Baseline Study Report, August 2018

Working with Women Project- II

Kingdom of the Netherlands

WORKING WITH women

SNV

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1' SNV Netherlands Development Organisation
2' Development Research Initiative

Working with Women Project- II

SNV through its Working with Women Project- II will leverage a collaborative approach to improve the health and wellbeing of garment workers in Bangladesh through Inclusive Business practices across the RMG value chain. This new phase builds on the success of a three-year pilot initiative from 2014 to 2017.

The Ready Made Garment (RMG) sector accounts for 81% of Bangladesh's total export income. The RMG workers are mostly migrants from disadvantaged backgrounds and lack access to products and services related to Sexual and Reproductive Health and Rights (SRHR). Drawing on SNV's extensive experience of engaging with business communities to promote responsible and inclusive business, the Working with Women Project- II will integrate three Inclusive Business (IB) models in 10 partner factories to harness market mechanisms for delivering win-win solutions for businesses and their workforce. This project is funded by Embassy of the Kingdom of the Netherlands.

For the next four years from October 2017 to September 2021, the project will work with 200 factories in Gazipur, Tongi, Savar, and Narayanganj through different mechanisms and platforms, to ensure access to health, including SRHR of garment workers. To achieve the goals, the project aims to follow a three-tier approach: (i) educating the garment management on the policies related to SRHR and health for workers; (ii) scaling three IB models and fine-tune them to a more concrete shape for adoption across the garment sector and (iii) engaging more private companies to design affordable and accessible solutions for the garment workers. The new phase of the project will work with NGOs, service providers and businesses to set the stage for a self-sustaining sectoral change that will improve access to healthcare rights, especially SRHR, of workers. The following Inclusive Business Models will be implemented and scaled up under the project:

Power Plus: Designed to address gender-based violence in the garment sector. Training and practical guidance will be provided to mid-level factory staff to prevent and mitigate gender-based violence in the workplace. Factory welfare officers will be trained on psychosocial counselling.

Health Insurance Plus: Facilitates collaborations between insurance companies and garment factories to introduce health insurance for garment workers. The aim is to build smart financing mechanisms for providing comprehensive health care to workers.

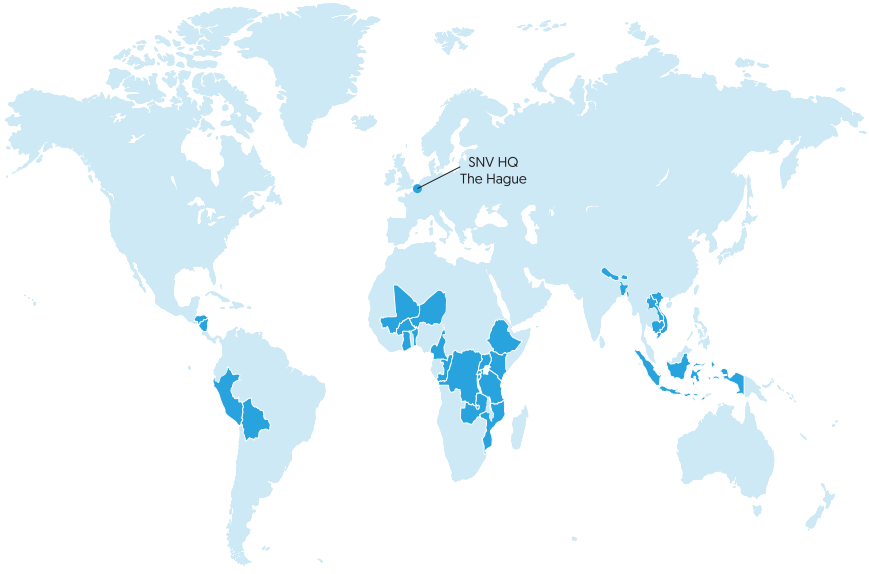
Menstrual Hygiene Management: Sets out a holistic approach starting from changing the behavior of workers, promoting hygiene practices, ensuring sanitary pads at workplace and building factory capacity to address MHM through a basket solution.

About SNV

Founded in the Netherlands in 1965, we have built a long-term, local presence in countries in Asia, Africa and Latin America. Our global team of local and international advisors work with local partners to equip communities, businesses and organisations with the tools, knowledge and connections they need to increase their incomes and gain access to basic services - empowering them to break the cycle of poverty and guide their own development. Our mission is to make a lasting difference in the lives of millions of people living in poverty.

By sharing our specialist expertise in Agriculture, Energy and Water, Sanitation & Hygiene, we contribute to solving some of the leading problems facing the world today - helping to find local solutions to global challenges and sowing the seeds of lasting change. We recognise that sustained poverty reduction requires people living in poverty to both contribute to and benefit from growth while having access to quality basic services. With this in mind, our work focuses on enabling the four factors we have learnt are essential for successful development: inclusive development, systemic change, local ownership, and contextualised solutions.

Where SNV works



Bangladesh	Congo-Brazzaville	Lao PDR	Rwanda
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Burkina Faso	Honduras	Nicaragua	Vietnam
Cambodia	Indonesia	Niger	Zambia
Cameroon	Kenya	Peru	Zimbabwe

Preface

The Ready Made Garment (RMG) industry, a mainstay of Bangladesh economy, employs about four million workers in semi-skilled and skilled jobs producing clothing for exports. The female workers who form the majority of this workforce come mostly from disadvantaged portion of the communities and often suffer from health issues including malnutrition, communicable diseases, pregnancy complications, incorrect use of family planning materials, reproductive infections and other such diseases related to Sexual and Reproductive Health and Rights (SRHR). They also carry misconceptions about health, wellness and SRHR issues, and the cultural, social, workplace and behavioral barriers attached to their lack of knowledge has resulted in workers not accessing these services.

SNV, under its "Working with Women" project, funded by the Embassy of the Kingdom of the Netherlands, implemented 10 inclusive business (IB) models in 20 garment factories and engaged both NGO service providers and private sector to introduce customized SRHR services and products targeting garment workers to make services available in a more accessible and affordable manner.

The pilot implementation of "Working with Women" project has resulted in positive changes: 14 partner factories out of 20 are investing in SRHR and workers are paying for SRHR services with 15,000 workers under Health Insurance model alone paying their premium contribution. Building on the success of this pilot initiative, SNV started the second phase of the project, "Working with Women-II" with a broader mandate to address the health and well-being of the garment workers, with a special focus on SRHR. Three IB models among the ten have been selected for industry-wide adoption.

This baseline study was aimed towards assessing the current situation of the existing SRHR service provision, accessibility, affordability, usage among workers, gender sensitiveness, and other social outcome and impact indicators including workplace laws and policies on SRHR, before initiating the three Inclusive Business (IB) models in target factories. This baseline provides us with operational recommendations to strategize our future efforts more efficiently.

The success of this study is the result of efforts of many people, starting from the researches and respondents to the service providers, factory owners/management and the team members of the working with women project. I would like to express my gratitude to all those who were involved a each and every step of this study. I must say that I am very optimistic that this study will effectively guide the implementation of this project.

Farhtheeba Rahat Khan
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Foreword

SNV Netherlands Development Organisation is implementing the Working with Women project with the support from the Embassy of the Kingdom of The Netherlands since 2014. The project aims to ensure Sexual and Reproductive Health and Rights (SRHR) services for female and male garment workers through Inclusive Business practices. SNV has been working to serve this purpose through engaging private sector to introduce SRHR and health products & services for garment workers in a more sustainable way. The Working with Women Project- II project sets the stage for a sectoral change in the RMG industry through improved health and well-being of workers, with a focus on Sexual and Reproductive Health and Rights.

This baseline study of Working with Women Project- II has examined the pre-intervention situation in factories to identify the gaps that are not being met currently and help the project to address these. This study has brought to light important information about the existing situation in target and control factories. I believe the recommendations from this study will assist the project in the fine-tuning of the planning process and will improve its implementation.

I am looking forwards to the next stages of this innovative project. I believe that this project will help to mitigate gaps amongst the stakeholders, engaged for the well-being of garment workers. The project will facilitate the building of effective partnerships for the enhancement of the quality of SRHR services and products available to the workers. This will in turn ensure better health conditions for the female workers – a crucial social responsibility as well as path to business success.

Dr. Annie Vestjens
First Secretary, SRHR and Gender
Embassy of the Kingdom of Netherlands
Dhaka
Bangladesh

Acknowledgement

We are thankful to the factory owners, staff and workers for their sincere and active cooperation during this study. We would also like to express our gratitude to all the service providers (NGOs and private) under each of the IB Models for their support and coordination during this study. Without their time and input, this study would not have been completed.

We also thank the data collectors, moderators and field supervisors for their dedication, commitment and hard work in completing the study.

We would like to acknowledge the generous support of DGFP, Ministry of Health and Family Welfare and Ministry of Labour and Employment, Bangladesh. We express our sincerest gratitude to Buyers' Forum and BGMEA for their suggestion and remarks.

We would like to express special gratitude to the factory managements for providing us with the time and necessary resources with sincerity to conduct FGDs and interviews with workers. We offer sincere gratitude to Ms. Annie Vestjens, First Secretary, SRHR and Gender, Embassy of the Kingdom of Netherlands for her strategic insights onto the provision of SRHR in Bangladesh, the priorities of Netherlands Embassy and their expectations from the study. This study would not have move forward without her guidance and support.

Last but not the least, many thanks to all study team members of Development Research Initiative (dRi) and SNV for providing their tremendous support and valuable inputs to undertake the study and complete this report.

Jason Belanger
Country Director
SNV Netherlands Development Organisation
Bangladesh

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BILS	Bangladesh Institute of Labour Studies
CSR	Corporate Social Responsibility
C-section	Caesarean Section
ECP	Emergency Contraceptive Pill
FGD	Focused Group Discussion
FP	Family Planning
HIV	Human Immune Deficiency Virus
HIP	Health Insurance Plus
IB Model	Inclusive Business Model
ICPD	International Conference on Population and Development
IDI	In-depth Interview
KII	Key Informant Interview
MHM	Menstrual Hygiene Management
MR	Menstrual Regulation
NGO	Non-governmental Organization
ODK	Open Data kit
PNC	Post-natal Care
PP	Power Plus
QIS	Qualitative Information System
RCT	Randomized Control Trial
RMG	Readymade Garments
ROI	Return on Investment
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
ToR	Terms of Reference
TT	Tetanus Toxoid
VAW	Violence Against Women
WwW	Working with Women

Operational Definitions

Inclusive Business Model

An inclusive business model is a commercially viable model that benefits low-income communities through including them in a company's value chain on the demand side as clients and customers, and/or on the supply side as producers, entrepreneurs or employees in a sustainable way. Inclusive business models both practice and reap the benefits of human development. It creates opportunities for the poor by meeting basic needs, enabling the poor to become more productive, increasing incomes, and empowering the poor (United Nations Development Program, 2008).

Sexual and Reproductive Health and Rights (SRHR)

SRHR encompass the right of all individuals to make decisions, regarding their sexual activity and reproduction, free from discrimination, coercion, and violence. Specifically, access to SRHR ensures individuals are able to choose whether, when, and with whom to engage in sexual activity, to choose whether and when to have children and to access the information and means to do so (United Nations Fund for Population Activities, 2014).

All couples and individuals have the right to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so. Decisions concerning reproduction should be made free from discrimination, coercion, and violence (United Nations Fund for Population Activities, 2014). For people to realize their reproductive rights, the International Conference on Population and Development (ICPD) Program of Action calls for and defines reproductive and sexual healthcare in the context of primary healthcare that include:

- Family planning
- Antenatal care, safe delivery, and postnatal care
- Prevention of abortion and management of the consequences of abortion
- Treatment of reproductive tract infections
- Prevention, care and treatment of STDs and HIV/AIDS
- Information, education and counselling, as appropriate, on human sexuality and reproductive health
- Prevention and surveillance of violence against women, care for survivors, and other actions to eliminate traditional harmful practices
- Appropriate referrals for further diagnosis, and management of the above

It is globally recognized that entrenched patterns of social and cultural discrimination are major contributors to sexual and reproductive ill health, along with the lack of information and services. SRH efforts are to be coordinated with interventions that address the pattern of social discrimination, gender inequalities and exclusion that hinder women, men and adolescents from exercising their reproductive rights (United Nations Women, 2014).

Gender, gender equity, and gender equality

Gender refers to men's and women's roles and responsibilities that are socially determined. Gender is related to how people are perceived and expected to think and act as women and men because of the way society is organized, not because of biological differences.

Gender equality entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles or

prejudices. Gender equality means that the different behaviors, aspirations and needs of women and men are considered, valued and favored equally. It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female.

Gender equity means fairness and justice in the distribution of benefits and responsibilities between men and women. The concept recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes (Ministry of Health and Family Welfare, 2001).

Violence against women (VAW)

VAW means any act of gender-based violence 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.

Executive Summary

Introduction

The Working with Women-II project aims to improve the health and wellbeing of garment workers in Bangladesh through Inclusive Business practices across the RMG value chain. The project follows a three-tier approach: educating the RMG management on SRHR laws and policies, scaling the IB models and fine-tuning them, and engaging more private companies to design affordable and accessible solutions and service package for the garment workers. The three Inclusive Business Models, selected during the piloting phase, are to be implemented and scaled-up under the project. The three IB models are Power Plus, Health Insurance Plus, and Menstrual Hygiene Management. Power Plus model is specially designed to address gender-based violence in the garment sector. Under this model, training on psychological counseling and legal aid support and institutionalization of workplace well-being management will be done. Health Insurance Plus model will facilitate collaborations between insurance companies, health service providers and garment factories to introduce health insurance for their workers. This is a smart financing mechanism for comprehensive health care for workers. The model intends to develop a sustainable system for workers' wellbeing as well as meeting the unmet health care needs of partner factory workers. Menstrual Hygiene Management (MHM) model will set out a holistic approach starting from changing the behavior of workers, promoting hygiene practices, ensuring sanitary pads at workplace and building factory capacity to address MHM through a basket solution. This model will equip and/or strengthen the factory medical centers for better Sexual and Reproductive Health and Rights (SRHR) for the targeted factory workers. The project implementation started on October, 2017 and will continue until September, 2021.

Study Objectives and Methodologies

The main purpose of the baseline study is to assess the pre-project situation of the existing SRHR service provision, accessibility, affordability, usage among workers, gender sensitiveness, and other social outcome and impact indicators along with SRHR laws and policies before the IB model starts. The baseline study used a quasi-experimental & cross-sectional survey and qualitative interviews/ focus group discussion to evaluate the project through different IB models, involving a random selection of RMG workers. The quantitative baseline survey was conducted among representative samples of female workers. In this randomization process the three arms used were: 1. Arm A: Training/awareness of SRHR & service provision, 2. Arm B: Training/awareness only, and 3. Arm C: Control factories with no interventions. The qualitative research included KIIs and FGDs with RMG management personnel, male RMG workers, and RMG health personnel. The quantitative survey used structured/semi-structured questionnaires through a paperless survey tools-Open Data Kit (ODK) and the qualitative part of the study used checklists/ guidelines among a representative sample for the study. The study covered mainly four areas: Gazipur, Savar, Tangail, and Narayanganj.

Profile of the Female RMG Workers

49 percent of the female RMG workers were below 24 years of age. The percentage of workers aged below 24 years were more among the Arm A (around 50 percent) respondents than the other two Arms (47 percent in both cases). 79 percent of the respondents were married while percentage of married respondents were the highest (nearly 82 percent) among the Arm B respondents. 81 percent of the female RMG workers have incomplete secondary education or lower than that. Larger numbers of husbands of the respondents were aged between 25-29 years, have incomplete secondary education, and lived with their wives. 34 percent of the survey respondents have been working in their current workplace for at least two years and the average involvement in the RMG sector of the total respondents is 5 years. Majority of the respondents earned between BDT 5001-7000 per month and used BDT 245 per capita on average for health expenses. Nearly all of the respondents (97 percent) have access to mobile phones.

Knowledge on Basic SRHR Components

Pills (95 percent), Injectables (83 percent),

condoms (69 percent), and implant/Norplant (43 percent) were the most known FP methods among the female RMG workers. The situation was the same for the respondents of all Arms with little deviations. FP methods for men were not popular at all (below 5 percent in all cases). The awareness of the respondents regarding methods to avoid pregnancy after unsafe sex is very low (only 11 percent). Arm B and Arm C also have the larger share of respondents, more than 50 percent in both cases, who were unaware of the contraceptive methods to avoid unintended pregnancy after unprotected sex. More than half of the respondents (55 percent) had no knowledge about MR or when to use the method. The scores by the respondents from Arm A, B, and C follow the general trend of ignorance whereas Arm A factories under MHM IB model presented the worst scenario with only about 24 percent respondents being aware of MR. The knowledge of the respondents on sanitary napkin usage was also significant (88 percent for Arm B and 82 percent or Arm C). Although majority (about 82 percent of ARM-A) of the female workers were aware of antenatal care (ANC), a significant portion of them (23 percent) were not aware of pregnancy related complications and safe motherhood. The awareness of the number of TT dose during pregnancy was also below 50 percent. The majority (75 percent) of ARM-A female workers interviewed were aware of safe delivery/birth preparedness while the half (50 percent) of ARM-A female workers interviewed were not aware of time of PNC. More than half of the total respondents identified the government hospitals as the main service provider for sexual and reproductive health (57 percent). Around 45 percent of the respondents considered their friends and neighbors as the main source to seek information on SRHR.

Unmet need, Use of Contraception, and MR Services

Percent of Total modern method user was 71 at Arm A. The respondents considered Pharmacy as the main sources of modern FP method. More than 85 percent respondents showed intentions to use FP methods in future. Only 8 percent female RMG workers of Arm-A had unmet needs of Family planning. Only two percent overall respondents had ever used ECP and the users took ECP from pharmacies to prevent sudden and unexpected pregnancy. The rate of MR usage is also very low, less than 3 percent. Private hospitals or clinics are the most known sources of MR services with 30 percent popularity.

Utilization of Maternal Health Care Services

About 38 percent of the mothers aged between 20-24 years have four or more ANC visits (ANC4+) whereas the percentage ANC4+ visits was the highest among the Arm A respondents (41 percent). Overall 88 percent of the respondents received ANC from trained providers and the popularity of the RMG health centers for ANC was 42 percent among them. About 46 percent delivered in institutional health facilities. IB model referral health centers received very low acceptance (only 3 percent) in case of delivery care. About 28 percent of the total respondents delivered by the caesarean section. Delivery by the medically trained professionals was higher among non-IB model respondents while the use of traditional, risky care-givers' services was also higher among them. Majority of the PNC receivers (about 47 percent) availed the PNC services within two days of delivery. About half of PNC receivers received PNC within 42 days. The PNC received from medically trained providers was the 36 percent in Arm A respondents.

Menstrual Hygiene Management

More than half of the respondents (57%) were aware of menstruation before they started experiencing menstruation. Family and friends were the major sources of MHM-related knowledge sharing and it was the same for respondents from all the study Arms. Half of the MHM model respondents used sanitary napkin during their menstruation. All the factories affiliated with the project have private places where women feel comfortable in changing sanitary pads/clothes. Dumping the used pads properly is a common practice among the MHM model respondents (51 percent > 37 percent > 40 percent) while washing and reuse was the highest practice among the respondents from other Arms. In case of management of menstrual waste at factories, only around 35 percent of the cumulative respondents reported using the bins to dispose the used items.

Sexual Harassment and Violence against Women (VAW)

36 percent (in overall) and 50 percent from Arm A (power plus model) respondents agreed to the statement that workers are beaten/slapped when they make mistakes at work. When asked, more than 60% of the female respondents could not identify acts of physical, mental and sexual harassment and abuse. The awareness was higher in Arm A respondents from Power Plus model factories than the two others while Arm B has the lowest level of awareness among the three. 8 percent of overall respondents reported that they were harassed ever their life. These percentage was varied from 5 to 10 (Arm C was lowest and Arm A was highest). Overall five percent victims faced harassment within six months.

Roadside harassment was the most common form of harassment they faced (nearly 59 percent in overall). About 42 percent of the victims sought help and/or protested against the harassment they faced. Most of the respondents from Arm A sought help when they faced harassment and the help from the factory management was higher at Arm-A than the others (about 27 percent > around 18 percent > nearly 7 percent).

Sexually Transmitted Diseases (STDs) and HIV/AIDS

Almost half of the respondents (nearly 50 percent) from all Arms did not know anything about STDs. The knowledge level was high (96%) among the respondents from Arm A than the two other Arms. The respondents presented themselves as unaware of STD symptoms since most of the symptoms received below 10 percent response. The most preferred STD service provider was the untrained doctors. About 80 percent respondents knew about HIV/AIDS. But only 7 percent of the Female RMG workers aged 18-24 years have comprehensive knowledge of HIV/AIDS at Arm A. Only 3 percent or below respondents from Arm B and Arm C had comprehensive HIV/AIDS knowledge. 63 percent of Arm A respondents could correctly identify all three means of mother to child transmission of HIV/AIDS.

Gender Equality, Equity, and Women Empowerment

The awareness about the gender equality was very high among all the study Arms (above 90 percent in all the three cases) with only Arm C respondents recorded having lower awareness level than the other two arms. Less than 15 percent respondents of all three Arms could contribute to the family decision-making. Majority of the respondents could identify the misbehaviors of husband but did not think such attitudes are needed to be justified.

Availability, Accessibility, Affordability, and Satisfaction with the availability and quality of SRHR issues

Overall 94 percent respondents reported of having a health center in their respective factories. The RMG health centers were accessible for nearly 8 hours per day for all the workers and the situation was the same for all the three Arms. The gender sensitiveness was again higher in health centers of Arm A factories (about 86 percent). Nearly 30 percent respondents, in all cases, recorded that required health services specially SRHR services were not available at the RMG health centers as per their needs. Only six types of SRHR services were available irrespective of Arms. In around 95 percent cases, the service providers were available at the health centers during work hours. The level of satisfaction (highly) regarding the type and quality of services in the RMG health centers were around 23 percent in all cases. Overall Arm A factories provided the most satisfactoryhealth services while the Arm-C RMG health centers were reported to be less satisfactory in regards to both type and quality of services in same level. Health insurance model provided the most satisfactory services.

Health Insurance Scheme

Access to any health insurance scheme was higher in the Insurance Plus IB model factories (Arm A) compared to the overall users but much lower than expected level (only 18 percent and 12 percent respectively). 82 percent respondents from IB model partner factories were not aware of

the health insurance schemes. Less than one percent of the total respondents had health insurance policies while 86 percent of the total respondents, in both Arm A and overall cases, showed lack of willingness for health insurance. According to the interested group of 242 respondents, service coverage (about 67 percent) and the product coverage (about 38 percent) were the two most important features of health insurance.

Understanding of SRHR issues among male RMG Workers

A total of 10 FGDs were conducted among the male RMG workers from three types of factories. Respondents were not well aware about the reasons and symptoms of STDs. The main reason behind that STDs is considered as a social taboo. Mass media and awareness raising campaigns were the main sources of information for them. The respondents across Arms showed misconception regarding infertility, genital and urine infections and premature ejaculations. The respondents think that the main purpose of contraceptives is to have fewer children. The Respondents were mostly young and unmarried and they perceived that only married workers should know about these issues. Married male respondents across Arms unanimously recognized that it is a husband's responsibility to care of his wife and take her to doctor when needed. There were two types of responses regarding the decision-making on contraceptive usage in both Arms. One group commented that they believe contraceptives are for women only and they do not like using condoms. So, their wives use contraceptives. The other group informed that the decision of using contraceptive was usually decided through a discussion between the husband and the wife. MR or safe MR for women was unknown to most of the respondents. During the discussion on HIV/AIDS, respondents from both Arms agreed that they know about AIDS but a little about the symptoms and treatments of the disease. The feelings regarding the RMG health centers were mixed. They agreed that the quality of the services was good but they also conveyed that the availability of the SRHR services were very low. The acts of sexual harassment or violence against women (VAW) were not common to the respondents. The respondents suggested that factories are all export-oriented and are very strict about workplace safety and security. However, women are vulnerable outside the factory, in public places and when they move at night.

Comparison of knowledge and practice by the Management Personnel on SRH laws, policies, and issues

Interviews were conducted with 23 management personnel of different RMG factories (10 from partner factories –Arm A, 8 from Arm B and 5 from Arm C). Six of the ten interviewees from partner factories mentioned that they did not have any clear idea about SRHR service related national laws and policies. They agreed that SRHR facilities could help the factories and would provide boosts to the production rate of the workers. But they had also mentioned that the factories had taken only little SRHR initiatives (i.e. distribution of sanitary napkins among few workers and some trainings and/or seminars).

