Kingdom of the Netherlands

SNV

Report

Findings of the Value Chain Analysis

WORKING WITH women

WORKING WITH women

SNV

SNV Netherlands Development Organization is a not-for-profit capacity building international development organisation, founded in the Netherlands in 1965. With support from the Dutch Embassy, SNV Bangladesh is implementing a project on "Promoting Sexual Reproductive Health Rights (SRHR) through Inclusive Business Practices within Ready Made Garment (RMG) Industry in Bangladesh". To achieve this, SNV's project will work with 10 factories and selected SRHR service providers to pilot and test activities that deliver win-win solutions for businesses and workers.

Due to a lack of knowledge, long working hours, and financial constraints, a significant portion of the workers are unable to source the goods and services required to meet their everyday needs. Most factories do not understand the value of investing in their female workforce's health needs. Nor are they aware of how to address the non-core business needs of workers. SNV will build demand and supply mechanisms that support female workers access to convenient, gender-friendly, affordable and quality SRHR products and services within or near factoriesthrough the project intervention. The programme goal is toexplore if there are existing interventions and/or new activities that prove that SRHR as part of an Inclusive Business approach is commercially viable in the RMG sector in Bangladeshworkers and the RMG industry as a whole.

In particular, this will be achieved and sustained through leveraging SNV's expertise with Inclusive Business models when approaching the aforementioned SRHR issues. This approach shifts away from traditional awareness and capacity building programmes targeted only at workers and will actively engage the private sector.

SNV will work together with the factory owners to contribute to better sexual and reproductive health for their employees. SNV has extensive experience with this way of working and the women of Bangladesh can profit from this.

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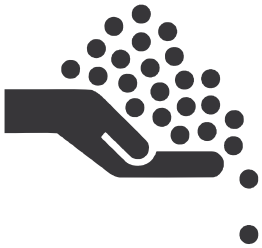
Promoting SRHR through Inclusive Business Practices in the Ready Made Garment Industry in Bangladesh

This report presents the findings of the value chain analysis of the Ready Made Garment (RMG) sector in Bangladesh from the perspective of ensuring Sexual and Reproductive Health and Rights (SRHR) through inclusive business practices. The study was commissioned and supported by SNV and jointly conducted by SNV and Innovision Consulting Private Limited.

November 23, 2014

Acknowledgement



This study was a joint effort between SNV and Innovision Consulting Private Limited. We are thankful to Dr. Mohammad Bellal Hossain, Associate Professor and Chairperson, Department of Population Sciences (DPS), University of Dhaka & Ms. Astrid K. Dier, Gender Advisor, Independent Consultant on Gender, for their technical advice.

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We would like to express appreciation to the factory managements for providing insights and their supportive role in conducting FGDs and interviews with workers. We offers sincere gratitude to Ms. Ella de Voogd, First Secretary, SRHR, Education and Gender, Embassay of the Kingdom of the 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 gone forward without the guidance and support of her.

Last but not the least many thanks to all study team members of the Innovision & SNV for providing the tremendous support to undertake the study and complete this report.

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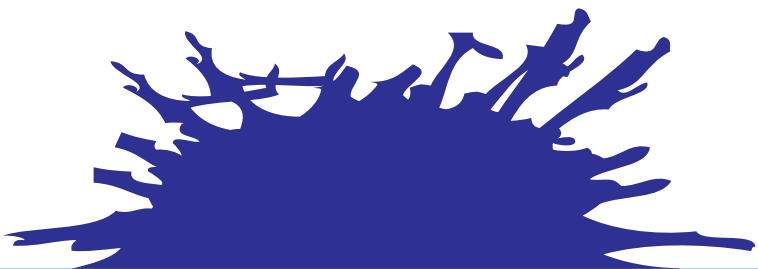
Acronyms

ACI	Advanced Chemical Industries
ACLAB	Alliance for Cooperation and Legal Aid Bangladesh
ANC	Antenatal Care
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BBW	Business for Benefit and Workers
BCC	Behavioral Change Communication
BGMEA	Bangladesh Garment Manufacturers' and Exporters' Association
BKMEA	Bangladesh Knitwear Manufacturers' and Exporters' Association
BMB	Beerenschot, Morret & Bosboom
BRAC	Bangladesh Rural Advancement Committee
BSR-HER	Business for Social Responsibility-Health Enabled Return
BTMC	Bangladesh Textiles Mills Corporations
CCC	Clean Clothes Campaign
CHC	Community Health Clinic
CSR	Corporate Social Responsibility
DFID	Department For International Development
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EKN	Embassy of the Kingdom of the Netherlands
EPZ	Export Processing Zone
EU	European Union
EU-GSP	EU Generalized System of Preferences
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
FMCG	Fast Moving Consumer Goods
FY	Fiscal Year
GDP	Gross Domestic Product
GIZ	Gesellschaft für Internationale Zusammenarbeit
HASAB	HIV/AIDS and STD Alliance Bangladesh
HR	Human Resource
IB	Inclusive Business
IDI	In-Depth Interviews
IFC	International Financial Corporation
ILO	International Labor Organization
IUD	Intrauterine Device
MFA	Multi Fibre Agreement
MOC	Ministry of Commerce
MOH	Ministry of Health
MoU	Memorandum of Understanding
MoWCA	Ministry of Women's and Children's Affairs
MR	Menstrual Regulation
NAP	National Plan of Action
NGO	Non-Government Organization
NUFFIC	Netherlands University Foundation For International Cooperation VAWG Violence Against Women and Girls
OHS	Occupational Health and Safety
OTC	Over the Counter
OXFAM	Oxford Committee for Famine Relief
PNC	Postnatal Care
PSTC	Population Service Training Center
RFSU	Riksforbundet for Sexuell Upplysning
RHSTEP	Reproductive Health Service Training and Education Program
RMG	Ready Made Garment
ROI	Return on Investment
RTI	Reproductive Tract Infections
SAFE	Growing Up Safe and Healthy Project
SIDA	Swedish International Development Agency
SMC	Social Marketing Company
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
URI	University of Rhode Islam
US	United States
USFIA	United States Fashion Industry Association
UTI	Urinary Tract Infection
VCA	Value Chain Analysis
WHO	World Health Organization



Executive Summary

This study was undertaken for SNV Bangladesh by Innovision Consulting Private Limited with the objective to assess the provision of Sexual and Reproductive Health and Rights (SRHR) for the female RMG workers in Bangladesh from the perspective of the Ready Made Garment (RMG) value chain. The study investigates the degree to which the RMG value chain could incentivize the provision of SRHR for female workers and the scope to which an inclusive business model could be effective in the provision of SRHR for the female workers. The study draws key conclusions on interventions that could be facilitated through an inclusive business project for sustainable provision of SRHR for female workers in the RMG sector in Bangladesh. It is expected that the findings from the study will inform SNV Bangladesh to make strategic decisions on management of the project which is being funded by the Embassy of Kingdom of Netherlands (EKN).

This report summarizes the findings from an in-depth qualitative analysis that was undertaken to analyze the prospect of intervening through the RMG value chain to create sustainable access to commodities and services that are critical to the provision of SRHR for the female RMG workers. The respondents of the study included female factory workers, husbands of female workers, factory staffs (Welfare officers, compliance officers, training officers, doctors, paramedics, management, and owners), Non-Government Organization (NGO) and project representatives working on SRHR of RMG workers, private sector commodity suppliers, government officials, compliance managers of key buyers that are sourcing from Bangladesh. Care was taken to ensure gender diversity with respect to male and female respondents. The study also involved rigorous review of published literature on the RMG sector in Bangladesh and SRHR issues of the female garment workers.

Findings suggest that there is a compelling business case for investment on an inclusive business model for the provision of SRHR for the female RMG workers in Bangladesh. The sector currently accounts for USD 21b in export and is projected to record USD 50b in export by 2021. It currently employs around 4.2 million workers of whom 90% are reported to be women. Most of these women workers are found to have health risks resulting from improper personal hygiene practices, unsafe abortion, unsafe sex and improper family planning methods. If these issues are not resolved, given the projected growth rate, the large number of women workers that would be employed by the sector would escalate the health risks to the extent at which it can potentially become a crisis that the sector is currently observing due to the Rana Plaza and Tazrin Garment tragedies which have significantly tarnished the image of the sector amongst the consumers and the stakeholders.

Our findings suggest that the interventions that are currently being undertaken are mostly ad hoc and non-strategic; targeting limited number of factories and their workers. These interventions are time bound and are driven by the agenda to reach out to the workers primarily for creating awareness and short term provision of services through satellite clinics and referrals. The projects and interventions are yet to instigate transformative change which could facilitate industry wide adoption of interventions on SRHR that could be financed and managed by the RMG value chain actors that includes the factories and buyers, and the SRHR service providers that includes NGOs and private sector commodity suppliers. Albeit there are evidences of factories, buyers, NGOs and commodity suppliers investing on their own to tackle the issues, these interventions are yet to be leveraged. In this context an inclusive business model for tackling the SRHR issues of the RMG workers could stimulate systemic and transformative change resulting from improved health of workers contributing to increased productivity of the factories and reduced sourcing cost of the buyers and improved image of the consumers.

The inclusive business model could also potentially tackle the social and behavioral barriers, work place barriers, investment barriers, accessibility barriers and capacity barriers that were identified as key challenges in the provision of SRHR for the female RMG workers in Bangladesh. Our findings suggest that there need to be

innovative approach to instigate behavioral change amongst the workers since the current interventions do not effectively address the challenges posed by lack of awareness amongst the workers' communities, peers and husbands and in general the taboo that is associated with sexual health. Large number of workers in the factories, limited time of the workers to consult formal providers and health care facilities and in general the social stigma which restrict the workers to seek professional assistance to tackle the SRHR issues (even if they are aware of the needs and solutions) are significant threats to translating awareness to usage and practices. Existing interventions attempt to address these challenges through satellite clinics, peer training and master training models the impact of which remains limited to the scope and scale of the project that is being undertaken.

Male dominates the human resources in the factories and in the service delivery channels. Besides, the husbands play a critical role in the decision making power of the married workers. Even though interviews with relevant male actors reveal some degree of awareness and empathy towards the workers SRHR issues, the male actors are yet to become a positive force in influencing SRHR of the female workers. Female workers are reluctant to discuss SRHR issues with male staffs in the factories or in the service delivery channels. This creates disconnect between the workers and the service providers. These barriers need to be tackled for interventions to deliver results.

Assessment of the worker's income and expenses suggest that the workers hardly have savings even after the latest increment in their salaries. However, there appears to be a general interest amongst the female workers to buy premium quality consumables (soap, shampoo, hair oil etc.) which further constrains their capacity to spend on commodities like sanitary napkins and contraceptives. The interviews also revealed that the workers do not account for expenses on these commodities. This indicates lack of effective demand for commodities and services related to SRHR.

While the findings reveal the need for the factories to have their own capacities to tackle the SRHR issues of the workers, the dependency on donor funded projects and NGOs means that the factories are yet to build their capacities to address the issues on their own. NGOs on the other hand are driven by donor mandate which is yet to embrace inclusive solutions are targeted to achieve quick and visible results that are measured by the number of workers reached, number of factories reached and number of trainings and awareness campaigns that are being undertaken. On the other hand, the buyers, who could be a key driver to the promotion of SRHR for the workers in their supply chain, are primarily concerned about Occupational Health and Safety (OHS) and consider SRHR as a Corporate Social Responsibility (CSR) issue. Thus they are either reluctant to invest on SRHR or are investing under the scope of CSR the scale of which remains mostly limited. Consumers are disconnected from the workers and have started to take an interest on the workers' needs only recently after the tragic accidents that took lives of thousands of workers. The RMG value chain is thus yet to embrace an inclusive model involving the value chain actors, the service providers and the actors in the enabling environment.

