislation, such as ILO conventions. The key aspects of the right to health are that health care is: people-centered, safe, equitable, integrated, timely, effective and efficient and applied to all levels of care between primary, secondary and tertiary care. However, this study focuses on primary healthcare in garment factories.

Phenix Center also conducted a detailed desk review and conduct a legal analysis to identify the legal gaps in the regulations (national labour law, international law) that govern the provision of healthcare services in the garment sector consulting with a legal expert in the field. In addition, Phenix Center collected and reviewed further national and international healthcare quality assurance standards in consultation with a medical doctor.

1.2.1. Focus Group Discussions

To assess the health care services from all angles, Phenix Center collected data from employees, stakeholders, and employers on their assessment of the quality and availability of health care services at the garment factories.Focus Group Discussions (FGD) were conducted in the three industrial zones in Irbid, Sahab, and Al Dhail, as well as two satellite sites in Nothern Jordan Valley and the South of Jordan.

- **Group 1:** Bangladeshi Females,
- **Group 2:** Jordanian Males and Females,
- **Group 3:** Bangladeshi Females,
- **Group 4:** Indian Males,
- **Group 5:** Sri Lankan Females,
- **Group 6:** Bangladeshi males,
- **Group 7:** Jordanian females,
- **Group 8:** Jordanian males and females,
- **Group 9:** Jordanian females,

Focus Group Discussions were held with both female and male workers at equitable representation according to the demographics of the workforce, taking into account gender and nationality.[3] The Focus Group Discussions took place at factory premises and were organised in cooperation with the Trade Union. Same-gender facilitators were present at the sessions, with several sessions being held separately between men and women to ensure the safety and comfort of the participants in the discussion of medical issues.

3 Bangladeshi workers represent nearly 50% of workers. Better Work Jordan Annual Report 2022, "An Industry and Compliance Review"

1.2.2. Quality Assurance Visits

Phenix Center conducted five on-site inspection visits under the leadership of a medical doctor. A checklist was prepared prior to the visits and shared with ILO for approval. The inspection visits were conducted at the same factories mentioned above. These inspections determined the following:

- General information and basic clinic statistics
- Human resources at the clinics
- Policies and procedures of the clinic
- Infrastructure
- Availability of treatment services across the following areas:
  - Common emergency conditions
  - Health promotion
  - Non-communicable diseases
  - Communicable diseases
  - ANC / PNC care
  - Reproductive Health

1.2.3. Key Informant Interviews

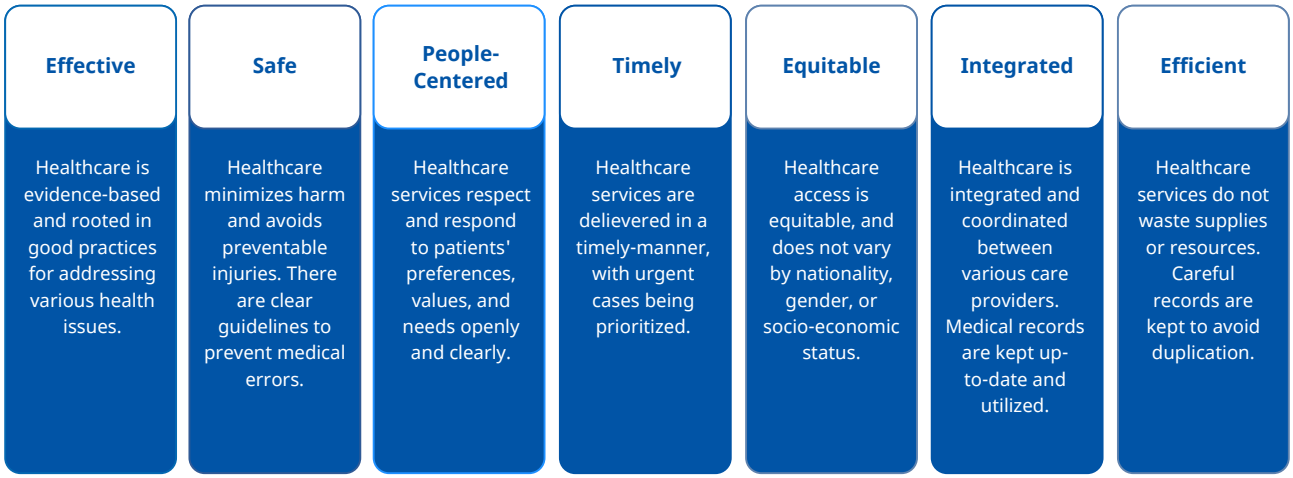
Phenix Center conducted a total of thirteen key informant interviews with stakeholders and staff of the medical health clinics in order to complement the perception of the workers from the perspective of the stakeholders. Phenix Center conducted Key Informant Interviews with:

- One representative from the Trade Union
- One medical staff from a Trade Union clinic
- One representative each from J-GATE and the Textile and Readymade Clothes Syndicate
- One representative from the Ministry of Health
- One representative of the Ministry of Labour
- Three of the garment factories' medical staff (including nurses and general practitioners)
- Three managers from the garment factories in the three industrial zones

1.3. Analytical Framework and Guiding Questions

As this assessment seeks to determine the quality of healthcare services provided to employees at the factory clinics, it is necessary to develop and understanding of the meaning of 'quality healthcare' and the basis on which quality is assessed. There are a number of definitions of Quality Care and Quality Standards. Quality Care has been defined by the World Health Organization as health which embodies seven major concepts: it is effective, safe, people-centered, timely, equitable, integrated, and efficient. These concepts are defined in Figure 2.For the purpose of this assessment, Phenix Center will utilize the WHO Quality Care Standards as its basis for analysis. Participants were asked questions related to determining the effectiveness, safety, people-centeredness, timeliness, equitability, integration and efficiency of the care. For complete research tools, please see Annex A.

Figure 1: World Health Organization Quality Care Standards



In addition to the standards above, there are a number of other widely recognized standards for high-quality care. For example, SafeCare has developed standards accredited by the International Society for Quality in Healthcare (ISQua). Unlike the WHO standards, the SafeCare [4] standards look, in detail, at specific indicators for quality care, including infrastructure, cleanliness, and quality of services provided. While these standards are comprehensive and cover healthcare quality at the system, tertiary, secondary, and primary levels, only standards for primary care were as health clinics within factories are not meant to provide secondary or tertiary care services. For the purpose of this analysis, these standards have been integrated with the WHO standards to create a specific analysis framework.

Table 1: Integrated Analysis Framework

WHO Standard	Essential and Guiding Questions (Based on SAFECARE Standards and WHO Quality Standards)	
1.Effective and Efficient	**1.1.**	Are basic services (minimum package) being provided to workers? Do these services align with good standards/ practices for treatment of specific diseases / illnesses?
	1.2.	Are factory workers satisfied with the healthcare services they receive? Are the treatments which are prescribed effective in addressing their illnesses?
	1.3.	Do patients often need to visit the clinic multiple times to receive effective treatment? Are patients prescribed medicines which they do not need / over-prescribed medicines?
	1.4.	Do clinics keep adequate financial and equipment-use records? Do they manage equipment in a responsible and useful way?

4 https://www.safe-care.org/

WHO Standard	Essential and Guiding Questions (Based on SAFECARE Standards and WHO Quality Standards)	
2.Safe	**1.5.**	Are healthcare facilities and infrastructure sanitary, well-ventilated, well-maintained, and organized?
	1.6.	Do healthcare facilities have adequate spaces for the provision of care, including spaces with privacy?
	1.7.	Do healthcare facilities have adequate seating and disability accessibility?
	1.8.	Do healthcare staff utilize effective handwashing and hygiene measures? Are there adequate handwashing facilities? Do staff use PPE and cleaning materials?
	1.9.	Do clinics and staff have necessary registrations and licenses for operation?
	1.10.	Do clinics have treatment guidelines and policies?
3.People-Centered	**1.11.**	What are the health needs of the patients, and do clinic services align with these needs? Are patients able to meet their health needs at the clinic or must they go elsewhere?
	1.12.	Open information: Do clinic staff respect patients' privacy? Do they communicate openly about treatment options and diagnoses?
	1.13.	Comfort and respect: Do patients feel comfortable asking questions to clinicians? Do patients feel like clinicians take them seriously?
	1.14.	Do clinics prioritize the needs of the patients? Do they allow patients to rest if they are tired?
	1.15.	Do workers receive sick leaves? Are these leaves sufficient? Are they paid or unpaid?
4. Timely & Integrated	**1.16.**	How long do workers generally wait to receive care?
	1.17.	Are doctors usually available? What happens when doctors are not available?
	1.18.	What happens if workers experience health issues during working hours? What happens if they experience health issues after working hours?
	1.19.	Do clinics have adequate policies and recording practices for sick leaves, assessment forms, follow-up forms, and referrals?
	1.20.	Do clinics have a referral system that is adequate and effective for receiving care? Are referrals accessible for all populations?
5. Equitable	**1.21.**	Do all workers have access to healthcare services regardless of factors such as disability, nationality, race, and gender? Are the services received of the same quality across all demographics?
	1.22.	For workers who do not speak Arabic, are translators available?
	1.23.	Are all treatment options affordable for all populations? Who is responsible for paying for treatment options? Are there any treatments that are not included (i.e. dental, hospitalization, etc.)
	1.24.	Do women feel comfortable discussing women's health issues with clinicians? Are women's health services provided without judgement? Are men's health issues addressed?
	1.25.	Are healthcare services accessible (both physically, financially, and socially) to people with disabilities? Are people with disabilities
	1.26.	Do clinics have policies on prevention of violence and harassment, including GBV?

2. Legal Framework and the Right to Health

2. Legal Framework and the Right to Health

The right to health is a fundamental part of the conventions on human rights that Jordan has ratified. Based on the 1946 Constitution of the World Health Organization (WHO), it is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[5]. It is an inclusive right as there is a wide range of factors affecting human wellbeing. The Committee on Economic, Social, and Cultural Rights, which monitors the International Covenant on Economic, Social and Cultural Rights, refer to them as the "underlying determinants of health including safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality"[6]. Accordingly, the right to health is considered a comprehensive right and is not limited to the provision of health care services, but extends to other components such as clean water, healthy food, security, adequate housing, and a healthy environment.

Many international treaties have emphasized and confirmed the right to health, considering it linked to a set of personal or individual rights, such as the rights to human dignity, life, physical safety, equality, and non-discrimination. States are obliged to to anything to ensure the right to health and refrain from legislative of policy action that could prevent access to health care services.

