Midterm Survey and Evaluation of Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Garment Factory Workers

John Paul Nicewinter, Lachlan Bruce, Ian Ramage

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Executive Summary

Partnering to Save Lives (PSL) is a collaboration of three nongovernmental organizations (NGO) in Cambodia (CARE, Marie Stopes International Cambodia (Marie Stopes) and Save the Children), in partnership with the Cambodian Ministry of Health (MOH) and the Australian Department of Foreign Affairs and Trade (DFAT). Beginning in 2013, PSL was designed to support the objectives of MOH's Fast-Track Initiative Roadmap for Reducing Maternal and Neonatal Mortality (FTIRMN) in six key areas: emergency obstetric and neonatal care; skilled birth attendance; family planning (FP); safe abortion; behaviour change communication (BCC); and financial barriers to accessing healthcare.

In the garment sector, PSL has worked in cooperation with garment factories to improve female workers' access to sexual and reproductive health services through factory infirmaries and referrals to external health providers, and implemented numerous BCC activities to promote sexual and reproductive health and rights (SRHR), including knowledge of contraceptives and safe abortion.[1]

In 2015, PSL engaged in their midterm review process. After establishing baseline values for project indicators in the Monitoring, Evaluation, Reporting and Improvement (MERI) framework in 2014, the current midline study seeks to assess changes in the levels of female garment factory workers' (GFW) knowledge, attitudes and practices (KAP) towards these indicators, as well as determining the level of exposure and participation in BCC activities, and qualitative information about the effectiveness of PSL in achieving its objectives and outcomes.

The midline survey utilised a mixed methods approach, combining quantitative and qualitative data to fulfil the objectives. The midline was conducted in four factories purposively selected by PSL for their participation in program activities. Specific data collection activities conducted for this study were:

- A quantitative survey of 905 female GFW of reproductive age (15-49 years old), randomly selected from factory worker lists or exit interviews (proportional to number of female workers in all four factories);

[1] Note: the MERI indicators on GFW cover the spectrum of RMNH, however as PSL activities to date have focused on only sexual and reproductive health as review of progress against these indicators will be the focus.

- In-depth qualitative interviews (IDIs) with seven factory infirmary staff in the four target factories;
- Four focus group discussions (FGDs), evenly divided between married and single female GFW.

As part of the quantitative study, 103 women that had given birth in the last 24 months before the interview were purposively targeted, to improve the confidence in the maternal health findings. Because of the incidental oversampling in some factories, and the purposive oversampling of WRA that gave birth in the last 24 months, a weighting coefficient was applied to control for differences in the probability of selection between factories and WRA that gave birth in the last 24 months, by comparing against a similar population of women (the baseline).

Where possible, comparability with the baseline survey and the MERI indicators has been maintained, including in the total sample size, questionnaire development, data management and analysis. One exception is the sample selection, where workers were selected from dormitories and rent houses for the baseline and by lists of all female workers in each factory at the midline. The midline method provided a sample that is representative of all female workers in the target factories, and is more inclusive of older and married women (and those more likely to live with family outside of worker housing). Because of the purposive selection of factories, the study is representative of these four factories; care should be taken when considering the results in a broader context, as different levels or types of interventions may have produced different indicator values in other factories.

Socio-demographic characteristics

The average female GFW in the midline study was 27 years old, and had completed primary education (grade six). Half (49%) were currently married; 43.2% were single and not in a committed relationship. Nearly all (92.7%) werecohabiting with someone else. Most of these women wereliving with their relatives, spouses or parents. Using the Washington Group method of assessing disability, 3.6% of female GFW reported having a serious impairment, which would indicate disability. The most common impairments were cognitive (remembering/concentrating) and visual.

The average female GFW had 4-6 years of experience in factories, and made more than $200 from all sources last month. Two-thirds of workers sent remittances in the last month, sending $100 – half of their monthly income – to other family members.