In light of these findings, several interventions has been recommended - (i) action research/pilot on inclusive solutions to SRHR issues of the workers through factories, NGOs/ private sector service providers and buyers, that could create an evidence base on the effectiveness of inclusive business models in reaching out to large number of workers sustainably and equitably, (ii) capacity building which could support the value chain actors and service providers to develop their capacities to design and manage inclusive business models and (iii) advocacy; which could create the interest amongst the value chain actors, donors, service providers, government agencies, trade bodies and consumers on the solutions to SRHR issues of the female RMG workers through inclusive business models. To operationalize the strategies it would be important that SNV works with change agents at each level of the value chain (factories, buyers and consumers and NGO/ Private sector providers related to SRHR). This report summarizes the roles and responsibilities of these stakeholders in the interventions. Additionally, this report provides key recommendations to the knowledge management and communication strategy that could be adopted by SNV for the promotion of Inclusive Business models for SRHR issues of the RMG workers. It is recommended that the strategies presented in this report are updated as the project learns and matures. This would ensure that the project is able to ride on the evolving market opportunities and take advantage on the interest that is being generated by the interventions and the early signs of impacts from the interventions.

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Chapter 1
Introduction

1.1 Background

SNV Bangladesh has received a grant from the Dutch Embassy (EKN) for "Promoting Sexual and Reproductive Health and Rights (SRHR) through Inclusive Business Practices within Ready Made Garment (RMG) Industry in Bangladesh." Innovision Consulting Bangladesh was commissioned to undertake a value chain analysis (VCA) of the RMG industry from the perspective of ensuring SRHR through inclusive models in the RMG value chain. The project is set on the context that even though number of development organizations and donors, includ
ing the Dutch Embassy (EKN), have been supporting SRHR initiatives for addressing improved working environments for female workers in the RMG sector in Bangladesh, gap remains with respect to achieving transformative change with regards to SRHR practices since the focus of the programs remains primarily limited to raising awareness and education. A scoping study commissioned by EKN and conducted by Beerenschot, Morret & Bosboom (BMB) Mott MacDonald concluded on several gaps in the strategy and impacts of the current donor funded projects which could potentially be addressed through a systemic approach by incentivizing the RMG value chain actors and wider stakeholders to address SRHR as part of their strategy for business growth.

Gaps in SRHR Service Provision in the RMG Sector in Bangladesh: Key Conclusions from the EKN Scoping Study by BMB Mott MacDonald

Scoping study conducted by BMB Mott MacDonald revealed that awareness and education is the key focus of the projects that are being undertaken to address SRHR issues in the RMG sector in Bangladesh. The report suggested that the projects are not designed based on pre-project formative research and thus the interventions that are being undertaken do not reflect in-depth understanding of the needs, attributes and interests of the workers. The report emphasized on the need for transformative changes and concluded that the projects are yet to have deeper impact on empowering the female workers so that they are able to take decisions and respond to the challenges exerted by their families and communities.

Defining the contents of the training programs as 'theoretical' and 'not something that the workers can relate to the report concluded that there is a gap in thinking out-of-the box and replacing traditional communication tools like leaflets and pamphlets with interactive tools. The projects are yet to take advantage of technologies like SMS, MMS, Voice Calls etc. even though some attempts have been made.

The study further concluded that the mind-set of the service providers' needs to change with respect to adopting better strategies for sensitization on a topic (SRHR) that is thought of as taboo. As per the report, SRHR is not a key agenda for advocacy (as is the case for fire, safety and wage rate) and there is a strong gap in coordination amongst the projects (about 20 active projects on SRHR as identified by the scoping study team) which leads to overlaps in interventions. The study concluded that the projects lack a clear exit strategy that could ensure that the processes that are being promoted could be carried forward beyond the project and after the project support is withdrawn.

In this context, SNV decided to adopt the Inclusive Business (IB) approach which could facilitate businesses to address development challenges for business gains. SNV defines inclusive business as ''an entrepreneurial initiative seeking to build bridges between business and low income populations for the benefit of both' (SNV, 2008). The assumption is that if the RMG value chain actors (which include factories and buyers) and the SRHR service and product suppliers understand the business gain that could be achieved by addressing SRHR, they would be more interested to innovate and invest on ensuring provision of SRHR. This could potentially address the existing challenges related to lack of awareness amongst the RMG factories on the value of investing in their workers' health, inability of the workers to source goods and services because of long working hours, lack of knowledge and financial constraints. Importantly, an inclusive business project could facilitate realize the market potential of SRHR.

How Inclusive Business could facilitate Sustainable Provision of SRHR for the Female RMG workers in Bangladesh- The Hypothesis

A study conducted by Kaizen CRS, a market research firm in Bangladesh, revealed several ill practices related to Menstrual Hygiene among the female RMG workers. The findings from the study suggests that 95% of the garment workers use dirty rags and rejected fabric scraps and 90% of them wash the rags without soap and reuse without drying. The study also revealed that 20% of the workers remain absent due to illness related to menstrual hygiene that leads to loss to 10% of the working days annually due to absenteeism. The economic loss of this absenteeism for the RMG sector is estimated to be around USD 22.5 million per annum. For the workers it creates an evil cycle (figure 1) of illness leading to absenteeism leading to lower wage and higher medical expenses and therefore poor living conditions that further reduce the capacity of the workers to access and avail SRHR.

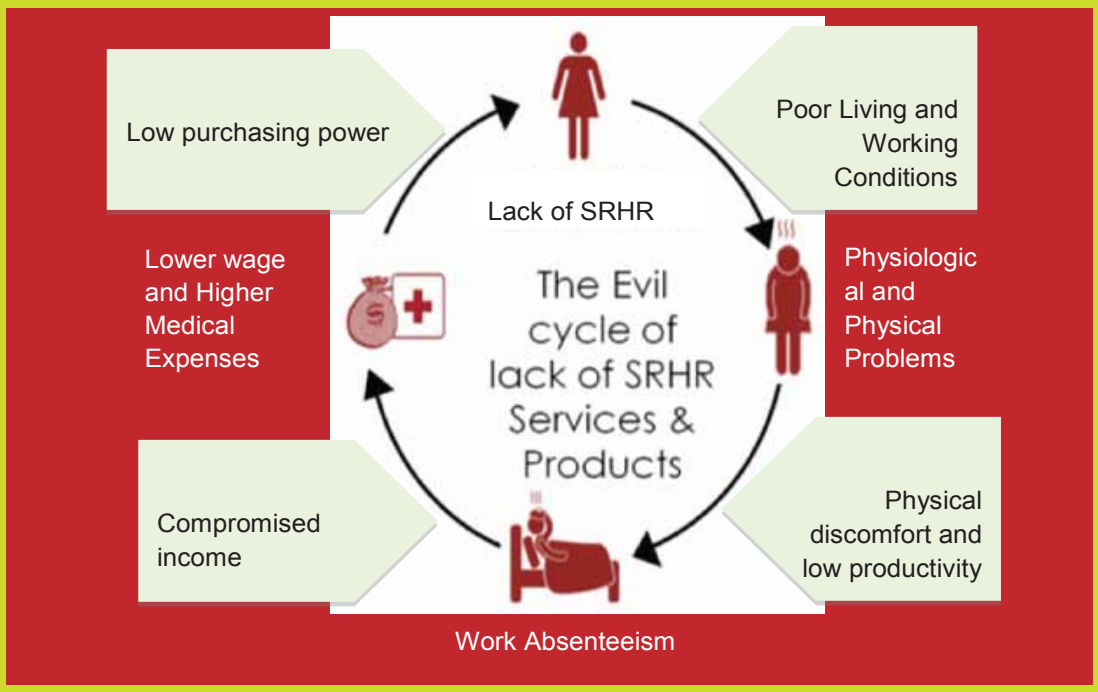
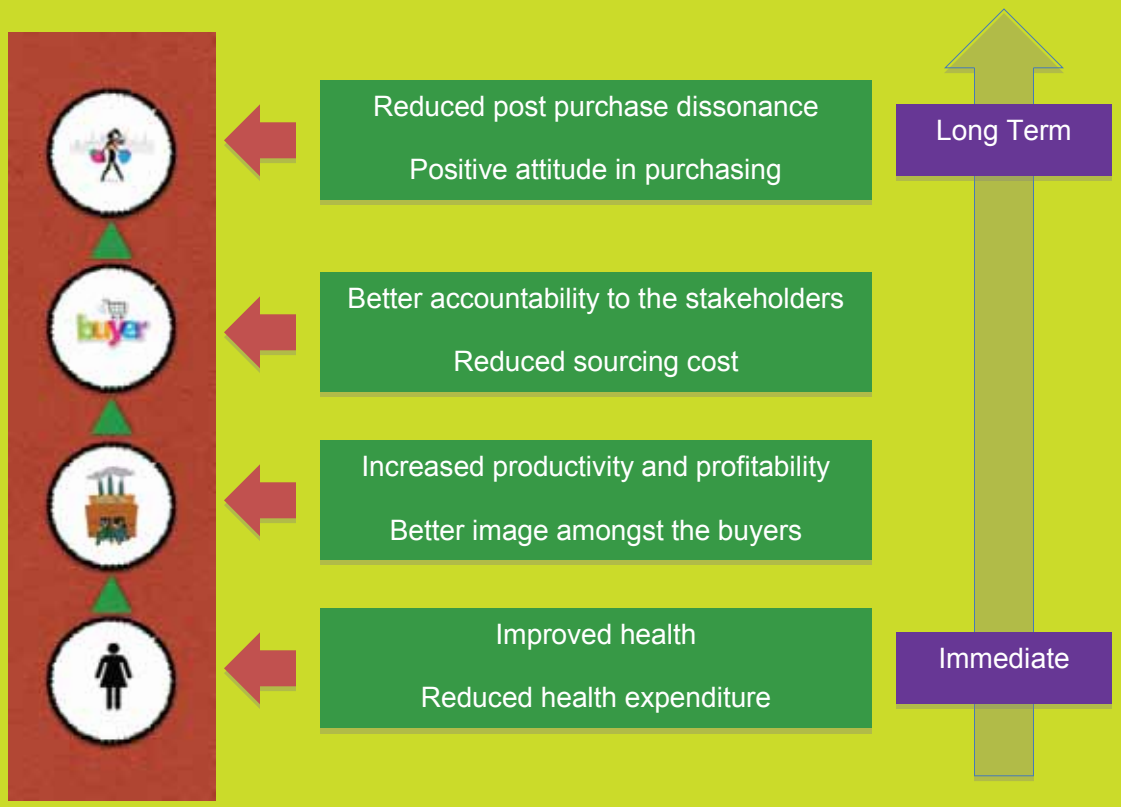


Figure 1: The evil cycle of lack of SRHR on worker's health and productivity

Innovision Consulting Private Limited

Figure 2: The transformative impact of investment on SRHR by RMG value chain actors- The Theory of Change



Set on this background, this study was undertaken to contribute to the design of a program for promoting inclusive business models in the RMG value chain in Bangladesh for the provision of SRHR. The study details the needs and incentives of the value chain actors (workers, factories, buyers and consumers) as well as the actors in the wider enabling environment (SRHR products and service providers, trade association, donors and NGO funded project, government) and draws conclusions on strategies that could be adopted by the project address SRHR issues of the female RMG workers in Bangladesh through inclusive business models.