The right to health has not been included in the Jordanian constitution, despite the numerous constitutional amendments that have taken place. It is not included within the constitution despite the existence of a public health law that organizes the functions of the Ministry of Health and defines its objectives and conditions for practicing medical professions. The Public Health Law could have served as a basis on which the Right to Health was enforced, as it also defines infectious diseases, the powers of inspection, control of epidemics, vaccination, immunization, mental health, drinking water control, and other competencies and powers.

In the following, the legal framework regulating the contractual relations between workers in the garment sector with regards to health care services will be analysed.

2.1. International Agreements Related to the Right to Health

The Right to Health has been enshrined in a number of international agreements, conventions, and treaties. International interest in enshrining a 'Right to Health' first emerged with the development and ratification of the constitution of the World Health Organization. The World Health Organization has explicitly recognized that the right to health is a basic human right, as included within the WHO Constitution Preamble.[7] The preamble to the WHO Constitution also emphasizes that governments are responsible for the health of their people and that these responsibilities cannot be fulfilled without taking adequate health and social measures.

5 WHO Factsheet on the Right to Health. Available at: https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf
6 Committee on Economic, Social, and Cultural Rights. Available at: https://www.ohchr.org/en/treaty-bodies/cescr
7 Preamble to the Constitution of the World Health Organization.

Like the World Health Organization's constitution, the Universal Declaration of Human Rights in 1948 also affirms the Right to Health, stating in the first paragraph of Article 25 that "everyone has the right to a standard of living sufficient to ensure the health and well-being of himself and his family, especially in terms of food, clothing, housing, medical care and social services."[8] Other provisions include special care for mothers and children[9] and prohibitions on discrimination regarding health care services.[10] Article 12 of the International Covenant on Economic, Social and Cultural Rights (CESCR) expanded upon the Right to Health by providing specific steps and requirements to ensure this righ and includes "aspects of environmental and industrial health."[11]

Furthermore, the Committee on Economic, Social and Cultural Rights, at its twenty-second session in the year 2000, issued General Comment No. 14 to clarify and activate the text of Article 12 of the International Covenant on Economic, Social and Cultural Rights. According to this General Comment, the right to health includes not only the timely provision of health care services, but also the underlying determinants of health, such as the provision of clean and potable water, adequate sanitation, adequate supplies of food, safe nutritious foods, safe housing, healthy occupational and environmental conditions, and the provision of education. The right to health thus includes four elements:

Figure 2: Requirements of the Right to Health (CESCR)

Availability	A sufficient amount of public health facilities, health care facilities, goods, services and programs must be available.
Accessibility	Everyone should benefit from opportunities to access health facilities, goods and services, within the jurisdiction of the State Party. Accessibility has four dimensions: non-discrimination, physical accessibility, economic accessbility, and access to information.
Acceptability	All facilities, goods and services must respect medical ethics, be culturally appropriate, and consider gender and life-cycle requirements
Quality	Health facilities, goods and services must be scientifically and medically appropriate and of good quality . The right to health also imposes on state parties, like all human rights, three types of obligations: Respect : non-interference in the enjoyment of the right to health Protection : Any guarantee that third parties (other than states) do not impede the enjoyment of the right to health Performance : Any positive steps taken to realize the right to health

8 Universal Declaration of Human Rights Art. 25(1)
9 Article 25 of the Universal Declaration of Human Rights
10 https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial
11 *Art. 12 CESR reads: "1- The states party to this covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. To ensure the full exercise of this right, the measures necessary to:*
A- Work to reduce the stillbirth rate and infant mortality rate and ensure the healthy growth of the child
B- Improving aspects of environmental and industrial health
C- Prevention of epidemic, endemic and occupational diseases and diseases
D- Creating conditions that would secure medical services and medical care for all in case of illness."

According to the General Comment, The Right to Health also includes "essential content" relating to the minimum level of services included within the right to health. This includes basic primary care, minimum amounts of basic foods and nutritious foods, pure and potable water, and essential medicines.

Another commitment of signatories of the Covenant is the adoption and implementation of a national public health strategy and action plan, taking into account vulnerable and marginalised groups, as well as the principle of progressive realization – meaning that when it comes to health, States need to move forward at the fastest pace possible.

2.1.1. Right to Health for Specific Groups

The right to health is also stipulated in many other international agreements that regulate the enjoyment of certain groups of the right to health, such as the Geneva Conventions of 1949 and the protocols annexed thereto, which prohibit attacks on the physical or mental integrity of persons deprived of their liberty. Similarly, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), stipulates in Article 12 that (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to guarantee them, on the basis of equality of men and women, access to health care services, including those related to family planning.

Important for this research is also the International Convention on the Protection of the Rights of Migrant Workers and Members of Their Families, specifically in Article 25, which stipulates: migrant workers shall enjoy treatment no less favorable than that which applies to nationals of the State of employment in terms of remuneration and in terms of overtime pay, hours of work, weekly rest, days off with pay, safety, health, termination of the employment relationship, and other conditions of work covered by this term under national law and practice.

The Convention on the Rights of Persons with Disabilities also requires signatories to recognize that persons with disabilities have the right to enjoy the highest levels of health without discrimination based on disability. State Parties shall take all appropriate measures to ensure to ensure that persons with disabilities have access to health services that consider gender differences, including health rehabilitation services.

2.1.2. Jordanian Ratification of the International Health Rights Protocols

While the aforementioned protocols establish rights to health within international law, the enforcement of a number of these rights is dependent upon state's ratification. Of the protocols, Jordan has ratified all but the Convention on the Protection of Rights of Migrant Workers and Members of their Families.

Table 2: Integrated Analysis Framework

Protocol	Jordan Ratification Status:
The Convention on the Elimination of All Forms of Racial Discrimination	☑
International Covenant on Economic, Social and Cultural Rights (Article 12)	☑
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	☑
Convention on the Protection of the Rights of Migrant Workers and Members of Their Families	☒
Convention on the Rights of Persons with Disabilities	☑

All protocols which have been ratified are legally enforceable within Jordan. However, as the Convention on the Protection of the Rights of Migrant Workers and Members of Their Families has not been ratified, the provisions within this protocol do not extend to migrant workers within Jordan. This may present considerable challenges within the Garment Sector specifically, where the majority of workers are migrant workers.

Furthermore, Jordan has ratified several international treaties and conventions on the rights of workers, both migrant and national. It also ratified several international labor conventions such as the one on the Elimination of All Forms of Forced or Compulsory Labor and Elimination of Discrimination in Respect to Employment and Occupation. Out of 25 conventions, 14 international labor conventions have been published in the Official Gazette. According to Jordanian Supreme Court decisions, even those not published in the Gazette, but ratified by the government become part of Jordanian law by default after a month of ratification.

2.1.3 Jordanian Labor Law and by-laws on health of workers

In general the Labor Law nor the Public Health Law do not include detailed texts dealing with the issue of health and physical care for workers in establishments in accordance with international standards and rules for human rights. The Public Health Law, discusses preventive healthcare and occupational safety but does not include provisions for healthcare for workers. For example, standards are generally meant to protect the health of customers, such as proper food safety in restaurant establishments, but do not account for provision of healthcare services for workers within these establishments. Even where legislation exists, the law is not comprehensive.

The Jordanian Constitution and Labor Law protect the worker's rights in the areas of occupational safety and health (OSH). Articles 78, 79, 80, 84, and 85 of the Jordanian Labor Law [12] as well as the Jordanian Constitution Chapter 2 Article 23 [13] provide the legal basis of the national legal reference. In alignment

12 Jordanian Labor Law. Available at: https://ilo.org/dyn/natlex/docs/ELECTRONIC/45676/84920/F-1672011876/JOR45676%20Eng.pdf
13 Jordanian Constitution. Available at: http://parliament.jo/en/node/150#ch2

with the international conventions, the constitution details the State's obligations to the citizens, and the Labor Law provides specific guidance on the requirements to prevent the risks related to OSH. Based on general provisions of the Labor Law, employers shall guarantee the occupational health and safety of the workers, including migrants. Although there is a clear responsibility on the governmental and enterprise side, the scope of risks and the ways to prevent as well as respond to them are open to interpretation.

By-Law No. 42 of 1998 on Preventive and Curative Care for Workers in Establishments also requires an update to comply with the emerging needs of the workers and international covenants. This by-law is at times unclear and ambiguous: While it does define duties for employers if they employ more than 50 workers, it mainly refers to occupational health and safety and not the right to health in its general sense. The regulation is not detailed and explanatory and only stipulates the need for the presence of a clinic, a doctor, a nurse and a paramedic, and the minimum equipment for an emergency clinic. The by law also stipulates that the employer is not only obliged to protect but also to inform the worker of the job-related risks.

Table 3. Requirements of medical care staff in establishments according to By-Laws on Preventive and Curative Care for Workers in Establishments No. 42 of 1998

Number of Workers	Part-time physician	Full-time physician	Nurse	Medical Unit
50-100	1	-	1	1
101-500	-	1	2	1
500-1001	-	2	3	1
More than 1001	-	3	4	1

However, the services that need to be provided are not very clear and where they are, they mirror typical first aid procedures. In that sense, the Decision on First Aid Tools and Equipment for Workers at Establishments of 1997 and the Decision by the Minister on the Periodic Exam Form of 2002 offers some guidelines. Employers must provide first aid tools and equipment for workers in the work place according to the nature of work and the number of workers. These must be kept in a box that is visible and safe place and must be accessible to workers and include:

- fever-reducing medicine and pain relievers and ointment for burns (Vaseline)
- Gauze, cotton, adhesive tape for gauze and band aids in several sizes
- Rubbing alcohol / disinfectant, hydrogen to clean wounds, iodine, compressors and triangular bands
- Container, tweezers, scissors and gloves.

At the same time, the administering of other medicine is not envisaged in the by-law, making the administration of these medications illegal and a task of ambulance teams and outside medical professionals. This however, opens room for other questions such as the covering of transportation for patients to outside clinics, and the covering of treatment costs outside the internal clinics, including overnight hospital stays and costly operations.

This represents a considerable legal gap within Jordanian national laws and weakens the bargaining position of workers attempting to secure healthcare rights in the workplace. In addition, enforcement of these laws and requirements is weak. Employers face penalties between 50 and 100 JD for non-compliance,[14] which compared to the costs of running a medical unit and salaries for medical staff might be rather a counter-incentive for establishments.

