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

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Acronyms and Abbreviations

ANC Antenatal care
BCC Behaviour change communication
CAC Comprehensive abortion care
CDHS Cambodia Demographic and Health Survey
DFAT Department of Foreign Affairs and Trade (of the Australian Government)
FGD Focus group discussion
FP Family planning
FTIRMN Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality
GFW Garment factory worker
HEF/SOA Health equity fund/Special operating agency
IDI In-depth interview
IUD Inter-uterine device
KAP Knowledge, attitude and practice
LAPM Long-acting and permanent methods (of contraception)
MERI Monitoring, evaluation, reporting and improvement
MFI Microfinance institution
MOH Ministry of Health
NGO Nongovernmental organization
NIPH National Institute of Public Health
PNC Post-natal care
PSL Partnering to Save Lives
RHAC Reproductive Health Association of Cambodia
RMNH Reproductive, maternal and neonatal health
SBA Skilled birth attendant
SRHR Sexual and reproductive health and rights
STI Sexually transmitted infection
TBA Traditional birth attendant
WRA Woman (women) of reproductive age (15-49 years old)

Note: All monetary values in the report are in United States dollars ($). These have been converted from Cambodian riel (KHR) at a rate of $1 = KHR 4,000.
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This midline study is conducted under the authority of the Partnering to Save Lives (PSL) program; a consortium of three nongovernmental organizations (CARE, Marie Stopes International Cambodia (Marie Stopes), and Save the Children), working to improve the quality, access and utilisation of reproductive, maternal and neonatal health services in Cambodia, in partnership with the Cambodian Ministry of Health and the Australian Department of Foreign Affairs and Trade (DFAT).

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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 mid-term 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);
- 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 workers.

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.
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%) were cohabiting with someone else. Most of these women were living 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 were passive – 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 was used 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 could be done to improve women’s access to financial support and/or formal credit mechanisms 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.
Introduction

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 (PSL 2014).

The garment industry is the single largest formal employer in Cambodia, employing around 600,000 workers in an industry valued at around $6 billion per year (ILO 2015). Factories clustered in and around the capital city of Phnom Penh have drawn workers from many different parts of the country, seeking higher wages and steady employment. Most of the workers in this industry – around 90% – are female. Away from their family and community support structures, or recently arrived in unfamiliar areas, these women have unique reproductive, maternal and neonatal health (RMNH) needs. Due to the migratory nature of these women, these approaches can be effectively facilitated through cooperation with garment factories.

In the garment sector, PSL has worked with garment factories to improve the quality of infirmary care and the use of referrals to external health providers, and implemented numerous BCC activities to promote sexual and reproductive health and rights (SRHR), including knowledge on contraceptives and safe abortion.

Objectives

A baseline survey conducted in 2014 at the start of the project established pre-intervention levels of knowledge, attitudes and practices (KAP) of female garment factory workers (GFW) in the target areas. The overall objectives of the midline survey are to:

1. Assess changes in the knowledge, attitudes and practices (KAP) of female garment factory workers (GFW) towards reproductive, maternal and neonatal health (RMNH) from the baseline indicators in the Monitoring, Evaluation, Reporting and Improvement (MERI) framework;
2. Determine the exposure and participation of garment factory workers (GFW) in the BCC and Chat! Contraceptive campaign activities, and any effects on MERI indicators; and
3. Gather qualitative information about the effectiveness of PSL in achieving its objectives and outcomes.

The findings in this study will be incorporated into the midterm program review process, and used to improve the design and implementation of activities in the latter half of PSL implementation.

Methodology

This midline study utilised a mixed methods approach, incorporating both quantitative measures of knowledge, attitudes and perceptions, and qualitative knowledge of garment factory infirmary staff and GFW to objectively evaluate the impact of PSL activities in targeted garment factories. Where possible, comparability with the baseline survey developed by Cambodia’s National Institute of Public Health (NIPH), and PSL’s MERI indicators has been maintained, including in the total sample size, questionnaire development, data management and analysis. Specific activities conducted for this evaluation were:
• Quantitative interviews with 900 women of reproductive age (15-49 years old) who currently work in one of the selected garment factories receiving PSL interventions;
• Qualitative, in-depth interviews with garment factory infirmary staff (1-2 per factory);
• Focus group discussions (FGDs) among respondents of the quantitative interviews purposively selected from among those with the most exposure to the program, organized among married and single female GFW separately;

Per the baseline sample size calculations, 900 women of reproductive age (WRA; 17-49 years old) were selected for participation in the midline survey from among all women in four PSL target factories (Table 1). The four factories were purposively selected by PSL, based on the level and frequency of activities in each factory. Research and field staff were unaware of the PSL activities conducted in each factory, so as to not bias the results and interpretation of findings. The number of WRA to be interviewed in each factory was then determined proportional to the total number of WRA in the four factories, as provided by factory management for the month preceding the survey. Random selection from among all WRA in each factory was then conducted. Where possible, WRA were randomly selected from lists of all current WRA workers, as provided by factory management, using a random number generator to ensure an equal probability of selection. These factories also allowed field staff to conduct interviews within the factory during working hours; in a private conference room or empty office space, to ensure confidentiality.

For one factory, worker lists were not available. In this factory, a sampling interval was determined based on the total number of WRA, and in-person selection was conducted by field staff at the factory gates when workers were leaving for lunch and at closing times. Care was made to ensure that all possible exits and times (i.e., lunch time, official end-of-day, and after two hours’ overtime) were covered by field staff, to ensure all workers were included in the sampling. At time of selection, eligible workers’ contact details were recorded, and field staff followed up during off hours (lunchtime, after work and on weekends) to complete the interviews. Face-to-face interviews were primarily conducted for all factories, but where this was not possible due to respondent availability, phone interviews were conducted. In total, phone interviews were conducted with less than 10% of all respondents to the quantitative interview.

Within the initial sample of 900 WRA, 100 WRA that had given birth within the last 24 months (two years) were purposively targeted, proportional to the overall sample in each factory. These women were purposively sampled in order to increase the confidence in the results of the sections on maternal and neonatal health, where the general prevalence of such women in the overall population would limit the ability to make statistically accurate measurements. Prevalence was considered against the baseline, where 8.8% of completed interviews were with WRA that gave birth in the last 24 months. These women were selected using the same selection methods for the overall sample in each factory. When prevalence of these women was not sufficient among the factory sample, additional female workers were randomly selected and screened for childbirth eligibility, until the target within each factory was achieved.

In total, 933 eligible WRA were selected and approached for the survey. 905 of these gave their informed consent and completed the quantitative interview; a 97% response rate, including 103 women that gave birth in the last 24 months. Most of the refusals were in the factory with exit interviews. An additional 237 GFW were initially selected, but were unable to be contacted further, for reasons including: workers changing their telephone number; field staff incorrectly recording contact information; worker resignations from the factory (those that resigned within the month before the survey); and, further selection of workers to screen for those that had given birth in the last 24 months.
The current midline study is therefore representative of all eligible WRA in the four target factories of this study. Consideration should be given when attempting to compare or apply these results to other factories, as there may be unique conditions or activities conducted in these factories which were not present in other PSL program areas. See the Limitations section, below, for further cautions in the interpretation of the data.

This is a slight difference to the sampling methodology from the baseline. In the baseline, eligible WRA were selected through use of a cluster method, whereby known GFW residences (i.e., rental rooms and dormitories) were randomly selected from among all known residences affiliated with workers from the selected factories. All eligible WRA in each selected residence were then approached for interviews. This method, while effective and random, has a natural bias towards workers that live in group accommodations. It therefore may exclude workers that live alone, those that live with relatives in single-family residences, those native to the area, and those that live further away from the factory (as worker accommodation tends to be clustered near the factory).

Qualitative data
In addition to the individual quantitative interviews with eligible WRA, qualitative in-depth interviews (IDIs) and FGDs were also conducted with infirmary staff and single/married female GFW, respectively. Both types of data explored the issues around the MERI indicators of program success, including participation in the behaviour change communication (BCC) campaign and Chat! Contraception activities, as well as understanding and use of RMNH services, including contraception. Respondents also gave their opinions about the program and activities, and recommendations for improvement.

For infirmary staff IDIs, field staff interviewed all available staff at each infirmary (two people each in three factories; one person in the fourth factory). For FGDs, field team supervisors selected respondents to the quantitative survey who had the most exposure to program activities, or the most involvement in RMNH services, as these women could best provide information about the success and implementation of PSL program activities. One FGD was organized with the respondents in each of the four factories. Because there may be differences between the responses of married women (including those in committed relationships who are living with their partners) and unmarried women (single women living alone or without their partner), the FGDs were grouped into married and unmarried women. Ten respondents were invited to participate in each FGD; between six and nine respondents participated, with an average of 7 respondents per FGD.

Table 1: Midline sample, selection methodology and response rates.

<table>
<thead>
<tr>
<th>Strata</th>
<th>Number</th>
<th>Proportion</th>
<th>Selection method</th>
<th>Response (% complete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factory</td>
<td>4</td>
<td>4 / 9</td>
<td>Purposive</td>
<td>4 (100%)</td>
</tr>
<tr>
<td>GFW</td>
<td>900</td>
<td>Proportional to WRA in factory</td>
<td>Random (worker lists and exit interviews)</td>
<td>905 (97%)</td>
</tr>
<tr>
<td>GFW that gave birth in last 24 months</td>
<td>100</td>
<td>Proportional to WRA in factory</td>
<td>Random (worker lists and exit interviews)</td>
<td>103 (103%)</td>
</tr>
<tr>
<td>Infirmary staff</td>
<td>7</td>
<td>1 - 2 / factory</td>
<td>Purposive (all staff)</td>
<td>7 (100%)</td>
</tr>
<tr>
<td>FGDs (GFW)</td>
<td>4</td>
<td>1 / factory</td>
<td>Purposive (involvement)</td>
<td>4 (100%)</td>
</tr>
<tr>
<td>Strata</td>
<td>Number</td>
<td>Proportion</td>
<td>Selection method</td>
<td>Response (% complete)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Single WRA living alone</td>
<td>2</td>
<td>6 - 10 WRA/FGD</td>
<td>Purposive</td>
<td>15 (100%)</td>
</tr>
<tr>
<td>Married WRA</td>
<td>2</td>
<td>6 - 10 WRA/FGD</td>
<td>Purposive</td>
<td>13 (100%)</td>
</tr>
<tr>
<td>Total Respondents (All Components)</td>
<td>940</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Questionnaires**

The quantitative survey questionnaire was derived from the initial baseline questionnaire. The overall structure and format of the questionnaire was maintained, as was the phrasing of most questions in both English and Khmer, to ensure comparability with the baseline data. Where necessary, changes were made in cooperation with PSL staff. These included:

- Changes to the maternal and neonatal health sections, including definitions of antenatal care (ANC) and postnatal care (PNC), post-natal and post-abortion family planning (FP) counselling and uptake, to comply with changes in MOH’s RMNH indicators (via FTIRMN);
- Restricting maternal and neonatal health respondents to those that have given birth in the last 24 months (instead of WRA that had ever given birth, as in the baseline), to measure changes in these indicators since the start of PSL activities;
- The addition of modules on media use and access (including social media and internet), and participation in BCC and/or Chat! Contraception activities;
- Considering contraception use for WRA that have been sexually active in the last 12 months (rather than any sexual experience);
- The inclusion of prompted knowledge of contraception (in addition to unprompted knowledge);
- Inclusion of RMNH service and transport expenses in each service section (rather than grouped together).

Where these changes have been implemented, the differences with the baseline have been explained in their respective results sections, below.

**Analysis**

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 account for differences in the probability of selection between factories, and prevalence of WRA that gave birth in the last 24 months among a similar population of women; i.e., those included in the baseline (8.8% prevalence). Table 2 lists the population weights for the different groups. These weights were applied to the analysis of the general data, but were not considered for the data on maternal and neonatal health. In general, weighting only slightly affected the results, with a ±0.1% -0.2% difference from the non-weighted findings.

**Table 2: Sample weighting coefficients for WRA with/without childbirth in the last 24 months.**

<table>
<thead>
<tr>
<th>Factory ID</th>
<th>WRA birth ≤24m</th>
<th>Midline Population</th>
<th>Baseline Target</th>
<th>Weighting coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factory 1</td>
<td>Yes</td>
<td>11.5%</td>
<td>8.8%</td>
<td>76.4500%</td>
</tr>
<tr>
<td>Factory 2</td>
<td>Yes</td>
<td>10.9%</td>
<td>8.8%</td>
<td>80.8762%</td>
</tr>
<tr>
<td>Factory 3</td>
<td>Yes</td>
<td>11.0%</td>
<td>8.8%</td>
<td>80.0585%</td>
</tr>
<tr>
<td>Factory 4</td>
<td>Yes</td>
<td>12.5%</td>
<td>8.8%</td>
<td>70.4000%</td>
</tr>
<tr>
<td>Factory 1</td>
<td>No</td>
<td>88.5%</td>
<td>91.2%</td>
<td>103.0634%</td>
</tr>
</tbody>
</table>
Data was analysed in two different ways: descriptive analysis, for comparison with the baseline indicators; and comparative analysis to understand the effects of exposure to the BCC and Chat! campaigns. Where possible, the indicators have been measured in the same way as the baseline (and in line with the definition and indicator measurement provided in the MERI framework). Where differences are unavoidable (e.g., due to methodological revisions), they have been clearly defined and explained. Because the use of sample weights changes the count (or “n”) from the number of respondents to a weighted value, the percentage is a more useful indicator of values than the count, and will be preferred throughout this report. Counts are occasionally given in the sections on maternal and neonatal health, where the data has not been weighted.

**Limitations**

Because of the purposive selection of garment factories for the midline, the data collected is representative of those specific factories. Unique conditions and program implementation in the other targeted factories may differ from those of the four factories studied in this survey. In addition, changes to the sampling methods from the baseline (cluster sampling) to the midline (individual selection), may have changed the characteristics of the population selected for the study (and therefore their KAP and RMNH behaviours). These differences are clearly described in the socioeconomic characteristics section, below. Consideration should therefore be given to these issues when considering the results in the overall program context.

The quantitative questionnaire has been revised from the baseline. This has been done for many reasons, including: to reflect changes in national RMNH indicators, and alignment with FTIRMN (e.g., differences in PNC visit times and frequencies); to improve the flow of the questionnaire and ease of interviewing (e.g., by including the costs of RMNH services at the end of each service section, rather than in clustered at the beginning); and to improve filtering and relevant responses (e.g., by examining contraceptive use only among women sexually active in the last 12 months, rather than those with any previous sexual activity; and asking about pregnancy and maternal health only for women that gave birth in the last 24 months). Such differences may affect the interpretation of results, and thus the comparability with the previous baseline and/or previous national indicators. Where relevant, these changes are noted in the results sections.

All data collected for this survey was self-reported by respondents, who may have over-reported or under-reported their characteristics, knowledge, experiences and attitudes, for a variety of reasons (forgetfulness, loss of face, hope of additional support, fear of repercussion, etc.). Especially notable for this study may be the effect of acquiescence bias on participation in the BCC and Chat! Contraceptive campaign, whereby participation levels may be overestimated.
A significance test between baseline and midline indicators was not possible, due to the following factors:

1. **Garment Factory populations:**
   a. Two distinct selection processes were used for the surveyed populations during the baseline and midline surveys. The baseline factories were randomly selected, while the midline factories were purposively selected by PSL. Thus, it has not been possible to carry out a statistical significance test between the garment populations, who are considered to be two separate groups.

2. **Indicators:**
   a. The baseline and midline confidence intervals were +/-5%, which means that a change of 10% or more would be needed to show significant differences between the indicators in the overall population (n=900). As many of the indicators have been filtered by a particular subgroup rather than the total population, this makes it likely that confidence intervals will have increased.
   b. There was an increase in nearly all indicators, making the statistical significance of a single indicator less important in the analysis than the overall trend data. For instance, we would have reported the same, consistent increases across all the indicators whether or not they were statistically significant. Significance tests therefore would not change the overall findings, conclusions or recommendations.
   c. PSL activities did not focus on all indicators between the baseline and midline surveys, which would mean that highlighting a significant difference in these indicators would not show a change correlated with PSL activities.
Socio-demographic Characteristics

Sample differences

This section examines the results of the study among the 905 eligible WRA surveyed in the four factories. As shown in Table 3, the completed interviews were spread across the four factories, proportional to the number of WRA in all four factories, providing representation of the overall WRA population. Because of slight differences in probability of selection and oversampling of women that gave birth recently, the general data analysis (excluding maternal and neonatal health indicators), uses a weighting coefficient to control for these differences (see methodology section, above, for coefficient details).