1.2 Objectives

The specific objectives of the study were to assess:

- The market dynamics involved in ensuring SRHR services with respect to accessibility, affordability and quality of services
- The purchasing powers of workers in accessing SRHR services and the position of the garment workers as consumers in the value chain of SRHR services
- Gaps, opportunities and interventions related at all points of the SRHR value chain (factory management, existing NGOs and private service providers, garment workers and other relevant stakeholders) in the value chain
- Gaps, opportunities and interventions related to the enabling environment of SRHR services
- Possible approaches and actions for engaging with IB through SRHR at all points
- Supports required from government institutions, institutional buyers and employers' and workers' organizations as part of the broader enabling environment
- Existence of any opportunity in the whole RMG value chain that could provide leverage for promoting SRHR service

1.3 Study Process

The study involved a five-step process (figure 3) ensuring engagement and consultation with the RMG value chain actors, stakeholders in the wider enabling environment of the RMG value chain and the SRHR products and service providers who are and can potentially cater to the female workers in the RMG factories.

1. Background review: At the inception of the study we undertook a thorough review of the available literature on the RMG sector and value chain in Bangladesh and the provision of SRHR products and services to the female RMG workers with the goal to identify key issues pertaining to the provision of SRHR for female workers and to map the SRHR products and service providers and key actors in the RMG value chain and the wider enabling environment of the RMG value chain.

2. Internal workshop: The consultants along with the project staffs worked together on a day long consultation workshop to have a common understanding of the scope of the study, the respondents for the study, the methodology with respect to stakeholder consultation and engagement, study tools and the activity plan. The discussion was used to finalize the question guides (Annex 2) that were used for the primary investigation with the respondents.

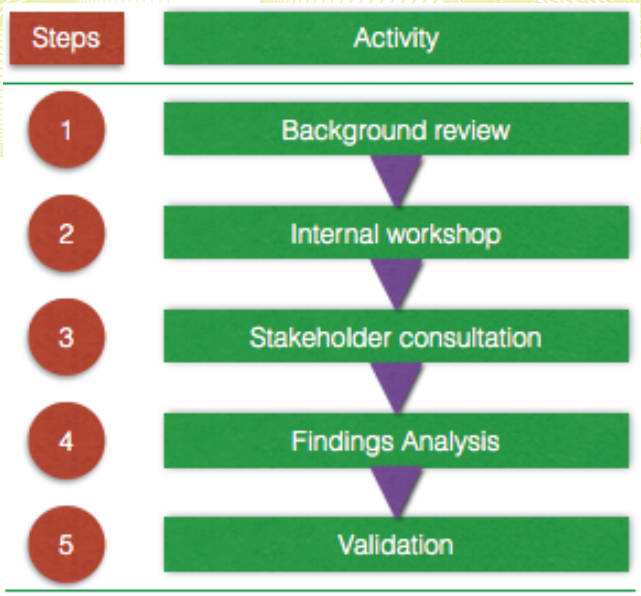


Figure 3: Study process

3. Stakeholder consultation: The consultants and the project staffs jointly conducted interviews with respondents that included the following group of stakeholders. Stakeholder selection and interview process is detailed in section 1.4 on the methodology of the study.

Workers and worker's representatives: Respondents included both male and female workers. Focus Group Discussions (FGDs) and in-depth interviews with female workers were held separately in their community and in their work place. The consultants and the project staffs also interviewed husbands of female workers as an influence group.

Factory owners and management: Respondents included directors of the selected factories, key management staffs, welfare officers, compliance officers, line supervisors', doctors and paramedics in the factories.

Buyers: The consultants interviewed representatives of buyers, specially the compliance managers who have direct oversight on the programmes managed by the buyers for the RMG workers.

NGOs and medical service providers: The consultants interviewed key staff members and project managers from the leading NGOs that are working in the provision of SRHR for RMG workers. Besides, staffs and medical professionals of private and NGO health centers serving the female workers were also interviewed.

Pharmaceuticals and Toiletries: The consultants interviewed key staff members of pharmaceuticals and consumer goods companies engaged in production and marketing of products related to SRHR. This includes contraceptives and health and hygiene products.

Pharmacies and private health facilities: The respondents included staffs of pharmacy outlets in the selected RMG clusters. Besides, staff members and medical professionals from private health facilities in the RMG clusters were also interviewed.

Wider stakeholders: This included officials from the Department of Family Planning, Government of Bangladesh and officials from Bangladesh Garment Manufacturers and Exporters' Association (BGMEA) and Bangladesh Knitwear Manufacturers' and Exporters' Association (BKMEA). Initial interviews with garment owners revealed that there is a tension between garment owners and trade unions. There was thus an apprehension that interview with trade unions could potentially disengage the factories from participating in the study. The study therefore opted not to interview the trade unions. The buy-in of the garment owners in providing access to the study team to interview the workers was regarded as a study priority in this respect.

4. Findings Analysis: On completion of the interviews with the targeted respondents the consultants and the project staffs held a two-day analysis workshop to discuss and agree on the findings on the study topics.

5. Validation: SNV organized a daylong validation workshop in Dhaka to present the findings and provide an opportunity to the stakeholders to validate the findings and provide further inputs that could be used to finalize the interventions of the program.

'The study involved a five-step process ensuring engagement and consultation with the RMG value chain actors, stakeholders in the wider enabling environment of the RMG value chain and the SRHR products and service providers'

1.4 Methodology

Selection of Respondents

It should be noted that this is an exploratory study and therefore the selection of respondents was guided by the objective to have an in-depth qualitative understanding of the issues summarized on the objectives of this study. The selection was guided by the following principles:

- Gender sensitivity and diversity: Although the ultimate target group of the study was female factory workers, several male workers, primarily the husbands of female garment workers were interviewed since initial interviews with female workers revealed that the husbands of married female workers have influence on purchasing decisions, behavioral approach and patterns, attitude and perception towards SRHR issues.

Though SRHR was assessed from the perspective of the female workers, the perception about SRHR of male population was found to be a key determinant on the provision of SRHR as is evident from the fact that respondents from the external stakeholder including factory management and owners, compliance officers, line supervisors, buyers and several product and service providers were primarily male.

The factories interviewed had both male and female doctors and the interviewers assessed the implication of male doctors on the female garment worker's interest to consult SRHR issues. Paramedics and nurses interviewed in this study were all female.

The health welfare officers and floor managers interviewed were both male and female; this helped us to explore the differences in gender perceptions within the factory premises with respect to SRHR connotations. A few of the service providers such as NGOs and pharmaceuticals had both male and female respondents which further assisted in exploring the diversity in gender perceptions regarding SRHR. The respondents from pharmacy outlets were male and this was found to have a major influence on female worker's access to SRHR commodities.

'...husbands of female garment workers were interviewed since initial interviews with female workers revealed that the husbands of married female workers have influence on purchasing decisions, behavioral approach and patterns, attitude and perception towards SRHR issues.'

An interesting point to note here is that the selection of respondent from the factory management, wider stakeholders and service providers was not directed by male-female segregation. The natural selection of male and female respondents in these groups thus provides an indication on the involvement of males or females in the group/ type of respondent. This is evident from the fact that none of the line supervisors interviewed were female and none of the health welfare officers in the factories were male. There was almost an even distribution of male and female doctors amongst the respondents (Table 1).

Table 1: Respondents of the study (see Annex 1 for details)

Respondent	Female	Male	Total
Workers and Worker's Representatives	56	6	**62**
Factory Owner and Factory Management****	1	33	**34**
Factory Doctors	5	6	**11**
Line Supervisors	0	6	**6**
Health Welfare Officers	10	0	**10**
NGO representatives*	7	5	**12**
Representatives from medical service providers**	5	10	**15**
Buyers***	2	8	**10**
Pharmacies	0	6	**6**
Representatives from Toiletries and Pharmaceuticals*****	1	3	**4**
Representatives from trade bodies and government organizations******	1	8	**9**

* Total number of NGOs interviewed-8. ** Total number of medical service providers -9. ***Total number of buyers -8 **** Total number of factories-20 ***** Total number of toiletries and Pharmaceuticals 4 ******total number of trade bodies and government organizations-7

Figure 4: Male-female distribution of respondents

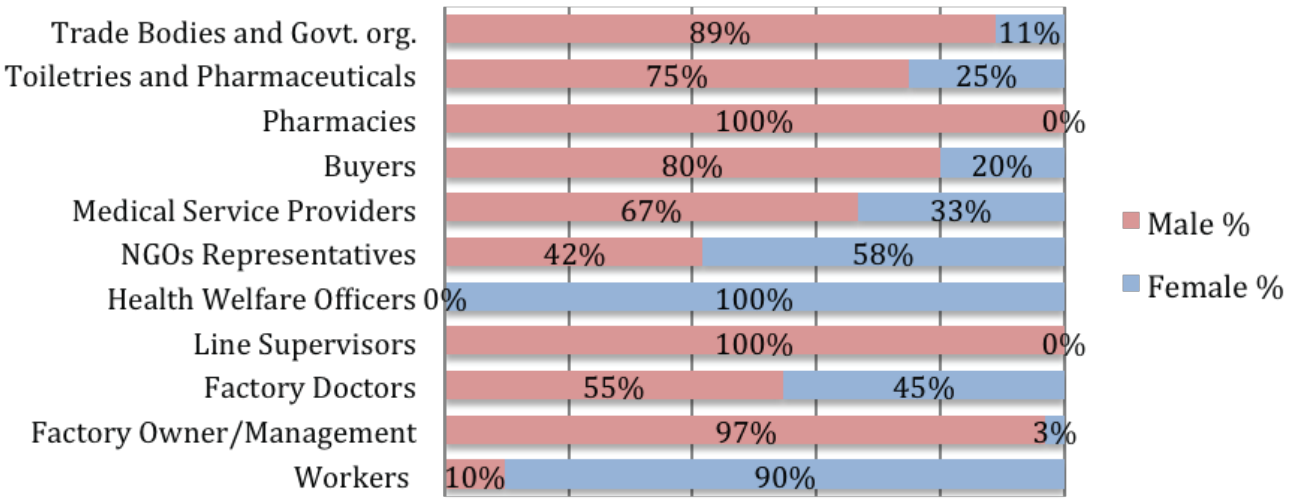
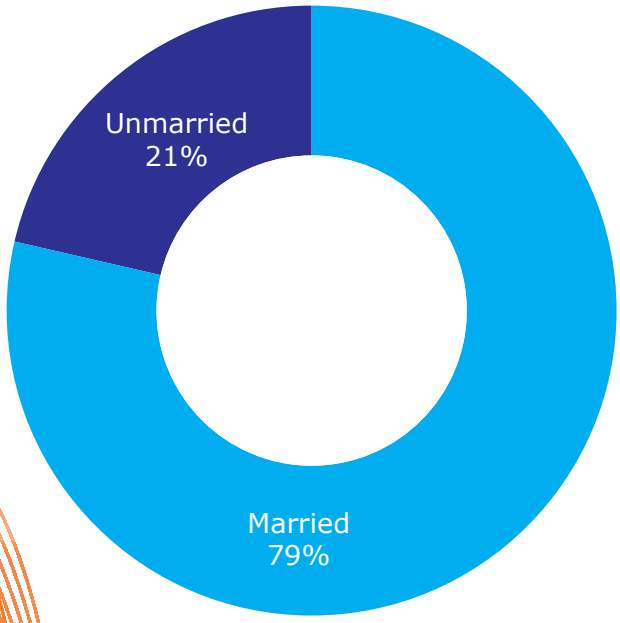
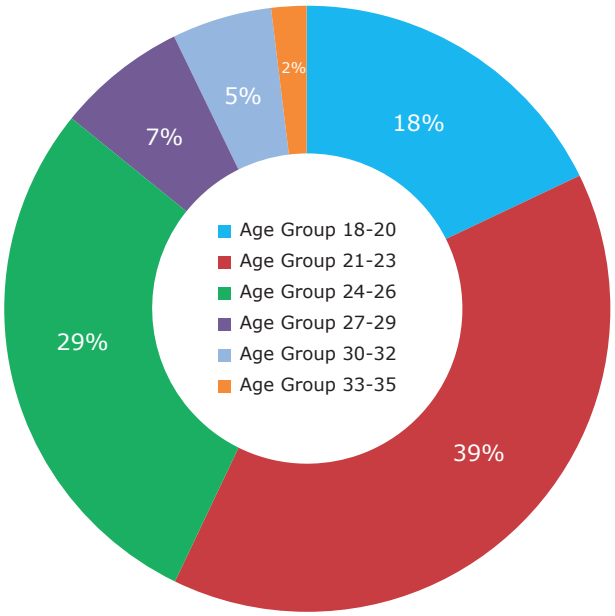


