Preface

The global goal of UNFPA is to achieve universal access to sexual and reproductive health, to realize reproductive rights, and to reduce maternal mortality. The work of UNFPA is centred on attaining this goal, particularly through an enhanced focus on family planning, maternal health, and HIV/AIDS. Reaching this goal can bring enormous benefits to people across the world, accelerate progress on the ICPD agenda, and make a major contribution to reaching the targets set by the Millennium Development Goals (MDGs). MDGs 5a and 5b on maternal mortality and reproductive health are central to UNFPA's work.

Women, adolescents and youth are the key beneficiaries of UNFPA's efforts. The organization prioritizes the most vulnerable and marginalized, particularly adolescent girls and also indigenous people, ethnic minorities, migrants, sex workers, persons living with HIV, and persons with disabilities. UNFPA endeavors to improve their health and their ability to participate in decision-making processes on issues that affect their lives, whether those decisions are made at the individual, familial, community, or national levels.

In Cambodia, there are a significant number of migrant factory workers, and most of them are female adolescents and youth, living around Phnom Penh. Thus there is a need to support and respond to their health needs, particularly their sexual and reproductive health and rights. However, very little is known at the national level about the health status and needs of this group. There has not been sufficient documentation on the sexual and reproductive health and rights of female garment factory workers. Different programs and projects have been time bound and information on the reproductive health and gender concerns of female migrant factory workers is limited. Therefore, there is a need to gather information and evidence that will be used at the national level. Furthermore, in order to achieve universal access to sexual and reproductive health, promote reproductive rights, and reduce maternal mortality and accelarate progress on the ICPD agenda and MDG 5, special attention is needed for marginalized groups including migrants, particularly urban migrants who are seeking and working at various factories and firms around Phnom Penh, and surrounding provinces.

In view of the paucity of such crucial data, the UNFPA Cambodia Country Office decided to commission this literature review, based primarily on evidence from desk reviews, backed up with interviews with key informants to explore the current sexual and reproductive health and rights of this particular vulnerable group.

With these findings and other sources of available data, UNFPA seeks to draw the attention to the sexual and reproductive health and rights of garment factory workers, their access to reproductive health services, and more importantly the fulfillment of their reproductive rights. We call upon planners, policymakers and the donor community to take proactive measures to ensure that factory workers, who are the main actors and contributors to economic development, are benefiting from the industry as well, rather than becoming the victims of it. I hope the review will therefore help policy makers and providers to strengthen practice, and interventions that would lead to strengthening the progress towards realizing universal access to reproductive health in Cambodia.

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UNFPA Representative in Cambodia
Phnom Penh, November 2014

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BFC	Better Factories Cambodia
BSS	Behavioural Sentinel Surveillance
CDHS	Cambodian Demographic Health Survey
DFAT	Department of Foreign Affairs and Trade
EW	Entertainment Worker
FDC	Fixed Duration Contract
GBV	Gender Based Violence
GMAC	Garment Manufacturers Association of Cambodia
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
IUD	Intra Uterine Device
MoH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
MSIC	Marie Stopes International Cambodia
NCHADS	National Centre for HIV/AIDS and Dermatology
NGO	Non-Government Organisation
NMCHC	National Maternal and Child Health Centre
PSL	Partnering to Save Lives
RHAC	Reproductive Health Association of Cambodia
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UDC	Undetermined Contract
UNFPA	United Nations Population Fund
VCCT	Voluntary Confidential Counselling and Testing

Executive summary

Garment factory workers represent a significant proportion of the labour force in Cambodia, with almost 500,000 workers employed in the garment industry. The majority of garment factory workers are young women of reproductive age who have migrated from rural provinces to Phnom Penh. Given the significant number of migrant garment factory workers living in and around Phnom Penh, there is a need to respond to and support their health needs, particularly their sexual and reproductive health and rights. Recognising this need, UNFPA Cambodia commissioned this report to bring together existing literature to better understand the sexual and reproductive health behaviour, needs and access to relevant services of garment factory workers. This report provides an evidence base for the design of UNFPA's program to support garment factory workers in Cambodia.

A review of the literature identified a number of key issues: reproductive and maternal health, family planning, abortion, gender-based violence, STIs and HIV/AIDS.

FINDINGS:

General

- Workers are typically young and unmarried with low levels of education.
- The vast majority of workers migrate from rural provinces to work in factories in and around Phnom Penh.
- Housing conditions of workers are basic with safety, hygiene and sanitation issues.
- Most workers live with a relative or family member, indicating that they have some form of support network when moving to the city.
- Workers are most likely to access health services from the private sector and do not have health insurance or other forms of support to pay for healthcare expenses.

Reproductive and maternal health

- Workers have reasonably high rates of skilled birth attendance, with most delivering in a public health facility[1] back in their home province close to family and relatives.
- Workers have reasonably high rates of ANC, but there are possible gaps for workers in the provinces.
- There are low rates of exclusive breastfeeding up to 6 months among workers due to lack of nursing and childcare facilities, distance from factory to home, lack of suitable transportation of infants and long working hours.
- Working conditions and contractual agreements likely discourage and delay workers from having children.

1. A public health facility for the purposes of this report is defined as a government run hospital or health centre

Family planning

- Knowledge and use of contraception is consistent with results seen among the general population. For example, knowledge of family planning methods among workers was found to be high but use is common only among married workers.
- Short-term family planning methods are more commonly used than long-term family planning methods. Withdrawal is also reported as a method used to prevent pregnancy.
- Rumours about negative side effects and infertility following use of contraceptives persist.

Abortion

- Garment workers have higher rates of abortion if compared with the general population.
- Knowledge among workers of the legality of abortion is low. As a result, garment workers do not know where to go for safe abortion services and access expensive and potentially unsafe services predominantly in the private sector.