Table 3: Midline completed sample, by factory and childbirth in the last 24 months (unweighted).

<table>
<thead>
<tr>
<th>Total GFW</th>
<th>Midline: WRA without Recent Birth</th>
<th>Midline: WRA (Birth ≤24m)</th>
<th>Midline: Total WRA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>Factory 1</td>
<td>1,777</td>
<td>15.3%</td>
<td>16</td>
</tr>
<tr>
<td>Factory 2</td>
<td>2,583</td>
<td>21.4%</td>
<td>21</td>
</tr>
<tr>
<td>Factory 3</td>
<td>4,755</td>
<td>41.4%</td>
<td>41</td>
</tr>
<tr>
<td>Factory 4</td>
<td>2,465</td>
<td>21.8%</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>11,580</td>
<td>100.0%</td>
<td>103</td>
</tr>
</tbody>
</table>

Respondent characteristics

Table 4, below, summarizes the social, economic and demographic characteristics of the women in the four target factories for the midline survey. On average, the female garment factory workers (GFW) are 27 years old. Nearly all (95%) have some education; the average GFW completed primary school (grade six). Only 5.8% have high school level education (grade 10) or higher; one respondent reported having university-level education. Around half of women are currently married (49%), and 6.9% were previously married (divorced/widowed). Slightly less than half of respondents are single (44.5%), most of whom did not report being in a relationship (43.2%).

Nearly all female GFW are cohabiting with someone else; only 7.3% live alone. Among women that cohabit, most live with their relatives (60.8%). Two-fifths live with their spouse (39.8%), and about one in ten live with their parents (11.8%) and/or friends (10%). Less than one percent (0.4%) live with their romantic partner (sweetheart).

Female GFW at the midline had four to five years of experience in the garment industry (mean 5.6; median 4.0), although there is a wide range of answers represented; from less than one year to 21 years’ experience. On average, respondents made US$208.41 from all income sources in the last month, with a similar median value (US$204). Two-thirds of respondents sent money to their family members in the month before the midline survey. On average these workers sent around US$100 per month, or nearly half (49%) or their monthly income.
In terms of these characteristics, the age and education level of respondents are similar to the baseline. However, women in the baseline survey were less likely to be married or single (no relationship), and more likely to be single in a committed relationship. Baseline respondents were also less likely to live with any relatives (including spouses and parents), and more likely to live with friends. Baseline respondents were also less experienced in the garment industry. These differences are reflective of the changes to the sample selection methods employed by the different survey rounds, where the baseline sampled women living in dormitory-style housing.

Interestingly, the differences in total average income (US$66.41 difference) are reflective of changes in the minimum wage between 2014 and 2016. Between the baseline and midline data collection, the minimum wage in Cambodia increased by US$60, from US$80 to US$140. Workers’ average income from all sources, therefore, appears to be closely correlated with their garment factory salaries.

Table 4: Socio-demographic characteristics.

<table>
<thead>
<tr>
<th></th>
<th>Midline</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years (median)</td>
<td>27.1 (26.0)</td>
<td>25.8 (25)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No schooling</td>
<td>4.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Any schooling</td>
<td>95.3%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Highest grade (median)</td>
<td>6.2 (6.0)</td>
<td>6.2 (6.0)</td>
</tr>
<tr>
<td>University level</td>
<td>0.1%</td>
<td>–</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>48.7%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Single and not in a regular relationship</td>
<td>43.2%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Widowed/ Divorced</td>
<td>6.9%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Single in committed relationship</td>
<td>1.3%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Lives alone</td>
<td>7.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Cohabitation*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With relatives</td>
<td>60.8%</td>
<td>48.3%</td>
</tr>
<tr>
<td>With spouse</td>
<td>39.8%</td>
<td>26.3%</td>
</tr>
<tr>
<td>With parent</td>
<td>11.8%</td>
<td>6.7%</td>
</tr>
<tr>
<td>With friends (in rental house/room)</td>
<td>10.0%</td>
<td>13.5%</td>
</tr>
<tr>
<td>With sweetheart</td>
<td>0.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Experience in garment industry, in years (median)</td>
<td>5.6 (4.0)</td>
<td>4.1 (3.0)</td>
</tr>
<tr>
<td>Total income in previous month, in US$ (median)</td>
<td>$208.41 ($204)</td>
<td>$142 ($138)</td>
</tr>
<tr>
<td>Sent money to family last month</td>
<td>67.3%</td>
<td>–</td>
</tr>
<tr>
<td>Remittance value last month, in US$ (median)</td>
<td>$102.66 ($100)</td>
<td>–</td>
</tr>
</tbody>
</table>

*Multiple responses possible at midline. The sum of values may be greater than 100%.

Disability

In line with the baseline survey, the presence and severity of disability among female GFW was assessed using the Washington Group method, an internationally recognized standard for measuring disability. This assessment was made in six areas: seeing; hearing; walking/climbing stairs; remembering or concentrating; self-washing and dressing; and communicating. The Washington Group on Disability Statistics (or Washington Group) is a working group tasked by the United Nations Statistical Commission to develop measures of disability suitable for censuses and surveys. The short form questions used here were designed for use in censuses and large-scale surveys to identify people with similar types and levels of limitations in accomplishing basic and daily tasks (Washington Group 2006). They are purposefully broad, designed to be used in many different countries, regardless of differences in nationality or culture. The impetus is on the
respondent to identify their own impairments, rather than defining disability by the lack of a body part or its functioning. According to the Washington Group, “The proposed questions identify the population with functional limitations that have the potential to limit independent participation in society.... It would not represent the total population with limitations nor would it necessarily represent the ‘true’ population with disability which would require measuring limitation in all domains and which would require a much more extensive set of questions” (Washington Group 2010). Therefore, the results should be cautiously applied to the overall population.

The Washington Group Scale allows respondents to be classified as having a disability in two ways: the inclusive measure, whereby any respondent who has a minimum of some difficulty in any of the measures is considered to have a disability; and the exclusive measure, where one would be considered to have a disability if they had a lot of difficulty, or complete lack of ability, on any measure. In terms of inclusive disability, slightly over half (51.2%) of female GFW reported having any kind of limitation in any of the six areas. This is considerably higher than the inclusive disability rate reported by women in the Cambodia Demographic and Health Survey (CDHS), which also applied the Washington Group method in 2014, of 10.5%. Differences between these surveys may be due to variations in the wording or translation, sampling methodology (individual interview, compared to the CDHS’s household interview), questionnaire design, interview style, or biases (such as primacy, satisficing, or acquiescence). It may also be the case that, at the end of a factory work shift, workers have some difficulty in seeing, concentrating or hearing (the three most common impairments reported in the midline), which are symptoms of fatigue rather than disability. Whatever the cause, this metric should be considered cautiously, and exclusive disability preferred (below).

Exclusive disability, as the more limited measure of disability – severe or complete lack of ability – was reported by 3.6% of midline respondents. This is less than half of the baseline value (7.3%), and in line with the exclusive disability rates for women in CDHS 2014 (2.3%). All of these workers reported severe lack of ability; no workers reported a complete lack of function in any of the six areas.

The most common functional area respondents reported difficulty with was remembering or concentrating (Table 5). Almost one-third (32.9%) had some difficulty with these activities, with 2.4% reporting a lot of difficulty.

Table 5: Reported disabilities and severity, among all workers.

<table>
<thead>
<tr>
<th>Difficulty seeing, even if wearing glasses</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difficulty</td>
<td>71.0%</td>
</tr>
<tr>
<td>Yes, some difficulty</td>
<td>27.8%</td>
</tr>
<tr>
<td>Yes, a lot of difficulty</td>
<td>1.1%</td>
</tr>
<tr>
<td>Yes, cannot do it at all</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difficulty hearing, even if using a hearing aid</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difficulty</td>
<td>88.1%</td>
</tr>
<tr>
<td>Yes, some difficulty</td>
<td>11.2%</td>
</tr>
<tr>
<td>Yes, a lot of difficulty</td>
<td>0.7%</td>
</tr>
<tr>
<td>Yes, cannot do it at all</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
<tr>
<td>Difficulty</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Difficulty walking or climbing stairs</td>
<td></td>
</tr>
<tr>
<td>No difficulty</td>
<td>92.3%</td>
</tr>
<tr>
<td>Yes, some difficulty</td>
<td>7.2%</td>
</tr>
<tr>
<td>Yes, a lot of difficulty</td>
<td>0.5%</td>
</tr>
<tr>
<td>Yes, cannot do it at all</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
<tr>
<td>Difficulty remembering or concentrating</td>
<td></td>
</tr>
<tr>
<td>No difficulty</td>
<td>64.7%</td>
</tr>
<tr>
<td>Yes, some difficulty</td>
<td>32.9%</td>
</tr>
<tr>
<td>Yes, a lot of difficulty</td>
<td>2.4%</td>
</tr>
<tr>
<td>Yes, cannot do it at all</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
<tr>
<td>Difficulty with self-care, such as washing all over or dressing</td>
<td></td>
</tr>
<tr>
<td>No difficulty</td>
<td>98.7%</td>
</tr>
<tr>
<td>Yes, some difficulty</td>
<td>1.2%</td>
</tr>
<tr>
<td>Yes, a lot of difficulty</td>
<td>0.1%</td>
</tr>
<tr>
<td>Yes, cannot do it at all</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
<tr>
<td>Difficulty communicating, for example understanding or being understood</td>
<td></td>
</tr>
<tr>
<td>No difficulty</td>
<td>92.0%</td>
</tr>
<tr>
<td>Yes, some difficulty</td>
<td>8.0%</td>
</tr>
<tr>
<td>Yes, a lot of difficulty</td>
<td>0.0%</td>
</tr>
<tr>
<td>Yes, cannot do it at all</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Media Access and Use

This section measures the access that female GFW have to various forms of media, and their frequency of use. The large majority of female GFW reported owning a mobile phone (Figure 1). Mobile phones are nearly evenly divided between those that can assess the internet (smartphones; owned by 43% of women), and mobile phones without internet capability (49%). Less than one in ten women (8%) reported not owning a mobile phone.

![Figure 1: Mobile phone ownership among female GFW.](image)

Similar to mobile phone ownership, access to media was also very high, with 92.7% of respondents accessing media in any form (newspaper, TV, radio, internet, etc.) at least once per week. Figure 2, below, details the media that respondents access regularly. The most common media is TV, accessed at least once a week by over three-quarters (81.5%) of respondents. Radio and facebook were also popular options, accessed by around two-thirds and half of respondents at least once per week (69.7% and 45.8%, respectively).

![Figure 2: Media accessed at least once a week, among female GFW with media access.](image)

Next, respondents were asked about their primary media. Again, the three most popular media were TV, facebook and radio (Figure 3). Over two-fifths of female GFW said that they accessed TV; more than other
media. Facebook and radio were the primary media of around one-quarter of women each (28.2% and 24.2%, respectively). Other forms of media, such as internet, printed magazines and newspapers were the primary media of a very small number of female GFW; less than 5% for these sources combined.

![Primary media source](image)

**Figure 3: Primary media source, among female GFW with media access.**

Lastly in this section, respondents were asked about their sources of information on contraception, and to rank these information sources from most important to least important (where 1 is the most important and 9 the least). Thus a lower average score means the source is considered more favourably (in Table 6, below). In general, female GFW value interpersonal relationships as their most important sources of contraceptive information. Overall, the primary source of information about contraception for all WRA was health centre staff, followed by factory infirmary staff, and family/friends/colleagues. These were followed by mass media (radio and TV), and then by NGO staff/activities. The least personal sources of information were also the lowest ranked, with facebook, other internet sites, and leaflets/banners/T-shirts making up the least important sources.

There were no significant differences between the use of media for contraceptive information between factories, and women who gave birth recently and those that did not. However, there were considerable differences in rankings between single and married women. Although health centre staff were the most important source of contraceptive information for both groups, the other sources varied. Single GFW valued radio as much as health centre staff (same mean value; 3.09), followed by family/friends/colleagues, TV, and factory infirmary staff. Married women valued all interpersonal relationship sources more than mass media, with infirmary staff and family/friends/colleagues their second and third most important sources, respectively. This was followed by radio, and then TV.

Interestingly despite high facebook and internet usage, respondents in both groups did not consider it to be an important information source for contraceptives.
Table 6: Ranking and scores of contraceptive information sources, from most important (1) to least important (9), and disaggregated by single and married WRA.

<table>
<thead>
<tr>
<th>Media</th>
<th>All GFW</th>
<th></th>
<th>Single WRA</th>
<th></th>
<th>Married WRA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Score (mean)</td>
<td>Rank</td>
<td>Score (mean)</td>
<td>Rank</td>
<td>Score (mean)</td>
</tr>
<tr>
<td>Health centre staff</td>
<td>1</td>
<td>3.22</td>
<td>1</td>
<td>3.09</td>
<td>1</td>
<td>2.95</td>
</tr>
<tr>
<td>Factory infirmary staff</td>
<td>2</td>
<td>3.70</td>
<td>5</td>
<td>4.71</td>
<td>2</td>
<td>3.38</td>
</tr>
<tr>
<td>Family/friends/colleagues</td>
<td>3</td>
<td>3.89</td>
<td>3</td>
<td>3.64</td>
<td>3</td>
<td>3.85</td>
</tr>
<tr>
<td>Radio</td>
<td>4</td>
<td>4.14</td>
<td>2</td>
<td>3.09</td>
<td>4</td>
<td>4.29</td>
</tr>
<tr>
<td>TV</td>
<td>5</td>
<td>4.36</td>
<td>4</td>
<td>4.09</td>
<td>5</td>
<td>4.34</td>
</tr>
<tr>
<td>NGO staff/activities</td>
<td>6</td>
<td>5.48</td>
<td>7</td>
<td>6.36</td>
<td>6</td>
<td>5.35</td>
</tr>
<tr>
<td>Facebook</td>
<td>7</td>
<td>6.11</td>
<td>6</td>
<td>5.91</td>
<td>7</td>
<td>6.54</td>
</tr>
<tr>
<td>Internet</td>
<td>8</td>
<td>7.01</td>
<td>9</td>
<td>7.09</td>
<td>9</td>
<td>7.26</td>
</tr>
<tr>
<td>Leaflet/banner/T-shirt</td>
<td>9</td>
<td>7.08</td>
<td>8</td>
<td>7.01</td>
<td>8</td>
<td>7.04</td>
</tr>
</tbody>
</table>

BCC and Chat! Contraceptive Campaign Participation

Next, respondents were asked about their exposure and participation in any contraceptive behaviour change communication (BCC) campaign activities, and also specifically about involvement in the Chat! Contraception activities, which included videos, sessions and a mobile game.

Overall, four in five respondents (80.8%) in all factories had exposure to some or all of the BCC campaign activities in the last three months before the interview, which included contraceptive advertising, posters/leaflets/hotline cards, lunchtime meetings on sexual and reproductive health, and counselling with peer educators (Table 7). The most common activities that female GFW experienced were exposure to contraceptive advertising, reported by around three-quarters of workers (73.5%). Nearly half of workers (42.5%) saw posters, leaflets or “Khnom Samrab Nak” hotline cards. Around one-quarter of women (28.7%) spoke to a peer educator in the last three months, and around one-fifth (19.7%) reported attending a lunchtime sexual and reproductive health meeting. Most female GFW were exposed to one to two BCC activities (mean 1.7 activities Error! Reference source not found.), with similar exposure and participation rates across factories.

Table 7: Participation in types of BCC activities, by factory.

In the last three months, did you ever...

<table>
<thead>
<tr>
<th></th>
<th>Factory 1</th>
<th>Factory 2</th>
<th>Factory 3</th>
<th>Factory 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hear or see any contraceptive advertising?</td>
<td>69.1%</td>
<td>68.3%</td>
<td>77.5%</td>
<td>74.1%</td>
<td>73.5%</td>
</tr>
<tr>
<td>See a poster /leaflet /Khnom Samrab Nak hotline card?</td>
<td>33.1%</td>
<td>44.1%</td>
<td>46.5%</td>
<td>39.9%</td>
<td>42.5%</td>
</tr>
<tr>
<td>Speak to a peer educator?</td>
<td>20.0%</td>
<td>35.6%</td>
<td>28.6%</td>
<td>28.5%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Attend a lunchtime sexual and reproductive health meeting?</td>
<td>20.4%</td>
<td>15.6%</td>
<td>20.9%</td>
<td>21.2%</td>
<td>19.7%</td>
</tr>
</tbody>
</table>

Next, in the two factories where Chat! was being implemented, workers were asked about their individual participation in Chat! Contraceptive campaign activities. Although the Chat! Contraceptive campaign was not yet 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. The most frequently attended Chat! activity was viewing the videos; around one-third of female GFW (34.1%) in these factories...
saw a Chat! video in the last three months (Table 8). On average, these women viewed Chat! videos one to two times. Around one in six women (17.6%) attended a Chat! session, with most attending two sessions. Overall, only a very small percentage of workers (3.3%) said that they had played the mobile game. Women that played the mobile game did so for less than one hour on average, and achieved level five. Workers that participated in Chat! activities generally participated in one activity; around one in eight workers (13.2%) participated in multiple Chat! activities.

