Evaluation of Advocacy for Reproductive Health Education and Services for Garment Factory Workers

[Final Report]

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1. Introduction

1.1 The setting

The need of raising reproductive health knowledge in reducing morbidity and mortality during pregnancy was widely reported although the level of awareness had remained very poor in the developing countries (Hussain *et al.*, 1997). Community-based intervention to promote health knowledge had been launched in many countries but the assessment of such attempts indicated that the achievements were minimal (Laverack *et al.*, 1997). Although the long-term behaviour change among the poor and marginalised groups was difficult by only education, health communication through mass media was effective in raising knowledge and facilitating behaviour change. Various health communication strategies such as interpersonal meetings and the use of mass media were adopted in disseminating knowledge. One major reason of high maternal morbidity in Bangladesh is the lack of maternal knowledge about the need of antenatal care and preventive measures. Despite the significant expansion of health services in the last two decades in the countryside, the health status has remained poor in Bangladesh (BBS, 1995).

Several health promotion approaches ranging from individual contacts to the use of popular arts were attempted in Bangladesh. Studies reported that the interpersonal communication was more effective than entertainment approach when the messages were targeted to general public (Hussain *et al*, 1997). Health promotion through raising the awareness of women was tried in many countries. The assumption was that women would become more interested in their own health and health care if their status and rights were improved. Reaching the poor and women was considered essential for any effective health system because, as found in many studies, the carefully designed programme could significantly change health behaviour (Rogers, 1996).

1.2 UNFPA supported projects

UNFPA has provided assistance to Bangladesh since 1974, initially through family planning programmes. Thereafter, emphasis had shifted towards women's health, accessibility and quality of maternal and child health services during the Third and Fourth Country Programmes of UNFPA. In its Fifth Country Programme (CP-V), the overall goal was to contribute to the improvement of the reproductive health and family welfare of the people of Bangladesh. The main purposes of CP-V were to increase the accessibility and utilization of reproductive health services among the hard-to-reach and vulnerable populations, improve the quality of reproductive health services, facilitate positive behavioural changes, create a supportive environment for improved health services and contribute to increased national technical capability to implement population policies and programmes. To achieve these objectives, three

sub-programmes had been designed in the areas of reproductive health, advocacy, and population and development strategies.

The advocacy programmes, focusing to improve the reproductive health and gender issues, were among the most innovative projects in Bangladesh. It as found that the public discussions were very limited in the media about the promotion of reproductive health and gender equality. It was expected that advocacy project would initiate a process of community dialogue and actions to reduce and prevent violence against women, early marriage and risky sexual behaviours, and promote access to better care during pregnancy and delivery. This can only happen if a critical mass of influential people could act as pressure groups to promote improved reproductive health services for the community. To foster a deeper interest and generate yielding discussions in civil society, several projects were designed and implemented. One of such projects was the promotion of reproductive health services and gender equity through *Bangladesh Garment Manufacturers and Exporters Association* (BGMEA). The projects began from late 1998 and continued till the end of 2002. This report is the end of project evaluation of the advocacy component project for garment factory workers.

1.3 Reproductive health education for garment workers

Family welfare and reproductive health education of garment workers was implemented by the *Bangladesh Garment Manufacturers and Exporters Association* (BGMEA). The project was aimed at increasing reproductive health education and make health services readily available for garment workers. Each factory had a Workers Welfare Committee, consisting of about 5 to 8 factory workers, who was responsible for first aid facilities, essential drugs, and contraceptive supplies. Each factory had at least two personnel designated as Factory Health Workers (FHW) who were trained in reproductive health, reproductive rights and gender issues, one of them being trained to be a paramedic. The project director, who is also a BGMEA director, was responsible for the overall management and monitoring of this project. The advocacy project was implemented in one industrial zone with 175 garment factories covering nearly 100,000 workers.

2. Purpose and methodology

2.1 Purpose

The purpose of this evaluation study was to evaluate the advocacy for reproductive health education and services for the garment factory workers. The specific objectives were to

- identify the constraints in implementing the project,
- assess the role of project in raising knowledge about reproductive health and gender equity,
- measure the promotion of the use of reproductive health services,
- examine the effectiveness of advocacy project activities.
- recommend suggestions for the expansion of the project.

