

# Endline Survey of Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Garment Factory Workers

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The Endline Survey of Reproductive, Maternal and Neonatal Health Services for Garment Factory Workers, upon which this research is based, was approved by the National Ethics Committee for Health Research, Ministry of Health, Cambodia, letter no.287NECHR, dated 26 December 2017.

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## **Acronyms and Abbreviations**

ANC	Antenatal care
BCC	Behaviour change communication
CAC	Comprehensive abortion care
CDHS	Cambodia Demographic and Health Survey
CLU	Coordination and Learning Unit
DFAT	Department of Foreign Affairs and Trade (of the Australian Government)
FGD	Focus group discussion
FP	Family planning
FTIRM	Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
GFW	Garment factory worker
HEF	Health equity fund
HR	Human Resources
IDI	In-depth interview
IEC	Information, education and communication
IUD	Intrauterine device
КАР	Knowledge, attitude and practice
LAPM	Long-acting and permanent methods (of contraception)
MCM	Modern contraceptive method
MERI	Monitoring, evaluation, reporting and improvement
MFI	Microfinance institution
MOH	Ministry of Health
NGO	Non-governmental organisation
NIPH	National Institute of Public Health
NSSF	National Social Security Fund
PNC	Postnatal care
PSL	Partnering to Save Lives
RHAC	Reproductive Health Association of Cambodia
RMNH	Reproductive, maternal and neonatal health
SBA	Skilled birth attendant
SDG	Sustainable Development Goal(s)
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
ТВА	Traditional birth attendant
WG-SS	Washington Group Short Set on Functioning
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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## **Executive Summary**

Partnering to Save Lives (PSL) is a collaboration of three non-governmental organisations (NGO) in Cambodia (CARE International in Cambodia, Marie Stopes International Cambodia (Marie Stopes) and Save the Children<sup>1</sup>), 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 Road Map for Reducing Maternal and Neonatal Mortality (FTIRM) (MOH, 2010) 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).

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.

In 2017, PSL began their end of project review process. After establishing baseline values for project indicators in the Monitoring, Evaluation, Reporting and Improvement (MERI) framework in 2014, and updated figures at the 2016 midline, the current endline study seeks to assess female garment factory workers' (GFW) knowledge, attitudes and practices (KAP) towards these indicators at the conclusion of the project, as well as the changes in these indicators since the start of PSL. Where possible, these values are correlated with the level of exposure and participation in PSL-supported BCC activities. Qualitative information about the effectiveness of PSL in achieving its objectives and outcomes has also been collected.

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

- A quantitative survey of 911 female GFW of reproductive age (18-49 years old), randomly selected from factory worker lists (proportional to number of female workers in all four factories);
- In-depth qualitative interviews (IDIs) with eight factory infirmary staff and four human resources (HR) staff in the four target factories;
- Four focus group discussions (FGDs), evenly divided between married and single female GFW, and youth (age 18-24) and older workers.

As part of the quantitative study, 100 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. Through the random sampling of workers, 107 women that fulfilled this criteria were able to be interviewed. Because this sample was acquired holistically within the overall sampling framework, there was no difference in the probability of selection for these women relative to the overall sample, and thus sample weights were not needed for the endline. This is similar to the baseline, where sample weights were not used. Sample weights have been applied for the midline values, based on the weights calculated at midline.

<sup>&</sup>lt;sup>1</sup> Save the Children International (SCI) is subject to Protecting Life in Global Health Assistance (PLGHA) and has not engaged in activities that are not compliant with PLGHA.



Where possible, comparability with the baseline and midline methodologies for representative sampling and analysis of the MERI indicators have been maintained, including in the sample selection, questionnaire development, data management and analysis. One exception is the sample selection methodology. At the baseline, workers were selected from dormitories and rental housing clustered near the target factories. The midline and endline samples were randomly selected from lists of all eligible female workers, and are thus more inclusive of the total female worker population, including workers that are more likely to live with family outside of group housing (generally older and married women). Because of the purposive selection of factories at the midline and endline, the study is only representative of factories at each survey round; 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.

## **Findings**

Overall, the indicators of project success detailed in the PSL MERI guidelines have increased since the start of the PSL project and calculation of baseline indicators. Of the 14 MERI indicators relevant to the garment factory activities, seven recorded a statistically significant increase from the baseline. These are excellent numbers, which highlight the efforts that Cambodia and the PSL project have made in improving SRHR.

Indicators of women's knowledge have undergone mixed changes. Although not a MERI indicator, nearly all women know of contraception and especially modern contraception (from three to 10 methods known). This is a significant increase from the baseline. Knowledge of pregnancy danger signs is still fairly low, and unchanged from the baseline (14%, compared to 8.7% at baseline). And, although knowledge of neonatal danger signs has risen significantly since the baseline (17.8%, compared to 3.8%), less than 20% of women that gave birth recently are able to name three danger signs of neonatal distress. Knowledge of the legality of abortion in Cambodia has nearly doubled since the baseline (from 8% to 15%), but is still quite low, even among women that have experienced an abortion.

There has been a significant increase in the use of modern contraceptive methods, from 10.6% at baseline to 25.2% of all women at endline. At endline, nearly half of sexually active women (43.1%) were using a modern contraceptive, compared to only 24.2% of sexually active women at the baseline. Use of LAPMs remains low, similar to CDHS 2014, and there was no significant change in the use of LAPM methods throughout the study period (13.5%, compared to 11.5% at baseline).

Female garment factory workers at the endline had a satisfied demand for modern contraception of 60.7%. This is greater than the satisfied demand for modern contraception in both the urban and general populations of married women, per CDHS 2014 (46.5% and 56.4%, respectively).

The indicator on contraceptive uptake post-abortion was only slightly higher than the baseline, with no statistically significant difference (38.3%, compared to 22.5% at baseline).

Although there was a significant change in the number of women that accessed reproductive, maternal and newborn health (RMNH) services in the last 12 months (11.5%, compared to 6.8% at baseline), the overall figure is still low. However, overall satisfaction with RMNH services has gone up significantly from 23.1% to



51.0% of women that accessed RMNH services, suggesting improvements in the quality of service delivery targeted toward factory workers. The use of financial support mechanisms has also risen exponentially from 6.9% at baseline to 30.1% at endline. This rise can be attributed to the initiation of National Social Security Fund (NSSF) support for health services, rather than specific project-based interventions.

Women's feelings of empowerment to discuss and use contraceptives and to refuse sex with their husband/partner have both increased significantly since the baseline. From only 5.3% of women at baseline, 25.0% of women now feel empowered to discuss and use modern family planning with their husband/partner in all situations. In addition, 17.6% of married/partnered women reported making their own informed decisions on sexual relations, contraceptive use and reproductive health care (Sustainable Development Goal Indicator 5.6.1).

Indicators of childbirth and antenatal care saw substantial increases. The number of women accessing four or more ANC visits increased from 69.5% at baseline to nearly universal adoption at endline (97.2%); there were similar increases for women that gave birth in the last 12 months (64.1% and 98.1%, respectively). Nearly all women at endline (99.1%) gave birth in a health facility with a skilled birth attendant (SBA); a significant increase from the same indicator at baseline (79.3%).

Results related to postnatal care were less significant. Although a positive increase was noted at the endline, there was no significant change in the number of women that had appropriate PNC visits from the midline or baseline (32.7%, compared to 25.2% at midline and 22.1% at baseline). There was a noticeable decline in the number of women who received postnatal counselling in contraceptive methods (30.8%, compared to 56% at baseline), but again this change was not significant.

#### **Effect of BCC participation**

*Chat!* and other BCC activities were found to have positive influences on many of these indicators, including knowledge and use of modern contraception, and women's empowerment. Participation in any BCC activity was correlated with significant increases in knowledge of modern contraceptive methods. Participation in these interventions was also correlated with improved knowledge of abortion legality, and uptake of modern contraception after an abortion. Participation in *Chat!* was directly correlated with increased use of modern contraception, increased use of RMNH services in the last 12 months, and empowerment to discuss and use modern family planning methods among all women at the endline. Many of these indicators showed changes across multiple socioeconomic groups (youth/older women, single/married women, etc.) indicating that BCC activities were inclusive of different types of women. Notably, differences in BCC activity participation among women of different educational levels at midline was no longer present at endline.

#### **Recommendations**

Although PSL is ending, there are some recommendations that could be made from the endline analysis for future garment factory interventions. The overall recommendation that can be made from these findings is that future activities should be more targeted to specific sub-groups and areas of unmet need. Knowledge of contraception is nearly universal among WRA in Cambodia, including among female garment factory



workers in our study. Further contraceptive activities could thus target women specifically based on either high need (sexually active women who want birth spacing/limiting) and/or low utilisation; e.g., women in specific sub-groups with lower utilisation, such as younger women (under 25 years old) and those with higher education. Other recommendations that may be helpful for future projects on topics with similar populations, and include:

- **Increase knowledge in specific areas.** The knowledge areas with the greatest potential for improvement after the endline are:
  - Pregnancy danger signs;
  - Neonatal danger signs;
  - Legality of abortion;
  - Safe abortion providers.
- Focus on increasing utilisation of LAPM. Future interventions could focus specifically on the promotion of LAPM. Efforts could include vouchers for LAPM at trained healthcare providers that have partnered with the project (public, private, or NGO providers), promotional materials and communication campaigns specifically targeted to LAPM, and discussions with women in target factories to understand and assuage their reasons for hesitancy in using LAPM.
- Improve contraceptive counselling and uptake of modern contraceptive methods after birth and abortion. Future programs or activities could focus on improving contraceptive knowledge and utilisation in these situations, where women clearly have a need for contraception (either for birth spacing or limiting) which this study shows is not being met. Such an intervention would likely need to be undertaken in collaboration with local, external medical providers (public and private) to be most effective.
- Enhance understanding of the importance of follow-up visits after childbirth (PNC2). Further work could therefore be done to emphasise the importance of these follow-up visits at medical facilities, for the health of both mothers and children.



	Baseline	Midline	Endline
O1.4. #/% of women delivering in a health facility	79.3%*	00.0%	00.1%
with a skilled birth attendant (FTIRM)	(80%)	99.0%	99.1%
O2.1. #/% of target population using modern			
contraception (FTIRM)	10.6%*	20.3%*	25.2%*
- All women of reproductive age	24.2%	40.4%	43.1%
<ul> <li>Sexually active women of reproductive age</li> </ul>			
O2.2. % of women (modern family planning users)			
using long acting or permanent methods (LAPM) of	11.5%	15.0%	13.5%
family planning			
O2.3. % of garment factory workers accessing	6.8%*	10.5%	
reproductive, maternal or neonatal health (RMNH)	(8.6%)	(9.9%)	11.5%
services in the previous 12 months	(/	()	
O3.1. % of women receiving Comprehensive			
Abortion Care (CAC) who receive post abortion	22.5%	56.0%*	38.3%*
family planning			
O3.2. % of women attending postnatal care (PNC)	56%	33.3%	30.8%
who receive counselling in modern FP methods			
03.3. % of target population who report being highly	23.1%*	39.1%	51.0%*
Satisfied with RivinH services provided			
O4.1. #/% OF women attending four or more	60 60/* (70 60/)	06 19/	07 20/
Most recent delivery	09.5% (70.0%)	90.1%	97.2%
- Most recent delivery - Delivery within the past 12 months	04.170 (02.170)	90.570	50.170
- Derivery within the past 12 months O(1.2, #/% of women receiving two or more PNC			
visite	22.1%	25.2%	37 7%
- Most recent delivery	12 5%	27.6%	24 5%
- Delivery within the past 12 months	12.370	27.070	21.370
13.1. # /% of target population accessing RMNH			
services using a financial support mechanism in the	6.9%	3.2%	30.1%*
previous 12 months	(11%)		
I4.1. % of women of reproductive age who can	0 70/*		4.40/
identify three danger signs during pregnancy	8.7%*	17.5%*	14%
I4.2. % of target population who can identify three	2 00/*	25 00/*	17 00/*
danger signs for neonatal distress	3.8%*	35.9%*	17.8%*
I4.3. % of women who feel empowered to discuss	5.3%*	71 00/	25.0%
and use modern family planning	(5%)	24.070	23.0%
I4.4. % of women who know that abortion is legal	7.9%* (8%)	16.5%	15.3%

#### Table 1: Master list of MERI indicators

\* Statistically significant (p≤0.05)

Note: All indicators were re-calculated at endline; where the endline value differed from previous figures (e.g., due to changes in indicator terms), the previous value is given in parentheses. The values calculated at endline were used for significance tests of all indicators.



## Introduction

Partnering to Save Lives (PSL) is a collaboration of three non-governmental organisations (NGO) in Cambodia (CARE International in Cambodia, 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 Road Map for Reducing Maternal and Neonatal Mortality (FTIRM) (MOH, 2010) 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 \$7 billion per year (ILO, 2017). 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, living 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**

Baseline and midline surveys conducted at the initiation and midway through the project (in 2014 and 2016, respectively) established pre-intervention and periodic levels of knowledge, attitudes and practices (KAP) of female garment factory workers (GFW) in the target areas. The overall objectives of the endline survey are to:

- Review the MERI indicators related to female garment factory workers across baseline, midline and endline;
- Determine the level of progress and achievement of the project at outcome level, with a focus on outcomes 1, 2, 3, and 4;
- Identify possible reasons or factors for any changes observed.

The findings in this study will be incorporated into the final review process, and used to understand the effectiveness of PSL implementation.

## Methodology

The endline study utilised a mixed methods approach, incorporating both quantitative measures of knowledge, attitudes and practices, and qualitative knowledge of garment factory staff and workers, 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), the midline survey conducted by Angkor Research, and PSL's MERI indicators has been maintained. Specific activities conducted for this study were:

- Quantitative interviews with a target of 900 women of reproductive age (15-49 years old) currently working in one of the selected garment factories receiving PSL intervention, and who have been working there continuously for at least the last three months before the interview;
- Qualitative, in-depth interviews with one to two garment factory infirmary and human resource (HR) staff per factory;
- One focus group discussion (FGD) in each factory, among respondents of the quantitative interviews purposively selected based on marital status (married/partnered and single) and age (youth age 18-24 and workers over age 24).

Per the baseline calculations, 900 women of reproductive age (WRA) were targeted for this survey (Table 2). This number was calculated to provide a 95% confidence interval for the results, with a one-sided power direction of 80%, and a design effect of 2 (PSL 2014). Female reproductive age is commonly defined as 15-49 years old; however, the youngest garment factory worker identified in the endline was 18 years old (compared to 17 years old at the midline, and 16 years old at the baseline). The other eligibility criteria was that women must have worked continually at the target factory for at least the last three months before the day of the interview. This was a new criteria introduced at the endline to ensure respondents had sufficient time to participate in PSL activities.

	Total GFW	Female GFW	Target sample	Total sample	WRA without recent birth	WRA with recent birth	Overall response rate
Baseline	11,576	10,179	900	909	829	80	94%
Midline	13,140	11,580	900	905	802	103	97%
Endline	11,113	9,651	900	911	804	107	88%
Total	35,829	31,410	1,800	2,725	2,435	290	

#### Table 2: Samples and response rates, all three survey rounds.

The four factories in the sample were purposively selected by PSL, based on involvement in the midline. Efforts were made to ensure the same factories from the midline were included in the endline. Three midline factories agreed to participate in the endline, but one of the factories had closed since midline. To compensate for this loss, one additional factory was selected by PSL based on their level of involvement with PSL activities. The number of WRA to be interviewed in each factory was then determined proportional to the total number of women 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. WRA were randomly selected from lists of all current female workers, as provided by factory management, using a random number generator to ensure an equal probability of selection. All four factories allowed field staff to conduct interviews within the factory during working hours. Interviews were conducted in a private conference or meeting room, to ensure confidentiality; all interviews took place in January, 2018.



Within the initial target sample of 900 WRA, 100 WRA that had given birth within the last 24 months were purposively targeted, proportional to the overall sample in each factory. This sub-sample was targeted 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 may 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. Contrary to the midline, where these women had to be oversampled during fieldwork, the random sampling of WRA at the endline yielded sufficient numbers of women with birth events in the last 24 months that further oversampling was not needed.

In total, 1,078 WRA were selected and approached for the survey, of which 1,033 met eligibility criteria. 911 of these women gave their informed consent and completed the quantitative interview, including 107 women that gave birth in the last 24 months. This is an 88% response rate. Most of the non-response was due to absences (after three attempts to interview) and third party refusals by managers due to deadlines for certain production lines.

The current endline 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 areas. See the Limitations section, below, for further cautions in the interpretation of the data.

	Target	Complete	Proportion	Selection method
Factory	4	4	4/16	Purposive
Female GFW (WRA)	900	911	Proportional to WRA in factory	Random (worker lists)
WRA that gave birth in last 24 months	100	107	Proportional to WRA in factory	Random (worker lists)
IDI: Infirmary staff	8	8	2 / factory	Purposive (infirmary staff)
IDI: HR staff	4	5	1-2 / factory	Purposive (PSL involvement)
FGDs (GFW)	4	4	1 / factory	Purposive (PSL involvement)
Single WRA, age 18-24	6 - 10 WRA	9		Purposive
Married WRA, age 18-24	6 - 10 WRA	8		Purposive
Single WRA, age 25-49	6 - 10 WRA	9		Purposive
Married WRA, age 25-49	6 - 10 WRA	8		Purposive

Table 3: Endline sample, selection	on methodology and response rates
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#### **Qualitative data**

In addition to the individual quantitative interviews with eligible WRA, qualitative data was also collected from garment factory infirmary and HR staff, and female GFW. Qualitative data was collected using IDIs (factory staff) and focus groups (workers). Both types of data explored the issues around the MERI indicators of success, including participation of factories and individuals in the behaviour change



communication (BCC) and *Chat!* activities, as well as understanding and use of RMNH services, including contraception. Respondents also gave their opinions about the activities, and recommendations for improvement.

For infirmary staff IDIs, field staff interviewed all available staff at each infirmary (two people in each factory). For HR staff, the HR staff member that had the primary contact with PSL and partner NGO staff was targeted for the IDI. In one factory where it was unclear who the primary member was, two HR staff IDIs were conducted to ensure that the appropriate data was captured. All interviews were conducted within the factory grounds in a private meeting room or office. A total of eight infirmary staff and five HR staff were interviewed at endline.

For FGDs, field team supervisors selected respondents that completed the quantitative survey and had the most exposure to PSL activities, or the most involvement with RMNH services, as these women could best provide information about the success and implementation of PSL activities. FGDs were organised by three criteria – factory, marital status, and age – to understand the different needs and exposure of these groups to PSL. One FGD was conducted with each group. Approximately 10 respondents were invited to participate in each FGD. Between eight and nine respondents participated in each FGD, for a total of 34 women in all four FGDs (Table 3). FGDs took place in the factory, when factories were willing to provide time for the workers to participate, or outside the factory in a quiet, private location (such as a meeting room at the local pagoda).

#### Questionnaires

The quantitative survey questionnaire was derived from the midline questionnaire, which was based on the baseline instrument. The overall structure and format of the original questionnaire was maintained, as was the phrasing of most questions in both English and Khmer, to ensure comparability with the previous survey rounds. Where necessary, changes were made in cooperation with PSL staff. At the endline, these included:

- Changes to the maternal and neonatal health sections, including definitions of postnatal care (PNC), to comply with changes in the latest Safe Motherhood Clinical Management Protocol for Health Centres (MOH, 2016);
- Slight changes to the wording of the questions on disability, to incorporate changes to the Washington Group module;
- Changes to the timeframe and exposure to PSL activities. The timeframe from the midline (the last three months) was limited at the endline as some PSL activities had already concluded more than three months ago. The decision was made to add questions about any exposure to PSL activities (including *Chat!*), as well as exposure in the last three months, to be comparable with the midline;
- Reasons for not using or discontinuing use of contraception in the last 12 months;
- Demand satisfied for modern contraception. The module for this indicator in the Cambodia Demographic and Health Survey (CDHS) 2014 was adopted for this study. It is designed to understand the satisfied demand and unmet contraceptive need among WRA. This module was not in either the baseline or midline.