Conclusion and Recommendations

On the basis of the study findings, the following conclusions can be drawn:

- The short-term FP methods are popular among the RMG workers while the long-term and male-user FP methods are less popular. Most of the workers also lack knowledge about MR.

- The level of consciousness on menstrual hygiene is high. A vast number of the female RMG workers used sanitary napkins. But improvements in the hygienic practice specially MHM is needed.

- The workers' level of awareness on long term and male-user FP methods, maternity care, MHM, STDs and HIV/AIDS need advancements while areas like MR and Health Insurance demands serious

improvements.

- The health centers lack SRHR-oriented services. The workers' appreciation and recognition of the health centers is not at a desired level, let alone satisfactory level.

- The type of SRHR services in the partner factories are limited and not at an adequate level. There is still room for significant improvement in areas like long term and male-user FP methods, ECP, contraception usage, maternity care, MHM practice, STDs, HIV/AIDS, MR, Health Insurance etc.

- The VAW incidents are not very limited but there is adequate support system available to the workers if any such incident occurs.

- The gender sensitivity is high in the RMG factories. Gender equality prevails. But individual mobilization and decision-making capabilities by the female RMG workers need serious progress.

- Only a handful of the RMG workers have health insurances and a few are interested. This indicates the need for consciousness raising among the workers on the importance health insurance schemes.

- Sensitiveness towards SRHR laws and policies were low among the factory management personnel. Most of them didn't have clear idea while some even didn't see the importance of executing the existing SRHR laws and policies.

Based on the findings of the study, some suggested endeavors, at IB model level, are included below that might positively impact the project's implementation and success:

1. Power Plus Model

Sensitization about VAW : Perception, awareness and practices regarding sexual harassment and VAW needs serious attention as well as more focused actions should be taken to improve the situation in the aspects related to sexual harassment and VAW.

2. Menstrual Hygiene Management (MHM) Model & Health Insurance Model (common issues)

i. Awareness Campaigns on SRHR Issues: The awareness on SRHR services available to the workers is not properly known to most of them. Initiatives should be taken to improve the level of awareness.

ii. Inclusive Family Planning: Knowledge and awareness on the FP methods also need serious attention. Both the awareness of male about contraceptives and women's decision-making capacity are found to be alarmingly low. It is highly recommended that, any program targeted towards FP must incorporate male partner in the process.

3. Only for Menstrual Hygiene Management (MHM) Model

Sanitary Napkin distribution & Safe Disposal Mechanism for Menstruation Items at the factories: Although the awareness and practices of menstrual hygiene are in good shape, Sanitary Napkin distribution and safe disposal of sanitary materials need to be incorporated by an authorized waste disposal body.

4. Health Insurance Model

i. Information Campaign on Health Insurances: A key reason for lack of enthusiasm for health insurance is the lack of knowledge about the benefits and facilities offered by the insurance schemes. A three-step strategy need to be designed in order to increase the willingness among the RMG workers. A short health survey should identify the key issues. In next stage, the insurance provider and the factory owners should come to an agreement about cost sharing among parties. Also, the scheme needs to respond to the health needs and offer coverage to the issues that workers are suffering. Finally, the program needs to develop an easily understandable yet informative campaigns and communication materials about the health insurance schemes for the RMG workers.

ii. Enhanced Awareness about ECP and MR: The awareness regarding ECPs and MR is also very low. Initiatives should be taken to ensure awareness on those aspects.

iii. Information on Pregnancy and Maternal Services: The respondents should be made aware of the importance of ANC and PNC for the mother, delivery care, birth preparedness, importance of TT and checkups etc.

iv. Information Dissemination on STDS and Available Support Systems: The awareness regarding STDs and HIV/AIDS needs to be improved in a manner that the workers can identify the diseases properly when the symptoms appear and report them to doctors.

5. Inclusive Healthcare in Factories and Targeted Meetings with Factory Management: The RMG health centers and IB model referral centers requires modernization. Implementation of SRHR laws and policies as well as ensuring SRH services should be made certain and extensive. Meetings need to be held with the factory management to make them aware about their responsibilities of providing SRHR services inside the factory.

INTRODUCTION

1. Introduction

The Ready-Made Garment (RMG) sector accounts for 81 percent of Bangladesh's total export income. Bangladesh is the world's third largest garment producer with more than 5,600 factories currently employing around 4.2 million workers, an estimated 90 percent of them are women (SNV Netherlands Development Organisation, 2015). The large portion of RMG workers represent migrants from disadvantaged backgrounds with limited or no access to products and services related to Sexual and Reproductive Health and Rights (SRHR). They also carry misconceptions about health, wellness and SRHR issues. The cultural, social, workplace and behavioral barriers attached to their lack of knowledge have resulted in workers not accessing these services.

Results from studies undertaken in different countries show that if factories invest in SRHR for their workers, the economic returns will be significant. One study in Egypt suggested that investing in worker's health is more than a moral imperative—there is a compelling business case for the investment. Return on Investment (ROI) study related to SRHR in RMG sector in Bangladesh is yet to be undertaken. However, according to existing data, for every $1 invested in women's health, one Bangladeshi factory observes a $3 return through higher productivity, lower turnover and reduced absenteeism (BSR HERproject Report, 2014).

After completing the three-year pilot phase of Working with Women Project- I (2014 to 2017), the project found out some achievements (SNV Netherlands Development Organisation, 2017), which derived SNV to design Working with Women Project- II. These are the key achievements of the pilot project:

(i) 10 Inclusive Business models were piloted in 20 factories, delivering improved and affordable gender-friendly SRHR and health services for more than 30,000 workers.

(ii) 14 partner factories out of 20 started investing in SRHR and workers are now also sharing for SRHR services, 15,000 workers subscribed to health insurance plans.

(iii) SRHR service accessibility increased more than 6 times: from 3,434 in the first quarter of the IB model launch (Aug-Oct 2015) to 22,727 in the last quarter (Jan-Mar 2017).

Drawing on SNV's extensive experience of engaging with business communities to promote responsible and inclusive business, the Working with Women Project-II will integrate three Inclusive Business (IB) models in 10 partner factories to harness market mechanisms for delivering win-win solutions for businesses and their workforce. The main goal of the Working with Women Project- II is determined to ensure access to health services including SRHR of the RMG workers. To achieve the goal, the project aims to follow a three-tier approach: educating the garment management on the laws and policies related to SRHR and health for workers; scaling three IB models and fine-tuning them to a more concrete shape for adoption across the garment sector; and engaging more private companies to design affordable and accessible solutions and service package for the garment workers. For four years (from October 2017 to September 2021), the project will work with more than 200 factories in Gazipur, Tangail, Savar, and Narayanganj through different mechanisms and platforms, to ensure access to health services, including SRHR of garment workers.

Under this project, the following key activities and objectives are to be carried out by different partners:

1. Supporting better implementation of workplace policies on SRHR and health in garment factories by identifying knowledge gaps and providing capacity building support to incorporate SRHR related issues:

The service provider, Bangladesh Institute of Labor Studies (BILS) is given the assignment to promote implementation of workplace Laws & Policies related to health and SRHR in RMG factories with a view to supporting the RMG sector adopt gender-sensitive and women-friendly SRHR services for their workers. The intended activities by BILS are as follows:

a) BILS will play the capacity building role in enhancing the knowledge of both partner and non-partner factories on the existing laws and policies on SRHR, facilitating linkages with available solutions and creating the evidence that how implementing these laws in workplace could be beneficial for the overall business success. The activities will be carried out in factories in the project locations of Gazipur, Tongi, Savar and Narayanganj area.

b) BILS will also review the existing policies related to SRHR and assess the knowledge gap in the RMG sector on these laws and policies.

c) Based on the assessment, BILS will develop curricula and training models, design session plans, and execute the training in both partner and non-partner factories.

d) BILS will facilitate linkage for service provisions, conduct follow-up visits in partner and non-partner factories to monitor status, identify support requirements and address those in consultation with SNV.

2. Implementing three Inclusive Business models in 10 partner factories for sector-wide adoption:

The new phase of the project involves NGOs, service providers and businesses to set the ground for a self-sustaining sectoral change that will safeguard the healthcare rights of workers, including SRHR. This is to be achieved through three IB models selected during the piloting phase. The following Inclusive Business Models are to be implemented and scaled up under the project (SNV Netherlands Development Organisation, 2017).

I. Power Plus Model: Power plus model is specially designed to address gender-based violence in the garment sector. Training and practical guidance will be provided to mid-level factory staff to prevent and mitigate gender-based violence in the workplace. Factory welfare officers will be trained on psychosocial counselling to help workers in reporting gender-based violence and also provide mental support to the victims. Power plus has two dimensions. One is system for para-counseling and legal aid support in partner factories and the other one is to institutionalize workplace wellbeing management (WWM) course for developing counselors for the RMG sector. Power plus Model will be jointly implemented by Sajeda Foundation, UCEP and Fair Wear Foundation. Sajeda Foundation will work on developing the system for para-counseling and legal aid support in partner factories (SNV Netherlands Development Organisation, 2017) and UCEP will offer workplace wellbeing management (WWM) course to RMG factories to increase their knowledge level on compliance as well as developing quality welfare officers to support the workers (SNV Netherlands Development Organisation, 2017).

II. Health Insurance Plus model: The Health Insurance model will facilitate collaborations between insurance companies, health service providers and garment factories to introduce health insurance for their workers. This is a smart financing mechanism for comprehensive health care for workers. The model intends to develop a sustainable system for workers' wellbeing as well as meeting the unmet health care needs of partner factory workers. Approximately 6,100 male and female workers of partner factories will be direct and/or indirect beneficiaries through this initiative and will get the opportunity to avail health services. The annual insurance per workers is BDT 575 and the coverage against the premium is BDT 15,000 annually. Out of the BDT 575 premium, factories will pay factories and workers BDT 200, 300, and 400 chronologically for the next three years. The rest of the premium will be paid by SNV through the donor's fund. There will be four major outputs (SNV Netherlands Development Organisation, 2017):

a) An established partnership/networking to make health insurance operational;

b) An established health service delivery system for the selected factory workers;

c) Sensitized factory staff, workers and management on health insurance scheme; and

d) An established monitoring and evaluation (M&E) system for dissemination and/or sharing of information and other evidences.

III. Menstrual Hygiene Management (MHM) Model: Menstrual Hygiene Management is an important part of our SRHR intervention. This business model will set out a holistic approach starting from changing the behavior of workers, promoting hygiene practices, ensuring sanitary pads at workplace and building factory capacity to address Menstrual Hygiene Management through a basket solution. This model will equip and/or strengthen the factory medical centers for better Sexual and Reproductive Health and Rights (SRHR) services for the targeted factory workers. The beneficiaries are targeted factory workers, both male and female. The objective is to support factories to gain access to affordable sanitary pads and also ensure family planning services and products to the factory workers. Approximately 40,000 female workers from both partner and non-partner factories will be supported to access affordable sanitary pads as a part of MHM activities. Five major outputs will occur (SNV Netherlands Development Organisation, 2017):

a) An established partnership and networking with stakeholders to make initiatives operational and sustainable;

b) Recruitment of necessary human resources and operationalized project intervention in the factories;

c) Health facilities at partner factories are equipped, strengthened and/or utilized for providing counseling, consultation, and services on SRHR;

d) Workers, factory staff, and management are sensitized on the project intervention and also on health including SRHR; and

e) Established monitoring system for dissemination of reports/ information and other evidences.

3. **Engaging the private sector to introduce SRHR and health products/services for garment workers**: SNV is looking to engage private stakeholders more directly with a view to introducing SRHR and health products and/or services for the garment workers.

The study focuses mainly on the first two objectives of the project and also tries to find out the prevailing level of awareness among the factory management on SRHR issues, their attitude and practices on SRHR laws and policies, and establishing the baseline situation for the project as well as IB model indicators.

1.1. Objectives of the Study

The main purpose of the study is to assess the current situation of the existing SRHR service provision, accessibility, affordability, usage among workers, gender sensitiveness, and other social outcome and impact indicators including SRHR laws and policies before the IB model starts. The study also aimed to generate qualitative and quantitative data on key social impact and outcome indicators. The study objectives are as follows:

1. To collect data that will further inform the program management to plan accordingly and implement the IB models;
2. To establish the baseline situation for the project's key indicators and also for the overall working with women -II project that can be used to measure different IB models as well as the project performance; and
3. To make recommendations that will assist in the fine-tuning of the planning process and improve the implementation of the project.

1.2. Layout of the Report

The next section, section two, discusses the methodology that the study followed. Section three covers the quantitative survey findings of study including the background characteristics of the respondents, their knowledge and understanding of SRHR and health care services, use of contraception and MR services, utilization of maternity care services, menstrual hygiene management, their understanding on STIs and HIV/AIDs, and finally, about their understanding on gender equality, violence against women, health insurance scheme etc. Section four of the report presents analysis of the qualitative data collected from KIIs and FGDs with male RMG workers, factory management, and factory health personnel about their understanding on SRHR and violence against women (VAW) related policies and practices. In the end, some recommendations are suggested in the final section, section five, that will help more effective and inclusive project implementation.

METHODOLOGY

2. Methodology

According to the ToR, this baseline study of 'Working with Women - II project' gathered data on the existing situation to provide an information base against which monitoring and assessment of different activities'/interventions' progress, effectiveness and impact during implementation and after the interventions were completed through different IB models and assess whether the results (Impacts and Outcomes) were achieved as expected, identify bottle-necks or propose corrective actions for future programs. The study also assessed the possibility of synergy and cooperation between all key stakeholders of the project- especially among SNV and the implementing partners (service provides and RMG factories) at field level. The evaluation further assessed all IB models and their key outputs and outputs of the project and assessed achievements in different RMG factories.

Based on the understanding of the project, its goals and objectives of the final evaluation, this study deployed a cross-sectional survey design (mainly quantitative) employing mixed method research approach to evaluate the project through different IB models, involving a random selection of RMG workers. The quantitative baseline survey (one of the main tasks of this assignment) was conducted among representative samples of female workers. The quantitative survey used structured/ semi-structured questionnaires and the qualitative part of the study used checklists/ guidelines among representative sample for the study.

The methodology had been finalized before implementation of the survey in consultation with SNV. The detailed methodology that the study followed is described below:

2.1. Study Area

According to the ToR, this evaluation study was administered in the catchment and control areas of 'Working with Women' project. Therefore, the study areas are as follows:

The specific study areas and garments factories were finalized in consultation with SNV.

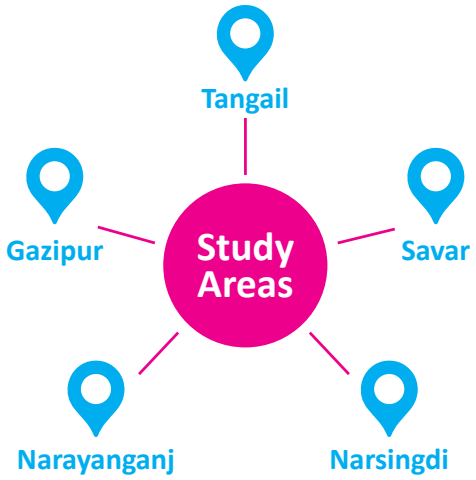


Figure 1: Study Areas

2.2. Target Population

The final evaluation study included a wide range of population covering all relevant participants and stakeholders of the 'Working with Women' project. In-depth information was collected through using various research techniques with a variety of study population. Therefore, information was gathered from the respondents that included:

1. Female RMG workers;
2. Male RMG workers;
3. Health professional of different Factories/ personnel of welfare departments; and
4. Managers/senior management of RMG factories.

2.3. Sources of Data

The study intended to assess the existing situation of knowledge/awareness, attitude and practices among RMG workers, assess health professionals/management of RMG factories' knowledge/awareness, capacity development status of implementing partners (service providers) and also desired impact/outcomes of the project. Therefore, the study utilized both primary and secondary sources of data and the types of sources of data are stated below:

2.3.1. Primary data

The primary data was collected from the target population of the study utilizing a combination of both qualitative and quantitative methods to acquire the wide range of information needed for the study.

To collect the empirical information, following data collection techniques were adopted with specific target respondents:

1. Quantitative Method: In order to collect quantitative data a representative sample size was determined and proportionate distribution of size was ensured including appropriate sampling approach. The sample size was determined in a way that it ensured a sufficient representation of the garment workers of Arm A, Arm B and Arm C and reflected a confidence level which is considered appropriate for the situation. A cluster-systematic random sampling was deemed appropriate for the survey.

   A set of structured/ semi-structured questionnaires was used through a paperless study called open data kit (ODK)[1] for the survey to collect quantitative data from the respondents through face-to-face interview. The respondents for the quantitative survey were the female RMG workers.

2. Qualitative Method: The study demanded effective administration of qualitative methods to collect information from the target population. Therefore, a significant amount of participatory research techniques or qualitative techniques, e.g. Focus Group Discussion (FGD), Key Informant Interview (KII) and In-Depth Interview (IDI) were used to collect qualitative data using semi-structured guidelines with the following respondents:

   I. Male RMG workers
   II. Health professional of different Factories/ personnel of welfare departments
   III. Managers/senior management of RMG factories

2.3.2. Secondary data

As part of the study secondary information, related and relevant secondary literature were reviewed that included:

1. Previous project and study reports;
2. M&E plan/Result framework;
3. Guidelines/policy documents/previous tools;
4. ToR by the SNV's partners;
5. Project Proposal; and
6. SNV website/webpage.

2.4. Data Collection Techniques

The aforementioned data collection techniques and sample size calculation are detailed below:

2.4.1. Quantitative Method

In order to collect primary data, quantitative survey was conducted with the targeted respondents through face-to-face interview. Therefore, structured interview technique was utilized for conducting the baseline survey.

2.4.1.1. Sample Size Calculation

Based on the ToR, there was an aspiration to conduct an experimental evaluation whereby impacts of two types of interventions were measured against a control group using randomized control trial (RCT) approach. The RCT arms used were:

1. Arm A: Training/awareness of SRHR and service provision at partner factories,
2. Arm B: Training/awareness only at non-partner factories, and
3. Arm C: Control/factories with no interventions.

However, the factories for Arm A were already identified as SNV had partnership with them whereas the factories in Arm B and C were non-partners. Therefore, a three-arm RCT was not feasible. As an alternative, a combination of quasi-experimental and experimental approach was proposed whereby the factories in Arm A were selected from the partners (quasi-experiment) and the current non-partners were randomly divided into Arm B and Arm C to have the experimental impact assessment of the training/awareness component. Therefore, the design was a cluster-level randomized control and quasi-experiment.

[1] Open Data Kit (ODK) is a suite of tools that allows data collection using mobile devices and data submission to an online server, even without an Internet connection or mobile carrier service at the time of data collection. One can collect data remotely without an internet connection or cell carrier access. One can gather text, numeric data, media and more with a mobile device.

In impact evaluation, the common approach for statistical power calculation was to measure the minimum detectable effect for a given sample size. This was different from power calculation method for descriptive studies that looked at the level of precision of the statistics from quantitative data. A scenario of power calculation was presented based on impact assessment approach followed by its implication on level of precision for descriptive statistics at baseline.

The method for power calculation in cluster RCT is follows:

$$MDES = \frac{M_{J-2}}{\sqrt{J}}\sqrt{p + \frac{1-p}{n}}\sqrt{\frac{1}{P(1-P)}}$$

Where MDES stood for minimum detectable effects, M was the sum of z-value a given values of power (0.8) and confidence interval (95percent). J was the number of clusters that were to be divided into a treatment and comparison group, P was the ratio of clusters distributed between treatment and control, n was the number of observation per cluster, and ρ was the intra-cluster correlation. Assuming 10 clusters (i.e. factories) in each of the three arms with 50 observations (i.e. workers) per cluster, the MDE (at 80percent power, 95percent confidence interval and assuming ρ=0.05 for ICC) was 0.33 standard deviation for scale outcomes. However, since many of the outcome variables were categorical that needed to be analyzed as proportions, the MDEs for different scenarios are shown here :

Indicator	Control mean (assumed)[2]	MDE
Family planning acceptor	77 percent	0.12
Unmet family planning need	6 percent	0.10
At least 4 ANC visits	36 percent	0.16

*All power calculations assume 10 factories in each of the three arms (except Arm C), 50 respondents per cluster and ICC of 0.05.[2]

As the figures in the above table indicates, for the evaluation with 10 factories in each arm with 50 observations per factory, the sample was to capture effects on family planning uptake at 80percent power if the effect size was 12 percentage or higher.

For descriptive statistics with a precision level of 0.05 (assuming p=0.5 and at 95 percent confidence level) required a sample size of 384 observations for each population group of interest. Adopting a 1.5 design effect, the sample size came to 576. However, it was also realized that there was further sub-group among the factories in Arm A, which are -

1. IB Model 1 (Power plus) – where 2 garments out of 10 partner garments;
2. IB Model 2 (Health Insurance Plus) – where 5 garments out of 10 partner garments; and
3. IB Model 3 (Menstrual Hygiene Management) – where 3 garments out of 10 partner garments.

To produce sub-group analysis, this sample size needed to be increased by three-fold. Given that the combined sample of Arm A had much higher precision level than required, increasing the number of observation per factory in Arm A from 50 to 150 was proposed (i.e. adopting 1.17 to 1.56 design effect) for each of the sub-group analysis in Arm A. This increase in sample size improved the MDE further as discussed earlier while meeting the requirement specified in TOR for descriptive analysis. Finally, a 20 percent increase in this sample size for Group B and C was proposed to account for 20 percent respondents who were not married and hence, many of the reproductive health questions were not applicable.

So, the total targeted sample size was: Arm A + Arm B + Arm C = 1500 + 600 + 600 = 2700.

And the total sample coverage was: Arm A + Arm B + Arm C = 1434 + 596 + 600 = 2630.

[1] The control mean comes from SNV baseline data of Working with Women, 2015 (Phase 1) Project
[1] Example of STATA code used for the calculations is "power two proportions .77, k1(10) k2(10) m1(50) m2(50) rho(0.05) power(0.8)"

The sample distribution was as follows:

Table 1: Sample size distribution as per the Arm

Category	Targeted Sample	Sample Coverage	Sample overage Percent
Arm A			
IB Model 1: Power plus (2 partner factories and 225 workers per factory)	450	450	100 percent
IB Model 2: Health Insurance Plus (5 partner factories and 120 workers per factory)	600	600	100 percent
IB Model 3: Menstrual Hygiene Management (3 partner factories and 150 workers per factory)	450	384	85 percent
Sub Total	**1500**	**1434**	**96 percent**
Arm B Training only (8 non-partner factories and 75 workers per factory)	600	596	99 percent
Arm C Control (5 no-intervention factories and 120 workers per factory)	600	600	100 percent
Total	**2700**	**2630**	**97 percent**

1.4.1.2. Sample Selection Procedure

The survey was conducted among the female garments workers in five different geographical locations. The detail procedure of sample selection are as follows:

1. The study covered all garments factories covered by the intervention under each IB model (10 partner garments) and 13 non-partner factories;
2. The study covered 384-600 workers for each Inclusive Business (IB) models; means total 1434 workers from Arm A;
3. Identified 13 non-partner factories and collect data from a random sample of 75-120 female workers from each factory (596 respondents from Arm B and 600 respondents from Arm C);
4. Paired the factories from the non-partners to create 5 pairs, and randomly assigned one to Arm B and the other into Arm C;
5. The factories in Arm C would receive theinterventions after the evaluation ends;
6. In case of non-availability of the workers' list, dRi prepared a list of workers with the help of SNV, factory management and the partner organizations based on availability or the workers were randomly selected for the interview by adopting a systematic sampling procedures;
7. In case of non-response, the next sample was covered with replacement; and
8. Each interview was conducted either factory premises or at workers' community.

1.4.2. Qualitative Method

In order to collect qualitative data from the target population, multiple research techniques were utilized. Thus, it was possible to collect in-depth information against the study objectives and indicators. Therefore, following techniques were used to collect qualitative data:

1. Focus Group Discussions (FGDs): FGDs were conducted to gather a wide variety of information across the large number of target respondents in the study areas. The groups were composed with 6-8 participants. Group discussions were conducted with the respondents from all the study areas. Focused questions were asked to the participants in order to encourage discussion and expression of differing opinions and points of view

regarding workers' financial capacity and willingness in health seeking behavior, workers' satisfaction with the availability of SRHR services in and around targeted factories and knowledge, consciousness and awareness about SRHR. Further, the group discussion dug down from where male RMG workers acquired SRHR products and services as per their need, knowledge about Health Insurance and capacity in health seeking behavior. Male workers' roles and responsibilities towards female workers as a colleague/peer/husband, existing violence against women and social barriers and influences against SRHR were also assessed through FGDs with respective (male workers) groups. Participants for the FGDs were selected on the basis of their availability and willingness to participate in the discussions.