Media access and use

Nearly all women (91.9%) reported owning a mobile phone, and nearly half (43%) owned a smartphone. Women most commonly accessed TV, radio and facebook. However, for contraceptive information these women valued interpersonal relationships more than mass media, prioritizing health centre and factory infirmary staff, as well as family/friends/colleagues over other sources of information.

BCC and Chat! Contraceptive campaign participation

A large majority of female GFW (81%) have participated in some form of BCC campaign activities; most have participated in two activities (average 1.7). The most common activities werepassive − seeing contraceptive advertising and posters/leaflets/hotline cards (74% and 42.5% of women, respectively).

Although the Chat! Contraceptive campaign was not yet been fully implemented at the time of data collection, around two-fifths of female GFW in the target factories (41.2%) had already participated in

any Chat! Contraception activities. Workers that participated in Chat! activities generally participated in only one activity; around one in eight workers (13.2%) participated in multiple Chat! activities.

Health-seeking behaviour

Nearly all respondents (99%) knew that their factory had an infirmary. Most female GFW (80%) had used the infirmary in the last 12 months, but this was primarily for minor health problems (97% of workers) and first aid (9%). Around one in ten female GFW (11%) used the infirmary for RMNH services; most commonly short-term family planning (4% of workers). Nearly all workers (95%) were satisfied or very satisfied with infirmary services. Around 4% of workers received referrals for RMNH services at external health facilities. From the FGDs and interviews, women had a positive perception of the infirmaries. Workers that never used the infirmary did so because they did not need health services, rather than through a perceived lack of quality goods or services.

Three-quarters of female GFW (76%) used external health facilities in the last 12 months, preferring private clinics/hospitals (56%) to public ones (23%). Nearly all (93%) were satisfied or very satisfied with the services they received at these facilities.

Contraceptive knowledge and use

Nearly all women (99%) knew about contraception; most commonly the daily pill,injection, inter-uterine device (IUD) and implant (98% - 97% of all women each). The least known modern contraceptives were the female condom (34%) and vasectomy (56%). Age, marital status, sexual activity in the last 12 months, and exposure/participation in the BCC and Chat! activities all increased knowledge of contraception.

Among women that knew about contraception, the average woman knew 10 total contraceptive methods, including 8 modern methods. Women that were older, married/widowed/divorced, sexually active and/or had experience with BCC or Chat! activities knew more methods of modern contraception than other women.

Half of female GFW (50%) were sexually active in the last 12 months; most commonly married women (99%) and those in committed relationships (91%). No single women reported sexual activity outside of committed relationships. Around three-quarters of sexually active women (77%) used contraception in the last year; the most popular method was the daily pill, used by just over half of sexually active women(53%).

Of the aforementioned women who had used contraception in the last year, most were also currently using contraception (84%), with daily pills still the preferred method (44%). In total, more than half (59.6%) of sexually active respondents were currently using a modern contraceptive method. The most common location for receiving modern contraception was a private pharmacy or drug store (39% of modern contraceptive users), followed by public (24%) and private (20%) health facilities. Nearly all (93%) paid money for their modern contraception, with half of users paying $0.50 or less the last time they purchased contraception.

Among traditional methods, the most commonly known and utilised method was withdrawal. Withdrawal was known by four in five women (80%), and was used by exactly half of sexually active women in the last year. At the time of data collection, over one-third of respondents (38%) were

currently using withdrawal, highlighting its continued prevalence in the contraceptive mix of Cambodian women.

Abortion and post-abortion care

Only one-quarter of respondents (24%) knew that abortion is legal in Cambodia; however, nearly half (44%) knew at least one safe abortion provider. 11% of female GFW ever had an abortion. The likelihood of having an abortion increased with age, lower educational attainment (no schooling or only primary-level), and disability. Two-thirds of women that had an abortion (63.6%) received comprehensive abortion care (CAC).

Half of female GFW (51%) who had abortions received modern contraceptive counselling within two weeks of their most recent abortion. Half of these women (47%) began using a modern contraceptive within two weeks of their last abortion. Women that received CAC were twice as likely to adopt a modern FP method as non-CAC users.