Where these changes have been implemented, the differences with the midline and baseline have been explained in their respective results sections and the MERI indicators.

#### Analysis

#### Weighting

At the midline, the results were weighted to account for the oversampling of women that gave birth in the last 24 months in the sample. This weight was based on the prevalence of these women in the baseline (8.8% of the sample), and was applied to the results for general population indicators (Table 4). For the maternal and neonatal health indicators, which only apply to these women, no weighting of results is necessary.

At the endline, the target sample of 100 women with a recent birth was achieved naturally within the randomly selected workers, and oversampling was not required. Although the prevalence of these women was higher at endline than at baseline (11.7%, compared to 8.8%), the probability of selection of all respondents is the same and thus weighting of the endline results is not necessary. Within the comparative analysis of indicators by survey round, the midline results are weighted the same as at the midline. The baseline and endline results are not weighted. In general weighting only slightly affected the results, with a  $\pm 0.1\%$  -0.2% difference from the non-weighted findings.

Factory ID	WRA birth ≤24m	Midline Population	Baseline Target	Weighting coefficient
Factory 1	Yes	11.5%	8.8%	76.4500%
Factory 2	Yes	10.9%	8.8%	80.8762%
Factory 3	Yes	11.0%	8.8%	80.0585%
Factory 4	Yes	12.5%	8.8%	70.4000%
Factory 1	No	88.5%	91.2%	103.0634%
Factory 2	No	89.1%	91.2%	102.3349%
Factory 3	No	89.0%	91.2%	102.4627%
Factory 4	No	87.5%	91.2%	104.2286%

## Table 4: Sample weighting coefficients for WRA with/without childbirth in the last 24 months (midline only).

At the endline, data was analysed across the three different survey rounds, as well as between groups with different exposure and participation to the BCC and *Chat!* activities. Specific data was also analysed by age, education, disability status, wealth (salary), and parity (number of live births), depending on the relevance. Where possible, the indicators have been measured in the same way as the baseline and midline (and in line with the definition and indicator measurement provided in the MERI framework). Where differences are unavoidable (e.g., due to changes in the methodology) they have been clearly defined and explained.

Comparative analysis between the rounds includes tests of statistical significance at standard levels of significance (p value less than or equal to 5%). Where results were significantly different, they are indicated with an asterisk (\*) in the tables. All MERI indicators were tested for statistical significance between the



survey rounds. However, because of differences in sampling and worker selection between the survey rounds, caution should be taken when correlating statistically significant differences in indicators with project activities. The use of asterisks to indicate significance between the values in the three survey rounds was as follows:

- If only one value has an asterisk, that value is significantly different than both other values (e.g., if the baseline value is different from both the midline and the endline, but midline and endline values are not different from each other);
- If two values have asterisks those values are significantly different from each other, but the value without an asterisk is not significantly different from the other two values (e.g., if the baseline and endline values are different from each other, but the midline value is similar to both the baseline and the endline);
- If all three values have asterisks, all values are significantly different from each other.

#### **Changes from midline**

Some of the changes adopted at the midline were carried through to the endline. These are:

- The use of worker lists provided by the factory to conduct random sampling of all eligible female workers in each factory. The baseline identified clusters of worker residences and interviewed workers at these residences, which favoured workers that live in group accommodations and excluded those living far from the factory and those in single family housing.
- The focus on women that gave birth in the last 24 months. While the midline required oversampling to achieve the target, the target sample of 100 women with recent births was achieved in the course of the random worker selection. Weighting of results for these women was therefore not necessary for the endline.

There were a few differences in the sampling methodology and framework from the baseline and midline to the endline. These were:

- The use of computer-assisted personal interview (CAPI) devices (tablet computers) to conduct the quantitative interviews at endline. The use of CAPI allowed field staff to more thoroughly screen respondents for eligibility before the interview, which is one of the reasons for the lower response rate at the endline.
- At the endline, all four target factories agreed to provide access during work hours, allowing field staff to interview workers within the factories. This improved the speed and efficiency of the endline data collection relative to the baseline and endline and ensured a random, representative sample of all female workers in each factory. The cooperation of the factories with PSL and the endline research team should therefore be commended.
- Qualitative IDIs were conducted with HR staff in each factory to help PSL understand how factories perceived the implementation and success of project activities.

#### Limitations

Because of the purposive selection of garment factories for the midline and endline, the data collected is representative of only those specific factories, not all factories where PSL conducted activities. Unique



conditions and implementation in the other targeted factories may differ from those of the 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). This sampling change was made at the midline to ensure that the sample was accurately representative of all female workers in each of the target factories, rather than those that only lived in group housing close to the factory. Any 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 context.

This study was designed to be able to compare differences across time in similar populations. The lack of a control group and a consistent sample (e.g., longitudinal interviews of the same respondents across all survey rounds) means that these changes cannot be attributed to any single factor, either PSL or other influence. The study results report whether a change has occurred in the population of WRA in the four target garment factories, and whether that change was different – at a statistically significant level – from the indicator values at the previous survey rounds. Comparisons with *Chat!*/BCC populations have the same limitations. These changes can therefore not be directly ascribed to PSL activities.

The quantitative questionnaire has been slightly revised from the baseline and midline. This has been done for many reasons, including: to reflect changes in national RMNH indicators, and alignment with FTIRM and the Safe Motherhood Clinical Management Protocol for Health Centres (e.g., differences in PNC definitions); to include additional data requests by PSL partners (such as demand satisfied for modern contraception); to ensure questions are relevant to recent programming in each factory (e.g., changes in timeframe for PSL exposure); and to improve questionnaire flow and ease of interviewing (e.g., skip patterns). Such differences may affect the interpretation of results, and thus the comparability with the previous baseline and/or 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 underreported 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 BCC activities, and in the reporting of functional impairment (disability), whereby levels may be overestimated. On the other hand, social desirability bias may cause women to underreport undesirable activities (such as premarital sex or abortion), and recall bias may cause women to underreport their participation in BCC, depending on the time that elapsed since the activities (i.e., more recent activities are more likely to be remembered). Mitigation efforts included the use of neutral phrasing in the questionnaires, the use of independent research staff (who are not involved with PSL), and training that these questions were to be delivered in a neutral, non-judgmental way. There may also be a spillover effect present, whereby even women who did not participate in BCC activities have received the same knowledge through interactions/discussions with participants. Care should thus be taken in interpreting the results described below.



## Socio-demographic Characteristics

Table 5, below, details the basic demographic and social characteristics of the female GFW interviewed in all three survey rounds.

The average age of women in the study at the endline was 28 to 29 years old (mean 29.1; median 28). This is slightly older than the midline (26 - 27 years old) and the baseline (25 - 26 years old); the differences of which are significant, although all within four years of each other. One of the reasons for this difference is the baseline sampling method. The baseline sampling over selected women that live in group housing close to the target factories, who are generally younger and single. This is reflected in the age groups, where nearly half of the women surveyed at baseline (48.3%) were classified as youth (16 – 24 years old), as opposed to only one-quarter of women at the endline (24.6%).

Among women that had some education, the average grade completed was grade 6. Around 5.2% of women had no formal schooling – a number which was consistent across survey rounds. Over half of women had completed at least primary school in each survey round. The education level of women at endline was slightly lower than at midline and baseline. This may be because, generally, older people in Cambodia have lower educational attainment than the younger generations. This is consistent with educational trends seen in CDHS 2014, where young women (age 20-24) had an average of 6.5 years of school (median value), compared to only 2.3 years of school for the oldest WRA (age 45-49).

Over half of the women at the endline (59.2%) were married/partnered; a significant increase from the midline. The number of single women has dropped proportionally as well, from 43.2% to 31.1%, while the number of previously married women has stayed steady at less than 10% of WRA. This increase in married women may be a function of the rising age of the sample, as older women are more likely to be married.

Around half of the women (53.0%) surveyed in 2017 had children. Only married/partnered and formerly married workers reported having children; on average these women had one child each. This metric was not captured at baseline or midline, so comparison is not possible.

Only around one in seven workers (13.5%) were living by themselves in 2017. This is, however, more than double the number of workers living alone at midline and baseline; differences which are statistically significant. Workers living with other people tended to live with their relatives and/or spouse. Other workers lived with their parents or friends. Living with a sweetheart was very uncommon; only three to four women reported living with a sweetheart at each survey round. In line with increases in age and changes to marital status, women in the endline were more likely to live with their spouse than at the midline.



	Baseline (n=909)	Midline (n=905)	Endline (n=911)
Age in years, mean (median)	25.8* (25)	27.1* (26.0)	29.1* (28.0)
Age 16-24	48.3%*	37.9%*	24.6%*
Age 25-34	41.9%*	50.5%	55.1%
Age 35-49	9.8%	11.6%	20.3%*
Education			
No schooling	4.2%	4.7%	5.2%
Completed primary (grade 6)	63.3%	59.7%	54.0%
University level	0.2%	0.1%	0.3%
Highest grade completed, mean		(2)	Г 9* <i>(С</i> 0)
(median)	0.5 (7.0)	0.2 (0.0)	5.8 (0.0)
Marital status			
Single	38.9%	43.2%	31.1%*
Married/partnered	53.0%	49.9%	59.2%*
Widowed/divorced	8.0%	6.9%	9.8%
Has children	-	-	53.0%
Lives alone	4.5%*	7.3%*	13.5%*
Cohabitation *			
With relatives (including children)	50.6%	60.8%	63.3%
With spouse	27.5%	39.8%*	53.2%*
With parent	7.0%	11.8%	14.3%
With friends	14.2%	10.0%*	6.1%*
With sweetheart	0.3%	0.4%	0.5%
Other	0.3%	0%	0.1%
Experience in garment industry, in mean	/ 1* (3 0)	5.6* (4.0)	6.8* (6.0)
years (median)	4.1 (5.0)	5.0 (4.0)	0.8 (0.0)
Experience in target factory, in mean	_	_	3 0 (3 0)
years (median)			5.5 (5.0)
Total income in previous month, in mean	\$142.05* (\$138)	\$208.41* (\$204)	\$253.36* (\$250)
\$ (median)	<i>+</i> = · <b>1</b> ·00 ( <i>+</i> <b>1</b> 00)	+(+01)	+======================================
Sent money to family last month	-	67.3%*	75.9%*
Remittance value last month, in mean \$	-	\$102.66* (\$100)	\$114.01* (\$100)

Table 5: Socio-demographic characteristics.

\* Statistically significant (p≤0.05)

<sup>†</sup>*Multiple responses at midline/endline (the sum of values may be greater than 100%). These values are not comparable with baseline.* 

Women interviewed at endline were also more experienced in garment factories, with an average of 6-7 years of experience (mean 6.8; median 6), compared to 5-6 and 3-4 years at midline and baseline, respectively. At endline, around half of their garment factory experience was in their current garment factory (mean 3.9; median 3 years).

Women at endline earned around \$40 more than women at the midline. This may be due to their increased experience at endline, but also to increases in the minimum wage since 2016, from \$140 to \$153 (ILO, 2017). Average incomes at the endline were around \$250, compared to \$208 and \$142 at midline and baseline, respectively. These differences were also statistically significant.



Women at endline were also more likely to send remittances to other family members; around threequarters of women (75.9%) sent remittances in 2017, compared to around two-thirds of women (67.3%) in the 2016 midline. On average, these women sent over \$100 in remittances in the last month; slightly less than half of their monthly income. Although there was an increase in the mean value of remittances sent from midline to endline, remittances as a percentage of monthly income fell slightly, from 49.3% to 45.0% of income last month (as a proportion of mean values).

## Disability

As with the previous survey rounds, the presence and severity of functional impairment was measured among female workers using the Washington Group on Disability Statistics (or Washington Group) Short Set on Functioning (WG-SS). This is an internationally recognised method of assessing individual disability, and covers six domains: seeing; hearing; walking/climbing stairs; remembering or concentrating; self-washing and dressing; and communicating. The Washington Group is a working group tasked by the United Nations Statistical Commission to develop measures of disability suitable for censuses and surveys.<sup>2</sup> 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. They allow individuals to judge and interpret their own impairments across a number of functions, and are therefore highly subjective. The same module was used in CDHS 2014; however, given the highly individual nature of the results, comparisons between population groups should be made cautiously.

The Washington Group recommends analysing the short set of questions using four thresholds of functional impairment (Washington Group, 2017):

- DISABILITY1. This is the most inclusive measure of disability, where a respondent indicates some, a lot, or full impairment in at least one domain;
- DISABILITY2. This cut-off is used when a respondent reports at least some difficulty in at least 2 domains, or full impairment in at least one domain;
- DISABILITY3. Classified as having a lot or full impairment in at least one domain;
- DISABILITY4. The most severe form of impairment, classified as having full impairment in at least one domain.

The Washington Group recommends using DISABILITY3 to identify individuals that are considered to have a functional impairment or disability. This threshold will thus be used throughout this report.

At the endline, 5.2% of women reported a severe lack of ability to perform key functions in at least one domain (Table 6). This was a significant decline from the baseline prevalence of 8.8%, but an increase from the midline (3.6%). However, the difference from midline to endline is not statistically significant. No women reported a complete lack of ability in any of the disability areas in any survey rounds.

https://www.cdc.gov/nchs/washington\_group/index.htm (last accessed 11 April 2018).



<sup>&</sup>lt;sup>2</sup> For more information on the Washington Group, see website:

The incidence of severe lack of ability among female garment factory workers at endline is more than twice the prevalence among women in the general population (2.3% among all women older than 5 years old, from CDHS 2014). But, it is important to remember that the WG-SS is highly subjective and based on selfreported data. One explanation for the higher rate of reported impairment could be that garment factory workers perform routine manual labour, and experience physical tiredness after conducting these tasks for long periods of time; e.g., after using a sewing machine for 8 hours, they may report difficulty seeing or concentrating. We could also consider that the workers in this study are older than the average woman in the general population – 28-29 years old, compared to 26 years in the average population (CIA, 2018) – and that disability increases with age.

The most common disability workers mentioned was remembering/concentrating; this was true for both inclusive and exclusive disability, and across all three surveys. Up to half of workers (49%) at the endline reported having some difficulty remembering or concentrating, with an additional 2% reporting a lot of difficulty. This was followed by difficulty seeing (23% at endline). Difficulty communicating in one's native language (17% at endline), and difficulty hearing (14% at endline), were also frequently reported across all survey rounds. Self-care was the least reported difficulty among all six metrics, with less than 1% of female workers reporting some difficulty with self-care at the endline.

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
DISABILITY3	8.8%*	3.6%	5.2%
Difficulty seeing, even if wearing glasses			
No difficulty	75.2%	71.0%	74.5%
Some difficulty	20.7%*	27.8%*	23.3%
A lot of difficulty	4.1%*	1.1%*	2.2%
Difficulty hearing, even if using a hearing aid			
No difficulty	88.1%	88.1%	85.3%
Some difficulty	10.2%*	11.2%	14.2%*
A lot of difficulty	1.7%	0.7%	0.5%
Difficulty walking or climbing stairs			
No difficulty	86.0%	92.3%*	88.4%
Some difficulty	11.7%	7.2%*	11.0%*
A lot of difficulty	2.3%	0.5%	0.7%
Difficulty remembering or concentrating			
No difficulty	69.7%	64.7%	48.6%*
Some difficulty	25.9%*	32.9%*	49.1%*
A lot of difficulty	4.4%*	2.4%	2.3%
Difficulty with self-care, such as washing all over	or dressing		
No difficulty	96.8%*	98.7%*	99.8%*
Some difficulty	2.9%*	1.2%*	0.2%*
A lot of difficulty	0.3%	0.1%	0%
Difficulty communicating, for example understanding or being understood in one's usual (customary)			
language			
No difficulty	90.0%	92.0%	82.5%*
Some difficulty	9.3%	8.0%	17.0%*
A lot of difficulty	0.8%	0.0%	0.4%
* Statistically significant (p≤0.05)			

#### Table 6: Reported levels of functional impairment in each domain, by survey round.



Youth were least affected by disability across each survey round (Figure 1). Reporting a severe lack of ability in any of the target domains increased with age across all three survey rounds, in line with trends seen in national population surveys (i.e., CDHS 2014).



Figure 1: Prevalence of severe functional impairment (DISABILITY3) by age, all survey rounds.

Workers that identified themselves as having a severe functional impairment also had lower incomes than workers with no impairment or a minor impairment (Table 7). This difference is statistically significant when the data from all three survey rounds (baseline, midline and endline) is analysed together. Women reporting a lot of difficulties earned on average 7.6% less per month than women without a disability.

Table 7: Monthly income, by disability status (all survey rounds combined; h=2,725).				
	No disability (n=2565)	DISABILITY3 (n=159)		
Mean income, in US\$ (median)	\$202.21* (\$200)	\$186.74* (\$179)		
* Statistically significant ( $p \le 0.05$ )				

Table 7: Monthly income, b	y disability status (all survey	rounds combined; n=2,725).
	No disability (n=2565)	



## Media Access and Use

Female garment factory workers were asked about their media behaviours. Although not captured at the baseline, these metrics are important to understand how female GFW access information and the most effective ways that projects like PSL can reach their target audience.

Nine out of ten women reported owning a mobile phone in both the endline and midline (89.1% and 91.9%, respectively) (Figure 2). These are increases from the baseline mobile phone ownership rate (81.6%). The availability of smartphones has gone up considerably since the midline; close to two-thirds of women (62.3%) at endline report that they have a smartphone and use it to access the internet, compared to 43.3% of women at the midline (this metric was not available at the baseline).



Figure 2: Smartphone and mobile phone ownership, at midline and endline.

Nearly all women at both the midline and endline also said that they had access to some form of media in the last week (93% and 94%, respectively). This includes print media (newspapers, magazines), radio and television, as well as the use of the internet and Facebook to access any of these media.<sup>3</sup> However, there have been significant changes in the type of media that women access. Whereas television and radio were the most common forms of media used at the midline, Facebook and the internet have now become the most common media platforms (Figure 3:). Nearly three-quarters of women (73.0%) with any media access reported using Facebook in the last week; two-thirds (63.7%) reported using the internet in general in the last week.

Television is the only traditional form of media still used by more than half of the respondents; 54.2% of women said that they watch television at least once a week – a decline of 27.3 percentage points since the midline. Radio was still used by around one-third of women (33.1%), but print newspapers and magazines were only accessed by around 2.2% and 5.1% of women, respectively.

<sup>&</sup>lt;sup>3</sup> Some Cambodians make a distinction between accessing the internet through Facebook and through other websites, so they were separated in the questionnaire for this study.





Figure 3: Media accessed at least once a week, among female GFW with weekly media access (\*statistically significant between the survey rounds for this metric).

Asked to name the most important forms of media, over 40% of women said that Facebook was their primary source for media (Figure 4), with television being the second most common source of primary media. This is a reversal from the midline, when television was the first source and Facebook was the second. The Internet (ex-Facebook) is now the third most common primary media form, displacing radio. All of these differences are statistically significant, with the exception of printed media, which were the primary media for only around 1% of women in both surveys.



Figure 4: Primary media source, among female GFW with weekly media access (\*statistically significant between the survey rounds for this metric).