2. **In-Depth Interview (IDI):** In-Depth Interviews (IDIs) and/or Key Informant Interviews (KIIs) were conducted with the following persons to assess the knowledge and awareness about the effectiveness of incorporating SRHR laws/policies/guidelines/approaches in their operations, types of SRHR services and products available for factories.

   I. Health professional of factories /personnel of welfare departments; and

   II. Managers/senior management of RMG factories.

2.4.2.1. Qualitative Sample Distribution

For qualitative part, respondents were selected following purposive sampling technique. The study participants and sample size that was used for the study is stated below:

Table 2: Qualitative Sample Distribution

Research Technique	Respondent Category	Sample
FGD	Male RMG workers (5 in partners, 4 non-partners and 3 control factories)	12
	Total	**12**
KII	Factory management/personnel of welfare departments	23
	Medical personnel/health professional of Factories / Welfare Officer	10
	Total	**33**

2.5. Document Review

As secondary source of information, review of relevant documents was conducted. This thorough literature and documents review assisted to supplement and enrich the review process and findings and provided background information to support the primary findings. Therefore, relevant literature was reviewed based on the given criteria to gain better understanding about the project activities and objectives. Documents that were included in desk review included:

1. M&E plan/result framework;
2. Study/research reports;
3. Previous phase reports;
4. ToR by the SNV's partners;
5. Project Proposal; and
6. Relevant website/web-page of SNV.

2.6. Limitations of the Study

The researchers made their best efforts to maintain high quality of the data collected. However, the limited time frame for conducting the study put pressure on the research team to conduct field research, analyze data and write the report. The research team tried its best to complete the task in a timely manner. However, some additional time would have made the process easier.

There is an important limitation in quantitative analysis, which involves adjusting the quantitative data to match the study criteria. The sample had to be adjusted according to the SNV's management of the factories in all the three stages: pre-study, during, and post-study stages. This had caused a change in the sample frame.

QUANTITATIVE FINDINGS

3. Quantitative Findings

This section elucidates the quantitative survey findings of the study including the background data of the respondents, their knowledge and understanding of SRHR and health care services, use of contraception and MR services, utilization of maternity care services, menstrual hygiene management, their understanding on STIs and HIV/AIDs, and finally, about their understanding on gender equality, violence against women, health insurance scheme etc.

3.1. Background Characteristics of Female RMG Workers

Box 1: Summary of the Background Characteristics Section

- 49 percent of the female RMG workers were below 24 years of age. The percentage of workers aged below 24 years were more among the Arm A (around 50 percent) respondents than the other two Arms (47 percent in both cases).
- 79 percent of the respondents were married. Percentage of married respondents were the highest (nearly 82 percent) among the Arm B respondents.
- Most of the respondents have very low educational status. 81 percent of the female RMG workers have incomplete secondary education or lower than that.
- Larger number of husbands of the respondents was aged between 25-29 years, has incomplete secondary education, and also lived with their wives.
- 34 percent of the survey respondents have been working in their current workplace for at least two years and the average involvement in the RMG sector of the total respondents is 5 years. If the factories of different Arms are arranged in a descending order based on the average duration of involvement by the workers, Arm A comes first with around 52 months average duration of work by the workers.
- Majority of the respondents earned between BDT 5001-7000 per month and used BDT 245 per capita on average for health expenses. The average monthly wages are slightly higher (6892 BDT) in Arm A than it is in the other two Arms. The respondents from Arm A also displayed higher contributions to health expenses than the average level (BDT 254> BDT 245).
- Nearly all of the respondents (97 percent) have access to mobile phones.

This section provides information regarding the socio-economic context of female RMG workers who were interviewed using the survey questionnaire for collecting quantitative data. The study looks into the demographic characteristics of the participants along with their level of education, background characteristics of their husbands, working experience, earning, and health expenses. In addition, the respondents were asked about their exposure to mobile phone.

3.1.1. Demographic Characteristics

The female RMG workers are overwhelmingly young. Approximately half of the total survey respondents (49 percent) reported their age below 24 years old. This observation closely follows the age distribution of the country as a whole (Bangladesh National Institute of Population Research and Training, 2016). Overall, Majority of the study respondents are already married (about 79 percent) and percentage of married respondents were the highest (nearly 82 percent) among the Arm B respondents. Nearly 10 percent female respondents are divorced, separated, deserted or widowed. Another 10 percent respondents reported to be single. The situation is similar across three groups: IB models, training only, and control.

Table 3: Demographic Characteristics of the Respondents.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Total Number of Respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Age							
18-19	11.8	9.5	9.9	10.3	12.6	16.8	12.3
20-24	35.8	39.7	45.1	39.9	34.9	30.7	36.7
25-29	25.1	30.7	25.8	27.6	25.0	25.8	26.6
30-34	14.0	12.0	12.5	12.8	13.9	12.5	13.0
35-39	9.8	5.5	6.3	7.0	8.6	8.0	7.6
40-44	2.9	1.8	0.3	1.7	2.7	3.8	2.4
45+	0.7	0.8	0.3	0.6	2.3	2.3	1.4
Marital status							
Currently married	78.2	79.5	78.9	78.9	81.9	75.3	78.8
Divorced/separated/widow /deserted	8.9	8.3	7.0	8.2	8.2	10.5	8.7
Never married	12.9	12.2	14.1	12.9	9.9	14.2	12.5

3.1.2. Education

In general, the survey respondents reflected low educational qualification. While 91 percent of the respondents received some form of education, majority of the respondents reported about their incomplete educational levels to some degree. Approximately 42 percent of the respondents did not complete primary level education. The highest response against level of education in the study arms was also incomplete education at secondary level (ref: Table 4). The situation of having no education is higher in Arm B (around 11 percent) and Arm C (around 15 percent) than the Arm A in total (around 5 percent). The lower educational qualification needs to be considered while designing programs.

Table 4: Education level of the respondents by age and study arms.

	No education (0 years)	Primary (1-5 years)	Secondary Incomplete (6-9 years)	Secondary or Higher (10+ years)	Number of respondents (n)
Total Number of Respondents (n)	**450**	**450**	**384**	**1434**	**596**
Age of the Respondents					
18-19	3.1	23.5	56.2	17.3	324
20-24	3.5	22.2	47.1	27.2	964
25-29	7.9	36.7	42.7	12.7	700
30-34	13.2	36.4	36.1	14.4	341
35-39	23.0	44.0	23.0	10.0	200
40-44	40.6	43.8	12.5	3.1	64
45+	48.7	48.7	2.7	0.0	37
Study Arms					
Arm A: Power Plus	6.2	29.1	40.7	24.0	450
Arm A: Health Insurance Plus	5.5	29.5	46.7	18.3	600
Arm A: Menstrual Hygiene Management	3.6	24.0	47.1	25.3	384
Arm A Total: All IB models	5.2	27.9	44.9	22.0	1484
Arm B: Training Only	11.2	33.9	37.9	16.9	596
Arm C: Control	15.3	33.8	40.5	10.3	600
Total	8.9	30.6	42.3	18.2	2630

3.1.3. Background Characteristics of their Husbands

One-third of the husbands of the respondents belonged to 25-29 years of age group (about 32 percent). Majority of the husbands were young with more than half of the respondents (nearly 58 percent) to an age range between 25 and 34 years of age. About 2 percent of the respondents were unable to report the age of their husbands. Similar to the survey respondents, their husbands also reflected having low level educational qualification.

Around 41 percent of the husbands had either no education or only finished primary level of education. Another 32 percent husbands never finished secondary education. The evidence was similar in Arm A (34 percent) while husbands in Arm B (about 30 percent) and Arm C (about 29 percent) had fallen a little short. Most of the husbands stayed with their wives (about 94 percent).

Table 5: Background characteristics of the husbands of the respondents

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Age							
18-19	0.0	0.2	0.0	0.1	0.2	0.0	0.1
20-24	9.1	6.5	5.0	6.9	9.0	9.3	7.9
25-29	31.3	33.5	37.6	33.9	30.3	27.9	31.8
30-34	21.9	28.9	29.7	26.9	24.4	24.6	25.8
35-39	19.9	18.4	19.1	19.1	15.4	19.2	18.2
40-44	9.9	6.7	6.3	7.6	9.8	7.5	8.1
45+	4.8	4.8	2.0	4.1	8.2	9.3	6.2
Don't know/missing	3.1	0.8	0.3	1.4	2.7	2.2	1.9
Education							
No education (0 years)	6.8	9.4	11.6	9.2	18.2	23.2	14.4
Primary (1-5 years)	24.1	26.6	20.1	24.1	26.6	31.9	26.4
Secondary incomplete (6-9 years)	32.1	35.6	34.0	34.1	29.7	28.8	31.9
Secondary or higher (10+ years)	36.9	28.3	34.3	32.6	25.4	16.2	27.3
Education							
Lives with wife	95.2	92.5	92.1	93.2	95.9	92.3	93.6
Staying outside and within county	3.1	6.5	6.6	5.5	3.1	6.9	5.2
Staying outside and abroad	1.7	1.0	1.3	1.3	1.0	0.9	1.2
Number of Currently Married Women	**352**	**477**	**303**	**1132**	**488**	**452**	**2072**

3.1.4. Working Experience, Earnings, and Health Expenditure

The survey respondents have been engaged in the RMG sector for a significant period. One third of the respondents (34 percent) have been working in their current work location for at least two years (ref. Table 6). The average duration of work in the current factories for all the respondents was nearly 31 months and it was the highest (31.1 percent to be exact) among the Arm A factories. On the other hand, when their duration of work in the RMG profession was considered, the average duration of their involvement in this sector was more than 4 years (50 months). If the factories of different Arms are arranged in a descending order according to the average duration of involvement by the workers, Arm A comes first with around 52 months average duration of work by the workers. This evidence indicates that the respondents were quite experienced in the RMG sector and they have a tendency to stay in the same factory for longer period.

Table 6: Work Experience of Female RMG Workers

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Total Number of Respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Duration of work in the current factory							
Less than 1 year	22.7	29.7	45.6	31.7	30.9	38.2	33.0
1 to 2 years	39.6	30.7	41.7	36.4	32.6	29.8	34.0
3 to 4 years	11.1	19.7	8.3	13.9	18.8	14.5	15.2
5 to 6 years	12.7	10.0	3.4	9.1	11.4	10.2	9.8
7 years or more	14.0	10.0	1.0	8.9	6.4	7.3	7.9
Average duration of work in the current factory (in months)	38.8	33.9	17.7	31.1	30.8	28.6	30.5
Duration of work in this profession							
Less than 1 year	11.8	15.3	18.0	14.9	15.8	18.0	15.8
1 to 2 years	23.1	24.8	35.4	27.1	27.0	25.3	26.7
3 to 4 years	19.6	22.2	20.3	20.9	21.5	23.2	21.5
5 to 6 years	20.0	15.8	14.3	16.7	18.6	16.0	17.0
7 years or more	25.6	21.8	12.0	20.4	17.1	17.5	19.0
Average duration of work in the profession (in months)	59.7	52.5	42.8	52.1	49.7	47.1	50.4

The average monthly wage for the female RMG workers was BDT 6737 (ref. Table 7). Highest percent of workers earned monthly wages ranging from BDT 5001 - 7000 (nearly 59 percent). The average monthly wages were slightly higher (6892 BDT) in Arm A than it was in the other two Arms. The average per capita health expense for workers was BDT 245 and the average per capita health expenses for families was BDT 718. In both the indicators, the respondents from Arm A displayed higher contributions to health expenses than the average level (BDT 254> BDT 245 and BDT 753> BDT 718). The respondents from Arm B and Arm C factories came second and third respectively. This finding implies the effectiveness of the models and the trainings among the targeted beneficiaries. The average household size was 3 persons across the three arms.

Table 7: Earnings and health expenses of the workers.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Minimum monthly wage (excluding overtime) (BDT)							
<=5000	0.7	1.0	2.9	1.4	1.8	5.3	2.4
5001-7000	54.2	58.2	57.8	56.8	62.8	58.5	58.6
7001-9000	44.7	38.5	36.2	39.8	33.2	36.0	37.5
>9000	0.4	2.3	3.1	2.0	2.2	0.2	1.6
Average monthly wage (BDT)	6963	6870	6769	6872	6707	6442	6737
Own monthly health expenditure (BDT)							
Less than 100	15.8	26.8	22.1	22.1	27.3	19.5	22.7
100-199	22.4	23.5	38.0	27.1	28.2	37.2	29.6
200-299	19.1	16.2	20.1	18.1	17.4	17.3	17.8
300 or more	42.7	33.5	19.8	32.7	27.0	26.0	29.9
Own monthly health expenditure (BDT)	**294**	**261**	**197**	**254**	**240**	**227**	**245**
Less than 200	10.9	15.0	14.1	13.5	16.4	11.7	13.7
200-399	18.7	20.8	29.2	22.4	23.8	25.0	23.3
400-599	19.3	22.0	23.2	21.5	19.3	25.2	21.8
600-799	6.4	7.3	7.6	7.1	8.4	9.0	7.8
800-999	5.3	6.3	3.6	5.3	4.4	5.0	5.0
1000-1199	13.8	9.3	9.1	10.7	9.1	10.5	10.3
1200 or more	25.6	19.2	13.3	19.6	18.6	13.7	18.0
Average monthly health expenditure-family (BDT)	**859**	**743**	**644**	**753**	**703**	**648**	**718**
Average HH size (n)	**3.1**	**3.0**	**2.9**	**3.0**	**3.0**	**2.9**	**3.0**

3.1.5. Exposure to Mobile Phone

The survey respondents were highly exposed to mobile phone. Nearly 97 percent of the respondents have access to mobile phones (through either their own or someone else's) (ref. Table 8). Nearly 73 percent of the respondents owned mobile phones. 723 respondents expressed that they did not own any personal mobile phone. Out of the 723 respondents were without any mobile phones for themselves, around 88 percent have access to someone else's mobile phone. Again, the respondents of Arm A factories displayed higher scores. But in this case, the respondents from Arm B or Arm C were not far behind and their scores were very close to those of the Arm A.

Table 8: The female RMG workers' exposure to mobile phones.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Total Number of Respondents	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Exposure to Mobile Phone							
Owns mobile phone	81.6	73.3	77.9	77.1	66.1	67.8	72.5
Respondents with no phone (n)	83	160	85	328	202	193	723
Has access to someone else's mobile phone (among the group who do not own mobile phone)	89.2	85.6	90.6	87.8	90.1	87.6	88.4
Has access to own or someone else's mobile phone	98.0	96.2	97.9	97.2	96.6	96.0	96.8

3.2. Knowledge on basic components of SRHR

The survey respondents were highly exposed to mobile phone. Nearly 97 percent of the respondents have access to mobile phones (through either their own or someone else's) (ref. Table 8). Nearly 73 percent of the respondents owned mobile phones. 723 respondents expressed that they did not own any personal mobile phone. Out of the 723 respondents were without any mobile phones for themselves, around 88 percent have access to someone else's mobile phone. Again, the respondents of Arm A factories displayed higher scores. But in this case, the respondents from Arm B or Arm C were not far behind and their scores were very close to those of the Arm A.

Box 2: Summary of the Knowledge on basic components of SRHR section

- Pills (95 percent), Injectables (83 percent), condoms (69 percent), and implant/Norplant (43 percent) were the most known FP methods among the female RMG workers. The situation was the same for the respondents of all Arms with a little deviations. FP methods for men were not popular at all (below 5 percent in all cases).

- The awareness of the respondents regarding methods to avoid pregnancy after unsafe sex was very low (only 11 percent). Arm B and Arm C also have the larger share of respondents, more than 50 percent in both cases, who were unaware of the contraceptive methods to avoid unintended pregnancy after unprotected sex. 45 percent of the respondents knew the methods to avoid unwanted pregnancy only by the common name of the ECP and 30 percent respondents did not have the knowledge about the time to use the methods.
- More than half of the respondents (55 percent) have no knowledge about MR or when to use the method. The scores by the Respondents from Arm A, B, and C followed the general trend of ignorance whereas Arm A factories under MHM IB model presented the worst scenario with only about 24 percent respondents being aware of MR.
- Most of the respondents (around 96 percent) were aware of the fact that health depends on cleanliness during menstruation. In case of respondents from Arm A, more than 90 percent response was recorded on using sanitary napkin or pad. The response in favor of sanitary napkin use was also significant (88 percent for Arm B and 82 percent or Arm C).
- Majority (about 82 percent of ARM-A) of the female workers were aware of antenatal care (ANC). A significant portion of them (23 percent) were not aware of pregnancy related complications and safe motherhood.
- The majority (75 percent) of ARM-A female workers interviewed were aware of safe delivery/birth preparedness.
- The half of ARM-A female workers interviewed were not aware of time of PNC.
- More than half of the total respondents identified the government hospitals as the main service provider for sexual and reproductive health (57 percent). Although the scores by the respondents from different Arms differed from one another, the pattern of recognitions towards each sources have been similar. Around 45 percent of the respondents considered their friends and neighbors as the main source to seek information on SRHR.

This section focuses on the knowledge of basic components of SRHR among RMG female workers working in the factories affiliated with the project. This study considers FP, ECP, safe MR, menstrual hygiene management, and maternal delivery care as the basic SRHR components. Moreover, STDs, HIV/AIDS, and VAW are also addressed but have been described in separate sections.

3.2.1. Knowledge of FP Methods, ECP, and MR

The knowledge of family planning methods has been reported very high among the female RMG workers (nearly 91 percent) (ref. Table 9). Pills (about 95 percent), injectable (nearly 83 percent), and condoms (about 69 percent) are the most popular FP methods among the workers. Implant or Norplant was another notable FP method with 43 percent popularity. An interesting observation here is that FP methods for the male (male vasectomy or withdrawal) are not very popular ones (only four and one percent respectively). Contraceptive prevalence has been historically dominated by women in Bangladesh (Rahman, Islam and Ahmed, 2008). There are several possible reasons for such low knowledge. First, a study by CPD and UNFPA (2003) reported that male partners' reluctance towards family planning was more than double compared to their female counterparts. Second, the same study showed that higher percent of male respondents mentioned about religious beliefs and fear of infertility from using contraceptives. Thirdly, male members dominate over the female members in making decision over family planning. Therefore, men enjoy an upper hand to transfer the responsibility of using contraceptives to the women.

Table 9: Knowledge of FP Methods

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Total Number of Respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Knows about Method to delay/avoid getting pregnant	**83.8**	**89.5**	**91.1**	**88.1**	**95.3**	**91.2**	**90.5**
Total Number of Respondents (n)	**377**	**537**	**350**	**1264**	**568**	**547**	**2379**
Method to delay/avoid getting pregnant							
Female Tubectomy	18.6	14.7	8.6	14.2	19.4	16.8	16.0
Male Vasectomy	5.3	4.7	3.7	4.6	4.8	2.6	4.2
IUD	11.1	16.0	8.3	12.4	11.4	8.6	11.3
Injection	80.9	81.2	80.3	80.9	86.8	83.0	82.8
Implant/ Norplant	40.1	40.6	48.0	42.5	42.4	44.8	43.0
Pill	96.0	93.7	94.0	94.5	96.5	94.2	94.9
Condom	74.8	69.1	66.0	69.9	71.0	64.2	68.9
Safe period/ periodic abstinence	5.0	7.6	3.1	5.6	7.2	6.8	6.3
Withdrawal	1.3	1.3	2.3	1.6	0.7	0.4	1.1
Other	0.0	0.2	0.0	0.1	0.2	0.0	0.1

The awareness among the respondents regarding methods to avoid pregnancy after unsafe sex was very low (only around 11 percent) (ref. Table 10). The larger share of them (nearly 45 percent) could not remember any such contraceptive methods. Many of them know of the contraceptive methods as ECPs (around 33 percent). Norix is the ECP that was the most popular among the female RMG workers (nearly 17 percent). The ECP, Norix was more known among the respondents from Arm B and Arm C than the Arm A in total. However, it is worth mentioning that, Arm B and Arm C also have the larger share of respondents, more than 50 percent in both cases, who were unaware of the contraceptive methods to avoid unintended pregnancy after unprotected sex. The respondents, in general, also lacked knowledge about the time when the methods can be used (nearly 30 percent).

Table 10: Knowledge on ECP methods

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Aware of any method to avoid unintended pregnancy after unsafe sex	**14.9**	**14.2**	**6.3**	**12.3**	**12.2**	**8.3**	**11.4**
Total number of worker aware of ECP (n)	**67**	**85**	**24**	**176**	**73**	**50**	**299**
Aware of contraceptive methods to avoid unintended pregnancy after unsafe sex							
ECP	32.8	54.1	16.7	40.9	27.4	14.0	33.1
Norix	6.0	18.8	12.5	13.1	17.8	28.0	16.7
Emcon	4.5	8.2	12.5	7.4	4.1	6.0	6.4
Norpill	14.9	1.2	8.3	7.4	1.4	4.0	5.4
Ipill	7.5	0.0	0.0	2.8	0.0	0.0	1.7
Postinor-2	0.0	0.0	4.2	0.6	0.0	2.0	0.7
Other (Doctor's/traditional healer's advice/MR)	3.0	2.4	0.0	2.3	1.4	0.0	1.7
Can't remember	50.8	23.5	58.3	38.6	53.4	52.0	44.5
Time when these methods can be used							
Within 1 day	16.4	29.4	4.2	21.0	20.5	28.0	22.1
Within 2 days	32.8	14.1	20.8	22.2	19.2	24.0	21.7
Within 3 days	16.4	20.0	41.7	21.6	28.8	36.0	25.8
Don't know	34.3	34.1	33.3	34.1	31.5	10.0	29.4
Other (5,7 days)	0.0	2.4	0.0	1.1	0.0	2.0	1.0

The respondents have limited knowledge about MR. About 55 percent of them have never heard of MR (ref. Table 11). Nearly 61 percent of the 1166 respondents did not know about MR. Nearly 23 percent of the respondents reported the time for MR as six to ten weeks. The scores by the respondents from Arm A, B, and C followed the general trend whereas Arm A factories under MHM IB model presented the worst scenario with only about 24percent respondents being aware of MR.

Table 11: Knowledge of MR

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Heard about MR	**52.0**	**45.3**	**43.5**	**46.9**	**41.6**	**40.8**	**44.3**
Number of Respondents heard about MR (n)	**234**	**272**	**167**	**673**	**248**	**245**	**1166**
Time for MR							
Less than 6 weeks	11.5	11.4	4.2	9.7	2.4	5.7	7.3
6-10 weeks	20.9	21.0	15.6	19.6	27.8	25.3	22.6
More than 10 weeks	8.5	4.4	4.8	5.9	12.9	16.3	9.6
Don't know	59.0	63.2	75.4	64.8	56.9	52.7	60.5

3.2.2. Knowledge of Menstrual Hygiene Management

Most of the respondents (around 96 percent) were aware of the fact that health depends on cleanliness during menstruation. About 89 percent of the respondents agreed that sanitary pad or napkin should be used during menstruation to remain healthy. Clean cloth was selected by 62 percent as a safe means of cleanliness while having menstruation. Surprisingly, around 11 percent gave their consent on using dirty clothes during menstruation. In case of respondents from Arm A, more than 90 percent response on using sanitary napkin or pad was recorded the highest. Again, another astonishing finding came out when nearly 14 percent response was given in favor of using dirty cloth during menstruation by the respondents under MHM model. The response in favor of sanitary napkin use was also significant (88 percent for Arm B and 82 percent or Arm C).

Table 12: Knowledge of MHM

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Aware that health depends on cleanliness during menstruation	**93.3**	**97.3**	**97.4**	**96.1**	**96.5**	**96.0**	**96.2**
Number of Respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Materials that can be used during menstrual period							
Sanitary Napkin/Pad	92.0	94.7	90.4	92.7	88.1	81.7	89.1
Cotton	7.3	4.0	0.8	4.2	5.2	4.7	4.5
Clean cloth	54.9	57.2	69.3	59.7	60.4	69.0	62.0
Dirty clothes	5.6	13.0	13.8	10.9	8.1	15.8	11.4
Toilet Tissue	16.7	13.3	13.8	14.5	19.6	15.3	15.9
Don't Know	1.8	0.2	0.5	0.8	1.0	0.8	0.8
Other (undergarments, nothing)	0.2	1.0	0.3	0.6	0.0	0.3	0.4

3.2.3. Knowledge on Maternal Health care

About 78 percent of the female RMG workers were aware of the danger signs of pregnancy, delivery, and post-partum period (ref. Table 13). Overall, the respondents recognized that severe headache was the most dangerous sign during the period (nearly 49 percent). Convulsions (around 44 percent), blurred vision (around 35 percent), high fever (24 percent), and excessive vaginal bleeding (about 20 percent) were the other dangerous symptoms recognized by the respondents. The agreements by the respondents from different Arms followed the same pattern as the overall and the drawbacks from the overall data could be extended and also rendered applicable for all the Arms. The awareness of regular checkups during pregnancy was quite high as about 82 percent of ARM-A female workers were aware of antenatal care (ANC). Out of the 2406 respondents, nearly 45 percent female RMG workers expressed that four or more checkups are needed during pregnancy. In contrast, 21 percent respondents did not have the required number of checkups during pregnancy. The awareness of the number of TT dose during pregnancy was also below 50 percent as 45 percent respondents identified the required number of TT doses being four. In this case, nearly 19 percent was not aware of the necessary number of TT doses.

