What is PSL?
Partnering to Save Lives (PSL) is a partnership between CARE, Marie Stopes International Cambodia, Save the Children, the Australian Government and the Cambodian Ministry of Health (MoH). PSL aims ‘to save the lives of women and neonates in Cambodia through improved quality, access and utilisation of reproductive, maternal and neonatal health (RMNH) services through a partnership approach’ in line with the objectives of the MoH’s Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality (FTIRMN).

What are the issues?
Up to half a million people are employed in Cambodia’s growing garment sector and many of these workers are young women who have migrated from rural areas to work in factories in Phnom Penh and other large towns. PSL’s baseline survey showed that around one third are married and a similar proportion has children. Garment factory workers (GFWs) are particularly vulnerable with regard to RMNH for a variety of reasons, including isolation from their family and community support networks. There is also substantial movement back and forth between urban and rural areas (e.g. GFWs returning to their village to give birth), highlighting the importance of an integrated approach to RMNH awareness-raising and service delivery that is consistent with MoH protocols.

The PSL program aims to increase access to RMNH information and services for GFWs by:
- improving the capacity of garment factory infirmaries to deliver a wider range of high quality RMNH services and institutionalising a set of national guidelines on RMNH service delivery by infirmaries
- promoting positive RMNH behaviours through innovative means as part of the PSL’s Behaviour Change Communication (BCC) Framework
- strengthening systems for referral of GFWs to affordable quality services from public and private providers in the factory catchment areas.

PSL’s Quality Team, comprising technical representatives from the three NGOs, advises on technical issues, including the selection or development of guidelines, standards and protocols for health service quality improvement and for capacity development among garment factory infirmary service providers.

Successful implementation requires an in-depth understanding of GFWs’ RMNH knowledge, attitudes and practices, and their opportunities for accessing and using health services. Advocacy for greater engagement by garment factory management in RMNH issues depends on the ability to link workers’ improved RMNH status with the industry’s ‘bottom line’.

What have we learned?

Married GFWs expect to have children, which honour the family, but they may delay having children due to the economic status of the family. Married couples discuss different contraceptive methods, but women are responsible for their use.

Most Unmarried Female GFWs have boyfriends but pre-marital sex and pregnancy are taboo and shameful. They value contraception for preventing pregnancy, but service providers, peers and unmarried women themselves perceive that they are not entitled to access contraception. Unmarried women report that they primarily have unprotected sex due to lack of planning and sometimes being coerced into having sex. Unmarried men view sex before marriage as just for fun, and have low perception of pregnancy risk. There is also poor communication between unmarried couples about contraceptive use. These factors combine to increase the likelihood of unplanned pregnancies among unmarried GFWs, at which point their sexual partners are likely to abandon them. If an unmarried woman becomes pregnant it is expected that she will terminate the pregnancy, rather than get married while pregnant.

Most GFWs have good Awareness of Modern Contraceptive Methods but not the details of their use. Both married and unmarried women report knowing about pills, IUDs, implants, injections, condoms and natural methods such as withdrawal and rhythm. Men are less familiar with contraceptives. Women learn about contraceptives from NGOs, health facilities, TV, and friends, including peer educators. Fears centre on their effectiveness and impact on health and fertility. GFWs are concerned about side effects with hormonal methods: particularly nausea and weight gain or loss. Women tend to prefer the least invasive method.

What learning approaches have we used?
PSL has used qualitative methods to learn more about these issues, including:
- research conducted in mid-2014 in preparation for development of PSL’s BCC Framework, which comprised a literature review, in-depth interviews (IDIs) with 25 key informants at national level, IDIs and focus group discussions with a total of 84 respondents
- investigation into GFWs’ perceptions relating to RMNH, involving a desk review and five focus group discussions with married and unmarried women and men.
- meetings with officials at the Ministry of Labour and Vocational Training (MoLVT) and MoH to investigate the legal and policy framework for garment factory infirmaries.