Figure 5: Distribution of respondent female workers- marital status and age





- Depth in investigation: The core principle was to allow for in-depth consultation. Therefore, the quality and completeness of the investigation rather than the number of samples interviewed was taken as a priority for the assessment. The factory management selected the respondent workers randomly. The consultants nevertheless tried to ensure that the respondents belong to different age groups (in case of workers) and different marital status (both married and unmarried) and were picked from different settings (factory premise and community) and different classes of factories (progressive factories which already adopted some good practices and non-progressive factories that are yet to adopt good practices). Figure 4 and Figure 5 respectively shows the gender segregation amongst the different types of respondents and the distribution of respondent female workers based on age and marital status.

- Relevance: Organizations that were found to have relevance in provision of SRHR and are engaged on provision of SRHR for the RMG workers were selected though secondary literature review. Besides, using the snowball approach, organizations that were cited during an interview as relevant in the provision of SRHR, were later selected for interview. The buyers, pharmaceuticals and toilteries, NGOs and projects, service providers that were interviewed for this study were primarily selected in this approach.

Team Structure for the interviews

The team included experts on SRHR, inclusive business, value chain development. Moreover, the team comprised of RMG sector experts and a well equipped research team. The consulting team comprised of both male and female members. This allowed for fluent discussion between the respondents and the interviewers. Additional female researchers and interviewers were recruited to conduct the interviews with the female workers. While the interviews were taking place, the surrounding area was secured so as to make the female workers comfortable to discuss about SRHR issues. The male members were asked to exit the area, since their inclusion could hamper the disclosure of the female workers.

On the other hand, the male representatives from the team were tasked to interview the husbands of the female workers, where once again, the area was secured from any female inclusion. The same structure and process had been used during the one on one interviews, indepth interviews, and FGDs. There had been immediate consultation by the team members with the team after conducting the interviews. This helped the team in interchanging ideas, concepts and relevant findings.

One on one interviews

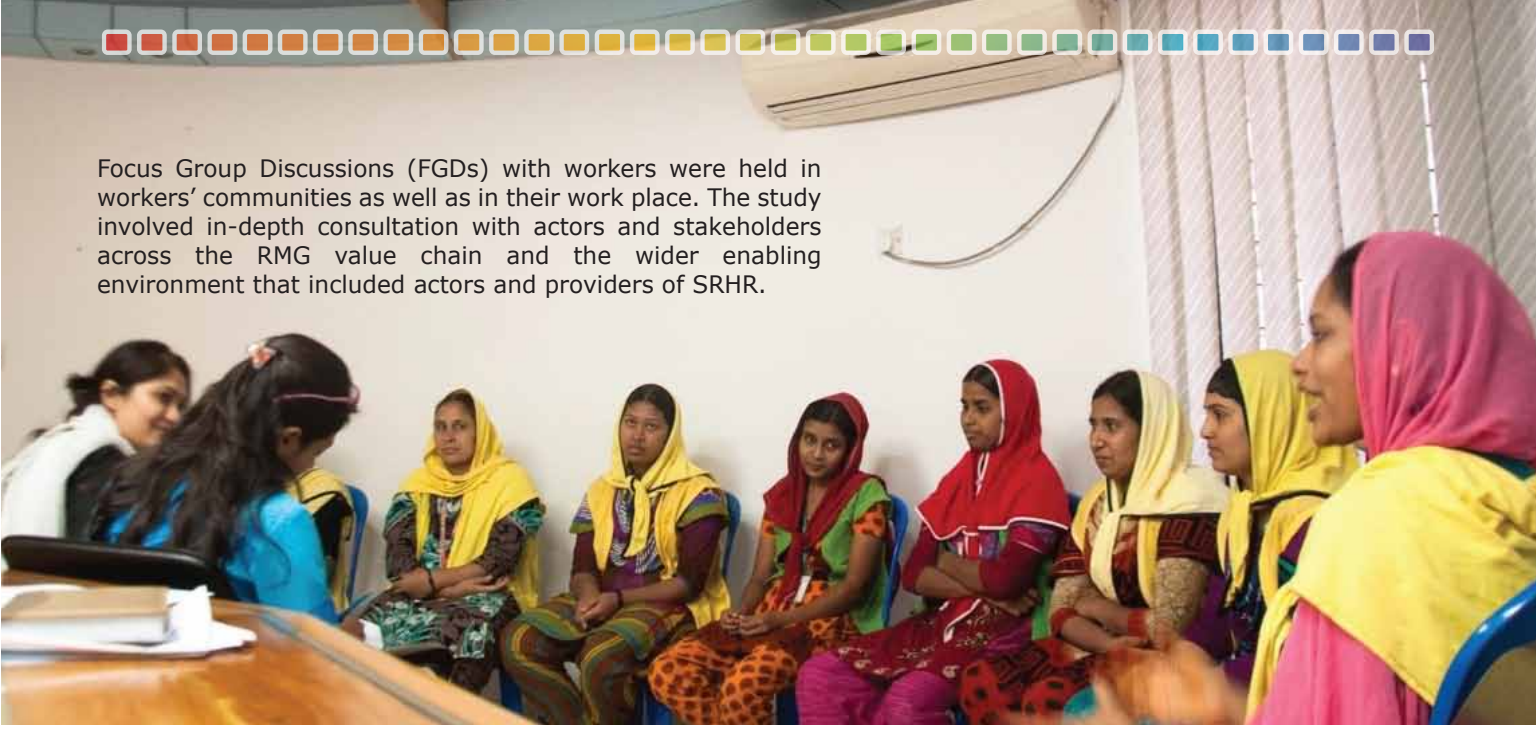
The questionnaire guide sets (Annex 2) from in-depth interviews were developed through an extensive literature review on SRHR and its implications on the RMG workers, the current status of the RMG sector in Bangladesh with reference to SRHR and its supplementary adaptations and the existing service provisions and policy interventions in the country. Furthermore, the questionnaires (for each of the stakeholders) had undergone a pre and post clarification before and after the initial round of interviews with female workers and external stakeholders. This enabled us to exclude unessential questions and adapt additional questions in the discussion guide sets and questionnaires. Besides, the early interviews with the workers helped us phrase the key questions for the husbands as influence group. This led to the development of a separate question guide set for the husbands (see Annex 2). The question guides for the other respondents were not customized to gender. However, the consultants investigated for implication of gender, for instance, whether the garment workers were comfortable in consulting with the male doctors, whenever the investigation was found relevant.

Focus Group Discussion

The FGD question guide was designed on completion of the first set of in-depth investigation with the female workers and other respondents that included the factory management, doctors, nurses, welfare offices. This allowed us to incorporate questions that required group discussion and observation of responses in-group setting. The FGD question guide set is attached in Annex 2.

'Selection of respondents for the study was guided by three principles- (i) ensuring gender sensitivity and diversity (ii) allowing depth in investigation and (iii) ensuring relevance to the purpose of the study.'

Focus Group Discussions (FGDs) with workers were held in workers' communities as well as in their work place. The study involved in-depth consultation with actors and stakeholders across the RMG value chain and the wider enabling environment that included actors and providers of SRHR.



Validation: In addition to the respondents of the primary investigation, the participants of the validation workshop included personnel from organizations that were identified as relevant and important during the primary investigation. The participants engaged on group discussion and presentation to reach a common ground on five key questions:

- How SRHR could contribute to the RMG value chain in Bangladesh?
- What are the critical challenges in ensuring SRHR for female workers in the RMG sector?
- What are the opportunities for creating provision of SRHR in the RMG value chain?
- What interventions could tackle the challenges and build on the opportunities?
- What could be the role of RMG value chain actors and stakeholders in the provision of SRHR for female workers?

Methodology for Analysis of the RMG Value Chain:

This value chain study was not undertaken with the goal to upgrade the RMG value chain to incorporate poor in different functions of the value chain. The analysis was done with the goal to support female garment workers, a specific actor within the value chain, to have access to SRHR, so that it generates benefits for the workers, factories, buyers and consumers in the value chain (the win-win case for the value chain stakeholders).

This study thus does not provide details on several aspects of the RMG value chain - (i) it does not provide a detailed analysis of the value added at different levels of the RMG value chain and the bottlenecks related to value added at each level (ii) it does not provide analysis of inequalities in the RMG value chain; i.e how the poor are included or excluded in the value chain or whether it generates disproportionate return to the non-poor as opposed to the poor and (iii) strategies for upgrading the value chain.

The study replaces these components with the following: analysis of the value added at different levels is replaced with potential benefits for different value chain actorsif SRHR practices are availed by female workers (ii) inequalities at different level of the value chain is replaced with analysis of bottlenecks within the RMG value chain and in the SRHR service provision market that deprives female workers from addressing their SRHR needs and (iii) strategies for upgrading the RMG value chain is replaced with strategies for incentivizing RMG value chain actors to create provision for SRHR for the female workers. These are further detailed in section 1.6 (structure of the report).

1.5 Scope

Sexual and Reproductive Health and Rights (SRHR) becomes a very crucial issue in context of RMG factories where 80% of the workers are female and most of them belong to reproductive age .Given the sensitivity of the subject, most respondents of this study preferred to define SRHR as 'female health issues' that covers menstruation period, abortion, use of contraceptives, sexual abuse and harassment. To ensure a common understanding of SRHR we followed the definition of World Health Organization (WHO) and Sexual Reproductive Health Rights in Dutch foreign policy 2009. The World Health Organization's definition of sexual health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

According to the Sexual and Reproductive Health and Right in Dutch Foreign policy (2009) -Sexual and reproductive health and rights encompass abroad range of issues, such as access to prenatal and postnatal care, safe delivery, family planning, prevention and control of sexually transmitted infections (STIs) and reproductive tract infections (RTI), as well as information and dedication about sexuality, safe abortion, female genital mutilation (FGM), fistulae, maternal and new-born mortality and morbidity. For the purpose of this study we accepted this as a working definition of SRHR.

Respondent factories: During the design workshop, the programme manager and the consultants discussed and agreed to restrict the interviews to factories that have more than 2000 workers since the pilot interventions are expected to be undertaken with factories that are more prepared to invest on addressing SRHR issues of the workers. Since these are mostly progressive factories, the status of provision of SRHR and the SRHR needs of the workers in these factories are expected to be different than the factories that have lesser number of workers and are yet to invest on provision of SRHR. Also, the respondent factories and workers were selected from the Gazipur and Savar clusters where SNV intends to conduct the pilot. The provision of SRHR and the status of SRHR needs of the workers in these areas might differ with that of workers from other clusters like Narayanganj. To address this issue, the interviews with national stakeholders, for instance the buyers, association and SRHR service providers were undertaken from a broader perspective so that the sector wide issues and opportunities could be identified and underscored.