Table 13: Knowledge on Pregnancy care.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Total Number of Respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Aware of danger signs of pregnancy, delivery, and post-partum period							
Severe Headache	43.1	64.2	36.2	50.1	52.0	42.7	48.8
Blurred Vision	28.2	48.3	20.8	34.7	40.6	31.0	35.2
High fever	22.9	28.2	16.9	23.5	26.9	22.5	24.0
Delayed/Prolonged labor	19.3	22.3	20.1	20.8	19.5	24.7	21.4
Convulsions/fits	38.0	49.7	31.5	41.1	51.9	44.7	44.4
Excessive vaginal bleeding	15.8	26.2	15.6	20.1	22.2	15.8	19.6
Other (Vomiting, inability to eat, edema, high pressure, weakness, vertigo)	12.0	10.8	5.5	9.8	4.7	5.7	7.7
Don't know	**23.6**	**14.7**	**35.9**	**23.2**	**17.8**	**22.3**	**21.8**
Number of respondents	**416**	**561**	**331**	**1308**	**567**	**531**	**2406**
Knowledge on number of ANC (check-up) needed during pregnancy							
1	0.5	0.9	0.6	0.7	1.2	0.0	0.7
2	7.0	6.2	6.3	6.5	7.2	5.5	6.4
3	32.2	33.0	26.0	31.0	23.5	22.0	27.2
4 or more	**44.0**	**45.5**	**40.2**	**43.7**	**48.3**	**43.1**	**44.6**
Don't know	**16.3**	**14.4**	**26.9**	**18.2**	**19.8**	**29.4**	**21.0**
Number of respondents	**450**	**600**	**384**	**1434**	**596**	**600s**	**2630**

Table 7: Earnings and health expenses of the workers.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Aware of number of TT doses during pregnancy							
None	0.2	0.0	0.3	0.1	0.0	0.5	0.2
1	0.4	1.0	0.3	0.6	0.5	1.2	0.7
2	20.2	9.8	9.6	13.0	16.1	14.3	14.0
3	18.9	21.8	19.5	20.3	25.0	20.3	21.4
4	42.2	52.7	43.5	46.9	43.1	42.3	45.0
Don't know	**18.0**	**14.7**	**26.8**	**19.0**	**15.3**	**21.3**	**18.7**

When the respondents were asked about their knowledge on birth preparedness, more than half of the total respondents gave priority towards saving money (nearly 58 percent) (ref. Table 14). The next two priorities by the respondents were the selection of the required transport (about 37 percent) and the selection of appropriate place for delivery (about 35 percent). A vast majority (75 percent) of ARM-A female workers interviewed were aware of safe delivery/birth preparedness. Selection of a person to assist in delivery (nearly 30 percent) and selection of blood donor (around 21 percent) were the other two issues prioritized by the respondents. For the respondents of different Arms, the top priority issues were same but the priorities differed significantly.

Table 14: Knowledge on Birth Preparedness.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Knowledge on birth preparedness							
Select the appropriate placefor delivery	32.2	45.7	22.4	35.2	40.3	28.2	34.8
Select provider/person to assist in delivery	29.1	37.3	19.8	30.1	32.6	25.5	29.6
Select the required transport	37.8	45.0	24.2	37.2	42.3	30.7	36.8
Select blood donor	20.7	26.0	14.1	21.1	23.7	18.8	21.2
Save money	52.4	65.0	47.1	56.3	66.6	51.7	57.6
Select a person to accompany to facility	7.3	10.7	6.5	8.5	9.6	9.7	9.0
Select person to take care the newborn	4.0	7.5	3.1	5.2	3.9	3.8	4.6
Collect delivery kits/ n-kits/ bag	10.9	20.2	9.9	14.5	13.4	11.7	13.6
Collect medicine to prevent excess bleeding	0.7	1.8	1.3	1.3	0.8	0.5	1.0
Other (collect blade/ thread/needle, rest, eat plenty, be careful, keep phone of FWA, doctor, communicate with doctor etc.)	0.7	0.8	1.0	0.8	0.2	0.8	0.7
Don't know	**25.6**	**14.3**	**41.2**	**25.0**	**15.3**	**27.3**	**23.4**

About 47 percent respondents did not possess knowledge on the time of post-natal care (ref. Table 15). A significant portion, around 41 percent, stated that the post-natal care should start immediately after birth. The state of lack of awareness was higher among the respondents from Arm B and Arm C. The half of ARM-A female workers interviewed were not aware of time of PNC.

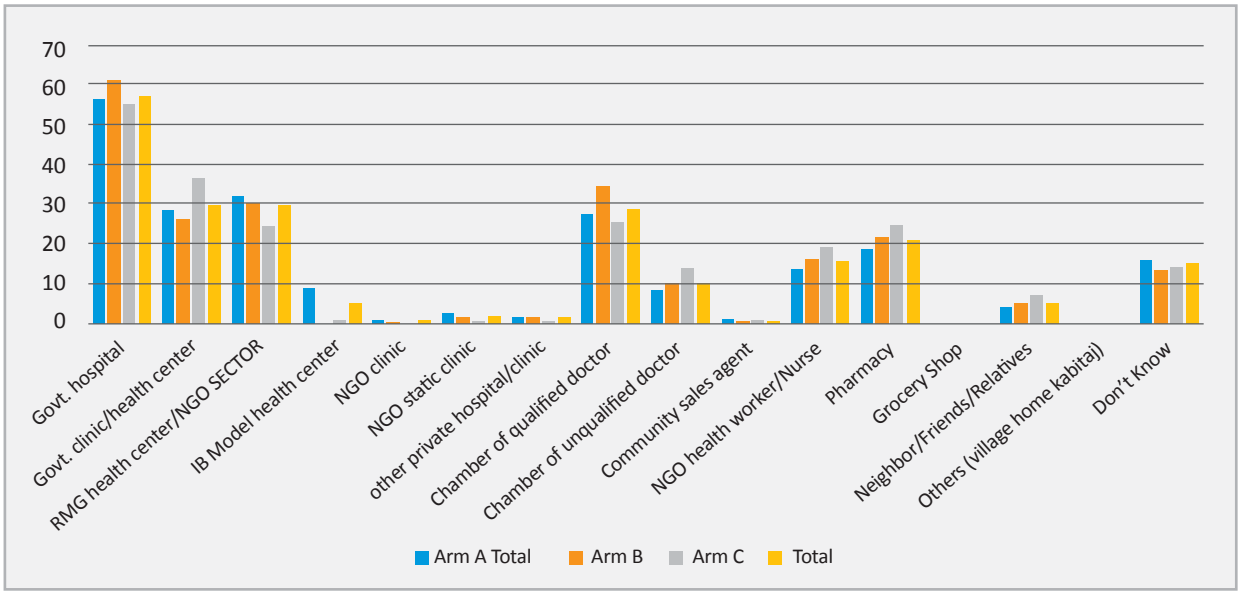
Table 15: Knowledge on PNC

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Knowledge on time of PNC							
Immediately after birth	41.3	44.5	42.4	43.0	44.1	33.7	41.1
Within 2-6 days after birth	1.3	0.8	0.3	0.8	1.3	1.2	1.0
Within 7-42 days after birth	9.8	4.5	3.4	5.9	2.5	4.2	4.7
More than 42 days after birth	0.2	0.2	0.8	0.3	0.5	0.3	0.4
Don't know	**47.3**	**50.0**	**53.1**	**50.0**	**51.5**	**60.7**	**52.8**

3.2.4. Knowledge on SRHR Service Providers

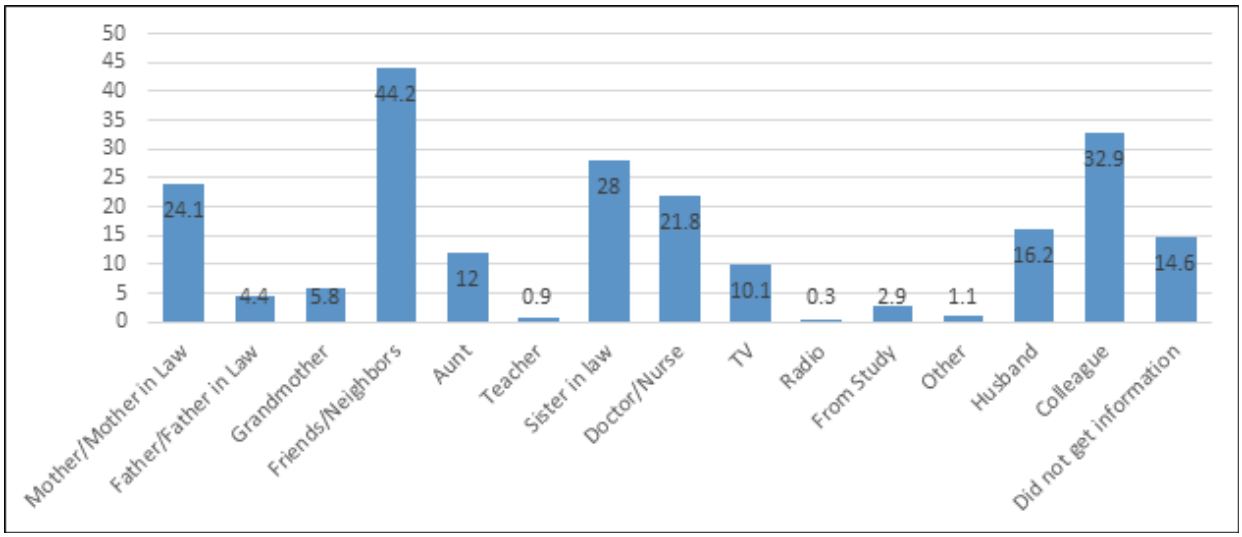
More than half of the total respondents identified the government hospitals as the main service provider for sexual and reproductive health (57 percent) (ref. Figure 2). The second-most recognized SRH service provider were jointly the government clinics (nearly 30percent) and the RMG health centers (30 percent). Qualified doctors' chambers were also recognized as an important source for SRH services (nearly 29 percent). The least recognized SRH service provider was the Kabiraj or village quack doctors (only 0.2 percent). Although the scores by the respondents from different Arms differed from one another, the pattern of recognitions towards each sources have been similar.

Figure 2: Sources of knowledge on service provider for sexual and reproductive health



Family and friends work as important sources for respondents to know about SRHR services. Around 45 percent of the respondents considered their friends and neighbors as the main source to seek information on SRHR (ref. Figure 3). Respondents also received information from sister in law (27 percent) and mother/mother in law (24 percent). Other than friends, family and neighbors, the next group which delivered SRHR related information to the respondents were their colleagues (about 33 percent). Nearly 15 percent of the respondents declared themselves as the deprived ones from any SRHR information. The respondents basically identified persons with whom they were comfortable and open to discuss sensitive issues or the persons they believe trustworthy.

Figure 3: Source of information on sexual and reproductive health services



3.3. Unmet need, use of Contraception and MR services

Box 3: Summary of the unmet need, use of contraception and MR services section

- Three-fourth (only 12 out of 16) of the respondents opted to wait some time for a child. All of the respondents (only three) from MHM model factories and also the factories in Arm C chose to wait more for a child. The majority of the respondents (three out of four) from Power Plus model factories picked the option of not wanting any child while in the other cases, more than half of the respondents settled for waiting for more time.
- Pills, injectables, and condoms were the most popular methods of FP among the respondents from all Arms. The respondents did not consider RMG health centers (nearly three percent) or IB model health centers (below one percent percent) as major sources of modern method. Percent of Total modern method user was 70 in Arm A. More than 85 percent respondents showed intentions to use FP methods in future. Only 8 percent female RMG workers of Arm-A have unmet needs of Family planning.
- Only two percent respondents have ever used ECP and the users took ECP from pharmacies to prevent sudden and unexpected pregnancy. About half of ECP users from all Arms except the MHM model factories recorded taking ECPs in less than last one month.
- The rate of MR usage was also very low, less than 3 percent. Private hospitals or clinics were the most known sources of MR services with 30 percent popularity.

This section focuses on the unmet need, use of contraception, and use of MR services by the RMG female workers working in the factories affiliated with the project. The respondents were asked about current pregnancy status, use of contraception, use of ECPs, and MR-related practices to check the level of practices and services they receive.

3.3.1. Current Pregnancy Status

Out of the 1720 respondents, 99 respondents (nearly 6 percent) were pregnant. Percentage of currently pregnant women were 5.9 percent at Arm A and this figure was a bit higher than other two Arms. 1267 women (48 percent) have at least one child, 353 have no child, and 16 women were pregnant but did not want any child then (ref. Table 16). Around 48 percent of the women with one child wanted more children whereas the willingness was naturally higher (around 90 percent) among the women with no child. Nearly 84 percent respondents wanted to get pregnant. A few respondents who are currently pregnant but did not want child, opted to wait for some time for a child. Overall, three-fourth (only 12 out of 16) of the respondents opted to wait for some time for a child. All of the respondents (only three) from MHM model factories and also the factories in Arm C chose to wait more for a child. The majority of the respondents (three out of four) from Power Plus model factories picked the option of not wanting any child while in the other cases, more than half of the respondents settled for waiting for more time.

Table 16: Current Pregnancy Status of the respondents

	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
Number of Respondents who are currently married	**477**	**303**	**780**	**488**	**452**	**1,720**
Currently pregnant	4.6	7.9	5.9	5.7	5.5	5.8
Number of women who are currently pregnant (n)	**22**	**24**	**46**	**28**	**25**	**99**
Currently pregnant	81.8	87.5	84.8	78.6	88.0	83.8
Number of women with at least a child (n)	**364**	**218**	**582**	**351**	**334**	**1267**
Wants child/more child (women with at least a child)	52.5	60.6	55.5	44.7	39.2	48.2
Number of women with no child (n)	**90**	**61**	**151**	**109**	**93**	**353**
Wants child/more child	92.2	95.1	93.4	89.9	84.9	90.1
Number of women who are currently pregnant but did not want child (in number)	**90**	**61**	**151**	**109**	**93**	**353**
Number of women who wanted to wait for some time (n)	92.2	95.1	93.4	89.9	84.9	90.1
Number of women who did not want any child (n)	92.2	95.1	93.4	89.9	84.9	90.1

3.3.2. Use of Contraception

Around 79 percent respondents were using contraception during the survey. Pills (around 45 percent) and injectable (17 percent) were the two mostly used contraceptives used by the respondents. The respondents also used condoms (around 7 percent) and safe period/periodic abstinence (nearly 6 percent). Percent of total modern method user was 71 at Arm A. Around 86 percent respondents selected pharmacy as the source of accessing modern method. The respondents did not consider RMG health centers (nearly three percent) or IB model health centers (below one percent percent) as major sources of modern method. More than 85 percent respondents showed intention to use FP methods in future. Similar to past or current uses, pills (around 63 percent), injectable (nearly 26 percent), and condoms (around 7 percent) are most preferred choices by the respondents for FP in the future.

Table 17: Use of Contraception by the respondents

	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
Number of eligible user (n)	**455**	**279**	**734**	**460**	**427**	**1621**
Currently using contraception	**77.6**	**81.4**	**79.0**	**79.1**	**79.6**	**79.2**
Number of women who are currently using contraception (n)	**353**	**227**	**580**	**364**	**340**	**1284**
Method used						
Female sterilization	0.9	1.1	0.9	1.5	2.3	1.5
Male sterilization	0.2	0.3	0.3	0.6	0.5	0.4
IUD	0.5	0.0	0.3	0.4	0.5	0.4
Injectable	14.3	14.7	14.4	14.8	21.8	16.5
Implants	0.5	1.8	1.0	0.4	1.0	0.8
Pill	43.4	45.6	44.2	49.1	42.6	45.2
Condom	10.3	9.5	10.0	4.6	4.0	6.9
Percent of Total modern method user	**70.0**	**73.0**	**71.1**	**71.5**	**72.6**	**71.6**
Safe period/periodic abstinence	4.7	4.9	4.8	6.5	6.1	5.6
Withdrawal	1.9	2.4	2.1	0.6	1.0	1.4
Other (Kabiraji medicine)	1.0	1.1	1.1	0.4	0.0	0.6
Percentage of Total Traditional method user	**7.6**	**8.4**	**7.9**	**7.5**	**7.0**	**7.6**

Table 17.1: Source of modern method & intention to use family planning method in future

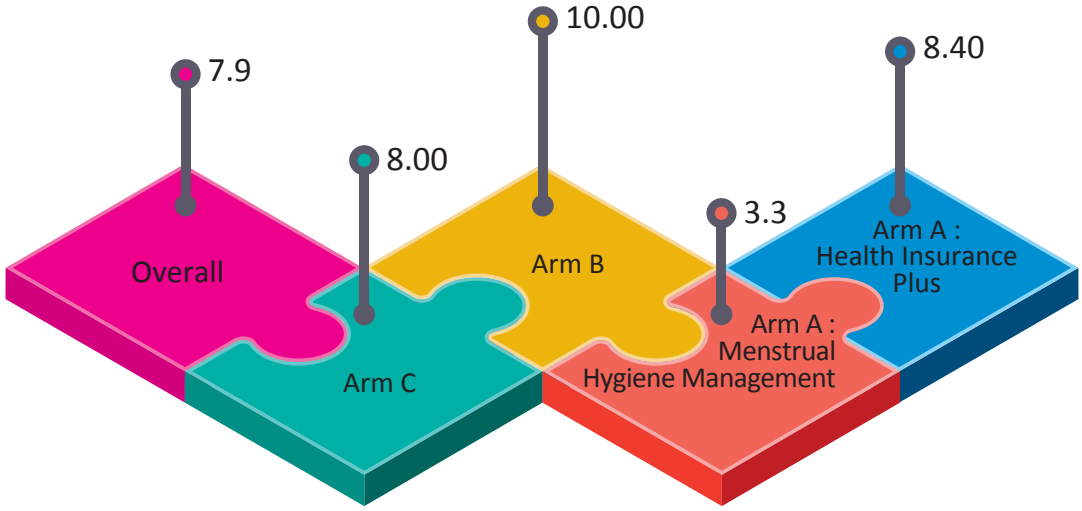
	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
Source of modern method						
Govt. hospital	6.7	3.3	5.3	5.2	8.1	6.0
Govt. clinic/health center	3.7	1.4	2.8	4.6	8.7	4.8
RMG health center	1.8	0.5	1.3	7.0	1.3	2.9
IB Model referral hospital/clinic	0.9	0.0	0.6	0.0	0.0	0.3
NGO clinic	0.0	0.9	0.4	0.0	0.3	0.3
NGO Satellite clinic	0.3	0.0	0.2	0.0	0.0	0.1
Other private hospital/clinic	0.0	0.5	0.2	0.0	0.0	0.1
Chamber of qualified Doctor	1.2	0.9	1.1	0.9	1.9	1.3
Chamber of Unqualified Doctor	0.6	1.9	1.1	1.2	2.6	1.5
Community sales agent	0.6	0.5	0.6	0.3	0.0	0.3
NGO health worker/Nurse	2.1	0.5	1.5	0.9	1.3	1.3
Pharmacy	87.2	90.2	88.4	85.7	82.6	86.1
Grocery Shop	0.6	0.5	0.6	0.3	0.0	0.3
Neighbor/Friends/Relatives	0.0	0.0	0.0	0.0	0.3	0.1
Others (FWA)	1.2	0.9	1.1	0.3	0.3	0.7
Don't know	0.6	0.0	0.4	0.3	0.3	0.3
Intention to use family planning method in future (n)	**477**	**303**	**780**	**488**	**452**	**1720**
Yes	**477**	**303**	**780**	**488**	**452**	**1720**
Preferred method (n)	427	278	705	421	386	1512
Female sterilization	1.2	2.2	1.6	1.9	2.9	2.0
Male sterilization	0.0	0.4	0.1	0.2	0.3	0.2
IUD	0.2	0.4	0.3	0.2	0.3	0.3
Injectable	26.5	22.7	25.0	22.3	30.6	25.7
Implants	4.9	3.6	4.4	1.9	2.1	3.1
Pill	63.2	61.2	62.4	68.7	59.1	63.3
Condom	11.9	6.5	9.8	6.2	4.4	7.4
Safe period/periodic abstinence	3.0	1.8	2.6	4.3	4.2	3.4
Withdrawal	0.7	1.1	0.9	0.2	0.5	0.6
Other (Have not decided yet, will consult with doctor before deciding)	0.2	3.2	1.4	0.0	0.3	0.7

Unmet needs of FP:

Unmet need for family planning refers to fecund women who are not using contraception but wish to postpone the next birth or stop pregnancy altogether. Women are considered to have unmet need for spacing only if - 1) they are at risk for not using contraception, and either do not want to become pregnant within next two years or are unsure about the time when they want to get pregnant; and 2) pregnant with a untimely pregnancy. Women are considered to have unmet need for limiting or stopping pregnancy altogether only if – 1) they are at risk of becoming pregnant and do not want pregnancy; and 2) pregnant with an unwanted pregnancy.

Unmet need, total demand, and percentage of demand satisfied by modern methods are defined as such-

- Unmet need: sum of unmet need for both spacing and limiting.
- Total Demand: sum of unmet need and total contraceptive use
- Percentage of demand satisfied: total contraceptive use is divided by the sum of unmet need and total contraceptive use. (Bangladesh Demographic Health Survey, 2014)



Only about 8 percent female RMG workers have unmet needs of Family planning (ref. Figure 4). MHM model respondents have the lowest unmet FP needs of all (only around 3 percent). The Arm A respondents have lesser unmet FP needs than the respondents from the other two Arms, B and C. Arm B has the highest percentage of respondents, 10 percent, who have unmet needs of FP.

3.3.3. Emergency Contraceptive Pill (ECP)

Among the respondents, 1720 were married. About 98 percent of them have never used ECP (ref. Table 18). Only 38 respondents (2 percent) were ECP users and 25 of them were from respondents of IB model factories. The respondents who use ECP were also frequent users of it. About half of the ECP users from all Arms except the MHM model factories recorded taking ECPs in less than last one month. The respondents reported reason behind using the ECPs as an emergency measure. 24 out of 38 ECP users identified the cause behind ECP usage being the fear of sudden and unexpected pregnancy. A noteworthy number (11) of ECP users were non-family planners. Again, the MHM model respondents showed their higher level of consciousness by noting that they used ECPs only because they have not been using any FP methods. The major source of ECP was the pharmacies for about half of the ECP-users.

Table 18: Use of ECP by the respondents

	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
Number of currently married women	**455**	**279**	**734**	**460**	**427**	**1621**
Ever used ECP	**77.6**	**81.4**	**79.0**	**79.1**	**79.6**	**79.2**
Number of respondents	**353**	**227**	**580**	**364**	**340**	**1284**
Time of last use (n)						
Less than a month	0.9	1.1	0.9	1.5	2.3	1.5
Within last one year (1-12 months)	0.2	0.3	0.3	0.6	0.5	0.4
More than 12 months ago	0.5	0.0	0.3	0.4	0.5	0.4
Reason behind using ECP (n)						
Did not use any FP method	0.9	1.1	0.9	1.5	2.3	1.5
Forgot to take pill for 3 consecutive day	0.2	0.3	0.3	0.6	0.5	0.4
Full or partial exit of IUD	0.5	0.0	0.3	0.4	0.5	0.4
Other(so that I don't conceive)	0.2	0.3	0.3	0.6	0.5	0.4
Sources of ECP (n)						
Govt. hospital	0.9	1.1	0.9	1.5	2.3	1.5
Govt. clinic/health center	0.2	0.3	0.3	0.6	0.5	0.4
RMG/IB Model health center /NGO SECTOR (CWCH)	0.5	0.0	0.3	0.4	0.5	0.4
RMG health center	0.2	0.3	0.3	0.6	0.5	0.4
Chamber of qualified Doctors	0.9	1.1	0.9	1.5	2.3	1.5
NGO health worker/Nurse	0.2	0.3	0.3	0.6	0.5	0.4
Pharmacy	0.5	0.0	0.3	0.4	0.5	0.4
Neighbor/Friends/Relatives	0.9	1.1	0.9	1.5	2.3	1.5
Don't know	0.2	0.3	0.3	0.6	0.5	0.4

3.3.4. Menstrual Regulation (MR)

The rate of receiving MR was also very low among the respondents. Almost 97 percent of the respondents have never received MR. Of the total (46) MR recipients, 11 of the MR users received MR services from government hospitals. The private hospitals/clinics were the most popular sources of MR services among the IB model respondents (6). IB model referral hospital were not popular as only one respondent received MR from the source. Qualified doctors (five service-receivers) and nurses/midwives or paramedics (two care-receivers) were the two most popular MR Service providers among the Arm A Respondents.