2.2 Methodology

In this evaluation, a combination of approaches was used. These were sample survey of the garment workers, in-depth interviews with garment health workers and key project officials. The survey of workers focused essentially on the awareness and knowledge of selected issues of gender equity, reproductive health and reproductive rights, and health service utilisation patterns in the factory workers. A comparison group of garment workers with similar background who never received such services was interviewed. In addition, interviews with BGMEA officials and staff of BGMEA health centre were carried out. Also, factory facilities and project-related background documents were also examined.

A total of 39 garment factories were selected at random from 188 factories that were covered by advocacy project. In each selected factory, about 10-15 garment workers were again selected at random for the interviews. Thus, 627 workers were selected from the project garment factories. Similarly, 651 workers were randomly selected from the 37 non-project factories as a comparison group. In-depth interviews were conducted with a total of 42 factory health workers (FHW) from 22 project garment factories. For obvious reasons there was no comparison group for factory health workers. It should be noted that some of the project factories were now closed.

3. Assessment of advocacy through BGMEA

3.1 The advocacy project

3.1.1 Project implementation

Advocates in the project were the factory health workers who received training from a group of highly qualified trainers and resource persons. The factory health workers disseminate the reproductive health messages that they learned to their fellow colleagues in addition to other services as will be explained in the following sections. Such dissemination meetings were expected to be held monthly in batches of 30-35 factory workers. They were supposed to use posters, overhead projectors, chalkboard, and handouts for the dissemination meetings. Over 6,500 meetings have been held so far at the factory level since the project began in October 1998. However, the performance of those meeting was poor and the factory workers learned little from those meetings.

Table 1: Proportion of factory health workers having knowledge of gender and health issues

Characteristics	%	N
Gender inequality	11.9	5
Women's empowerment		
Equal rights	76.3	32
Decision about family planning	26.2	11
Decision making capacity	9.5	4
Reproductive health		
Reproductive organs	38.1	16
Safe motherhood	7.1	3
Adolescent health	38.4	16

3.1.2 Selection of advocates

The choice of garment factory workers as advocates for the promotion of reproductive rights and gender issues was inappropriate for two basic reasons. First, their social position and the level of understanding about various issues of reproductive health and gender equality did not allow them to be accepted among other workers (Table 1). Second, nearly half of the advocates were men who were expected to

disseminate such sensitive issues as reproductive rights and sexually transmitted diseases to women workers.

3.1.3 Design of the project

As had been mentioned in previous reports of the advocacy projects, there was a major flaw in the design of the advocacy project. The project for the garment factory workers should not be termed 'advocacy' projects. Rather, it was an IEM (information, education and motivation) project.

The project had a provision to collect benchmark information which helped to assess the impact of advocacy activities on selected aspects of reproductive health. However, no other reports, available for this evaluation, as found very useful. No information on the processes or changes were collected and reported.

3.2 Logical framework outputs and indicators

As mentioned earlier, the choice of factory workers to serve as advocates was a major error. Rather, the owners and BGMEA members could serve as advocates. However, it is noteworthy that the owners and BGMEA have allowed time, space and funds for the factory workers to take part in the advocacy projects. Future efforts should target factory owners and management staff to serve as potential advocates in health and gender issues.

The primary target group in this project had been the garment factory workers who are mostly women and poor. However, the project was purely educational and not designed for them to be advocates. In regard to positive attitudes and behaviour, the projects have been successful in some issues while not in others. The following sections will highlight the successes and shortcomings of the programmes on the participants. The awareness about gender equality and reproductive health issues appeared to increase as a result of the projects. But the extents to which they have gained knowledge on these issues have been limited as will be evidenced in later sections.

3.3 Factory health worker

The responsibility of factory health workers was to educate other factory workers on reproductive health, reproductive rights and gender issues. In addition, they would provide counselling and information, and contraceptives to their fellow workers. A *Workers Welfare Committee*, composed of 6-8 members of factory workers, provides information, conducts training sessions, and holds monthly meetings to educate other factory workers on reproductive health and gender issues. However, there has been limited success in raising awareness and knowledge. The utilisation of health services and the use of contraceptives

increased. These findings suggest that the meetings with the factory workers have been effective up to certain extent while there is still room for improvement.