SRHR confidence

Regarding women's confidence in discussing and using family planning with their partners, one-quarter of women (24.8%) were completely sure about their reproductive health rights in all four scenarios, with the average woman "somewhat sure" for all scenarios.

Similar values were seen for the scenarios on sexual rights (the right to refuse sex with a partner). One-quarter of female GFW (26.4%) were completely confident that they could refuse sex with their partner in all five scenarios, including when threatened with violence. The average woman was "somewhat sure" for all scenarios.

Sexually active women were more confident than sexually inactive women. Participation in BCC and/or Chat! activities also increased confidence slightly.

Pregnancy and maternal health

Half of female GFW (50%) had ever been pregnant, with 89% of those ever giving birth. Of the 103 women that gave birth in the last 24 months, all received antenatal care (ANC) in a health facility, with nearly all of these with a skilled birth attendant (SBA; 99%). The average woman attended eight ANC visits; most commonly at a health centre (75% of women). The average costs for ANC were $4.25, including transportation.

The most widely known pregnancy danger sign was vaginal bleeding, identified by nearly half (43.7%) of respondents overall. This was followed by anaemia (23%), abdominal pains in early/late pregnancy (17.5% and 19.4%, respectively), and difficulty breathing. On average, respondents knew two pregnancy danger signs each; only 1% of these women knew five or more.

Looking at childbirth, nearly all women (99%) that gave birth in the last 24 months did so in a health facility and with SBA. Only one woman gave birth at home with a traditional birth attendant (TBA). Four in five women (82%) went to a public health facility to give birth; most commonly a health centre (53%). On average, childbirth cost respondents $160, including fees and transport (median $47.50). This ranged from $4.75 up to $2,000.

Overall, 90% of female GFW had some form of PNC in the first week after childbirth; 82% had the first PNC within 48 hours of delivery, in a health facility and with SBA. A similarly large majority of women (87.4%) received any kind of PNC check-up within the first six weeks (after the first 48 hours), with an average of 12 PNC visits per respondent. Three-quarters of these visits (76%) were for the mother only; nearly all (98%) were attended by a trained health professional, with more than half (59%) of these in the respondent's home. Only 27% of women received a full PNC2 follow-up within the first week after delivery.

One-third of women (33.3%) received counselling in modern contraceptive methods within one week of giving birth.

Four-fifths of women (79%) identified any indicators of neonatal distress; most commonly abnormal body temperature (64%). 15% of women knew three to four indicators.

Financial assistance for RMNH services

Among female GFW that used any of the aforementioned health and RMNH services, only 3.8% received some kind of financial assistance, with 2.2% receiving some form of public assistance (vouchers, referrals, HEF/SOA, community insurance and/or NSSF). Of those that received financial assistance, the most common was private contributions, received by 29% of these women. Public forms of assistance were received by a further quarter (25%). RMNH users were slightly more likely to receive public assistance (3.2% of RMNH users, compared to 1.7% of non-users), but were also more likely to borrow money than women that received other medical services (17% of RMNH users, compared to 11% of non-users). Borrowing among RMNH users averaged $132, compared to $102 overall, and was most commonly used for the costs of pregnancy. Nearly all borrowers (98.4%) used local and informal moneylending services, exposing them to higher interest rates and unregulated practices.

Conclusions and recommendations

Overall, women in PSL partner factories have shown positive improvements in their RMNH knowledge, attitudes and practices. Changes have been most notable in the areas of: safe childbirth (in a health facility with SBA); improved ANC and PNC care; uptake of modern contraception (generally and post-abortion); and women's empowerment and confidence in their sexual and reproductive health rights (SRHR). Most women were exposed to BCC information, or participated in BCC/Chat! activities in the last three months. Individual participation in BCC and Chat! campaign activities was directly correlated with improvements in knowledge of contraception, post-abortion contraceptive uptake, empowerment of women's SRHR and knowledge of abortion, in line with the program's activities and focus in garment factories. Although not a focus of PSL activities in the garment factories, women that participated in BCC and Chat! also showed improvements in knowledge of neonatal distress signs and frequency of ANC and PNC visits.

