CARE CAMBODIA

Garment Factory Worker Perceptions

Reproductive Health

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Contents

Background

Under the auspices of Australian Aid's Australian Mekong NGO Engagement Platform (AMNEP) an NGO partnership was formed between Save the Children, CARE and Marie Stopes International Cambodia to contribute to addressing Cambodia's most urgent needs in reproductive, maternal and neonatal health. The Partnering to Save Lives (PSL) program, as represented by the three implementing NGOs, the Cambodian Ministry of Health (MoH) and Australian Aid, has been designed to support meeting the *Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality* (FTIRMN) targets for 2015, including Emergency Obstetric and Neonatal Care, Skilled Birth Attendance, Family Planning, Safe Abortion, Behaviour Change Communication (BCC), and Reducing Financial Barriers.

The overall goal of PSL is to save the lives of women and neonates in Cambodia through improved quality, access and utilization of reproductive, maternal and neonatal health services through a partnership approach

- Improved quality reproductive, maternal and neonatal health (RMNH) services for target populations
- Greater equity of access to appropriate RMNH services for target populations
- More responsive RMNH services meet the needs of target populations
- Improved RMNH behaviours amongst target populations
- Evidence-based innovation and learning that contributes to improved policy and practices
- A partnership model that demonstrates impact and value for money to achieve RMNH

Over the course of the next three years, PSL and partners will deliver activities designed to focus on six FTIRMN components on the populations in greatest need, while ensuring a strong focus on the enabling environment required initiating and sustaining change with the main aim to improve equitable access to quality RMNH services for garment factory workers.

A baseline survey was conducted to collect data to ensure the efficiency and effectiveness as well as promote accountability for the funding. The baseline established information about reproductive, maternal and newborn health among targeted female garment factory aged 18 to 30 years old in Phnom Penh and Kandal provinces. Based on findings in the baseline this research seeks to further understand some key findings related to reproductive health.

Objectives

The purpose of the Sexual, Reproductive and Maternal Health Garment Factory Workers Perception Research is to produce a better understanding of garment factory workers **perceived rights, perceptions, and barriers** to achieving improvements in sexual, reproductive and maternal health **with a particular focus on family planning, female and male relationship expectations, and gender norms.**

The specific objectives are:

- To understand why people are using or not using the services and commodities that are available for family planning and other relevant RMNH services, and to better understand how we can translate worker knowledge into worker practice.
- Collect key findings that will immediately and practically inform the BCC strategies and toolkit development for garment factories

Methodology

The methodology for this research was qualitative and included a brief desk review and focus group discussions.

Desk Review: A desk review was completed that included a review of the *Literature Review on Sexual and Reproductive Health Rights of Migrant Garment Factory Workers in Cambodia* conducted by UNFPA in June 2014, and the Baseline Survey Report on Knowledge and Access to Reproductive, Maternal and Newborn Health Services among Female Garment Factory Workers in Phnom Penh and Kandal province conducted by CARE Cambodia.

Focus Group Discussions: Focus Group Discussions (FGD) were used to gain insights with garment factory workers to better understanding some findings in the CARE's recent Baseline Survey particularly around family planning and contraception. A FGD guide was developed and is available in Annex A.

Since it was expected that perception, knowledge and practice might be different between married and non-married women, two FGDs were conducted with married women and 2 FGD with non-married women. To understand perceptions of men, 1 FGD was conducted with male garment factory workers. Each group had between 8-10 participants.

Garment factory workers participating in the FGDs were invited to join the FGD by CARE (3 FGDs) and through the support of the Worker Information Centers (2 FGDs). The FGDs were selected in communes of CARE's Safe Workplace Safe Communities Project. The FGDs participants also participated in discussions about sexual harassment. Those findings are reported in a separate report.

Consent and Confidentiality

At the beginning of each FGD participants were told verbally that the information they provided in the discussion would be added to information from other groups (aggregated) and that no persons' name would be reported. FGD participants were also told that any question that was too sensitive did not have to be answered, and that participants could leave at any time. FGD participants were asked for verbal agreement and all agreed to participate.

Limits of Research

The research is necessarily limited by the type of data collected. The responses have to be taken at face value as they cannot be verified and are opinions and perceptions.

Findings and discussion

The findings are categorized into key topic areas however, as the topics are inter-related some discussion overlaps.