**Table 8: Participation in Chat! Contraceptive campaign activities.**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>See any of the Chat! videos?</td>
<td>34.1%</td>
</tr>
<tr>
<td>Average video views</td>
<td>1.8</td>
</tr>
<tr>
<td>Attend any Chat! sessions?</td>
<td>17.6%</td>
</tr>
<tr>
<td>Average sessions</td>
<td>1.9</td>
</tr>
<tr>
<td>Play the Chat! mobile game?</td>
<td>3.3%</td>
</tr>
<tr>
<td>Average hours</td>
<td>2.1</td>
</tr>
<tr>
<td>Average level</td>
<td>5.2</td>
</tr>
</tbody>
</table>

These findings were reflected during the FGDs, where all groups reported that they had seen communications about reproductive health. Additionally, most respondents felt that these communications were helpful to them. This sentiment was also shared by factory infirmary staff in the IDIs.

*I think it’s good and provides us with knowledge and understanding of reproductive health and contraception such as daily pill, implant in the arm, injection and condom. So they [GFWs] have options. I think it is useful because they don’t want a lot of children while they are working, their health will become weak so they want contraceptive method.* – IDI 7

**Health-seeking Behaviour**

This section examines female GFWs’ use of the factory infirmary for various services and referrals, as well as their use of external health facilities.

**Infirmary access and use**

Nearly all respondents (99.4%) knew that their factory had an infirmary for worker use. A large majority of female GFW (80.1%) had used their factory infirmary in the last 12 months. This rate varied by factory, from about three-quarters of WRA (72.2%) to nearly all (93.1%). The infirmary staff IDIs confirmed that many GFW found the infirmary a convenient source of medical support.

*Because it is near them, they don’t waste time and it is cheaper.* – IDI 3

Among workers that used the infirmary, the primary use was for minor health problems, such as symptomatic relief of headaches, colds, etc. (Figure 4). Around one in ten female GFW (8.9%) visited the infirmary for an injury or other first aid treatment. Use of the infirmary for family planning (FP) or other RMNH services had considerably lower prevalence; among users, around one in ten (10.6%) accessed any
RMNH services from the infirmaries (8.4% of all female GFW). The most common RMNH service received was short-term family planning (4%); the least common was abortion counselling and referrals (0.5%).

These rates for minor health problems are similar to the baseline value (95.6% of baseline users). However, the number of women accessing RMNH services at infirmaries has increased from 3.6% to 10.6% of all infirmary users. Usage of individual RMNH services is still too small to make accurate comparisons, but use of all RMNH services has increased since the baseline.

![Figure 4: Reasons for infirmary use, among workers that ever used the factory (multiple response).](image)

Among eligible workers (those that ever used and those that were not sure if they used the infirmary in the last 12 months), nearly all did not receive a referral for external health services (91.9%). Most of the workers with referrals received general first aid and emergency accident/injury treatment (4.3%). A further 3.8% received referrals for any RMNH services; primarily FP and sexually transmitted illness (STI) services. This is similar to the frequency of referrals in the baseline (9%), although referrals for RMNH services are more frequent at the baseline (8.1% of eligible workers, as opposed to 3.8% at the midline).

Overall, approximately one-tenth of female GFW (9.9%) received RMNH services or referrals from the factory infirmaries in the last 12 months (Indicator O2.2). Although this is only a slight increase from the baseline value (8.6%), it represents a positive trend of increased utilisation.

**Infirmary non-use**

Workers who never used the infirmary were asked the reasons for their non-use. Workers that did not use the factory infirmary primarily reported that they did not require services, or were not ill (87.2%). Other reasons for non-use were considerably less prevalent (mentioned by 5% of workers or less), but included negative perceptions about a lack of commodities (5.2%) and ineffective medicines (4.6%), as well as the need for a recommendation letter (5.0%), which some workers may find inhibitive.
This indicates that infirmaries generally have a positive reputation, but many workers are either not aware that these infirmaries offer FP services, or have no need for them. This finding was reinforced by the qualitative IDIs and FGDs. In one FGD, workers stated that their infirmary only had “simple medicines”, and did not offer FP or other services. Others said that there was only short-term contraception available at the infirmary and, although this was cheaper, they would like the infirmary to provide long-acting contraceptive methods (IUD, implant, etc.) as well.

*If there is someone wants to have IUD service, they go to RHAC because there is that service in there. And there is only daily pill, tablets and condom in factory infirmary.* – FGD 1

*Of course, people get service from outside the factory because they don’t know the factory has these services. But once they know they say they wouldn’t buy from outside because it is cheaper in factory.* – IDI 6

**Figure 5: Reasons for not using factory infirmary, among WRA that never used infirmary (multiple response).**

**Infirmary satisfaction**

Overall, respondents that used the infirmary were satisfied with the services they received, with over 95% of respondents either satisfied (73.4%) or very satisfied (22%; Figure 6). Less than 2% of users said they were somewhat or very dissatisfied. Average satisfaction scores across factories were fairly consistent, and ranged from 1.76 to 1.93 on a scale from 1-5, with 1 being very satisfied and 5 being very dissatisfied. In addition, four-fifths of female GFW (81.3%) said that they would recommend the infirmary to their friends.
High satisfaction with RMNH services received at the factory infirmaries was able to be calculated, and was found to be similar to the overall satisfaction rate; 28.1% of infirmary RMNH users were highly satisfied with the RMNH services received. This was slightly lower than the baseline level of high satisfaction (33.3%). However, the remainder of infirmary RMNH users (71.9%) were satisfied, with none dissatisfied, unlike at the baseline where 19% of users said services were only acceptable (the middle value in the 5-point satisfaction scale). The small sample size at the baseline (n=21) makes it difficult to compare these numbers, but overall satisfaction with RMNH services at infirmaries appears to have slightly improved.

**External health services**

Over three-quarters of respondents (76.4%) had used either a private or public health facility in the past twelve months. The most common was the private clinic or hospital, which accounted for over half of the most recent visits (55.8%; Figure 7). Public hospitals/health centres and NGO clinics were less popular, accounting for around one-third of most recent visits (23.2% and 6.8%, respectively). Around one in seven female GFW (14.2%) went to a pharmacy seeking care.

Overall respondents were satisfied with their experiences at these facilities; 92.7% of respondents said they were either very satisfied or satisfied with the facility (Figure 8). A further 3.1% said they were neither satisfied nor dissatisfied (an “acceptable” service), with only 4.2% reporting any dissatisfaction with facility
services. Satisfaction with external health services appears to have increased since the baseline. Much of the shift has been from the “neither satisfied nor dissatisfied” category (labelled as “acceptable” in the baseline) to the satisfied category. However, discrepancies in the baseline data indicate that these comparisons should be considered cautiously.

Figure 8: Satisfaction with last health facility visited, compared between midline and baseline.

**Overall satisfaction with health services**

Users of both the infirmary and external health services seem generally satisfied. The number of female GFW who report being highly satisfied with the infirmary and/or external health services increased by 5.1% to 28.6%, from the baseline value of 23.5% (Indicator O3.3). Due to the structure of this section of the questionnaire, it is not possible to calculate the satisfaction with only RMNH services in both the infirmary and external health facilities; the indicator was thus revised at the baseline to reflect high satisfaction with any service received at both of these locations.²

Thus, it appears that satisfaction with infirmary and external health facilities is high. Even among non-users, the reasons for non-use appear to be more closely related to a lack of need for services, rather than a dissatisfaction or aversion to the infirmary, or concerns about quality of care. However, qualitative responses seem to indicate that female GFW are unaware that infirmaries offer RMNH services. In this case, further awareness raising activities may be beneficial in increasing use of RMNH services and referrals at the factory level.

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²The baseline questionnaire did not ask whether a referral for RMNH services led to use of external health facilities, only whether respondents had received a referral for RMNH services, and then if they had ever used an external health facility in the last 12 months. The reasons for facility use are not then asked. This format was carried over to the midline (see annex for the questionnaire). It is thus not possible to link a referral for RMNH services with the use of an external facility, nor is it possible to link the follow-up indicator on facility satisfaction with receipt of RMNH services at that facility.
Contraceptive Knowledge and Use

Contraceptive knowledge

To begin this section, respondents were asked if they were aware of contraception ("things a man or woman can do to prevent pregnancy"). Nearly all respondents (98.8%) said that they were aware of contraception. Those who were aware of contraception were asked which methods they knew of, through both spontaneous and prompted recall. First, they were asked to name any contraceptive methods they knew. Next, they were asked if they had ever heard of the methods that they did not name. Both answers were recorded and calculated separately. The reasons for asking this module twice is because measurement of spontaneous knowledge can underestimate overall knowledge (respondents may be nervous, forgetful, etc.). Conversely, only asking for prompted knowledge can overestimate overall knowledge (due to acquiescence and other biases). Combining the two methods provides a more accurate understanding of respondents’ true knowledge on contraceptive methods (Figure 9).

The daily pill and contraceptive injection were the two most recognised methods; each identified by nearly all workers (98%). This was also reflected in the in-depth interviews (IDIs) when respondents were asked which methods were most popular for workers; the most common responses were the daily pill and the injection. Nearly as well known were the inter-uterine device (IUD) and implant (97% each). Male condoms and tubal ligation were each known by around 90% of respondents (94% and 89%, respectively). Other forms of modern contraception were known by over half of women, with the exception of the female condom which was only known by 34% of women. Emergency contraception is also somewhat unknown, and only recognized by around one-quarter of respondents (24%).

Withdrawal was the most common traditional method, known by about 80% of women. Over half of women knew about abstinence and the calendar/rhythm methods (62% and 59%, respectively). Lactic amenorrhoea was the least recognised traditional contraception; only 41% of respondents knew about this method.
Female GFW’s knowledge of all contraceptive methods had increased substantially since the baseline. The most commonly known methods at the baseline -- the daily pill, injection and IUD -- were known by just over half of respondents. By the midline these methods, as well as the implant, enjoyed nearly universal knowledge among the women surveyed. Female GFW now show similar contraceptive knowledge to WRA in the overall population (via CDHS 2014), and have higher knowledge of some lesser known contraceptives such as the monthly pill and female condom.
On average, female GFW knew 10 contraceptive methods (mean 10.1; median 10). Women were able to name four methods spontaneously, and recalled knowing another six methods via the prompted portion of the questionnaire. Knowledge of contraception appears to be influenced by a number of factors, including age, marital status, sexual activity in the last 12 months, and exposure/participation in the BCC and Chat! campaigns (Table 9). Knowledge of methods ranged from 8-9 for the youngest GFW, single women, those sexually inactive and without BCC exposure, and from 10-12 for women in their 40s, married/widowed/divorced women, sexually active, and those that participated in the BCC and/or Chat! campaign. Women that did not participate in BCC and/or Chat! knew an average of 8.8 methods; nearly the same as the average WRA in CDHS 2014 (8.7). However, BCC/Chat! participation is correlated with an increase in knowledge of 18%, up to an average of 10.4 methods.

Among the ten modern methods, female GFW knew an average of 8 methods (mean 7.7; median 8). Knowledge of modern methods followed the same patterns as overall contraceptive knowledge (Table 9). 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.

Table 9: Knowledge of contraceptive methods (average), disaggregated by respondent characteristics and type of method.

<table>
<thead>
<tr>
<th></th>
<th>All methods</th>
<th>Modern methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teens</td>
<td>8.56</td>
<td>6.94</td>
</tr>
<tr>
<td>20s</td>
<td>9.84</td>
<td>7.59</td>
</tr>
<tr>
<td>30s</td>
<td>10.79</td>
<td>8.01</td>
</tr>
<tr>
<td>40s</td>
<td>11.95</td>
<td>8.83</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single and NOT in a regular relationship</td>
<td>9.07</td>
<td>7.24</td>
</tr>
</tbody>
</table>

Figure 10: Midline knowledge of contraceptive methods among all female GFW, compared with the CDHS 2014 and PSL baseline values.
Contraceptive use

Next, respondents were asked if they had been sexually active in the last 12 months, and if they had used contraception during that time. Not surprisingly, sexual activity in the past 12 months varied greatly depending on relationship status, from high rates for married women and those in a committed relationship (98.8% and 90.8%, respectively), to 0% of single respondents. Overall, half of the respondents had been sexually active in the last year (Figure 11).

![Figure 11: Any sexual activity in the last 12 months, disaggregated by relationship status.](image)

Among female GFW that were sexually active in the last year, around three-quarters (77.3%) used contraception during that time. This is a significant increase from the baseline, when 40.9% of ever sexually active women were using contraception in the last 12 months. Part of this increase can be due to changes in the methodology; the baseline asked about contraceptive use in the last 12 months among all WRA that were ever sexually active, which could have included women that were not sexually active in the last year. The midline considers contraceptive use only among women that have been sexually active in the same time period (12 months), to provide an accurate estimation of current contraceptive use among relevant respondents.
At the time of the midline, married women were somewhat more likely to use contraception than widowed/divorced and single women in a committed relationship (78%, 70% and 60%, respectively). However, the small number of sexually active widowed/divorced and single women in a committed relationship (around 10 eligible respondents each) means that these disaggregations should be considered cautiously.

Among female GFW that used contraception in the last year, the most popular methods were the daily pill and withdrawal, each used by around half of women (53% and 50%, respectively). One in seven women received the contraceptive injection (14.4%); the next most popular option. All other forms of modern and traditional FP were each used by less than 10% of female GFW in the last year. On average, female GFW used 1.4 methods of modern contraception in the last year.

Four in five contraceptive users in the last year (83.7%) were also currently using contraception at the time of the interview. Current contraceptive popularity is similar to the last 12 months, with daily pills and withdrawal still dominating the contraceptive mix among female workers (44% and 38%, respectively; Figure 12). Injections were still being received by 8.4% of respondents. In total, more than half (59.6%) of sexually active respondents were currently using a modern contraceptive method.

In terms of all women in the study, one-fifth (20.3%) were currently using a modern contraceptive method. Among the half of women that were sexually active in the last 12 months, this number doubles to 40.4% (Indicator O2.1). Both of these numbers are considerable increases from the baseline values of 10.6% and 24.2%, respectively. Although, part of the increase in contraceptive use can be due to a change in the analysis method, some of this improvement can be attributed to changes in women’s contraceptive practices. The midline contraceptive use for sexually active WRA is similar to the 2014 CDHS indicator for current contraceptive use among married women (38.8%).

The number of contraceptive users currently using long-acting and permanent methods of contraception (LAPM) also increased, from the baseline value of 11.5% to 15.0% at the midline (Indicator O4.4). However,
the daily pill (a short-term method) remains the most popular contraceptive method (both modern and traditional) among female GFW.

Interestingly, although BCC and/or Chat! campaign participation was correlated with higher knowledge of contraceptive methods, there is no relationship between participation and higher use of modern contraception or LAPMs.

**Last contraceptive use**

Figure 13, below, focuses on modern contraceptive methods, which were used by around three-fifths (59.6%) of respondents who used contraception in the last year. For nearly half of users (41%), the last modern method used was again the daily pill. This was followed by the injection, IUD and implant, each with less than 10% of users. One female GFW in the survey had a tubal ligation in the last year, accounting for the inclusion of this method.

![Figure 13: Last modern contraceptive used in the last year, among all contraceptive users.](image)

The breakdown of contraceptive providers is similar to the baseline, with pharmacies and health centres the most common location for receiving modern contraception. Private pharmacies and drug stores were visited by around two in five (39%) modern contraceptive users the last time they procured contraception (Figure 14). This is in line with the popularity of the daily pill, many brands of which are sold over the counter at local pharmacies. Around one-quarter of users (24%) went to either a public hospital or health centre, with one-fifth (20%) going to private hospitals/clinics. Health centres were the most popular choice of public health facility (22% overall, or 92% of public facility users). NGO clinics and garment factory infirmaries captured a similar share of users, with 7% each. Other facilities and locations were each accessed by less than 1% of users.
Among modern contraceptive users in the last 12 months, nearly all (93.1%) paid money for them. The average amount spent on family planning services was $10.18 (Table 10). This includes both the costs of services and related fees ($9.77), and costs of transportation ($0.41). However, the average value here is highly influenced by the one respondent who had a tubal ligation in the last year, and paid $1,000 for services and $25 for transportation. In this case, the median values of $0.50 and $0.00 for the costs of services and transportation, respectively, are preferred.