Looking at primary media source among women with different characteristics at the endline, the women that use Facebook the most are single youth with a secondary education (Figure 5). Older women tended to use television and radio more than younger women. Married/partnered and previously married women used Facebook as their primary media source, but they also tended to use traditional media (primarily television) more than single women. Women with the lowest education level (no school / did not complete primary) tended to have television as their primary media source, all other educational groups had Facebook as their primary media source. The use of Facebook increases with education level, while television has the opposite trend.



Figure 5: Primary media source by age, marital status and education level, among women with any media access at endline (n=855).

## Receipt of reproductive health information

The garment factory workers were asked to rate the different ways that they receive information about contraception and reproductive health. In order to do this, they were shown cards with different information sources on them (internet, Facebook, friends, factory infirmary staff, etc.) and asked to rank these sources based on how frequently they receive reproductive health information (or to imagine how often they would use this source, in the case of women who have not accessed any reproductive health information). Baseline information on this metric is not available.

The most trusted sources of information on reproductive health are still individuals: health centre staff and family/friends/colleagues (Table 8). Health centre staff are still the most important information source, while family/friends/colleagues has moved up to become the second most important source. The importance of factory infirmary staff has declined from 2<sup>nd</sup> to 5<sup>th</sup> place, while television and Facebook have both jumped to become the 3<sup>rd</sup> and 4<sup>th</sup> most important sources, respectively. The use of the internet for reproductive health information also increased slightly. Notably, the importance of NGO staff or activities



has declined slightly. This may be partly due to the cessation of PSL related activities, where NGOs are no longer as visible in the factories, or to other reasons.

## Table 8: Ranking of reproductive health information sources, from most important (1) to least important(9), by survey round.

	•		
	Midline (n=905)	Endline (n=911)	Change from Midline
Health centre staff	1	1	_
Family / friends / colleagues	3	2	+1
TV	5	3	+2
Facebook	7*	4*	+3
Factory infirmary staff	2*	5*	-3
Radio	4*	6*	-2
Internet	8*	7*	+1
NGO staff / activities	6*	8*	-2
Leaflet / banner / T-shirt	9	9	_
* Statistically significant (p≤0.05)			

## **BCC participation**

CARE and Marie Stopes implemented some BCC activities in factories. In the first half of the project, these included peer educator activities, health promotion activities during lunchtime, and distribution of information, education and communication (IEC) materials such as posters, leaflets, booklets, banners and *Knhom Samrab Nak* hotline cards. During the third year of PSL, these BCC activities were replaced by the *Chat! Contraception* package (*'Chat!'*), which included eight interactive training sessions, five male engagement sessions, three video dramas with guided discussions, and a mobile quiz application, along with posters and promotional materials. During the last year of PSL, an abridged version of *Chat!* was directly implemented by garment factory focal points, with monitoring and support from CARE.

At the midline and endline, women in each factory were asked about their exposure to contraceptive information in the factory via any BCC activities. The use of the term "BCC" throughout this report refers to any contraceptive information materials and/or specific activities, regardless of branding or source. The use of BCC as a generic term therefore includes all *Chat!* activities, as well as "other BCC" activities which may have occurred in some factories throughout the PSL implementation period. Aside from *Chat!*, the source of other BCC activities was not inquired about at the midline and endline, as many women are not aware or do not pay attention to this.

Overall, nearly nine out of ten female workers (88.7%) had participated in any BCC activity by the time of the endline survey (Table 9). This is an increase from the midline, when 82.2% of women had participated in any BCC activities in the last three months before the midline interview. Although slight, this increase is statistically significant. When looking at this number, it is important to remember that garment factories can have high staff turnover, and thus prevalence of women still in the factory may not be reflective of the total number of women who participated in the activities.



	Midline (n=905)	Endline (n=911)
Any BCC exposure (ever)	82.2%*	88.7%*
Any Chat! activity exposure	(n=512)	(n=727)
Ever	_	52.3%
Last 3 months	41.2%*	9.9%*
Chat! videos		
Ever	-	44.0%
Last 3 months	34.0%*	5.5%*
Chat! session		
Ever	-	26.4%
Last 3 months	17.6%*	5.5%*
Chat! mobile game		
Ever	-	4.3%
Last 3 months	3.3%*	1.4%*
	(n=905)	(n=911)
Any other BCC activity exposure (ever)	80.8%*	85.3%*
Contraceptive advertising (last 3 months)	73.5%*	67.6%*
Poster/leaflet/hotline card (last 3 months)	42.5%*	26.3%*
Lunchtime SRH meeting		
Ever	-	39.4%
Last 3 months	19.7%	_
Interaction with peer educator		
Ever	_	36.8%
Last 3 months	28.8%	_
* Statistically significant (p≤0.05)		

## Table 9: BCC activity exposure and participation, by survey round.

#### **Chat! participation**

*Chat!* activities involved the use of videos, a smartphone game, and interactive training sessions with female and male GFWs. It was implemented in two of the sampled factories at midline and three at endline. In the factories where the *Chat!* activities were implemented, specific questions were asked about women's involvement in the interventions. Similarly to the general BCC activities above, women were asked about their involvement in the *Chat!* activities in the last three months, as well as any involvement since the activities started.

Recent participation in *Chat!* activities declined significantly between the midline and endline; 9.9% of women participated in any *Chat!* activities in the three months before the endline, compared with 41.2% at midline (Table 9). However, the overall participation in activities is more important at the end of the project than periodic involvement, and will be the focus of this section. Overall, by the time of the endline interview around half of women (52.3%) reported participating in at least one *Chat!* activity at any time while they were employed at the factory.



The most common *Chat!* activity was watching the *Chat!* videos. Overall, 44.0% of women had ever watched at least one *Chat!* video since the start of activities. Women that had ever watched any *Chat!* videos watched two videos on average (Table 10).

One-quarter of women (26%) had ever participated in a *Chat*! interactive training session; the second most common *Chat*! activity. On average, a woman that participated in any *Chat*! sessions went to 1 to 2 sessions (mean 1.8; median 1).

The *Chat!* mobile game was the least utilised *Chat!* activity. In total, only around 4% of women reported ever playing the *Chat!* mobile game. The number of game players has only increased slightly since the midline, even though overall smartphone ownership and access has increased significantly among the sample. Women who had ever played the *Chat!* mobile game played for less than one hour on average, and achieved level 4 - 5 (mean 5.1; median 4).

There were very few differences between different groups of women and their participation in *Chat!* activities. At the midline, *Chat!* participation was directly correlated with education level; only about one-third of the least educated women (35%) had recently participated in *Chat!*, as opposed to 85% of women that completed high school. However, this difference was no longer significant at the endline. Instead, married and previously married women tended to have more participation in *Chat!* than single women; over half of married and previously married women. The difference between single women and married/previously married women was statistically significant at endline.



Figure 6: *Chat!* participation among workers in factories where *Chat!* was implemented at midline (n=512) and endline (n=727) (\**indicates statistically significant difference between midline and endline values*).



Table 10: Level of participation in Chat! activities, among workers in factories where Chat! wasimplemented at endline (n=727).

	Mean
Number of <i>Chat!</i> videos ever watched (median)	2.0 (2)
Number of <i>Chat!</i> sessions ever attended (median)	1.8 (1)
Total hours of <i>Chat!</i> mobile game played (median)	0.7 (0)
Max level on Chat! mobile game (median)	5.1 (4)

#### Other BCC participation

Because the lunchtime SRH meetings and peer educator activities were discontinued more than three months before the endline survey, women were only asked if they had ever participated in these activities. However, because the passive activities (contraceptive advertising and posters/leaflets/hotline cards) were still in the factories at the endline, women were asked if they had seen any of these items within the last three months, in order to be comparable with the midline and to reduce any issues with memory and recall.

At the endline, a large majority of women (85.3%) had been exposed to or participated in any of the other BCC activities mentioned. This is a slight but statistically significant increase from the midline (80.8%), following the overall BCC participation trend. The most common activity was seeing contraceptive advertising in the last three months, followed by posters/leaflets/hotline cards. Recent exposure to these BCC activities decreased by the endline, with around two-thirds of women (67.6%) seeing a contraceptive advertisement in the last three months, compared to around three-quarters of women (73.5%) at the midline. Similarly, only around one-quarter of women (26.3%) had seen a poster/leaflet/hotline card (*Knhom Samrab Nak*) in the last three months at endline – a decline from the midline (42.5%). This is not surprising, given the decrease in activities shortly before the conclusion of the PSL project.

By the end of the PSL project activities, around 40% of women had ever participated in a lunchtime SRH meeting (39%), and/or had a discussion with a peer educator (37%). Although not directly comparable with the midline results, these are considerable increases from the recent participation of workers at the midline.

Examining results from both survey rounds, youth (women age 16-24 years old) had less exposure to contraceptive advertisements than older women (age 25-49); 67.8%, compared to over 73% for older age groups. Single women were also less likely to be exposed to these ads than married and widowed/divorced women (66%, compared to 73.4% and 72.7%, respectively). Moreover, women who had no schooling or had not completed primary school (less than grade 6) had less exposure to posters/leaflets/hotline cards than women with at least a primary school education. All of these differences were statistically significant ( $p \le 0.05$ ). There was no significant difference in participation in other BCC activities among women may be due to their lack of need for contraception and thus, they are not internalising the ads/BCC materials even



though they may be exposed to ads at the same rates as other women in the same factory. The reduced exposure among women with lower education levels may be due to the limited literacy ability of these women.

Similarly to the contraceptive advertising, young women and single women had less participation in lunchtime SRH meetings. While there was no difference in lunchtime SRH participation by women with different education levels, women with limited formal education were less likely to have discussions with peer educators.

#### Perception and success of BCC activities

In the FGDs, many women reported that the BCC activities – especially the *Chat!* messages – were very helpful for them. Specifically, they learned how to avoid unwanted pregnancy and improve their health. Several older women (age 25-49) explained that this information helped them improve their living and financial situations.

Based on the qualitative interviews with infirmary and HR staff, the main success of *Chat!* was that it raised the knowledge and confidence of women on RMNH issues, allowed them to discuss personal problems, know about available RMNH services, and to enable them to plan their families. Respondents were glad that this impact was reached through entertaining IEC materials as it motivated workers to learn easily. Infirmary staff found this support very positive, as the workers gained knowledge, access to affordable contraceptive methods and other support services, and also continued to work efficiently.

Coverage by the PSL NGO partners was mentioned by the factory infirmary staff, who reported that the NGOs come frequently to provide information about contraception: "[BCC activities are] good not only for the worker, but also good for me. It provides a lot of information related to contraceptive methods, service fees, and also know about its side effects. The educational message is useful because before, they only heard about contraception from each other. But now, [the NGO partners] come to educate and explain directly. They are skilful at it. They tell us things related to all of the contraceptive methods, what are the side effects and benefits when we use it. I think it is good."

## **Health-seeking Behaviour**

In this section, the use of different health providers will be assessed. Here, the focus is on the use of the garment factory infirmary and/or referrals from the infirmary or peer educators to external health facilities for reproductive, maternal and/or neonatal health (RMNH) services.

#### Garment factory infirmary

Among female workers in the four factories surveyed, nearly all (99.9%) know that their factory





has an infirmary. Around three-quarters of women (76.5%) have used the infirmary in the last 12 months (Table 11). The large majority of women across all three survey rounds have visited the infirmary for minor health issues, such as stomach aches and headaches. Around 10% of workers at midline and endline also visited the infirmary for first aid or injury treatment, such as a cut or a needle stab (this option was not available at the baseline).

FGD respondents reported that many workers use the factory infirmary as it is convenient in terms of distance (close), cost (free) and time (efficient). "When we come to work and we are sick a little bit, it is hard for us to go outside and to avoid spending money," said one single worker. "It is easy and near workplace," said another.

Across all three survey rounds, RMNH issues accounted for a fairly small proportion of infirmary use. While the use of infirmaries for RMNH services rose to 11.4% at midline (from 3.3% at baseline), the use of RMNH services at endline was similar to the baseline (4.6%). The most common RMNH services at infirmaries were sexually transmitted infection (STI) counselling and referrals, family planning counselling and referrals, and general reproductive health counselling and referrals (1.1% each).

We go to the factory infirmary when we are a little bit sick, like for coining and ask to rest there. It does not cost money, the medicine is also good and the infirmary never complains if we come to ask for medicine more than once per day. When we sick they give us advice. – Single, FGD respondent

For most workers that did not use the infirmary in the last 12 months, the primary reason was because they had no need of

services (87.9% at endline). This was similar across all three survey rounds. All other reasons were mentioned by a minority of workers each, and at the endline included a lack of specific commodities (4.7%), ineffective medicines (3.7%) and a lack of specific health services (3.7%).

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
Use of factory infirmary in last 12 months	69.6%*	80.1%	76.5%
Infirmary services used +	(n=633)	(n=721)	(n=696)
Minor health problem	95.6%*	97.2%	98.1%*
Injury/first aid	-	8.9%	10.9%
Any RMNH service	3.3%	11.4%*	4.6%
Coining	-	2.4%	1.4%
Other (specify)	1.9%	0.3%	0.9%
Reasons for not using infirmary†	(n=276)	(n=179)	(n=214)
Did not require any health services / not sick	84.4%	87.2%	87.9%
No commodity available	1.8%	5.2%	4.7%

#### Table 11: Use of factory infirmary, by survey round.



	Baseline (n=909)	Midline (n=905)	Endline (n=911)
Medicine not effective	0.0%	4.6%	3.7%
Type of health service required not available	2.5%	0.6%	3.7%
Service takes too long	2.5%	1.7%	1.9%
Need recommendation letter	0.0%	5.0%	1.9%
Quality of service is not good	3.3%	1.1%	0.9%
Service not available at convenient times	1.1%	1.2%	0.0%
Service is too expensive	0.4%	0.0%	0.0%
Provider is unfriendly	1.1%	0.6%	0.0%
Lack of confidentiality	0.4%	0.4%	0.0%
Other (specify)	4.7%	2.0%	1.9%

\* Statistically significant (p≤0.05)

*†* Multiple response. Answers do not total to 100%.

Nearly all infirmary users (90.1%) were satisfied (55.9%) or highly satisfied (34.2%). In addition, three-quarters of users (76.4%) would recommend the infirmary to their friends/colleagues. Both of these metrics are similar to the midline values (95% and 81%, respectively), but are slight increases from the baseline (81.4% and 70.4%, respectively). Regarding the qualitative data, many of the women in the FGDs agreed that the factory infirmary had improved since they started using it.

The infirmary is better than before. When we ask for medicine, they quickly provide us the medicine. Their service is good. –Young, married FGD respondent



Figure 7: Satisfaction with infirmary services, by survey round (Note: baseline is only among users of infirmary for RMNH services; midline/endline are all users).


#### Endline Survey of Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Garment Factory Workers





#### **Referrals**

Less than 10% of workers received referrals for RMNH services from either infirmary staff or a peer educator in the last 12 months (Table 12). At the endline, there was a surprising increase in the number of workers referred for HIV testing (VCCT; 4.7% of all workers surveyed). This may be due to changes in the questionnaire at the endline, whereby this question was asked to all workers in the study. Previous survey rounds only asked this question to workers that had ever used the factory infirmary, although peer educators/focal points can also provide referrals. Thus, it may

[The referral directory] is useful... there is specific detail of location and map... Sometimes Marie Stopes discount price when we refer workers there for contraception service. – Secondary nurse at factory infirmary

be that peer educators are providing more referrals for HIV testing than infirmary staff.

	Baseline (n=908)	Midline (n=725)	Endline (n=911)
Received referral for any RMNH services <sup>†</sup>	7.7%	3.8%*	8.7%
VCCT	1.7%	0.7%	4.7%
Family planning services	1.5%	1.8%	2.6%
STI services	1.2%	1.6%	2.1%
ANC and PNC service	0.8%	0.6%	1.6%
Safe abortion	0.4%	0.4%	0.7%

#### Table 12: Referrals for RMNH services, by survey round.

\* Statistically significant (p≤0.05)

*†* Multiple response. Answers do not total to 100%.

In terms of the referral directory, many of the HR and infirmary staff found the directory useful. They found it clear and easy to use. The fact that some NGOs and private providers offered discounts for garment factory workers, which was shown in the directory, was also appreciated.



## Indicator analysis

Examining the use of RMNH services in both factory infirmaries and through referrals, a total of around 12% of workers utilised these mechanisms to receive RMNH services in the last 12 months (MERI indicator; Table 13). This is a significant increase from the baseline utilisation rate of around 7%. Most of this increase happened in the first half of the project implementation phase, between the baseline and midline survey rounds.

There was also a significant increase in satisfaction with these services. For women that accessed health services for any reasons, high satisfaction (women that were "very satisfied" with services) increased from 23% at baseline to 40% at endline. For women that accessed RMNH services, high satisfaction increased to 51% at endline. Both increases are statistically significant between the baseline and endline.

#### Table 13: MERI indicators of RMNH service utilisation and satisfaction, by round.

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
O2.3. % of garment factory workers accessing RMNH services in the previous 12 months	6.8%* (8.6%)	10.5%	11.5%
	(n=52)	(n=95)	(n=102)
O3.3 % of target population who report being highly satisfied with RMNH services provided†	23.1%*	39.1%	51.0%*

\* Statistically significant (p≤0.05)

**†** Among WRA that accessed RMNH services at the factory infirmary or external health provider

## **Contraceptive Knowledge and Use**

## Knowledge of contraception

Knowledge of any form of contraception is nearly universal (99%) among female garment factory workers, as it is among the general population of WRA in the CDHS 2014. Women were asked to name all of the different contraceptive methods that they knew, including both modern and traditional methods, without prompting by the interviewer. At the midline and endline, women were then asked about all of the contraceptive methods that they did not name spontaneously. To do this, the interviewer read out the name and a short description of each unnamed method, and asked the woman if they had ever heard of this method.

At the baseline, women were able to spontaneously name an average of 2.7 modern contraceptive methods. The number of spontaneous modern methods known increased by the midline to an average of 3.91, and stayed steady until the endline (mean 3.97); a difference which was significant between the baseline and the midline/endline.



Without prompting, the five most commonly known contraceptive methods among female factory workers in the study are all modern methods (Figure 10): the daily pill, intrauterine device (IUD), implant, injection, and male condoms. These methods were each spontaneously named by over half of women at both midline and endline (Figure 9). Among traditional methods, women had the highest spontaneous knowledge of withdrawal, with nearly half of women at endline (48.7%) mentioning it without prompting. Spontaneous knowledge of nearly all modern contraceptive methods increased significantly since the baseline. The only modern methods where spontaneous knowledge did not significantly increase from the baseline were also the least well known methods: male sterilisation, female condoms, and emergency contraception.



Figure 9: Unprompted knowledge of contraceptive methods, by survey round (multiple response) (\*statistically significant difference between survey rounds).

With prompting, women at the endline were aware of an average of 7.51 modern methods. This is a slight decline from the total number of modern methods known at the midline (7.71); a difference which was statistically significant, although slight. The top five modern methods were nearly universally known by the female garment factory workers (Figure 10). At endline, the daily pill was known by nearly all women in the survey (98.2%). This was closely followed by the long-acting methods of implants (97.1%), IUDs (96.8%), and injections (95.7%). Condoms (specifically male condoms) were known by 94.5% of women. Withdrawal was the most commonly known traditional birth control method (85%), and female sterilisation was the most commonly known permanent contraceptive (84%).

There were few significantly distinct changes in knowledge of these methods from the midline to the endline.<sup>4</sup> The three modern contraceptive methods with significant changes from the midline to the endline (injections, female and male sterilisation) all showed declines in knowledge during that time period, as did the traditional calendar/rhythm method. The only method which had a statistically significant

<sup>&</sup>lt;sup>4</sup> Note that the baseline knowledge is not comparable here, as the methodology is different (baseline was only spontaneous knowledge, included in discussion above).



increase in overall knowledge from the midline to the endline was the traditional method of withdrawal; knowledge of this method increased from 79.3% to 85.1% of women from 2016 to 2018.