Table 19: MR of the respondents

	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
Number of women who are currently married women (n)	**477**	**303**	**780**	**488**	**452**	**1720**
Ever received MR	**2.3**	**3.0**	**2.6**	**2.3**	**3.3**	**2.7**
Number of respondents (n)	**11**	**9**	**20**	**11**	**15**	**46**
Source of MR services (n)						
Govt. hospital	1	1	2	2	7	11
Govt. clinic/health center	1	0	1	0	5	6
IB model health centers (Kumudini Hospital)	1	0	1	0	0	1
NGO clinic (Amena, Marie stopes)	0	1	1	1	0	2
NGO satellite clinic	0	0	0	0	1	1
Private hospital/clinic (Can't remember, Modern, Sotota clinic)	4	2	6	0	0	6
Qualified doctor's chamber	1	4	5	2	1	8
Untrained doctor's chamber	2	0	2	3	0	5
Other Private Organization	0	0	0	0	1	1
Other Organization (pharmacy, home, nurse)	1	1	2	3	0	5

	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
MR service providers (n)	**477**	**303**	**780**	**488**	**452**	**1720**
Health service provider of IB Model Referral center	1	0	1	0	0	1
Qualified Doctor	5	4	9	4	5	18
Trained Nurses/ Midwives/ Paramedics	2	4	6	2	9	17
Traditional Doctor	2	0	2	3	0	5
NGO worker/Nurse	0	0	0	0	1	1
Others (Pharmacy, Own arranged)	1	1	2	2	0	4

3.4. Utilization of Maternal Health Care Services

Box 4: Summary of the utilization of maternity health care services

- About 38 percent of the mothers aged between 20-24 years have four or more ANC visits whereas the percentage of four or more ANC visits was the highest (41 percent) among the Arm A respondents.
- Overall 88 percent of the respondents received ANC from trained providers and the popularity of the RMG health centers for ANC was 42 percent among them. ANC receiving rate was the highest among the control factories with the Arm A factories trailing by only a fraction. 20 percent respondents recorded RMG health centers/IB model referral centers as the place of their last ANC visit.
- The respondents' selection of respective residences/home for the delivery was more than 50 percent for all the Arms with Arms C respondents displaying the highest level of preference (70 percent). The respondent preferred their respective home as the place of delivery if no complication was there and/or C-section was not needed. The receiving rate of TT vaccination was higher for Arm A respondents than the respondents from the other two Arms, B and C. IB model referral hospital received very low acceptance (3 percent) in case of delivery care. Delivery by the medically trained professionals was higher among non-IB model respondents but the use of traditional, risky care-givers' services was also higher among them.
- Majority of the PNC receivers (about 47 percent) availed the PNC services within two days of delivery. About half of ARM-A PNC receivers received PNC within 42 days. The tendency of receiving PNC and the quick response for PNC happened highly in cases when the mother's age was below 19 years and also for mothers aged above 34 years. The percent of PNC recipients was lower among the non-IB model group than the IB model respondents. The PNC received from medically trained providers was the highest (about 38 percent) among the Arm C. respons.

The respondents who have been married and delivered at least one child were questioned about the maternity care services they had experienced. The questionnaire was designed to check the state of services they had used during the three stages of pregnancy - antenatal, delivery, and postnatal period.

3.4.1. Antenatal Care

The antenatal period presents important opportunities for examining pregnant women at intervals that may be vital to their health and wellbeing and as well their infants. Better understanding of foetal growth and development and its relationship to the mother's health has resulted in increased attention to the potential of antenatal care as an intervention to improve both maternal and newborn health. For example, antenatal care can be used to inform women and families about risks and symptoms in pregnancy and about the risks of labor and delivery, and therefore it may provide the route for ensuring that pregnant women do, in practice, deliver with the assistance of a skilled health care provider. Antenatal visits also provided an opportunity to supply information on birth spacing, which is recognized as an important factor in improving infant survival. Tetanus immunization during pregnancy can be life-saving for both the mother and the infant. The prevention and treatment of malaria among pregnant women, management of anemia during pregnancy and treatment of sexually transmitted infections (STIs) can significantly improve foetal outcomes and improve maternal health. Adverse outcomes such as low birth weight can be reduced through a combination of interventions to improve women's nutritional status and prevent infections (e.g., malaria and STIs) during pregnancy. More recently, the potential of the antenatal care as an entry point for HIV prevention and care, in particular for the prevention of HIV transmission from mother to child, has led to renewed interest in access to and use of antenatal services (BBS, 2012-13). WHO recommends a minimum of four antenatal visits based on a review of the effectiveness of different models of antenatal care. About 38 percent of the mothers aged between 20-24 years have four or more ANC visits whereas the percentage of four or more ANC visits was the highest (41 percent) among the Arm A respondents.

Table 20: Number of ANC Visits

	None	1	2	3	4+	Total	Number of women with >1year Child
Total	**8.3**	**10.0**	**18.3**	**24.2**	**39.2**	**100.0**	**120**
Mother's age							
18-19	0.0	0.0	60.0	20.0	20.0	100.0	5
20-24	13.3	8.3	16.7	23.3	38.3	100.0	60
25-29	2.9	17.1	8.6	28.6	42.9	100.0	35
30-34	5.3	5.3	31.6	15.8	42.1	100.0	19
35-39	0.0	0.0	0.0	100.0	0.0	100.0	1
Intervention type							
Arm A: Health insurance	6.9	10.3	10.3	31.0	41.4	100.0	58
Arm A: MHM	7.1	28.6	21.4	7.1	35.7	100.0	14
Arm B: Training	11.4	2.9	25.7	22.9	37.1	100.0	35
Arm C: Control	7.7	7.7	30.8	15.4	38.5	100.0	13

Among 120 respondents, about 92 percent received some form of ANC and about 88 percent of them received ANC from trained providers (ref. Table 21). About 42 percent of the respondents who received ANC from trained providers acquired the services from the health centers from their respective factories. Another 39 percent opted to visit the qualified doctors for ANC. Very few of them (only 3 percent) accrued ANC from unskilled providers. If the age of the mothers is considered, the number of ANC receivers (60) were the highest among the mothers of 20-24 years of age. They visited the RMG health centers the most (about 48 percent). It is an important evidence that the ANC receiving rate was the highest among the control factories with Arm A trailing by only a fraction.

Table 21: Providers of ANC

Area	No ANC	Medically trained				Unskilled provider	Don't know	Received any ANC	Number of respon-dents (n)
		Health service provide of factory	Health service provider of IB Model Referral center	Qualified Doctor	Trained Nurses/ Midwives/ Paramedics				
Total	**8.3**	**41.7**	**5.0**	**38.3**	**2.5**	**3.3**	**0.8**	**91.7**	**120**
Mother's age									
18-19	0.0	0.0	20.0	80.0	0.0	0.0	0.0	100.0	5
20-24	13.3	48.3	3.3	31.7	1.7	1.7	0.0	86.7	60
25-29	2.9	40.0	5.7	42.9	2.9	2.9	2.9	97.1	35
30-34	5.3	36.8	5.3	42.1	0.0	10.5	0.0	94.7	19
35-39	0.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	1
Intervention type									
Arm A: Health insurance	6.9	53.4	8.6	29.3	1.7	0.0	0.0	93.1	58
Arm A: MHM	7.1	21.4	0.0	64.3	0.0	7.1	0.0	92.9	14
Arm B: Training Only	11.4	34.3	0.0	40.0	2.9	8.6	2.9	88.6	35
Arm C: Control	7.7	30.8	0.0	46.2	7.7	7.7	0.0	92.3	13

Figure 5: Place of last ANC visit among the respondents who reported an ANC visit (percent)

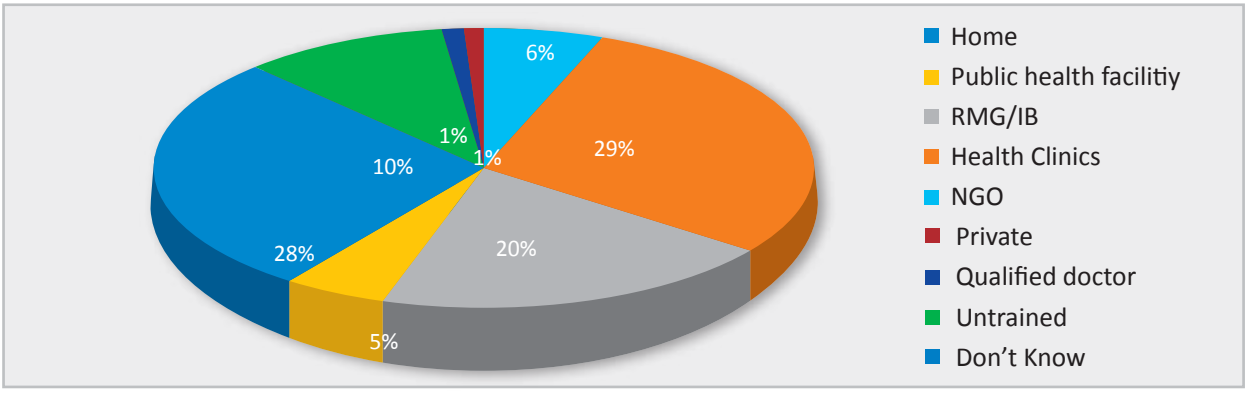


Figure 5 illustrates the place of ANC visit among the respondents (in percentage) who have reported an ANC visit within one year. Most of the respondents (about 29 percent) visited public health facility while 20 percent of respondent received ANC from RMG/IB model health clinics.

3.4.2. Delivery Care

Three quarters of all maternal deaths occur during delivery or the immediate post-partum period. The single most critical intervention for safe motherhood is to ensure that a competent health worker with at least midwifery skills is present at every birth, and in case of emergency a mode of transport is available to a referral facility for obstetric care (BBS, 2012-13). For baseline, we considered doctor, nurse, midwife and TTBA as skilled attendants.

More than half of the mothers delivered their babies at their respective homes (around 54 percent) (ref. Table 22). Nearly 46 percent delivered in health facilities like public health facilities, IB model health clinics, and NGO and private facilities. About 28 percent of the total respondents delivered by the caesarean section. More than 50 percent of the respondents who delivered in health facilities delivered by C-section. This finding indicates that the respondent preferred their respective home as the place of delivery if no complication was there and/or C-section was not needed. Only the mothers of 20-24 years of age preferred health centers more than their homes (about 52 percent > around 48 percent). See through the intervention lenses, the result was the same for all the arms where more than 50percent respondents chose their respective home for delivery.

Table 22: Place of delivery

Area	Home	Public health facility	IB health clinic/ referral hospital	NGO	Private	Percent delivered in Health facility	Percent delivered by C section	Number of respondent (women with <1year child)
Total	**8.3**	**41.7**	**5.0**	**38.3**	**2.5**	**3.3**	**0.8**	**91.7**
Mother's age								
18-19	80.0	0.0	20.0	0.0	0.0	20.0	0.0	5
20-24	48.3	23.3	3.3	5.0	20.0	51.7	30.0	60
25-29	54.3	17.1	5.7	2.9	20.0	45.7	31.4	35
30-34	68.4	15.8	0.0	0.0	15.8	31.6	15.8	19
35-39	0.0	100.0	0.0	0.0	0.0	100.0	100.0	1
Intervention type								
Arm A: Health insurance	51.7	20.7	8.6	3.4	15.5	48.3	24.1	58
Arm A: MHM	50.0	14.3	0.0	0.0	35.7	50.0	35.7	14
Arm A in total (all IB Models)	51.4	19.4	6.9	2.8	19.4	48.6	26.4	72
Arm B: Training Only	54.3	22.9	0.0	5.7	17.1	45.7	31.4	35
Arm C: Control	69.2	15.4	0.0	0.0	15.4	30.8	23.1	13

Most of the mothers decided to go for C-section after the labor had started (nearly 76 percent of the cumulative response). This response established their tendency of not going to C-section until it turned to be mandatory. Nearly 91 percent of the cumulative and also more than 85 percent of the respondents from all arms received TT vaccination. Out of 109 TT vaccine receivers, about 48 percent received four or more doses of TT vaccine. The receiving rate of TT vaccination was higher for Arm A respondents than the respondents from the other two Arms B and C.

Table 23: Decision for C-section and TT vaccination

	Arm A		Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Menstrual Hygiene Management	IB models	Training only	Control	
Number of respondents (n)	**14**	**5**	**19**	**11**	**3**	**33**
Decision for C-Section (in number)						
Before labor started	7	0	7	1	0	8
After labor started	7	5	12	10	3	25
Number of respondents (n)	**58**	**14**	**72**	**35**	**13**	**120**
Received TT vaccination	**91.4**	**85.7**	**90.3**	**88.6**	**100.0**	**90.8**
Number of respondents (n)	**53**	**12**	**65**	**31**	**13**	**109**
Number of doses						
1	9.4	8.3	9.2	12.9	0.0	9.2
2	24.5	0.0	20.0	19.4	30.8	21.1
3	18.9	33.3	21.5	16.1	38.5	22.0
4 or more	47.2	58.3	49.2	51.6	30.8	47.7

Figure 06 reveals the respondents' response regarding the delivery care providers. 71 percent respondents delivered with assistance from medically trained professionals ie. Qualified Doctor, Trained Caregivers, Trained Midwives, NGO worker/nurse as expected, the most preferred delivery care provider was the qualified doctors (about 31 percent). Trained and/or traditional midwives were also preferred. When the IB model vs non-IB model comparison is drawn (see figure 07), it becomes evident that delivery by the medically trained professionals was higher among non-IB model respondents but the use of traditional, risky care-givers' services was also higher among

Figure 6: The respondents' response regarding the delivery care providers

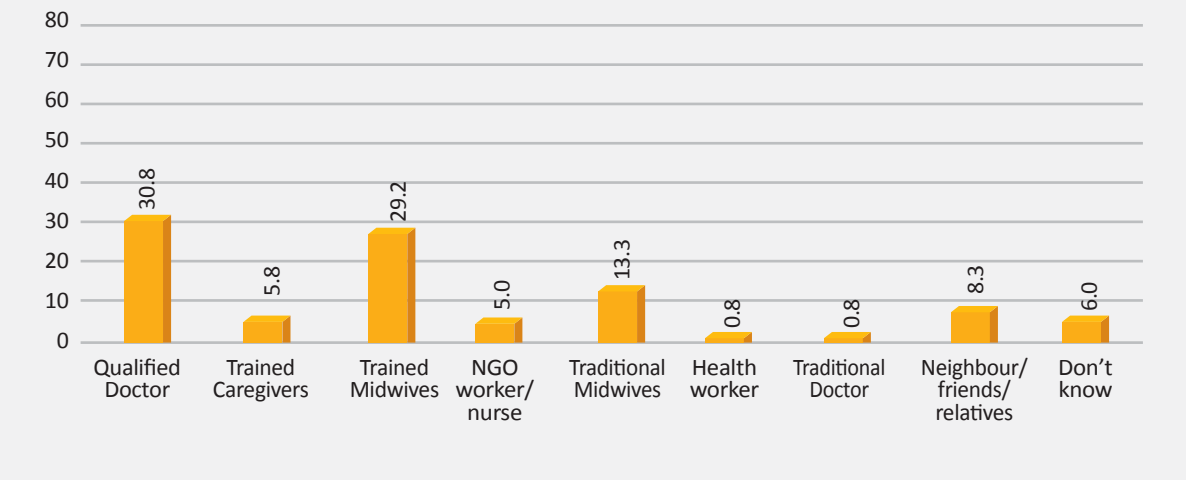
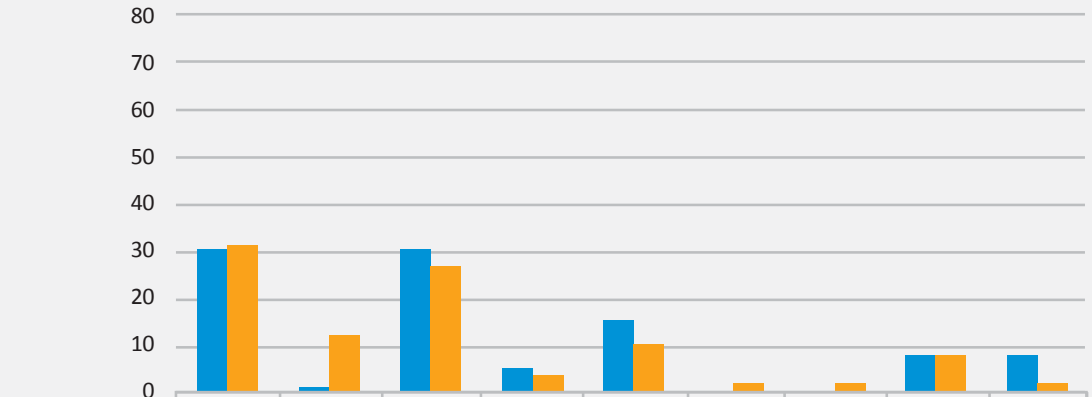


Figure 7: The respondents' response regarding the delivery care providers (IB Model vs Non-IB Model comparison)



	Qualified Doctor	Trained Caregivers	Trained Midwives	NGO worker/ nurse	Traditional Midwives	Health worker	Traditional Doctor	Neighbour /friends /relatives	Don't know
BI Model	30.6	1.4	30.6	5.6	15.3	0.0	0.0	8.3	8.4
Non-BI Model	31.3	12.5	27.1	4.2	10.4	2.1	2.1	8.3	2.1

3.4.3. Postnatal Care

Both mother and newborn are vulnerable during postnatal period, particularly during the first 24 hours after birth. In Bangladesh, most of maternal deaths occur during postnatal period. Therefore, early postnatal visits have been recommended to save mother and newborn. Postnatal care package included interventions for both mothers and neonate to promote healthy practices, identify complications and facilitate early referral (MICS, Bangladesh, 2012-13).

Safe motherhood Programmes have recently increased emphasis on the importance of postnatal care, recommending that all women and newborns receive a health check within two days of delivery (Joint WHO-UNICEF Statement on Early PNC). To assess the extent of post-natal care utilization, women were asked whether they received a health check after the delivery, the timing of the first check, the type of health provider and place of PNC for the woman's last birth within one year preceding the survey (Baseline Report of Working with Women Project, 2015).

About 44 percent of all mothers received no PNC (ref. Table 24). Majority of the PNC receivers availed the PNC services within two days (about 47percent) of delivery. PNC received by mothers from different age groups denotes that the tendency of receiving PNC and the quick response for PNC happened if the mothers' age was below 19 years and also for mothers aged above 34 years. The percent of PNC recipients was lower among the non-IB model group.

Table 24: Timing of PNC from any provider

Area	Within two days	Within 3-6 days	Within 7-42 days	Don't know	No PNC	Number of women (n)
Total						
Mother's age						
18-19	60.0	0.0	0.0	0.0	40.0	5
20-24	45.0	0.0	1.7	6.7	46.7	60
25-29	45.7	2.9	0.0	11.4	40.0	35
30-34	47.4	0.0	0.0	5.3	47.4	19
35-39	100.0	0.0	0.0	0.0	0.0	1
Intervention type						
Arm A: Health insurance	51.7	0.0	1.7	6.9	39.7	58
Arm A: MHM	35.7	0.0	0.0	14.3	50.0	14
Arm A in total (all IB Models)	48.6	0.0	1.4	8.3	41.7	72
Arm B: Training Only	45.7	0.0	0.0	5.7	48.6	35
Arm C: Control	38.5	7.7	0.0	7.7	46.2	13

35 percent of the mothers from 120 respondents (those who needed PNC services) received PNC from medically trained providers (ref Figure 8). About 44 percent received no PNC whereas PNC recipients from unqualified providers was about 21 percent. The highest number of PNC receivers was mothers aged in-between 20-24 years (ref. Table 25). 40 percent from the age group received PNC from medically trained providers. The PNC received from medically trained providers was the highest among the Arm C respondents (about 38 percent).

Figure 8: The respondents' response regarding the PNC providers

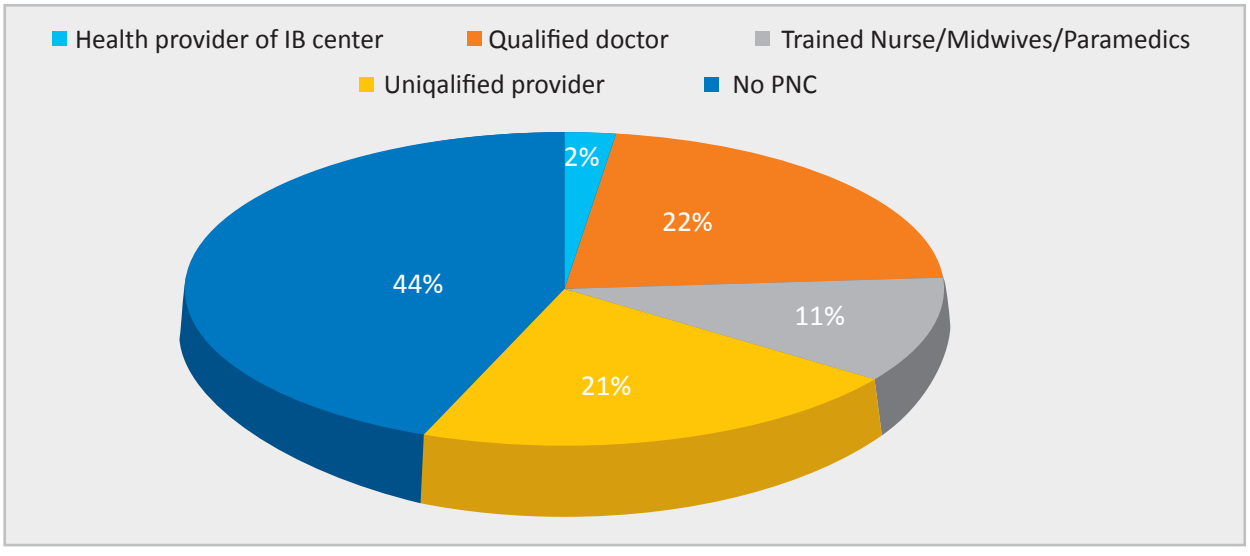


Table 25: The respondents' response regarding the PNC providers

	Medically trained provider			Unqualified provider	No PNC	PNC from medically trained provider	Number of women (n)
	Health provider of IB center	Qualified doctor	Trained Nurses/ Midwives/ Paramedics				
Total	**1.7**	**21.7**	**11.7**	**20.8**	**44.2**	**35.0**	**120**
Mother's age							
18-19	0.0	20.0	0.0	40.0	40.0	20.0	5
20-24	1.7	20.0	18.3	13.3	46.7	40.0	60
25-29	2.9	22.9	5.7	28.6	40.0	31.4	35
30-34	0.0	21.1	5.3	26.3	47.4	26.3	19
35-39	0.0	100.0	0.0	0.0	0.0	100.0	1
Intervention type							
Arm A: Health insurance	3.4	25.9	8.6	22.4	39.7	37.9	58
Arm A: MHM	0.0	21.4	7.1	21.4	50.0	28.6	14
Arm A in total (all IB Models)	2.8	25.0	8.3	22.2	41.7	36.1	72
Arm B: Training Only	0.0	14.3	17.1	20.0	48.6	31.4	35
Arm C: Control	0.0	23.1	15.4	15.4	46.2	38.5	13

3.5. Menstrual Hygiene Management

Box 5: Summary of the utilization of maternity health care services

- One third of the total respondents (35 percent) were not aware of MHM and MHM model respondents were a bit more conscious about MHM than the Arm C and Arm B respondents (66 percent > 54 percent >59 percent).
- More than half of the respondents (57%) were aware of menstruation before they started experiencing menstruation. Family and friends were the major sources of MHM-related knowledge sharing and it was the same for respondents from all the study Arms.
- Half of the MHM model respondents used sanitary napkin during their menstruation.
- All the factories affiliated with the project have private places where women feel comfortable in changing their sanitary pads/clothes.
- Dumping the things properly was a common practice among the MHM model respondents (51 percent > 37 percent > 40 percent) while washing and reuse was the highest practice among the respondents from other Arms.
- In case of management of menstrual waste at factories, only around 35 percent of the cumulative respondents have reported using the bins to dispose the used items. MHM model's respondents mostly practiced putting/throwing (41 percent) the used pad in the bin as a way of disposal whereas nearly 35 percent practiced taking the items outside.
- When evaluated using a QIS method, it became evident that MHM model factories were at the level two of the ladder (0-4 scale) and were followed by Arm B and Arm C factories standing at ladder one.