**Table 10: Service fees and transport costs for last contraceptive purchase (US$).**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Valid N</th>
<th>Mean</th>
<th>Median</th>
<th>Std. Deviation</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning fees</td>
<td>195</td>
<td>9.77</td>
<td>0.50</td>
<td>79.29</td>
<td>1,000.00</td>
<td>0.00</td>
<td>1,000.00</td>
</tr>
<tr>
<td>Transport costs</td>
<td>195</td>
<td>0.41</td>
<td>0.00</td>
<td>1.89</td>
<td>25.00</td>
<td>0.00</td>
<td>25.00</td>
</tr>
</tbody>
</table>

**Abortion and Post-abortion Care**

Although abortion is legal in Cambodia up to 12 weeks (and after in certain situations), three-quarters of female GFW (75.6%) thought that it was illegal. Only one in six female GFW (16.5%) correctly said that abortion is legal (Indicator I6.4), although this has doubled since the baseline (8%). Similarly, over half of female GFW (55.9%) do not know where to access safe abortion services; defined as abortion provided at a medical facility (public, private or NGO clinic; Figure 15). However, over half (54.3%) of women at the midline reportedly don’t know any abortion providers, and a few women named only potentially unsafe abortion providers (pharmacies and traditional birth attendants). Overall, 44.1% of female GFW correctly identified at least one safe abortion provider; a considerable increase from the baseline (27%). Around one-third of female GFW (31.2%) identified public health facilities as places that provide safe abortion services; the most common response in the midline. One-quarter of respondents (23.2%) named private health...
providers, and 8.7% identified NGO clinics as safe abortion providers. Knowledge of all safe abortion providers has increased since the baseline.

![Figure 15: Knowledge of abortion providers, among all female GFW (multiple response among GFW that know any providers).](image)

BCC/Chat! participation was associated with both increased knowledge of legality and safe abortion providers. BCC/Chat! participants had a small increase in knowledge of legality, from 11.2% for non-participants to 17.6% for participants in any BCC or Chat! activity. However, program participation was also correlated with considerable increases in knowledge of safe abortion providers; one-quarter (24.6%) of non-participants knew at least one safe abortion provider, compared to around half (48.3%) of BCC/Chat! participants.

Thus, it appears that the BCC and Chat! campaigns are having an effect on increasing knowledge of safe abortion providers, as respondents without BCC or Chat! participation have knowledge levels similar to the baseline. However, the MERI indicator for abortion knowledge (knowledge of legality) has considerable room for improvement during the next project phase.

Slightly more than one in ten female GFW (11%) has ever had an abortion. The likelihood of female GFW having an abortion increased with age, lower educational attainment (no schooling or only primary-level), and disability. Among women in committed relationships, married, widowed or divorced, abortion rates were similar (18%-19%). No single women who were not currently in a committed relationship reported having an abortion. Women in their 40s and those with a considerable disability (exclusive disability) were most likely to have had an abortion (39% and 25%, respectively), although the number of respondents in each of these groups is limited (around 24 and 32, respectively).
Among women that ever had an abortion, most had one abortion (median 1). About one-quarter of women (28.9%) had more than one abortion, ranging from two to 11 for one respondent. Half of these women had their last abortions before 2013.

The methods used by respondents for their last induced abortion was nearly evenly split between medical abortion pills (50.9%) and vacuum aspiration (48.1%). There were only nominal mentions for other methods (injections and self-abortion). This was similar to the baseline, where medical pills and vacuum aspiration made up 97% of induced abortions, as well as CDHS 2014.
Medical facilities were used by two-thirds (66.7%) of female GFW for their most recent induced abortion (Figure 18). The most common place of induced abortion was private hospitals/clinics, accounting for over one-third (38%) of most recent abortions. This was followed by pharmacies/drug stores (21.3%). One-fifth of respondents went to any kind of public facility (19.5% combined); most commonly a health centre (11%). Around one in eight respondents (12%) induced abortion at home. The types of response are similar to the baseline, although respondents at the midline showed increased use of pharmacies, public facilities and NGO clinics, and decreased use of private providers and at-home abortion.

![Figure 18: Place of most recent induced abortion, compared between baseline and midline.](image)

Based on MERI and MOH guidelines, comprehensive abortion care (CAC) is defined as medically induced abortion (medical pills or vacuum aspiration) occurring in a health facility. For female GFW, two-thirds of them (63.6%) received medically induced abortions at a health facility, qualifying as CAC services. The other one-third (36.4%) did not receive CAC, mostly due to the prevalence of pharmacies and at-home abortions.

All except for one respondent paid something for their last abortion. The average total costs for abortion were $35.09, although costs ranged from $1.50 to $210 (Table 11). Half of these women paid $24 or less for abortion costs (median 23.92).

**Table 11: Abortion costs (services and transport), among all women that paid for abortions the last time, in US$**.

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Median</th>
<th>Standard deviation</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service fees</td>
<td>32.57</td>
<td>20.00</td>
<td>36.31</td>
<td>200.00</td>
<td>-</td>
<td>200.00</td>
</tr>
<tr>
<td>Transport fees</td>
<td>2.52</td>
<td>1.00</td>
<td>6.76</td>
<td>62.50</td>
<td>-</td>
<td>62.50</td>
</tr>
<tr>
<td>Total costs</td>
<td>35.09</td>
<td>23.92</td>
<td>37.45</td>
<td>208.50</td>
<td>1.50</td>
<td>210.00</td>
</tr>
</tbody>
</table>
Post-abortion contraceptive counselling

Approximately half of female GFW (51.4%) that had abortions had contraceptive counselling within two weeks (14 days) of their most recent abortion. All of these women discussed modern contraceptive methods during this counselling. The most common method discussed was the daily pill; discussed by nearly three-quarters of these women (70.4%). Other commonly referenced methods were the IUD, implant and injection; discussed by around 40% of women each. All other modern methods were less frequently mentioned. The traditional methods of withdrawal and the rhythm method were also discussed at this time, but they were not exclusively mentioned by any women.

Table 12: Contraceptive methods discussed post-abortion, among all women that received post-abortion contraceptive counselling (multiple response).

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily pills</td>
<td>70.4%</td>
</tr>
<tr>
<td>IUD</td>
<td>43.7%</td>
</tr>
<tr>
<td>Implant</td>
<td>38.3%</td>
</tr>
<tr>
<td>Injection</td>
<td>37.6%</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>15.1%</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>10.1%</td>
</tr>
<tr>
<td>Condom (male)</td>
<td>10.1%</td>
</tr>
<tr>
<td>Monthly pills</td>
<td>6.0%</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Although only half of women that had an abortion received contraceptive counselling, nearly two-thirds (61.6%) started using a contraceptive method within 14 days after their last abortion. Half of women (46.6%) began using a modern contraceptive, with 14% using a traditional method (withdrawal). Over half of women that received CAC services (56.0%) began using a modern contraceptive method within 14 days of their last abortion (Indicator O3.1). This number is more than double the baseline value (22.5%), and represents a strong, positive improvement in modern contraceptive uptake after abortion.

Among contraceptive adopters, the most popular method was the daily pill (44.9% of FP users post-abortion; Table 13). One-quarter (28.3%) began using withdrawal, although many of these women used withdrawal in combination with a modern method. The popularity of daily pills and withdrawal is similar to the overall popularity of these methods among all female GFW. Smaller percentages of women began using injections (16%), IUDs (8.5%), condoms and implants (3.5% and 3.4%, respectively). Two women also had a tubal ligation after their last abortion. These are similar proportions to the baseline, although the small number of respondents in each group (approximately 60 at midline, and 20 at baseline) makes accurate comparison difficult.
Table 13: Contraceptive methods adopted within 14 days of most recent abortion, among all women that began using methods in that time (multiple response), and compared with baseline.

<table>
<thead>
<tr>
<th>Method</th>
<th>Midline</th>
<th>Baseline*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily pills</td>
<td>44.9%</td>
<td>40%</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>28.3%</td>
<td>5%</td>
</tr>
<tr>
<td>Injection</td>
<td>16.0%</td>
<td>15%</td>
</tr>
<tr>
<td>IUD</td>
<td>8.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Male condom</td>
<td>3.5%</td>
<td>10%</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>3.4%</td>
<td>5%</td>
</tr>
<tr>
<td>Implant</td>
<td>3.4%</td>
<td>5%</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Monthly pills</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>0%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Note: Baseline period for uptake was within 28 days post-abortion; at midline PSL revised this to 14 days in line with MOH guidelines. The midline was multiple response, while the baseline was a single response question.

Looking at women that received CAC services compared to those that did not, women that received CAC were more likely to receive contraceptive counselling than non-CAC respondents (Figure 19). Women that received CAC services were also more likely to adopt any contraceptive method after the last abortion, and were nearly twice as likely to adopt a modern contraceptive method as those that did not receive CAC services.

Figure 19: Comparison of CAC and non-CAC female GFW for post-abortion FP counselling and uptake.
SRHR Confidence

This section of the study examined the attitudes and confidence levels of women around various issues related to sexual and reproductive health. For the reproductive health section, female GFW were asked to imagine four scenarios where they would discuss or use contraception with their partner, and gauge how likely they were to respond to the situation. Next, the women were asked how confident they were that they could refuse sex with their partner in five different scenarios. The confidence of women in these scenarios provides insight into how well they have understood the BCC/Chat! campaign messages, and their own sexual and reproductive health rights.

Reproductive health rights

Examining the results of the section on confidence in reproductive health (Table 14), female GFW show very high confidence in discussing and using family planning with their partners in most scenarios. Over half of female GFW said that they were “completely sure” they could discuss, tell their partner they wanted to use contraception, and use contraception. These are considerable increases from the baseline values of 20% - 25%.

However, only one-third of women (33.5%) were completely sure they could use contraception if their partner did not want to. One-fifth of women (21.2%) were not at all sure they could use contraception if their partner objected; the highest rate of insecurity in this section. However, this is also a considerable increase from the baseline confidence in this scenario of only 7.3%.

Averaging the scores for all of the reproductive health indicators, female GFW were “somewhat sure” for all of the scenarios. The average woman had a score for the four scenarios of 4.13 (median 4), where 5 is completely sure, 1 is not at all sure, and 0 is no answer. One-quarter of women (24.8%) feel empowered to discuss and use modern family planning methods in all scenarios, even when their partner doesn’t want to (Indicator I6.3). This is a significant increase from the baseline value of only 5%, and represents that female GFW have improved confidence and awareness of their reproductive health rights. Improvements in women’s knowledge and usage of contraception since the baseline may have also increased their confidence in these scenarios, giving them real-world experience with these issues. This may be demonstrated by the fact that sexually active women have higher confidence in these scenarios than sexually inactive women.

BCC and Chat! participation also makes respondents more confident in their reproductive health rights, although the difference is slight; from an average confidence level of 4.0 to 4.2.

Table 14: Confidence in family planning scenarios, disaggregated by sexually active and inactive GFW.

<table>
<thead>
<tr>
<th>How sure are you that you could...</th>
<th>Sexually inactive</th>
<th>Sexually active</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bring up the topic of family planning with your husband or partner?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>3.0%</td>
<td>0.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>3.0%</td>
<td>2.5%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Somewhat unsure/Unsure</td>
<td>1.8%</td>
<td>1.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>2.7%</td>
<td>1.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>39.7%</td>
<td>32.1%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>49.8%</td>
<td>62.3%</td>
<td>56.1%</td>
</tr>
</tbody>
</table>
How sure are you that you could...

<table>
<thead>
<tr>
<th></th>
<th>Sexually inactive</th>
<th>Sexually active</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tell your husband or partner that you wanted to use family planning?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>2.5%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>2.5%</td>
<td>1.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>1.6%</td>
<td>1.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>3.0%</td>
<td>1.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>40.6%</td>
<td>32.3%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>49.8%</td>
<td>62.7%</td>
<td>56.3%</td>
</tr>
<tr>
<td><strong>Use family planning?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>2.3%</td>
<td>0.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>5.3%</td>
<td>6.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>4.4%</td>
<td>4.1%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>3.7%</td>
<td>1.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>36.3%</td>
<td>29.4%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>48.1%</td>
<td>58.8%</td>
<td>53.5%</td>
</tr>
<tr>
<td><strong>Use family planning, even if your husband or partner did not want to?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>3.7%</td>
<td>0.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>17.9%</td>
<td>24.5%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>13.7%</td>
<td>10.2%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>6.6%</td>
<td>2.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>30.1%</td>
<td>24.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>28.0%</td>
<td>38.8%</td>
<td>33.5%</td>
</tr>
</tbody>
</table>

**Sexual health rights**

In regards to the scenarios on sexual rights (the right of a woman to refuse sex with their partner), three-fifths of women (60.6%) were completely confident that they could refuse sex if they were tired (Table 15). This is the highest confidence rate in this section, and a considerable increase from the same scenario in the baseline, when only 22.6% of women were completely confident in this scenario. In each of the other four scenarios, nearly half of women were completely confident they could refuse sex with their partner, ranging from 45% to 47.4%. In each of these scenarios, the number of completely confident women has more than doubled from the baseline values of between 10% and 16.8%.

The scenarios with the highest insecurity rates were when a woman’s partner threatens them with violence or having sex with another woman (11.6% and 10.9%, respectively). Although sexually active women were more confident in other aspects of SRHR, in these scenarios there was little difference in the number of “not at all sure” women between the active and inactive groups.

Looking at average response scores for women across all five sexual health scenarios, the average woman was “somewhat sure” they could refuse sex across all five scenarios (average 4.1; median 4.2). Sexually active women were slightly more confident than inactive women (average 4.2 and 4.0, respectively). One-quarter of female GFW (26.4%) were completely confident that they could refuse sex with their partner in all five scenarios.
BCC and Chat! participation also increased confidence slightly, from an average confidence of 4.0 among non-participants to 4.1 among women that participated in any BCC/Chat! activities.

Table 15: Confidence in sexual scenarios, disaggregated by sexually active and inactive female GFW.

<table>
<thead>
<tr>
<th>How sure are you that you could refuse sex with your partner...</th>
<th>Sexually inactive</th>
<th>Sexually active</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When you don’t want to, but he does?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>3.0%</td>
<td>0.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>6.4%</td>
<td>8.1%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>9.4%</td>
<td>5.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>4.1%</td>
<td>1.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>37.2%</td>
<td>31.2%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>39.9%</td>
<td>53.9%</td>
<td>47.0%</td>
</tr>
<tr>
<td><strong>When you are tired?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>2.5%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>2.8%</td>
<td>2.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>1.8%</td>
<td>1.1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>1.6%</td>
<td>.7%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>34.7%</td>
<td>30.9%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>56.6%</td>
<td>64.5%</td>
<td>60.6%</td>
</tr>
<tr>
<td><strong>When he gets angry with you if you don’t want to?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>3.7%</td>
<td>.8%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>7.8%</td>
<td>5.8%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>7.3%</td>
<td>7.1%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>6.4%</td>
<td>2.1%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>35.1%</td>
<td>31.8%</td>
<td>33.5%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>39.7%</td>
<td>52.4%</td>
<td>46.1%</td>
</tr>
<tr>
<td><strong>When he threatens to hurt you if you don’t want to?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>3.0%</td>
<td>.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>11.5%</td>
<td>11.7%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>9.2%</td>
<td>9.8%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>4.8%</td>
<td>2.3%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>29.8%</td>
<td>27.6%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>41.7%</td>
<td>48.2%</td>
<td>45.0%</td>
</tr>
<tr>
<td><strong>When he threatens to have sex with other women if you don’t want to?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>2.8%</td>
<td>1.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Not at all sure</td>
<td>9.9%</td>
<td>11.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Somewhat unsure</td>
<td>7.8%</td>
<td>6.7%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Neither sure/Unsure</td>
<td>4.6%</td>
<td>1.3%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Somewhat sure</td>
<td>29.2%</td>
<td>30.2%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Completely sure</td>
<td>45.8%</td>
<td>48.9%</td>
<td>47.4%</td>
</tr>
</tbody>
</table>
Pregnancy and Maternal Health

Pregnancy

Overall, around half of respondents (49.5%) had ever been pregnant. This was reasonably steady across the four factories surveyed. Those who had been pregnant before had been pregnant an average of 2.23 times each (median 2). Among ever-pregnant women, nearly half (41.4%) were using contraception the last time they became pregnant. The most common contraceptive methods being used at the time of last pregnancy were the daily pill and withdrawal, used by nearly half (44.8%) and one-third (35.9%) of women that were using contraception the last time they were pregnant (Figure 20). This is in line with the popularity of these methods among all female GFW. Among respondents that were ever pregnant, 88.7% had ever given birth. On average, these women gave birth to 1.6 children each (median 1).