Decision to have children

The FGDs began with a general discussion about the desire and decision to have children by women and men in Cambodia. Both male and female participants reported universally that in Cambodia married couples *expect* to have children. This was based on what was described as "Cambodian culture". Couples want to have children and expect to have children as this "honors" the family. However, just as strongly was the expectation that unmarried women would/should not have children.

FGD participants were asked about how couples (or individuals) make the decision to have children. This discussion included 'is the decision to have children discussed between the couple? Who decides about having children? Can the woman say what she wants in the decision-making process?'

Participants in FGDs reported that married couples very commonly have a discussion to make the decision about when to have children. The participants clearly described this as a decision about *when* to have children, not *whether* to have children. Again married couples expect to have children. The discussion between married couples about having children was not reported to be difficult or sensitive. Women reported that they felt confident to have this discussion with their husbands and could say what their opinions are easily. This did not seem to be an area of difficulty. When asked who made the final decision about having children most women said it was a joint decision. A minority did mention that if their husbands really wanted a child they would agree even if they were not ready.

For unmarried women their expectation (and the expectation of others) about having children when not married was very different. Participants reported clearly and strongly that unmarried women would/should not intentionally make a decision to have a child before marriage. This is further discussed in the section below.

Reasons for pregnancy prevention

Participants were asked to discuss under what conditions women (or couples) want to prevent pregnancy. Prevention of pregnancy was routinely described for two main reasons 1) economics, and 2) being unmarried.

As identified above, married couples expect to have children. This was universal. However, the FGD participants reported that couples do commonly make a decision to delay having children. This was based most commonly on the economic status of the family. Participants would report that they (couples) would wait to have children due to "lack of money" or a "poor economic situation" or "job or livelihood that is not stable". Both men and women gave examples of trying to save money and make the family economic situation better before having children.

The other primary reason for pregnancy prevention was being unmarried. Initially it was difficult to get the participants to talk about sex before marriage. To encourage discussion the group leader asked the participants to discuss unmarried women being sexually active in their same age, status and occupation, but not to report on themselves. Through this method, participants talked more openly about single people that are sexually active.

In these discussions both male and female participants reported that women would/should not have a child when not married. Participants said that a woman that had a child without being married would be "looked down on" and would "bring shame to the family". In fact, the participants felt strongly (both women and men) that a woman should not have a child without being married. This was very consistent.

The discussion included unmarried women that had casual sex and unmarried women that were in committed relationships. In neither circumstance was it ok for a woman to have a child before marriage. Even if a woman was in a committed relationship, if she got pregnant before marriage she would be expected

to terminate the pregnancy before marriage. In one FGD with married women, the participants reported that getting married when pregnant was "bad luck" and "was disrespectful to ancestors".

In FGD men reported that having sex with a woman before marriage was "just for fun" usually. Men did not believe that if a woman got pregnant they would be expected to marry her. They reported that she would terminate the pregnancy. The same consequences for men (being looked down on, bringing shame to the family) were not mentioned for men that were fathers without being married.

Some examples were given of men and women that lived together without formally registering the marriage, and in this circumstance it was more accepted, as in most respects except for formal registration they were considered married. In this circumstance if a woman had a child, the child's father might later formally marry the mother.

Contraceptive Methods

Participants were asked about popular contraceptive methods, where they got information, how they decided with partners and issues with consistency and usage.

In all FGDs participants were aware of various contraceptive methods. Both married and unmarried women reported knowing about pills, IUDs, implants, injections and condoms. Participants also talked about "natural methods" and these were described as withdrawal and rhythm. Additionally males in FGDs also knew about different methods of contraception, but not as detailed as the females.

Participants reported they learned information about contraceptive methods from a variety of sources. This included from NGOs, Health Center, Hospitals, TV awareness campaigns, and friends. This also included peer educators.

Participants (both male and female) reported that married couples could and would discuss birth control methods, but that generally the woman was responsible for birth control. The male FGD participants all said that women made the decision about birth control. Unmarried females reported also that they were responsible for contraception, and said yes, that women (not themselves), could talk about birth control with their partner, but it was more difficult if you were unmarried because sex was not "always planned."

Participants were asked about the preferred contraceptive methods used by women in their age, job, etc. This generated significant discussion. Participants knew about different types of contraceptive methods, but they reported usage of different methods varied.