Lesser known contraceptives include the traditional lactational amenorrhea method (LAM), as well as the female condom; each was known by only around one-third of respondents. Emergency contraception (also known as Plan B, or the morning after pill) was the least known method, known by only 22% of respondents.



Figure 10: All knowledge of contraceptive methods, spontaneous and prompted, at midline and endline (multiple response) (\*statistically significant difference between survey rounds).

Knowledge of modern contraceptive methods is directly correlated with age (women older than 24 years old know more methods than youth), marital status (married and previously married workers know more methods than single workers), and education (workers with secondary education know more methods than workers with primary or limited education) (Figure 11).



Figure 11: Number of modern contraceptive methods spontaneously known (mean), by respondent characteristics and survey round (*\*statistically significant difference between sub-groups*).



Most of these differences are statistically significant across the different survey rounds; educational differences are only significant at the baseline, although the same trend is seen at midline and endline.

#### **Effect of BCC participation**

Participation in any BCC activities was directly correlated with higher knowledge of modern contraceptive methods (Figure 12) at both the midline and endline. These differences were statistically significant for participants in *Chat!* and/or other BCC activities. BCC participation was directly correlated with an increase of approximately one modern contraceptive method known by women. BCC participation was correlated with increases in both overall knowledge, as well as spontaneous (unprompted) knowledge of contraceptive methods.

[Since participating in BCC activities] we gain knowledge on contraception... understand about pills, implants, IUD, female sterilisation, condom, injection, natural contraception. – Single FGD respondent



Figure 12: Mean number of modern contraceptive methods known, by BCC participation and survey round (\*statistically significant difference between sub-groups).

#### Current contraceptive use

Next, women were asked if they were sexually active in the last 12 months, and if so, were they using any form of contraception. The question of recent sexual activity helps to determine the number of women who may have a need for contraception, and filters out women for whom contraception is unnecessary. Further discussion of contraceptive need is discussed in the subsection, below. At the time of the endline, over half of women (58.6%) reported being sexually active in the last 12 months (Figure 13). The overwhelming majority of sexually active women were currently married/partnered; only one single woman and nine formerly married women reported being sexually active recently.

Around two in five women (39.4%) were currently using some form of contraception, including the onequarter of women (25.2%) that were currently using modern contraception and the 14.2% of women that were currently using traditional contraception. About 19.2% of women were sexually active but not currently using contraception; 6.0% stopped using contraception sometime in the last 12 months, while 13.2% had not used contraception at all in the last 12 months. Among the 6.0% of women that discontinued contraceptive use in the last 12 months, half (54.5%) had been using modern contraception



(mostly male condoms) and a further half (56.3%) had been using a traditional method (mostly withdrawal). Note that some women reported using and discontinuing more than one method in the last 12 months.



Figure 13: Sexual activity and contraceptive use in last 12 months, at endline (n=911).

Among women with recent sexual activity, the proportion of women currently using modern contraceptives was 43.1% (Table 14). The proportion of women currently using modern contraception has significantly increased every survey round, from around one in ten women (10.6%) at baseline to one in four women (25.2%) at endline. The proportion of sexually active women currently using modern contraception has also increased every survey round, but tests of statistical significance could not be conducted between baseline and midline due to changes in the methodology (women who had ever had sex were considered at baseline, but this was refined to women who had sex in the last 12 months at midline and endline). Between the midline and endline, there was no statistically significant change, partly due to the small percentage change (2.7 percentage point increase) between midline and endline.

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
O2.1. #/% of target population using modern contraception (FTIRM)			
WRA	10.6%*	20.3%*	25.2%*
Sexually active <sup>+</sup>	24.2%	40.4%	43.1%
* Statistically cignificant (p<0.05)			

\* Statistically significant (p≤0.05)

<sup>+</sup> Defined as ever sexually active at baseline, and sexually active in last 12 months at midline and endline. Not comparable between baseline and midline/endline; tests of statistical significance were not performed for these metrics between baseline and midline/endline.

Among current contraceptive users, the most popular method was the daily pill, used by nearly half of all current users (47.4%) at the endline (Figure 14). This was followed by the traditional method of withdrawal,



which was used by around one-third of current users (36.8%). Other methods were significantly less common; the third most common method was IUDs, which were used by only 5.0% of women at endline. These usage figures are similar to the midline and CDHS 2014, where the daily pill and withdrawal were the first and second most common methods used by women.



Figure 14: Contraceptive method mix among current users at each survey round (multiple response) (\*statistically significant difference between survey rounds).

Older women and married women were more likely to use modern contraception than their young, single counterparts (Figure 15). These differences were statistically significant across all survey rounds. Modern contraceptive use increased among all age groups and among currently married women between the baseline and the endline. Women with severe levels of functional impairment (DISABILITY3) were more likely to use modern contraceptives than women without severe impairments, although the small sample sizes make this difference not statistically significant at any round, there is an overall positive trend visible in the data for this group. Interestingly, women with lower education levels (women with less than a secondary education) were more likely to be currently using modern contraception than women with higher education; however, this difference was only statistically significant at the baseline.





Figure 15: Current use of modern contraception, by respondent characteristics at each survey round (\*statistically significant difference between sub-groups within survey rounds).

#### **Current LAPM contraceptive use**

In total, around 13.5% of women that were currently using modern contraception at the time of the

endline were using a long-acting or permanent method of contraception (LAPM) (Table 15). LAPMs include female sterilisation, male sterilisation, IUDs and implants. This corresponds to around 3.4% of all women surveyed at endline. This is a slight increase in the proportion of women using LAPM since the baseline (11.5%), but this is not a statistically significant change, possibly due to the small difference and sample size at each survey round. It is also similar to the use of LAPMs among urban women noted in CDHS 2014 (11.4%).

Some people insert implant/IUDs. Inserting implant/IUDs is not difficult and not worried about forgetting [to use contraception]. It has the expiration year. - Married FGD respondent

Table 15: MERI Indicator O2.2: Women currently using LAPM, among all women using modern contraceptive methods, by survey round.

	Baseline (n=142)	Midline (n=295)	Endline (n=359)
O2.2. % of women (modern FP users) using long acting or permanent methods (LAPM) of FP			
Current modern contraceptive users <sup>+</sup>	11.5%	15.0%	13.5%
+ Defined as MPA who are surrently using a	ny form of mod	orn contracontia	'n

† Defined as WRA who are currently using any form of modern contraception.



#### **Effect of BCC participation**

Women that had ever participated in any BCC activities were more likely to use modern contraception at both the midline and endline. This difference was not statistically significant for participants in any BCC activities. However, this difference was statistically significant for *Chat!* participants (29.2%, compared to 21.6% of non-participants). See Annex 1 for more detailed tables. Participation in BCC activities was also correlated with a slight decrease in LAPM use at both survey rounds. This difference was also not statistically significant, and may be more reflective of the type of women that were likely to attend BCC activities than a direct effect of these activities.



Figure 16: Modern contraceptive use (among all women) and LAPM use (among all modern contraceptive users), by *Chat!*/BCC participation and survey round.

#### Reasons for discontinuing or not using contraception

Among women that were recently sexually active but had not used contraception, or stopped using contraception in the last 12 months, the reasons for their disuse were asked at the time of the endline survey. At the baseline, the women that stopped using contraception in the last 12 months were asked the same question. At baseline, women were asked to cite their primary reason for not using contraception (single select), while at endline all reasons for non-use were queried (multiple response).

The primary reason for not using contraception at the endline was due to wanting to have another child; over two-thirds of women who were sexually active but not using contraception (70.9%) cited this reason (Table 16). The other reasons were mentioned by less than 10% of women each, and included infrequent sexual activity (e.g., because their partner was away or they had separated) and an inability to bear children. A few women were afraid of the effects of contraceptives on their health, such as a fear of side effects and permanent infertility, although these numbers were considerably lower than at the baseline.

The desire to have a child was especially prevalent among women that had not used contraception at all in the last 12 months (83.3% of these women). However, less than half of women that stopped using contraception in the last 12 months (43.6%) cited this reason; a difference between discontinuers and



women that did not use contraception that was statistically significant. The women that stopped using contraception in the last 12 months had more varied reasons for not using contraception than the women who had not used contraception at all in the last 12 months. Beyond the desire to have a child, other common reasons for discontinuation included being currently pregnant, and/or no longer being in a relationship (18.2% of women each). Around 12.7% of these women reported that they were not frequently sexually active; approximately one in ten of these women (9.1%) also said that they did not like the side effects of contraception. All other responses were mentioned by less than 10% of these women each.

The results from the baseline are more vague, and are not generally comparable to the endline, partly due to the reasons mentioned above (different target populations and single select/multiple response formats). The most common reason for discontinuation at the baseline was "other", which was a combination of various reasons not clearly listed (sterility and the desire for children were cited in the baseline report). The most commonly cited single reason at baseline

Using long term contraception may cause bleeding. If we fit to the [daily] pill, will be fat. But if not fit, we will be thin. Married FGD respondent

was an aversion to the side effects of contraception, mentioned by 29.2% of women. An additional one in five women (20.8%) found that using contraception was not convenient for them at baseline. Other reasons were less commonly mentioned, and included a lack of reliability (8.3%), fear of complications/effects on health (2.1%), and disapproval by family or partner (2.1%).

	Baseline		Endline <sup>+</sup>	
	Stopped using contraception in last 12 months (n=48)	All women (n=175)	Not used contraception in last 12 months (n=120)	Stopped using contraception in last 12 months (n=55)
Reasons for discontinuation/ new	ver use			
Want to have a child	-	70.9%	83.3%*	43.6%*
Not having sex/ husband far away	-	9.1%	7.5%	12.7%
Fear of complications/ effect on health	2.1%	7.4%	7.5%	7.3%
No longer in relationship (divorced, etc.)	-	6.3%	0.8%*	18.2%*
Currently pregnant	-	5.7%	0.0%	18.2%
Cannot have child (infecund, menopause, etc.)	-	4.0%	5.0%	1.8%
Do not like side effects	29.2%	4.0%	1.7%*	9.1%*
Disapproval by family or partner	2.1%	0.6%	0.0%	1.8%
Not convenient	20.8%			
Not reliable	8.3%			
Other	37.5%	0.6%	0.8%	0.0%
* Statistically significant (n<0.05)				

#### Table 16: Reasons for not using contraception, at endline and baseline.

*†* Multiple response in each column. Answers do not total to 100%.



### SDG Indicator 3.7.1: Demand satisfied for modern contraception

New to the endline, PSL requested that the endline survey include a section on contraceptive need, and a calculation of the demand satisfied for modern contraceptive methods (MCM) among WRA, in line with Sustainable Development Goal indicator 3.7.1. This module of the instrument, and the indicator calculations, were taken directly from the CDHS 2014 questionnaire for women of reproductive age; however, CDHS only asks this section to married WRA, whereas our survey asks all WRA who are sexually active in the last 12 months, regardless of marital status. Women not sexually active are assumed not to need contraception, and thus are not considered to have demand for modern contraception.

The initial calculation involves determining the unmet need component. The unmet need is the number of sexually active WRA who are capable of getting pregnant and do not want a child in the next 24 months, but are not currently using any form of contraception. As seen in Table 17, the number of sexually active female garment factory workers with unmet contraceptive needs is quite low – only 3.8%. This is considerably lower than the number of women with unmet needs in the general population (12.5%), and in the urban population (10.8%), per CDHS 2014.

A further two-thirds of women (67.2%) were currently using any form of contraception. That is to say, their need for contraception was being met. This includes the 43.1% of sexually active women who were currently using a modern contraceptive. The total demand for contraception is therefore 71.0% of women; the sum of women with met and unmet needs. The remaining 29% of women simply do not have a need for contraception – either due to a current pregnancy, infertility, or the desire to conceive a child soon.

Calculating the met need as a proportion of total demand shows that the satisfied demand for contraceptives among this population in very high – 94.7% of women that have a demand for contraception have that demand satisfied. This is considerably higher than the satisfied demand among WRA in Cambodia (both general and urban populations), and reflects the higher rates of both traditional and modern contraceptive use seen among garment factory workers at the endline.

The demand satisfied by modern contraceptive methods is 60.7%. This is slightly higher than the demand satisfied by modern contraceptives among WRA in the overall population (56.4%), and considerably higher than demand satisfied by modern contraceptives among urban women, due to the lower rates of modern contraceptive use by urban women highlighted in CDHS 2014.

When asked in the FGDs about the challenges women still face in accessing and using family planning, some women mentioned the health-related risks and possible effects on fertility of using modern contraception. A few women mentioned that using some kinds of contraception will impact their body by making them fatter. One of the issues raised by both workers and infirmary staff is the "shyness" of women in discussing contraception and reproductive health issues, even with medical professionals.



	Unmet need	Met need (any)	Met need (MCM)	Total demand for FP (any)	% demand satisfied (any) (n=379)	% demand satisfied by MCM (n=379)
Variable	A	В	С	A+B=D	B/D	C/D
PSL Lot 2 Endline						
Percentage	3.8%	67.2%	43.1%	71.0%	94.7%	60.7%
Frequency	20	359	230	379	359/379	230/379
CDHS 2014						
All WRA (n=11,898)	12.5%	56.3%	38.8%	68.8%	81.9%	56.4%
Urban WRA (n=1,818)	10.8%	59.8%	32.8%	70.6%	84.7%	46.5%

#### Table 17: Demand satisfied for modern contraceptives, among all women sexually active in the last 12 months at endline (n=534), and compared with CDHS 2014.

## **Abortion and Post-abortion Care**

Next, women in the survey were asked about their knowledge and access to abortion. Only around one in six women (15%) at the endline knew that abortion was legal in Cambodia (Table 18). This is a significant increase in knowledge from the baseline, but consistent with the knowledge displayed at the midline.

#### Table 18: MERI indicator I4.4: Knowledge of legality of abortion, by survey round.

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
I4.4. % of women who know that abortion is legal		-	-
WRA	7.9%*	16.5%	15.3%
* Statistically significant (p≤0.05)			

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Knowledge of where to access safe abortion services has increased considerably since the baseline (Table 19). From an initial knowledge of safe abortion services of 20%, over half of workers at the endline (55%) knew where to access safe abortion services. These changes were also statistically significant. In all three survey rounds, public providers were the most commonly cited locations for safe abortions, followed by private medical providers, and then NGO clinics.

#### Table 19: Knowledge of safe abortion providers, by survey round.

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
Know where to access safe abortion services	20.1%*	44.1%*	55.0%*
* Statistically significant (p≤0.05)			



Around 16.5% of women had ever had an abortion at the endline; a significantly higher prevalence than at the midline (11%) and baseline (7.8%) (Table 20). In the last two years before the endline, 5.4% of women had their most recent abortion within the last two years. This is similar to the prevalence of last abortion in the last two years before the midline (4.7%). Although the figures show a slight increase, there is no statistically significant difference in this figure at midline and endline.

Private health facilities were preferred locations for abortions in all survey rounds. Although private residences were the second most common locations for abortions at the baseline, the use of residences for abortions has declined significantly since then, and only around 2.0% of women had their last abortion at a residence at the endline. Inversely, the use of pharmacies/drug stores for abortions increased from a nominal value at the baseline (2.8%) to nearly one-third of women at the endline; a change which was statistically significant. The use of NGO clinics for abortion decreased significantly from the baseline and midline to the endline. In terms of method used, medical abortion pills and vacuum aspiration were the most common methods at all survey rounds. Other methods were mentioned by less than 10% of women in each survey round.

Comprehensive abortion care (CAC) refers to the use of medically appropriate abortion methods (vacuum aspiration, medical abortifacient pills) administered in medical facilities (public facilities, private facilities, and NGO clinics). Among women that ever had an abortion, around two-thirds of women in each survey round received CAC (Table 20). There was no significant difference in the use of CAC among women that had a recent abortion (within two years of the midline/endline), and those that had earlier abortions.

	Baseline	Midline	Endline
Women that had an abortion	(n=909)	(n=905)	(n=911)
Ever	7.8%	11.0%	16.5%*
In last 2 years	n/a	4.7%	5.4%
Women that had CAC abortion, among women that had an abortion	(n=71)	(n=99)	(n=150)
Ever	63.4%	63.6%	62.7%
In last 2 years	n/a	56.0%	63.3%
Method of last abortion	(n=71)	(n=99)	(n=150)
Medical abortion pill	40.8%*	50.9%	59.3%*
Vacuum aspiration	50.7%	48.1%	39.3%
Traditional method	2.8%	0.0%	1.3%
Self-aborted	1.4%	1.0%	0.0%
Other	4.2%	3.9%	6.0%
Location of last abortion	(n=71)	(n=99)	(n=150)
Private	47.9%	37.9%	42.7%
Pharmacy/drug store	2.8%*	21.3%	32.7%
Public	12.7%	19.5%	20.7%
Residence	29.6%*	12.0%*	2.0%*
NGO clinic	7.0%	9.3%*	1.3%*
Other	0.0%	0.0%	0.7%
* Statistically significant (p≤0.05)			

#### Table 20: Abortion rates and locations, by survey round.



Older women, women with disabilities and those with lower education levels were more likely to have had an abortion (Figure 17). Youth were significantly less likely to have had an abortion, but that may be related more to the lower marital rates and subsequent lower sexual activity among this age group (more than 50% of youth were single in each survey round). Women with a severe disability (Disability 3) had the highest abortion rates in the study – up to one-quarter of women with severe functional impairment (24.8%) at endline reported ever having an abortion.



Figure 17: Abortion prevalence, by different subgroups at endline (n=911).

## Post-abortion care

Across each survey round, around half of women that had an abortion received contraceptive counselling after their most recent abortion (Table 21).<sup>5</sup> The receipt of contraceptive counselling at endline was similar to the other survey rounds, with 48.0% of women that had an abortion reportedly receiving contraceptive counselling within that timeframe. At the midline and endline, the rates of contraceptive counselling were slightly higher for women that had a recent abortion than for women that had abortions longer than two years ago (56.5% and 53.1% at midline and endline, respectively), although these differences were not statistically significant between women that had recent compared to earlier abortions.

Independent of counselling at the endline, around one-third of women that had an abortion (37.3%) began using a modern contraceptive method within 14 days of the last abortion (Table 21). There were similar rates for women with recent abortions and those with earlier abortions. The modern contraceptive uptake rate was higher at midline, when around half of women adopted a modern contraceptive after their last abortion, although the difference is not statistically significant.

<sup>&</sup>lt;sup>5</sup> The time period for this counseling varied by survey round; from 28 days after the last abortion at the baseline to 14 days after the last abortion at the midline/endline. This change was due to revisions in the MOH guidelines.



Women that received counselling post-abortion were significantly more likely to begin using modern contraception. Over half of women (58%) who received counselling at either midline or endline began using modern contraception after their last abortion, as opposed to one-quarter of women (24%) who did not receive counselling; a rate that is statistically significant.

Table 21: Post-abortion indicators, by survey round.					
	Baseline (n=71)	Midline (n=99)	Endline (n=150)		
Women that received post-abortion counselling in contraceptive methods <sup>†</sup>					
Ever	50.7%	51.4%	48.0%		
In last 2 years	n/a	56.5%	53.1%		
Uptake of modern contraceptive method after abortion <sup>‡</sup>	(n=27)				
Ever	n/a	46.6%	37.3%		
In last 2 years	n/a	59.7%*	34.7%*		
After receiving counselling	81.5%	68.2%	51.4%		

+ Baseline timeframe is within 28 days after the most recent abortion. Midline/endline timeframe is

*‡* Baseline is only women that received contraceptive counselling within 28 days after the most recent abortion. Midline/endline is among all women that had an abortion, regardless of counselling.