Gender-based violence

- Physical and verbal abuse, harassment and rape have all been reported by garment workers both inside and outside the workplace.
- Workers leaving factories in the evening after working overtime, lack of policing, poor lighting in and around factories and inadequate housing conditions contribute to insecurity, violence and harassment experienced among workers.

HIV/AIDS and STIs

- Garment factory workers are not at a high risk for STIs and HIV/AIDS due to lack of sexual activity, with sexual debut typically only after marriage, which is consistent with sexual debut within the general population.
- There are high rates of understanding of consistent condom use to protect against HIV/AIDS and STIs but low rates of use. Strong associations between condom use and transactional sex.
- Gaps in knowledge and understanding of how HIV/AIDS is transmitted and low understanding of STIs and symptoms.
- The global financial crisis may have contributed to some cross-over of workers into entertainment and sex work which in turn may increase risk.

Other issues

- Workers have limited time during working hours and after work to access health services
- Public facility working hours are not conducive to workers, often closed on Sunday when workers have a day off work.
- The private sector provides more flexible working hours, but service quality is an issue due to lack of regulation and monitoring.
- Costs and distances to services also act as barriers to accessing sexual and reproductive health related services.
- Lack of confidentiality and perceived low quality of health services provided in factory infirmaries and lack of time during work hours discourage workers from accessing factory infirmaries for relevant services that may be on offer.

Introduction

The garment industry is the largest employer of workers in Cambodia and is a key export earner. With a little over 500 factories operating in the country with almost 500,000 mostly young female workers of reproductive age, the garment industry is the single biggest employer of women in Cambodia. Female migrant workers make up a significant proportion of the industry, with one in three migrant women employed in factories (Ministry of Planning 2012).

Migrant garment factory workers represent an important group for providing health information, education and services due to their perceived vulnerabilities. Being away from their homes and traditional support networks in rural provinces; low levels of education, lack of access to health information and low wages which may inhibit access to healthcare services, places workers at potential risk for exploitation and poor health outcomes.

The Ministry of Health has made significant commitments and concerted efforts to improve the sexual and reproductive health of Cambodian women. The Millennium Development Goals (MDGs), the Fast Track Initiative Roadmap and the release at the end of 2012 of the National Strategy for Reproductive and Sexual Health 2012-2016 have all contributed to a significant reduction in maternal mortality from 472 per 100,000 live births in 2005 to 206 per 100,000 births in 2010 (CDHS 2010).

In order to accelerate progress in the area of sexual and reproductive health and to meet MDG and national targets, a specific focus on marginalised and vulnerable groups whose needs are not fully met such as young migrant garment factory workers is needed.

As part of the current Country Program Action Plan 2011-2015 and Global UNFPA strategy, the UNFPA Cambodia Country Office is committed to supporting marginalised and underserved groups. This literature review aims to guide UNFPA in developing its strategy for addressing the specific sexual and reproductive health needs of migrant garment factory workers through providing an understanding of the situation of workers in Cambodia and gaps for meeting their unique sexual and reproductive health needs.

While a number of different projects and programs to date have been implemented in Cambodia, data and information on the sexual and reproductive health and rights of female migrant factory workers is fragmented. This literature pulls together existing documents and data found either in the public domain or shared directly by agencies and organisations involved with supporting the sexual and reproductive health and rights of garment factory workers.

This report will provide information and evidence that while migrant garment factory workers indeed have special sexual and reproductive health related needs and vulnerabilities, they also possess high knowledge and positive health seeking behaviour in others areas of sexual and reproductive health. This report will also identify some suggested key areas where UNFPA's support would greatly improve the sexual and reproductive health status of migrant garment factory workers.

The Cambodian garment industry and its workers

Size and composition of the Cambodian garment industry

According to the International Labour Organisation (ILO) Better Factories Cambodia (BFC), as of 31 March 2014, there were approximately 465,666 workers employed in the garment sector in Cambodia (females: 396,568 and males: 69,098) with 496 active garment factories and 13 footwear factories. This includes all factories with export licenses and some subcontractors. The actual number of factories and workers is likely to be much higher than this figure due to the number of subcontractors who are unregistered and or not monitored as part of ILO's BFC program.

Garment factory workers in Cambodia

As the above data illustrates, the Cambodian garment sector labour force is highly feminised with female workers forming 85 percent of the workforce. Workers are typically young and of reproductive age, under 24 years old (PSL[2] 2014). This is consistent with other countries with large garment export industries, where young women are chosen due to their perceived willingness to work, docility and nimble fingers (Derks 2008).

The majority of factory workers are single, with estimates ranging from close to 40 percent (PSL 2014) to 63 percent (Levi Strauss/CARE 2013). Sexual activity among garment workers is less well researched, particularly among unmarried garment workers. However, research to date would suggest that workers are not sexually active until after marriage, with sexual debut reported to be on average at around 20 years of age (NCHADS 2005; PSL 2014). This is similar to women in the general population (CDHS 2010). Workers are most likely to not have any children or to delay childbearing, while married workers who do have any children are most likely to have only one child (ILO BFC/CARE 2012; Sim 2004).[3] Some studies suggest that the children of garment workers typically live with their grandparents back in their home village (Levi Strauss 2013), while others would suggest that up to 63.2 percent of children of workers continue to live with them (Ministry of Planning 2013).