2.2. Right to Health within the Collective Bargaining Agreement in the Garment Sector

The final, and perhaps most important, guiding legal framework for this analysis is the collective bargaining agreement signed between the Jordan Garments, Accessories & Textile Exporters Association (J-GATE), the Association of Owners of Factories, Workshops, and Garments (AOFWG), and the General Trade Union of Workers in Textile, Garment, and Clothing Industries (GTUWTGCI) on November 21st, 2019. Included in the contract are several provisions regarding healthcare services to be offered within the factories (Articles 10 & 11), which identify the requirements of the clinics and health obligations of employers. These are also included within the contracts signed by both Jordanian and migrant workers, however migrant workers receive additional healthcare services that are not required for Jordanians, including care during off-hours free-of-charge. If migrant workers need health care services from outside the clinic, the factories have to pay the costs incurred under the CBA– this is particularly important for migrant workers, as they do not always have access to health insurance during their stay at Jordanian factories.

In relation to Right to Health, however, the signed agreements create little specification on the applicable Jordanian laws for the specific services, which must be provided within the clinics. A legal review of the documents identified the following shortcomings:

- There is ambiguity regarding the timeframe for which healthcare services should be provided within the CBA. The time in which factories are obligated to provide care is limited to working hours, meaning that the worker does not have the right to health care before and after the official working hours. This violates Right to Health standards of availability, accessibility and quality in the health services provided.

- The collective contract and the standard contracts do not consider the standard that the number of medical staff of the clinic providing health care is proportional to the number of workers in the facility (factory) according to the standard of providing reasonable and acceptable medical care and service and the By-law 42. It also does not specify whether these professionals must remain at the clinic during its open hours.

14 Labor Code Article 139

- It must be noted that the medical clinics in industrial establishments are supposed to take into account the nature of the medical specialization for each of them according to the nature of the profession practiced by the industrial activity, and not only the presence of a general physician. Affect public health (such as noise, vibration and sound disturbance) must be taken into account when determining the appropriateness of the clinic's equipment with hearing examination devices or medical devices and medicines to treat or mitigate the diseases associated with it.

- The mechanism mentioned in Item 11 does not consider gender and cultural specificities, societal customs, differences, and diversity. It fails to reflect the disparate social and medical needs of male and female populations, as well as ensuring that men and women can receive care services from a same-gender professional if this is what is most comfortable for them. There is no mention that care must be provided in a language that is understandable to the workers.It must be noted however that Jordanian labor law is restrictive when it comes to the hiring of non-Jordanian medical staff.

- The collective agreement and standard contracts do not address requirements of confidentiality of medical data of workers and the need to protect their privacy and personal data.

While the existence of the CBA in itself is an achievement, it still does need to be revisited to comply with international standards for workers' health care, which revolve around "providing a state of complete physical, psychological and social safety, not just the absence of disease or disability." Most of the provisions of the agreement thus far are procedural and revolve around providing a state of disease relief, and are thus devoid of appropriate indicators of the right to health and healthcare services. The collective agreement thus needs to be re-visisted and codified in a detailed manner that clarifies and meets the real need in return for implementation and leaves a realistic impression among workers of their enjoyment of the right to health and health care and meets the minimum limits of this right according to international standards as well as Jordanian law.

3. Quality of Care

3. Quality of Care

This section examines the findings of interviews, focus group discussions, and inspection checklists within the framework of the World Health Organization's Quality Care standards.

In general, there were considerable disparities in responses across factories regarding the quality of health services received, with some discussion participants reporting complete satisfaction with the work environment and the quality of healthcare services received, while others reported that conditions were very, very poor. This disparity also manifested across nationality lines, with **migrant workers more likely to report positive experiences**. The reason for this finding is multidimensional: firstly, migrant workers are provided health insurance to visit governmental clinics under the CBA, while Jordanian workers are not. As such, referral to external care providers, a common practice for the factory clinics, is not an effective means of care for Jordanian workers, who often cannot afford the out-of-pocket expenses associated with non-insured healthcare access. Another reason may be due to migrants' feeling uncomfortable speaking openly about their experiences: for example, one translator for a focus group discussion with migrants noted that the participants seemed nervous or scared. Finally, Jordanians may also have higher standards for care services than their migrant counterparts.

There were also several non-health-related concerns that participants raised regarding the safety of their work environment, including some **very serious violations** of their rights both within Jordanian labor law as well as according to the collective bargaining agreement. These are explored in detail following chapter, which examines the compliance of the healthcare provided in clinics with the Collective Bargaining Agreement and other legal standards.

3.1. Are Healthcare Services Effective and Efficient?

3.1.1. Provision of Services

As stated above, the number of required medical staff in the factories depends on the number of workers employed in the factories. Of the 77 factories that were assessed during data collection for the Better Work Annual Report 2022, only around half [15] of the factories complied with the required number of physicians needed according to the law, however importantly, health clinics were mostly present where needed.

> *The only services and provided at the clinic are the ones that I could get at home.*
> **Female Worker, Jordanian**

However, findings from checklist examinations and focus group discussions confirmed that the services provided at clinics are minimal, but also that considerable difference in service provision remain between factories. During an interview with clinic staff, it was found that there is no standard 'minimum care

15 41 out of 77. Detailed underlying data provided by Better Work Jordan based on the "Better Work Jordan Annual Report 2022: An Industry and Compliance Review", 14 April 2022.

package' provided at the clinics; rather, provided services are based on the services which are greatest needed, such as treating fatigue, minor work injuries, and common illnesses.

> *The clinic usually on provides basic services, such as painkillers and stomachache medicine, or providing a place to rest if we feel ill. If there are any bigger issues, they are sent to the hospital.*
> **Indian Worker, Male**

However, without the minimum care package, clinics are generally unable to respond to some of the most essential emergency conditions. For example, of the twelve common emergency conditions identified by physician experts, only one clinic provided treatment for more than half. The only common emergency treatments that were provided by all clinics were for work injuries, such as cuts. This aligns with the findings of focus group discussions, where participants reported the most common treatments that they received in the clinic were painkillers/ bandages. Participants from most factories reported that any more 'serious' condition was referred to an external hospital or health centre. However, it is important to note that this may not entirely be due to lack of resources at the health clinics: as noted by one clinic doctor, he is limited by the Ministry of Health in the services he can provide as a general practitioner. In addition, this is in line with by-law 42, basically limiting the services at the clinics to these first aid services.

As noted in Key Informant Interviews with a Textile Workers Syndicate representative as well as the employers' organisation, a full examination of workers is also required by law before they start working at the factories, and according to the representative of the Syndicate even by specialists outside the clinics [not by the factory doctor].[16] In fact, an internal assessment by Better Work [17] found that out of 77 factories, only 12 factories appeared to be non-compliant with this requirement. Focus Group Discussions, however reported a lack of examination. In the Better Work assessment, those factory managements who did not provide the examination acknowledged this issue and were putting measures in place to improve this. Yet, this finding from FGDs is surprising since, as the representative of the Syndicate noted, an initial and annual assessment of the fitness of workers is required for foreign workers in order to renew their work permit. The same representative also noted that migrant workers are required to produce a certificate of fitness from their home country before coming to Jordan, but that they have to redo the examination in Jordan, in particular to contain the spread of infectious diseases. It might not be unlikely that FGD participants did not tell facilitators about the initial medical assessment, if done by doctors outside the clinics, as they were mainly asked about the role of the on-site health clinics. Therefore, stakeholders should closely monitor this issue to make sure that all workers are examined according to the law – whether that is by factory doctors or outside specialists.

Clinics did provide some health promotion services: all clinics provided health counselling and training/ education about occupational safety. Some clinics provided screening services, such as checks for hypertension and diabetes. For example, Bangladeshi male workers from a factorynoted that they had all be screened for high blood pressure in the last three months by their factory clinic health team. These screenings were provided to all workers. Similarly, blood tests and diabetes tests were available

16 KIIs with J-GATE, Trade Union representative
17 "Detailed underlying data provided by Better Work Jordan based on the "Better Work Jordan Annual Report 2022: An Industry and Compliance Review," 14 April 2022.

to workers in a factory in Dhlail free-of-charge. However, health information sessions were highly limited to occupational health and safety, with little other information sessions being conducted and certainly not at a regular occurrence. No mental health related information sessions were found to be conducted by factory clinics, though it could be possible that factories are hiring external experts to conduct these sessions, as they are a requirement of the Collective Bargaining Agreement.

However, as explored below, the ability to provide standard treatment for these conditions is limited by the lack of available equipment in facilities. For non-communicable disease conditions, clinics did have diabetic monitoring and hypertension services. Most clinics also had written protocols for addressing suicide attempts and suicidal tendencies, though this primarily involved referral to an external hospital or specialist, and it could not be verified if these policies were actually implemented.[18] The only communicable diseases which were treated at clinics were respiratory infections.

Dental care was not provided by any clinic, nor did any clinic provide health information regarding dental hygiene and oral care. Managers at a factory in Dhleil mentioned this as being one of the leading challenges that workers faced in regard to healthcare, as these services are difficult to provide within factory settings and are often not included within the healthcare packages offered at the external governmental hospitals and clinics that they have partnered with. Similarly, no clinics provided any form of reproductive health services, antenatal, or postnatal care for workers.

In general, however, the partnering of factory health clinics with hospitals in the vicinity was perceived positively by all stakeholders. In an interview with a representative from factory management revealed that they felt that by partnering with a local hospital they could provide better and more comprehensive health care services to workers, also at times that the health clinic in the factory was not opened. As they noted "those who are staying at the factory might have health needs 24/7 and not just during work hours." [19] Similar positive experiences with hospital partnerships were noted by J-GATE, the Textile Workers' Syndicate as well as workers. However, the provision of these hospital services mostly extended to migrant workers, as Jordanian workers, generally, are not covered. The representative of J-GATE recounted that migrant workers' operations, even if expensive, are covered by the factories and that in some cases, workers are even reimbursed to undergo medical treatment in their home countries. However, as was noted by many Jordanian workers in FGDs, the Union and Syndicate representatives, health insurance for Jordanians covering all health care needs is so far not comprehensive. The Syndicate representative cited financial challenges for factories to provide Jordanian workers with comprehensive health insurance due to the increase in staff and therefore production costs that this would bring, discouraging buyers to buy from Jordanian factories. The discrepancy between health care services provided to Jordanian and migrant workers will be further discussed throughout this report.