Menstrual hygiene management is an important component of the project. The respondents were asked two types of questions. One type of questions aimed to reveal the respondents' perception about menstruation. The other type of questions was about their menstrual practices. Out of 384 respondents of MHM model, around 66 percent perceived the menstruation as a common issue of female reproductive health and about 37 percent were ignorant (ref. Table 26). Nearly 57 percent of all the respondents heard about menstruation issues before the start of menstruation. The sources of the information were mostly the female members of the family and the kith and kin.

Table 26: The respondents' perception about menstruation

	Arm A Menstrual Hygiene Management	Arm B Training only	Arm C Control	Total
Number of respondents (n)	**66.4**	**48.5**	**54.8**	**55.3**
Idea about menstrual period				
Common issue of female reproductive health	66.4	48.5	54.8	55.3
Illness of female	3.6	8.6	7.8	7.1
Curse of Allah/ God/ Creator	3.4	1.7	1.8	2.2
No idea	11.5	23.7	15.7	17.7
Don't know	15.1	17.6	19.8	17.8
Heard about menstrual issues before the start of menstruation	**54.2**	**57.7**	**57.2**	**56.6**
Source of information about menstruation				
Mother	26.0	30.8	40.2	33.3
Father	0.0	0.9	0.3	0.5
Grand mother	32.2	23.8	27.7	27.3
Friend	21.2	29.7	23.0	25.1
Aunt	21.6	22.7	23.9	22.9
Teacher	0.0	1.5	0.6	0.8
Sister/Sister-in-law	54.8	48.6	36.7	45.5
Doctor/ Nurse	6.3	5.5	7.6	6.5
TV	1.4	0.6	3.5	1.9
Radio	0.5	0.6	0.3	0.5
From Study	5.3	4.1	3.8	4.3
Husband	0.0	0.0	0.3	0.1
Neighbor	0.0	0.3	0.0	0.1
NGO	0.0	0.0	0.3	0.1

When all-inclusive, cloth (about 49 percent) and napkin/pad (about 41 percent) were the most used items during menstruation (ref. Table 27). Half of the MHM model respondents used sanitary napkin during their menstruation. Only a few of the MHM model respondents used things other than clean cloth and napkin. The most popular practices of managing menstrual items were washing with soda and water (around 49 percent) and dumping in household garbage (about 42 percent). Dumping

the things properly was a common practice among the MHM model respondents (51 percent > 37 percent > 40 percent) while washing and reuse was the highest practice among the respondents from other Arms. In case of management of menstrual items at factories, only around 35 percent of the cumulative respondents reported using the bins to dispose the used items. MHM model's respondents mostly practiced throwing the used pad in the bin as a way of disposal whereas nearly 35 percent practiced taking the items outside. Secret/safe place for changing pad/cloth in the factory was mostly available in all the Arms. MHM model factories has nearly 100 percent score in case of availability of secret/safe place for changing pad/cloth. The respondents from all the Arms agreed that they have 100 percent privacy in their respective factories. 82 percent of the 1576 respondents recorded that toilets have adequate water and soap supply for maintaining hygiene. Predictably the MHM model respondents have the better score once again (around 95 percent). Majority of the respondents dried their menstrual items inside their homes (about 72 percent) and a significant percent of the respondents used to store the items in drawer/wardrobe (around 43 percent), kept them under bed (around 33 percent), and kept with other clothes (nearly 25 percent). The fund was mostly available to the household head for buying sanitary napkin/pad (96 percent).

Table 27: The respondents' practices regarding menstruation

	Arm A Menstrual Hygiene Management	Arm B Training only	Arm C Control	Total
Number of respondents (n)	**384**	**596**	**600**	**1580**
Things used during menstruation				
Napkin/pad	49.7	38.4	37.5	40.8
Cotton	0.3	0.2	0.2	0.2
Cloth	46.1	48.3	50.0	48.4
Garments RAG/waste	3.1	8.9	9.7	7.8
Toilet Tissue	0.8	3.9	1.5	2.2
Nothing	0.0	0.0	0.5	0.2
No Menstruation at all	0.0	0.3	0.7	0.4
Management of menstrual cloth/tissue/pad at home				
Washed it with water	5.5	7.1	6.5	6.5
Washed with soap/soda and water	44.5	50.7	51.0	49.3
Boil with soap/soda	9.6	5.2	2.7	5.3
Throw it anywhere	0.3	0.0	0.0	0.1
Dumped with household garbage	51.3	37.1	39.8	41.6
Dumped in toilet	2.6	4.5	2.3	3.2
Put in the Bin	1.6	3.0	1.0	1.9
Burned	0.3	0.0	0.8	0.4
Buried in the soil	3.9	4.4	4.0	4.1
Others	0.3	0.7	1.3	0.8
Management of menstrual cloth/tissue/pad at factory				
Washed it with water	4.7	14.4	7.2	9.3
Washed with soap/ soda and water	10.2	13.3	11.8	12.0
Boil with soap/soda	5.5	2.2	0.7	2.4

	Arm A Menstrual Hygiene Management	Arm B Training only	Arm C Control	Total
Throw it anywhere	0.3	0.0	0.0	0.1
Dumped with factory's garbage	14.8	32.7	23.5	24.9
Dumped in toilet	3.9	2.7	3.5	3.3
Put in the Bin	41.4	28.0	38.3	35.2
Burned	0.0	0.2	0.2	0.1
Buried in the soil	0.3	0.5	0.5	0.4
Others	2.1	1.2	5.8	3.2
Take it outside	34.9	19.1	21.3	23.8
Availability of secret/safe places to change the pad/cloth in the factory				
Yes, At toilet	99.7	90.6	94.7	94.4
yes, other place	0.3	8.7	5.3	5.4
No	0.0	0.7	0.0	0.3
Number of respondents (n)	384	592	600	1576
Does the water and soap system have to be cleaned on the factory toilet				
No	0.0	0.3	1.0	0.5
Yes, only water	4.7	19.0	26.2	18.2
Yes, water and soap	95.3	80.7	72.8	81.3
Number of respondents (n) **Place of drying cloths used during menstruation**	**177**	**288**	**300**	**765**
In the back of the house	1.1	4.9	5.3	4.2
Inside room	72.9	75.4	69.3	72.4
Under the hot sun but under other clothes	13.6	6.3	17.0	12.2
Under the hot sun	16.4	17.0	11.3	14.6
Behind Cloth Rack	0.6	0.4	0.0	0.3
At Balcony	0.0	0.4	0.0	0.1
Throw Away/throw in toilet	2.3	1.4	2.0	1.8
Usual place for storing menstrual cloths				
Under mattress	1.1	0.4	1.3	0.9
Under bed	24.9	32.3	38.7	33.1
With other clothes	33.3	20.1	27.3	26.0
Under toilet roof	0.6	2.8	2.7	2.2
Hanging on kitchen/room wall	1.1	2.8	1.3	1.8
Keep in drawer/almery	43.5	35.1	25.0	33.1
Behind the cloth rack	0.0	0.4	2.0	0.9
Poly Bag	1.7	6.9	4.0	4.6
In secret place	0.0	0.7	0.7	0.5
Throw away/Bury	1.7	0.7	2.0	1.4
Availability of funds to household head for buying sanitary napkin	**98.4**	**93.4**	**96.4**	**96.0**

SNV's performance monitoring framework uses ladders which is called Qualitative Information System (QIS) which was developed by IRC and WSP at the end of the 1990s as a means to quantify qualitative data used in process indicators and outcome indicators. Qualitative information is quantified with the help of progressive scales called 'ladders'. Each step on the ladder has a short description, called 'mini-scenario', which are factual statements that describe the situation for a particular score. Each scale ranges from the absence of the particular indicator at the lowest level (score 0) to the optimal mini-scenario at the highest level (score 4). Levels 1, 2 and 3 describe the scenarios in-between levels 0 and 4 for each specific indicator. Where there is a benchmark, it is usually indicated at level 2. A typical scale looks like this:

Description	Level
None of the characteristics are present (Condition or practice is not present)	0
One characteristic is present	1
BENCHMARK: Two characteristics are present	2
Three characteristics are present	3
IDEAL: All four (key) characteristics are present	4

The sampled female workers' availability of facilities for safe Menstrual Hygiene Management (MHM) has been classified at various level of importance. These level starts at 0 and ends at 4. The level indicates respondents' behaviour related to menstrual hygiene management at RMG factories. Upper level of the indicators tends to show a safe menstrual hygiene management while the lower level indicates partial or unsafe hygiene management. The following Indicator Box depicts level wise indicators and their description in brief.

QIS Level	Indicators	Description
Level 0	No Facility for Menstrual Hygiene Management	❖ Factory Premises have no place where women are comfortable changing sanitary pads/cloths ❖ OR no bin dispose of used pads/rags/cloths ❖ OR no appropriate materials/facility for rinsing/washing sanitary cloths (in case of reusable)
Level 1	Facility for Menstrual Hygiene Management	❖ Factory Premises/households have a private place where women are comfortable changing sanitary pads/cloths ❖ AND a bin to dispose of used pads/ rags/ cloths ❖ OR an appropriate materials and facility for rinsing/washing sanitary cloths (in case of reusable)
Level 2	Safe facility for Menstrual Hygiene Management	❖ As above, ❖ AND there is opportunity to clean one-self in the place for changing
Level 3	Safe facility for Menstrual Hygiene Management with adequate place for drying	❖ As above, ❖ AND a specific place for drying sanitary cloths hygienically (sunny) in case of reusable
Level 4	Safe facility for Menstrual Hygiene Management with adequate final disposal	❖ As above, ❖ AND final disposal of used pads/rags/ cloths by onsite burning in the premises, or off-site burning by an authorized waste disposal body (private or government waste collector)

Table 29: Arm vs. QIS Indicator Table

	Private Changing Facilities	Use of Bin to dispose pads	Opportunity to clean oneself	Place for dying sanitary clothes hygienically if reusable	Final disposal system
Arm A (MHM Model)	99.7	41.4	95.3	0.0	0.0
Arm B	90.6	28.0	80.7	0.0	0.0
Arm C	94.7	38.3	72.8	0.0	0.0

Now, when the QIS scale (ref. Table 27) and available data were considered, it can be said that the MHM factories (Arm A), Arm B, and Arm C were all at level two status (ref. Table 28). All of the factories have private changing facilities, more than 90 percent in all cases. Less than 50 percent use of bins indicated two things: availability of bins and MHM practice-related deficiency. All the Arms provided female RMG workers opportunities to clean themselves at factory during menstruation (95 percent, 81 percent, and 73 percent for Arm A, Arm B, and Arm C respectively). None of the Arms have facilities such as place for dying reusable sanitary clothes and final disposal system to dispose used sanitary products. Although all of the Arms were at level two, there were significant differences among them. MHM model factories have better facilities than factories from Arm B and Arm C.

3.6. Sexual Harassment and Violence against Women (VAW)

Box 7: Summary of Sexual Harassment and VAW section

- 36 percent (in overall) and 50 percent from Arm A (power plus model) respondents agreed to the statement that workers were beaten/slapped when they make mistakes in work.
- When asked with examples, more than 60% of the female respondents could not identify acts of physical, mental and sexual harassment and abuse.
- The consciousness is higher in Arm A respondents from Power Plus model factories than the two others while Arm B has the lowest level of awareness among the three.
- 8 percent of overall respondents (female RMG workers) reported that they were harassed over their life. These parentage was varied from 5 to 10 (Arm C was lowest and Arm A was highest). Overall 5 percent victims faced harassment within six months.
- Roadside harassment was the most common form of harassment they faced (nearly 59 percent in overall). About 42 percent (61 out of 135) of the victims sought help and/or protested against the harassment they faced. Most of the respondents from Arm A sought help when faced with harassment and when asked for help, the help from the factory management of Arm_A was higher in comparisons with other two Arms (about 27 percent > around 18 percent > nearly 7 percent).

This section reflects on the sexual harassment and violence against women (VAW) related awareness among the RMG female workers working in the factories affiliated with the project. The respondents were provided with some statements about sexual harassment and VAW and their responses were recorded. Among 1571 respondents, around 36 percent workers agreed to the statement that workers were beaten/slapped when they are doing wrong in work. Around 47 percent female workers

stated that they would be abused if they talked to others. Most of the workers (more than 60 percent) did not consider the following acts as acts of sexual harassment or VAW - like not allowing workers to go to toilet, touching, harassment on the way, acid attack, harassment in public, rape or rape attempts, spreading photos or videos over internet, disturbing via SMS or inappropriate proposal, kidnapping or trafficking, harassment in public transports, indecent propositions, indecent indications, showing porn either strategically or forcefully, deliberate pushing, sensitive touch, indecent gestures, following, passing comments, and indecent gestures. These responses indicated low level of knowledge and consciousness (less than 40 percent) among the workers regarding sexual harassment and VAW. The consciousness was higher in Arm A respondents from Power Plus model factories than the two others while Arm B has the lowest level of awareness (as the scores are very low) among the three.

Table 30: workers attitudes regarding Sexual Harassment and Violence against Women

	Arm A Power plus	Arm B Training only	Arm C Control	Total
Number of respondents	450	521	600	1571
Agreement to Sexual Harassment & VAW-related Statements				
If women workers are wrong in work, they were beaten/ slapped	49.3	16.9	43.5	36.4
If female workers talk to others in the factory, they will be abused	52.3	34.1	54.7	47.2
Not allowing women workers to go to the toilet due to work pressure	43.5	15.4	40.8	33.1
Touching women workers on the excuse of work	46.6	17.1	45.7	36.5
Harassment at or on the way to work	46.7	22.2	46.6	38.6
Attacking with acid in the workplace or on the way	49.4	18.2	46.2	37.8
Sexual harassment in public place	45.6	19.4	46.3	37.2
Trying to rape	46.9	19.4	45.6	37.3
Publish mobile / camera photos, video over internet or the website	45.6	19.8	46.0	37.2
Calling or disturbing via SMS, and making unnecessary offers of marriage, love	45.6	19.7	46.0	37.2
Kidnapping / trafficking	45.1	15.9	43.3	34.7
Sexual harassment in transit / transport	45.4	19.2	45.7	36.8
Giving indecent/obscene propositions on the way	47.5	22.7	46.6	39.0
Giving indecent indications	45.1	17.2	44.8	35.7
Forcefully or strategically show pornography	40.9	15.7	43.0	33.3
Deliberately pushing	46.9	23.4	45.3	38.5
Touching body/sensitive place during the exit or entry into the factory	43.1	19.0	44.7	35.7
Intimidating for establishing physical relationships	44.4	20.2	46.9	37.3
Following after leaving factory	40.9	18.7	43.8	34.6
Making bad comments by surrounding people	40.6	23.1	45.8	36.8
Make indecent gesture	42.0	17.9	43.2	34.5

Table 31 illustrates that 8 percent of overall respondents (female RMG workers) reported that they were harassed over/every step of their life. These percentage was varied from 5 to 10 (Arm C lowest and Arm C highest). Nearly 64 percent of them (overall 5%) faced harassment within six months. Roadside harassment was the most common form of harassment they faced (nearly 59 percent in overall). About 42 percent (61 in number) of the victims sought help and/or protested against the harassment they faced. Only 35 from the 61 victim women received help. Family, relatives, and colleagues were the ones who mostly helped them (about 83 percent). The victim of harassment was 43 respondents from Arm A. Most of the respondents from Arm A sought help when faced harassment and the help from the factory management was higher in Arm A in comparison with other two Arm (about 27 percent > around 18 percent > nearly 7 percent).

Table 31: Frequency, nature, and practice of Support against VAW/Sexual Harassment

	Arm A	Arm B	Arm C	Total
	Power plus	Training only	Control	
Total number of respondents	**450**	**596**	**600**	**1646**
Percent of women who faced harassment	**10**	**5**	**10**	**8**
Number of women who faced harassment	**43**	**32**	**60**	**135**
If yes, how long last time?				
0 to 1 month	25.6	21.9	41.7	31.9
Within 1 to 6 months	16.3	43.8	36.7	31.9
Within 6 to 12 months	14.0	31.3	5.0	14.1
1-2 years	11.6	0.0	3.3	5.2
2-5 years	16.3	3.1	3.3	7.4
More than 5 years	16.3	0.0	10.0	9.6
The Place where you faced sexual harassment				
Roadside	79.1	25.0	61.7	58.5
Bus Stop	0.0	18.8	6.7	7.4
Public Transport	11.6	59.4	30.0	31.1
Market Place	14.0	21.9	8.3	13.3
Workplace	18.6	18.8	23.3	20.7
Community	16.3	6.3	15.0	13.3
Have protested or sought help after someone harassed the person	32.6	56.3	48.3	45.2
Number of Women who sought help or protested (n)	**14**	**18**	**29**	**61**
Women received help	78.6	61.1	44.8	57.4
Number of women who received help (n)	**11**	**11**	**13**	**35**
The person or organization that helped the victim				
Factory management	27.3	18.2	7.7	17.1
Friends/relatives/colleagues	72.7	81.8	92.3	82.9
Aine and Salis Kendra	0.0	9.1	7.7	5.7
Neighbors	0.0	0.0	7.7	2.9

3.7. Sexually Transmitted Diseases (STDs) and HIV/AIDS

Box 8: Summary of the Sexually Transmitted diseases (STDs) and HIV/AIDS section

- Almost half of the respondents (nearly 50 percent) from all Arms did not know anything about STDs. The knowledge level was high (96%) among the respondents from Arm A than the two other Arms.
- The respondents presented themselves as unaware of STD symptoms since most of the symptoms received below 10 percent response. The awareness was slightly high among the Arm A respondents but not at a desirable level.
- The most preferred STD service provider was the untrained doctors. RMG health centers (nearly 10 percent) and IB model health centers (around 6 percent) are among the least recognized. The two sources got more acceptance among the Arm A respondents but not at a desired level (about 14 percent and 9 percent respectively).
- About 80 percent respondents knew about HIV/AIDS.
- 7 percent of the Female RMG workers aged 18-24 years have comprehensive knowledge of HIV/AIDS at Arm A. Only 3 percent or below respondents from Arm B and Arm C have comprehensive HIV/AIDS knowledge.
- Of female workers aged 18-49 years who could correctly identify ways of preventing the sexual transmission of HIV/AIDS were about 43 percent for Arm A, around 35 percent for Arm B, and nearly 32 percent for Arm C.
- Female workers aged 18-49 years who could correctly identify all three means of mother to child transmission were 63 percent among the Arm A respondents whereas the percentages for Arm B and Arm C were chronologically 58 percent and about 50 percent.
- About 95 percent of the respondents showcased some form of knowledge on HIV/AIDS. Respondents from all the study Arms exhibited medium level of knowledge whereas the scores by the Arm A respondents were slightly higher. Safe sexual activities (around 51 percent), examination of HIV in blood before transfusion (around 41 percent), and using disposable syringes and needles (nearly 40 percent) were the top three preventive measures against HIV/AIDS.

This section focuses on the sexually transmitted diseases (STDs) and HIV/AIDS related knowledge, awareness and practices among the RMG female workers working in the factories affiliated with the project. The respondents were asked about their knowledge and practices for both the STDs and the HIV/AIDS.

3.7.1. Knowledge and Prevalence about STDs

Almost half of the respondents (about 49 percent) did not know anything about STDs (ref. Table 29). Those who knew about STDs could only identify AIDS as the disease and recognized by nearly 50 percent of the study population. The diseases like Syphilis (around 5 percent) and Gonorrhea (around 6 percent) were the lesser known while Herpes and Chlamydia were the least appreciated ones (less than one percent each). The awareness level was high among the respondents from Arm A than the two other Arms.

About 69 percent of the respondents have no idea about the symptoms of the STDs. Genital ulcers (21 percent), lower abdominal pain (about 14 percent), vaginal discharge (around 11 percent), smelly discharge (around 10 percent), and pain during sexual intercourse (around 6 percent) are recognized by the respondents as the symptoms of STDs in a chronological order.

Table 32: Knowledge and Prevalence of STDs

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
What are STD's							
Syphilis	5.3	8.5	3.4	6.1	4.5	4.3	5.4
Gonorrhea	9.3	9.8	4.4	8.2	4.7	4.0	6.5
AIDS	56.9	59.7	44.3	54.7	47.8	39.0	49.5
Herpes	0.4	0.7	0.8	0.6	0.3	0.5	0.5
Chlamydia	0.0	0.2	0.3	0.1	0.0	0.2	0.1
Other (vomiting, uterine cancer/tumor/infection, HPV)	0.9	0.0	0.3	0.4	0.3	0.0	0.3
Don't know	**40.4**	**39.0**	**55.2**	**43.8**	**49.8**	**59.0**	**48.6**
Symptoms of STDs							
Vaginal discharge	14.2	14.0	5.7	11.9	11.2	9.0	11.1
Smelly discharge	14.0	12.0	5.5	10.9	9.6	8.7	10.1
Genital ulcers/sores	22.7	27.5	14.3	22.5	19.1	19.5	21.0
Lower abdominal pain	11.6	19.0	5.2	13.0	15.3	13.7	13.7
Pain during sexual intercourse	2.7	9.8	2.6	5.7	8.1	6.7	6.4
Other (Fever, Itch, feeling tired, loss of weight)	1.1	4.0	1.0	2.3	1.3	1.5	1.9
Don't know	**66.0**	**59.3**	**80.5**	**67.1**	**70.1**	**70.2**	**68.5**

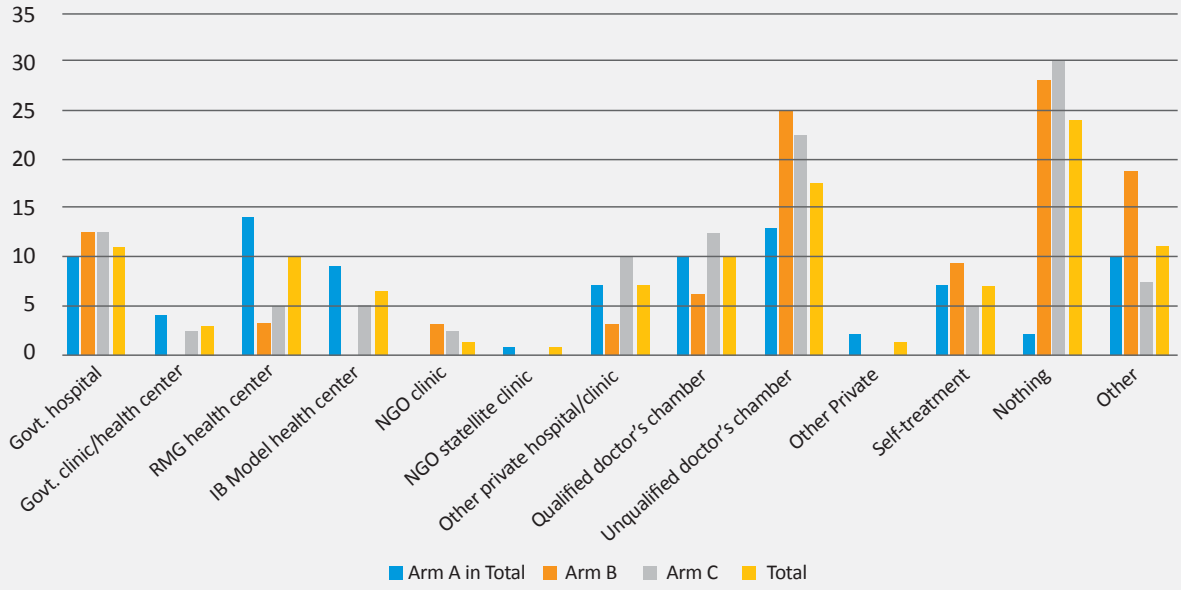
Only about 42 percent of the cumulative respondents reported having some forms of awareness on STDs. The respondents prioritized safe sexual activities as the top most measures to prevent the STDs (about 35 percent). "Maintain trusting relation between husband and wife" was another notable preventive measure by the respondents (around 15 percent). The respondents presented themselves as unaware of STD symptoms while as most of the symptoms received below 10 percent response. The awareness was slightly high among the Arm A respondents but not at a desirable level.