Some had tried different methods or had heard about them and did not like the methods. Significant discussion was held about side effects of hormonal contraceptive methods. Participants reported that either themselves or friends had "felt sick", "lost or gained weight", or "did not like how they felt" when using different hormonal methods. Others reported fears that if they used the hormonal methods it would prevent pregnancy in the future (make them sterile). In one FGD a woman reported about a friend that had used an implant and was later not able to conceive. The FGD participants all agreed it was likely caused by the implant with no discussion of other reasons she could not conceive.

Participants discussed usage of the pill. This was a common method of birth control that many had used. Women reported however, challenges with consistency of use. FDG participants reported that they knew people that would "forget to take the pill" or "were not clear on how to take them."

Other discussion was held about consistency of use and discontinuation of contraception methods. Participants would report that sometimes they (or friends) had tried one method and did not like it so would stop, and would delay getting another method. Others reported they really did not have clear information on how to use different methods.

When asked about condom usage (for HIV prevention), the men said they were aware of them, and that "some" men used them. The same for female participants – "some" used condoms for HIV prevention and birth control.

Unmarried Women and Unprotected Sex

In FGDs participants were asked to discuss reasons that unmarried women would have unprotected sex, and about ease of access to contraception for unmarried women.

Participants said the reasons for unmarried women to have unprotected sex were carelessness, not planning for sex, being embarrassed or ashamed to go for birth control. When prompted participants did say that sometimes women were coerced into sex.

Participants did say that it was relatively easy for unmarried women to get birth control. FGD participants did say that sometimes unmarried women were embarrassed to get birth control and would ask friends to get it for them. A few participants mentioned that sometimes unmarried women would to go a place not near their home so no one knew them. When asked about attitudes of pharmacies, the participants said to avoid negative attitudes (if there were any) they would go somewhere away from their immediate home.

After the discussion was completed and no one mentioned hopes for marriage as a reason for unprotected sex, the FGD facilitator asked directly if women in Cambodia would hope that pregnancy would lead to marriage. Participants said that no woman would get pregnant thinking that it would lead to marriage. In fact the participants reported the opposite. They reported that it was more common that the man would abandon the woman if she got pregnant before marriage. As stated earlier, there is significant stigma about unmarried women getting pregnant and having children.

Unwanted Pregnancy

In FGDs participants were asked what women (that worked in their factory) did when they had an unwanted pregnancy. The participants universally reported abortion. Participants could describe different abortion methods ranging from self-inducing methods to taking pills for 3 days to surgical abortions. Participants believed that women had a right to an abortion and most were aware of many options. This was not a sensitive topic and participants (both men and women) talked openly about abortion options.

In one FGD participants talked about abortion methods as a hierarchy – the group said that commonly pregnant women trying to abort would try a home remedy ranging from herbs to hitting the stomach. If this was not successful, the next effort to abort was taking pills from a pharmacy (3 days sometimes without labels). If this method did not work then they would go for a medical or surgical abortion. FGD participants knew about many different options for abortions and places to get them. Participants were asked about safe abortions, and responses were again to describe the different types of abortions. Participants did know about private clinics, and what they considered to be NGO clinics. For medical or surgical abortions these would be considered along with government facilities.

Participants also said that women commonly have abortions. In one FDG some participants said abortions were "safer" than contraception. In other FGDs participants talked about the cost of abortion being less than birth control. It is unclear if this is true, or if women took the risk of not using birth control and hoped not to get pregnant and saved money that way or if in reality birth control is more expensive than abortion. This was not researched in this process. Clearly women had a range of knowledge about abortion services.

When asked about Emergency Contraception (EC), most women knew about it, but not all. The participants that were aware of it reported significant side effects. They said they did not want to use it because they had heard they would bleed and it could cause them to be sterile. This was the method that FGD participants

least wanted to use (however, the groups did report that 'friends' had used EC). Males in the FGD were unaware of EC.

Generally participants in all FGDs appeared comfortable with options for abortion - some even more than with contraception options. Trying to better understand this, the FGD facilitator asked if there are side effects to abortion. Participants either said they did not know or no – and the benefit to abortion is that it was over quickly. This seemed to a 'benefit' to abortion. It was a 'one time event'.

Access to Reproductive Health Services

Participants were asked where they preferred to get reproductive health services and what barriers to obtaining services in different settings were.