Availability of Essential Medicines and Equipment

In general, by-law 42 limits the administering of medication in workplace health clinics considerably. However, most health clinics visited had medication on hand to treat their patients. This in itself already shows ambiguity regarding the requirements that health clinics are to provide to workers. While

18 Quality Assurance Visist Checklist results
19 Interview with a representative from factory management.

administering medicine might not comply with by-law 42, it does extend the services offers to workers, and in particular those who do not have health insurance.

> *One of my colleagues has diabetes. She has to bring the insulin needle with her, and in the event of a diabetic attack, she needs to go to the clinic and take it on her own without the help of the nurse. There's also no refrigerator for her to keep her needle in; she puts it in a cold-water container and hopes that it doesn't spoil.*
>
> **Female Worker, Jordanian**

When assessing the medication the clinics were able to provide, on average, the clinics reviewed carried between 10%-30% of the medicines identified as essential by consulting physicians. This includes adrenaline injections, such as Epinephrine (i.e. Epi Pens), used to treat anaphylactic shock and severe allergic reactions for emergencies. Only one clinic carried more than half of the essential medicines as defined by the independent experts. Similarly, other common medications for emergency conditions, such as hydrocortisone, were not provided by any clinics. Even participants who were generally satisfied with the clinic services noted that "only Panadol and simple medicines" were provided (Bangladeshi Female, Irbid). This means that most clinics studied neither complied with the requirements of the law to not administer medicine, nor- ignoring that law for a moment- did they have all essential medicines that would have been needed. This points to a common problem that will reappear throughout the study: Different perceptions and interpretations of the applicable rules and regulations regarding the role of health clinics in factories.

The checklist review also found that most clinics were lacking essential equipment. For example, only one clinic had an emergency tray that had emergency injections (such as those medicines mentioned above). Only two clinics had refrigeration / freezers. This has demonstrable effects for the preservation of medicines that workers with chronic diseases depend on. For example, one FGD participant noted that the clinic at her factory had no place for a diabetic colleague to store insulin safely, which must be refrigerated. Thus, while clinics may provide screening services such as diabetic monitoring, they lack the equipment to treat these conditions in event of an actual emergency.

Limited equipment was one of the leading challenges noted by clinic staff. For example, a nurse noted that while the factory was usually able to provide the equipment needed, there were some limitations: "Some services, such as needles, electrocardiograms, and others, are not available. Certainly, if these services were provided, the healthcare service would be perfect." (Interview with female nurse). The same nurse assessed the quality of the clinic she worked in to be a 7/10, and that to increase this quality, the clinic would need a glucose meter for measuring diabetic blood sugar levels as well as a O2 meter for measuring blood oxygen levels.

Additionally, observational review of clinics found that they are broadly not able to accommodate any kind of emergency conditions. According to the independent medical expert, "Emergency cases are transferred without first aid due to the lack of necessary materials." Clinics are broadly not equipped to handle the majority of emergency conditions. In the event of emergency, workers are generally transported to hospitals. In a Better Work assessment for its Annual Report 2022, it was however found, that only 6 out of 77 factories were non-compliant with providing accessible and sufficient first aid

materials and that 67 out of 77 factories had provided first aid training to their workers.[20] These practices need to be extended to cover all garment factories to ensure that First Aid is given to all that need it.

3.1.2. Use of "Good Practices"

One frequent complaint of workers was the fact that the doctor usually did not conduct a full examination when they went to visit the clinic. This was noted even amongst FGDs where the respondents reported generally positive perceptions of the care services provided, such as in one satellite factory in the Jordan Valley, and confirmed by the independent medical expert, whose observational review of clinics found that more than a third of all patients receive treatment without an examination.

In line with this, checklist review of the services and procedures at the clinics found that most clinics did not have treatment guidelines or disease management protocols, nor did they have health assessment forms to assist with diagnoses. The lack of full examinations performed by doctors led to a number of health incidents, according to FGD participants. One participant noted that she was feeling quite ill and went to the doctor to receive care; after listening to her describe her symptoms, the doctor dismissed her condition as muscle strain and told her to return to work. Shortly after resuming her work, she fainted. Even after that, the doctor was unwilling to provide her with medical leave and her supervisor had to direct the doctor to give leave. As will be explored in a later section, doctors might be under orders from factory managers (not supervisors) to minimize the amount of medical leaves given.

Other patients also noted that the doctors dismissed their health complaints; one participant noted that the clinic doctor told him that he did not have any severe health issues; conversely, a specialist at a government hospital recommended that he get surgery to address what the specialist perceived as a serious health problem. [21]

3.1.3. Effectiveness of Care

Workers broadly had mixed feelings regarding the effectiveness of the healthcare services, which they receive. These differences manifested across nationality as well as location. Notably, migrant workers were more likely to report satisfaction with services than Jordanian workers. For example, one migrant worker from Bangladesh stated that in the ten years that she's been working at one of the factories in this study that she has been to both public health clinics as well as the factory clinic and vastly prefers the factory clinic for her non-serious health needs. Similarly, Bangladeshi female participants as well as Bangladeshi male participants in had generally positive feedback regarding the quality of care at the clinics at the factories.

> *I wasn't examined. [The Doctor] listened to me when I explained to him the nature of my illness, and then told me that my health was normal and that, even if I needed an operation, it might only take five minutes and just two days of leave, but the doctor at the government hospital told me that I needed a full operation.*
> **Jordanian Worker, Male**

20 Detailed underlying data provided by Better Work Jordan based on the "Better Work Jordan Annual Report 2022: An Industry and Compliance Review," 14 April 2022.
21 The participant did not wish to specify his condition as there were female colleagues within the focus group. .

Some Jordanian workers also had positive feedback regarding the quality of care. For example, Jordanian workers at a satellite factory also stated that they felt the quality of care at their factory was excellent. However, broadly, Jordanians were much more critical of the effectiveness of the services received. For example, female participants in focus group discussion in the South stated that there were given incorrect medicines for the conditions that they have—one woman remarked that her friend had a cold but was given medicine for heartburn. Another participant noted that she had a headache and was given medicine for blood pressure patients. Workers remarked that the majority of the medicines / treatments that they receive from the clinic are inappropriate for the conditions they have, and they ultimately get rid of the medicines prescribed to them because they are not meant to treat the condition that they have.

> *For all health problems only one medication is given: painkillers (Panadol). The blood pressure device usually doesn't work. There is a lot of neglect.*
> **Jordanian Worker, female**

3.1.4. Efficiency of Care

Another key component of quality healthcare is its efficiency. Quality care should not be wasteful of resources, not duplicative of health efforts. A key component of efficiency is the careful maintenance of care records, as well as equipment records and medical lists. As such, this was included as an essential component of the doctor-conducted inspection checklists of the clinic.

Through the checklist review of clinics conducted by external medical experts, it was found that none of the clinics have any equipment and maintenance records, nor do they keep financial records of clinic expenditures and usage of medications and materials. Without such records, clinics are not able to monitor the general efficiency of medicine use and determine if certain medications are being overused. Furthermore, none of the clinics had any type of formalized reporting and notification system if communicable diseases were found to be present at the clinic. According to an interview with a doctor, the only notification of patients' illnesses is given to the factory management and not reported in any other way. However, it's also important to consider the fact that more serious illnesses are almost always referred out of the clinic, and as such it would be rare for clinic doctors to be diagnosing communicable diseases in the first place.

3.2. Are Healthcare Services Safe?

The second key component of quality healthcare is health safety. Healthcare should have clear guidelines for prevention of medical error and offer services within environments which are safe, clean and conducive to good health. As previously noted in Section 3.1.2., the majority of clinics within the factories reviewed did not have standardized treatment guidelines or disease management protocols. Doctors, even at factories where workers expressed the most satisfaction, often did not conduct full evaluations of patients' health. In some instances, workers reported they were provided with medicine that does not match the illness that they have. As already seen, this has manifested in several incidents where a worker's health was jeopardized when these procedures were not adequately followed, affecting the overall safety of the workers and the healthcare services they are receiving. Furthermore, the limited availability of the health professionals in some factories has also led to some safety concerns.

For example, workers in one factory in noted that, when the doctor and nurse were not present, "the security official comes and gives us medicine."

3.2.1. Infrastructure, Hygiene and Sanitation in Clinics

Clinic Infrastructure

An essential component of the review checklist was to determine whether the infrastructure of the clinics was conducive to a safe environment for providing care. All clinics were found to be well-ventilated and well lit. However, only two clinics were found to have adequate space for service delivery as required by MoH licensing standards (see below). The clinics generally had quite minimal fittings: none of the clinics had a waiting room, and only one clinic had a private examination room. As such, it is unsurprising that some participants reported there being a lack of privacy within the clinic when receiving examinations and consulting with the doctor. One clinic however, was an exception to this: that clinic had two separate examination rooms for men and women, to ensure comfort and privacy. The clinic also had three beds to allow patients to rest if they felt ill during the workday.

Hygiene and Sanitation in Clinics

During the checklist review of clinics conducted by independent medical experts, it was found that all clinics do conduct necessary segregation of medical waste and safe disposal of any medical materials. Furthermore, all clinics were found to regularly clean the clinic space and have a documented and specified cleaning procedure and schedule. Most clinics also had necessary provisions such as running water, a handwashing station, and drinking water for patients.

> *Sanitary procedures and workers' health are very important. I mean, according to our capabilities and according to the capabilities of each facility, we provide what is required of us.*
> **Factory Manager**

However, there were also some significant sanitation concerns. One clinic lacked the bare necessities of hygiene and sanitation: there were no handwashing stations for health staff, nor was there running water or even drinking water for patients. This observational information conflicts with what was shared in interviews with clinic staff; for example, when asked if improved facilities would improve the quality of services, the nurse at the factory clinic replied "Of course, but the current situation is sufficient for the workers' needs." (Interview with Factory Nurse). Similarly, the manager at the factory said that worker sanitation and health were very important to them and that they provided services 'within their capabilities' and according to the requirements that are outlined for them as per the collective bargaining agreement. As this agreement has no specifications regarding the provisions, infrastructure, or sanitation of factory clinics, there are no requirements for factory management to improve clinic quality through basic infrastructure interventions, such as providing running water.

3.2.2. Safety, Hygiene, and Sanitation in Factories

In addition to the hygiene of the clinics, some participants also noted that there are some infrastructure, hygiene, and sanitation challenges within the factories themselves that affect the health and safety of the workers. Participants in several discussions remarked that some areas of the factory were not ventilated and did not have any form of air conditioning other than fans, noting that this causes difficulties breathing. Others stated that the bathrooms at the factories were in poor condition; this was, in-part, due to the cancellation of smoking breaks during the workday, causing workers to discreetly smoke in bathrooms. In fact, improving bathroom cleanliness was a frequent request in several focus group discussions. This is also notably a direct violation of the collective bargaining agreement, which in Article 10 Clause F states that "Restrooms shall be kept in a clean, sanitary, and safe condition, and provide privacy for both sexes."