Throughout all three surveys, the most common contraceptive method started after an abortion was the daily pill. Utilisation of this method increased over time, and was used by over half of women that started any method after their last abortion at the endline (Figure 18). Withdrawal was the second most common method at the midline and endline, being used by one-quarter of contraceptive adopters after an abortion (28.3% and 27.4% at the midline and endline, respectively). The LAPM methods of injection and IUD were also used by a few women after abortion.



Figure 18: Contraceptive methods used post-abortion, among women that started any contraception after an abortion, by survey round (multiple response for midline and endline).



within 14 days after most recent abortion.

The popularity of different methods among women that began using contraception after their last abortion is similar to the overall contraceptive popularity among all women in the study, as noted in the section on contraceptive use above.

## Indicator analysis

Among women that received CAC, around one-third began using a modern contraceptive method within 14 days of their most recent abortion (Table 22). This is significantly lower than at midline, when over half of women began using a modern contraceptive method. However, it is around 15.8 percentage points higher than at baseline (a 70.2% increase), although differences in the timeframe queried make these numbers not directly comparable using standard tests of statistical significance (the baseline timeframe was 28 days post abortion, which was shortened to 14 days for the midline/endline instruments).

Among women who had an abortion in the last 2 years before the midline or endline interview, there was a similarly significant decline in modern contraceptive uptake from the midline (73.9% of women with recent abortions) to the endline (35.5%). This decline was also statistically significant.

## Table 22: MERI Indicator O3.1: Women receiving CAC that started using a modern family planning method within 14/28 days.

	Baseline	Midline	Endline
O3.1. % of women receiving Comprehensive Abortion Care (CAC) who receive post abortion family planning (FP)	(n=45)	(n=63)	(n=94)
WRA	35.6% (22.5%)	56.0%*	38.3%*
		(n=24)	(n=31)
Recent abortion (last 2 years)	_	73.9%*	35.5%*

\* Statistically significant ( $p \le 0.05$ )

Note: Baseline indicator is among WRA with CAC that received FP counselling within 28 days and then started modern contraception. Midline/endline are among WRA with CAC that started contraceptive method within 14 days, regardless of counselling.

#### **Effect of BCC participation**

BCC participants had increased knowledge of abortion legality compared to female garment factory workers who did not participate in any BCC activities (

Table 23). This difference was only significant at the midline, although both survey rounds show a similar increase. Surprisingly, there was a significant decline in the knowledge of where to access safe abortion services among BCC participants, whereby BCC participants were less likely to know where to access safe abortion services than women that did not participate in any BCC. However, *Chat!* participants had greater knowledge of where to access safe abortions than non-participants at both the midline and endline; differences which were significant in both survey rounds (see Annex 1).

Among women who had any type of abortion, participants in *Chat!* or other BCC activities were more likely to begin using a modern contraceptive method post-abortion than women that had not participated in



these activities. This difference was only significant at the endline – 40.1%, compared to 7.7% of women who did not participate in any BCC activities – but the trend was seen across both survey rounds.

Some qualitative interview respondents mentioned that PSL provided both workers and infirmary staff with knowledge of safe abortion providers, and that the referral system was a helpful resource for these services as well.

	Midline		Endline	
	No participation (n=161)	Any <i>Chat!</i> /BCC participation (n=477)	No participation (n=103)	Any <i>Chat!</i> /BCC participation (n=808)
Know that abortion is legal	11.2%*	17.6%*	10.7%	15.8%
Know where to access safe abortion services	75.4%*	51.8%*	59.2%*	43.2%*
	(n=7)	(n=92)	(n=13)	(n=137)
Uptake of modern contraceptive method after abortion	44.0%	46.8%	7.7%*	40.1%*
* Statistically significant (p<0.05)				

## Table 23: Abortion indicators, by any *Chat!*/BCC participation.

## **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 *Chat!*/BCC messages, and their own sexual and reproductive health rights. If women did not have a husband/partner, they were asked to imagine how they would respond in the same scenarios.

## Reproductive health rights

Examining the results on reproductive health, women showed high confidence in their ability to discuss and use contraception with their partners in most scenarios (Figure 19). Over half of women said they were completely confident they could discuss contraception, tell their partner they wanted to use it, and use family planning. However, only about one-third of women (33.6%) said that they were completely sure they could use family planning if their partner did not want to. There were significant increases in the number of completely confident women from the baseline to the midline/endline for all four scenarios. At baseline, only about one-quarter of women were completely confident that they could talk about family planning with their husband/partner; numbers which had doubled by the midline and stayed the same at endline. Overall, the average woman in the study was "somewhat sure" or "completely sure" for all four scenarios, with average scores of 4.1, where five is "completely sure" and one is "not at all sure" (Table 24).



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Figure 19: Women that were "completely sure" in each of the reproductive health scenarios, by survey round. Some missing answers for each round/scenario (\**significant difference between survey rounds*).

Next, the percentage of women that were "completely sure" in all four scenarios was analysed by different sub-groups across all three survey rounds (Figure 20). All sub-groups experienced considerable increases in empowerment since the baseline. Older women and married women showed greater signs of empowerment in reproductive health than younger women, and single or previously married women. These differences among women of different ages and marital statuses were only significant at the midline and endline. There were no statistically significant differences between women of different functional disability levels, and women with different education levels.



Figure 20: Women that were "completely sure" in all four reproductive health scenarios, by survey round and characteristics. Some missing answers for each round/scenario (\**significant difference between sub-groups*).



#### Health care decision-making

In addition, women were asked who made decisions about their health care. This question was only asked at the endline, and so comparison with previous rounds of the study are not available. At the endline, nearly two-thirds of women (62.8%) said that they were directly responsible for their own health care decision-making (Figure 21, left). A further 21.1% of women said that they made health care decisions jointly with their partner; in total over 80% of women (83.9%) were directly involved in their own health care decisions. Around 16.1% of women had someone else make health care decisions for them; usually their husband/partner (10.1% of women). Six percent of women said that someone other than themselves and their partner made their health care decisions. This was usually a relative or family member (such as a parent).

Among currently married/partnered women, the woman is still the primary decision-maker for their own health care (48.8% of married women), although there is a shift in decision-making to a joint decision between the woman and her spouse/partner (Figure 21, right). However, when individual and joint decision-making is taken together, there is little loss of control over women's health care decision-making after marriage (83.9% for all women, compared to 82.6% for currently married/partnered women).



# Figure 21: Primary decision-makers for women's health care, by all women (L) and currently married women (R) at endline.

Compared to the national averages in CDHS 2014, which only consider currently married WRA, married female garment factory workers appear to have similar individual control over their health care decision-making (48.8% of married female garment workers, compared to 46% of married women in CDHS 2014). But, married/partnered garment workers had less joint decision-making (33.8%, compared to 45% in CDHS 2014). In total, married female garment factory workers had slightly less participation (both individual and joint control) in decisions about their health care than the average Cambodian WRA in CDHS 2014 (82.6%, compared to 92% in CDHS), although a large majority of female garment factory workers are still responsible for their own health care decision-making.



## Sexual health rights

In regards to the scenarios on the ability of a woman to refuse sex with their husband/partner, two-thirds of women at the endline (67.1%) were completely confident that they could refuse sex if they were tired (Figure 22:). This is the highest confidence rate in this section, and a statistically significant increase from the same scenario in the baseline and midline, when 22.9% and 61.4% of women were completely confident, respectively. In each of the other four scenarios at endline, around half of women were completely confident they could refuse sex with their partner, ranging from 62.8% (when the woman is tired) to 50.1% (when the husband/partner threatens to have sex with other women). In each of these scenarios, the number of completely confident women has increased significantly from the baseline values of less than 20%. The scenarios with the highest insecurity rates were when a woman's partner threatens them with violence or infidelity ("not at all sure" responses of 13% and 16%, respectively).



Figure 22: Women that were "completely sure" they could refuse sex in each sexual health scenario, by survey round; some missing values for each round/scenario (\**significant difference between survey rounds*).

Next, the number of women that were "completely sure" for all five sexual health scenarios was examined by socioeconomic characteristics (age, marital status, disability and educational attainment) and across the three survey rounds (Figure 23). Women in each of the examined sub-groups experienced considerable increases since the baseline; less than 5% of women in all sub-groups reported that they could refuse sex in all five scenarios at baseline. By endline, this increased to over 20% of women in all sub-groups reporting that they could confidently refuse sex in all scenarios. As with the confidence in reproductive health situations, older women and married women were reportedly more confident in sexual health situations than younger, single women. However, these differences were only significant at the midline. Disability and



educational attainment had no effect on women's confidence in sexual health scenarios in each survey round; although, there were considerable increases in confidence among women with functional disability and those with higher educational attainment from the midline to the endline.



Figure 23: Women that were "completely sure" in all five sexual health scenarios, by survey round and characteristics. Some missing answers for each round/scenario (\**significant difference between sub-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 (mean 4.2; median 4.2).<sup>6</sup> One-quarter of women (28.0%) were completely confident that they could refuse sex with their partner in all five scenarios. These confidence rates are significantly higher than at baseline, when only 3.7% of women were completely sure that they could refuse sex in all five scenarios, although there is no significant change from the midline value (27.1%). Likewise, the average confidence score for all five scenarios has increased from 3.6 at baseline (mean 4.0), to 4.2 at endline (Table 24). This difference is also statistically significant between the baseline and the midline/endline values.

#### Table 24: Feelings of empowerment (mean value among all questions in each group, in each survey

round.				
	Baseline (n=909)	Midline (n=905)	Endline (n=911)	
Empowerment to discuss and use modern family planning	3.7*	4.2	4.1	
Empowerment to refuse sex	3.6*	4.1	4.2	
* Statistically significant (n<0.05)				

\* Statistically significant (p≤0.05)

Note: Some missing values for each survey round.

<sup>&</sup>lt;sup>6</sup> On a five-point scale, where five is "completely sure" and one is "not at all sure".



## Indicator analysis

The indicator for this section is only concerned with the empowerment of women to discuss and use family planning methods. In this metric, there has been a statistically significant increase from the baseline value of only 5.3%, to the midline and endline values of around 25% (Table 25). Nearly all of this increase has occurred between the baseline and the midline; the rate of empowerment did not change significantly between the midline and endline.

#### Table 25: MERI Indicator I4.3: Women that feel empowered to discuss and use family planning.

	Baseline (n=909)	Midline (n=905)	Endline (n=911)
I4.3. % of women who feel empowered to discuss and use modern family planning			
WRA	5.3%*	24.8%	25.0%
* Statistically significant (p≤0.05)			

#### **Effect of BCC participation**

Participation in either *Chat!* and/or other BCC activities was directly correlated with increased confidence in discussing and using family planning methods at the endline. This is a similar result to the midline, and shows the positive impact of these interventions on SRHR confidence and decision-making abilities among women (Figure 24). *Chat!* participants were also significantly more empowered than non-participants at the endline (Annex 1).

Respondents in the FGDs also reported that BCC activities were helpful for them to understand the availability of contraception and ways to protect themselves during intercourse, and also how to empower themselves to discuss contraception and control their own sexual health and rights.

[Participation in PSL BCC activities] has changed our mind-set to know more than before. Makes us know clearer and more about the sexual health issues and when we do not want to have a baby, we can prevent by injection and taking pill. Changed our knowledge of topics such as the protection of contraception and sexual health. – Single FGD respondents

Likewise, participation in any BCC activities was correlated with higher average confidence in empowerment of sexual health (ability to refuse sex with a husband/partner). This difference is statistically significant for participants in any BCC activity at the endline.





Figure 24: Effect of BCC on women's reproductive and sexual health empowerment (mean value on 1-5 scale, where 5 is completely confident) (\* Statistically significant difference among sub-groups in each survey round).

### SDG Indicator 5.6.1: Informed decision-making

At the request of CARE Cambodia, we have included additional analysis at the time of the endline to determine the "proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care", in line with Sustainable Development Goal indicator 5.6.1 (UNSD, 2018). This involved the inclusion of one additional question in the questionnaire, and calculating the incidence of all women who reported:

- Being completely sure that they could refuse sex with their husband/partner if the woman didn't want to have intercourse;
- Being completely sure that they could use family planning, even if their husband/partner didn't want them to use contraception;
- That they were the primary decision-maker for their own health care (additional question).

In line with the recommendations of the United Nations for calculation of this indicator, only women that are currently in a marriage or marriage-like union ("partnered") are considered for this indicator.

Using these criteria, the proportion of married/partnered women in the survey that make their own informed decisions on these aspects of their lives is 17.6%, or about one in six women (Table 26). Interestingly, women that self-reported a severe functional impairment were significantly more likely to also report having control over their sexual, contraceptive and healthcare decision-making. There were no statistically significant differences by age or education level. There were also no differences in this indicator between women that participated in BCC activities and women that did not participate.



# Table 26: SDG Indicator 5.6.1: Informed decision-making by women, among married/partnered womenand sub-groups, at endline.

	Endline (n=539)
SDG Indicator 5.6.1: Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	
Married/partnered WRA	17.6%
Age group	
Age 16-24	13.0%
Age 25-34	18.4%
Age 35-49	18.3%
Education	
None/Some primary	16.9%
Completed primary	17.6%
Completed middle	22.2%
Completed high school	20.0%
University	0.0%
Disability	
No disability	16.5%*
DISABILITY3	35.5%*
* Statistically significant (p≤0.05)	



## **Pregnancy and Maternal Health**

The next section discusses the maternal and neonatal health issues among female garment factory workers. The PSL activities in garment factories did not directly focus on these aspects of RMNH, but these indicators are included in the MERI framework, and implemented by PSL in its activities in the northeast provinces. These indicators are reported below, although there is no additional analysis of the effects of BCC participation on these indicators.

### Pregnancy

At endline, 60% of women in the study had ever given birth. This is higher than the rate at midline (50%), and is probably related to the increased age and marital status of the sample at endline. Pregnancy rates were on average two per woman (mean 2.3; median 2), with a maximum of 10 pregnancies for two women. The large majority of women that had ever been pregnant (89%) also gave birth.

At endline, 11.7% of women gave birth in the last 24 months, with half of these births (5.8% of women) giving birth in the last year. This is a higher rate of women giving birth recently than at the baseline (8.8%), but these women were sampled holistically within the random sampling procedures described above, and the prevalence is not statistically different from the baseline or midline (p>0.05 between rounds).

The baseline data considered all women that had ever given birth for the following sections. However, 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 at the midline and endline. All of these women only had one childbirth in the last 24 months. Note that, as this section is not asked to all survey respondents, the analyses in this section are unweighted for all survey rounds.

## Antenatal care and awareness

All women at both endline and midline went to official health facilities for all antenatal care (ANC) visits. These women had an average of 9 ANC visits for their last pregnancy in the last 24 months (mean 9.5; median 9), with a maximum of 36 ANC visits (one per week during the pregnancy) by one woman. In total among the 107 women at endline, there were 1,019 ANC visits attended.

Public facilities were the most common locations of ANC; over half of all ANC visits (56.1%) were at public facilities (Figure 25). A further 41.8% of ANC occurred at private facilities, with NGO clinics making up 5.0% of ANC locations. Nearly all ANC were conducted by trained health providers; most commonly midwives (66.3% of ANC). Only 12 ANC visits (1.2%) were conducted by providers whose qualifications were unknown. However, as these ANC were at public and private medical facilities, it is assumed that there was a trained medical provider attending to these visits.



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Figure 25: Facilities and providers for ANC visits, by number of all ANC visits at endline (n=1,019 visits).

Nearly all women (95.3%) spent money for ANC visits at the endline. For all ANC visits in total, women spent around \$20 - \$37 for service fees (mean \$37.20; median \$20), and around \$8 - \$10 for transport (mean \$10.49; median \$7.69).

#### Knowledge of pregnancy danger signs

Women who gave birth were asked – unprompted – to identify any danger signs indicating a problem during pregnancy. On average, women were only able to name one to two danger signs at the midline and endline (Table 27). However, this was an increase in knowledge of pregnancy danger signs from the baseline, where half of women (53.9%) were unable to name any danger signs (Figure 26). This increase is significant from the baseline to the midline. Although higher than at baseline, the slight decline at the endline means that overall there has not been a significant increase from the baseline to the endline.

	Baseline (n=323)	Midline (n=103)	Endline (n=107)	
Pregnancy danger signs				
Mean	0.8*	1.5*	1.2	
Median	0.0	2.0	1.0	
<i>†Baseline population is women that were ever pregnant (n=323).</i>				

#### Table 27: Number of pregnancy danger signs known by women, by survey round.

TBaseline population is women that were ever pregnant (n=323). Midline/endline are women that gave birth in last 24 months (n=103 and n=107, respectively).





Figure 26: Number of pregnancy danger signs known by women that gave birth in the last 24 months (midline/endline), or were ever pregnant (baseline).

#### **Indicator analysis**

Among all women that gave birth in the last 24 months, nearly all had at least four official ANC visits at the time of both the endline (97.2%) and midline (96.1%). This is a significant improvement from the baseline, when only around two-thirds of women (69.5%) had four ANC visits, although the baseline methodology makes further comparison difficult; the baseline was for all women that were ever pregnant, regardless of how many years ago they gave birth. Among women with the most recent births (in the last 12 months) at all survey rounds, there was a similarly significant increase from 64% of women at baseline to 98% of women with recent births at both midline and endline receiving at least four ANC visits.

Table 28: MERI Indicator O4.1: Women that received at least four official ANC visits, among women that
gave birth, by survey round.

	Baseline	Midline	Endline
	(n=279)	(n=103)	(n=107)
O4.1. #/% of women attending 4 or more antenatal care (ANC) consultations (FTIRM)			
Most recent delivery †	69.5%*	96.1%	97.2%
	(n=32)	(n=58)	(n=53)
Delivery within the past 12 months * Statistically significant (p<0.05)	64.1%*	98.3%	98.1%

<sup>+</sup>Baseline population is women that ever had a live birth (n=279). Midline/endline are women that gave birth in last 24 months (n=103 and n=107, respectively).

The initial indicator of knowledge of pregnancy danger signs was knowledge of at least five signs. However, at baseline and midline only around 1% of women were able to name this many danger signs. Among women that gave birth recently at the endline, none were able to name five danger signs of pregnancy. PSL revised this indicator after the midline review to calculate the number of women that know at least three pregnancy danger signs (Table 29). After re-computing this metric for all survey rounds for these changes,



there was a considerable increase in the number of women that have sufficient knowledge of pregnancy danger signs at each survey round. Knowledge of at least three danger signs doubled from the baseline to the midline (from 8.7% to 17.5%); a change that was statistically significant. However, knowledge slightly declined from the midline to the endline although this change is not statistically significant.

	Baseline	Midline	Endline
	(n=323)	(n=103)	(n=107)
I4.1. % of women of reproductive age who can identify three danger	-		
signs during pregnancy			
Most recent delivery <sup>+</sup>	8.7%*	17.5%*	14.0%
<i>†Baseline population is women that</i>	were ever pregn	ant (n=323). Mi	dline/ endline

Table 29: MERI Indicator I4.1: Knowledge of pregnancy danger signs, by survey round.

are women that gave birth in last 24 months (n=103 and n=107, respectively).

## Childbirth

Childbirth indicators also showed positive progress since the baseline. All women who gave birth in the last 24 months did so with a skilled birth attendant (SBA) (Figure 27); an increase from the baseline value of 90% of women that had ever given birth using a SBA. Nearly all women delivered in a health facility (Figure 28). Public health facilities were the most common facilities for women to give birth; three-quarters of women (73.8%) gave birth in a public facility at the endline. Health centres were the most common facility, used by over one-third of women (36%) the last time they gave birth. National hospitals and private hospitals were also popular; used by around one-quarter and one-fifth of women (23% and 19%, respectively). Only one woman delivered outside of a health facility (in her own home) at the endline, but she was attended by a midwife (SBA).