![Figure 20: Contraception used at last pregnancy, among women using contraception at time of last pregnancy.](image)

Of the women that had ever given birth, only the women that gave birth in the last 24 months were selected for the maternal and neonatal health sections. All of these women only had one childbirth in the last 24 months. These women were oversampled during the fieldwork; in total, 103 women were asked about their experiences with maternal and neonatal health in the last 24 months. Note that the answers in this section are unweighted.

Antenatal care and awareness

All 103 women who gave birth in the last 24 months went for antenatal care (ANC). The number of ANC visits ranged from 1 to 12, with an average of 8 ANC visits each (median 9). Nearly all (96.1%) WRA that gave birth in the last 24 months had four or more ANC consultations in a health facility with a skilled provider (Indicator O4.2). This number increases to 98.3% for WRA that gave birth in the last 12 months, with only 1 WRA in this group not receiving four ANC visits. These are both considerable increases from the baseline values of 70.6% and 82.1%, respectively. The midline rates are also improvements on the prevalence of skilled ANC consultations in CDHS 2014. Nationally, nearly all women in Cambodia (95.3%) that gave birth in the last five years received at least one ANC consultation with SBA, but only three-quarters (75.6%) had four or more ANC visits. As well, participation in BCC and/or Chat! campaign was
correlated with an increase in the number of ANC visits that women received, from an average of 7.1 to 8.2.

All ANC were in a health facility (public, private, or NGO clinic), and nearly all were with a skilled provider. Most of these women (83.5%) had ANC visits at public health facilities (Figure 15). The most popular public facilities for ANC were health centres, used by three-quarters (75.3%) of respondents, which were also the most popular facilities overall. Around one-third of respondents (38.8%) went to private hospitals or clinics, and a further 7.8% went to NGO clinics; most commonly RHAC.

![Figure 21: Location of ANC visits, among women who gave birth in last 24 months (multiple response).](image)

Among eligible WRA, two-thirds (67%) were seen by a midwife for ANC, with two-fifths (41.7%) receiving at least one ANC consultation with a doctor (Figure 22). Other ANC attendants include nurses and other trained health personnel (5.8% each). One respondent didn’t know who performed her ANC examination, but received this ANC consultation at a private hospital, making it highly likely that there was a trained attendant.

![Figure 22: Health personnel seen by women at ANC visits, among all women that gave birth in last 24 months (multiple response).](image)

On average, the total costs for antenatal care (all visits) were $3.13, with transport costs of $1.11. The combined total costs are $4.25, with a median value of $2.50. The overall range is considerable, with some women spending $30.50 for ANC visits, and others spending as little as $0.38.
Women who gave birth in the last 24 months were asked – unprompted – to identify any danger signs indicating a problem during pregnancy (Table 16). The most widely known pregnancy danger signs were vaginal bleeding, identified by nearly half (43.7%) of respondents, and anaemia (23%). These were the most commonly known danger signs during the baseline as well (26.9% and 16.7%, respectively). The subsequent danger signs were abdominal pains in early/late pregnancy (17.5% and 19.4%, respectively), and difficulty breathing. On average, respondents knew 2 danger signs each (mean 1.5; median 2). One-quarter of respondents (26.2%) knew none of the danger signs. There were no real difference between the women that gave birth in the last 12 months, and those that gave birth in the last 2 years.

Only 1.0% of eligible WRA knew five or more danger signs, using unprompted recall (Indicator O4.1). This is very low, but similar to the baseline value (1.2%). Part of the reason for this may be the nature of the question. With unprompted recall, respondents sometimes do not remember all of the items they are aware of, or may become tired with the question after identifying only one or two points. Using some form of prompted recall (e.g., “Would you consider — as a reason to seek health care during pregnancy?”) may improve the number of danger signs that respondents identify.

Table 16: Danger signs during pregnancy, as identified by WRA that gave birth in last 24 months (multiple response).

<table>
<thead>
<tr>
<th>Danger Sign</th>
<th>Birth more than 12 months ago</th>
<th>Birth within last 12 months</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>Vaginal bleeding in early and late pregnancy</td>
<td>18</td>
<td>40.0%</td>
<td>27</td>
</tr>
<tr>
<td>Anaemia</td>
<td>13</td>
<td>28.9%</td>
<td>11</td>
</tr>
<tr>
<td>Abdominal pain in later pregnancy</td>
<td>12</td>
<td>26.7%</td>
<td>8</td>
</tr>
<tr>
<td>Abdominal pain in early pregnancy</td>
<td>5</td>
<td>11.1%</td>
<td>13</td>
</tr>
<tr>
<td>Difficulty breathing</td>
<td>8</td>
<td>17.8%</td>
<td>8</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>5</td>
<td>11.1%</td>
<td>6</td>
</tr>
<tr>
<td>Fever during pregnancy and labour</td>
<td>4</td>
<td>8.9%</td>
<td>7</td>
</tr>
<tr>
<td>Pre-labour rupture of membranes</td>
<td>1</td>
<td>2.2%</td>
<td>4</td>
</tr>
<tr>
<td>Loss of fetal movements</td>
<td>1</td>
<td>2.2%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>33.3%</td>
<td>15</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
<td>15.6%</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0%</td>
<td>58</td>
</tr>
</tbody>
</table>

**Childbirth**

The childbirth indicators both also showed extremely positive progress since the baseline, with nearly all (99%) women giving birth in a health facility and with a skilled birth attendant (SBA; Indicator O1.2 and Indicator I6.5, respectively). Only one woman gave birth outside a health facility (at their home; Figure 23). Four in five women (81.6%) went to some form of public health facility to give birth. This was most commonly a health centre; used by over half of women (53.4%). National and provincial hospitals were the next most popular public facilities. Private hospitals and clinics were preferred by around one in six women (17.5% combined).
Likewise, 99% of women were assisted by a skilled birth attendant (Figure 24). The most common SBA were midwives, used by just over two-thirds of women (68.9%). Doctors assisted with another third (30.1%) of births. Only one respondent used a traditional birth attendant; the same respondent that gave birth at home.

The attendance of SBA has increased from the baseline vale of 80%, and delivery in a health facility with SBA has increased from 90.6%at the baseline. These indicators are both higher than national averages in CDHS 2014, where 83% delivered in a health facility and 89% used SBA, and are similar to the higher rates of these indicators among urban women (96% and 98%, respectively).

On average, childbirth cost respondents $160, including fees and transport. This ranged from $4.75 up to $2,000. Because a few respondents had very high costs for pregnancy, the median is preferred here. Half of female GFW spent $47.50 or less for their delivery in the last 24 months (median value).
Post-natal care

Post-natal care (PNC) is defined as any check-ups (medical visits) for the mother and/or child held in a health facility and attended by a SBA or other trained health professional within six weeks of childbirth. According to recent MOH guidelines, the first check-up should be within 48 hours of giving birth; defined as PNC1. This is a change from the guidelines at baseline, which stressed the first PNC visit should occur within 24 hours of birth. A second PNC visit under the same conditions should occur after 48 hours, but within the first week of delivery (PNC2). However, women had a number of PNC experiences which differed from these definitions and guidelines, as explained below.

Overall, 90.3% of female GFW that gave birth in the last 24 months had some form of PNC in the first week after childbirth; and a large majority (88.3%) had a PNC visit within the first 48 hours (Figure 25). Three-quarters of these women (78.6%) had check-ups for both the mother and child at this time. Nearly all (96.7%) of these initial PNC check-ups were at a health facility (Figure 26). A similar number (95.6%) were with a trained health professional; most commonly a nurse or doctor (50.5% and 40.7%, respectively). Public health providers were preferred by over three-quarters (79.1%) of women that received an initial PNC, with nearly half (47.3%) going to a health centre. Private providers were used by 17.6% of women that had PNC within the first 48 hours. These numbers are similar to the percentages of women that delivered in these facilities, most likely because the first PNC visit occurred before the mother and child were discharged from the facility post-delivery.

The number of female GFW that received PNC within the first 48 hours after delivery is similar to the overall average in CDHS 2014 (90.3%, among all Cambodian women that gave birth in the last 2 years). However, female GFW were more likely to receive this first PNC check-up from a trained health provider (95.6%, compared to 87% for the overall population). In this instance, as in ANC and childbirth, female GFW more closely resemble urban women; 98% of urban women received their first PNC with a trained provider.

![Figure 25: Type of post-natal care received within the first 48 hours of childbirth, among WRA that received PNC at this time.](image)
Based on the definition under MOH guidelines, around four-fifths of women that gave birth in the last 24 months (81.6%) had a “full” PNC1 check-up. Slightly more women (88.3%) received some kind of PNC in the first 48 hours, but because of the location (3 respondents had PNC in their homes) and status of health provider (some respondents didn’t know if the health personnel were trained), not all PNC visits in the first 48 hours qualified as PNC1.

A similarly large majority of women (87.4%) received any kind of PNC check-up within the first six weeks (after the initial 48 hours). Of these women, three-quarters (77.8%) had a PNC visit within the first week after delivery. Women that received further PNC had an average of 12.1 PNC visits during the first six weeks after childbirth (median 10 visits). The maximum number of PNC visits received by a respondent was 42; approximately one per day for the first six weeks.

Among all PNC visits received after the first 48 hours, three-quarters (75.7%) were for the mother only (Figure 27). A further 16.8% were for both the mother and child, with only around 7.5% of PNC after the first 48 hours only for the baby. Nearly all (98%) of these PNC visits were attended by a trained health professional, but more than half (58.8%) occurred in the respondent’s home. Only 41.2% of PNC visits after 48 hours occurred at a health facility; the majority (58.8%) occurred at the respondent’s home.
Although a large percentage of women who gave birth in the last 24 months received a follow-up PNC visit, according to the MOH guidelines for PNC2 only around one-quarter of women that gave birth in the last 24 months (27.2%) had a “full” PNC2 check-up. This is due to the high prevalence of home-based PNC visits after 48 hours, and the fact that only around half (52.7%) of follow-up visits occurred during the first week after childbirth.

Although the number of women that received sufficient ANC care and delivered in a health facility with SBA were both very high, the post-delivery care that meets MOH and MERI standards is considerably lower. Only one-quarter of women that gave birth in the last 24 months (25.2%) received two or more PNC visits with a trained provider, in a health facility, within the time periods specified by MOH (one in the first 48 hours and the second within the first week). Women that gave birth more recently were slightly more likely to receive appropriate PNC care (27.6% of women that gave birth in the last 12 months).

Although PSL was not directly targeting maternal health issues, both of these numbers have increased from the baseline values of 22.1% and 12.5%, respectively. PNC care for women that gave birth in the last 12 months especially shows a considerable improvement in this area (a 121% increase). BCC/Chat! participation was directly correlated with increased frequency of PNC visits after 48 hours, from averages of 7.2 for non-participants to 12.8 for participants.

Three-quarters of women that gave birth in the last 24 months (76.7%) paid for PNC care. On average these women paid $67.24 for all PNC care, including the costs of fees and transportation. The range of PNC costs was considerable – from $0 to $300. Half of women paid around $50 or less for PNC (median $52.25).

**PNC contraceptive counselling**

In terms of PNC contraceptive counselling, one-third of women (33.3%) that received any PNC in the first week after delivery also received counselling in modern contraceptive methods. This is a decrease from the baseline value (56%), although this indicator was not a primary consideration of the GFW component of PSL. Differences in contraceptive counselling may also be due to differences in indicator calculation; the baseline included all women that had ever given birth for the PNC care and contraceptive counselling sections, while the midline considered only women that gave birth in the last 24 months. Increasing uptake of PNC at public and/or private health facilities may increase this indicator, as less than half (41.2%) of respondents with PNC in the first week went to a health facility.
On average, each respondent who received PNC counselling discussed three contraceptive methods (average 2.9; median 3). Three-quarters (75.8%) discussed the daily pill. This was followed by the implant, injection and IUD, each discussed by around half of these women (57.6%, 51.5% and 45.5%, respectively). Other contraceptive methods, including traditional methods, were less commonly discussed. Out of the 33 respondents that discussed contraception, only one reported not talking about some form of modern contraceptive method, discussing only abstinence. Women that gave birth in the last 12 months were more likely to discuss contraceptive methods in the first week following delivery than women that gave birth in the last 24 months (37.5% and 27%, respectively).

![Figure 28: Contraceptive methods discussed during PNC contraceptive counselling within one week of delivery (n=33).](image)

**Childrearing**

After childbirth, nearly all women (96.1%) attempted to breastfeed, waiting on average 1 - 5 hours after delivery to start breastfeeding (mean 4.8 hours; median 1 hour). However, 8.1% of respondents waited 24 hours or more to attempt breastfeeding (up to 72 hours). Among the small sample of mothers with children less than six months old (17 women), slightly less than one-third (29.4%) were currently exclusively breastfeeding.

Maternal leave among female GFW ranged from one to 20 months, with most taking between three and six months before returning to work (average 5.9; median 3). Around half of women (48.5%) that gave birth in the last 24 months are currently living with their children. This number is higher among those that gave birth in the last 12 months; 55.2%, compared to 40% of women that gave birth more than 12 months ago.

Lastly in the maternal health section, mothers were asked if they knew of any signs of neonatal distress (Figure 29). One-fifth of these women (21%) said they did not know any indicators of neonatal distress. Among those that identified any danger signs, the most common was abnormal body temperature, named by nearly two-thirds (64%) of respondents. One-quarter (24%) identified vomiting/abdominal distension as a danger sign. Although not a danger sign in the MERI indicators, fast or difficult breathing is considered a neonatal distress sign in other MOH guidelines (such as the Safe Motherhood Protocol Clinical Management for Health Center, issued by MOH in July 2010). Fast/difficult breathing was the third most commonly identified danger sign, given by 18% of respondents. Bleeding, lethargy and feeding difficulties...
were all identified by around one in ten respondents. Convulsions, an MOH indicator not included in MERI, were identified by similar numbers of respondents (9%).

In terms of the number of MERI indicators of neonatal distress, most respondents know 1.2 danger signs (median 1; Figure 30). Over one-quarter (27.2%) do not know any of the MERI indicators, although a further quarter (25.2%) know two. Around one in seven women knew three or more MERI indicators of neonatal distress, including one respondent that knew four indicators (14.6%; Indicator I6.2). This is a 10-point increase from the baseline value of 4%. The number of women that do not know any indicators also declined by half from the baseline (59.8%) to 27.2% at midline.
Financial Assistance for RMNH Services

Among female GFW that used any of the above mentioned health and RMNH services (including for healthcare, contraception, ANC, delivery, PNC, and/or abortion), 3.8% received some kind of financial assistance. Women that accessed RMNH services were somewhat more likely to receive financial assistance than women that accessed other services (6.8% and 2.4%, respectively). Note that the small sample size (around 35 women in total) means the results in this section should be considered carefully.

Among all women that received financial assistance, the most common type of assistance was private contributions, received by 29% of women (Figure 31). This was followed by referrals (23.1%) and support from the National Social Security Fund (NSSF; 20.7%). Other types of assistance were less commonly used.

Considering only public forms of assistance (FP vouchers, referral slips, health equity funds/special operating agencies (HEF/SOA), community health insurance and NSSF), the number of utilisers drops to only 2.2% of all female GFW, and 3.2% of RMNH users(Indicator I5.1). Even among RMNH users, these financial support services were rarely utilised. The number of women utilising public or institutional financial support services to access RMNH services appears to have declined from the baseline value of 11%. Part of this may be due to changes in the methodology; the baseline asked about all service fees at the same time, at the start of the survey, while the midline asks about service fees in each RMNH section (contraception, ANC, childbirth, PNC, etc.) with follow-up questions on financial mechanisms and loans at the end of the interview. It may also be that the sample selection affected this indicator, and that married women living with family are somehow less targeted for financial services than women living in factory housing. The midline also expanded on the types of financial supports available, including NSSF, HEF/SOA and community health insurances, which the baseline did not calculate.

Regardless, use of financial support mechanisms remains limited to a small percentage of overall users of RMNH services.