> *I prefer the factory clinic because in the hospitals, the doctor has many cases. Here, the doctor gives you your time and explains things to you.*
> **Jordanian Female Workers**

3.3. Are Healthcare Services People-Centered?

3.3.1. Alignment with Patient Needs

As previously noted, overall satisfaction with services varied considerably across focus group discussions. For example, workers at the factory in Dhlail stated that the clinic was perfectly aligned with their needs at work, and they had no further suggestions for how to improve it. Conversely, other workers noted that the clinics did not provide the full range of services which they needed.

Workers in one focus group discussion noted that they wished the medicines offered at the clinics were more robust. For example, one Jordanian participant noted that if the medicine she needed for her chronic health condition was covered and provided by the factory, she would likely not need to take medical leave as often for healthcare services related to this condition.

Patients in nearly all factories also noted that dental services were not included within the healthcare package provided, neither for migrant workers nor Jordanians. In general, toothaches were treated by clinicians by giving painkillers. Furthermore, several patients reported that their dental services were often rejected for medical leave, particularly if they went to a private dentist and not a governmental dentist. In one factory, all requested leave for dental services were rejected, according to participants.

3.3.2. Respect for Workers / Patients

In general, focus group discussion participants reported feeling comfortable speaking with the medical staff at the clinics, and usually had somewhat positive relationships with the staff themselves. Even in instances where medical staff were unable to provide the services they needed, or refused to provide medical leave, workers attributed these shortcomings not to the staff but rather to the factory

management. In all cases where workers were asked who is responsible for improving the clinic quality, workers said that it was the responsibility of the factory management.

Unsurprisingly, workers reported much greater disrespect from factory management than the doctors. For example, one woman told a story of how HR staff-person treated her when she tried to explain her medical absence, for which she did not get prior approval from the clinic doctor. She said that when she tried to explain the reason for her absence, the HR staff were dismissive and rude to her, not providing her an opportunity to explain why she was absent and instead deducting three days' pay from her salary, despite only missing one day of work. Similarly, other patients, particularly Jordanians, reported managers as being distrustful of their medical needs. Speculation may not be entirely unwarranted, as participants in FDGs did note that they have co-workers who have fabricated or exaggerated medical reports; however, the frequency in which legitimate medical concerns were underplayed outpaced the frequency with which these concerns were exaggerated. Furthermore, the observational checklist review of clinics conducted by medical experts found that only one clinic had any sort of formal complaints mechanism. However, as the representative of the J-GATE noted in a KII, workers should be aware of the contact details of the employers' information and that they are open to receiving complaints and have so in the past. In addition, one international buyer noted that they had also established a third-party complaints mechanism for workers to directly reach them in case they did not want to report issues to factory management. Workers however might not be aware of these mechanisms in all factories to the same extent.

> *They [Human Resources] did not allow me to explain my absence [for a medical condition]. They told me 'do you want to tell us your life story?'"*
> **Jordanian Female**

> *I went to the clinic to ask for sick leave but the doctor didn't give it to me. I asked him why, and he told me it was because the management at [Factory Name] is different from other factories and very severe. Knowing this, I went to a government clinic and received the sick leave, but I had to pay the expenses myself.*
> **Jordanian Male Worker**

> *We are supposed to have 14 sick days and 14 annual leave days… but the reality is that they do not give us leave, and in the event of our absence, they deduct the days from our salary without warning. For sick leaves, we must fill out a form the day before we are absent, but if we request the form, they refuse to give it to us.*
> **Jordanian Male Worker**

3.3.3. Sick Leaves

Perhaps the most significant finding of this research, and the area where workers' right to health had the most violations, was the provision of sick leaves. It is important to note that within the collective bargaining agreement, workers are entitled to 14 days of sick leave per year during the first five years of employment, after which it increases to 21 days of sick leave. Workers were generally aware of the fact that they had a right to sick leaves as well as annual vacation days. In most focus group discussions, all or most workers were aware of their sick leave allowances. However, workers in several factories

reported that, although this right was guaranteed within their contracts, many factories had practices and internal regulations that reduced the capacities of workers to take leaves. These problems were identified in over half of the factories included in the study, though are not ubiquitous within all factories within the garment sector.

One of the most common practices is the spoken or unspoken policy of discouraging clinic doctors from providing leaves. For example, workers in a factory in Irbid reported that the doctor at their clinic was given specific instructions by their factory manager to not give medical leave to any workers. In these instances, some workers reported having to travel to government clinics at their own expense to receive sick leave permission. However, this is not always a solution: sometimes, leave permissions even from a governmental hospital or clinic would not be accepted by factory management as legitimate, and as such not approved for the sick leave. Sick leave granted from private clinics was almost never accepted, as these are considered unauthorized. This was true at nearly all factories.

> *I have breast cancer. One day I felt ill and went to the government hospital at dawn. But they refused to give me medical leave because the manager of the factory told [the hospital doctor] not to give leave to any factory workers leave without a paper from the factory.*
> **Jordanian Female Worker**

> *On one occasion I had to leave because of a toothache. The next day I went to the nurse to present the leave paper, but she did not accept it on the pretext that I had not told her the day before that I would not come to work. But my toothache came suddenly – I couldn't have foreseen that it would happen. They deducted my salary for unexcused leave.*
> **Jordanian Female Workers**

In an even more extreme case, workers from another factory also reported that they were unable to receive sick leave permission from an external clinic, for example a government clinic, unless they requested a form in advance of the day they were absent. This practice, according to the workers, essentially caused them to have to take unpaid leave if they woke up feeling ill, as they were unable to get the required permissions ahead of time. The alternative option was to come into work while ill, and hope that the clinic doctor would agree to grant sick leave; however, as already noted, clinic doctors are often under instruction not to grant leave. Furthermore, workers stated that, even if they requested the sick leave forms, they were often not provided by the HR department.

The factory has also incorporated the nearby public health clinic into this sick leave policy, instructing clinic management to not provide sick leave forms to patients unless they had the proper paperwork. There are clear negative impacts of this sick leave policy. One worker at the one factory who has breast cancer told a story of being denied medical leave from the local hospital as she did not have the proper paperwork from the factory in advance.

If workers are denied leave, which they often are, they may take unpaid leave, which counts as a work absence and acts as a demerit against their work performance. In one factory, missing one day of work would result in three days' salary deduction. For example, a female worker said that when she had

coronavirus her leaves were not covered, and that she lost fourteen days of salary when being infected with corona. Another woman stated that she lost three days of salary when she did not come to work due to severe menstrual pain.

> *The process of getting permission and going to the factory clinic doesn't take more than ten minutes.*
> **Jordanian Female Worker**

According to participants, fear of having salaries deducted caused several workers within the factory to hide diagnoses, particularly during the COVID-19 pandemic. Some workers had contracted the coronavirus but did not share their results with the factory as they could not afford the salary deduction. This practice was standard across a number of factories: according to a participant, "People who are suspected to have corona are given leave and transferred to the hospital to conduct corona tests at their personal expense, and this time will be deducted from their salary." However, workers in other factories who contracted COVID-19 noted that their entire leave and quarantine period was covered by the factory; for example, an Indian worker noted that when he contracted COVID, not only were his leave days covered, but the factory also provided an appropriate space within the housing for him to quarantine and the housing manager took care of his needs during that time. This points to discrepancies between factories in the provision of health care services to workers at different clinics.

Similarly, the practice of not honoring sick leave requests also was not ubiquitous. Generally, migrant workers in Focus Group Discussions were more likely to report that their requests for medical leave were granted than Jordanians. Bangladeshi workers in a factory in reported that their factory management had honored the provisions of the collective bargaining agreement, including the increase in vacation days after three years of work. They also noted that if sick leave needs need to extend past 14 days, these days are paid and covered by the factory.

In a validation meeting with several stakeholders, factory managements, J-GATE and the Union were surprised by these findings regarding sick leave as they have mechanisms in place to monitor the adherence to the law. Stakeholders agreed the issue needs to be followed up as a priority.

3.4. Are Healthcare Services Timely and Integrated?

3.4.1. Clinic Referrals and Wait Times

One area in which nearly all participants – both Jordanians and non-Jordanians- had positive feedback was the wait times at the clinic, as well as the referral process to go visit the factory clinic.

Some factories did require permission to go to the clinic; however, even in these factories, the majority of participants reported that they did not have any challenges getting permission. Generally, permission was requested from the direct supervisor, who gave a small slip of paper that allowed workers to go to the clinic. Even in factories where workers reported the strictest treatment, wait times were minimal. In other factories, workers did not even require permission from supervisor to go to the clinic and were able to go immediately.

No participants reported there to be long wait times to receive examinations and care at the factory clinics. However, a checklist review of the clinics conducted by external medical experts found the number of workers to be vastly disproportionate to the number of medical professionals in most clinics, as most factories had several thousand employees, but only one doctor. Even factories which had over 3000 employees only employed one doctor. This might have several reasons. While Jordanian labour law is clear in the number of required medical staff, factories might feel that they do not need more staff if waiting times are not long for patients. Similarly, the CBA does not mirror Jordanian labour law with regards to the number of medical staff required. This means that if factories only consult the CBA, they might be under the impression of being compliant. Here, the language of the CBA needs to be adapted to mirror the Jordanian labor law outlined above, as it has also been found in a previous study that 41 out of 77 factories did not provide the required number of medical staff for their factory size.[22] All stakeholders need to make sure the required medical staff is hired or requirements are revisisted to meet the needs of factories and clinics.

3.4.2. Availability of Doctor

The degree to which the doctor was available for workers' needs was highly dependent on the specific factory. For example, participants from a factory in Sahab stated that the doctor was available at all times when they were working, and was on-call even when they were at their residences. If someone had a healthcare issue, the doctor would come, do a check-up, and either give them medicine or take them to the hospital if the issue was serious. Similarly, workers in a satellite factory in noted that the doctor was available nearly the entirety of the work day (until 3:30), and a nurse was available at all times (until 4:30). Conversely, participants from another factory stated that the doctor was only available once per week. Otherwise, healthcare was provided by a nurse. Sometimes, in the event that no medical professional was available, medicine was distributed by the factory security guard. The phenomenon of unqualified individuals dispensing medicine was also noted by the independent medical experts who evaluated the clinics.