Table 2. Assessment of training by garment health workers

Characteristics	%
Quality of training	
No, not enough	42.9
Moderate	33.3
Yes, sufficient	23.8
Problems in receiving training	
Workers are not interested	31.0
Not enough time is given	47.6
Scarcity of space for training	9.6
Training not done timely	14.3

To evaluate the level of knowledge in the factory workers, a total of 42 health workers were interviewed from 22 factories. As have seen earlier, their level of knowledge in various aspects of reproductive and gender issues were limited. When asked about the quality of training they received, only a quarter expressed their satisfaction with the training and nearly half of them regarded that the training was inadequate (Table 2). They mentioned lack of adequate time and space as obstacles to proper training.

3.4 BGMEA and garment factory owners

Before the project was implemented, workshops were organized with garment factory owners and BGMEA members to increase their knowledge and awareness on gender and reproductive health issues and gain their support for the implementation of the advocacy projects. These sessions were successful up to certain extent. Interviews with factory managers and BGMEA officials revealed a very supportive attitude toward this project. They understood that workers' health status was important to reduce time loss from work due to ill health. It is commendable to see that they took this advocacy project quite seriously and provided funds, time and space for the project. As stated previously, they could act as advocates rather than the factory workers.

3.5 The working environment

A total of 22 garment factories were inspected by the evaluation team members to assess the working conditions in the factories. Overall, the conditions were satisfactory in terms of air quality, space, toilet facilities, availability of drinking water, and waste disposal. However, there was no separate rest lounge for the workers to relax or take their meals. No childcare services were available in any of the factories. The factory management rarely included women which could significantly improve the working environment as well as the reduce gender-based harassment in the factories.

3.6 BGMEA health centre

The services provided at the health centre include treatment for minor injuries at work, antenatal care, skin diseases, and other illnesses. The project documents revealed that the use of contraceptives has increased manifold among garment workers. These figures indicate that the centre played an important role in raising contraceptive prevalence. The work-related injuries has significantly dropped from 53% to around 25% indicating a positive impact to raise the awareness on injury at the garment factories.

In-depth interviews with staff at the health centre revealed that the physicians could not give adequate time to the patients due to the high number of patients coming to the health centre every day. As a result, no time could be made to inquire or provide information on reproductive health issues. There is not enough room for privacy during treatment. Management of delivery with basic essential obstetric care can be provided in the health centre if appropriate equipment and trained staff could be placed.

Table 3. Decision-making role

Decision-making	Advocacy project	
	Participant	Non-participant
Spending money		
Alone	29.5	27.5
Need permission	26.2	24.5
Consult	11.3	9.6
Others	7.7	9.6
Education for children		
Alone	9.6	8.1
Need permission	20.8	17.6
Consult	8.6	4.3
Jointly	22.0	29.1
Treatment		
Alone	12.9	11.6
Need permission	29.9	26.5
Consult	15.8	12.5
Jointly	8.6	14.2

3.7 Decision-making

Decision-making capacity among workers is an indicator of their status in their household. In Table 3, decision-making role among the garment workers was seen in spending money for themselves that they earn, deciding whether their children or sisters should go to school and seeking health care when needed. Overall, it appears that the project garment workers were better able to decide by themselves but the difference was not significant.

3.8 Family planning

The awareness of family planning as a way to reduce unwanted birth was found universal amongst eligible women in Bangladesh. However, not all women were equally aware about the family planning methods (Table 4). Oral pills and condoms were widely known but the other methods such as injections, ligations, vasectomy and other methods were not well known. Compared to the baseline survey of 2000, the knowledge about methods seemed to significantly improve among the garment workers under the advocacy project. The observed differences in the level of awareness between the project garment workers and other workers was insignificant indicating that the interventions had very limited role in promoting contraceptive methods. The contraceptive prevalence rate, however, has improved during this period from 52.3% to 65.4%. The availability of reproductive health services and free medicines and contraceptives through UNFPA-funded clinic might have helped to raise the use of contraceptives.

Table 4. Types of family planning methods

Methods	Advocacy project	
	Participant	Non-participant
Oral pill	98.4	97.9
Condom	64.1	64.5
Injection	48.0	47.6
IUD	13.8	14.6
Norplant	5.3	5.0
Ligation	7.4	7.1
Vasectomy	6.1	4.7
MR	2.1	1.2
Safe period	3.4	1.2
Use of FP method		
Yes	65.4	55.6
No	34.6	44.4

3.9 Child preference

The desire for children was reduced as a result of the improvement of gender equity (Table 5). Similarly, the gender variation in preferring child (estimated as mean number of children), although still biased towards boys, tended to reduce among the project garment workers. Such difference was negligible but implies that advocacy project had some positive elements to reduce inherent gender bias among women and promote equity.