![Figure 31: Types of financial assistance, among all women that received financial assistance (multiple response).](image-url)
Looking at borrowing to pay for medical costs, just over one in eight female GFW (12.8%) borrowed money to pay for medical costs (Figure 32). RMNH users borrowed money at greater levels than women that borrowed money to pay for other medical costs (16.8% of RMNH users, compared to 10.9% of non-users). As well as the frequency of borrowing, the amount borrowed varied between RMNH users and non-users. On average RMNH users borrowed $132.18, while non-users borrowed $79.44 (Table 17). These amounts have a large range and deviation. However, this difference is still clear when looking at the median values; the median value of RMNH users’ loans is double that of non-users ($50 and $25, respectively). Higher borrowing among RMNH users appears to be primarily related to the high costs of pregnancy reported in the survey; up to $2,000 for the last delivery, in the case of one respondent.

![Figure 32: Borrowing to pay for medical costs, among all female GFW.](image)

<table>
<thead>
<tr>
<th>Loan Values among RMNH Users and Non-users.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid N</td>
</tr>
<tr>
<td>RMNH Users</td>
</tr>
<tr>
<td>RMNH Non-users</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Among borrowers, nearly all utilised informal lenders to pay for these services (Figure 33). Only 1.6% of female GFW that took a loan for health care or RMNH services used a microfinance institution (MFI). The other respondents borrowed evenly from friends/neighbours (37%), relatives/family members (33%), and local money lenders (30%). The danger with informal lending is that it exposes these women to unregulated lending practices, such as high interest rates and abbreviated payback periods. These issues were not further inquired about during the baseline or midline, but could be interesting to explore in further monitoring and evaluation activities.
Conclusions and Recommendations

Due to changes in the sampling methodology, the average female GFW is older, and more likely to be married and live with relatives/spouses than the women surveyed at the baseline. Salaries have increased considerably, in line with changes to the minimum wage. Nearly all women have a mobile phone, and frequent access to mass media (TV, radio) and social media (facebook). Most women are exposed to BCC advertising and information, and many are participating in awareness raising sessions, meetings and peer counselling.

In general, the RMNH situation of the female GFW in target factories has improved since the baseline study in 2014. Nearly all indicators of project success have increased since the baseline. Some of the most significant increases have been in the areas of sexual and reproductive health, which were the focus of the PSL activities in garment factories. The most notable of these are:

- Uptake of modern contraception, which has nearly doubled among female GFW. Use of LAPMS has also increased, although it remains a fairly small proportion of modern contraceptive users.
- Uptake of modern FP methods post-abortion, which has more than doubled. Even women that did not receive CAC services or post-abortion counselling were adopting modern contraceptive methods within 14 days of abortion; a positive sign of behaviour change.
- Women’s empowerment has increased considerably. This includes the ability of women to discuss and use family planning, and refuse sex with their partner, even in the face of adversity or threats. The number of women that felt fully empowered at the baseline was near zero, and has now increased to one-quarter of female GFW across both indicators.
- Knowledge of abortion and safe abortion providers. Women appear more engaged in their contraceptive and family planning decision-making, and have considerably increased their knowledge of abortion’s legality and locations where they can access safe abortion services.

![Figure 33: Borrowers for health care and RMNH loans, among female GFW that took loans for these purposes (multiple response).](image-url)
Although not a focus of the PSL program in garment factories to date, there were also considerable increases in maternal and neonatal health indicators. These included:

- Safe childbirth (delivering in health facility with SBA). These indicators increased from already high rates to near-universal adoption in the last two years.
- Women receiving appropriate ANC care (four or more visits), which has also increased to near-universal adoption.
- Appropriate PNC follow-up, which has more than doubled among female GFW that gave birth most recently (in the last 12 months).
- Awareness of neonatal distress signs has risen over 300%, although this remains fairly low.

In addition, BCC and/or Chat! campaign participation among female GFW are correlated with many of these indicators of project success (see Annex 1). These programs have been especially useful in raising awareness, increasing knowledge, and empowering women in their rights. Their impact has been especially felt in the areas of:

- Contraceptive knowledge;
- Knowledge of safe abortion providers;
- Post-abortion contraceptive uptake;
- Confidence in sexual and reproductive health rights.

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 services declined slightly from the baseline, and was used by only a few female GFW in 2016. Although living in and around Phnom Penh increases women’s access to high quality public and private health facilities, it also increases the costs of many forms of RMNH care. Delivery is especially expensive, with costs of up to $2,000. Faced with these costs and a lack of public assistance, many women rely on private contributions or loans from informal lenders to pay for RMNH services. This exposes them to unregulated practices, such as high interest rates and unfair payment conditions. More work could be done to improve women’s access to financial support and/or credit to pay for RMNH services when they are needed.
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. This could be done as an additional promotion, or through existing activities such as lunchtime meetings. 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 RMHN services). Increasing women’s awareness of the infirmary and its RMHN 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 RMHN services indicates a need for increased access to financial support mechanisms, especially for the higher cost services such as delivery, abortion and sterilisation. Raising women’s awareness – and access to – existing support mechanisms can improve their quality of care (by providing more options), and reduce the need for informal credit. This could be done through increased training to infirmary staff or peer educators, or through an aggregate hotline, which directs women to support services appropriate to their needs. Such partnerships have proven successful in linking gender-based violence victims to appropriate and available support mechanisms, and could prove useful in this case as well.

- **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.


Annex 1: MERI Indicators

Baseline and midline MERI indicator values. Note that midline indicators have been further disaggregated by exposure to the various BCC campaigns. Disaggregation is both at the factory level (depending on where each campaign was active), and by individual GFW participation in activities.

<table>
<thead>
<tr>
<th>Outcome Level</th>
<th>Indicators</th>
<th>Baseline Data</th>
<th>Midline Data</th>
<th>Chat! Exposure</th>
<th>SRH BCC Exposure</th>
<th>Other BCC Exposure</th>
<th>Any BCC/Chat! Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5 Year Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improved quality RMNH services for target populations</strong></td>
<td>O1.2. #/% of women delivering in a health facility with a skilled birth attendant (SBA) (FTIRMN)</td>
<td>80%</td>
<td>99.0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Greater equity of access to appropriate RMNH services for target populations</strong></td>
<td>O2.1. #/% of target population using modern contraception (FTIRMN) - WRA - Ever sexually active</td>
<td>10.6%</td>
<td>20.3%</td>
<td>21.5%</td>
<td>19.7%</td>
<td>22.3%</td>
<td>21.0%</td>
</tr>
<tr>
<td></td>
<td>O2.2. #/ % of garment factory workers accessing RMNH services in the previous 12 months</td>
<td>8.6%</td>
<td>9.9%</td>
<td>8.5%</td>
<td>12.5%</td>
<td>14.4%</td>
<td>13.0%</td>
</tr>
<tr>
<td><strong>More responsive RMNH services meet the needs of target populations</strong></td>
<td>O3.1. % of women receiving Comprehensive Abortion Care (CAC) who receive post abortion family planning (FP)</td>
<td>22.5%</td>
<td>56.0%</td>
<td>55.6%</td>
<td>77.4%</td>
<td>65.0%</td>
<td>72.1%</td>
</tr>
<tr>
<td></td>
<td>O3.2. % of women attending post natal care (PNC) who receive counselling in modern FP methods</td>
<td>56%</td>
<td>33.3%</td>
<td>23.8%</td>
<td>39.6%</td>
<td>36.7%</td>
<td>37.5%</td>
</tr>
<tr>
<td></td>
<td>O3.3. % of target population who report being highly satisfied with RMNH services provided</td>
<td>23.5%</td>
<td>28.6%</td>
<td>20.3%</td>
<td>28.7%</td>
<td>30.6%</td>
<td>29.4%</td>
</tr>
<tr>
<td>Outcome Level</td>
<td>Indicators</td>
<td>Baseline Data</td>
<td>Midline Data</td>
<td>Chat! Exposure</td>
<td>SRH BCC Exposure</td>
<td>Other BCC Exposure</td>
<td>Any BCC/Chat! Exposure</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>----------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Improved RMNH behaviours amongst target population</td>
<td>O4.1. % of women of reproductive age who can identify 5 danger signs during pregnancy</td>
<td>1.2%</td>
<td>1.0%</td>
<td>0.0%</td>
<td>1.8%</td>
<td>0.0%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
|                                                                              | O4.2. #/% of women attending 4 or more antenatal care (ANC) consultations (FTIRMN)  
- Most recent delivery  
- Delivery within past 12 months                                                                                                                   | 70.6%         | 96.1%        | 100%           | 98.2%            | 96.9%               | 97.8%               |
|                                                                              |                                                                                                                                             | 82.1%         | 98.3%        | 100%           | 97.3%            | 100%                | 98.1%               |
|                                                                              | O4.3. #/% of women receiving 2 or more PNC visits  
- Most recent delivery  
- Delivery within past 12 months                                                                                                                 | 22.1%         | 25.2%        | 29.2%          | 27.3%            | 25.0%               | 27.0%               |
<p>|                                                                              |                                                                                                                                             | 12.5%         | 27.6%        | 33.3%          | 29.7%            | 33.3%               | 30.8%               |
|                                                                              | O4.4. % of women (modern FP users) using long acting or permanent methods (LAPM) of FP                                                                                                                  | 11.5%         | 15.0%        | 10.8%          | 11.0%            | 20.9%               | 14.5%               |
| Intermediate Outcomes                                                         |                                                                                                                                             |               |              |                |                  |                     |                      |
| Financial mechanisms enable access to RMNH services                            | I5.1. # /% of target population accessing RMNH services using a financial support mechanism in the previous 12 months                                                                                  | 11%           | 3.2%         | 4.9%           | 4.5%             | 9.9%                | 6.4%                 |
| RMNH BCC strategy developed and implemented                                    | I6.2. % of target population who can identify 3 danger signs for neonatal distress                                                                                                                      | 4%            | 14.6%        | 12.5%          | 18.2%            | 9.4%                | 14.6%               |
|                                                                              | I6.3. % of women who feel empowered to discuss and use modern family planning                                                                  | 5%            | 24.8%        | 30.0%          | 27.9%            | 24.5%               | 26.3%               |</p>
<table>
<thead>
<tr>
<th>Outcome Level</th>
<th>Indicators</th>
<th>Baseline Data</th>
<th>Midline Data</th>
<th>Chat! Exposure</th>
<th>SRH BCC Exposure</th>
<th>Other BCC Exposure</th>
<th>Any BCC/Chat! Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I6.4. % of women who know that abortion is legal</td>
<td></td>
<td>8%</td>
<td><strong>16.5%</strong></td>
<td>23.2%</td>
<td>20.5%</td>
<td>12.8%</td>
<td>17.6%</td>
</tr>
<tr>
<td>I6.5. % of women delivering with a SBA (FTIRMN)</td>
<td></td>
<td>90.6%</td>
<td><strong>99.0%</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Annex 2: BCC and Chat! Participation

This table contains additional analysis conducted on non-MERI indicators of project success, disaggregated by participation in BCC and Chat! activities. This data is included in the body of the report for any exposure. Data is weighted the same as in the report and other analysis; thus, count values may not directly correlate to individual respondents.

<table>
<thead>
<tr>
<th></th>
<th>Chat! Exposure</th>
<th>SRH BCC Exposure</th>
<th>Other BCC Exposure</th>
<th>Any BCC/Chat! Exposure</th>
<th>No Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Mean</td>
<td>%</td>
<td>Count</td>
<td>Mean</td>
</tr>
<tr>
<td>Contraceptive knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>10.68</td>
<td>46.8%</td>
<td>461</td>
<td>10.37</td>
</tr>
<tr>
<td>Spontaneous knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>4.50</td>
<td>4.5%</td>
<td>461</td>
<td>4.44</td>
</tr>
<tr>
<td>Prompted knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>6.18</td>
<td>6.2%</td>
<td>461</td>
<td>5.92</td>
</tr>
<tr>
<td>Current modern contraceptive users</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>45</td>
<td>38.8%</td>
<td></td>
<td>91</td>
<td>41.2%</td>
</tr>
<tr>
<td>Current LAPM users</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4.2%</td>
<td></td>
<td>10</td>
<td>4.6%</td>
</tr>
<tr>
<td>Number of ANC visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>8.08</td>
<td></td>
<td>462</td>
<td>8.11</td>
</tr>
<tr>
<td>Number of PNC check-ups after 48 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>15.14</td>
<td></td>
<td>462</td>
<td>12.18</td>
</tr>
<tr>
<td>Knowledge of neonatal distress signs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>1.25</td>
<td></td>
<td>462</td>
<td>1.38</td>
</tr>
<tr>
<td>Know at least one safe abortion provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>117</td>
<td>55.5%</td>
<td></td>
<td>223</td>
<td>48.4%</td>
</tr>
<tr>
<td>Reproductive health confidence level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>4.21</td>
<td></td>
<td>461</td>
<td>4.18</td>
</tr>
<tr>
<td>Sexual health confidence level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>211</td>
<td>4.09</td>
<td></td>
<td>461</td>
<td>4.17</td>
</tr>
</tbody>
</table>
Annex 3: Midline Individual Questionnaire

### Section 1: Socio demographics

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>1.1 How old are you now? (in western age)</td>
<td>Years:</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Have you ever been to school?</td>
<td>No <em>(Skip to Q4)</em> 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes 1</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>What is the highest grade you completed?</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Code 13 if university level.</em></td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>1.3 What is your current marital status?</td>
<td>Single and <strong>NOT</strong> in a regular relationship 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single in committed relationship 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Married 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Widowed/Divorced 4</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Are you living alone?</td>
<td>No 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes <em>(skip to Q7)</em> 1</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>1.4 Who do you live with now? <em>Multiple answer possible</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parent 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relatives <em>(including children)</em> 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Husband 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Friends <em>(in rental room)</em> 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sweetheart <em>(intimate partner)</em> 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other <em>(specify)</em> 88</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>1.5 How long have you worked as a garment factory worker in total? <em>Add together total time of all garment factory contracts</em></td>
<td>Years:</td>
</tr>
</tbody>
</table>
### Section 2: Household Assets, Wealth and Debt

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. 1.6 How much did you earn last month in total <strong>USD</strong>?</td>
<td>USD:</td>
</tr>
<tr>
<td><em>(including overtime and other sources of income)</em></td>
<td></td>
</tr>
<tr>
<td>9. Last month, did you send any money to your family?</td>
<td>No (Skip to Q11) 0, Yes 1</td>
</tr>
<tr>
<td>10. Last month, how much money did you send to your family?</td>
<td>USD:</td>
</tr>
</tbody>
</table>

### Section 3: Disability

*Now, I would like to ask some questions about your general health. The next questions ask about difficulties you may have doing certain activities because of a health problem.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. 2.1 Do you have difficulty seeing, even if wearing glasses?</td>
<td>No difficulty 0, Yes, some difficulty 1, Yes, a lot of difficulty 2, Yes, cannot do it at all 3</td>
</tr>
<tr>
<td>12. 2.2 Do you have difficulty hearing, even if using a hearing aid?</td>
<td>No difficulty 0, Yes, some difficulty 1, Yes, a lot of difficulty 2, Yes, cannot do it at all 3</td>
</tr>
<tr>
<td>13. 2.3 Do you have difficulty walking or climbing stairs?</td>
<td>No difficulty 0, Yes, some difficulty 1, Yes, a lot of difficulty 2, Yes, cannot do it at all 3</td>
</tr>
<tr>
<td>14. 2.4 Do you have difficulty remembering or concentrating?</td>
<td>No difficulty 0, Yes, some difficulty 1, Yes, a lot of difficulty 2, Yes, cannot do it at all 3</td>
</tr>
<tr>
<td>15. 2.5 Do you have difficulty with self-care, such as washing all over or dressing?</td>
<td>No difficulty 0, Yes, some difficulty 1</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
</tbody>
</table>
| **16.** 2.6 Do you have difficulty communicating, for example understanding or being understood? | Yes, a lot of difficulty 2  
Yes, cannot do it at all 3 |       |
| **Section 4: Media (including social media)**                            |                                              |       |
| **Now, I want to ask you some questions about the media that you access and use.** |                                              |       |
| **17.** Do you have a mobile phone?                                     | No (skip to Q19) 0  
Yes 1 |       |
| **18.** Do you have a smartphone that you use to access the internet?    | No 0  
Yes 1 |       |
| **19.** Do you access any forms of media, like newspapers, radio, TV or internet at least once per week? | No (Skip to Q22) 0  
Yes 1 |       |
| **20.** Which forms of media do you access at least once per week?       | Radio 1  
Television 2  
Printed newspapers 3  
Printed magazines 4  
Internet 5  
Facebook 6  
Other 88 |       |
| *Multiple answers possible*                                              |                                              |       |
| *Read each type of media and check if they access it.*                   |                                              |       |
| **21.** Which form of media do you access the most?                      | Radio 1  
Television 2  
Printed newspapers 3  
Printed magazines 4  
Internet 5  
Facebook 6  
Other 88 |       |
| *Only one answer. Check with response in Q20 above.*                     |                                              |       |
Section 5: Ranking Sources of Information Related to Reproductive Health

I will show you some cards with different types of source of information.