Quantitative analysis: The methodology of this study was qualitative in nature. The number of samples from different categories of respondents was not drawn scientifically and therefore, we did not present quantitative analysis of the findings from the in-depth interviews with various stakeholders in the RMG value chain and the FGDs with the female workers. However, we have drawn quantitative information on the RMG sector in Bangladesh and the issues of SRHR based on published secondary literature and authentic sources. These are presented across the report. Given the need for a quantitative investigation on prevalence of SRHR issues amongst the female workers, SNV decided to undertake a quantitative research on completion of the value chain study. We believe, the findings from this study will complement the qualitative evidences that are presented in this report.

1.6 Structure of the Report

The objectives of the analysis are addressed in the report as below:

Objective: The opportunities in the RMG value chain that could provide leverage for promoting SRHR for the female workers:

Chapter 2 provides an insight into the RMG industry and the RMG value chain in Bangladesh and its structure, strengths and competencies that are critical to the analysis of the relevance and the prospect of promoting SRHR through inclusive business models.

- The chapter begins with a brief description of the RMG value chain. This description provides a detailed map of the different actors in the RMG value chain and their relationships along with the information onnumber of different types of actors engaged in the RMG value chain (based on available and validated information only)

- The sections on historical evolution of the RMG value chain in Bangladesh, the current status and prospects and challenges summarize the factors that contributed to the growth of the industry in Bangladesh and the factors that are expected to contribute to further growth of the industry. This chapter provides insights on the end market of the RMG value chain. It deals with the question, the degree to which end market opportunities for growth of the RMG value chain or market demand for apparels from Bangladesh is conducive in attracting investment from the value chain actors on provision of SRHR for the female workers.

- Finally in the section on 'the context of SRHR' it draws critical conclusions on the trends and the conditions in the RMG value chain that can be associated with the prospect and challenges in promotion of SRHR for the female workers in the RMG value chain

Chapter 3, details our findings on the scope for promoting SRHR in the RMG value chain. It first summarizes the prevailing SRHR issues amongst the female workers that need to be addressed. It then provides the business case or incentives for promoting SRHR in the RMG value chain. Analysis of the business case provides insights on incentives of the value chain actors in integrating SRHR for their workers. The section on opportunities in the RMG value chain for promotion of SRHR provides insights on the opportunities that exist in the chain for integrating SRHR. Finally the section on business enabling environment provides details on the opportunities to leverage the stakeholders in the chain- the government/ regulatory bodies, associations of factories and buyers, financial service providers and the donors.

Objective: The market dynamics involved in ensuring SRHR services with respect to accessibility, affordability and quality of services

Chapter 4 exclusively deals with this objective. The key providers of SRHR services, both in NGO sector and private sector that can be linked to the factories, and their role in enhancing service quality is analyzed in three categories- (i) factory and community level service provision, (ii) NGO and project driven service provision and (iii) private sector service provision and (iv) public sector provision. The analysis also details existing SRHR initiatives that are in place and identifies capacity building institutions and training providers in SRHR technical skills, communication, marketing skills, leadership training etc.

Objective: The purchasing powers of workers in accessing SRHR services and the position of the garment workers as consumers in the value chain of SRHR services

The purchasing powers of workers in accessing SRHR and the position of garment workers as consumers in the value chain of SRHR services is assessed with respect to the opportunities in the RMG value chain for promotion of SRHR in chapter 3, section 3.3. This also includes discussion on gender issues (for example relationship between the female workers and the female health welfare officers, female workers and their husbands, the husband's knowledge and attitude towards SRHR, the age and marital status of the worker and their attitude towards availing SRHR. The connection between gender issues and productivity is analysed through the interface between gender and SRHR in section 3.3 and between SRHR and productivity in 3.1

Objectives: Gaps, opportunities and interventions related at all points of the SRHR value chain (factory management, existing NGOs and private service providers, garment workers and other relevant stakeholders) in the value chain Gaps and opportunities related to all points of the SRHR value chain are analysed in chapter 5 under constraints in promoting SRHR in the RMG value chain. Proposed interventions are discussed in chapter 6 under strategic recommendations.

Objectives: Gaps, opportunities and interventions related to the enabling environment of SRHR services

Gaps and opportunities related to enabling environment are discussed in chapter 5 specifically under section 5.3 and 5.4. Proposed interventions are discussed in chapter 6 under strategic recommendations.

Objectives: Possible approaches and actions for engaging with IB through SRHR at all points

Chapter 6, section 6.1 provides the detailed approach and actions for engaging with IB through SRHR at all points of the RMG value chain.

Objectives: **Supports required from government institutions, institutional buyers and employers' and workers' organizations as part of the broader enabling environment**

Key stakeholders and their roles are detailed in Chapter 6, section 6.1.

Chapter 2: Overview of the RMG value chain, its historical evolution, current status and prospects

2.1 Brief Description of the RMG Value Chain in Bangladesh

Functions: The core functions of the value chain are input supply, garment manufacturing and exporting; and sourcing and marketing. Within the input supply function we can identify several sub-functions that includes cotton import, spinning, yarn dyeing, knitting or weaving, accessories supply, grey fabric sourcing, dyeing and all over printing. The garment manufacturing and export function includes cutting, panel printing/ embroidery, sewing, finishing, quality control and branding, packing and shipment. While all these functions are carried out by workers (both male and female) a significant input to the value creation process is the management function that is performed by high skilled professionals employed by the factories. We therefore chose to separate the labors as an input to the value creation process which helped us assess the value created by the workers in the total process.

The sourcing and marketing functions include sourcing, inspection, quality control and compliance, warehousing, branding and retailing functions. It should be noted that sourcing, inspection, quality control and compliance activities are conducted before the input sourcing, garment manufacturing and exporting activities are undertaken by the RMG manufacturers and exporters. We chose to group the functions undertaken by specific actors, for instance the buyers, so that we could evaluate their contribution to the overall value creation process. Finally, the product reaches the end market or the individuals who purchase the products from the brand outlets or retail stores.

Actors: The key actors in the value chain include input suppliers, garment manufacturers and exporters, brands and buyers. This section explains the actors and their roles in the value chain. Key facts related to the number of different types of actors, export value and volume, major export destinations and the percentage share of export in terms of destination are presented in section 2.2, 2.3 and 2.4.

Yarn Suppliers: For Knit products, up to 80% of the yarn requirement are met by domestic suppliers, whereas 20% of the yarn is still imported. This is due to the various blends that are demanded by international clients for the making of the knitted garments. This yarn is not easily available within Bangladesh and hence imported by the RMG factories or by merchant traders.

The raw material for yarn is cotton but in Bangladesh only around 5% of the need for cotton is met by local production and the rest needs to be imported. But once the cotton is imported the fabric and yarn can be produced in Bangladesh by local manufacturer, yet the import of yarn is high due to excess demand for yarn

Fabric Suppliers: Only 20% of the woven requirement for the RMG sector is catered locally, despite investment constraints, usage of local woven fabric also increased to about 20% from about 5% in 1994. Local fabric suppliers are normally part of integrated factory groups that provide for their own RMG factories and sometimes also trade with other RMG units. Fabric is

imported mainly from China, HK China, India, Pakistan, Korea, and Taiwan. Quite often, these fabric suppliers are nominated mills provided by the buyer.

Accessories Suppliers: Our interviews with different factories revealed that most of the domestic trim suppliers are importers who supply to the local RMG industry. There are a burgeoning group of trim manufacturers who have setup industry here and are catering to the domestic RMG sector. Trims that are imported are mainly: buttons, lace, zips, etc. Several international trim suppliers have representative offices now in Bangladesh and take orders directly.

Factories: Factories can be categorized as composite as well as non-composite factories. Composite knit garment manufacturers are units which produce their own fabric, have their own dye houses and thus can compete very effectively in price and delivery lead time. On the other hand the value addition by a non-composite factory is only cutting and making of garments, therefore their value contribution in garment manufacturing comes from the competitive advantage of cost effective labor.

Production units or factories can be further classified according to the number of workers employed.

Type 1: Medium to Large: Usually having more than 1000 workers. Only the medium to large factories are able to take on international export orders to countries such as the European Union (EU), United States (US), Japan, etc. These factories are either vertically integrated from yarn to finished product (Composite), or have very good alliances with fabric mills locally and internationally. Most of these factories have good compliance levels and have several certifications in place. Some of the larger factories collaborate with international clients as strategic partners.

Type 2: Small to Medium: They usually have up to 1000 workers. These are mostly non-composite factories. Although their size and scope does not allow a high level of strategic partnership with their clients, they still have a professional relationship with them.

Type 3: Small: Having less than 500 workers, these factories are mostly sub-contractors(second-tier suppliers) or do small orders, which are for direct export, but they do not conduct direct export themselves.

Labors: Workers or labors are at the core of the production function. Workers in a garment factory are engaged in a complex division of labor, where every individual worker has a specific task to be undertaken. The workers are engaged in functions such as cutting, printing, sewing, ironing, finishing, packing etc. Garment workers, particularly female garment workers, generally are young, un-married, with little education, of rural origin and from poor families. Studies further indicate that most women who work in the garment industry have had no prior wage work experience.

Data collected from the factories visited for this study reflects that around 70% of the women working in RMG sector are in the age group of 18-35 years. Their educational background ranges from no schooling to Higher Secondary Schools. However female workers account for only about 35 percent of the workforce employed in factories manufacturing knitwear, whereas in the factories manufacturing woven wear, they account for 68 percent of the total workforce (Majumder & Begum, June 2000). Even in the sewing section of the knitwear factories, female workers'share is much less than that of their male counterparts, advantage, as a determinant of women's recruitment, is lost when jobs become technologically skilled.

Exporters: Our detailed discussion with various actors in RMG value chain revealed that, Type 1 producers, in most cases, are exporters themselves. They have direct linkage with their foreign buyers, thus are not required to go through intermediaries such as exporting agents or buying houses. In case of medium to small manufacturers they mostly work with buying houses or they work as an outsourced agent with large RMG factories. Usually medium to small factories form a consortium which is coordinated by buying houses in order to deliver big orders.