Garment factory workers live in rented, dormitory style accommodation in densely populated, areas surrounding the factories (Taylor 2011). Living conditions are usually very basic, with reports of security, hygiene and sanitation issues (Taylor 2011; ActionAid 2012; Sim 2004, ILO 2012a). Most married workers live with their husbands but some also live apart (PSL 2014, Levi Strauss/CARE 2013; Sim 2004).[4] Unmarried workers live with siblings or extended family members and to a lesser extent share with friends or co-workers (PSL 2014; Levi Strauss/CARE 2013). This would seem to contradict common perceptions that migrant garment workers tend to live away from family and support structures.[5]

2. Partnering to Save Lives (PSL) is a multi-year partnership of the organisations: CARE, Marie Stopes International Cambodia, and Save the Children, financed by the Australian Department of Foreign Affairs and Trade (DFAT) in support to the Cambodian Ministry of Health and the National Maternal and Child Health Centre (NMCHC). It should be noted that at the time of writing the PSL baseline report was in draft form and that the findings as referenced throughout this report are preliminary only.
3. ILO/BFC (2012) found that 62 percent of workers reported not having any children and 25 percent had only one child. Sim (2004) also found that among the workers with children, 47 percent reported having only one child.
4. PSL (2014) found that among 34 percent of married workers surveyed, 78 percent lived with their spouse; Sim (2004) found 61 percent of workers live with their husbands. Levi Strauss/CARE (2013) reported that among 40 married workers, 32 lived with their spouse.
5. The preliminary findings from the PSL Baseline survey found that around 80 percent of workers live with a relative, spouse or parents.

Almost all workers are migrants from rural provinces surrounding Phnom Penh that are heavily reliant on rice and agricultural production (Ministry of Planning 2013). While no regular data is collected, surveys conducted over the past 10 years consistently report migrant garment workers originating from the following provinces: Prey Veng, Kandal, Takeo, Kampong Cham and Svay Rieng (Sim 2004; Ministry of Planning 2012; Levi Strauss/CARE 2013). Motivating factors reported by workers for migrating to work in the garment sector are to earn money or as a result of family problems e.g. a sick family member (Levi Strauss/CARE 2013).

Levels of education among workers are usually quite low, having generally completed some primary education (PSL 2014; ILO-BFC-CARE 2012); however literacy levels among workers have been reported as high as 80 percent (Levi Strauss/CARE 2013).

The current minimum monthly wage for garment factory workers is $100 USD following an increase by the Ministry of Labour and Vocational Training (MoLVT) at the beginning of 2014. Workers earn on average between $100-$160 USD per month which includes salary as well as any overtime payments and other bonuses (ILO/CARE 2012; PSL 2014; CARE 2012). Almost all workers report spending their own income on healthcare expenses (CARE 2012; PSL 2014; ILO/CARE 2012).[6] Few workers have health insurance or receive financial support for healthcare. Workers are most likely to access healthcare services from the private sector including pharmacies and public health centres (ILO/CARE 2012, PSL 2014; CARE 2012).

Photo: UNFPA Cambodia

6. The numbers of workers reporting spending their own income on health care expenses ranged from 90 percent (ILO/CARE 2012; PSL 2014) to 97 percent (CARE 2012).

Current situation of sexual and reproductive health and rights of migrant factory workers

Reproductive and maternal health services and information

Reproductive and maternal health, specifically ante-natal care (ANC), safe-delivery, skilled birth attendance and exclusive breast feeding are priority areas outlined by the Ministry of Health (MoH) for contributing to the reduction in maternal mortality in Cambodia.

Ante-natal care

National guidelines recommend pregnant women attend ante-natal care (ANC) checks at least four times throughout pregnancy. The most recent study of garment factory workers available found high rates of ANC, with around three quarters of workers reporting 4 or more ANC visits (PSL 2014). In two smaller studies, 63 percent of workers reported at least 3 ANC visits (Levi Strauss/CARE 2013), however workers interviewed from factories in Svay Rieng and Kampong Speu reported never going for ANC checks during their pregnancy (ILO 2010a).This could indicate a greater need for maternal health interventions among workers in provincial areas. Awareness of potential danger signs during pregnancy was very low with less than 2 percent of workers able to identify five major danger signs (PSL 2014).[7]

It is not a requirement under the Labour Law that employers allow time off for ANC visits for workers, although there are reports that some factories do make allowances. For example, some employers may allow 1-2 hours, one half day or one full days leave once per month (ILO 2010a, ILO 2012b). However, after factoring in travel time and the often long waiting times experienced at public facilities, 1-2 hours is deemed by workers to generally not be sufficient enough time. Some factories simply do not permit workers to take time off for ANC visits, deducting from their wages for time off or require pregnant workers to make up time on a Sunday (ILO 2010a; ILO 2012b). As a result, many pregnant workers express reluctance to take time off work to go for ANC visits to avoid having their wages cut.

Safe delivery and skilled birth-attendance

Studies show that the vast majority of workers report delivering their babies at a public hospital or health centre (PSL 2014; Levi Strauss/CARE 2013) with high levels of skilled birth attendance also reported during delivery (PSL 2014).[8] Few workers reported delivering at a private clinic and even less reported deliveries at home (PSL 2014, Levi Strauss/CARE 2013). While most workers deliver within a public health facility, workers report returning to their home province to be close to family support for the delivery and because medical and hospital fees are cheaper than in Phnom Penh (ILO 2012a).

Post-natal care

While rates of ante-natal care appear to be high among garment workers, post-natal checks among workers are much lower. For example, one study found that only 30 percent of women reported going for a check-up post-delivery (PSL 2014). Awareness on neonatal health is also low, with only 4 percent of workers able to correctly identify 3 danger signs for neonatal distress (PSL 2014).[9]

7. Danger signs during pregnancy include: anaemia, vaginal bleeding, high blood pressure, abdominal pain, loss of foetal movement, difficulty breathing, fever, pre-labour rupture of membranes.
8. In the Levi Strauss/CARE study (2013), 28 out of 30 workers delivered their last child at a hospital and two had delivered at home. All were assisted by a skilled birth attendant. In the PSL Baseline survey (2014) close to 40 percent reported delivering in a health centre or health post, 17 percent at the provincial or referral hospital, and 8 percent at a national hospital. 89 percent reported skilled birth attendance by either a midwife (67 percent), doctor or medical assistant (22 percent). Around 18 percent reported delivering at home.
9. Danger signs for neonatal distress include: Abnormal body temperature; difficulties feeding; lethargy; vomiting and or abdominal distension; red and swollen umbilicus, draining pus or foul smelling; convulsions; red eyes, swollen; jaundice; bleeding and or pale.