Generally most participants reported they preferred to get services from the government Health Center. This was very clear for married women. When asked why, it was because detailed information was provided. Participants did mention that sometimes there were challenges due to cost of transportation or timing of services, but still preferred the government services if possible.

Participants said in some private clinics they were given no information. Clearly they trusted the government more. The other category was NGOs and this was organizations like Marie Stopes. They also trusted these services, but saw them as providers of abortion.

As mentioned earlier, unmarried women seek some services in a way that is more confidential – going to a distant place, or where no one knows them. However unmarried women also said they preferred the government services if possible, but they also were concerned about confidentiality. This was particularly true if they went or services near where they lived.

When asked about reproductive health services in the garment factory infirmary, few women said they used the infirmaries for reproductive health services if available. Again they sited confidentiality and issue of detailed information available. Some women did go there for referrals and for other services.

Male participants were also asked about the need for reproductive health services for men. They stated they needed no services these were 'services for women'.

Conclusions

Married women in Cambodia expect to have children. Married women delay pregnancy due to economic reasons. Unmarried women try to prevent pregnancy due to the strong stigma against getting pregnant before marriage and getting married when pregnant.

FGD participants are generally aware of different types of birth control methods, but do not necessarily have correct information about their usage, side effects (short and long-term).

FGD participants are concerned about the side effects of hormonal contraceptive methods including a fear of causing sterility, short term illness or weight gain or loss. Emergency contraception is the least favored method although it was used.

Unmarried women have unprotected sex primarily due to a lack of planning, or sometimes from being coerced into sex. Unmarried women do not expect to get married if they are pregnant and will most likely terminate the pregnancy. Contraception is readily available to unmarried women although some are uncomfortable getting it (being known) and will ask others to get it or go to an area where they are not known.

FGD participants report that married and unmarried women commonly have an abortion for an unwanted pregnancy. Different methods of abortion range from trying to self-induce a miscarriage to surgical abortion.

Women prefer the least invasive method that will work (try to self-induce, then take pills, then go to formal medical facility). Women understand their right to abortion and there seems to be little stigma around abortion. The range of knowledge varied widely however.

Abortion is perceived by at least some women as a more safe and cheaper than contraception for preventing pregnancy.

Participants trust the government Health Centers for reproductive health services due to the provision of clear information. NGO clinics are perceived as abortion providers and are also trusted. Infirmaries are used for some services, but not generally reproductive health. One reason is concern about confidentiality. Services that are perceived as easy to use are services that are conveniently located, are confidential, provide good information, and cost is low.

Recommendations for key message themes

- Types of birth control and benefits and side effects of each method
- Types of Safe and Unsafe Abortion
- Effects of Abortion on Health
- Cost of Abortion versus Cost of Contraception
- Options (confidentiality) for access to birth control for unmarried women

Annex 1 Focus Group Discussion Guide

1. Do women commonly want to have children in Cambodia?

PROBES

- How is the decision about having children made?
- Under what circumstances do women want to prevent pregnancy?
    - (Unmarried, do not want children, not ready for children, too many children, etc.)
- How do men and women communicate about having children?
    - (is it discussed? man decides, woman decides, do women commonly say what they want)

2. When you are trying to prevent pregnancy what are the most popular contraceptive methods used?

PROBES

- What are the reasons you choose this method?
- How did you learn about it/get info about it? Where did you get information?
- How do you decide contraception use with partners?
- Is it discussed? Is it easy, difficult? Who decides? Do women have the right to make this decision?
- Consistency of use and discontinuation?

3. *What are the reasons for unmarried women to have unprotected sex?*

PROBES

- Want to have children even though not married
- No Choice? Coercion?
- Might lead to marriage?
- Negative attitudes from health providers or pharmacists about obtaining contraception?

4. What do women in your factory do when they have an unwanted pregnancy?

PROBES

- Emergency Contraception: Where do you get it? is it commonly used? why or why not?
- Abortion: When, Why and how does a woman decide to have an abortion? What is a safe way to have an abortion?
- Do women have the right to make this decision?

5. Where do women that work here get access to reproductive health services such as FP, planned pregnancy, ANC, delivery with SBA, PNC, STI prevention.

Probes:

- What makes the services easy to use? What are barriers to using these services?