Figure 27: Provider that assisted with last birth, by survey round.



Nearly all women paid something for their last birth. The costs of birth ranged from \$0 up to \$1,200, with additional transportation costs of up to \$100. On average women spent between \$50 and \$150 (mean \$151.59; median \$55.00) for combined service and transport fees related to childbirth at endline (Table 30). This is similar to the childbirth costs reported at midline, but double the costs described at the baseline. The large differences between the mean and median values are due to the large range of costs that women experienced for childbirth. Some women paid nothing, while others paid over one thousand dollars for childbirth.

	Baseline (n=107)	Midline (n=103)	Endline (n=107)
Total childhirth costs mean (median)	\$67.52	\$155.45	\$151.59
Total childbirth costs, mean (median)	(\$27.50)	(\$45.00)	(\$55.00)
Sanvica casts, maan (madian)	\$64.86	\$144.37	\$141.79
Service costs, mean (median)	(\$25.00)	(\$37.50)	(\$42.50)
Transport costs, moan (modian)	\$5.91	\$11.08	\$9.80
mansport costs, mean (median)	(\$1.25)	(\$2.50)	(\$5.00)

Table 30: Average childbirth costs, in US\$, by survey round.



Figure 28: Location of last birth.



#### Indicator analysis

Both the location where women are choosing to deliver their child, and the skill of the birth attendant, have improved from the baseline, and the use of skilled birth attendants to deliver in qualified health facilities is now nearly universal among female garment factory workers (Table 31). There was a statistically significant increase in this indicator from the baseline to the midline, with no real change from the midline to the endline.

#### Table 31: MERI Indicator O1.4: Women delivering with a skilled birth attendant in a health facility.

	Baseline (n=274)	Midline (n=103)	Endline (n=107)
O1.4. #/% of women delivering in a health facility with (SBA) (FTIRM)			
Most recent delivery +	79.3%*	99.0%	99.1%
* Statistically significant (p≤0.05) †Baseline population is all women	that ever gav	e birth (n=2	74).

Midline / endline are only women that gave birth in last 24 months.

## Postnatal care

There have been changes in how PNC has been defined by the Cambodian government and PSL since the start of the project. PNC has been defined as two check-ups for both mother and child by a SBA at a health facility. At the baseline, the first PNC (referred to as PNC1) was supposed to occur within the first 24 hours after birth; at the midline this was changed to 48 hours, a value which was maintained at the endline. The second PNC check-up (PNC2) should occur for both mother and child after PNC 1, but within the first week after delivery, at a health facility with a trained provider. At the baseline, only the total number of PNC visits was calculated. The time after delivery, provider, facility and patient (mother/child) were not queried. The terms PNC1 and PNC2 will be used to only refer to PNC that meets these criteria at the different survey rounds.

At endline, all women had some sort of health check after giving birth. The average women had 12 - 13 different check-ups after delivery, although this ranged from one check-up to up to 66 check-ups. Half of women had at least one check-up within four days of delivery (median time for all check-ups is 96 hours), although some women had check-ups for up to 14 weeks after delivery. In total, there were 1,425 post-natal check-ups at endline.

Over half of all check-ups (54.3%) were at health facilities – either public or private (Figure 29). Nearly half of all check-ups occurred at homes – mostly the women's own homes (45.7% of check-ups). Nearly all check-ups (98.1%) were with a trained provider.



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Figure 29: Type of facility and health care provider for postnatal care check-ups, among all postnatal check-ups at endline (n=1,425 check-ups).

At the endline, around one-third of women (32.7%) had both PNC1 and PNC2 (Figure 30). Around 80.4% of women had PNC1, which shows strong compliance with this check-up. However, despite the high number of postnatal visits, only around one-third of women (36.4%) had a proper PNC2 visit. Thus, the primary reason for low achievement of this indicator is due to women not having the second PNC check-up in accordance with the MOH standards for PNC. The importance of appropriate PNC2 could thus be a focus of future BCC activities.



Figure 30: PNC1 and PNC2 check-ups among women with recent delivery, at endline (n=107).

Considerably less women spent money for PNC than for delivery or ANC. Only two-thirds of women (68%) at endline spent any money for PNC. Average costs for all PNC ranged from \$50 - \$68 (mean \$68.16; median \$50), although costs for PNC ranged as high as \$870. Transportation costs for PNC were minimal, from \$0 - \$3 (mean \$2.71; median \$0), suggesting that many women had check-ups when they were still in the health facility after giving birth, and follow-up visits at their own homes after being discharged.



#### Indicator analysis

The amount of women receiving PNC1 and PNC2 has increased from the baseline, and even from the midline (Table 32). Although the differences are not statistically significant between the survey rounds due to the small sample size, the overall trend in PNC is positive. Among women that delivered in the last 12 months before the survey, rates of PNC1 and PNC2 have doubled between the baseline and the end of the project.

	Baseline	Midline	Endline
O4.2. #/% of women receiving 2 or more PNC visits	(n=272)	(n=103)	(n=107)
Most recent delivery +	22.1%	25.2%	32.7%
	(n=32)	(n=58)	(n=53)
Delivery within the past 12 months	12.5%	27.6%	24.5%
<i>†Baseline population is all women that ever gave birth. Midline/</i>			

#### Table 32: MERI Indicator O4.2: Women attending two or more PNC visits.

<sup>+</sup>Baseline population is all women that ever gave birth. Midline, endline are only women that gave birth in last 24 months.

#### Postnatal contraceptive counselling

At endline, around one-third of women that gave birth recently (31%) received counselling in family planning within seven days of childbirth. The most commonly discussed method was the daily pill, which maintains the popularity of this method seen elsewhere in the survey (Figure 31). Nearly all women that received postnatal FP counselling (91%) discussed the daily pill. The majority of women also discussed long-acting contraceptive methods. These include the injection, IUD, and implant (discussed by 82%, 76% and 55% of women, respectively). Withdrawal was the only traditional method discussed.



Figure 31: Contraceptive methods discussed after childbirth, among women that received postnatal family planning counselling, at endline (n=107).



#### **Indicator analysis**

The number of women that received postnatal counselling in family planning methods appears to have significantly decreased from the baseline. The indicator value at baseline is high (56.1% of women that received any PNC check-ups), especially considering that the timeframe for counselling at the baseline was within 24 hours of giving birth (PSL, 2014). The midline and endline values are consistent with each other, with around one-third of women (33.3% and 30.8%, respectively) that had any check-ups within the first week after delivery (even check-ups that do not quality as PNC1 or PNC2) also receiving counselling in family planning methods.

Table 33: MERI Ind	icator O3.2: Women wh	o received PNC	counselling in mod	ern contraception.

	Baseline (n=82)	Midline (n=93)	Endline (n=107)
O3.2. % of women attending PNC <sup>†</sup> who receive counselling in modern FP methods <sup>‡</sup>			
Most recent delivery	56.1%* (56.0%)	33.3%*	30.8%

\* Statistically significant (p≤0.05)

<sup>†</sup>Baseline criteria is any check-up after the last birth. Midline/endline criteria is any check-up within the first week after birth, among women that gave birth in last 24 months.

<sup>*†*</sup> Baseline timeframe is FP counselling within 24 hours of birth. Midline/endline timeframe is within 7 days of birth.

#### Neonatal danger signs

Lastly in this section, women were asked about their knowledge of neonatal distress signs. On average, women knew one to two signs at midline (mean 1.7; median 2) and slightly less at endline (mean 1.4; median 1). However, this is an increase from the baseline knowledge of less than one distress sign (mean 0.5; median 0). Around 70% of women at endline knew at least one danger sign of neonatal distress.

The most commonly known distress sign was abnormal body temperature; known by around half of women that had recently given birth (49%) at the endline (Figure 32). The next most common distress sign was vomiting/distended abdomen (35% of women). All other signs were less well known. All other signs were less commonly known, and included fast/difficult breathing, red or swollen umbilicus, and bleeding/pale colour.



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Figure 32: Knowledge of neonatal distress signs, at endline (n=107).

#### **Indicator analysis**

The number of women that gave birth recently who know at least three neonatal distress signs increased significantly from the baseline. While very few women knew neonatal distress signs at baseline, the number of women who knew at least three signs increased to one-third of women (35.9%) at midline, before declining at endline to 17.8%. Differences between each of the survey rounds were statistically significant for this indicator.

## Table 34: MERI Indicator I4.2: Women with recent birth that know at least three danger signs of neonatal distress.

	Baseline (n=323)	Midline (n=103)	Endline (n=107)				
14.2. % of target population who can identify three danger signs for neonatal distress							
Most recent delivery +	3.8%*	35.9%*	17.8%*				
* Statistically significant (p≤0.05)							

<sup>†</sup>*Midline/endline is all women that gave birth in the last 24 months. Baseline is all women that were ever pregnant.* 



## **Financial Assistance for RMNH Services**

Next, women were asked if they had received financial assistance for any of the services that they reported using above. These include use of health facilities for general health services, as well as the RMNH services of ANC, PNC, delivery, contraception and abortion. In total, around one-third of women (32%) said that they received financial assistance for any of these services. Nearly all women who accessed financial assistance (94%) used the National Social Security Fund (NSSF; Figure 33). Other forms of financial assistance were used by very few women; health equity fund (HEF) assistance was used by only 5% of women. This is a significant increase from the midline, when only 4% of women accessed financial assistance for any health services. The increase is primarily due to the initiation of NSSF support for services in September 2016, especially for childbirth.

Among women that used any RMNH services mentioned in the study (including FP services, ANC, childbirth, PNC and abortion), there was a similar utilisation of financial assistance, whereby 31% of women that used any RMNH services said that they received financial assistance. Rates of NSSF usage were over 90% for both RMNH users and non-users, although non-users had slightly higher utilisation of NSSF support than RMNH users (97.9% and 91.0%, respectively).



Figure 33: Financial assistance mechanisms used, among all women that used financial assistance, by survey round (multiple response; answers do not total to 100%).

Around 13.4% of women borrowed money to pay for healthcare costs at the endline; this is a similar proportion as at the midline (12.8%). Informal lending was the most common form of borrowing for health care costs at both survey rounds (Figure 34); friends, neighbours and family members were the most common sources of loans at both midline and endline. Informal money lenders were also common sources of loans – used by around 20% of women that borrowed money at endline and 30% of women at midline. MFIs and banks made up only a small proportion of loan agents – making loans to only 2% of women each at endline. RMNH users borrowed at similar levels to other health care users; 13.8% of RMNH users borrowed to pay for healthcare costs, compared to 12.9% of non-RMNH users at endline.





Figure 34: People/institutions borrowed from to pay for health costs, among all women that borrowed for these costs, at midline and endline.

#### **Indicator analysis**

In terms of the MERI indicator on utilisation of financial assistance mechanisms, there was a significant increase from the time of the baseline to the endline. This difference was statistically significant from endline to baseline/midline, with all of the increase occurring since the midline. As mentioned above, the primary reason for the increase in this indicator is the increase in NSSF support for health services among garment factory workers. PSL has supported the inclusion of NSSF among garment factory workers since its inception. This support has included NSSF orientations for infirmary staff, and by indicating the NSSF medical facilities in the referral directory to support the referral process. This indicator shows that the use of NSSF is becoming more common, and that support for NSSF should be considered in future activities targeted to garment factory workers.

able 55: MERI indicator 15.1. Ose of infancial support mechanisms for Riving Service					
	Baseline (n=204)	Midline (n=298)	Endline (n=455)		
I3.1. #/% of target population accessing RMNH services using a financial support mechanism in the previous 12 months <sup>+</sup>					

6.9%

3.2%

30.1%\*

#### Table 35: MERI Indicator I3.1: Use of financial support mechanisms for RMNH services.

\* Statistically significant (p≤0.05)

WRA

*†* Among WRA that accessed any RMNH services in the last 12 months.


## **Effect of BCC participation**

There was a slight difference in the usage of financial support mechanisms between women that had participated in any BCC activities, and those that did not (Table 36). These differences are not statistically significant, although they show a positive trend among participants of any BCC activities; a similar pattern was observed among only *Chat!* participants as well (Annex 1).

### Table 36: Financial support mechanism use among RMNH users, by any BCC participation.

	Midline Endline		line	
	No BCC participation (n=45)	Any BCC participation (n=261)	No BCC participation (n=45)	Any BCC participation (n=410)
Use of financial support mechanism among RMNH users	2.7%	3.2%	26.7%	30.5%



## **Conclusions and Recommendations**

Overall, the indicators of project success detailed in the PSL MERI guidelines have increased since the start of the PSL project and calculation of baseline indicators. Of the 14 MERI indicators relevant to the garment factory component of PSL, seven recorded a statistically significant increase from the baseline. These are excellent numbers, which highlight the efforts that Cambodia and the PSL project have made in improving SRHR among garment workers in these factories.

Knowledge of pregnancy danger signs is still low, and unchanged from the baseline. Although knowledge of neonatal danger signs has risen significantly compared to the baseline, the number of women aware of these danger signs is still low; less than 20% of women that gave birth recently are able to name three danger signs of neonatal distress.

Nearly all women know of contraception, and especially modern contraception (from 3 to 10 modern methods known), although this is not a MERI indicator. There has also been a significant increase in the use of modern contraceptive methods, from 11% at baseline to 25% of all women at endline; over 40% of sexually active women were using a modern contraceptive at endline. Women in this survey also have a very high rate of satisfied demand for contraception and modern contraception; greater than the satisfied demand in the urban and general populations. Unmet contraceptive need among these women at endline was low (3.8% of sexually active women). However, much of this demand is being satisfied by short-term contraceptive methods, especially the daily pill, and traditional methods, especially withdrawal. Use of LAPMs remains low, similar to national rates, and there was no significant change in the use of LAPM methods throughout the study period.

Although contraceptive knowledge and use is relatively high, there are areas where there are still unmet needs for these services. Counselling in contraceptive methods after a birth event (childbirth, abortion, etc.) is essentially unchanged from previous survey rounds, although in some cases the indicator values are not directly comparable. In addition, there has been a decline in the uptake of modern contraception post-abortion from the midline to the endline. Note that PSL did not work directly in these areas, so these indicators were not expected to be influenced by PSL activities in garment factories.

Although there was a significant change in the number of women that accessed RMNH services in the last 12 months (from 7% to 12%), the overall figure is still low. However, overall satisfaction with RMNH services has gone up significantly, from 23.1% to 51.0% of women that accessed RMNH services, suggesting improvements in the quality of service delivery targeted toward factory workers. The use of financial support mechanisms has also risen significantly, from 7% at baseline to 30% at endline. This rise can be attributed to the initiation of NSSF support for health services.

Knowledge of the legality of abortion in Cambodia has nearly doubled since the baseline (from 8% to 15%), but is still quite low, even among women that have experience with abortions. Knowledge of safe abortion providers has increased significantly each survey round, and at endline over 50% of women knew where to access safe abortion services. These are impressive changes in knowledge, but the use of CAC has not increased accordingly and has remained flat, even among women that had abortions recently.



Women's feelings of empowerment to discuss and use contraceptives, and to refuse sex with their husband/partner, have both increased significantly since the baseline. From less than 10% to over one-quarter of women now feel empowered in these aspects of their sexual and reproductive lives. A large majority of women (over 80%) are also directly responsible for their own health care decisions; either solely or jointly with their husband/partner.

Overall, participation in PSL activities was correlated with positive changes in many of these indicators of women's sexual and reproductive health, especially knowledge and use of modern contraception, and women's sexual and reproductive empowerment and decision-making. Participation in these interventions was also correlated with improved knowledge of abortion legality, and uptake of modern contraception after an abortion. Many of these indicators showed changes across multiple socioeconomic groups (youth/older women, single/married women, etc.) indicating that BCC activities were inclusive of different types of women. Differences in participation among women of different educational levels at midline was no longer present at endline, a fact which should be noted.

In terms of sustainability, the findings from the FGDs and interviews with HR and infirmary staff are that the factories (both management and workers) would like to continue with the BCC activities, as they were helpful for increasing then knowledge of both female workers and infirmary staff, especially on contraceptive methods and techniques. Some HR staff expressed that the factories are prepared to continue these communications themselves even when the NGOs stop their activities.

## **Recommendations**

Although PSL is ending, there are some recommendations that could be made from the endline analysis. The overall recommendation that can be made from these findings is that future activities should be more targeted to specific sub-groups and areas of unmet need. This is because knowledge of contraception is nearly universal among WRA in Cambodia, including among female garment factory workers. Unmet contraceptive need is also low among this group, although there is a high usage of traditional methods; especially withdrawal. Further contraceptive activities could thus target women specifically based on either high need (married women who want birth spacing/limiting) and/or low utilisation; e.g., women in specific sub-groups with lower utilisation, such as younger women (under 25 years old) and those with higher education. Activities could include identification and specific support for contraception for married women that have never used contraception (e.g., reproductive health vouchers for this group). Analysis of individual factories would probably be necessary to understand the barriers to access and utilisation among the specific target groups.

Other recommendations that may be helpful for future projects on similar topics with similar populations include:

- Increase knowledge in specific areas. The knowledge areas with the greatest potential for improvement after the endline are:
  - Pregnancy danger signs;
  - Neonatal danger signs;
  - Legality of abortion;



- Safe abortion providers.
- Focus on increasing utilisation of LAPMs. Nearly all women in this study are aware of LAPMs, and the proportion of contraceptive demand filled by modern contraceptives is relatively high. However, most of this demand is filled by the daily pill. Therefore, future interventions could focus specifically on increasing the utilisation of LAPMs. Efforts could include vouchers for LAPMs at trained healthcare providers that have partnered with the project (either public, private or NGO providers), promotional materials and communication campaigns specifically targeted to LAPMs, and discussions with women to understand and assuage their reasons for hesitancy in using LAPMs.
- Improve contraceptive counselling and uptake of modern contraceptive methods after birth and abortion. Contraceptive counselling indicators (after birth or an abortion) were flat throughout the study period, and uptake of modern contraception after an abortion significantly declined from the midline. Future programs or activities could focus on improving contraceptive knowledge and utilisation in these situations, where women clearly have a need for contraception (either for birth spacing or limiting) which this study shows is not being met. Such an intervention would likely need to be undertaken in collaboration with local, external medical providers (public and private) to be most effective. For an example of this type of program see the Marie Stopes/Population Council's WorkerHealth program, which created links between factories and private medical providers in the areas, including training private providers in contraception and counselling methods.
- Enhance understanding of the importance of follow-up visits after childbirth (PNC2). There was no significant change in the PNC indicator, mostly because women did not get appropriate follow-up visits after they checked out of the hospital (PNC2). Further work could therefore be done to emphasise the importance of these follow-up visits at medical facilities, for the health of both mothers and children.