Breastfeeding

National MoH guidelines recommend exclusive breastfeeding of infants for up to 6 months. Provisions under the Labour Law (Articles 184-185) are supportive of breastfeeding, entitling women to one hour per day paid breast-feeding breaks during work hours for up to 12 months after delivery.[10] Under the Labour Law, employers must also set up an operational nursing room in factories and child care facilities where there are 100 workers or more.[11] The provision of payment or provision of formula in the absence of breastfeeding breaks or a nursing room is prohibited under the law although payments can be made in the absence of childcare facilities. Factory monitoring by ILO BFC has found workers have a high awareness of their right to breastfeeding breaks and factories are generally compliant in providing such breaks to workers (ILO 2012b). Despite these provisions, practical difficulties such as the distance of the factory to the workers home, lack of safe transportation options to and from the factory for a baby, long working hours and lack of child care facilities, distrust of childcare providers where childcare facilities are provided, mean that working conditions are generally not compatible for exclusive breastfeeding (ILO 2010a; ILO 2012a). In one study, only 13 percent of workers with infants reported breastfeeding (ILO 2010a) and low numbers were also reported in a more recent study (ILO 2012a).

Other practical challenges were found during a small breastfeeding initiative piloted in 2011 as part of ILO's BFC Gender and Social Protection program. Implemented in 10 factories in partnership with the National Maternal and Child Health Centre, the pilot provided training to pregnant or breastfeeding workers on how to express breast-milk, providing participants with glass containers to store expressed milk. Small refrigerators within the factory infirmary were also provided for women to store their milk. While workers expressed increased knowledge and understanding of the benefits and how to express breast milk, ultimately few continued to practice. The main reasons for discontinuation were: no comfortable place for the women to express milk at the factory during working hours, the glass bottles provided as recommended by the national program for storing the expressed milk were difficult to transport and broke easily, and workers did not trust the infirmary service providers to take care of the breast milk when stored in refrigerators under their care (MSIC 2011).

Other supportive provisions for pregnant workers provided by factories although not legally required include factories allowing pregnant workers to leave the factory 15 minutes early before lunch and at the end of the day, to avoid crowds of workers leaving the factory, without any reduction in wages (ILO 2010a). Garment factory workers in general appear to have low rates of fertility. This is representative of the fact that the vast majority of garment factory workers are unmarried (as discussed earlier in the report). Among married workers in one study, nearly two thirds reported ever having a live birth (PSL 2014), with an older study finding almost 90 percent of workers reported having no children (Sim 2004). Conditions of work in the factories are also not conducive for pregnant women or women who wish to become pregnant, with long hours and overtime a frequent occurrence. Amenorrhea, the absence of a menstruation due to poor nutrition, fatigue and lack of sleep was also reported among workers, which may also contribute to infertility among workers (ILO 2012a; Taylor 2011).

10. Article 185-185 of the Labour Law states: "For the first year of a child's life, mothers have the right to one hour per day paid breast-feeding breaks during work hours. Mothers may take this hour as 2 periods of 30 minutes each (e.g. 30 minutes during both the morning and afternoon shifts). The exact time of breast-feeding should be agreed between the mother and her employer. If there is no agreement, the breaks should take place half way through each shift. Giving milk formula or payment instead of breast-feeding breaks is not allowed under the law."
11. Labour Law Article 186 states: An employer who employs 100 women or more must set up an operational nursing room. The Arbitration Council has found that giving milk formula or payment instead of providing a nursing room is not allowed under the law. An employer who employs 100 women or more must set up an operational day care centre. If an employer is not able to set up a day care centre for children over 18 months of age, then they must pay women employees the cost for providing day care for their children

The Constitution states that women shall not lose their job because of pregnancy (Article 46) and The Cambodian Labour Law (Articles 182-183) provides a number of provisions for maternity protection including 90 days maternity leave at half pay; workers are only required to perform light duties 2 months after delivery; entitlements to breast feeding breaks; the provision of nursing rooms and child care facilities (ILO 2005). In reality, only some workplaces are compliant with the law (ILO 2012b; Yale 2011).

Gender discrimination in the workplace through hiring practices do not provide job stability for women who wish to become pregnant. Pregnancy pre-screening of workers before hiring was reported by 30 percent of respondents in one study, despite such actions being prohibited by law (Nuon et.al. 2011). Maternity leave is only provided to workers that have worked uninterrupted for a minimum of 1 year at the same workplace. The current practice is for most factories to hire women on 3-6 month fixed duration contracts (FDC) rather than undetermined contracts (UDC), under which women are not entitled to such maternity benefits (Yale 2011). Studies have found that pregnant workers whose contracts are expiring when nearing delivery have not had their contract's renewed, having to change factories and work over time (prohibited by law) have been rehired as new staff and must complete the probationary period again after delivery, or have not received maternity pay until after they return to work (ILO 2012a, Yale 2011).

Family planning services, counselling and information

Research consistently shows that knowledge of different types of family planning methods among garment factory workers is high (PSL 2014; RHAC 2012; ILO-BFC/CARE, CARE 2012), with higher rates of awareness of short term methods (pills, injection, condoms) than for long-term methods (IUDs, implants) and permanent methods (tubal ligation and vasectomy).[12]

Knowledge of where to access contraception is also high (CARE 2012, ILO-BFC/CARE 2012). Family planning services, particularly short-term methods, are widely available through public health centres, private clinics, NGO clinics (RHAC and MSIC), and pharmacies located around the factories. Workers using contraception are most likely to access services from pharmacies, health centres and private clinics (PSL 2014). Some factory infirmaries with support by RHAC and MSIC also provide short-term methods of contraception as well as counselling on family planning methods. MSIC with support from ILO have developed a pilot toolkit for how factories can integrate family planning services into factory infirmaries (MSIC 2012).