Give respondent the cards for source of information types. Then ask them to rate from 1 - 9 and then get the cards with answer back. Number in order from 1 to 9 by asking and answering the following questions.

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factory infirmary staff</td>
<td></td>
</tr>
<tr>
<td>Family / friends / colleagues</td>
<td></td>
</tr>
<tr>
<td>Health centre staff</td>
<td></td>
</tr>
<tr>
<td>NGO staff/activities</td>
<td></td>
</tr>
<tr>
<td>Leaflet / banner / T-shirt</td>
<td></td>
</tr>
<tr>
<td>TV</td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td></td>
</tr>
<tr>
<td>Facebook</td>
<td></td>
</tr>
<tr>
<td>Internet</td>
<td></td>
</tr>
</tbody>
</table>

Section 6: Exposure to Current BCC Campaign

23. In the last 3 months, have you heard or seen any contraceptive advertising?
   - No: 0
   - Yes: 1

24. In the last 3 months, did you see a poster/leaflet/ Knhom Samrab Nak hotline card?
   - No: 0
   - Yes: 1
   - Don’t know/remember: 99

25. In the last 3 months, did you ever attend a lunchtime sexual and reproductive health meeting?
   - No: 0
   - Yes: 1
   - Don’t know/remember: 99

26. In the last 3 months, did you ever speak to a peer educator?
   - No: 0
   - Yes: 1
   - Don’t know/remember: 99

27. In the last 3 months, have you seen any of the Chat! Contraception videos?
   - No (Skip to Q29): 0
   - Yes: 1

28. How many Chat! Contraception video viewings did you see in the last 3 months?
   - Viewings:
     - Don’t know/remember: 99
<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
</table>
| 29. In the last 3 months, have you attended any of the Chat! Contraception sessions? | No (Skip to Q31) 0  
                      Yes 1 |
| 30. How many Chat! Contraception sessions did you attend in the last 3 months? | Times:  
                      Don’t know/remember 99 |
| 31. In the last 3 months, have you played the Chat! Contraception mobile game? | No (Skip to Q34) 0  
                      Yes 1 |
| 32. Approximately how long did you play the Chat! Contraception mobile game in the last 3 months? | Hours:  
                      Don’t know/remember 99 |
| 33. What is the highest level that you achieved on the Chat! Contraception mobile game? | Level:  
                      Don’t know/remember 99 |

**Section 7. Garment Factory Infirmary**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
</table>
| 34. Does the factory where you work have an infirmary?                  | No (skip to Q40) 0  
                      Yes 1 |
| 35. 3.1 Have you ever used the factory infirmary in the past 12 months? | No 0  
                      Yes (Skip to Q37) 1  
                      Don’t know /Maybe (Skip to Q37) 99 |
| 36. 3.2 If no, why not? Multiple answers possible. Skip to Q41 when complete. | Service not available at convenient times 1  
                      Service takes too long 2  
                      Service is too expensive 3  
                      Quality of service is not good 4  
                      Provider is unfriendly 5  
                      No commodity available 6  
                      Medicine not effective 7  
                      Infirmary is not clean 8  
                      Type of health service required not available 9  
                      Lack of confidentiality 10  
                      Did not require any health services / not sick 11  
                      Need recommendation letter 12 |
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 37. | 3.3 If yes, what services have you used from the factory infirmary?  
*Multiple answers possible* |
| | Other (specify) | 88 |
| | Minor health problem  | 1 |
| | Injury/first aid  | 2 |
| | ANC counseling  | 3 |
| | Short term family planning (condom, pill, injection)  | 4 |
| | HIV counseling/testing referral  | 5 |
| | STI counseling and referral  | 6 |
| | FP counseling and referral  | 7 |
| | Abortion counseling and referral  | 8 |
| | Other (specify)  | 88 |
| 38. | 3.4 How satisfied are you with the services provided at the infirmary?  
| | Very satisfied  | 1 |
| | Satisfied  | 2 |
| | Neither satisfied nor dissatisfied  | 3 |
| | Somewhat dissatisfied  | 4 |
| | Very dissatisfied  | 5 |
| 39. | 3.5 Would you recommend the infirmary services to your friends/co-workers? |  
| | No  | 0 |
| | Yes  | 1 |
| 40. | 3.6 Have you received a referral from the infirmary staff or factory peer educators in the past 12 months for any of the following services?  
*Prompt. Multiple answers possible.* |  
| | No referral  | 1 |
| | Family planning services  | 2 |
| | Safe abortion  | 3 |
| | STI services  | 4 |
| | ANC visit  | 5 |
| | PNC visit  | 6 |
| | VCCT  | 7 |
| | Other (specify)  | 88 |
| 41. | Have you ever used a public or private health facility in the past 12 months, apart from factory infirmary?  
| | No (skip to Q44)  | 0 |
| | Yes  | 1 |
| 42. | The last time you went to a health facility, which one? |  
| | Public hospital / health center  | 1 |
### Midterm Survey and Evaluation: RMNH KAP among Garment Factory Workers

#### Section 8-. Sexual activity and contraceptive use

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. How satisfied were you with the services provided at this health facility?</td>
<td><a href="#">Very satisfied</a>, <a href="#">Satisfied</a>, <a href="#">Neither satisfied nor dissatisfied</a>, <a href="#">Somewhat dissatisfied</a>, <a href="#">Very dissatisfied</a></td>
</tr>
<tr>
<td>44. Have you ever heard about contraception (things that a man or woman can do to stop the woman from becoming pregnant)?</td>
<td><a href="#">No (skip to Q59)</a>, <a href="#">Yes</a></td>
</tr>
</tbody>
</table>

What contraceptive methods have you heard of?

*Please circle 2 for all methods mentioned spontaneously. Ask, “Do you know any other methods?”*

*After all spontaneous methods are complete, read the name and description for every method not mentioned and ask “Have you ever heard of this method?”. Circle 1 for every method that they have heard of and 0 for every method they have never heard of.*

<table>
<thead>
<tr>
<th>Method</th>
<th>Spontaneous</th>
<th>Prompted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sterilization. The hands of a woman’s uterus can be tied to avoid getting pregnant.</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Male Sterilization. The man’s tubes can be knotted to avoid getting pregnant.</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>IUD. This device is placed in a woman’s uterus by a doctor or a nurse to prevent pregnancy.</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Injection. Woman can have an injection that prevents them from becoming pregnant for several months.</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Implant. This is a small rod that is placed in a woman’s upper arm, which can prevent pregnancy for several months.</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Daily pill. Woman can swallow a pill every day to avoid getting pregnant. (Daily pill)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>51. Monthly pill. Woman can take a pill every month to avoid getting pregnant. (Monthly pill)</td>
<td>2</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>52. Condom (male). Women/men can put a rubber sheath over the penis before sex.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>53. Female Condom. Women can put a rubber sheath in the vagina before sex.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>54. Emergency contraception. Pills can be swallowed up to 120 hours after unprotected sex to prevent pregnancy.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>55. Lactic Amenorrhoea Method. Women who exclusively breastfeed may avoid pregnancy.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>56. Calendar/Rhythm Method. Women can avoid having sex during fertile periods</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>57. Withdrawal. “Spilling water out of the jar” (removing penis before white liquid comes out)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>58. Abstinence. Women can avoid having sex altogether, to prevent pregnancy.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>59. Have you been sexually active in the last 12 months?</td>
<td>No (Skip to Q69)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>60. 4.3 In the past 12 months have you used any methods of contraception?</td>
<td>No (Skip to Q69)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>61. 4.4 If yes, which ones?</td>
<td>Female sterilization</td>
</tr>
<tr>
<td></td>
<td>Male sterilization</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>IUD</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Injection</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Implant</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Daily pills</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Monthly pills</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Condom(male)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Female condom</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Emergency contraception</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Lactational amenorrhea method</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Rhythm method</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Withdrawal</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>------------</td>
</tr>
<tr>
<td>62.</td>
<td>Are you <strong>currently</strong> using any contraception, including traditional methods?</td>
<td>No <em>(skip to Q64)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female sterilization</td>
</tr>
<tr>
<td></td>
<td>63.</td>
<td>Injection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly pills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency contraception</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Withdrawal</td>
</tr>
<tr>
<td>64.</td>
<td>What is the <strong>last</strong> modern contraceptive method that you used in the last 12 months?</td>
<td>No modern contraception <em>(skip to Q69)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IUD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily pills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female condom</td>
</tr>
</tbody>
</table>
### Midterm Survey and Evaluation: RMNH KAP among Garment Factory Workers

**PSL 2016**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>65. 4.5 Last time, where did you go to get this contraception?</strong></td>
<td>Other                                                                  88</td>
</tr>
<tr>
<td></td>
<td>National hospital (PP)                                                          1</td>
</tr>
<tr>
<td></td>
<td>Provincial hospital (RH)                                                        2</td>
</tr>
<tr>
<td></td>
<td>Referral hospital (RH)                                                          3</td>
</tr>
<tr>
<td></td>
<td>Health center or health post                                                     4</td>
</tr>
<tr>
<td></td>
<td>Garment factory infirmary                                                       5</td>
</tr>
<tr>
<td></td>
<td>NGO facility (specify)                                                          6</td>
</tr>
<tr>
<td></td>
<td>Private hospital (specify)                                                      7</td>
</tr>
<tr>
<td></td>
<td>Private clinic (specify)                                                        8</td>
</tr>
<tr>
<td></td>
<td>Private pharmacy/drugstore                                                      9</td>
</tr>
<tr>
<td></td>
<td>Community-based distributor                                                     10</td>
</tr>
<tr>
<td></td>
<td>Friend/relative                                                                  11</td>
</tr>
<tr>
<td></td>
<td>Other                                                                          88</td>
</tr>
</tbody>
</table>

| **66. Could you tell me, the last time you used family planning services, did you spend any money?** | No (Skip to Q69) 0 |
|                                                                                                             | Yes 1 |

| **67. How much money did you spend for fees for family planning services the last time?** | Riel: |
|                                                                                                             | Includes all related service costs: consultation, medicine, procedure, etc. |

| **68. How much money did you spend for transport for family planning services the last time?** | Riel: |
|                                                                                                             | Make sure costs are round-trip (cost to go to clinic and return to home). |

### Section 9. Pregnancy and Maternal Health

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>69. 5.1 Have you ever been pregnant?</strong></td>
<td>No (Skip to Q112) 0</td>
</tr>
<tr>
<td></td>
<td>Yes 1</td>
</tr>
</tbody>
</table>

| **70. 5.2 How many times have you been pregnant in your life (including miscarriages and abortions)?** | Times: |

| **71. The last time you got pregnant, were you using any method of contraception?** | No (skip to Q73) 0 |
|                                                                                                             | Yes 1 |

<p>| <strong>72. Which method of contraception were you using?</strong> | Female sterilization 1 |
|                                                                                                             | Male sterilization 2 |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>73.</td>
<td>Have you ever given birth <em>(including stillbirths)</em>?</td>
<td>No (skip to Q112) 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes 1</td>
</tr>
<tr>
<td>74.</td>
<td>5.4 How many live babies have you delivered?</td>
<td>Number babies:</td>
</tr>
<tr>
<td>75.</td>
<td>How many live births have you had <em>in the last 24 months</em>?</td>
<td>Births:</td>
</tr>
<tr>
<td></td>
<td><em>If 0, skip to Q112.</em></td>
<td></td>
</tr>
<tr>
<td>76.</td>
<td>5.5 How long ago was your last live birth?</td>
<td>Months:</td>
</tr>
<tr>
<td></td>
<td><em>If greater than 24 months (25 months or more), skip to Q112.</em></td>
<td></td>
</tr>
<tr>
<td>77.</td>
<td>5.8 When you were pregnant with your last live birth, did you ever go for antenatal care visits?</td>
<td>No (Skip to Q85) 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes 1</td>
</tr>
<tr>
<td>78.</td>
<td>5.9 How many antenatal care visits did you have?</td>
<td>Times:</td>
</tr>
<tr>
<td></td>
<td><em>If 0, skip to Q85. If 1 or more, complete the table on next page, using one line for each visit.</em></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>79. In which month of the pregnancy were these visits?</td>
<td>Month 0-9. Confirm frequency with Q78 above.</td>
<td></td>
</tr>
<tr>
<td>80. Where did you go for this antenatal care visit?</td>
<td>1: National hospital (PP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2: Provincial hospital (RH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3: District hospital (RH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4: Health centre or health post</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5: Military hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6: Other public facility (specify)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7: Private hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8: NGO clinic (specify)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9: Private clinic/cabinet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10: Other private medical facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11: Garment factory infirmary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12: Your home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13: Other home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>88: Other (specify)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99: Don’t know</td>
<td></td>
</tr>
<tr>
<td>81. Who examined you during this visit?</td>
<td>1: Doctor/Medical assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2: Midwife</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3: Nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4: Other trained health personnel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5: Traditional birth attendant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6: Relative/friend</td>
<td></td>
</tr>
<tr>
<td></td>
<td>88: Other (specify)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99: Don’t know</td>
<td></td>
</tr>
<tr>
<td>82. 3.9 Could you tell me, did you spend money for antenatal care services the last live birth?</td>
<td>No (Skip to Q85)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>83. How much money did you spend for fees for antenatal care services the last live birth?</td>
<td>Riel:</td>
<td></td>
</tr>
<tr>
<td>84. How much money did you spend for transport for antenatal care services the last live birth?</td>
<td>Riel:</td>
<td></td>
</tr>
</tbody>
</table>
5.11 Can you name any danger signs that indicate a problem during a pregnancy?