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## Annex 1: Selected MERI and SDG indicators disaggregated by *Chat!* participation

	Baseline	Mid	line	Endl	ine
	No <i>Chat!</i> participation (n=909)	No <i>Chat!</i> participation (n=301)	<i>Chat!</i> participation (n=211)	No <i>Chat!</i> participation (n=347)	<i>Chat!</i> participation (n=380)
O2.1. #/% of target population using modern					
contraception (FTIRM)	10.6%	20.8%	21.5%	21.6%*	29.2%*
- All women of reproductive age	24.2%	42.1%	38.8%	39.7%	45.5%
<ul> <li>Sexually active women of reproductive age</li> </ul>					
O2.2. % of women (modern family planning users) using					
long acting or permanent methods (LAPM) of family planning	11.5%	16.9%	10.7%	14.7%	14.4%
O2.3. % of garment factory workers accessing reproductive maternal or peopatal health (RMNH)	6.8%	5.2%	6.8%	8 1%*	13 7%*
services in the previous 12 months	0.070	5.270	0.070	0.170	13.770
O3.3: % of target population who report being highly satisfied with RMNH services provided	23.1%	18.1%	18.2%	40.7%	58.0%
I3.1: % of target population accessing RMNH services using a financial support mechanism in the previous 12 months	6.9%	1.1%	2.3%	30.7%	34.9%
I4.3: % of women who feel empowered to discuss and use modern family planning	6.1%	22.6%	30.0%	22.8%*	29.2%*
I4.4: % of women who know that abortion is legal	7.9%	15.9%*	23.2%*	11.0%	15.8%
% of women that know where to access safe abortion services	20.1%	34.0%*	55.4%*	49.0%*	57.9%*
SDG 3.7.1: Contraceptive demand satisfied by modern methods	-	-	-	59.1%	61.3%
SDG 5.6.1: Informed reproductive health decision-making	_	_	_	18.8%	17.6%
* Statistically significant difference (p≤0.05) between sub-gro	oups within each su	irvey round.			
Note: Sample was among the two factories at midline and th	ree factories at end	dline that were inv	olved in Chat!		



## **Annex 2: Endline Questionnaires**

## Quantitative questionnaire

					1
Factory:					2
					3
					4
Province:				Phnom Penh	12
				Other (specify)	88
Sex of respor	ident:			Male	1
				Female	2
Q1. 1.1 How	old are you?			Age (years):	
				No	0
nave you nat	any ive birth		Untils!	Yes	1
Name of resp	oondent:				
Worker ID Co	ode:				
	1 <sup>st</sup> attempt	1 <sup>st</sup> appointment	2 <sup>nd</sup> attempt	2 <sup>nd</sup> appointment	3 <sup>rd</sup> attempt
Date	/ /18	/ /18	/ /18	/ /18	/ /18
Time					
Location					
Interviewer					
		Result Code	s - Circle the corre	ct code	
				Completed	1



2	Incomplete-respondent termination
3	Incomplete-third party interruption
4	Respondent refusal
5	Parent/ administrator/ husband refusal
6	Respondent absent at 2nd appointment
7	Cannot interview respondent. e.g. mute/deaf/mental health etc
8	Respondent not eligible

#### Introduction

I am <u>(Your name)</u> working for Angkor Research in collaboration with the organizations CARE and Marie Stopes, as part of Partnering to Save Lives. We are conducting a survey of women working at garment factories in Phnom Penh and Kandal province. The purpose of the study is to assess knowledge about maternal, sexual and reproductive health, access and service utilization as well as to assess how successful the PSL program has been in improving access to sexual and reproductive health information and services. We would like to request your cooperation for no more than 30 minutes to ask you some questions.

I will ask you some personal questions. You are free to refuse to answer any question, or to pause or terminate the interview at any time. What you tell me will be kept strictly confidential. We won't share your information with anyone. Please be totally truthful in your responses. Your participation is very important and will help PSL to improve their health services for women and garment factory workers.

If you have any questions about this research or the survey, you can contact the Angkor Research administrator, Khim Sarun, on 023 222 501.

Do you have any questions for me?

Can I start asking the questions now?

#### Section 1: Socio-demographics

2	No ( <b>Skip to Q</b> 4)	0
۷.	Yes	1



3.	What is the highest grade you completed?	Grade:	
	1.3 What is your current marital status?	Single and <b>NOT</b> in a regular relationship Single in committed	1
4.		relationship	Z
		Married	3
		Widowed/ Divorced	4
4A	How many children do you have?	Number:	
5.	Are you living alone?	No	0
		Yes (skip to Q7)	1
	1.4 Who do you live with now?	Parent	1
		Relatives (including children)	2
6.		Husband	3
		Friends (in rental room)	4
		Sweetheart (intimate partner)	5
		Other (specify)	88
7.	1.5 How long have you worked as a garment factory worker in total?	Years:	
7A	How long have you worked in this garment factory?	Years:	
Sectio	n2: Household Assets, Wealth and Debt	-	
8.	1.6 How much did you earn last month in total <b>USD</b> ?	USD:	



9.	Last month did you send any money to your family?	No (Skip to Q11)	0
	Last month, did you send any money to your failing:	Yes	1
10.	Last month, how much money did you send to your family?	USD:	

### Section3. 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.

		No difficulty	0
		Yes, some difficulty	1
11.	2.1 Do you have difficulty seeing, even if wearing glasses?	Yes, a lot of difficulty	2
		Yes, cannot do it at all	3
		No difficulty	0
4.2	2.2 Do you have difficulty hearing, even if using a hearing	Yes, some difficulty	1
12.	aid?	Yes, a lot of difficulty	2
		Yes, cannot do it at all	3
	2.3 Do you have difficulty walking or climbing stairs?	No difficulty	0
40		Yes, some difficulty	1
13.		Yes, a lot of difficulty	2
		Yes, cannot do it at all	3
	2.4 Do you have difficulty remembering or concentrating?	No difficulty	0
		Yes, some difficulty	1
14.		Yes, a lot of difficulty	2
		Yes, cannot do it at all	3
		No difficulty	0
	2.5 Do you have difficulty with self-care, such as washing all	Yes, some difficulty	1
15.	over or dressing?	Yes, a lot of difficulty	2
		Yes, cannot do it at all	3



		No difficulty	0
	2.6 Using your usual (customary) language, do you have	Yes, some difficulty	1
16.	understood?	Yes, a lot of difficulty	2
		Yes, cannot do it at all	3
Secti	on 4: Media (including social media)		
Now,	I want to ask you some questions about the media that you acce	ess and use.	
		No (skin to 019)	0
17.	Do you have a mobile phone?		1
		No	0
18.	Do you have a smartphone that you use to access the internet?	No	1
		No (Skin to 022)	0
19.	Do you access any forms of media, like newspapers, radio, TV or internet at least once per week?		1
		Radio	1
	Which forms of media do you access at least once per week?	Television	2
		Printed newspapers	3
20.		Printed magazines	4
		Internet	5
		Facebook	6
		Other (specify)	88
		Radio	1
		Television	2
		Printed newspapers	З
			J 4
21.	Which form of media do you access the most?	Printed magazines	4
		Internet	5
		Facebook	6
		Other (specify)	88



#### Section5: 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.

		Factory infirmary staff
		Family / friends / colleagues
Which sources of information do you use or think you will	Health centre staff	
	NGO staff/activities	
22.	<b>22.</b> use, to get information on reproductive health? The next source?	Leaflet / banner / T-shirt
		TV
		Radio
		Facebook
		Internet

Section	6: Exposure to Current BCC Campaign		
23	In the last 3 months, have you heard or seen any contraceptive	No	0
23.	advertising?	Yes	1
		No	0
24.	In the <b>last 3 months,</b> did you see a poster/ leaflet/ Knhom Samrab Nak hotline card?	Yes	1
		Don't know/remember	99
		No	0
25. A	Did you <b>ever</b> attend a lunchtime sexual and reproductive health meeting?	Yes	1
		Don't know/remember	99
		No	0
26. A	Did you <b>ever</b> speak to a peer educator?	Yes	1
		Don't know/remember	99
	Section 6A: Chat! Contraception exposure.		
274	Have you ever seen any of the Chat! Contraception videos?	No (Skip to Q29A)	0
		Yes	1
27B	How many <i>Chat</i> ! Contraception video viewings have you seen in total?	Viewings:	



27	In the last 3 months, have you seen any of the Chat! Contraception	No (Skip to Q29A)	0
27.	videos?	Yes	1
20	How many <i>Chat</i> ! Contraception video viewings did you see in the <b>last 3</b>	Viewings:	
28.	months?	Don't know/remember	-99
20.4	Usua you ever attended any of the Chatl Contragention sessions?	No (Skip to Q31A)	0
294	have you ever attended any of the <i>Chut</i> ? Contraception sessions?	Yes	1
29B	How many Chat! Contraception sessions did you attend?	Times:	
29	In the last 3 months, have you attended any of the Chat! Contraception	No (Skip to Q31A)	0
29.	sessions?	Yes	1
20	How many <i>Chat!</i> Contraception sessions did you attend in the <b>last 3</b>	Times:	
30.	months?	Don't know/remember	-99
21.6	Have you ever played the <i>Chat!</i> Contraception mobile game ( <b>បងស្រី</b> ល្អ)?	No (Skip to C1)	0
31A		Yes	1
31B	Approximately how long did you play the <i>Chat!</i> Contraception mobile game ( <b>បងស្រី</b> ស្អ)	Hours:	
24	In the <b>last 3 months</b> , have you played the <i>Chat!</i> Contraception mobile	No <b>(Skip to Q33)</b>	0
31.	game ( <b>បំងំស្រំល្អ</b> )?	Yes	1
	Approximately how long did you play the <i>Chat!</i> Contraception mobile	Hours:	
32.	game ( <b>ប៉ង់ស្រ៊ីល្អ្</b> ) in the <b>last 3 months</b> ?	Don't know/remember	-99
22	What is the highest level that you achieved on the <i>Chat!</i> Contraception	Level:	
55.	mobile game?	Don't know/remember	-99
C1	Did you receive anything for your participation in <i>Chat!</i> Contraception	No (skip to Q34)	0
	meetings, events or games?	Yes	1
		Certificate	1
C2	What did you receive?	Jacket	2
		Other (specify)	88



Sectio	n 7. Garment Factory Infirmary		
		No (skip to Q40)	0
34.	Does the factory where you work have an infirmary?	Yes	1
		No	
35.	3.1 Have you ever used the factory infirmary in the past 12 months?	Yes ( <b>Skip to Q37)</b>	1
		Don't know /Maybe ( <b>Skip to Q37)</b>	99
		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 No commodity available Medicine not effective Infirmary is not clean Type of health service required not available Lack of confidentiality Did not require any health services / not sick	5
			6
36.	3.2 Why have you not used the infirmary?		7
			8
			9
			10
			11
		Need recommendation letter	12
		Other (specify)	Q40)0100100000000000000000000000000000011<
		Minor health problem	1
		Injury/first aid	2
		ANC counselling	3
	2.2. If yes, what services have you used from the factory	Short term family planning (condom, pill, injection)	4
37.	infirmary?	HIV counselling/testing referral	5
		STI counselling and referral	6
		FP counselling and referral	7
		Abortion counselling and referral	8
		Other (specify)	88



		Very satisfied	1
		Satisfied	2
38.	3.4 How satisfied are you with the services provided at the infirmary?	Neither satisfied nor dissatisfied3Somewhat dissatisfied4	3
			4
		Very dissatisfied	5
20	3.5 Would you recommend the infirmary services to your	No	0
39.	friends/co-workers?	Yes	
		No referral	1
		No referral1Family planning services2Safe abortion3STI services4ANC visit5PNC visit6	2
			3
40	3.6 Have you received a referral from the infirmary staff or		4
40.	following services?	ANC visit	5
		PNC visit VCCT	6
			7
		Other (specify)	88
41	Have you ever used a public or private health facility in the	No <b>(skip to Q44)</b>	0
41.	past 12 months, apart from factory infirmary?	Yes	1
		Public hospital / health center	1
	The last time you went to a health facility, which one did you	Private clinic or hospital	2
42.	go to?	No0Yes1No referral1Family planning services2Safe abortion3STI services4ANC visit5PNC visit6VCCT7Other (specify)88No (skip to Q44)0Yes1Public hospital / health center1Private clinic or hospital2NGO clinic3Other (specify)88Very satisfied1a. wi field1	3
		Other (specify)	88
		Very satisfied	1
		Satisfied	2
43.	3.8 How satisfied were you with the services provided at <b>this</b> health facility?	Neither satisfied nor dissatisfied	3
	near an analy i	Somewhat dissatisfied	4
		Very dissatisfied	5



Section 8 Sexual activity and contraceptive use					
44.	Have you ever heard about contraception (things that a man or	No <b>(ski</b>	p to Q59)		0
	woman can do to stop the woman from becoming pregnant)?	Yes			1
What contraceptive methods have you heard of?			Spontaneous	<b>Prom</b> Have y heard meta	<b>upted</b> ou ever of this hod?
			YES	YES	NO
45.	<b>Female Sterilization</b> . The hands of a woman's uterus can be tied to avoid getting pregnant.			1	0
46.	Male Sterilization. The man's tubes can be knotted to avoid getting pregnant.			1	0
47.	IUD. This device is placed in a woman's uterus by a doctor or a nurse to prevent pregnancy.		2	1	0
48.	<b>Injection</b> . Woman can have an injection that prevents them from becoming pregnant for several months.		2	1	0
49.	<b>Implant</b> . This is a small rod that is placed in a woman's upper arm, which can prevent pregnancy for several months.		2	1	0
50.	<b>Daily pill</b> . Woman can swallow a pill every day to avoid getting pregnant. (Daily pill)		2	1	0
51.	<b>Monthly pill.</b> Woman can take a pill every month to avoid getting pregnant. (Monthly pill)	3	2	1	0
52.	<b>Condom (male).</b> Women/men can put a rubber sheath over the penis before sex.		2	1	0
53.	<b>Female Condom</b> . Women can put a rubber sheath in the vagina before sex.		2	1	0
54.	Emergency contraception. Pills can be swallowed up to 120 hours after unprotected sex to prevent pregnancy.		2	1	0
55.	Lactic Amenorrhoea Method. Women who exclusively breastfee avoid pregnancy.	d may	2	1	0



56.	<b>Calendar/Rhythm Method</b> . Women can avoid having sex during fertile periods		2	1	0
57.	Withdrawal. "Spilling water out of the jar" (removing penis before white liquid comes out)		2	1	0
58.	<b>Abstinence</b> . Women can avoid having sex altogether, to prevent pregnancy.		2	1	0
		No <b>(Ski</b> j	o to Q69)		0
59.	Have you been sexually active in the last 12 months?	Yes			1
	4.3 In the past 12 months have you used any methods of	No <b>(Ski</b> j	o to Q68A)		0
60.	contraception?	Yes			1
		Female	sterilization		1
		Male sterilization		2	
		IUD		3	
		Injectio	n		4
		Implant			5
		Daily pi	lls		6
		Monthl	y pills		7
		Condon	n (male)		8
61.	4.4 If yes, which ones?	Female	condom		9
		Emerge	ncy contracep	tion	10
		Lactational amenorrhea method		11	
		Rhythm	method		12
		Withdra	awal		13
		Abstine	nce		14
		Other 1 (specify)		88	
		Other 2	(specify)		89
67	Are you <b>currently</b> using any contraception, including	No <b>(ski</b> j	o to Q2)		0
02.	traditional methods?	Yes			1



		Female sterilization	1
		Male sterilization	2
		IUD	3
		Injection	4
		Implant	5
		Daily pills	6
		Monthly pills	7
		Condom (male)	8
63.	Which contraceptive methods are you currently using?	Female condom	9
		Emergency contraception	10
		Lactational amenorrhea method11Rhythm Method12Withdrawal13Abstinence14Other 1 (specify)88	11
			12
			13
	Abstinence Other 1 (specify)	14	
		Other 1 (specify)	88
		Other 2 (specify)	89
		No modern contraceptive used	0
		Female sterilization	1
		Other 1 (specify)88Other 2 (specify)89No modern contraceptive used0Female sterilization1Male sterilization2UD2	2
		IUD	3
		Injection	4
64	What is the <b>last</b> modern contraceptive method that you used	Implant	5
04.	in the last 12 months?	Daily pills	6
		Monthly pills	7
		Condom (male)	8
		Female condom	9
		Emergency contraception	10
		Other modern contraceptive	88
65.	4.5 Last time, where did you go to get this contraception?	National hospital (PP)	1



		п — — — — — — — — — — — — — — — — — — —	
		Provincial hospital (RH)	2
		Referral hospital (RH)	3
		Health center or health post	4
		Garment factory infirmary	5
		NGO facility (specify)	6
		Private hospital (specify)	7
		Private clinic (specify)	8
		Private pharmacy/drug store	9
		Community-based distributor	10
		Friend/relative	11
		Other	88
	Could you tell me, the last time you used family planning	No (Skip to Q69)	0
66.	services, did you spend any money?	Yes	1
67.	How much money did you spend for fees for family planning	Riel:	
	services the last time?		
68.	How much money did you spend for <b>transport for family</b> planning services the last time?	Riel:	
		Not having sex / Husband far away	1
		Want to have a child	2
		Cannot have child anymore (infecund)	3
		Do not like side effects	4
		Fear of complications / effect on health	5
68A	Why did you not use contraception / stop using contraception?	Sexual dissatisfaction	6
		Too expensive	7
		Hard to find	8
		No longer in relationship (divorced, etc.)	9
		Disapproval by family or partner	10
		Other (specify)	88

Section 9. Pregnancy and maternal health



60	E 1 House your been programt?	No (Skip to QF2)	0
69.	5.1 Have you ever been pregnant?	Yes	1
70.	5.2 How many times have you been pregnant in your life?	Times:	
71	The last time you got pregnant, were you using <b>any</b> method	No (skip to Q73)	0
/1.	of contraception?	Yes	1
		Female sterilization	1
		Male sterilization	2
		IUD	3
72.		Injection	4
		Implant	5
		Daily pills	6
		Monthly pills7ere you using?Condom (male)8Female condom9Emergency contraception10Lactational amenorrhea method11Rhythm Method12	7
	Which method of contraception were you using?		8
			9
			10
			11
			12
	Withdrawal	13	
		Abstinence	14
		Other	88
73.	Have you ever given birth <i>(including stillbirths)</i> ?	No <b>(skip to QF1)</b> Yes	
	, , , , , , , , , , , , , , , , , , ,		
74.	5.4 How many live babies have you delivered?	Number babies :	
75.	How many live births have you had <b>in the last 24 months</b> ?	Births:	
76.	5.5 How long ago was your last live birth?	Months:	



77.	5.8 When you were pregnant with your last live birth, did you ever go for antenatal care visits?	No <b>(Skip to Q85)</b> Yes	0
78.	5.9 How many antenatal care visits did you have?	Times:	

Now, I	want to ask you about e 79. In which month of the pregnancy	each of these antenatal care visits, from the earlie 80. Where did you go for this antenatal care visit?	est to the most recent. 81. Who examined you during this visit?
	was visit?	1: National hospital (PP) 2: Provincial hospital (RH) 3: District hospital (RH) 4: Health centre or health post 5: Military hospital 6: Other public facility (specify) 7: Private hospital 8: NGO clinic (specify 9: Private clinic/cabinet 10: Other private medical facility 11: Garment factory infirmary 12. Your home 13: Other home 88: Other (specify) 99: Don't know	1: Doctor/Medical assistant 2: Midwife 3: Nurse 4: Other trained health personnel 5: Traditional birth attendant 6: Relative/friend 88: Other (specify) 99: Don't know
1			

82.	3.9 Could you tell me, did you spend money for antenatal care	No <b>(Skip to Q85)</b>	0
	services the last live birth?	Yes	1
83.	How much money did you spend for <b>fees for antenatal care</b> services the last live birth?	Riel:	
84.	How much money did you spend for <b>transport for antenatal</b> care services the last live birth?	Riel:	
85.	5.11 Can you name any danger signs that indicate a problem during a pregnancy?	Vaginal bleeding in early and late pregnancy	1
		Anaemia	2