3.4.3. Referral Processes and Documentation

One of the key components to ensuring that medical care is timely and integrated is ensuring adequate referral and follow-up. This allows doctors to adequately monitor the health conditions of patients over time, ensuring that changes in condition are identified rapidly and adequate steps are taken.

In general, follow-up on illness was not usually conducted by the factory clinics. For example, even workers whom had generally positive feedback regarding the factory clinic noted that the clinic doctors themselves did not usually follow-up on patients except in the case of needing to confirm or deny medical leave extensions. Patients who wished for follow-up care, however, were welcome to go to the clinic and request additional check-ups on their condition- these efforts generally had to be patient-initiated as opposed to doctor initiated. This is alignment with findings of the observational checklist review of the clincis, where independent experts found that systems for follow-up and referral were quite weak across nearly all clinics. For example, medical experts noted that "Most clinics lack an integrated records

22 Detailed underlying data provided by Better Work Jordan, 2021

system that medical professionals can refer back to when treating patients," "Patients with high blood pressure and diabetes are not followed up in clinics" and "There are no records of patients with chronic diseases in 4 out of 5 clinics reviewed." In contrast, a factory manager claimed the clinic constantly monitors the condition of patients with high blood pressure and diabetes, with the nurse requiring hypertension patients to have their blood pressure measured three times a day while diabetes patients are having blood glucose measured periodically as well as being followed-up with nurses regarding whether they have taken their necessary medications. However, the nurse for the factory in which these claims were made specifically remarked that the factory did not have an instrument for measuring blood glucose (glucometer).

▶ Table 4: Documentation Practices at Clinics

Documentation:	Factory Location				
	Location 1	Location 2	Location 3	Location 4	Location 5
Assessment forms	✗	✗	✓	✗	✗
Follow-up forms	✗	✗	✓	✓	✗
Sick Leave Reports	✗	✗	✓	✓	✓
Sick Leave Letters	✓	✓	✓	✓	✓
Work Injury Reports	✓	✓	✓	✓	✓
Referral Card	✓	✗	✗	✓	✓
White Card	✗	✗	✗	✗	✗

The lack of follow-up care and service integration found within clinics can also be linked to the overall poor reporting mechanisms which currently exist at the clinic level. While all clinics had sick leave letters and work injury forms on hand, only two clinics had follow-up forms, and only three had referral cards. Only one clinic included within the medical checklist review had a standardized reporting and patient record system per the evaluation of the independent medical experts; this stands in direct violation of the collective bargaining agreement, which states that the "employer shall maintain records of all medical check-ups and tests performed for workers shall be sorted into individual files for each worker." (CBA, Article 11, Clause 1, Point A). It is important to note that some factories, however, have made more active and concerted efforts to fulfil this agreement. For example, managers from one factory noted that they had contracts with local clinics and governmental hospitals to provide care on the expense of the factory; they have worked to integrate internal clinic services with these external providers to ensure greater continuity of care.

3.5. Are Healthcare Services Equitable?

The final component of quality health that this study explores is the equitability of care services across various social and economic strata. For the purposes of this study, the equitability of healthcare services across nationality, gender, and disability status were examined.

> *The first time I went to the clinic I was unable to communicate with the doctor and the nurse, but later they hired a Bangladeshi nurse in the clinic, and communication became very easy.*
> **Bangladeshi Female Worker**

3.5.1. Equitability Across Nationalities

As previously noted, focus group discussions with migrant workers regarding the quality of the healthcare they received in factories were overwhelmingly positive. Migrant workers highlighted the ease with which they received care, both during work hours as well as after hours while in company residences.

A key component of healthcare access for minority populations is language and ensuring that all health information provided is understandable to the patient receiving care. Migrant workers in focus group discussions noted that they were able to communicate relatively easily with medical professionals; some factories had hired a native speaker of the predominant language(s) of their workers, such as one factory, which hired a native Bangladeshi speaker as a nurse. Other factories hired specific medical translators to work with their non-Arabic-speaking populations. However, this was not the case in every factory: Jordanian workers in one of the satellite factories noted that there were usually no translators available, and that the non-Arabic speakers would usually have to wait until the doctor is available- which is only once per week. It has to be noted however that workers at satellite factories usually are in fact, Jordanian, as opposed to the worker's demographic in main factories.

> *There are foreigners in the factories who go to the same clinic as us. There is nobody there who speaks their language. They have to wait for the doctor to explain to them the nature of their illness, so they wait much longer periods of time.*
> **Female Worker, Jordanian**

> *There is a person in HR who specializes only in assisting foreign workers with their communication with the clinic, both in terms of language as well as dealing with the health system.*
> **Clinic Doctor**

While migrants may face challenges when communicating with medical professionals, Jordanians faced other disadvantages. Notably, medical costs- such as that of medications and external doctors' visits- were not covered by factories. Jordanians were usually not given health insurance, while migrant workers always were; this is reflected within the unified work contracts of both parties, where migrants' contracts include a clause regarding health care provision while Jordanian's contracts do not. This

was also confirmed during an interview with a representative of the Textile Workers' Syndicate who stated that even in case of operations exceeding thousands of dinars, the factory would cover these costs, which in some cases also put a strain on the financial situation of some factories.

> *If treatment is available, for foreigners, the company will take care of their healthcare, meaning they do not pay for treatment at their own expense. For foreigners, the company will provide medication.*
> *For Jordanians and local workers, the factory does not guarantee the treatment of any sickness unless it's a work injury, which will be covered.*
> **Factory Manager**

As a result, Jordanians had greater out-of-pocket health expenses and were more negatively affected by a lack of range of services offered in clinics. The frequent process of referring workers to external clinics for even the most mild of treatments meant that Jordanians were often paying for their healthcare services. Some participants reported that they decided to forgo treatment at government clinics even when this was recommended by the factory clinic. For example, one Jordanian worker told a story about having a high temperature and a nosebleed which lasted several hours. The clinic at the factory wanted to refer her to the governmental clinic, but she refused to go.

Additionally, transportation to and from the hospital was provided by the factory for migrant workers even during 'off' hours, as most migrant workers reside within company housing. Jordanians, conversely, do not. Transportation to and from hospitals and clinics may be part of the reason why Jordanians reported that their medical leave was denied more often: if Jordanians are responsible for their own transportation, they may be more likely to attend an 'unauthorized' local private clinic as opposed to traveling to Government clinics and hospitals farther away. This is exacerbated by the fact that government clinics are usually only opened for very limited hours, closing around 2:00 pm, whereas private clinics are open into the evenings. However, according to Jordanian participants, the disparity in the rate in which Jordanians receive medical approval relative to their non-Jordanian counterparts is related to discrimination; they stated that Jordanians are perceived as lazier, more likely to lie, and more likely to falsify medical records accords by management, particularly non-Jordanian managers. However, Jordanians in the factory felt that management was even harsher on migrants, who "are only given sick leave for very serious reasons, such as fractures."

Regardless of the source of this disparity, it is undeniable that Jordanians receive fewer healthcare benefits than their migrant counterparts, and, in most factories, faced additional hurdles when attempting to take medical leave. They also reported lower satisfaction with clinic services and their overall work environment. It is also important to note that Jordanians were also more likely to be working in satellite facilities.

3.5.2. Equitability for Women

Gender equality is also of significant importance when examining the quality of healthcare systems. In general, women's health services within factory clinics were highly limited. Firstly, review of the clinic services by the independent medical experts found that none of the clinics provided any form of maternal healthcare including, prenatal, postnatal, and reproductive healthcare services. None of the clinics provided any form of birth control or contraceptives to patients according to both focus group discussions and independent experts, nor was any reproductive health information provided in clinics neither in the form of pamphlets nor information sessions. Perhaps most importantly, none of the clinics provided feminine hygiene products. According to focus group discussion participants, some factories made accommodations for pregnant co-workers, including providing them additional rest time as needed. However, Indian participants from a factory in Sahab said that women in their factory who become pregnant are immediately repatriated to their country of origin, with contracts being canceled or suspended. While the CBA provides protections against asking for pregnancy tests during the hiring process, nothing is mentioned regarding the suspension of employees if they are later found to be pregnant.

Some female workers also noted that feminine medical needs were at times disregarded or underestimated. For example, one worker told a story about severe menstrual pain which she was not granted leave for. Female workers in one factory noted that it was difficult to get leave for pain due to menstruation. In these instances, if the worker is unable to use annual leave or sick leave, she loses three days salary for her one missed day.

Finally, no clinics provide health information regarding abuse, treatment, and protection of victims, nor information regarding linkages with law enforcement and social services. Furthermore, no clinics had internal policies for addressing gender-based violence and harassment.

3.5.3. Equitability for People with Disabilities and Chronic Illnesses

None of the focus group discussion participants had a disability, as defined by the Law. No. 20 of 2017 on the Rights of Persons with Disabilities. However, many participants had chronic diseases and illnesses, such as diabetes and heart disease.

Some participants noted that there are often few physical accommodations made for people who have chronic diseases or disabilities. Workers in one factory noted that it is forbidden to sit while at work, even for workers who have conditions like varicose veins, where standing for long periods can cause immense pain. For more information regarding health accommodations for people with

> *I am diabetic and the doctor is very cooperative. He told me that if I feel tired, I can come to him at any time. I go to him about twice a week because of insulin and blood sugar, and they do appropriate tests and give me medicines such as headache and stomach-ache pills, or insulin for my diabetes. I also have sick leave every month to go to my appointment with my doctor at Zaatari Camp, and the factory pays for it.*
>
> **Syrian Female**

chronic illnesses and disabilities, please see the Better Work report, **"Research and Mapping Exercise of the Current Situation Concerning Workers with Disabilities in Jordan's Garment Sector"**

The degree to which participants with chronic illnesses' healthcare needs were met varied significantly from factory to factory. For example, a Syrian worker with diabetes from a factory in Irbid noted that she is able to access the clinic for her health needs at any time, and the doctors conduct appropriate monitoring of her illness. She is also granted regular medical leave so that she can attend her doctor's appointments related to her condition. Notably, the clinic in the factory where this employee worked was the only clinic reviewed which offered services such as insulin injections, according to the observational checklist review.