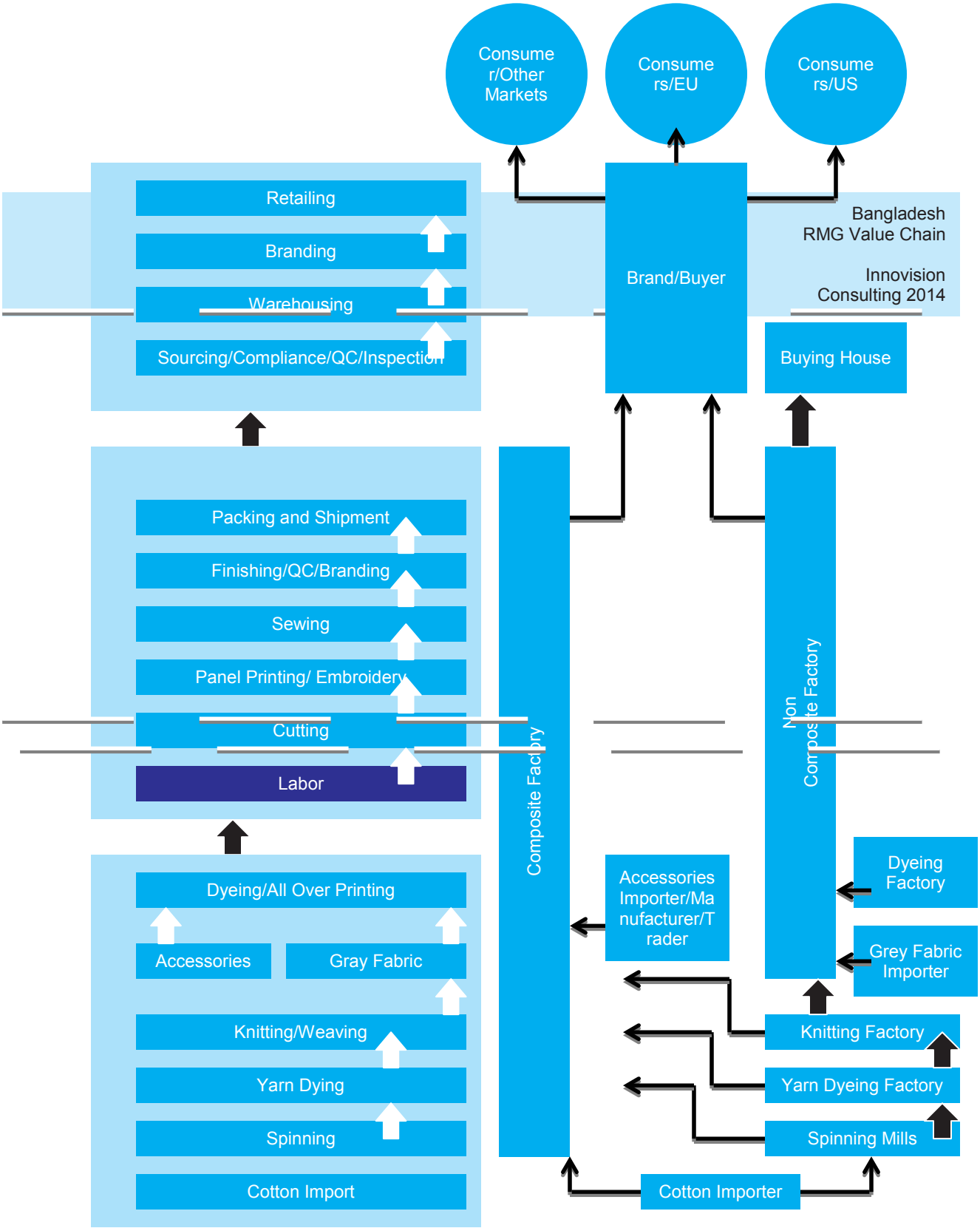
Intermediary traders: Those who work either on behalf of the manufacturer or on behalf of the buyer. In some cases, they work on behalf of both and get paid commissions for their work based on orders. The most common types are exporting agents and sourcing/ buying agents.

Exporting agents: Work on behalf of the suppliers in some cases and on behalf of buyers in other cases. Port orders to factories that do not have the possibility to conduct complete export logistics themselves. Exporting agents in many cases also work on marketing supply potentials in the supplier country to target international markets and exert on achieving the best price for the buyers.

Buying agents/houses: Operate as service providers to international brands and retailers. They also have representatives of different brands and retailers locally. Usually sourcing orders are placed by retailers and brands through the medium of the buying houses. One buying house is legit to hold multiple accounts for multiple brands at any point for varied product categories.

Brands/Buyers: The Buyers for the RMG products are globally spread out, however, mostly from first world countries. Some retailers have direct sourcing channels with the factories whereas others depend on the buying agents/ houses to source their products. The products produced in the RMG sector in Bangladesh, ultimately finds its way to the end consumers in the developed nations. The process is complete once a retail buyer in for example, New York buys a pair of denim jeans which is made in Bangladesh. Figure 6 illustrates the RMG value chain in Bangladesh.

Figure 6: Bangladesh RMG Value Chain



2.2 Historical Evolution of the Value Chain

The foundation of the RMG industry in Bangladesh was laid with the creation of trade unions in the Western World in the 1950s which pressed for greater worker's right and higher pay; which increased the cost of production. The retailers started searching for places where there was abundance of cheap and accessible labor. The then developing countries such as Hong Kong, Taiwan, China and South Korea presented as viable destinations for relocation with their open economic policies, along with non-unionization and abundance of cheap labor which could produce high quality products at a minimal rate (Bhuiyan, 2012). However, to control excessive exports of RMG goods from developing countries to developed countries, Multi Fiber Agreement (MFA) was created in 1974. The MFA imposed an additional 6% export rate exponentially every year from a developing country to a developed country. This restriction forced producers to relocate outside the umbrella of quotas and to a country with cheap and abundant labor force. This threat conversely opened up opportunities for Bangladesh and soon after, the country started receiving increased investments in the RMG industry (Chowdhury et al., 2014).

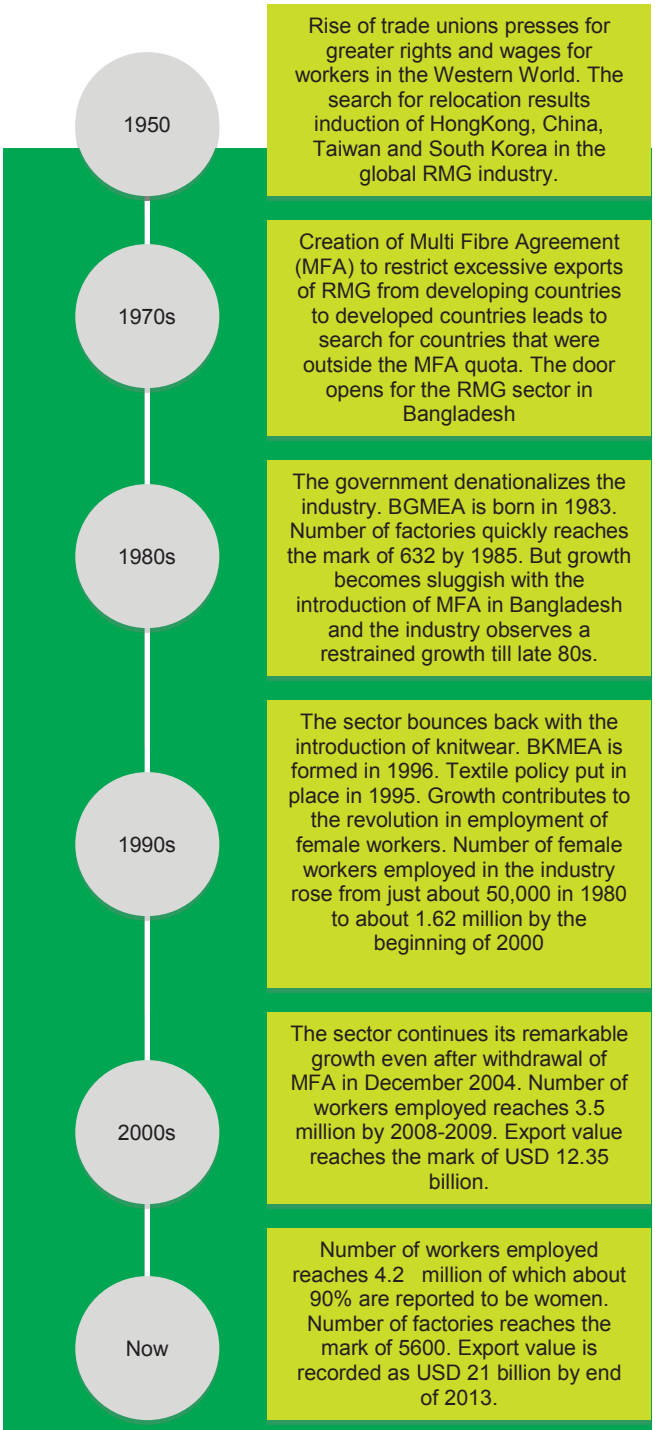
In the initial stages of growth and until the early 1980s, the industry remained under the control of Bangladesh Textiles Mills Corporations (BTMC). Bureaucratic problems along with lack of planning and accountability, poor machine maintenance and operation resulted in a lack of profit. Thus, the government gradually denationalized the industry which facilitated exponential expansion of the sector that persists till date (Islam et al., 2013).

Soon after, in 1983 Bangladesh Garment Manufacturers and Exporters Association (BGMEA) was created. This is a representative trade body which works to promote and facilitate the apparel industry through policy and advocacy to the government, services to members and ensuring worker's rights and social compliance (BGMEA, 2011).

Consequently, the number of factories in the garments industry increased rapidly and reached a phenomenal 632 during 1984-85 (Bhuiyan, 2012). However, this very rapid growth of imports of RMG from Bangladesh prompted the US, Canada and the European countries to impose the MFA Quotas in this country. This quota had directed the country towards a temporary plunge in the pace of growth of the RMG sector. There was a restrained increased in the number of factories from 744 in 1985-86 to 804 in 1989-90.

Nonetheless, 1990s onwards the sector bounced back (Bhuiyan, 2012). A very important development of the RMG sector occurred in the knitted garments export in the 1990s (Bhuiyan, 2012), also facilitated by the creation of Bangladesh Knitwear Manufacturers & Exporters Association (BKMEA) which was formed in 1996 (BKMEA, 2013). Initially, the industry was dominated by woven garments, until the US $ 131.20 million investment came across as the first window of opening of knitwear export from Bangladesh. Thereafter, knitwear expanded prominently during the 10 year period, between 1993 till 2004, at an annual growth rate of 23% and above which was higher than the annual growth rate of 10.6% achieved by the woven garments (Bhuiyan, 2012). Other developments in this period included the publication of the textile policy by the government of Bangladesh. This era also produced the revolution in the employment of female workers in Bangladesh. Number of female workers employed in the industry rose from just about 50,000 in 1980 to about 1.62 million by the beginning of 2000 (Swami, 2003).

By 2002 number of factories rose to 3200 (Debapriya et. al 2002) and the sector continued to post remarkable growth post MFA period in 2005. Export from RMG increased from about 4% of the total export in 1983-84 to about 80% in 2008-2009 (Sultana et. al 2011). Export value reached the mark of USD 12.35 billion by the end of 2008-2009. Today Bangladesh is of the 12 largest apparel exporters of the world, the 6th largest supplier in the US market and the 5th largest supplier of T-shirts in the EU market (Chowdhury et al., 2014).



Time Series Presentation of the Evolution of Bangladesh RMG Sector

Innovision Consulting 2014

2.3 Current Status

The sector is considered as a priority in the country's existing and prospective development strategies. This is especially due to its' explosive annual compound growth rates, increasing employment rates, higher percentage contribution to the yearly Gross Domestic Product (GDP) and nonetheless, the overall industrialization and economic development of the country.

Over the past twenty-seven years, the number of garment factory has grown from 384 to over 5600 currently. The factory growth rate was 3.70% in Fiscal Year (FY) 2012-2013. It is also mentionable that factory growth rate was never negative in past (Chowdhury et al., 2014). This rapid growth of the industries has been scattered across the country. The Ashulia and Savar industrial belt in Dhaka has more than 300 garment factories that together comprise 20% of the overall apparel exports from Bangladesh (BGMEA, 2013). Many of the factories are located in the Gazipur, Tongi, Tejgaon, Mohakhali, Gulshan, Rampura and Badda areas. The rapidly growing RMG sector is provided with export processing zones (EPZs) which are economic cooperatives that reduce duties and interventions to increase exports.