		Elevated blood pressure	3
		Eever during pregnancy and labour	۵ ۵
		Abdominal pain in early programsy	5
		Abdominal pain in later programs	5
		Difficulturin basething	7
		Difficulty in breatning	/
		Loss of fetal movements	8
		Pre-labour rupture of membranes	9
		Other (specify)	88
		Don't know	99
		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
86.	5.6 For your last live birth, where did you deliver the baby?	Private clinic/cabinet	8
		NGO facility (specify)	9
		NGO facility (specify)9Other private medical facility10	10
		Garment factory infirmary	11
		Your home	12
		Other home	13
		Other (specify)	88
		No one helped	1
		Doctor/Medical assistant	2
		Midwife	3
87.	5.7 Who assisted with the delivery of your last live birth?	Nurse	4
	, ,	Other trained health personnel	5
		Traditional birth attendant	6
		Relative/friend	7
			,



		Other (specify)	88
00	3.9 Could you tell me, did you spend money for <b>the most</b>	No (Skip to Q91)	0
00.	recent delivery and related services?	Yes	1
89.	How much money did you spent for <b>fees for delivery and</b> related services the last birth?	Riel:	
90.	How much money did you spend for <b>transport for delivery</b> and related services the last birth?	Riel:	
91.	Did you attempt to breastfeed this baby?	No <b>(skip to Q93A)</b>	0
		Yes	1
92.	How long after this delivery was the baby put to your breast?	Hours:	
937	After you gave birth, did anyone check on your health and/or	No (skip to Q105)	0
55A	the baby's health?	Yes	1
97A	How many check-ups did you and/or the baby receive?	Number:	

98. How long	98A. Time	<b>99.</b> Who	<b>100.</b> Where did they	<b>101.</b> Who performed the
after delivery was	unit	received	receive this check-up?	check-up?
check-up?		this check-	1: National hospital (PP)	1: Doctor/Medical assistar
	Hour	up?	2: Provincial hospital (RH)	2: Midwife
	Day		3: District hospital (RH)	3: Nurse
	Week	1: Mother	4: Health centre or health	4: Other trained health
		only	post	personnel
			5: Military hospital	5: Traditional birth
		2: Baby only	6: Other public facility	attendant
			(specify)	6: Relative/friend
		3: Both	7: Private hospital	88: Other (specify)
			8: NGO clinic (specify	99: Don't know
			9: Private clinic/cabinet	
			10: Other private medical	
			facility	
			11: Garment factory	
			infirmary	
			12. Your home	
			13: Other home	
			88: Other (specify)	
			99: Don't know	



1			

103	3.9 Could you tell me, did you spend any money for these	No <b>(Skip to Q105)</b>	0
102.	postnatal care services for the last birth?	Yes	1
103.	How much money did you spend for fees for postnatal care services the last birth?	Riel:	
104.	How much money did you spend for <b>transport for postnatal</b> care services the last birth?	Riel:	
105	5.16 Did anyone talk to you about your contraception choices	No <b>(Skip to Q107)</b>	0
105.	within 7 days after delivery of your most recent live birth?	Yes	1
		Female sterilization	1
	5.17 Which methods did they talk to you about?	Male sterilization	2
		IUD	3
		Injection	4
		Implant	5
		Daily pills	6
		Monthly pills	7
106.		Condom (male)	8
		Female condom	9
		Emergency contraception	10
		Lactation amenorrhea method	11
		Rhythm Method	12
		Withdrawal	13
		Abstinence	14
		Other (specify)	88
107.	How old is this baby now?	Months:	
400		No	0
108.	Yesterday, did this baby drink only breastmilk?	Yes	1
L	1	<u>_</u>	



		Don't know	99
109.	How long after this birth did you return to work?	Months:	
110	Deep this halos surrently live with you?	No	0
110.	Does this baby currently live with you?	Yes	1
		Abnormal body temperature	1
		Jaundice	2
	5.15 Can you name any danger signs of neonatal distress?	Lethargy	3
		Feeding difficulty	4
		Vomiting and/or abdominal distension	5
111.		Bleeding and/or pale	6
		Umbilicus red and swollen, draining pus, or foul smelling	7
		Eyes red, swollen, or draining pus	8
		Convulsion	9
		Other (specify)	88
		Don't know	99

## Section 9A. Fertility preference

		No	0
F1	Are you currently pregnant?	Yes	1
		Unsure / don't know	97
		Have a / another child	1
	<i>If currently pregnant, ask "After the birth of this child…"</i> Would you like to have a child / another child, or would you prefer not to have any (more) children?	No more / None (skip to QF5)	2
F2		Cannot get pregnant (sterile, infecund, etc.) ( <b>skip to Q112)</b>	3
		Undecided / don't know	99
		(skip to Q112)	
	If currently pregnant, ask "From the birth of this child"		
F3	From now, how long would you like to wait before the birth of another child?	Months:	
	You have said that you do not want another child soon. Can	Single / Not in relationship	0
F4	you tell me why you are <b>not</b> currently using a contraceptive method?	Not having sex / Husband far away	1



		Do not like side effects	2
		Fear of complications / effect on health	3
		Sexual dissatisfaction	4
		Too expensive	5
		Hard to find	6
		No longer in relationship (divorced, etc.)	7
		Disapproval by family or partner	8
		Other (specify)	88
		Not having sex / Husband far away	1
		Do not like side effects	2
		Fear of complications / effect on health	3
	You have said that you do not want a child / anymore children	Sexual dissatisfaction	4
F5	Can you tell me why you are <b>not</b> currently using a	Too expensive	5
	contraceptive method?	Hard to find	6
		No longer in relationship (divorced, etc.)	7
		Disapproval by family or partner	8
		Other (specify)	88

## Section 10. Abortion and post-abortion care

6.1 Do you know whether abortions are legal or illegal in Cambodia?	Legal	1
	Illegal	2
	Don't know	99
	Public health provider	1
6.2 Do you know where women can access safe abortion services?	Private health provider	2
	NGO clinic (Specify)	3
	Pharmacy	4
	Traditional birth attendant (TBA)	5
	<ul><li>6.1 Do you know whether abortions are legal or illegal in Cambodia?</li><li>6.2 Do you know where women can access safe abortion services?</li></ul>	6.1 Do you know whether abortions are legal or illegal in Cambodia?LegalIllegalDon't know6.2 Do you know where women can access safe abortion services?Public health providerPrivate health providerNGO clinic (Specify)PharmacyTraditional birth attendant (TBA)



		Other (specify)	88
		Don't know	99
		No (Skip to Q126)	0
114.	6.3 Have you ever had an induced abortion?	Yes	1
115.	6.4 If yes, how many times?	Times:	
116.	When was the last abortion?	Year:	
		Vacuum aspiration	1
		Medical abortion pill	2
117	C <b>The last time</b> how was the obsertion induced?	Traditional method	3
117.	6.5 The last time, now was the abortion induced?	Self-aborted	4
		Other (Specify)	88
		Don't know	99
		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
	6.6 Where did you go to receive the method in the <b>last</b>	Private hospital	7
118.	induced abortion?	Private clinic/cabinet	8
		Other private medical facility	9
		NGO facility	10
		Garment factory infirmary	11
		Pharmacy/drug store	12
		Your home	13
		Other home	14
		Other (specify)	88



110	3.9 Could you tell me, did you spend money for <b>the most recent</b>	No <b>(Skip to Q122</b> )	0
119.	abortion and related services?	Yes	1
120.	How much money did you spend for <b>fees for abortion-related</b> services the last time?	Riel:	
121.	How much money did you spend for transport for abortion- related services the last time?	Riel:	
122	6.7 Did anyone discuss your contraception choices with	No (Skip to Q124)	0
122.	you within 14 days after you had the abortion?	Yes	1
		Female sterilization	1
		Male sterilization	2
		IUD	3
		Injection	4
		Implant	5
		Daily pills	6
	6.8 Which methods did they talk to you shout?	Monthly pills	7
123.		Condom (male)	8
		Female condom	9
		Emergency contraception	10
		Lactational amenorrhea method	11
		Rhythm method	12
		Withdrawal	13
		Abstinence	14
		Other (specify)	88
124	6.9 Did you start to use any contraceptive method within 14	No <b>(Skip to Q126)</b>	0
124.	days of the last abortion?	Yes	1
		Female sterilization	1
125	6.10 Which method <b>s</b> did you start to use?	Male sterilization	2
125.	Multiple answers possible. Do not prompt.	IUD	3
		Injection	4



	Implant	5
	Daily pills	6
	Monthly pills	7
	Condom (male)	8
	Female condom	9
	Emergency contraception	10
	Lactational amenorrhea method	11
	Rhythm method	12
	Withdrawal	13
	Abstinence	14
	Other (specify)	88
<b>C</b>		

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.

126.	Did you receive any financial assistance for using any of the above mentioned services?	No <b>(skip to Q128)</b> Yes	0
		FP voucher	1
	If yes, which kind of assistance did you receive?	Referral slip	2
		HEF/SOA	3
127		Community health insurance	4
127.		Private/personal insurance	5
		National Social Security Fund	6
		Private contributions	7
		Other (specify)	88
128	Did you borrow any money to hav for any of the above costs?	No <b>(skip to Q131)</b>	0
120.	Did you borrow any money to pay for any of the above costs?	Yes	1
129.	What was the total value of all loans taken to pay for these services and transportation?	Riel:	



	Who did you borrow from for these loans?	Money lenders	1
		Friends/Neighbours	2
420		Microfinance institutions	3
130.		Banks	4
		Relatives	5
		Other (specify)	88
Section Now plann some	on 12. Sexual and Reproductive health rights I am going to ask you some questions about how confident or sure ing if wanted to do so. Even if you do not want to use family plann time in the future when you might wish to use it. How sure are you	e you are that you could use family ing right now, try to imagine u that you could:	
		No answer	0
		Not at all sure	1
121	7.1 Bring up the topic of family planning with your husband or	Somewhat unsure	2
131.	partner?	Neither sure/Unsure	3
		Somewhat sure	4
		Completely sure	5
	7.2 Tell your husband (or partner) that you wanted to use family planning?	No answer	0
		Not at all sure	1
122		Somewhat unsure	2
132.		Neither sure/Unsure	3
		Somewhat sure	4
		Completely sure	5
		No answer	0
		Not at all sure	1
122	7.2 Lico family planning?	Somewhat unsure	2
155.	7.3 Ose family planning:	Neither sure/Unsure	3
		Somewhat sure	4
		Completely sure	5
		No answer	0
124	7.4 Use family planning, even if your husband (or partner) did	Not at all sure	1
134.	not want to?	Somewhat unsure	2
		Neither sure/Unsure	3



		Somewhat sure	4				
		Completely sure	5				
134 A	Who usually makes decisions about health care for yourself: you, your husband/partner, you and your husband/partner jointly, or someone else?	Respondent	1				
		Husband / partner	2				
		Respondent and husband/partner jointly	3				
		Someone else	4				
		Other (specify)	88				
Now Even will b could	Now I am going to ask you some questions about whether you feel you can refuse to have sex in certain situations. Even if you are not in a relationship right now, try to imagine a time when you might be in a relationship. 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:						
		No answer	0				
		Not at all sure	1				
425		Somewhat unsure	2				
135.	7.5 When you don't want to, but he does?	Unsure	3				
		Somewhat sure	4				
		Completely sure	5				
	7.6 When you are tired?	No answer	0				
		Not at all sure	1				
120		Somewhat unsure	2				
136.		Unsure	3				
		Somewhat sure	4				
		Completely sure	5				
	7.7 When he gets angry with you if you don't want to?	No answer	0				
		Not at all sure	1				
127		Somewhat unsure	2				
137.		Unsure	3				
		Somewhat sure	4				
		Completely sure	5				
400	7.8 When he threatens to hurt you if you don't want to?	No answer	0				
138.		Not at all sure	1				



		Somewhat unsure	2
		Unsure	3
		Somewhat sure	4
		Completely sure	5
	7.9 When he threatens to have sex with other women if you don't want to?	No answer	0
		Not at all sure	1
139.		Somewhat unsure	2
		Unsure	3
		Somewhat sure	4
		Completely sure	5

901	Do you have a	a phone number?	Yes	01				
			No	02				
902	Record phone	e number.	Number:					
903 Do you have a second phone number		a second phone number?	Yes	01				
			No	02				
904	Record phone number.		Number:					
905	Thank you very much for your time today. We might need to		Yes	01				
	contact you again in the future to confirm your answers or find		No	02				
	out some more details. Would it be ok if we contact you on							
	one of these	phone numbers?						
COMMENTS		INTERVIEWER NOTES OR OPINIONS:						
Please note anything unusual or interesting about the interview. THANK YOU FOR YOUR PARTICIPATION IN THIS INTERVIEW !								



## Focus group discussion guide

**Factory Information** Factory name: 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:

## 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 Interventions**

- 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?
- 7. Do you think the factory should continue to do *Chat!* activities in the future? Which ones? Why?

### **RMNH Experience**

- 8. Do you know if this factory has a reproductive, maternal or neonatal health program?a. What does this program do in this factory?
- 9. 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?
- 10. How do you think the RMNH program in this factory could be improved? Are there topics you would like it to address?

## Infirmary Experience

- 11. 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?
- 12. Do many workers use the factory infirmary?
  - a. Please explain your answer: why or why not? What services do they primarily use?
- 13. Have you noticed any changes in the factory infirmary since you started using it? Do you think the infirmary is better or worse than before?
- 14. 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**

- 15. 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?

### NSSF

- 16. Are any of you registered with NSSF? That is, do you pay a certain amount from your paycheck every month for health insurance?
  - a. Do you know where the money you pay goes? If yes, where does it go?
  - b. Do you know where you can access services?
  - c. Do you know how much services cost?
  - d. Have you ever accessed services using NSSF health insurance? If yes, what were your experiences?
  - e. What would you like to know more about related to NSSF?

### Changes in individuals

- 17. Have you noticed any changes in your knowledge of sexual and reproductive health since you participated in these activities? How has your knowledge changed?
  - a. Have you noticed any changes in your co-workers' knowledge of sexual and reproductive health since participating in these activities? How has their knowledge changed?
- 18. Have you changed your understanding of contraception since you participated in these activities? How has your understanding changed?
  - b. Have your co-workers changed their understanding of contraception since participating in these activities? How has their understanding changed?



- 19. Have you changed the contraception that you use since participating in these activities? How have you changed?
  - c. Have you noticed changed in your **co-workers'** use of contraception since participating in these activities? How has it changed?
- 20. What challenges do women still experience in accessing and using family planning? How do you think access and use of family planning can be improved?



## In-depth interview guide: Factory infirmary staff

Factory Information Factory name: Province:

## **Respondent Characteristics**

### Respondent type:

Position in infirmary: Medical title (doctor, nurse, etc.):

### **Respondent information:**

Age: Sex (male/female): Education level (last grade, or last professional course completed): Number of years worked at this factory:

### **RMNH** Participation

- 1. 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?
- 2. 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?
- 3. What do you think is the most effective way to engage women in this factory on RMNH issues? Please give some examples.

### **BCC Interventions**

- 4. 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?
- 5. Have you seen/heard of the Chat! Contraception activities? Which activities have you seen/heard?
  - 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. Do you think the *Chat!* Contraception activities are useful for women in this factory? Why or why not?
- 7. How do you think *Chat!* Contraception can be improved? Are there any topics you would like it to address? Why?


#### **RMNH Experience**

- 8. Does this factory have a reproductive, maternal and neonatal health program?
  - a. What does this program do in this factory?
- 9. 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?
- 10. How do you think the RMNH program in this factory could be improved? Are there topics you would like it to address?
- 11. In terms of RMNH, what additional challenges does this infirmary face? Can you please give some examples?
- 12. What kind of training or additional support do you think would help improve RMNH services? Please give some examples.

## **Infirmary Experience**

- 13. What services does the infirmary offer? Which services are most popular with women in this factory?
- 14. Why do you think workers do/do not use the factory infirmary for some services? Please explain.
- 15. 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?

## Referrals

- 16. We would like to ask you about making referrals for workers to services outside the factory. Do you often refer workers for sexual reproductive health services?
  - a. If so, which sexual or reproductive health services do you refer for the most?
  - b. Do you use the referral directory?
  - c. What do you think about the referral directory? Is it useful or not?
  - d. What is your experience of making referrals to other facilities?
  - e. Are there ever any problems making these referrals? What are the main problems you experience making these referrals?
  - f. Do you ever follow up on these referrals with the workers?
  - g. In your opinion, what could be done to improve the way referrals are made?

#### NGO Support and Sustainability

- 17. How has (NGO) supported your infirmary? (e.g., with trainings, workshops, additional classes, etc.)
  - a. Has this NGO supported you? How
  - b. What changes have occurred in this infirmary after NGO support?
  - c. Has this support been mostly positive or negative? Please explain.
- 18. When the PSL project ends, do you think you will be able to sustain the same sexual reproductive health services, activities and referral options in your infirmary?
  - a. If yes, then what support would need to be in place to make this sustainable?
  - b. If no, why not? What more could be done?
  - c. How will you maintain training and capacity building for new infirmary staff?



- d. Will you need support from the Municipal Health Department (MHD) or the Ministry of Labour and Vocational Training (MoLVT)? What kind of support?
- 19. 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?



# In-depth interview guide: Factory human resource staff

## **Respondent Characteristics**

## Respondent type:

Position in factory:

#### **Respondent information:**

Age: Sex (male/female): Education level (last grade, or last professional course completed): Number of years worked at this factory:

## **RMNH** Participation

- 1. 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?
- 2. What does this factory do to support RMNH issues? Please give some examples.
  - a. Do you think these activities effective? Why or why not?
  - b. How could these activities be improved to make them more effective?
- 3. What do you think is the most effective way to engage women in this factory on RMNH issues? Please give some examples.

## **PSL Campaign Activities**

- 4. What do you know of the PSL program implemented in your factory? What has been your involvement in the program?
  - a. What did you think about the PSL programme and its messages and activities? Are they helpful?
  - b. Do you think the women in this factory are engaged with the PSL program? Are they learning anything from this campaign? Why?
  - c. What do you think can be done to improve the effectiveness of PSL?
- 5. When did you start implementing the *Chat!* Package within the factories?
- 6. What has been the greatest success and challenge of implementing the *Chat!* Package? What were your solutions to the challenges?
- 7. 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?
- 8. Do you think the *Chat!* Contraception activities are useful for women in this factory? Why or why not?
- 9. How do you think *Chat!* Contraception can be improved? Are there any topics you would like it to address? Why?



10. Do you think that the factory management's commitment to worker wellbeing has changed since the start of PSL? How has it changed?

#### **Infirmary Experience**

- 11. Which infirmary services are most popular with women in this factory? Why do you think workers do/do not use the factory infirmary for some services?
- 12. How easy or difficult is it for women to use the infirmary? Please explain.
- 13. Have you seen or heard of any changes in infirmary services and staff since the start of PSL cooperation? What changes have you seen or heard? Please give examples.
  - a. Why do you think these changes have happened? What were the biggest factors?
- 14. How do you think the infirmary staff or services could be improved? Please share your opinions with us. Are there any additional services you would like the infirmary to provide?
- 15. Have you ever used the infirmary directory?
  - a. When have you used it?
  - b. What do you think about the referral directory? Is it useful or not? How could it be improved?

#### NGO Support and Sustainability

- 16. When the PSL project ends, do you think you will be able to sustain the same sexual reproductive health services and activities (including *Chat!*) and referral options in your infirmary?
  - d. If yes, which activities? What support would need to be in place to make this sustainable?
  - e. If no, why not? What more could be done?
  - f. How will the factory support RMNH capacity building for new staff? Are any follow up activities planned?
  - g. Will you need support from the Municipal Health Department (MHD) or the Ministry of Labour and Vocational Training (MoLVT)? What kind of support?
- 17. Currently, what are the biggest challenges to improving worker health and wellbeing in your factory?
- 18. 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?
- 19. Is there anything else you would like to add?