Further iterations of the project could build on these improvements in sexual and reproductive health, as well as targeting areas of weakness for new support. Knowledge of neonatal and pregnancy danger signs is still low, as is the use of factory infirmaries for RMNH services. Feedback from the qualitative interviews suggests that female GFW are satisfied with infirmaries, but unaware that they also provide reproductive health services. Thus, increased awareness should improve uptake of these services. Improving access to reproductive health services at infirmaries may also improve modern contraceptive

uptake, which is still less than half of sexually active GFW. Although the frequency of PNC visits increased from the baseline, and was correlated with BCC/Chat! participation, most of these visits occurred in the home rather than a health facility. Some women received excessive amounts of PNC care; up to one visit a day by a trained health provider. Additional phases of the project could focus on increasing women's knowledge of appropriate PNC (i.e., in a health facility with a trained provider), which could reduce the number of superfluous visits and also increase the likelihood of these women receiving post-natal FP counselling.

In addition, access to financial support mechanisms declined slightly from the baseline, and wasused by only a few women for RMNH services. This left many women reliant on private contributions or loans from informal lenders, exposing them to unregulated practices, such as high interest rates and unfair payment conditions. More work couldbe done to improve women's access to financial support and/or formal credit mechanism to pay for RMNH services.

Recommendations

Recommendations for the PSL program include:

- **Increase exposure and participation in BCC and Chat! activities.** These have proven especially useful in increasing women's knowledge and empowerment. If these activities were able to be broadened to also focus on pregnancy and neonatal distress signs (or other areas of weakness), there could also be significant improvements in these indicators by the endline.
- **Focus on reducing unmet family planning needs, and increase women's knowledge of appropriate contraceptive usage.** Although contraceptive uptake improved, there is still more work that could be done in this area, and increased awareness has not translated into increased utilisation, or appropriate utilisation of contraceptives (around half of women that gave birth in the last 24 months were using modern contraception when they conceived, indicating inappropriate usage). Increasing women's confidence in how to appropriately use modern contraceptives may also increase uptake. Further training could be done to ensure that "front-line workers" (e.g., peer educators and infirmary staff) are knowledgeable and can demonstrate appropriate contraceptive usage to female GFW.
- **Work to increase awareness and use of factory infirmary for reproductive health services.** Use of infirmaries for RMHN services and referrals is still fairly low, with the primary reason for non-use being a lack of awareness (women don't know about the factory, and/or don't know it provides RMNH services). Increasing women's awareness of the infirmary and its RMNH services could improve modern contraceptive uptake, as these products are often cheaper at infirmaries than in pharmacies/drug stores. This could be accomplished through an addendum to the existing BCC/Chat! campaigns, or as a separate awareness-raising project, in conjunction with additional training for infirmary staff (see recommendation above). If such an activity is pursued, it is best to coordinate with the infirmary staff to ensure that the advertised contraceptives and services are available, and that infirmaries can handle increased demand.
- **Work with female GFW and PNC providers to improve post-natal FP counselling.** Overall, appropriate PNC usage only increased slightly from the baseline, and post-natal FP counselling declined. Although not a focus of PSL activities in garment factories, further iterations of the program could work with healthcare providers to ensure they are including FP counselling in their PNC services in a timely manner.

- **Improve access to financial support mechanisms.** The number of female GFW that went into debt to pay for RMNH services indicates a need for increased access to financial support mechanisms, especially for the higher cost services such as delivery, abortion and tubal litigation.
- **Consider alternative financing mechanisms for RMNH services.** As part of a long-term strategy, alternate financing mechanisms for women to access high-quality RMNH services could be considered. These could be independently provided, or conducted in partnership with an MFI, to ensure that women are not forced into debt when they need to access these services.