Table 5. Child preference

Pregnancy	Advocacy project	
	Participant	Non-participant
Desire for children		
1	14.0	9.5
2	69.1	67.4
3	16.9	23.1
Mean	2.00	2.05
Sex preference (mean)		
Boy	1.04	1.07
Girl	0.90	0.96

Table 6. Service provisions of the factories

Services	%
Types of services	
Health check-up	18.5
Medicines	18.9
TT	25.9
Behaviour of factory manager	
Very helpful	86.0
Not helpful	9.4
Improper/rude	4.6

3.10 Health service provisions

Only 43.3% of the workers received reproductive health services when in need (Table 6). Antenatal care services including routine health check-up and immunization during pregnancy were reported as the

primary reproductive services they received. The behaviour of factory managers towards the workers had also improved.

3.11 Safe motherhood and antenatal care

The level of awareness about the types of reproductive health services seemed to be poor among the garment workers (Table 7). No significant differences in understanding the types of reproductive illnesses, health care required and the need of visiting the health providers between the project and comparable garment workers were found. Unlike other advocacy projects, the garment workers were not fortunate to participate in training or workshop sessions. Instead, they had access to the health workers only who were poorly trained and had limited capacity to disseminate major features of reproductive health issues. This finding suggests that the garment workers should be given better access to information and services and use of the factory health workers for their training does not seem appropriate.

Table 7. Knowledge on maternal health and antenatal health care

Safe motherhood	Advocacy project	
	Participant	Non-participant
Type of sickness		
Anaemic/weakness	49.3	55.2
Dizziness	31.7	37.8
Headache	30.7	24.2
Oedema	22.8	15.7
Pain in abdomen	18.5	14.2
Fever	12.3	10.7
Convulsion	9.6	8.4
Vaginal bleeding	6.1	8.1
Breathlessness	7.8	6.7
Hazy vision	6.1	5.2
Services needed		
Nutritious diet	94.7	96.0
Adequate rest	72.9	72.8
TT	27.3	15.7
Treatment when needed	20.4	21.7
Iron supplementation	11.3	7.0
Sanitary toilet	4.2	5.4
Family planning advice	2.9	2.4

3.12 Reproductive rights

The advocacy project played a role in modifying the perceptions of reproductive rights among garment workers (Table 8). Regarding the decision in copulation and pregnancy, most of the garment workers felt

that the spouses should make joint decisions in both sexual acts and having a child. However, when asked whether women should decide alone about the use of contraceptive, less than half (49.4%) endorsed the idea that women should have the decision-making capacity by themselves. However, when compared to the non-intervention groups, there does not seem to be much difference in opinion suggesting that the intervention may not have played a major role in promoting reproductive rights among its participants.

Table 8. Knowledge of reproductive rights

Decision issues	Advocacy project	
	Participant	Non-participant
Sexual intercourse		
Both	96.3	95.7
Husband	21.1	3.2
Did not answer	1.6	1.1
Pregnancy		
Only husband	6.1	5.5
Only wife	3.1	3.4
Both	89.3	89.9
Contraception		
No	35.4	41.0
Yes	52.2	46.8
Partly	7.3	8.9

3.13 Sexually transmitted diseases (STD) and HIV/AIDS

The level of awareness of STD and AIDS was quite high and improved among the garment workers although the knowledge about their transmission and prevention were not so well known (Table 9). Only very few workers had a clear idea of how a person could be affected by sexually transmitted diseases. While the training curriculum of the advocacy on reproductive health services covered this aspect very well, the performance of health workers was probably not very satisfactory. This assumption was supported by the findings from in-depth interviews with the health workers who were expected to impart or disseminate health knowledge to their fellow colleagues. Of the health workers surveyed, only a small proportion of the sample factory health workers had a clear idea about STDs, the risk factors, preventive measures and treatment. As a result, role of the project in raising awareness among the garment workers was very limited.