Consequently, these industrializing areas are swarming with a high influx of female workers triggering rural-urban migration. The RMG sector has played a significant role in creating employment opportunities, especially with respect to female employment (Kabir, 2008). The trend values and forecasted employment reflect a positive preference in employment. The sector alone employed 4.2 million workers in FY 2012-2013 which is a drastic leap from only 0.12 million in FY 1984-85 (Chowdhury et al., 2014). It is also noteworthy that the garment sector is the largest employer for women in Bangladesh; 90% of the workers are female. This has enabled women to participate in the formal workforce, attain financial independence along with self-sufficiency (Islam et al., 2013).

Investment in the RMG sector has opened up employment opportunities for diverse segments of the population either through direct or indirect economic activities which further stimulates the country's socio-economic development, overall women empowerment and alleviates poverty (Paul and Sen, 2001). The success of RMG is not limited within the territory of Bangladesh only; it has secured a position as the second largest garments exporter next to China and Cape Verde (Mckinsey, 2011). 78% of the foreign export earnings are derived from this sector (Mahmud R.B., 2012). RMG exports contributed to 13% of the GDP in FY 2007-08 which was previously only 3% in FY 1991-1992 (Golden Fibre, 2014). In FY 2012-2013 Bangladesh reached the export value of 21 billion USD and by 2015 RMG industry aims to earn 30 billion USD and 50 billion USD by 2021. The annual compound growth rate of RMG export industries in Indonesia (31.2), Mauritius (23.8%) & Dominican Republic (21.1%) compares favorably with that of Bangladesh (81.3%) over the 1980-87 periods (Bhuiyan, 2012).

The major importers of Bangladeshi RMG products are European Union (46%), United State of America (35%), Canada (5%) and other countries (14%) (Source: EPB, Compiled by: RDTI Cell, BGMEA). The country mainly exports woven garments and knit garments in the form of shirts, trousers, jacket, t-shirt, sweater etc. The major buyers of RMG products are Wal-Mart, Target (Australia), JC Penny, Gap, Levi's, Zara, Mango, Bershka, K-Mart (USA), H&M (UK), Marks and Spencer, Tesco (UK), Carrefour (France), C&A (Germany), UNIQLO (Japan), Primark, Debenhams and etc. Nonetheless, the Bangladesh RMG sector is said to face formidable challenges and competition from China, India, Vietnam, Turkey, Mexico and African nations. This is mainly due to the liberalization of trade in textiles and clothing and the phasing out of MFA in 2005 (Hasan, 2013).

2.4 Prospects and Challenges

In the short term, Bangladesh has the potential to be the sourcing country of choice for the international buyers, according to Mckinsey, 2011. According to a recent study conducted jointly by the United States Fashion Industry Association (USFIA) and the University of Rhode Islam (URI), the potentials of the RMG are increasingly optimistic due to China's loss in retaining position for new and reputed buyers (Hasan, 2014). The McKinsey study shows that leading apparel buyers of Europe and US are collectively in support of relocating from China. The urgency for reallocation from the international buyers is due to a labor shortage in the industry which is pressing towards higher wages in the tight labor supply market (Mckinsey, 2011). Bangladesh is evidently predicted to be the preferred next stop within the next two years. Mckinsey, a global management consulting firm has depicted Bangladesh as the "next hot spot" in apparel sourcing (Hasan, 2014, Mckinsey, 2011).

Overtime since the 1980s, buyers have amplified their sourcing base in Bangladesh through direct sourcing and opening local offices in Dhaka and Chittagong. The Mckinsey study depicts that amongst the EU and US buyers, 72% of them source directly in Bangladesh. From the supply side, 69% of the Mckinsey surveyed suppliers work directly with international buyers. In the last 15 years, Bangladesh's contribution of RMG exports to Europe and US has augmented two folds, meanwhile positioning the country as No.3 in EU apparel imports and No. 4 in US apparel imports respectively. As of the Mckinsey 2011 study, 39% of the interviewed buyers have increased their sourcing in the sector by more than 30% (Mckinsey, 2011).

Due to its' exponential growth, Goldman Sachs included Bangladesh in the "Next 11" emerging countries following BRIC (Brazil, Russia, India and China). Additionally, JP Morgan enlisted Bangladesh amidst its' "FrontierFive" emerging economies which has potentiality to increase investment in (Mckinsey, 2011).

Bangladesh offers two main critical advantages- price and capacity- for which it is clearly ahead of other South Asian RMG suppliers. Indonesia has about 2450 factories, Vietnam 2000 and Cambodia 260 factories. Moreover, India and Pakistan are depicted to contain high risk rates of structural workforce factors which prevent the utilization of their capacity (Mckinsey, 2011).

Addition to the elements of price and capacity, a high share of European buyers are enthusiastic about vertical expansion in the country due to the broadening of favorable trade agreements. The EU Generalized System of Preferences (EU-GSP) implemented the rules of duty free imports from Bangladesh which has shifted the dominant knitwear of RMG to a more balanced sourcing product portfolio (Mckinsey, 2011).

Despite recent increment to the workers' minimum wages, the RMG industry in Bangladesh remains competitive. An average worker in Bangladesh is paid around USD 80/month in comparison to a Chinese worker who receives USD 320/month. This signifies high switching costs prevailing amongst buyers which confine them to relocate to alternative destinations.

However, moving forward, the growth shall not entirely be driven by the expansion in volume of current production categories as reported by McKinsey 2011. The sourcing strategy should be expanded to attain diversity through complex, fashionable and sophisticated products. Hence, the market will have to be well equipped to adopt and promote a more dynamic growth pattern to remain internationally competitive (Mckinsey, 2011). Additionally, according to industry experts, the RMG industry needs to achieve diversification of buyers, potentially Japan and Australia, so as to broaden its' target spectrum.

A critical challenge in sustaining the growth is the image of the RMG industry in Bangladesh which has been seriously tarnished due to the recent occurrences of the industrial accidents such as the Rana Plaza Building Collapse and Tazreen Fashion Fire which have stirred a major concern amongst the stakeholders of the industry. The incidences have led to stringent scrutiny of the Occupation Health Safety (OHS) standards and compliance of the factories. Two international agencies, Accord (led by EU buyers) and Alliance (led by US buyers) are driving OHS compliance across the country through various initiatives. The Government of Bangladesh has also joined forced along with BGMEA and BKMEA to promote better safety for workers and safeguard the industry.

Apart from the concerns on workers' safety, the political instability in the country is reported to be a major threat by the industry experts and factory owners who were interviewed for the purpose of the study. The factory owners reported that in the first 6 months of 2014, the industry underachieved export targets by TK 600 crores (USD 76 million). The series of strikes in the last quarter of 2013 and in conjunction with the national election in January 2015 led failures in onetime delivery and on securing orders; the impact of which is now being observed.

Despite the short term challenges of political instability and negative image and publicity of the industry, it is expected that the sector will sustain its growth since the switching cost for the buyers in general would be much more significant than investing on supporting the sector to resolve its challenges. This is evident from the engagement of Accord and Alliance in addressing the issues related to OHS.

2.5 The Context of SRHR

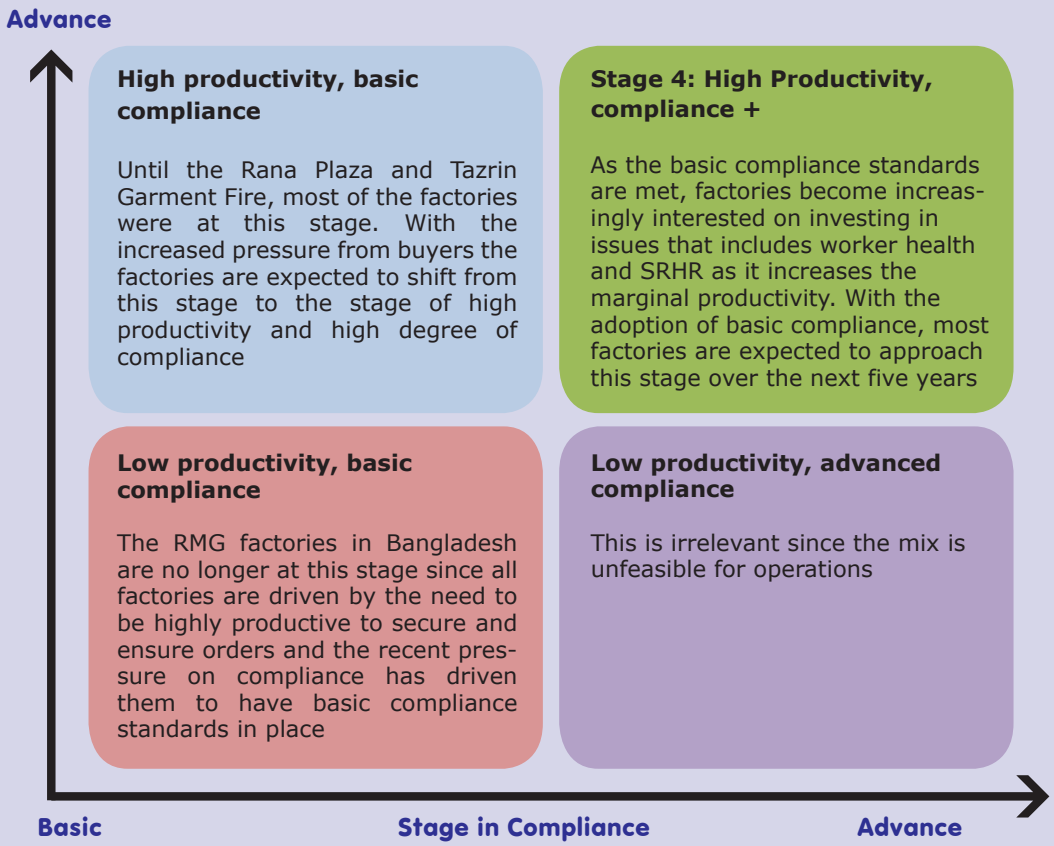
This review of the current status, prospects and challenges of the RMG sector in Bangladesh suggest that the sector would continue to grow since the factor conditions (high degree of switching costs for the buyers, increasing interest among the buyers to relocate from China, relatively weak status of the competing countries with respect to price and capacity) are favorable and compliance to OHS is set to improve by end of 2015. Even though the political situation continues to be erratic, the impact of it might lessen by 2015 as it gets more stable. The need for promoting SRHR in this context could be explained from two perspectives that came out during our primary investigation.

Firstly, OHS remained a non-priority till the situation worsened and incidences like Rana Plaza Collapse and Tazrin Garment Fire took place in quick successions and the world media started to publicize a negative image of the RMG sector in Bangladesh. The huge number of female workers in the RMG sector and the ill practices related to their SRHR (detailed in chapter 3,4 and 5) mean that it could act as a time bomb and become a point of interest for negative publicity of the sector once the industry become compliant to OHS. It would thus be of interest for the sector stakeholders to ensure that the SRHR issues are tackled before this becomes a significant threat to the sector's growth. Secondly, from our analysis we could deduce a trend in the willingness and interest of stakeholders in investing on workers' health and compliance; which can be hypothesized if not proved. As illustrated in figure 7, global demand for cheap apparels meant that the factories could sustain growth even without compliance which led to the recent pressure on sector wide adherence to compliance irrespective of the size of the factory.

However, some of the progressive factories which were already compliant and were promoted by the buyers as model factories figured out that they need to push boundaries and find inclusive solutions to workers' health problems since it directly helps improve factory productivity. These factories have now become the poster image of Bangladesh RMG sector and for the buyers as it helps them proof their accountability to their shareholders and their consumers. Consequently, several of the mid-tier factories that we interviewed, showed their willingness to follow suit of these progressive factories and invest on issues related to workers' health.