> *I had a treatment session at the Queen Alia Hospital for Oncology, and I went and asked the manager for the form so that I could take leave. He did not believe me, and told me "You're a liar, you just want to go to Amman [for fun]." I went to the treatment without taking the form.*
> **Syrian Female Worker**

Participants at other factories had less positive feedback regarding medical accommodation for their disabilities or chronic illnesses. Perhaps most shocking was the story of a woman with breast cancer working at the South of Jordan factory; she mentioned that she has been routinely denied medical leave for her cancer appointments, including an appointment at the Queen Alia Hospital for Oncology. The manager refused to provide the medical leave form, accusing her of lying about her upcoming appointment and claiming that she only wanted to go to Amman for recreational purposes.

4. Compliance with Legal Frameworks and Standards

4. Compliance with Legal Frameworks and Standards

4.1. Compliance with the International Right to Health and Quality Standards

There have been clear violations of the right to health for workers within Jordan's garment sector: most notably, some workers reported being unjustly denied sick leave as well as being forced to return to work shortly after a medical event, such as fainting. Furthermore, workers in nearly all factories are not provided what can be termed "quality care" according to the standards established by the World Health Organization or that which is outlined within the General Comment issued by the Committee on Economic, Social and Cultural Rights. Reviewing these criteria holistically, we can conclude the following regarding the healthcare services provided by clinics within the garment sector. Please note that these conclusions are not necessarily applicable to all clinics / factories (for example, some clinics are compliant with safety standards), but rather reflective of the broad situation within the sector as a whole:

Compliance with WHO's Quality Care Guidelines

Criteria:	Findings	Conclusion
Effective and Efficient	▶ At least 30% of the time, medical examinations were not conducted. ▶ Most clinics only provided basic services such as painkillers. Sometimes no interventions were conducted, and workers were just told to rest until they felt better. ▶ Most clinics did not carry the most essential emergency medicines, as defined by the medical experts in this study	Non-compliant
Safe	▶ Clinic infrastructure in most clinics was generally poor; one clinic did not have running water or a handwashing station, presenting considerable hygiene and sanitation risks. ▶ Most clinics did not have treatment guidelines or disease management protocols. ▶ Medicines and treatments were at times provided by non-medical staff if doctors and nurses were not present. ▶ Licence status of the clinics remained mostly inconclusive; only one clinic would meet the requirements for licensing according to medical experts.	Non-compliant

Criteria:	Findings	Conclusion
People-Centered	▶ Most workers reported that the services provided did not fully meet their needs and were minimal. Migrants generally reported greater satisfaction with services provided as they are given health insurance and able to go to external clinics and hospitals free of charge. ▶ Most workers reported generally positive interactions and communication with medical staff, though this was not ubiquitous. ▶ Several workers reported negative interactions with factory management and HR, who treated them with distrust. ▶ Medical leaves were routinely refused, or factories had systems which limited the capacity of doctors to grant leaves as well as workers to receive medical leave. In some factories, these systems were quite harsh and resulted in workers not being able to receive leave for important emergency conditions, such as a doctor's appointment for cancer treatment.	Partially compliant
Timely and Integrated	▶ Wait times at clinics were generally quite short, and the process of receiving permission to go to the clinic was usually easy. ▶ Doctors were not always available; in one clinic, the doctor was only present once per week. ▶ Patient records, follow-up, and referral mechanisms were very weak. Little patient follow-up was conducted. Most clinics did not have comprehensive records of worker's health and did not monitor health conditions over time.	Partially Compliant
Equitable	▶ Female health needs were not met; no reproductive healthcare services were offered by clinics and no clinics provided even basic feminine hygiene products. ▶ Factories generally made efforts to ensure that migrant workers were able to access health information in a language that was clear to them; however, this was not ubiquitous. ▶ Jordanians did not receive the extent of healthcare services and protections that their migrant counterparts received; Jordanians were routinely asked to pay out-of-pocket for services which were covered by the factory for migrants.	Non-Compliant

As seen through these findings, the quality of healthcare services provided by factory clinics in the garment sector is, generally, quite weak. Significant safety violations were found at some clinics, as well as inequality in the services provided across gender and nationality.

The World Health Organization's quality standards are not legally enforceable international agreements, but rather guidelines for developing quality health systems. However, the General Comment issued by the Committee on Economic, Social and Cultural Rights, of which Jordan is a signatory, does include provisions regarding the quality of healthcare. Notable amongst these is the requirement that the state protects against Third-Party interference in the enjoyment of the right to health. It could be argued that the unjust denial of sick leaves that occurs within factories is a direct violation of the right to health.

Under the CESCR General Comment, the Jordanian government is responsible for protecting against these violations and non-protection would be a direct violation of the CESCR.

This brings us to the role of the Ministry of Health and other relevant governmental bodies in ensuring that these protections are made.

4.2. Compliance with the Ministry of Health Standards

To determine if the conditions of the factory clinics were in alignment with Ministry of Health (MOH) standards, interviews were conducted with representatives from the ministry. According to these representatives, clinics located within occupational settings are considered as 'private health clinics' and thusly registered through the "Health Professions Institution Licensing Directorate" within the Ministry. The representative noted that no clinic within Jordan is allowed to operate without this license; however, a 2021 statement from the Director of the directorate noted that at that time only approximately 30% of medical clinics were licensed even though this is a requirement of the Ministry of Health to have an operational clinic.

According to Ministry of Health Regulation No.74 (2014) and Instruction No.1 of 2016, which detail the licensing requirements for clinics, clinics must be registered by a practicing physician and meet the following criteria:

1. Availability of necessary space 35m2
2. Comply with conditions of public health and safety
3. Have waiting rooms and bathroom facilities.
4. Have the basic treatment package available (information regarding what constitutes the basic treatment package is not publicly available)
5. The doctor who manages the center must work in it full-time, and is responsible for all treatment provided in the center before the Ministry of Health.

While the specifications of the basic treatment package are not publicly available, the majority of the factory clinics were not in compliance with Ministry of Health clinic licensing standards. None of the clinics in this study could show proof of licencing of the clinic. However, this does not mean that they were not licenced, especially since an assessment by Better Work found that the medical staff working at the factories were in fact approved by the Ministry of Labour (though approval by the Ministry of Health was not assessed). [23] This issue needs follow up by the Ministry of Health, the Ministry of Labour and Better Work.

4.3. Compliance with the Collective Bargaining Agreement

Finally, and perhaps most importantly, it is important to examine whether the services provided by clinics followed the Collective Bargaining Agreement signed between the Jordan Garments, Accessories & Textile Exporters Association (J-GATE), the Association of Owners of Factories, Workshops, and

23 Detailed underlying data provided by Better Work Jordan based on the "Better Work Jordan Annual Report 2022: An Industry and Compliance Review," 14 April 2022.

Garments (AOFWG), and the General Trade Union of Workers in Textile, Garment, and Clothing Industries (GTUWTGCI) on November 21st, 2019. Analysing each of the points included in Article (11) Physical and Psychological Healthcare, we can broadly conclude the following:

Article:	Requirement:	Findings:	Conclusion
First Clause, Point A:	*"Provide a health clinic and the workplace appropriately equipped with medical staff approved by the Ministry, including a general physician (GP) and at least one nurse certified by the Ministry of Health to provide adequate healthcare and required treatments."*	▶ Clinic staff were approved by the Ministry of Labour, but not by the Ministry of Health ▶ Clinics were not registered with the Ministry of Health. ▶ Healthcare services provided were quite minimal; however, no definition exists within the CBA regarding what 'adequate' services are.	Inconclusive due to ambiguity
First Clause, Point B:	*"The Clinic shall be open during all work hours."*	▶ Clinics were found to be open during all work hours. However, medical staff were not available during all work hours.	Inconclusive due to ambiguity
First Clause, Point C:	*"Employers shall maintain records of all medical checkups and tests performed for workers, which shall be sorted into individual files for each worker. These records will serve as a point of reference when doing periodic medical checkups for workers to continually monitor their health"*	▶ Most clinics did not have medical records of patients, and little monitoring and follow-up was conducted by factory clinics.	Non-compliant
First Clause, Point D:	*In emergencies and at the expense of the employer, medical staff should, expediently and without any delay, refer the relevant worker to a specialized doctor or hospital (as required) to have the worker receive the required medical care and treatments.*	▶ Clinics generally did have a referral system for emergencies. ▶ Clinics relied on referrals for the provision of even basic services. ▶ Medical costs were covered by the employer for migrant workers. However, Jordanian workers were at times not covered; for example, one factory reported that in the case of work injury, the Civil Defense is called and injuries are covered through the Social Security system.	Partially compliant

As seen by the above analysis, the ambiguity discussed within Section 1 in terms of the requirements of health clinics per the CBA has limited the capacity of the document to be used as an enforcement tool for quality healthcare services, as there is a lack of definition of what quality services are. For example, the CBA states that the factories are required to provide "Adequate Healthcare Treatments," but does not specify exactly what 'adequate' treatment is. Similarly, it states that the clinic must be "appropriately equipped with medical staff approved by the Ministry" but does not specify if the clinic itself is to be approved by the Ministry, or if just the medical staff is to be approved.

These ambiguities have no doubt worked in the favor of factory management at the expense of factory workers. For example, during an interview with a manager at one factory, the manager stated that they 'provide what is required' of them. This factory, notably, was the one which did not have running water within the clinic. Given that the CBA does not specify what 'adequate' services are, nor give any requirements regarding the infrastructure and size of the clinic, the factory is technically in compliance with the stipulations of the CBA, despite being in violation of MoH standards for the provision of healthcare services in primary clinics and medical centres.

> *We provide what is required of us. There are no specifications, other than that there is a clinic with a doctor and a nurse. As for medications, we must provide the most essential medications in each clinic.*
> **Factory Manager**

In addition to the health standards outlined within the CBA, it also specifies that factories are to provide medical leave for workers (up to 14 days, annually). However, workers in some factories noted that their factory management refused to issue sick days, even when the management was provided with excuses from approved sources. This was particularly the case in the factory in South of Jordan, which prohibited the use of medical leave without first obtaining a leave permission form, and working with the local governmental hospital to prevent doctors from giving leave unless that form was presented to them. This is in clear violation of their right to take medical leave for relevant conditions.

Finally, while the goal of this research was to specifically identify whether the healthcare services provided at the facilities comply with the collective bargaining agreement, a number of other, non-healthcare-related violations were identified. Notably, workers in a factory in Irbid reported that the manager had reduced their number of breaks: previously, they had two breaks (breakfast and lunch), but the manager had cancelled their breakfast break. They noted that the other factories within the same company did not have their breaks cancelled. Others noted that their attempts to discuss poor conditions with managers had been blocked by direct supervisors out of fear of repercussions from managers. Additionally, most workers were unaware that there was a collective bargaining agreement which included relevant health provisions, and were thus unaware that the factory was in violation of some of these provisions, such as providing clean bathrooms. Even more grave, workers at one factory stated that they were working **without signing a contract**.