Abortion
- Results from the two pieces of learning regarding Abortion suggest differences in women’s perceptions between their right to have an abortion and its legal status in the country. The BCC study confirmed the PSL baseline finding that the vast majority of...
women believe abortion is illegal, whereas the perceptions study reported that all women believe they have a right to an abortion. The BCC study found that stigma related to abortion among unmarried women leads to great secrecy. The perceptions study, which used different methods and focused solely on abortion and family planning, was able to explore this issue further and found that stigma attached to abortion may be reduced if it is done for economic reasons or for optimal birth spacing, particularly among married women. The BCC study reported good awareness of the risks of unsafe abortion, whereas some participants in the perceptions research believe that abortion is safer and cheaper than using contraception. The perceptions research reported that women tend to follow a sequence of methods until one is successful, starting with traditional (and unsafe) methods, then trying medical abortion pills from a pharmacy, finally going on to medical or surgical abortion at a health facility. Cost of facility-based services, which is seen as prohibitive, may be a factor in these choices, as may the perception of abortion as being illegal. All factories have a pregnancy policy, largely managed by the HR department, which covers issues such as maternity leave and time off for antenatal care (ANC). These Policies are governed by the Labour Law and related sub-decrees and ‘prakas’, issued and overseen by MoLVT. Infirmaries are mandatory for enterprises over a certain size. The Labour Law and related documents outline requirements for infirmary staffing and service hours (based on the size of the workforce), as well as basic infrastructure and equipment. However, there are no regulations relating to the quality of care provided and RMNH services (other than for HIV) are not mandated. The MoLVT has limited capacity for technical oversight of garment factory infirmaries and welcomes support from non-governmental partners, while infirmaries are outside the mandate of the MoH. However, the MoH sees the need to address the needs and vulnerabilities of the GFW population and has included technical support to development of RMNH guidelines for factory infirmaries in the NMCHC workplan for 2015.

Pregnancy-Related Services are not available from garment factory infirmaries (with the exception of pregnancy testing), which instead provide referrals to external providers. GFWs have good awareness of the benefits of ANC, skilled birth attendance (SBA) and post-natal care (PNC), but very limited knowledge of danger signs for mothers and babies during pregnancy and after delivery. Some women return to their home village for delivery, which disrupts the continuum of care and increases the likelihood of their having a home delivery with a traditional birth attendant. Perceptions of skilled staff, good equipment and sufficient supplies at health facilities, along with support from family and community, are likely to encourage SBA. GFWs observe many traditional practices during post-natal period. As PNC usually occurs during maternity leave, factories do not get involved in educating GFWs about PNC. While public health facilities are trusted as Sources of Healthcare because they have older, more skilled, midwives, and sufficient material and medicines, many women, particularly those who are unmarried, prefer to access private clinics, due to factors such as confidentiality and convenience. NGO clinics are trusted but seen as niche providers of specialised services. Unmarried women’s choice of RMNH service provider may be influenced by the likelihood of being seen by someone they know. Garment factory infirmaries represent untapped potential to reach GFWs with information and services but vary in their levels of confidentiality and privacy, number and capacity of staff, and services provided, which can all influence uptake.

Health is not a high priority for GFWs, so Behaviour Change Communication must be integrated into other activities. Edutainment, including songs, games and comedy shows, is popular; written messages are not. There is a lack of materials featuring young, urban, and particularly unmarried women. Information materials on abortion should be discreet (e.g. wallet-sized). More than 80% of GFWs own mobile phones and SMS provides a confidential mechanism for providing reproductive health information, particularly for youth, but evidence of impact of mHealth activities in Cambodia is limited. Key change agents within factories are factory owners, HR managers, supervisors and team leaders; all can have positive or negative impact. However, GFWs trust information from sources they can identify with, particularly aspirational characters. So peers are the main source of contraception and abortion information for GFWs, particularly unmarried women, although there is limited evidence of the effectiveness of formal peer education approaches.

What are we doing about it?

PSL is working to improve access to RMNH information and services through an integrated approach:

- Working with key stakeholders under the leadership of MoLVT, with technical guidance from MoH, to develop national guidelines on the delivery of RMNH services by garment factory infirmaries.
- Implementing a pilot referral system which facilitates access for GFWs to RMNH service providers close to their factory or home. The providers were selected based on previous trainings by NGOs such as MSIC and PSK, however no ongoing quality follow-up is provided at these facilities under PSL. The pilot will be reviewed and, if successful, expanded to cover a greater number of factories.
- Implementing an innovative multi-platform BCC approach, based on PSL’s BCC Framework, which particularly promotes informed choice of contraceptive methods and provides information on safe abortion services to sexually active unmarried GFWs. The package includes a mobile phone quiz application, video dramas, and a curriculum for training peer networks of GFWs.
- Building the capacity of garment factory infirmary staff to deliver high quality, convenient and non-judgemental RMNH services and referrals to all GFWs.
- Continuing to gather and share learning about RMNH among this large, diverse and rapidly evolving population of vulnerable women, through implementation of PSL’s Learning Agenda and Advocacy Action Plan. In particular, learning is shared through inputs into national Technical Working Groups, presentations to relevant stakeholders, including the PSL Technical Reference Group and the SAFE Working Group, and awareness-raising through site visits, publications and the media.