Table 33: Knowledge on awareness of STDs.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents	450	600	384	1434	596	600	2630
Awareness issues on STDs							
Safe sexual activities	40.9	46.3	30.0	40.2	33.4	25.8	35.4
Maintain trusting relation between husband and wife	18.7	17.3	6.5	14.9	16.8	15.5	15.4
Follow religious rules	6.7	3.3	1.0	3.8	1.3	2.8	3.0
Avoid polygamous dealings	10.7	8.3	6.3	8.5	5.4	4.2	6.8
Use sanitary napkin	10.2	10.5	5.0	8.9	8.4	6.2	8.2
Other (not using same syringe, rest, take doctor's advice, maintain cleanliness, do blood test)	1.1	1.5	0.3	1.1	0.5	0.7	0.8
Don't know	51.1	47.7	66.7	53.8	58.6	66.7	57.8
STD Symptoms							
Smelly Vaginal Discharge	7.3	4.7	2.3	4.9	3.9	4.5	4.6
Pain in Lower Stomach Area (not associated with period or any stomach upset)	5.6	2.0	2.6	3.3	3.4	2.3	3.1
Warts, sores or ulcers in genital area	1.3	0.7	1.0	1.0	1.5	1.5	1.2
Any of the above three symptoms	9.6	6.3	4.7	6.9	5.4	6.7	6.5

76 percent of the total respondents recognized some forms of the STD service-providers available to them (ref. Figure 8). The highest acknowledged source of STD care was the untrained doctors' chambers (around 17 percent). Again, RMG health centers (nearly 10 percent) and IB model referral hospital (around 6 percent) were among the least recognized ones when cumulative responses were considered. The two sources got more acceptance among the Arm A respondents (about 14 percent and 9 percent respectively).

Figure 9: Sources of STD care-seeking by the respondents.



3.7.2. Knowledge about HIV/AIDS

Overall, nearly 80 percent respondents responded that they had heard about HIV/AID. The consciousness level was higher among the IB model respondents (Arm A) than the non-IB model respondents (Arm B and C) (85 percent > 77 percent >72 percent). When the level of comprehensive knowledge among the younger respondents (18-24 years) was considered, Arm A topped again with medium level of score (5.7) whereas Arm B and C respondents very low score, (around 3) indicating their low level of comprehensive knowledge on HIV/AIDS. The percentage of women aged 18-49 years who could identify ways of HIV prevention and also who could identify ways of mother to child transmission of HIV/AIDS also presented a similar scenario as the descending order puts Arms A (43 percent; 63 percent) on top again followed by Arm B (35 percent; 58 percent) and Arm C (32 percent; 50 percent).

Table 34: Knowledge on HIV/AIDS

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Heard about AIDS							
Yes	84.0	83.5	85.4	84.2	76.7	72.3	79.8
No	16.0	16.5	14.6	15.8	23.3	27.7	20.2
Number of women aged 18-24 years (n)	**212**	**291**	**210**	**713**	**278**	**282**	**1273**
Female workers aged 18-24 years with comprehensive knowledge of HIV/AIDS	9.3	5.7	7.2	2.9	3.2	5.3	5.7

Table 34: Knowledge on HIV/AIDS

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of women aged 18-49 years (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Female workers aged 18-49 years who could correctly identify ways of preventing the sexual transmission of HIV/AIDS	35.1	45.5	47.4	42.7	35.5	31.8	38.6
Female workers aged 18-49 years who could correctly identify all three means of mother to child transmission	59.1	65.5	64.0	63.1	58.0	49.6	58.9

To check the respondents' knowledge about HIV/AIDS, they were provided nine statements and asked to respond to them. The statements were –

1. Chance of getting the AIDS virus can be reduced by having just one uninfected sex partner who has no other sex partners;
2. people can get AIDS virus through witch craft or other supernatural means;
3. chance of getting the AIDS virus are reduced by using a condom every time they have sex;
4. people can get the AIDS virus from mosquito;
5. people can get the AIDS virus by sharing food with a person who has the AIDS virus;
6. it is possible for a healthy-looking person to have the AIDS virus;
7. the virus that causes AIDS can be transmitted from a pregnant mother to her baby;
8. the virus that causes AIDS can be transmitted from a mother during delivery to her baby; and
9. the virus that causes AIDS can be transmitted from a mother by breastfeeding to her baby.

About 95 percent of the respondents showcased some form of knowledge on HIV/AIDS. About 50 percent respondents, out of 2630 in number, displayed medium level of knowledge as they correctly addressed 4 to 6 statements. Respondents from all the study Arms exhibited medium level of knowledge whereas the scores by the Arm A respondents were slightly higher (see the mean score in Table 35). Safe sexual activities (around 51 percent), examination of HIV in blood before transfusion (around 41 percent), and using disposable syringes and needles (nearly 40 percent) were the top three preventive measures against HIV/AIDS. The findings are the same for all the study arms.

Table 35: Knowledge and awareness of HIV/AIDS

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of Respondents	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Heard About AIDS	84.0	83.5	85.4	84.2	76.7	72.3	79.8
Composite knowledge score							
0	4.8	3.4	6.1	4.6	4.2	5.8	4.7
1 to 3	19.6	12.8	9.8	14.1	16.0	16.1	14.9
4 to 6	47.4	53.5	42.4	48.6	52.1	48.8	49.4
7 to 9	28.3	30.3	41.8	32.8	27.8	29.3	31.0
Mean Score	5.0	5.3	5.6	5.3	5.0	5.1	5.2
Awareness issues regarding HIV/AIDS							
Safe sexual activities	58.5	54.7	44.2	53.0	51.6	44.9	51.1
Maintain trust relation between husband and wife	25.1	23.0	11.9	20.6	24.5	23.7	22.1
Follow religious rules	6.4	4.0	1.8	4.1	2.8	5.8	4.2
Avoid polygamous dealings	18.0	11.6	13.1	14.0	10.1	9.0	12.1
Examination of HIV in blood before transfusion	32.8	45.5	33.5	38.3	48.8	35.9	40.1
Use disposable syringes and needle	28.0	46.5	42.1	39.5	46.8	33.9	39.9
Other (not feed child milk by an infected mother, maintain cleanliness, be careful, seek treatment)	0.5	2.0	2.4	1.7	0.9	0.5	1.2
Don't know	22.8	25.2	34.2	26.8	22.5	32.3	27.0

3.8. Gender Equality, Equity, and Women Empowerment

Box 9: Summary of Gender Equality, Equity and Women Empowerment section

- The awareness about the gender equality was very high among all the study Arms (above 90 percent in all the three cases) with only Arm C respondents recorded having lower consciousness level than the other two arms.
- 38 percent respondents of Arm could visit healthcare centers all by herself whereas about 18 percent respondents did not go to the healthcare centers. More or less same figures found for other two Arms.
- Less than 15 percent respondents of all three Arms could contribute to the family decision-making.
- Majority of the respondents could identify the misbehaviors of husband and did not think such attitudes are not justified.

The respondents, in a collective manner, labelled their work environment as gender-sensitive. More than 95 percent of the respondents expressed that the work environment is equally favorable for both male and female, they are allowed to take sick leave, and also they are willing to engage in current work. The awareness about the gender equality was very high among all the study Arms (as the scores were above 90 percent) with only Arm C respondents recorded having lower consciousness level than the other two arms.

Table 36: Work environment related information

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents (n)	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Thinks that working environment is equally favorable for both male and female workers	94.9	99.0	99.0	97.7	98.8	92.3	96.7
Allowed to take leave when sick	94.2	98.2	96.6	96.5	96.8	91.8	95.5
Willingly to engage in current work	98.9	99.0	99.5	99.1	98.3	99.3	99.0

Out of the 2630 respondents, about 38 percent respondents could visit health center alone (ref. Table 35), around 9 percent takes children with them, about 18 percent does not visit health centers, and 35 percent follow other means to receive health care services. About 62 percent respondents could not go to health center alone.

Table 37: The respondents' mobility to heath care services

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Goes to health center alone	43.1	36.8	37.2	38.9	37.2	38.0	38.3
Goes to health center with children	15.8	8.8	3.1	9.5	10.6	6.8	9.1
Doesn't go to health center	17.8	21.3	8.9	16.9	18.1	18.7	17.6
Other means	23.3	33.0	50.8	34.7	34.1	36.5	35.0

The respondents' decision-making capabilities were very limited (mean is approximately 15 percent) (ref. Table 36). About 20 percent of the respondents could decide how to spend the money they earn. Nearly 21 percent could decide to protect their own health. 94 percent could not decide the number of children they would conceive and give birth. Only around 13 percent could decide about buying something big in the family. 81 percent could not decide in favor of visiting their friends and relatives. Finally, only 9 percent of them could take decision about their children's health.

Table 38: The respondents' decision-making capabilities.

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
How to spend the money you earn	21.1	20.7	20.3	20.7	19.8	19.8	20.3
To protect own health	22.7	22.8	20.1	22.0	19.0	23.0	21.6
How many children to take	8.7	6.5	3.6	6.4	6.4	8.3	6.8
To buy something big in family	13.8	14.0	11.7	13.3	13.3	15.7	13.8
To visit friends or relatives home	19.8	19.2	22.4	20.2	15.6	22.3	19.7
About own child's health	10.2	9.5	8.6	9.5	8.2	11.3	9.6
Mean	**14.3**	**15**	**14.45**	**14.63**	**13.18**	**16**	**14.6**

Majority of the total respondents stated that the following cases do not justify the husbands' hurting towards the wife - a wife going somewhere without husband's consent (about 94 percent), neglecting the children (about 92 percent), arguing with the husband (about 93 percent), unwillingness to have sex (97 percent) or burning food (nearly 98 percent). The perceptions were higher among the IB model respondents indicating their high level of sensitiveness to VAW than the other Arms - B and C. On the other hand, the respondents expressed that the relationship between the husband and the wife should be based on mutual respect. According to the respondents, a wife arguing with her husband (around 88 percent) and a husband respecting his wife's decision of not to have sex (around 73 percent) can happen but a husband does not have the right to insult his wife (nearly 74 percent). One fourth of the respondents consented that, a person's interference on a husband's misbehavior with his wife (about 25 percent) should also prevail.

Table 39: Violence against women (VAW) related information

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents	**450**	**600**	**384**	**1434**	**596**	**600**	**2630**
Husband hurting wife is justifies when -							
The wife goes somewhere without telling her husband	9.1	3.0	3.9	5.2	7.2	6.3	5.9
A wife neglects the children	8.4	3.5	8.3	6.3	7.4	8.8	7.1
A wife argues with her husband	6.4	4.0	5.2	5.1	7.6	8.2	6.3
A wife is not willing to have sex with her husband	4.7	2.0	1.6	2.7	2.7	4.0	3.0
A wife burns food while cooking	2.4	1.2	0.5	1.4	1.5	1.2	1.4
Agreement to the statements regarding relationship issues between husband and wife							
A wife should express herself if she disagrees with her husband	84.2	92.5	87.2	88.5	89.2	87.0	88.3
In case of mistakes, a husband has the right to insult his wife	26.0	25.3	25.6	25.6	23.8	28.7	25.9
A person should interfere if a husband misbehaves with his wife	31.5	17.0	21.8	22.9	23.3	30.0	24.6
If a husband want to have sex but his wife do not, then the wife has right to say 'no' and it should be obeyed	69.5	78.3	75.8	74.9	74.0	68.5	73.2

3.9. Availability, Accessibility & Satisfaction with the availability and quality of SRHR services

Box 10: Summary of Availability, Accessibility, Affordability, and Satisfaction with the availability and quality of SRHR services section

- Overall 94 percent respondents reported having a health center in their respective factories. The percentage was higher than overall level in case of Arm A and Arm B factories (97 percent respectively) while about 85 percent Arm C respondents reported having health centers available.
- The RMG health centers were accessible for nearly 8 hours per day for all the workers and the situation was the same for all the three Arms.
- Six types of SRHR services available irrespective of Arms.
- The gender sensitiveness was again higher in health centers of Arm A factories (about 86 percent).
- Nearly 30 percent respondents, in all cases, recorded that required health services specially SRHR services were not available at the RMG health centers as per their needs.
- In around 95 percent cases, the service providers were available at the health centers during work hours.
- The level of satisfaction (highly) regarding the type and quality of services in the RMG health centers were about 23 percent in all cases. Overall Arm A factories provided the most satisfactory health services while the Arm-C health centers provided the less regards to type of services at same level (highly satisfied 27 vs 17).
- If we consider the level of highly satisfaction for the type of services , we could see that health centers from all the Arm A factories were successful in securing some higher satisfaction levels (very satisfied) than the satisfaction in the same level of other two Arm (highly satisfied 26 Vs 19).

Out of 2630 respondents, about 94 percent stated that they have health centers available in the factory (ref. Table 40). Only the Arm C factories have lower score in the aspect while all of the others' score were higher than all-inclusive/total score level. The health centers remained open for more than 10 hours per day and in around 82 percent cases, separate corners were available for female and male patients.

The gender sensitiveness was high among the health centers of the IB models' factories. The most recognized services available in the health centers were general health (around 91 percent), injury/accident (nearly 42 percent), ANC (51 percent), distribution of sanitary napkins (about 35 percent) etc. The service providers at the health centers were mostly available for work hours.

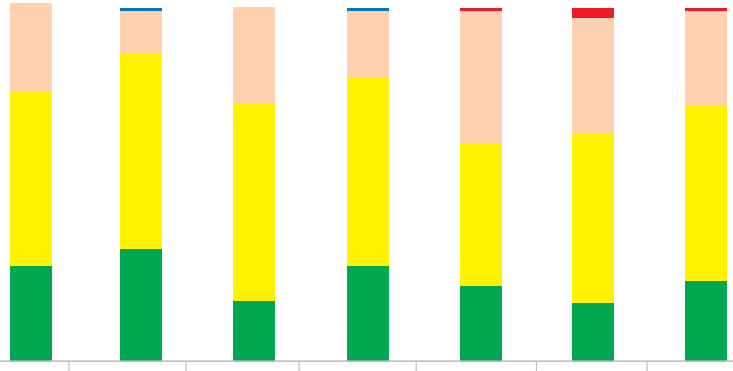
Table 40: Availability, Accessibility, Affordability, and Satisfaction with the availability and quality of SRHR services

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents (n)	450	600	384	1434	596	600	2630
Availability of health center in this factory to provide health services to the workers	96.2	96.8	98.2	97.0	97.0	84.7	94.2

	Arm A			Arm A Total	Arm B	Arm C	Total
	Power Plus	Health Insurance Plus	Menstrual Hygiene Management	All IB models	Training only	Control	
Number of respondents (n)	**433**	**581**	**377**	**1391**	**578**	**508**	**2477**
Average number of hours in a day when the health center is open	**8.1**	**8.1**	**8.0**	**8**	**8**	**8**	**8**
Availability of Separate corner for female-male	**87.5**	**81.6**	**89.1**	**85.5**	**75.3**	**82.3**	**82.4**
Type of services available in this clinic							
Family Planning counselling	33.3	28.2	12.5	25.5	20.8	18.3	22.9
Distribution of sanitary napkin	37.2	57.0	26.5	42.6	17.8	32.1	34.6
ANC	50.6	51.1	47.5	50.0	53.6	51.0	51.0
PNC	10.6	12.4	7.7	10.6	8.5	6.5	9.3
MR counselling	3.9	0.9	0.8	1.8	0.5	0.8	1.3
TT counselling	7.2	6.0	6.6	6.5	5.5	4.7	5.9
General Health	82.5	90.2	95.5	89.2	94.8	92.5	91.2
Injury/Accident	31.4	38.6	66.1	43.8	36.9	41.7	41.7
Services for Sexual harassment (VAW)	0.7	2.1	2.9	1.9	0.7	0.4	1.3
Other (X- ray, don't know)	0.0	0.5	0.5	0.4	0.9	1.2	0.7
Availability of services as per sexual and reproduction health needs	**73.7**	**80.4**	**62.9**	**73.5**	**73.7**	**70.7**	**73.0**
Service providers available at the health center during work hours							
Yes, sometimes	5.5	3.4	2.4	3.8	4.8	3.3	4.0
Yes, at all times	94.5	96.6	97.6	96.2	95.2	96.3	96.0
No, never	0.0	0.0	0.0	0.0	0.0	0.4	0.1

If the overall level of satisfaction for the type of services provided by the RMG health centers were compared, we could see that health centers from all the Arm A factories were successful in securing higher satisfaction levels (very satisfied) than the satisfaction in the same level of other two Arm (ref. Figure 10). Health centers from Arm C factories were the lowest satisfactory ones (nearly 17 percent very satisfied) whereas health centers from Health insurance model factories depicted highest level of satisfaction (very satisfied around 32 percent) when compared to all other categories. The level of satisfaction (highly) regarding the type of services in the RMG health centers were about 23 percent in all cases.

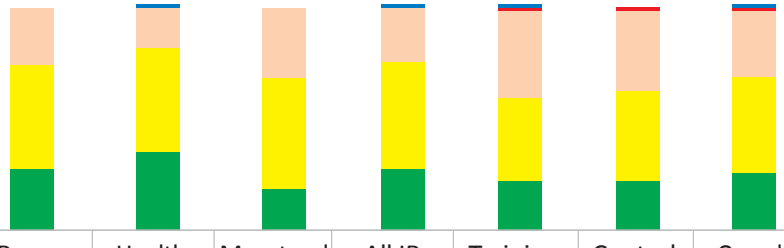
Figure 10: Overall satisfaction with the types of services



	Power Plus	Health Insurance Plus	Menstrual Hygiene Manage-ment	All IB Models (ArmA)	Training Only (ArmB)	Control (ArmC)	Overall
Very dissatisfied	0.0	0.2	0.0	0.1	0.0	0.0	0.0
Dissatisfied	0.0	0.0	0.0	0.0	0.7	2.2	0.6
Moderate	22.2	12.2	27.1	19.3	37.4	32.1	26.2
Satisfied	50.8	55.8	54.9	54.0	41.2	49.0	50.0
Very stisfied	27.0	31.8	18.0	26.6	20.8	16.7	23.2

If the overall level of satisfaction for the quality of services provided by the RMG health centers were compared, we could see that health centers from total Arm A factories were successful in securing higher satisfaction levels (very satisfied) than the other two Arm (ref. Figure 11). Health centers from Arm C factories were the lowest satisfactory ones (nearly 19 percent very satisfied) whereas health centers from Health insurance model factories depicted highest level of satisfaction (Very satisfied around 34 percent) when compared to all seven categories. The level of satisfaction (highly) regarding the quality of services in the RMG health centers were about 23 percent in all cases.

Figure 11: Overall satisfaction with the quality of services



	Power Plus	Health Insurance Plus	Menstrual Hygiene Manage-ment	All IB Models (ArmA)	Training Only (ArmB)	Control (ArmC)	Overall
Very dissatisfied	0.0	0.2	0.0	0.1	0.2	0.0	0.1
Dissatisfied	0.0	0.0	0.0	0.0	1.2	2.4	0.8
Moderate	24.9	18.6	32.4	24.3	40.3	37.4	30.7
Satisfied	51.0	47.0	51.5	49.5	38.2	41.5	45.2
Very stisfied	24.0	34.3	16.2	26.2	20.1	18.7	23.2

3.10. Health Insurance Scheme

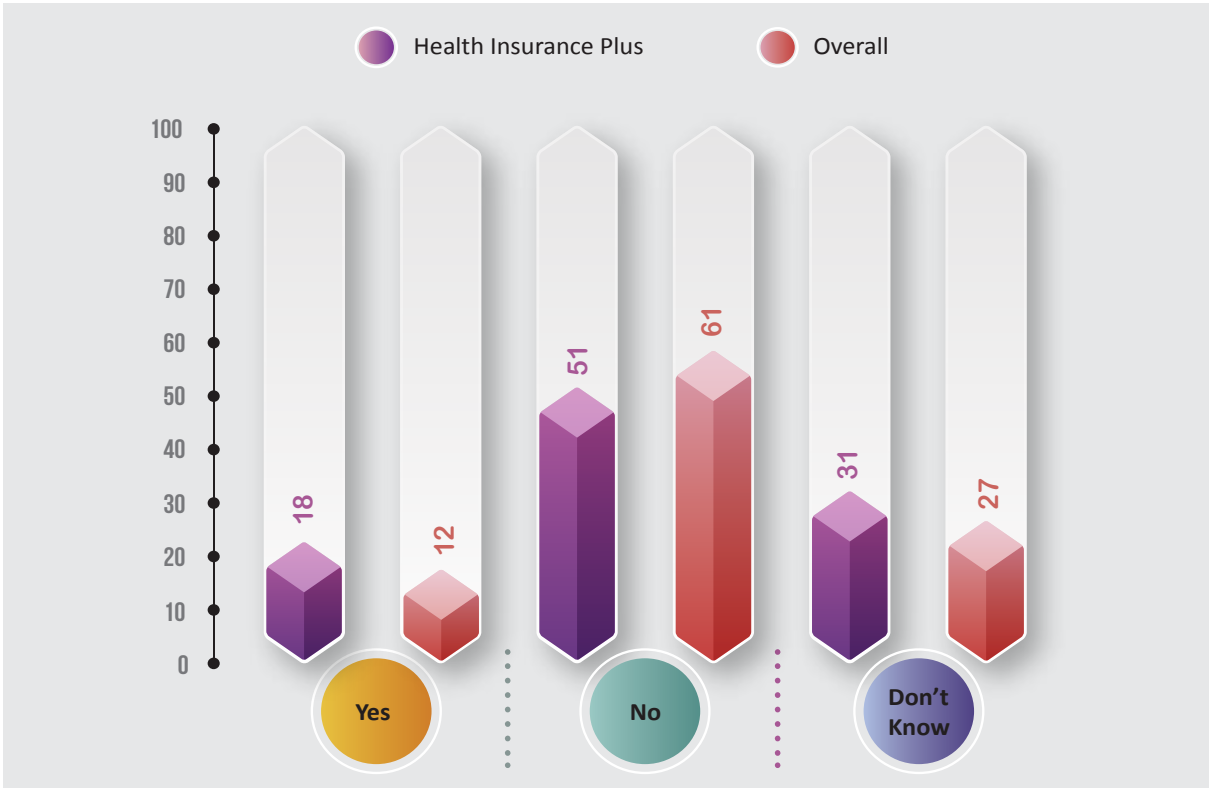
Box 11: Summary of Health Insurance Schemes

- Access to any health insurance scheme was higher in the Insurance Plus IB model factories (Arm A) compared to the overall users but much lower than expected level (only 18 percent and 12 percent respectively).
- 82 percent respondents from IB model partner factories were not aware of the health insurance schemes.
- Less than one percent of the total respondents have health insurance policies while 86 percent of the total respondents, in both Arm A and overall cases, showed lack of willingness for health insurance.
- According to the interested group of 242 respondents, service coverage (about 67 percent) and the product coverage (about 38 percent) were the two most important features of health insurance. These figures were the highest at Health Insurance model factories.

Only the respondents from Health Insurance IB model partner and all non-partner and control factories were asked about the health insurance scheme related questions. They were inquired about the access to health insurance scheme, providers of the service, the benefits of the scheme, payers of the premium, their willingness to take advantage of the scheme, and the reasons behind that willingness.

When the responses from the Health Insurance IB model partner factories and the overall responses were compared, it is identified that the access to health insurance was higher than the overall scenario (18 percent > 12 percent). But the percent of respondents with no knowledge about the health insurance was also higher in the Health Insurance IB model partner garments (31 percent > 27 percent).

Figure 12: Comparison of the responses between Health Insurance Plus and the Overall scenario



Only a few of the respondents, below one percent of the total (only 11 out of 1721), have insurance policies. Among the respondents having insurance policy, Pragati Insurance Company was the most popular one (2 out of 11 service receivers) while five of them reported not knowing the name of the company they were receiving service from. Most of the insurance holders (9 out of 11) revealed that the payments for the insurance was paid by themselves or any of their family members. About 86 percent of the accumulative respondents (only 242 out of 1710) conveyed their lack of willingness for health insurance. Those who were willing to use the service identified the service coverage (about 67 percent) and the product coverage (about 38 percent) as the main reason behind their eagerness.