Long-term methods are not currently being provided within factory infirmaries. This is for a number of reasons: firstly, MoH policy requires only trained midwives to provide long-term methods and most factory infirmaries are staffed by nurses or low level providers; infirmaries often lack equipment and materials; and infirmaries may not meet infection and prevention standards. Aside from existing infirmary service delivery constraints, other barriers include lack of time during working hours for workers to access infirmary services; distance of infirmary from factory floor, and the view that infirmary services are often low quality and lacking in confidentiality (MSIC 2011).

Contraceptive use among garment workers is reported to be from 30-40 percent (CARE 2012; ILO-BFC/CARE 2012; RHAC 2012), which is consistent with levels of use reported among the general population of 35 percent (CDHS 2010). Married women are more likely to report higher rates of contraceptive use than unmarried women (PSL 2014). Most commonly reported modern methods of contraception used are pills and to a lesser extent condoms and injection.[13] Withdrawal method

12. For example, PSL 2014 found knowledge of contraceptive methods among workers as: pills (64%), IUDs (54%), injections (52%) and male condoms (38%), implant (29.7%) and withdrawal (15.6%).
13. For example, PSL (2014) found the most commonly used contraceptive methods among workers to be pills (44.4%), withdrawal (22.2%), and injection (19.8%), rhythm method (11.1%), condoms (9.3%).

was also commonly used by between 10 - 20 percent of workers (ILO-BFC/CARE 2012, PSL 2014). There is also some evidence to suggest that condoms are perceived by workers as only for HIV/AIDS and STI prevention and not for family planning purposes (RHAC 2012, CARE 2012), which could be reflective of more widespread HIV/AIDS prevention activities within factories.

Reason for non-use of contraception among sexually active workers was mostly related to concerns about side effects, infertility and wanting to conceive (Levi Strauss/CARE 2013; PSL 2014). Rumours and myths about negative impacts of contraceptive use spread through information from friends and relatives was also reported, despite exposure to family planning information through the media such as TV and radio (Levi Strauss/CARE 2013).

Decision making around contraceptive use among married workers was reported to be made by both partners (Levi Strauss/CARE 2013). While workers were generally confident to discuss family planning with their husbands, they were less confident that they would be able to use family planning or to go against their husband's wishes (PSL 2014).

Concern has been raised that it is in the interest of the factories to control the reproduction of workers through family planning promotion (ILO 2012a), however lack of support from factory management for integrating family planning and other reproductive health counselling services into factories reported by NGO partners would provide evidence to suggest that this is not the case.

Abortion services, counselling and information

Little research has been conducted to date on the extent of abortion among garment factory workers. Abortion is legal on demand in Cambodia up to 12 weeks, however due to the continuing social stigma attached to abortion in Cambodia, particularly for young, unmarried women, the extent to which it occurs is likely to be underreported.

MSIC's Pregnancy Options and Advice Hotline[14] reported high numbers of garment workers calling seeking information on abortion. In 2013, the Hotline received over 3,000 calls from garment workers, with 22 percent of these calls from workers seeking information on abortion. Abortion related calls including where to access safe services, follow-up after accessing services at one of MSIC's clinics, side effects after using medical abortion etc., was the second most common reason workers called to MSIC's Hotline after family planning information (MSIC 2013).

Demand for abortion among garment workers seeking services at NGO clinics working in areas where factories are concentrated is reported to be high (ILO 2012a). Both young, unmarried workers as well as married women who cannot afford children are reported to seek abortion services (ILO 2012a). Work demands were cited among garment workers as one the reasons for seeking a termination (Hemming and Rolfe 2008). Contraceptive failure is also likely to be another reason for unwanted pregnancy and induced abortion, with 21 percent of workers in one study reporting using a modern form of contraception at the time they got pregnant (PSL 2014). Among a recent baseline survey of 900 garment factory workers (one of the first to examine abortion among garment factory workers in Cambodia) around 18 percent of workers who reported ever being pregnant had an induced abortion (PSL 2014), if compared with a rate of only 5 percent among the general population (CDHS 2010). In the same survey, married women living with their partners were found to have higher rates of abortion than unmarried workers.

14. MSIC's Hotline is a phone line service available to the general Cambodian population providing information on sexual and reproductive health, family planning, safe abortion, pregnancy and referrals to services at MSIC's centres, government facilities and other registered private facilities.

Knowledge of the legal status of abortion in Cambodia among garment factory workers is mixed.[15] 77 percent of callers (n= 101) to ILO-BFC's Kamako Chhnoeum phone quiz line answered correctly that abortion is legal up to 12 weeks. However, a much larger study found that among 900 workers, around 80 percent of workers thought abortion was illegal (PSL 2014). Unsurprisingly, this same study found that 75 percent did not know where to access safe abortion services. Lack of awareness that abortion is legal can lead women to seek unsafe abortions from untrained providers and having to pay high costs for services.

Abortion services are available at NGO clinics (MSIC), as well as private clinics that may or may not have been trained and certified by MoH to provide safe abortion services;[16] legal registered medical abortion products (Medabon® and Maripristᵀ), as well as other unregistered medical abortion products known as "chinese" pills are readily available over the counter (Hemming and Rolfe: 2008). Garment workers are more likely than the general population to use medical abortion, with 42 percent of workers reporting its use for abortion if compared with 31 percent of women in the general population (PSL 2014; CDHS 2010). Use of unregistered drugs such as chinese pills are a concern as their drug combinations are unknown and may result in incomplete abortion, complications and haemorrhage which in severe cases can lead to death if untreated. However further research is required to better understand chinese pill use among garment factory workers.