Table 9. Knowledge of STD and HIV/AIDS

STD/AIDS	Advocacy project	
	Participant	Non-participant
Transmission of STD		
Sexual relations	8.3	6.0
Contaminated blood	1.1	--
Infected needle	0.9	0.9
Transmission of AIDS		
Use of infected needle	43.6	44.5
Mating with sex workers	28.1	25.1
Infected partner	17.6	7.8
Multiple sexual partners	5.9	4.5
Prevention of AIDS		
Using condom	38.8	36.4
Sex among spouses only	7.8	8.4

4. Summary and recommendations

While most of the industries in Bangladesh do not provided health services for their workers and employees, this advocacy initiative should be regarded as a milestone in promoting reproductive health gender equity issues in Bangladesh. This evaluation shows clearly that overall the advocacy project had positive impact among the garment workers in raising awareness and changing attitudes toward reproductive health and gender issues. The following sections review some important issues and suggest possible recommendations.

- Most workers knew about oral pills and condoms as methods of contraception while other methods were relatively unknown. Although the contraceptive prevalence rate had increased, the project had very limited role in promoting other contraceptive methods. It should be noted that provision of free medicine and contraceptives was suspended since October 2002 when funding from UNFPA had ended. As a result, the number of patients at the BGMEA health centre had remarkably dropped compared to preceding months. *It is, therefore, recommended that the provision for free medicines and contraceptives should be continued. Also, the next advocacy project should place more emphasis on relatively unknown methods of contraception where spouse should be invited to attend the training sessions if possible.*

- Awareness about types of antenatal care was low among the garment workers indicating that there may have been inadequate focus on this very important issue during the training sessions. This was probably obvious because the factory health workers (who were responsible to train the garment workers) had very limited knowledge about antenatal care. The approach of using factory health workers as advocates did not work at all. In-depth discussions with both the garment workers and the advocates (health workers) revealed that the scope to discuss their problems with colleagues was very limited because of heavy workload and time constraint. The health workers were not capable of helping their colleagues because of their level of understanding most of the issues. No refresher or follow-up training was organised for them. *It is not conceivable that factory health workers should play the role of advocates. The focus should be shifted from them to the owners and managers of the factories. As the health workers have already in the advocacy programme, they may be used as volunteers who can disseminate reproductive health and gender related issues. Provision should be made to provide refresher training for the health workers. They should be given better scope to train their colleagues with practical and visual demonstrations.*

- Reproductive rights and gender inequality were two important issues in the advocacy project which poorly addressed in this sector. As discussed earlier, the health workers were not qualified enough to train others about such delicate and sensitive issues. *It is suggested that factory managers and owners should be targeted to become advocates for gender equity issues. The factory health workers may be used as links between the advocates and the garment workers.*

- The awareness of STDs including AIDS has improved compared to what was reflected in the baseline survey although their knowledge on STD transmission and prevention was low. It should be pointed out that the factory health workers (trainers) who were interviewed were not able to clearly state the modes of transmission and means of prevention of STDs. Also, the selection of men to disseminate knowledge on STD and AIDS among factory workers who were all women was inappropriate. *In next phase of the project, the trainers on sexual health should be women since most of the garment workers are female.*

- Although the awareness level regarding the availability of health services improved among the garment workers, the utilisation of health services was low. One possible reason has been the introduction of fees for the reproductive health services. Lack of time among the workers to visit health clinic unless emergency was another cause of poor use of services. *It is recommended that the reproductive health services should be made free or heavily subsidised for factory workers. Provisions should be made to ensure the use of health services in working hours. Various types of dissemination materials such as posters, pamphlets and flyers at the factories may be used to enhance use of health care centre among factory workers.*

- The reported low prevalence of gender-based harassment or violence by co-workers should be regarded an improvement as a result of advocacy project. It is, however, quite possible that the such events were overlooked or not regarded as sexual harassment or were not reported out of fear or shyness. Another welcoming development was the approval of maternity leave by the factory management more often than what was reported in the baseline survey. *The incidence of sexual harassment should be more rigorously monitored. The factories should be encouraged to have written policies on these issues. The next phase should also focus on rights of workers so that they can get what they deserve in addition to health services.*

Most of the above deficiencies could be overcome with proper motivation, planning and coordination by the project staff. Training sessions should be more effective so that there is increased retention of information among the participants. Efforts to motivate factory owners and managers should be enhanced

to gain their support in future projects. Though the effectiveness of the projects has been limited, the project should continue in a more effective manner for the improvement of well-being of health of garment factory workers.

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