4.4. Stakeholder Roles in Improving Conditions

4.4.1. The Role of Factory Management:

When asked who is responsible for improving health clinic conditions, workers overwhelmingly answered that it was the responsibility of factory management to do so. However, some factory managers felt that the services provided were already sufficient. For example, one manager said that they could not possibly provide more services, as they did not wish to be liable if the care provided caused some form of complication for the patients. The doctor at another clinic also stated that he felt providing healthcare services in the factory setting would always be limited, as he believed that general physicians are legally limited in their capacity to respond to emergency healthcare situations. Both stated that they would prefer if the clinics remained as they are, and that anything other than providing the most basic of medicines (i.e., painkillers) be referred externally to a government health clinic. However, other factories did not have this approach, as evidenced by the fact that healthcare services were expanded to include injections and other emergency treatments. In general, it will be important to reach a consensus amongst factory management and workers regarding what the role of the factory clinic should be in the provision of health services.

> *It's difficult for us to do more than this. We can't take the risk of providing complete treatment in the clinic because we can't be sure of what the medical situation we're dealing with is... it's forbidden to give injections in any form because we don't know the pathology of the girl who wants to take the injection. What if something happens and there are complications? We want to keep the clinic as it is.*
> **Factory Manager**

4.4.2. The role of the Jordanian Government, Ministries, and the Union

Based on interviews with relevant government stakeholders, current monitoring of health services provided within factory clinics is largely non-existent. For example, when the representative from the Ministry of Health was informed of the findings of the study and the health violations occurring, she remarked that the Ministry was not aware of the situation, and that general monitoring of conditions within the factory was quite weak. International buyers who noted that the overall role of mechanisms in addressing labour violations within the factories could be improved also confirmed this.

> *In the factory sector, there is weakness in supervision by all responsible institutions and ministries.*
> **Representative, Ministry of Health**

It is important to increase the involvement of the Ministry of Health into the overall monitoring process of factories within the Garment Sector. To do so, it will be important to not only make the ministry aware of these practices, but also ensure that workers are aware of their medical rights as well as mechanisms for lodging complaints against the clinic. As previously noted, only one clinic had any kind of complaints mechanism set up, which

was through a phone application. These complaints are sent to management, however, rather than the Ministry of Health. Furthermore, even when entities such as the labor union, Ministry of Labor, and Ministry of Health are made aware of these concerns, there is a lack of consistent monitoring or follow-up on the conditions. As noted by one worker, committees regularly come to inspect the factory, 'but there is no benefit.'

This is also compounded by the fact that workers often were unaware of their legal rights to health, the provision of the collective bargaining agreement, the standards of quality healthcare. Workers, particularly migrants who are unfamiliar with Jordanian law, may be unaware that they have protective legal documents which guarantee their rights to these services. Yet, actual enforcement of these rights lies with the Labor Union and relative ministries, whom, according to international buyers, are generally inactive, complacent, or overall unresponsive to concerns, including those raised by buyers.

> *A lot of committees come to us to inspect the clinic, but there is no benefit. There was a female worker who complained about the factory to the Ministry. She was dismissed.*
> **Jordanian female**

Furthermore, workers may feel intimated to raise complaints against factories and the clinics therein. One worker at South of Jordan noted that when one of her co-workers submitted a complain to the Ministry of Labor, she was shortly thereafter dismissed. While the factory had dismissed her based on her 'past performance' co-workers felt that the dismissal was directly retaliatory.

4.4.3. The Role of Buyers

Buyers, as the leading driver of this industry, also can play a substantial role in ensuring that the health rights of workers are upheld through creating internal stipulations and standards regarding the rights of the workers within factories which they buy from. In interviews, buyers noted their commitment to ensuring a safe workplace and the provision of healthcare services, highlighting that it is an important part of their corporate social responsibility and compliance mechanisms to ensure that factories comply with local laws and international labour standards. However, some buyers noted that the actual implementation of these standards is difficult, as they are not managers of these factories. Two of the three buyers said that they rely on Better Work to monitor labor violations on their behalf, while the other factory reported that they have their own inspection visits before authorizing them for production, as well as routine unannounced visits each year to the factory to monitor compliance with local laws as well as compliance with their own CSR policies. This particular company had also set up a complaint mechanism for workers to directly complain to the buyer regarding labor conditions, which was implemented in response to protests which broke out in the factory following the rumoured death of a worker. While this rumour was later confirmed not to be true, it prompted the buyer to develop a mechanism for workers to submit concerns that bypassed the factory management.

> *[...]engagement needs to be improved, more messages need to be sent to stakeholders and the government. [...] It must be the union, and it must be the government to follow the enforcement of these issues.*
> **International Buyer**

However, buyers noted that their capacity to act is limited by local laws and policies, which they argue need to be stronger in order for them to be able to adequately act on these complaints.

Another key finding from interviews with buyers is that there is a disparity in beliefs regarding what best practices are regarding providing healthcare services within a factory setting. Some buyers felt that the factory clinic should be equipped to conduct all necessary primary health services for workers, while other buyers felt that, due to constraints on the availability of medical equipment and medicines, the factory clinics should only be provide first aid and initial assessment of conditions, with all diagnoses needing to come through an external authorized medical clinic. According to this buyer, best practices are to establish partnerships with external clinics and refer all cases to these doctors to ensure that diagnoses are accurate.

Regardless of the proposed mechanism through which care is delivered, it is essential to ensure that this care is provided to all workers at no cost.

5. Recommendations

5. Recommendations

The quality of the healthcare within the clinic varied considerably from factory to factory. However, broadly, services were found to not align with the World Health Organizations' Quality Care criteria. To address the gaps in service provision and ensure that the rights of workers are being upheld both according to the Collective Bargaining Agreement, Jordanian Labor Law, and international standards regarding the Right to Health, the following key recommendations are made

Key Recommendations

- ***The Ministry of Labor*** should follow up with violations of the existing labor law in some factories by expanding its inspection visits. This study identified violations both with regards to the health care services offered to workers, sick leaves etc., but workers also brought up other labor rights violations in Focus Groups that were not immediately part of this study.
- ***The parties to CBA (J-GATE, Trade Union, Employers' Syndicate)*** should revisit and revise the Collective Bargaining Agreement to make sure that requirements for the provision of health services leave no room for different interpretations. For example, this can include creating requirements for the minimum services which must be provided, the number of hours a week in which a doctor is available, and the number of doctors needed to meet the needs of worker populations. Additionally, the CBA must outline policies and necessary procedures for requesting medical leave in a manner that ensures that workers do not have their medical leave unjustly refused. As it currently stands, the CBA does not have any specific provisions regarding the types and quality of services which must be provided.
- ***J-GATE and factory management*** should make sure that the infrastructure at all health clinics confirms with the legal standards and that the facilities are safe to use for medical staff and patients. This includes basic infrastructure such as clean running water and drinking water. In addition, factory management should ensure that hygiene and cleanliness of bathrooms and facilities is ensured at all times and in all factories to prevent the spread of communicable diseases.
- ***The Ministry of Labour*** should conduct an in-depth legal inquiry into the practice of workers from taking medical leave in some factories and address the issue with factory managements. The ***Trade Union*** should provide workers with information on their labour rights, including their rights to sick leave.
- ***All stakeholders should make an effort to create Consensus Amongst Workers, Buyers, and Management Regarding the Role of Factory Clinics.*** There is general disagreement both within and between parties regarding the services which should be provided by factory clinics: should they function as a primary care centre, or rather as a first aid / emergency response point, with all serious medical challenges being referred outwards. This consensus will be needed when developing the minimum service package. It is also important to ensure that, regardless of the role that factory clinics will play in the overall provision of healthcare, workers are able to access full and comprehensive primary and emergency care services at no cost.

- ***All stakeholders*** should encourage and take part in knowledge sharing across factories. Encourage factories which are providing expanded services, complying with the collective bargaining agreement, and ensuring quality clinic care to share their experiences, best practices and the methods they have undertaken to ensure these standards. Encourage these factories to highlight the benefits of a healthy workforce for the non-compliant factories and clear misconceptions regarding the capacity of factories to provide quality healthcare services in-house.
- ***All stakeholders*** should consult with each other on the way forward, gaps that remain and how these can be filled. These consultations should take place regularly, involving all stakeholders equally and in the form of an open dialogue to ensure the health of workers, the productivity of factories and the growth potential of the garment sector in Jordan.

Secondary recommendations:

- ***The Ministry of Health*** should follow up on the licencing of medical staff and clinics in the factories to ensure that all clinics and medical staff are licenced and meet the requirements for licencing through periodical inspections.
- ***The Ministry of Labor, ILO/Better Work, the Trade Union and, Factory-Management and J-GATE*** should ensure occupational health and safety in all clinics and factories to keep work injuries and work-related illnesses to a minimum. If needed, factory management should be trained and made aware of measures that can be improved.
- ***Factory management*** should ensure that they comply with the required number of medical staff according to Jordanian labor law and that all first aid kits are fully stocked. A sufficient number of workers should be trained in first aid and in the use of first aid equipment. If the legal requirements do not reflect the realities on the ground, the Ministry of Labour should revisit and reassess the legal provisions.
- ***Health Clinics*** at factories should expand their health care services offered to women such as the offering of feminine hygiene products and basic reproductive care. This could include contracting a gynecologist for a couple of hours per week in an “open hour”.
- ***The Ministry of Health*** in cooperation with ***CBA parties and ILO-Better Work*** should build the capacity of health clinic staff in order for the medical staff to attend to workers' needs. The Ministry and devise a minimum care package as well as protocols for dealing with health issues, including mental health. It should also and define quality assurance mechanisms for the health clinics. These could be included in an annex to a revised CBA.
- ***The Trade Union*** should enhance its efforts to monitor and improve the working conditions in factories. The Union should raise awareness among workers on their labor rights, in particular with regard to health care and sick leave. The Trade Union should advocate with the Ministry of Labour to ensure that inspections on labour rights and working conditions are implemented.
- ***The Ministry of Labour and the Social Security Cooperation*** should revisit regulations and plans for comprehensive health insurance for all Jordanian workers in order to end discrimination between Jordanian and migrant workers on the level of health services provided to workers.