Almost 75 percent reported receiving abortion services from either a private hospital, private clinic or at home with very few reports of seeking services in the public sector or from NGO clinics. Also in the same study, workers reported paying around $30 USD for abortion related services and transportation (PSL 2014). Indirect costs from unsafe abortion can also include time due to lost productive time and wages (MSIC 2013).

Information received by workers about post-abortion contraception is also lacking, with only 50 percent of workers reporting receiving information on family planning options from their provider (PSL 2014).

Gender based violence

Gender based violence (GBV) is defined by the United Nations Declaration on the Elimination of Violence Against Women as any act "that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life." The most commonly reported forms of GBV experienced by garment factory workers can be categorised by GBV experienced inside the workplace and experienced outside the workplace. In both categories, verbal and physical abuse, sexual harassment and to a lesser extent rape has been reported.

Inside the workplace

Harassment and verbal abuse is the most common form of GBV experienced in the workplace. Up to 50 percent of workers report verbal abuse from both supervisors and managers (Makin and Sakda 2006; ILO 2012a; Levi Strauss/CARE 2013). One in five workers was reported to have experienced sexual harassment or was the subject of humiliating behaviour with sexual undertones, typically from male co-workers (ILO 2012a). Rape in the workplace was also reported (Levi Strauss/CARE 2013).

15. Abortion has been legal in Cambodia since 1997.
16. Private providers in Cambodia are often "dual practice" providers, meaning they have been trained to provide services in public sector facilities but then may also open their own private clinic where they provide services such as abortion.

Sexual harassment and indecent behaviour are forbidden under the Labour Law (Article 172). But as has already been noted elsewhere (ILO 2012a; Makin and Sakda 2006), prevalence of sexual harassment in the workplace is difficult to assess as there are no uniform mechanisms to address the issue with very few cases reported to the Arbitration Council. Workers also report that they would generally only report cases of harassment to friends, would remain silent or would not know who to report to (Levi Strauss/CARE 2013; Ministry of Planning 2013). Very few said that they would report it to a supervisor or union representative.

Despite anecdotal reports that workers may be gaining jobs at garment factories in exchange for sex, no evidence of this was found and is likely to be the result of rumours associated with negative attitudes that garment workers are "easy" to have sex with (Makin and Sakda2006).

Outside the workplace

The common forms of GBV experienced by garment factory workers occurring outside the factories include sexual harassment, robbery and rape (Taylor 2011; Levi Strauss/CARE 2013; Makin and Sakda 2006; Sim 2004). Most factory workers walk to and from work as their homes are close by the factory or they cannot afford any other form of transportation (Levi Strauss/CARE 2013; Taylor 2011). Workers report a lack of lighting on roads when walking to and from the factory at night and in and around living quarters, particularly a lack of lighting around communal toilets near their rental rooms. There are also reports of workers having wages stolen when leaving the factory as factories only pay them in cash (Taylor 2011 ILO 2012a). Lack of policing at night was also a concern. Workers also report high rates of verbal and physical abuse in the street from male co-workers and 'gangsters', of sexual touching and harassment (Taylor 2011).

Workers have reported knowing of friends or they themselves have been the victim of rape including gang rape (Taylor 2011; Makin and Sakda 2006), with one study reporting incidence of rape among workers to be almost 10 percent (Makin and Sakda 2006). The same study also found that despite formal complaints made to police, perpetrators went unpunished. While rape appears to be less common than other forms of sexual harassment, impunity of perpetrators as well as the social stigma attached to rape may also mean that the extent to which it occurs is underreported.

Rates of domestic violence and abuse experienced by garment factory workers is also not well documented.The Cambodian Women's Crisis Centre (CWCC) however reports that in 2013 garment factory workers made up 10 percent of their domestic violence and sexual abuse cases in Phnom Penh.

Organisations known to be working to address issues of GBV among garment factory workers include CARE Cambodia (workplace harassment) and ActionAid (safety outside factories). In known cases of rape reported to NGOs, referrals are made to CWCC.

Sexually Transmitted Infections and HIV/AIDS

Knowledge of HIV/AIDS is high among garment factory workers; however gaps in some areas of awareness still exist. While studies have found that knowledge of consistent condom use to prevent HIV/AIDS and STIs is high, knowledge of other forms of protection (abstinence, avoiding having multiple concurrent sex partners etc.) is low (Levi Strauss/CARE 2013; CARE 2012). Knowledge of other modes of HIV transmission than unprotected sex (contact with infected blood, needle sharing, and mother to child) are also still relatively low. Misconceptions among garment workers about how HIV can be spread are also reported. For example, in one survey a high number of workers still

reported that the sharing of utensils can spread the disease (Levi Strauss/CARE 2013). Only one study has examined HIV prevalence among garment workers which found a prevalence rate of 0.9 percent (NCHADS 2005), which is similar to rates among the general Cambodian population.

Garment workers are far less knowledgeable on STIs if compared to HIV/AIDS, with low awareness of syphilis, gonorrhoea and hepatitis (CARE 2012). Studies have found that few workers are able to identify any signs and symptoms of STIs requiring treatment (Levis Strauss/CARE 2013; CARE 2012). Similar to HIV prevalence, little is known about prevalence of STIs among garment workers. One study found 9.3 percent prevalence of Herpes Simplex Virus type-2 (HSV-2) among predominantly married garment factory workers (NCHADS 2005), while another study found that 35 percent of workers reported having a STI (RHAC 2012). Candida and trichomoniasis as a result of unhygienic conditions in toilets and rented rooms was also reported (Taylor 2011).

Testing rates for HIV/AIDS among garment factory workers would appear to be low, with studies finding that around 40 percent have never tested for HIV (Levi Strauss/CARE 2013; RHAC 2012). Rates of STI testing and treatment also appear to be low. Among 35 percent of workers who reported having an STI only a little over 56 reported receiving treatment at a public facility or RHAC clinic (RHAC 2012).