Table 41: Health insurance scheme based information

	Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Training only	Control	
Number of respondents (n)	600	521	600	1721
Have health insurance scheme in your garments (%)				
Yes	18	13	6	12
No	51	60	72	61
Don't know	31	27	22	27
Have own health insurance policy (%)	1.0	1.0	0.0	0.6
Number of respondents (n)	6	5	0	11
Name of the health insurance company (n)				
Pragati insurance	2	0		2
Alfa life insurance	1	0		1
National Insurance	0	1		1
Grameen Bima	1	0		1
Islamic Insurance	0	1		1
Don't know	2	3		5
Benefits of Health Insurance Policy				
Health Insurance card	2	0		2
Yearly premium	2	3		5
Monthly Premium	1	0		1
No need for spending self-money/income for premium	2	1		3
Service coverage as per need	1	1		2
Product coverage as per need	2	0		2
No benefit	0	1		1
Payers for the insurance				
Self/ family member	4	5		9
NGO	2	0		2

	Arm A Total	Arm B	Arm C	Total
	Health Insurance Plus	Training only	Control	
Number of respondents (n)	594	516	600	1710
Willingness for health insurance (%)	14.8	12.6	14.8	14.2
Number of respondents (n)	88	65	89	242
Reason behind willingness for health insurance (%)				
Health Insurance card	35.2	24.6	34.8	32.2
Yearly premium	12.5	16.9	12.4	13.6
Monthly Premium	29.6	47.7	21.4	31.4
No need for spending self-money/income for premium	3.4	16.9	6.7	8.3
Service coverage as per need	73.9	50.8	76.4	68.6
Product coverage as per need	42.1	26.2	41.6	37.6
Outdoor service from hospital	10.2	3.1	10.1	8.3
Indoor service from hospital	11.4	1.5	5.6	6.6
Normal delivery	10.2	6.2	5.6	7.4
Caesarean section	5.7	6.2	2.3	4.6
Can get money once a time	1.1	1.5	0.0	0.8
Don't know	0.0	1.5	1.1	0.8

QUALITATIVE FINDINGS

4. Qualitative Findings

This section included analysis of the qualitative data collected from KIIs and FGDs with male RMG workers, factory management, and factory health personnel about their understanding on SRHR and violence against women (VAW) related policies and practices.

4.1. Understanding of SRHR issues among male RMG Workers

A total of 10 FGDs were conducted among the male RMG workers from three types of factories: five partner factories (Arm A), four non-partner factories (Arm B), and three control factories (Arm C). During the FGDs, the male RMG workers were asked about their understanding on the main issues of SRHR, a husband's duties towards his wife regarding the SRHR issues, SRHR-related awareness, centers for SRHR services and satisfaction towards them, health centers at their factories, quality, and gender sensitiveness of them, violence against women in factories and area, and their recommendations on SRHR issues. There was a little difference among the views of the male RMG workers from partner, non-partner, and control factories. The responses about SRHR issues by male RMG workers were similar across the three Arms of the study. Some common themes were evident from the FGDs with male workers from partner and non-partner factories:

1. Limited knowledge on STDs and male contraception:

Male respondents from both partner and non-partner groups responded that they were not well aware about the reasons and symptoms of STDs. There were several reasons for that. First, STDs were still considered as a matter of taboo in the society. These issues were not properly discussed and communicated in the society and public places. Some of the respondents showed discomfort discussing these sensitive topics during FGDs as well. One respondent commented:

> "We are feeling awkward since nobody discussed these issues with us before."

The social taboo of not talking about diseases related to male reproductive organs hindered them from having proper treatment as well. A male worker shared a story of his friend:

> "He had infection in his male organ. It was swollen and he was suffering from severe pain. Yet he did not go to the doctor because of shyness."

The importance of public awareness on STDs were prominent from the evidence that many of the respondents were able to identify reasons, symptoms and names of Syphilis, Gonorrhea, and AIDS correctly. Information about these diseases have been disseminated widely in mass media and medical centers. One male respondent from a partner factory shared the sources of knowledge:

> "I know about HIV AIDS from the television advertisement. The hospitals also display the precautions in large fonts on the wall."

They also mentioned about discussions with friends, roadside leaflets and advertisements of SRHR medicines etc. as means for learning about SRHR-related issues. On the other hand, respondents across Arms showed misconception regarding infertility, genital and urine infections and premature ejaculations. Since such health issues have not been discussed very often, prejudices and wrong information dominated their perception. For instance, a worker explained the reason for STD as:

> "If you have sex before you get married, you will develop erectile dysfunction."

The respondents mentioned that they have been using both synthetic and herbal medicines. While the topic-related discourse, one respondent quoted:

> "These diseases are taboo in our society. Many choose to keep them secret. When someone gets infected, they keep them secret and get medications secretly. The medicines are also available. But as they try to keep the issues secret, it sometimes causes the disease to intensify and also often gets maltreated. "

The male respondents thought that the main purpose of contraceptives was reduce the number of children. A respondent explained:

> "We are poor and cannot afford the expense of a large family. So, my wife takes birth control pills "

The male workers could identify only two methods of FP products available for them: condoms as short term means and injectable as long terms means. While giving his opinion, one of the respondents quoted:

> "FP methods are not for men; they are for women. Men can use condoms if they feel the need. Using condoms causes less satisfaction. So, it is better for women to use FP methods. It is both satisfactory and safe if women use them. It causes less problems."

Respondents identified one reason for not having enough knowledge related SRHR-related issues. Majority of them were young and unmarried and they thought that only married workers should know about these issues.

2. SRHR-related responsibilities towards wife

Married male respondents across all the Arms unanimously recognized that it is a husband's responsibility to care of his wife and take her to doctor when needed. They also recognized that it is the husband's responsibility to buy her medicines, take her to doctor, and even take her to hospitals when she becomes ill or pregnant. Few of them correlated a wife's sound health with peace within the family:

> "When the male household head falls ill, the family faces problems. But when the female household head falls ill, everything will collapse. All works within the family gets hampered. Moreover, they can't go to work if they fall ill. "

However, one respondent emphasized on a barrier of communication between husband and wife about STDs:

> "Sometimes when the women suffer from any STDs, they usually don't reveal the problems or the symptoms to their husbands. They do so mainly due to two reasons: fear of doubt and distrust by their husbands and their shyness. As a result, they keep their problems secrets even to their husbands. They also fear that their husbands wouldn't help them on those issues and get them treated. As such, these problems often go undetected as well as untreated or maltreated. "

The respondents commented that the women in their families mostly use contraceptives. There were two types of responses regarding the decision-making in both Arms. One group commented that they believe contraceptives are for women only and they do not like using condoms. So, their wives use contraceptives. The other group informed that the decision of using

contraceptive was usually decided through a discussion between the husband and the wife. Women usually used contraceptive pills, ligation, and injectables to avoid unwanted pregnancies. MR or safe MR for women was unknown to most of the respondents. While talking about the purchasing power of the workers and availability of the products, one of the respondents quoted:

> "Using condoms by men on a daily basis is more problematic than usage of pills by women. Taking pills doesn't require going to medicine shops daily. Injectables are more comfortable as their effects last up to three months. With the money needed to buy a packet of condoms, one can even buy contraceptive pills for two months. On the other hand, contraceptive pills are available. They can be easily purchased or collected from health workers. So FPis easier, affordable and cost-effective for women."

Interestingly, one respondent from non-partner factory expressed his dominant perspective about contraceptives:

> "Men do not need contraceptives. These are for women. If a man wishes, he can use condom or not. Women should either take the pill or get the needle (injectable). That is comfortable and hassle-free."

3. 3. Awareness about STDs and Available Healthcare Facilities

During the discussion on HIV/AIDS, respondents from both Arms agreed that they know about AIDS. Most of them have identified blood transfusion, improper use of syringe and unsafe sexual interactions as the main causes behind AIDS. But they knew very little about the symptoms and treatment for HIV infection.

The respondents from partner factories said that the factories have health centers but the centers did not offer SRHR related treatments and services. When asked about their satisfaction regarding those, they have expressed mixed feelings:

> "The quality of service is alright. But the space is limited and the center does not have all the necessary facilities. For example, the center does not have many medical equipment and medicines. They usually provide us with prescription and we buy it from outside pharmacies. But we cannot afford all the medicines always. So, it would be really helpful if the medical center can offer us some more medicines."

The medical centers offered treatments for diseases like fever, cough etc. Basic treatment for accidents is also available. Mostly, an MBBS doctor was available on two days for a limited period of time. Nurses were available and helpful. The treatment for basic diseases such as flu and coughs have been rendered satisfactory by the most of the respondents. In non-partner factories, the respondents mentioned that they did not know much about the services offered for pregnant workers in the factory health centers. On the other hand, one respondent from a partner factory explained how the quality and extended time can be supportive for the workers:

> "Besides basic treatment, no other treatment is offered here. MBBS doctors are available for two days a week, that for only two hours per day! The workers mostly cannot reach them when needed. It would be very helpful If they are available for longer periods such as at least 32 hours per week. If the workers can receive service from the health center, they would be able to save time and money for both the workers and the company. Nurses are usually helpful but they are incapable of providing quality treatment."

The acts of sexual harassment or violence against women (VAW) were not common to the respondents. Most of the male workers stated that they have not heard of any violence either in their factories or in the locality. Harassment or violence in factories was not familiar to them. Few have stated that the cause behind this was the tendency of the women to keep those incidents secret. One respondent quoted:

> "The places we live in are mostly industrial areas. The people come from different areas. The people are not familiar to one another. In this situation, if any such incident happens, people do not raise voices; rather they lay low and keep those incidents secret. As such, the incidents always get covered up. I have been here at this locality and also at this factory for eight long years. I have never heard of any such Incident here."

Several respondents from partner factories mentioned that there is an emergency number behind the identification card. Employees were instructed to call in the number in case of any crisis. Another respondent from the same Arm commented that there is little or no chance of sexual harassments inside the factory. The factories are all export-oriented and are very strict about workplace safety and security. However, women are vulnerable outside the factory, in public places and when they commute at night.

4. Recommendations from Respondents about SRHR Management

The respondents have provided some suggestive endeavors that could be helpful for them regarding SRHR issues. The suggestions by the respondents were as follows:

i. Separate and improved health centers should be ensured at factories;
ii. Seminars, meetings and trainings should be arranged to increase awareness on SRHR, FP, STDs, and gender equality at factory level ;
iii. Distribution of condoms and contraceptive pills among the workers;
iv. Improved health facilities with antenatal and post-natal care for pregnant women should be ensured
v. Health Insurance should be incorporated for the workers'.

4.2. SRHR Services and Facilities: Views from Health professionals

10 interviews were conducted with the health professionals such as the doctors and the nurses of the health centers from 10 different factories. They were asked about the SRHR services and facilities at their health centers, the services they provide and the workers' response to those, the workers' attitude towards basic SRHR issues and services, and finally, about the health insurance scheme prevailing at their factories.

1. Existing general facilities

The health professionals from partner-factories mentioned that the health centers offered free services to all of the factory workers including some emergency service, fast aid, flu, acidity, and more than 100 medical tests. A medical professional from partner-factory added:

> "Majority of our service recipients are women. We offer them free napkins, contraceptives and other medicines when needed."

Another respondent quoted:

> "When we cannot provide the necessary treatment, we refer them to the nearest hospital."

All the workers are recruited after a thorough medical checkup by the health centers. One healthcare professional discussed,

> "Each of the workers receive basic checkups and their blood groups are identified. The blood group is mentioned behind their identification cards. All the workers need to go through an annual health checkup. This annual checkup is even mandatory for the factory management team"

One of the health centers have high quality services about which the doctor quoted:

> "What we have here is not just a health center; rather it is a mini hospital. It has all the facilities of the mini hospital including 24 hour emergency service, primary treatment, free medication system, free napkin distribution, free tests for diagnosis, nebulizer and ECG facilities, pathology section, ultra-sonogram, ambulance facilities etc. Medicines we have available here is not available in most of the shops. Overall, no workers of our company need to go elsewhere unless they need to get operated."

2. Existing SRH facilities

The female workers received free sanitary napkins each month. The health centers also ran awareness raising campaigns on SRH issues and services. One international donor agency initiated a project titled HER (Health Enables Returns) Project[4]. Under this project, female workers received SRH services. Additionally, the General Manager of the factory started HIS (Health Improvement Society)[5] to ensure the SRH services for male factory workers. Under HER and HIS project, 79 and 130 staffs work respectively in order to ensure the service provision. Under this project, workers receive advice, counselling, awareness seminars, and free napkins. Men turnouts were very low so far under this initiative.

Female workers received several SRH support including training on menstrual hygiene management, nutritious food habit during pregnancy, free food during the period of pregnancy, maternal leave with payments etc. One factory offered child care services as well. Different factories also offered different life and health insurance schemes. One life insurance was mandatory requirement by the BGMEA and the workers did not have to pay any share for it. BRAC offered free insurance for the pregnant women. A health professional commented:

> "If the factory owners offer free health insurance, many would be interested. If the workers have to pay the insurance premium, I don't think there will be anyone willing to pay."

The health professionals commented that they tried their best to provide any services the workers need. In case of any insufficiency, they informed the management and the management responded accordingly. However, there have been a communication barrier between the workers and the service providers. The workers felt shy and awkward to share freely about SRH issues. If the workers could not communicate properly about their needs, it becomes difficult for the healthcare professionals to offer appropriate service. Even after providing training, many women workers still used dirty clothes during their period. The health professionals emphasized that the workers needed to be engaged in continuous awareness raising sessions.

The health professionals picked out condoms, ECPs and injectables as the most famous FP methods among the workers. They established that the workers used FP methods at large. As means for FP, condoms were popular among the male workers. They were reluctant to use any other method. The female workers preferred to use pills and injectables. One of the health professionals quoted:

> "The male workers use FP when they are counseled. But they forget to use them after a few days. The women are mostly entrusted with the responsibility of family planning. They prefer ECPs and injectables because they are available, dependable and easy to use. They do not use other methods because of their ignorance and fear of using them."

The health professionals stated that the workers were aware of the HIV/AIDS and the ways people might get affected by the disease. But the workers were not aware of the symptoms or effects of the

[4]HER project is a project introduced and run by a non-profit organisation titled Business for Social Responsibility (BSR). The main objective of the HER project is to stand with women as they take greater control of their lives, ensuring that they can make and act on choices they value. The HER project work on three dimensions: health, finance and respect.

[5]HIS or Health Improvement Societies work on the improvement of health and aims to ensure health services to all within a community or an organisation.

disease. On the other hand, the workers were not aware of the other STDs. The awareness level for other STDs like gonorrhea, syphilis etc. was very low. The factory health professionals were trying to make the workers aware of other STDs through different awareness raising activities.

According to the health professionals, safe menstrual management was an area of which the RMG workers were the most conscious. The health professionals perceived that the workers were well aware of safe menstrual management. Most of the female workers used sanitary pads. Sanitary napkins or pads were supplied by the factories. To make the workers more aware, the factory professionals held seminars on a monthly basis. One health professional stated:

> "The factories provide sanitary napkins to the workers. The factory provided the workers with different sanitary napkins to check their effectiveness. Because the effectiveness and efficiency of the sanitary pads depend highly on how they are used. After testing pads of different companies, Freedom napkin by ACI has been selected as it was preferred by the most. Separate bins are provided at the toilets for the disposal of pads. Also the toilets are kept clean so that the workers can use them for changing pads."

The health professionals have stated their limitations in providing services for pregnant workers. They have stated that there is little scope for them to help the pregnant women as they take leaves. In some factories, they were only provided with instructions while others provide some additional facilities in the form of iron tablets, TT (Tetanus and Tuberculosis) vaccination, checkups etc. But the maternity leave stated by the most of the health professionals was very low. The maternity leave provided by factories start from 60 days to 120 days. The maternity leave was stated fully paid leave by the health professionals. Most of the health professionals, except the professionals from two factories, have agreed to the fact that the factories did not have any health insurance policies. The health professionals from the two factories have mentioned the existence of health insurance in their factories which were provided by Alfa Life Insurance Company and Peoples' Life Insurance Company. Life insurances were familiar for the RMG sector. But health insurance was a relatively unfamiliar one. They revealed that the workers might be interested in the health insurance only if the premium was paid by the factories or a third party. The workers would not be interested if they have to pay for the insurances.

The management personnel of the factories were asked three knowledge-based questions. When asked about their knowledge about the SRHR issues the workers suffer from, the management personnel conveyed having very low information about them as those issues are managed and monitored by the health center and its officials. In response to the queries regarding their perception on the impact of SRHR issues, they revealed that the issues have severe impacts as they affect a person both physically and mentally. One of them quoted:

> "The problems effect a person and his family in many ways. SRHR problems have significant mental and physical impacts. On the other hand, the economic loss caused by the SRJR issues are the worst for the poor."

They exhibited having very low information about the initiatives needed by the male workers to get SRHR facilities. They stated that no worker has ever talked and/or discussed about this fact in the factories and so they have very little understanding about that.

The health centers at the partner factories also pointed out a few challenges. The factories mostly preferred female nurses or paramedics while the doctors were mostly male. Only a few of the health centers follow the 24-hour service delivery system. The health centers mostly delivered services on a working hour basis. The number of nurses/paramedics and also the doctors was very limited, one to six in number.

4.3. Comparison of knowledge and practice on SRH laws, policies, and issues between Partner and non-partner factories: Findings from interviews with Management Personnel

Interviews were conducted with 23 management personnel of different RMG factories (10 from partner factories and 13 from non-partner factories). They were inquired about their attitude and practices of SRHR policies. They were also asked about their knowledge, attitude and practice of different SRHR issues.

The management personnel were asked about their attitude and practices on four types of policies: SRHR related National laws and policies, SRHR in labor law (2006 & 2012) and rules (2015), SRHR in buyers' code of conduct, and National Occupational Health and safety policy (2013). Irrespective of the Arm, the management personnel lacked knowledge about SRHR related national laws and policies and also considered their practices not applicable in their factories. In case of other laws/policies, the management personnel have medium level of awareness about them.

The knowledge about SRH related policies and laws were limited across Arms. Six of the ten interviewees from partner factories mentioned that they did not have any clear idea about SRHR service related national law and policies. Two interviewees said that they have some kind of idea but did not think it as necessary. Only two interviewees commented that they have some understanding of the laws and policies and they felt that these were important issues. Two respondents mentioned that relevant clauses have been included in the factory policy and were followed by the management and employees. One respondent mentioned that the clauses existed in the factory policy but were not being followed properly. Five interviewees from partner factory pointed that they knew and valued the importance of the SRHR rules within labor law 2006/2012. Four interviewees have some idea about the law and conveyed that they were somewhat important. Only one respondent did not have any idea about the SRH issues within the labor law.

The interviewees from partner factories agreed to the fact that SRHR facilities should also be made available to the workers as they were also important like health and security issues. They agreed that SRHR facilities could help the factories and would provide boosts to the production rate of the workers. But they have also mentioned that the factories have taken little initiatives except distribution of sanitary napkins among workers and some trainings and/or seminars. One of the respondents quoted:

> "The workers are ignorant. They do not know what is good for them. As such, it is our responsibility to make them conscious of their rights…workers are the main factors of production. If they are affected, the production will also get affected in a negative manner. For example, the female workers can't contribute her 100% during her menstruation…the factory could do little in the development of SRHR policies. But the management tries to help them by all possible means when it is needed."

In case of the management personnel from non-partner factories, seven out of thirteen key interviewees said that they did not have any clear idea about SRHR service related national law and policies. One interviewee said that he have some kind of idea but did not consider them necessary. Five interviewees commented that they have some understanding of the laws and policies and they felt their importance. Five respondents mentioned that relevant clauses have been included in the factory policy and were followed by the management and employees. One respondent mentioned that although the clauses were added in the factory policy, those were not maintained strictly. Two interviewees knew about the SRH issues within the labor law and they perceived the issues being of somewhat important. Ten of the thirteen interviewees have knowledge about the issues within the labor law and considered the issues as high priority ones. Similarly, three interviewees have some knowledge about SRH issues in Buyer's code of conduct and they expressed that the issues were somewhat important. Seven interviewees displayed awareness about the Buyer's code of conduct and considered it as a highly important issue. Two factory respondents comprehended the SRH issues in the Buyer's code of conduct being some kind of important, but not much.

CONCLUSION AND RECOMMENDATION

5. Conclusion and Recommendation

On the basis of the study findings, the following conclusions can be drawn:

- • The short-term FP methods are popular among the RMG workers while the long-term and male-user FP methods are less popular. The awareness level on ECP is low. Most of the workers also lack knowledge about MR.
- The level of consciousness on menstrual hygiene is high. Majority of the female RMG workers used sanitary napkins. But improvements in the practice area are needed.
- The workers' level of awareness on long term and male-user FP methods, ECP, contraception usage, maternity care, MHM practice, STDs and HIV/AIDS need advancements while areas like MR and Health Insurance demand serious improvements.
- Although the level of satisfaction among the workers is very high regarding the type and quality of services by RMG health centers, the health centers lack SRHR-oriented services. The workers' appreciation and recognition of the health centers is not at a desired level, let alone satisfactory level.
- IB model referral centers are not enough popular among the workers and so the recognition was also low.
- The SRHR scores are good for the partner factories, but not at a desired level. There is still room for significant improvement in areas like long term and male-user FP methods, ECP, contraception usage, maternity care, MHM practice, STDs, HIV/AIDS, MR, Health Insurance etc.
- The VAW incidents are not frequent but there is support system available to the workers if any such incident occurs.
- The knowledge on HIV/AIDS is the highest of all STDs. But the symptoms are not popular at all. On the other hand, the level of consciousness on the other STDs like Syphilis, Gonorrhea etc. are very low.
- The gender sensitivity is high in the RMG factories. Gender equality prevails. But individual mobilization and decision-making capabilities by the female RMG workers need serious progress.
- Only a handful of the RMG workers have health insurances and a few are interested. This indicates the need for consciousness raising among the workers on the importance health insurance schemes.
- Sensitiveness towards SRH laws and policies are low among the factory management personnel. Most of them do not have clear idea while some even do not see the importance of executing the existing SRH laws and policies.

Based on the findings of the study, some suggested endeavors, at IB model level, are included below that might positively impact the project's implementation and success:

1. Power Plus Model

i. **Sensitization about VAW:** Perception, awareness and practices regarding sexual harassment and VAW needs serious attention and more focused actions should be taken to improve the situation in the aspects related to sexual harassment and VAW.

2. Menstrual Hygiene Management (MHM) Model & health insurance model

i. **Awareness Campaigns on SRHR Issues:** The awareness on SRHR and SRH services available to the workers is not properly known to most of them. Initiatives should be taken to improve the level of awareness. Mass media campaigns can be run. On the other hand, the existing campaigns like trainings, meetings, counseling etc. need to be made more effective.

ii. **Introduce Family Planning services:** Knowledge and awareness on the FP methods also need serious attention. Both

the awareness of male contraceptives and the women's decision-making capacity are found to be alarmingly low. It is highly recommended that, any program targeted towards FP must incorporate male household members in the process. Male household members should be encouraged to use the FP methods while the female should be well-informed and motivated so that they use other long-term FP methods.

3. Only for Menstrual Hygiene Management (MHM) Model

Safe Disposal Mechanism for Menstruation Items at the factories: Although the awareness and practices of menstrual hygiene are in good shape, facilities like the place for drying sanitary clothes hygienically (if reusable) and safe disposal of sanitary materials by an authorized waste disposal body need to be incorporated.

4. Health Insurance Model

i. **Information Campaign on Health Insurances:** A key reason for lack of enthusiasm for health insurance is the lack of knowledge about the benefits and facilities offered by the insurance schemes. A three-step strategy need to be designed in order to increase the willingness among the RMG workers. A short health survey should identify the following – the dire health needs of the workers and their family members, the medical cost the workers paid in last 1 year and the maximum amount the workers would be willing to bear for the insurance. In next stage, the insurance provider and the factory owners should come to an agreement about cost sharing among parties. Also, the scheme needs to respond to the health needs and offer coverage to the issues the workers are suffering. Finally, the program needs to develop an easily understandable yet informative campaigns and communication materials about the health insurance schemes for the RMG workers.

ii. **Enhanced Awareness about ECP and MR:** The awareness regarding ECPs and MR is also very low. Initiatives should be taken to ensure awareness on those aspects whereas the services regarding ECP and MR should also be made available at the RMG health centers as well as IB model referral centers.

iii. **Information on Pregnancy and Maternal Services:** The respondents should be made aware of the importance of ANC and PNC for the mother, delivery care, birth preparedness, importance of TT and checkups etc.

iv. **Information Dissemination on STDS and Available Support Systems:** The awareness regarding STDs and HIV/AIDS needs to be improved in a manner that the workers can identify the diseases properly when the symptoms appear and report them to doctors.

5. Inclusive Healthcare in Factories and Targeted Meetings with Factory Management:

The RMG health centers and IB model referral centers requires modernization. Implementation of SRHR laws and policies as well as ensuring SRH services should be made certain and extensive. Meetings need to be held with the factory management to make them aware about their responsibilities of providing SRH services inside the factory.

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