*Do not prompt. Multiple response.*

<table>
<thead>
<tr>
<th>Danger Sign</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal bleeding in early and late pregnancy</td>
<td>1</td>
</tr>
<tr>
<td>Anemia</td>
<td>2</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>3</td>
</tr>
<tr>
<td>Fever during pregnancy and labor</td>
<td>4</td>
</tr>
<tr>
<td>Abdominal pain in early pregnancy</td>
<td>5</td>
</tr>
<tr>
<td>Abdominal pain in later pregnancy</td>
<td>6</td>
</tr>
<tr>
<td>Difficulty in breathing</td>
<td>7</td>
</tr>
<tr>
<td>Loss of fetal movements</td>
<td>8</td>
</tr>
<tr>
<td>Pre-labor rupture of membranes</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>88</td>
</tr>
<tr>
<td>Don’t know</td>
<td>99</td>
</tr>
</tbody>
</table>

5.6 For your last live birth, where did you deliver the baby?

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>National hospital (PP)</td>
<td>1</td>
</tr>
<tr>
<td>Provincial hospital (RH)</td>
<td>2</td>
</tr>
<tr>
<td>District hospital (RH)</td>
<td>3</td>
</tr>
<tr>
<td>Health center or health post</td>
<td>4</td>
</tr>
<tr>
<td>Military hospital</td>
<td>5</td>
</tr>
<tr>
<td>Other public facility (specify):</td>
<td>6</td>
</tr>
<tr>
<td>Private hospital</td>
<td>7</td>
</tr>
<tr>
<td>Private clinic/cabinet</td>
<td>8</td>
</tr>
<tr>
<td>NGO facility (specify)</td>
<td>9</td>
</tr>
<tr>
<td>Other private medical facility</td>
<td>10</td>
</tr>
<tr>
<td>Garment factory infirmary</td>
<td>11</td>
</tr>
<tr>
<td>Your home</td>
<td>12</td>
</tr>
<tr>
<td>Other home</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>88</td>
</tr>
</tbody>
</table>

5.7 Who assisted with the delivery of your last live birth?

<table>
<thead>
<tr>
<th>Assister</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No one helped</td>
<td>1</td>
</tr>
<tr>
<td>Doctor/Medical assistant</td>
<td>2</td>
</tr>
<tr>
<td>Midwife</td>
<td>3</td>
</tr>
<tr>
<td>Nurse</td>
<td>4</td>
</tr>
<tr>
<td>Other trained health personnel</td>
<td>5</td>
</tr>
<tr>
<td>Traditional birth attendant</td>
<td>6</td>
</tr>
<tr>
<td>Question</td>
<td>Response Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>3.9 Could you tell me, did you spend money for the most recent delivery and related services?</td>
<td>Relative/friend 7 Other 88</td>
</tr>
<tr>
<td>How much money did you spend for fees for delivery and related services the last birth?</td>
<td>No (Skip to Q91) 0 Yes 1</td>
</tr>
<tr>
<td>How much money did you spend for transport for delivery and related services the last birth?</td>
<td>Riel:</td>
</tr>
<tr>
<td>Did you attempt to breastfeed this baby?</td>
<td>No (skip to Q93) 0 Yes 1</td>
</tr>
<tr>
<td>How long after this delivery was the baby put to your breast?</td>
<td>If less than one hour, code 0. Hours:</td>
</tr>
<tr>
<td>Did you or your baby receive an examination within 48 hours (2 days) after this birth?</td>
<td>No (skip to Q96) 0 Mother only 1 Baby only 2 Both 3</td>
</tr>
<tr>
<td>Where did you receive this check-up?</td>
<td>National hospital (PP) 1 Provincial hospital(RH) 2 District hospital (RH) 3 Health center or health post 4 Military hospital 5 Other public facility (specify): 6 Private hospital 7 Private clinic/cabinet 8 NGO facility (specify) 9 Other private medical facility 10 Garment factory infirmary 11 Your home 12 Other home 13 Other 88</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>95.</td>
<td>Who performed the check-up?</td>
</tr>
<tr>
<td>96.</td>
<td>Did you or the baby receive any check-ups after 48 hours?</td>
</tr>
<tr>
<td>97.</td>
<td>How many more check-ups did you and the baby receive?</td>
</tr>
<tr>
<td>98.</td>
<td>How long after delivery was the next check-up?</td>
</tr>
<tr>
<td>99.</td>
<td>Who received this check-up?</td>
</tr>
<tr>
<td>100.</td>
<td>Where did they receive this check-up?</td>
</tr>
<tr>
<td>101.</td>
<td>Who performed the check-up?</td>
</tr>
</tbody>
</table>
If more visits, use extra sheet.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>102.</td>
<td>3.9 Could you tell me, did you spend any money for these postnatal care services for the last birth?</td>
<td>No (Skip to Q105) 0  Yes 1</td>
</tr>
<tr>
<td>103.</td>
<td>How much money did you spend for fees for postnatal care services the last birth?</td>
<td>Riel:</td>
</tr>
<tr>
<td>104.</td>
<td>How much money did you spend for transport for postnatal care services the last birth?</td>
<td>Riel:</td>
</tr>
<tr>
<td>105.</td>
<td>5.16 Did anyone talk to you about your contraception choices within 7 days after delivery of your most recent live birth?</td>
<td>No (Skip to Q107) 0  Yes 1</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>106.</td>
<td>5.17 Which methods did they talk to you about?</td>
<td>Female sterilization 1  Male sterilization 2  IUD 3  Injection 4  Implant 5  Daily pills 6  Monthly pills 7  Condom (male) 8  Female condom 9  Emergency contraception 10  Lactation amenorrhea method 11  Rhythm method 12  Withdrawal 13  Abstinence 14  Other 88</td>
</tr>
</tbody>
</table>

Do not prompt. Multiple response.
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>107. How old is this baby now?</td>
<td>Months:</td>
<td></td>
</tr>
<tr>
<td>If 6 months or more, skip to Q109.</td>
<td>No: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know: 99</td>
<td></td>
</tr>
<tr>
<td>108. Yesterday, did this baby drink only breastmilk?</td>
<td>No: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know: 99</td>
<td></td>
</tr>
<tr>
<td>109. How long after this birth did you return to work?</td>
<td>Months:</td>
<td></td>
</tr>
<tr>
<td>If less than 1 month, code 0.</td>
<td>No: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 1</td>
<td></td>
</tr>
<tr>
<td>110. Does this baby currently live with you?</td>
<td>No: 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 1</td>
<td></td>
</tr>
<tr>
<td>111. 5.15 Can you name any danger signs of neonatal distress?</td>
<td>Abnormal body temperature: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jaundice: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lethargy: 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeding difficulty: 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vomiting and/or abdominal distension: 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bleeding and/or pale: 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Umbilicus red and swollen, draining pus, or foul smelling pus: 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eyes red, swollen, or draining pus: 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Convulsion: 9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other: 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know: 99</td>
<td></td>
</tr>
</tbody>
</table>

**Section 10. Abortion and post-abortion care**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>112. 6.1 Do you know whether abortions are legal or illegal in Cambodia?</td>
<td>Legal: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Illegal: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know: 99</td>
<td></td>
</tr>
<tr>
<td>113. 6.2 Do you know where women can access safe abortion services?</td>
<td>Public health provider: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private health provider: 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NGO clinic (Specify): 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacy: 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traditional birth attendant (TBA): 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other: 88</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Don't know</td>
<td>Yes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-----</td>
</tr>
<tr>
<td>114. Have you ever had an induced abortion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>115. If yes, how many times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>116. When was the last abortion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>117. <em>The last time</em>, how was the abortion induced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple answers possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>118. Where did you go to receive the method in the last induced abortion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>119. Could you tell me, did you spend money for the most recent abortion and related services?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- 6.3 Have you ever had an induced abortion?
- 6.4 If yes, how many times?
- 6.5 The last time, how was the abortion induced?
- 6.6 Where did you go to receive the method in the last induced abortion?
- 3.9 Could you tell me, did you spend money for the most recent abortion and related services?
<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>120.</strong> How much money did you spend for fees for abortion-related services the last time?</td>
<td>Riel:</td>
</tr>
<tr>
<td><em>Includes costs of post-abortion care (e.g., follow-up visits, medicines, etc.)</em></td>
<td></td>
</tr>
<tr>
<td><strong>121.</strong> How much money did you spend for transport for abortion-related services the last time?</td>
<td>Riel:</td>
</tr>
</tbody>
</table>
| **122.** 6.7 Did anyone discuss your contraception choices with you within 14 days after you had the abortion? | **No (Skip to Q124)** 0  
|                                                      | **Yes** 1                                                                       |
| 6.8 Which methods did they talk to you about?                           | Female sterilization 1  
|                                                      | Male sterilization 2  
|                                                      | IUD 3  
|                                                      | Injection 4  
|                                                      | Implant 5  
|                                                      | Daily pills 6  
|                                                      | Monthly pills 7  
|                                                      | Condom(male) 8  
|                                                      | Female condom 9  
|                                                      | Emergency contraception 10  
|                                                      | Lactational amenorrhhea method 11  
|                                                      | Rhythm method 12  
|                                                      | Withdrawal 13  
|                                                      | Abstinence 14  
|                                                      | Other 88                                                                       |
| **123.** 6.9 Did you start to use any contraceptive method within 14 days of the last abortion? | **No (Skip to Q126)** 0  
|                                                      | **Yes** 1                                                                       |
| 6.10 Which methods did you start to use?                                | Female sterilization 1  
|                                                      | Male sterilization 2  
|                                                      | IUD 3  
|                                                      | Injection 4  
|                                                      | Implant 5  
|                                                      | Daily pills 6  
|                                                      | Monthly pills 7  
| **Source:** Midterm Survey and Evaluation: RMNH KAP among Garment Factory Workers PSL 2016
### Section 11. Use of Financial Assistance/Loans

Now I am going to ask you some questions about the costs that you told us about for these services.

**Confirm accuracy with cost questions above.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive any financial assistance for using any of the above mentioned services?</td>
<td></td>
</tr>
<tr>
<td><strong>Excluding money from family members.</strong></td>
<td></td>
</tr>
<tr>
<td>Did you receive any financial assistance for using any of the above mentioned services?</td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No (skip to Q128)</strong></td>
</tr>
<tr>
<td>If yes, which kind of assistance did you receive?</td>
<td></td>
</tr>
<tr>
<td><strong>Multiple answers possible.</strong></td>
<td></td>
</tr>
<tr>
<td>Did you borrow any money to pay for any of the above costs?</td>
<td></td>
</tr>
<tr>
<td><strong>No (skip to Q131)</strong></td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>What was the total value of all loans taken to pay for these services and transportation?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Who did you borrow from for these loans?</td>
<td></td>
</tr>
<tr>
<td><strong>Multiple answers possible.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Table of Contraceptive Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom (male)</td>
<td>8</td>
</tr>
<tr>
<td>Female condom</td>
<td>9</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>10</td>
</tr>
<tr>
<td>Lactational amenorrhea method</td>
<td>11</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>12</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>13</td>
</tr>
<tr>
<td>Abstinence</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>88</td>
</tr>
</tbody>
</table>
**Section 12. Sexual and Reproductive health rights**

Now I am going to ask you some questions about how confident or sure you are that you could use family planning if you wanted to do so. Even if you do not want to use family planning right now, try to imagine sometime in the future when you might wish to use it. How sure are you that you could:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>131.</td>
<td>7.1 Bring up the topic of family planning with your husband or partner?</td>
<td>No answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neither sure/Unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completely sure</td>
</tr>
<tr>
<td>132.</td>
<td>7.2 Tell your husband (or partner) that you wanted to use family planning?</td>
<td>No answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neither sure/Unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completely sure</td>
</tr>
<tr>
<td>133.</td>
<td>7.3 Use family planning?</td>
<td>No answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neither sure/Unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completely sure</td>
</tr>
<tr>
<td>134.</td>
<td>7.4 Use family planning, even if your husband (or partner) did not want to?</td>
<td>No answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neither sure/Unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completely sure</td>
</tr>
</tbody>
</table>

Now I am going to ask you some questions about whether you feel you can refuse to have sex in certain situations. Your answers will be kept completely secret and you don’t have to answer questions you don’t want to. How sure are you that you could refuse to have sex with your husband or partner:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>135.</td>
<td>7.5 When you don’t want to, but he does?</td>
<td>No answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat unsure</td>
</tr>
<tr>
<td></td>
<td>7.6 When you are tired?</td>
<td>7.7 When he gets angry with you if you don’t want to?</td>
</tr>
<tr>
<td>---</td>
<td>------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>136</td>
<td>Neither sure/Unsure 3</td>
<td>No answer 0</td>
</tr>
<tr>
<td></td>
<td>Somewhat sure 4</td>
<td>Not at all sure 1</td>
</tr>
<tr>
<td></td>
<td>Completely sure 5</td>
<td>Somewhat unsure 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neither sure/Unsure 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Somewhat sure 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completely sure 5</td>
</tr>
</tbody>
</table>

When you are tired?

136. Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

No answer 0
Not at all sure 1
Somewhat unsure 2
Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

When he gets angry with you if you don’t want to?

137. Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

No answer 0
Not at all sure 1
Somewhat unsure 2
Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

When he threatens to hurt you if you don’t want to?

138. Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

No answer 0
Not at all sure 1
Somewhat unsure 2
Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

When he threatens to have sex with other women if you don’t want to?

139. Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5

No answer 0
Not at all sure 1
Somewhat unsure 2
Neither sure/Unsure 3
Somewhat sure 4
Completely sure 5
Annex 4: Midline Focus Group Discussion Guide

**Factory Information**
Factory name:
Factory ID code:
Province:

**Respondent Characteristics**

**Respondent type (should be the same for all FGD members):**
1. Single (unmarried) and living alone
2. Married and/or Living with partner

**Respondent #1-10 (list individually for each respondent):**

Age:
Education level (last grade completed):
Number of years worked at this factory:
Quantitative questionnaire number:

**Media and Communications**
1. What kind of media do you access frequently?
   a. Do you access the internet? Do you use a smart phone or computer to access the internet?
   b. What kind of websites do you like to visit? Do you ever use facebook or other social media?
2. How do you prefer to get information about contraception and reproductive health?
3. Would you like to get more information from social media or your smart phone? Why?

**BCC Campaign**
4. Recently, have you seen any communications about contraception and reproductive health?
   a. Where did you see these communications? (e.g., on smartphone, on TV, radio, etc.)
   b. What messages did they say?
   c. What did you think about those messages? Were they helpful for you?
5. Have you participated in any Chat! Contraception activities? Which activities?
   a. Did you watch the videos? What did you think of them? Were they helpful or informative?
   b. Did you attend a session? What did you think of it? Was it helpful or informative? What did you learn from it?
   c. Did you play the mobile game? What did you think of it? Was it helpful or informative? What did you learn from it?
6. How do you think Chat! Contraception can be improved? Are there any topics you would like it to address? Why?

**RMNH Experience**
7. Do you know if this factory has a reproductive, maternal or neonatal health program?
   a. What does this program do in this factory?
8. Have you ever participated in this program?
b. If yes, please tell us about your experiences. How did you participate? Did you enjoy it? Were you satisfied with the program?

9. How do you think the RMNH program in this factory could be improved? Are there topics you would like it to address?

**Infirmary Experience**

10. Have you ever used the factory infirmary for services, or received a referral for reproductive, maternal or neonatal health services from this infirmary?
   a. If yes, please tell us about your experiences. What service did you use? Why did you use the service? What happened? Were you satisfied with the service you received? Did you have to pay any money?

11. Do many workers use the factory infirmary?
   a. Please explain your answer: why or why not? What services do they primarily use?

12. How do you think the infirmary could be improved? Please share your opinions with us. Are there any other services you would like the infirmary to provide?

**ANC/PNC Experience**

13. Have you ever used public or private health services for antenatal care or postnatal care?
   a. If yes, please tell us about your experiences. What service did you use? Why did you use the service? What happened? Were you satisfied with the service you received? Did you have to pay any money?

**Peer Educate Peer Program**

14. Do you know the Peer Educate Peer program? Have you ever participated in a PEP session?
   a. What did you learn from the PEP program?
   b. Was the PEP program helpful for you?

15. How do you think the PEP program can be improved? Are there any topics you would like it to address?

16. Are there any other recommendations you would like to make, regarding any of the issues we have discussed?
Annex 5: Midline Infirmary Staff IDI Guide

Factory Information
Factory name:
Factory ID code:
Province:

Respondent Characteristics

Respondent type:
3. Position in infirmary:
4. Medical title (doctor, nurse, etc.):

Respondent information:
Age:
Education level (last grade, or last professional course completed):
Number of years worked at this factory:

RMNH Participation
17. How concerned do you think the women in this factory are with reproductive, maternal and neonatal health (RMNH) issues?
   a. Why do you think this?

18. What does this factory/infirmary do to support RMNH issues? Please give some examples.
   a. Are these activities effective? Why or why not?
   b. How could these activities be improved to make them more effective?

19. What do you think is the most effective way to engage women in this factory on RMNH issues? Please give some examples.

BCC Campaign
20. Is there a BCC campaign on contraception and reproductive health in this factory?
   a. What messages have you heard? What did you think about those messages? Are they helpful?
   b. Do you think the women in this factory are engaged with this campaign? Are they learning anything from this campaign? Why?
   c. What do you think can be done to improve the effectiveness of this campaign?

21. Have you seen/heard of the Chat! Contraception activities? Which activities have you seen/heard?
   d. Did you watch the videos? What did you think of them? Were they helpful or informative?
   e. Did you attend a session? What did you think of it? Was it helpful or informative? What did you learn from it?
   f. Did you play the mobile game? What did you think of it? Was it helpful or informative? What did you learn from it?
22. Do you think the Chat! Contraception activities are useful for women in this factory? Why or why not?

23. How do you think Chat! Contraception can be improved? Are there any topics you would like it to address? Why?

RMNH Experience
24. Does this factory have a reproductive, maternal and neonatal health program?
   c. What does this program do in this factory?

25. How do the infirmary staff participate in this program? Do you participate in this program?
   a. If you participate, please tell us about your experiences. How do you participate? Are you satisfied with the program?

26. How do you think the RMNH program in this factory could be improved? Are there topics you would like it to address?

Infirmary Experience
27. What services does the infirmary offer? Which services are most popular with women in this factory?

28. Why do you think workers do/do not use the factory infirmary for some services? Please explain.

29. How do you think the infirmary could be improved? Please share your opinions with us. Are there any other services you would like the infirmary to provide?

NGO Support and Recommendations
30. How has (NGO) supported your infirmary? (e.g., with trainings, workshops, additional classes, etc.)
   a. Has this NGO supported you? How
   b. Has this support been mostly positive or negative? Please explain.

31. What kind of support would you like from this NGO in the future? Why?

32. Would you like this factory to provide additional infirmary or RMNH services in the future? What kind of services would you like this factory to provide?