While knowledge of condom use to protect against HIV and STI transmission among garment factory workers is high, the use of condoms is low. A project evaluation by RHAC found a little over half (54.5 percent) of workers reported using a condom when having sex with their sweetheart and much higher rates were reported (83 percent) among male factory workers when having sex with a sex worker (RHAC 2012). Most married workers (81 percent) report not using condoms with their husbands (NCHADS 2005).

But one should caution that low rate of condom use does not indicate that garment workers are at a high risk for STI or HIV/AIDS. Garment factory workers typically only have sex with their husbands once they are married, with very low rates of sexual activity among unmarried factory workers. For example, a comprehensive study examining sexual risk and HIV and STI among 464 factory workers which used both self-reported data and testing of HIV and HSV-2 (a proxy indicator for sexual activity in the absence of self-reportage) found only 3 unmarried women to be sexually active (NCHADS 2005). This same study also found that most workers had only one sexual partner in their lifetime (94.8 percent) and that this was most likely to be with their husband (96.6 percent).

Attitudes towards pre-marital sex and sexual behaviour among garment factory workers may have changed in the time since this survey was conducted, with around 1 in 5 workers in a recent survey reporting having a sweetheart/partner (PSL 2014); however more research is needed as to the extent and type of sexual behaviour within these relationships.

Workers are more likely to be at risk from their husbands or male partners. Due to cultural and societal attitudes which permit Cambodian men to engage with multiple sex partners (including paid sexual encounters with entertainment and sex workers) both before and after marriage, husbands or sweethearts may expose workers to possible infection, particularly as condom use within these relationships is low. Women were found to be more at risk the older they were, if they were married and if they lived away from their partners which, suggests that in their absence their husbands are engaging in sex with other partners and transmitting infection to their wives (NCHADS 2005). Unmarried workers were also more likely to engage in pre-marital sex the longer they were working in factories, but not in a risky way (NCHADS 2005). There is a strong association among garment

workers between condom use and sex work and that they are used only outside of “trusting” relationships (Webber 2010). Such views make prevention activities potentially challenging among this population.

There may be some small crossover between garment factory workers and the entertainment industry. Sex work is entered into by workers who are laid off from factory work, who are seeking additional income to supplement their low factory wages or as an alternative form of employment with more flexible hours than working in factories (APHEDA 2011). Factory workers engaging in transactional sex is not a new phenomenon with evidence reported as early as 2000 (Nishigaya 2002) and again after the global financial crisis (APHEDA 2011; BSS 2010). Behavioural Surveillance Survey (BSS 2010) data found that 5.1 percent of moto-taxi drivers had reported buying sex from female factory workers as compared to 3 percent in the 2007 BSS. As the report notes, this may indicate that factory workers are indeed selling sex in exchange for money, or sex workers may use the occupation of factory worker as a ruse to hide their real occupation from clients.

Little is known about illicit drug use among garment factory workers, which can increase risky sexual behaviour by decreasing inhibitions or through the sharing of infected needles. The only available evidence found 1.3 percent of workers used any type of drugs, which would suggest that this is currently not an issue among this population (RHAC 2012).

Laws are supportive of HIV/AIDS and STI prevention in the workplace. Prakas #086[17] specifically mandates that all workplaces in Cambodia with eight to fifty workers must establish a HIV/AIDS working group with larger workplaces required to set up a HIV/AIDS committee (ILO 2010b). The roles of the HIV/AIDS working groups and committees are to disseminate information to educate workers on HIV/AIDS and STI transmission, reduce stigma and discrimination in the workplace and encourage testing and treatment (ILO 2010b). Some of the committees are also trained by NGOs to integrate other health topics such as family planning and sexual and reproductive health. Compliance with the Prakas is however reported to be low due to lack of awareness of its existence among factories and limited government resources to monitor and enforce the law.

17. The full title of Prakas #086 is “The Prakas on the creation of the HIV/AIDS committee in enterprises and establishments and the prevention of HIV/AIDS in the workplace”.

Summary of health seeking behaviour, barriers to SRHR services and information availability, health facilities that are accessible to migrant factory workers

The following section summaries the main sexual and reproductive health behaviours of garment factory workers as discussed in this report and some of the barriers to workers accessing relevant services.

Ante natal care

- Reasonably high rates of ANC visits, possible gaps in knowledge among factory workers based in provincial areas
- Low awareness of dangers signs to watch out for during pregnancy.
- Barriers to services: lack of mandated time off provided by factories (not a requirement under the law), need for medical certificates to be provided by a doctor for factories to approve sick leave

Post natal care

- Low numbers of workers accessing post-natal care and a lack of awareness on danger signs for neonatal distress.

Breastfeeding

- Low number of workers exclusive breastfeeding until 6 months
- Breastfeeding mandated under Cambodian law and provided by factories
- Barriers: distance from factory to home, lack of safe transportation suitable for infants, long working hours, lack of nursing and childcare facilities at factories

Delivery

- Majority delivered in a public health facility with a skilled birth attendant. Preference for public facilities in hometown close to family

Pregnancy

- Job insecurity of fixed-term contracts make it difficult for workers who may wish to become pregnant

Abortion

- High numbers of workers are accessing abortion services.
- Barriers to services and information: Stigma, low awareness among workers of the legality of abortion and lack of educational campaigns on abortion, lack of knowledge of where to access safe services
- Services predominantly accessed in the private sector although safe abortion services also available in the public sector and NGO clinics close to factories.
- Costs for services high: <$30 USD

Family planning

- High knowledge of different kinds of family planning methods, particularly short term methods (condoms, pills, injection).
- Some use of short term methods and withdrawal. Low use of long-term methods. Methods mostly used by married workers.

- Services accessed from private sector, including pharmacies, public sector, and to a lesser extent NGO clinics. Short terms methods also available from some factory infirmaries with support of NGOs.
- Barriers to services and information: Side effects, myths and rumours, long-term methods cannot be provided in factory infirmaries due to restrictions under MoH policy related to types of service providers who can provide family planning and lack of trained staff.

STIs and HIV/AIDS

- High knowledge of consistent condom use to prevent HIV/AIDS and STI transmission, low knowledge of other ways to protect against transmission and low knowledge of different modes of transmission
- Low understanding on different types of STIs and possible symptoms
- Barriers: Lack of knowledge and awareness of STIs and how to identify STI symptoms; association between condom use and sex work, issue of trust within sweetheart and married relationships.

Gender based violence

- High rates of verbal and physical abuse, sexual harassment experienced both inside and outside the factories, some reports of rape.
- Barriers: Lack of reporting mechanisms for workers who experience harassment and violence, lack of understanding on how to report; stigma - workers may feel ashamed to report acts of violence or rape; lack of policing and security enforcement around factories and where workers live.

Other barriers to accessing services

- Limited time during working hours and after work hours to access services. Only 1 day off per week (Sundays).
- Public health facility opening hours are not conducive to workers schedules. Public health facilities should be open 7 days a week with staff on standby. But in reality, they are often closed on Sundays, which is the only day off for factory workers. Private facilities are more likely to have flexible and late opening hours, but quality of services is unclear as they are not regulated by MoH.
- Lack of confidentiality and perceived low quality of infirmaries, lack of time during work hours to access infirmaries
- High costs of relevant sexual and reproductive health services
- Distance to services from workers homes and factories

Photo: UNFPA Cambodia

Current service delivery structures and processes

The following section provides information on the current actors providing information and direct services related to sexual and reproductive health and rights to garment factory workers in Cambodia.

Government Ministries

Ministry of Labour and Vocational Training	
Project Name:	N/A
Project Focus:	Responsible for training to garment factory staff and monitoring of occupational safety and health, provide training to HIV/AIDS working groups and workplace committees
Location:	24 provinces
Number of factories:	>500 garment factories
Number of workers:	>50,000 workers

United Nations Agencies

International Labour Organisation	
Project Name:	Better Factories Cambodia, HerProject, KamakoChhnoeum
Project Focus:	Monitors factory compliance with labour standards; hygiene, nutrition, reproductive health; Hotline providing information on SRH, personal health, salary and allowances.
Location:	Phnom Penh and Kandal
Number of factories:	>400
Number of workers:	>20,000

Non-Government Organisations (NGOs)

ActionAID Cambodia	
Project Name:	Safe Cities Programme and Campaign
Project Focus:	Gender based violence in public space (garment workers, beer promoters, sex workers and university students)
Location:	Phnom Penh
Number of factories:	43
Number of workers:	5,000

Cambodian Business Coalition on AIDS (CBCA)	
Project Name:	Sewing for a Brighter Future (sub-grant from CARE), Promoting Gender Equality and HIV/AIDS in the Workplace
Project Focus:	Providing training on HIV/AIDS to workers, setting up HIV/AIDS workplace committees in garment factories, distribute IEC materials
Location:	Phnom Penh and Kandal
Number of factories:	10 factories
Number of workers:	>30,000

Cambodian Women for Peace and Development (CWDP)	
Project Name:	Sewing for a Brighter Future (sub-grant from CARE)
Project Focus:	Increase access to sexual and reproductive health and HIV/AIDS information, microfinance/saving tools and mechanisms, health insurance and other social protection services for young garment factory workers to reduce their vulnerabilities/risks as young economic migrant workers.
Location:	Phnom Penh
Number of factories:	8
Number of workers:	14,000

CARE International Cambodia	
Project Name:	Safe Workplaces, Safe Communities; Partnering to Save Lives (PSL); Sewing for a Brighter Future
Project Focus:	Workplace harassment, gender-based violence, sexual/ reproductive health, HIV/AIDS, maternal and child health (MCH), nutrition and hygiene; financial services, including savings and remittances; working conditions in factories, labour laws for both GFWs and factory managers.
Location:	Phnom Penh and surroundings
Number of factories:	45 in total across 3 projects
Number of workers:	50,000

Garment Manufacturing Association of Cambodia (GMAC)	
Project Name:	N/A
Project Focus:	Provide training to workers and garment factory staff related to laws, policies, quality of control, etc.
Location:	Phnom Penh, Kampong Cham, Kampong Som,Kampong Chhnang, Kampong Speu, Kampot, Kandal,PreyVeng, Pursat, Batambang, Takeo, Koh Kong.
Number of factories:	490 Garment, 51 shoe wear , 32 associate, 38 sub-contract
Number of workers:	41,3157; 79,804; 582; 11,043

Marie Stopes International Cambodia	
Project Name:	Partnering to Save Lives (PSL); Expanded Sexual and Reproductive Health Access (ERA) Project
Project Focus:	Sexual and reproductive health, family planning, safe abortion; Hotline
Location:	Phnom Penh and Kandal
Number of factories:	8 (PSL), ERA (22)
Number of workers:	22,000

Reproductive Health Association Cambodia (RHAC)	
Project Name:	Work Health Program
Project Focus:	Sexual and Reproductive Health and HIV services, Maternal and Child Health, Family Planning, STI, Anaemia, Hydration, General Hygiene, Nutrition, De-worming etc.
Location:	Phnom Penh City, Kandal, Preah Sihanouk and Kampong Speu province
Number of factories:	37 Factories: Phnom Penh (22); Kandal (1); Sihanoukville (9); Kampong Speu (5)
Number of workers:	76,049

Workers Information Centre (WIC)	
Project Name:	Empowering Women Garment Workers
Project Focus:	Providing training on labour law, promoting women's leadership unit in the workplace
Location:	Phnom Penh
Number of factories:	43
Number of workers:	250

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List of stakeholders consulted

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