We can thus forecast that as soon as the pressure for OHS compliance is relaxed due to industry wide adoption of standard OHS practices, there would be a new wave of change leading factories to invest increasingly on ensuring worker's health. It is in this context, a pilot project on inclusive business model for SRHR is well placed since it could help lay the seed for the development that is inevitable given the growth trends and historical evolution of the sector.

Figure 7: TheContext of Promoting SRHR in the RMG Value Chain in Bangladesh



Chapter 3: Scope for Promoting SRHR in the RMG Value Chain in Bangladesh

3.1 Prevailing SRHR issues amongst the female workers in the RMG sector in Bangladesh

Improper management of menstruation period: Improper practices on handling menstruation period were identified by the workers, medical doctors and paramedics in factories as the major SRHR issue among the female workers. Use of factory scraps and rags (locally called jhut) is a common practice and leads to fever, abdominal pain and cervical infection. The major health risk of cervical cancer is not duly assessed. According to the medical doctors about 30% of the cases (on an average 10-30 depending on the number of workers in the factory) that they handle daily are related to improper management of menstruation period. Even though some factories have been providing subsidized sanitary napkins or low cost napkins, the rate of use of sanitary napkins is reported to be low. In the communities, 2 out of every 9 females interviewed used pads (very minimal usage, they are comfortable with the rags and do not even intend on shifting to sanitary napkins). Among the users, almost all women send husbands to pharmacies to buy sanitary napkins.

Unsafe MR: Unsafe MR was identified as the second major issue by the medical doctors and paramedics in the factories and the heath NGOs working on SRHR issues of the female workers in the RMG sector. However, this was not acknowledged directly by the female workers who were interviewed during the field investigation. The issue of high rate of unsafe abortion was verified in our interviews with private medical clinics and pharmacies around the factories and communities where the workers live. It was also reported that some of the pharmacies conduct MR at minimum price (TK 200-300) through unqualified doctors. Even though clinics operated by the NGOs, for instance, Marie Stopes deal with significant number of MR cases every month; not all workers visit the health centers due to the fear of being seen by fellow workers and neighbors. Cost of MR services in the NGOs is low and facilities like Marie Stopes have provision of subsidized services that match the price of the services provided by the likes of the pharmacies. Cost thus cannot be established as a constraint on promotion formal providers for MR.

Low usage of family planning methods: Overall, Pill is very popular, so are injections, very recently. Even though the workers are aware about the commodities and contraceptive methods, the use of contraceptive has remained limited and in cases faulty. For instance, it was reported that if an adult women who takes pills miss to take it, her male partner will have to use condom or other form of contraceptive over the next two days during intercourse. However, the male partners are reluctant to use condoms. Workers are yet to have such depth in knowledge in use of family planning products

which eventually leads to high rate of unexpected pregnancy and therefore abortions. Besides, as reported by our respondents, even though the government is extensively promoting family planning products for free and subsidized rates, the workers usually do not prefer to go to the government health facilities because of long queues and paperworks. The practice of having (both male and female) multiple sexual partners, but on a limited scale, has been reported by medical doctors, paramedics and welfare officers of the factories. This issue is not published or reported or was acknowledged by the workers since it is a sensitive case and could potentially spark religious sentiments.

Risk of STI: The risk of STI is high amongst both male and female workers especially due to their lifestyle and improper use of contraceptives. We attempted to investigate the prevalence of STIs amongst the female workers but could not develop a conclusive picture since workers do not visit medical doctors and paramedics in their factories or the health NGOs and government facilities on issues related to STI. But based on our interviews we can suggest that the workers usually try to neglect such cases till it becomes serious. The first point of contact in such case is friends or peers. The second point of contact is pharmacies but this is relevant only for the male workers. Eventually informal providers or unqualified doctors are consulted.

Apathy to use antinatal and post-natal care services: Antenatal and post-natal care services are not widely available for the workers. However, our interviews suggest that there is good understanding about health and nutrition requirements and both husband and wife seek advice of professional doctor in a health facility at least once prior to the delivery. Usually the workers go back to their village or their hometowns for the delivery. In their own communities they are vulnerable to issues like postpartum hemorrhage since informal providers and in some cases the family members usually do the deliveries.

Vulnerability to sexual harassment: Primary investigation suggests that the female workers are vulnerable to sexual harassment in their factories as well as in their communities. However, at the factory level, sexual harassment is dealt strongly by the factory management through the welfare officers since it can potentially create unrest within and outside the factory. Buyers too are conscious about the risk of sexual harassment within the work place and require the factories to ensure strict adherence to policies to mitigate the risk. However, harassment at the communities are not addressed and this has a direct consequence on worker's mental health and physical health which eventually affects productivity and profitability of the factories. Since labor is abundant, the factories have the choice of replacing the workers and therefore the economic burden of sexual harassment is shifted to the female worker.

Lack of knowledge about sexual and reproductive health rights: As per definition, sexual and reproductive health rights involve choice of making decisions with respect to sexual behavior and seeking services to address sexual issues. Choice is related to knowledge about good and bad, what is available and what is not and what should be available but is not. For instance, if workers are unaware about the availability of free contraceptives, they are depriving themselves of their right to have the commodities. Similarly, if the workers are unaware of the fact that it is their right to have access to safe sanitation and toilet facilities in their factory, they are unlikely to ask for it. However, rights is a sensitive issue in the RMG sector in Bangladesh, particularly because of the violence that occurred over the last several years on issues related to wages and others. The factory owners have a strong opinion that by trying to promote rights, the NGOs have unsettled the balance. Therefore, there is a challenge that even if the RMG value chain actors buy into the idea of actively promoting sexual and reproductive health, they would be unwilling to accept it as a right for the workers. A possible solution could be establishing workers' participatory committee where they could discuss their rights.

The aforementioned conclusions are based on the findings from the interviews of the respondents, which was conducted by our team. The best approach to investigate these issues even further is through action research and extended in-depth interviews with the involved stakeholders. This phenomenon has been further proposed in the recommendations segment of this study.

3.2 The Business Case for Promoting SRHR in the RMG Value Chain: The Interconnectedness between Factory Level Productivity and the Market

Productivity Improvement: In dealing with management, or rather, in presenting SRHR to the factory management, it can be observed that an argument from economic incentives works better than presenting it as a Corporate Social Responsibility (CSR) initiative (BMB Mott Mc Donald, 2013). Return on Investment (ROI) study related to SRHR in RMG sector in Bangladesh is yet to be undertaken. Results from studies undertaken in Egypt suggest that investing in worker's health is more than a moral imperative—there is a compelling business case for the investment. For every $1 invested in women's health, one Bangladeshi factory observes a $3 return through higher productivity, lower turnover and reduced absenteeism (BSR HER Project, 2014).

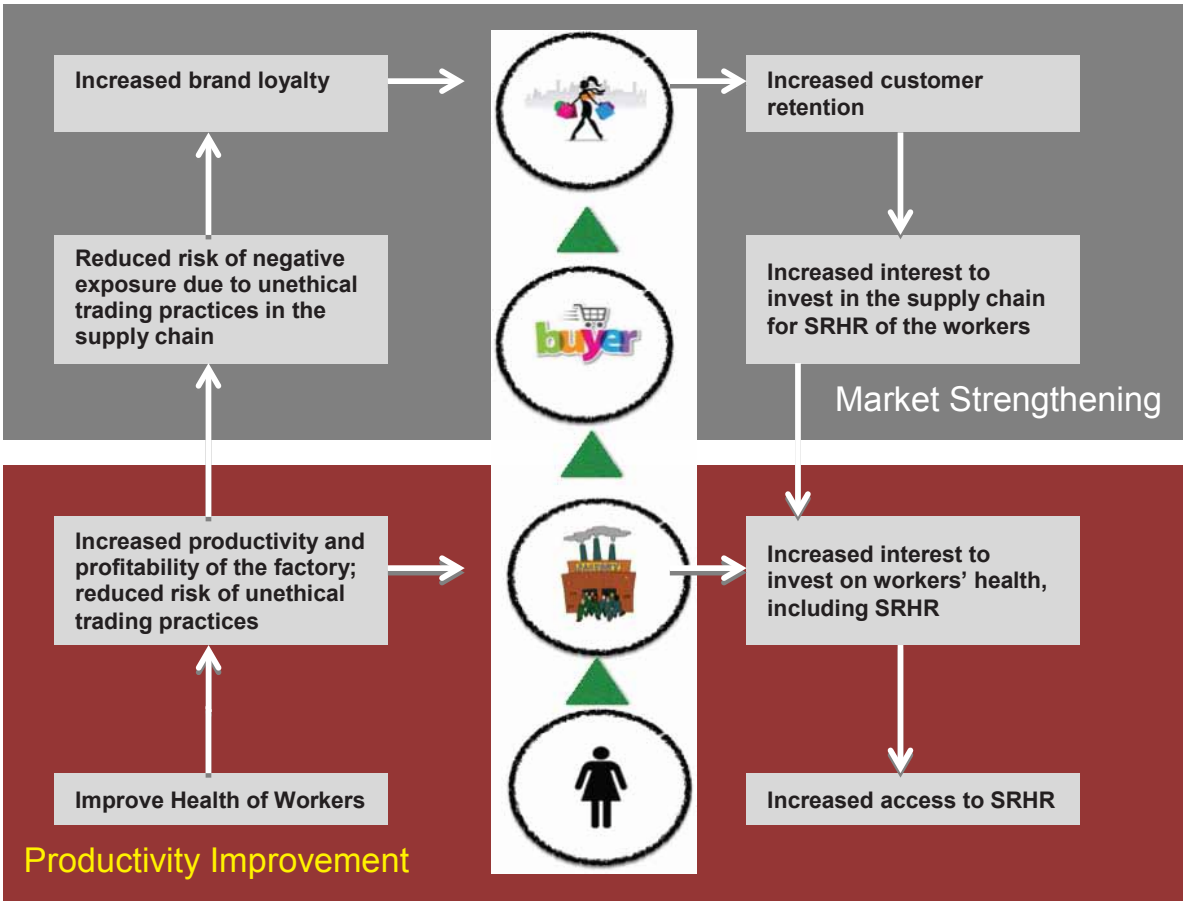
A program such as BSR HER Project, which promotes SRHR in RMG factories, has already established the mere fact that improvement in the health of workers, improves the overall productivity of the factory. This link between good health and economic prosperity is well established and can be detected in numerous measures, such as increased income, wages, and efficiency (BMB Mott Mc Donald, 2013). Additional benefits of SRHR in the factories include increased interaction between workers and factory management, employee belongingness to the organization and lower grievance among workers. These positively impact the factory's financial books and create a better image that makes the factory owners/management far more amenable to sponsoring and continuing such programs. It is expected that once factories start adopting SRHR as an inclusive business practice thereby achieving business benefits, the rival factories will initiate replicating the model in their business management. Eventually, it is expected that the benefits of SRHR practice will spread out to workers across the entire industry.

Market Strengthening: In our interviews, most of the factory owners and management revealed that while the progressive factories (plotted as high drive for productivity and willingness to invest on workers' health and OHS in figure 7) are already investing on issues related to SRHR without being pushed by the buyers; the general trend is to follow the recommendations of the buyers. The buyers are currently concerned with OHS and are yet to generally embrace SRHR as a need even though some of the buyers under the umbrella of BSR-HER project have been investing on education and awareness on SRHR.

Given that the industry is highly driven by price competitiveness, even though the consumers are increasingly concerned about ethical trading practices, it is unlikely that they would provide premium while purchasing products from brands that have invested on compliance or SRHR. But they are likely to switch from brands if those are constantly on news headlines due to unethical trading practices. Even though SRHR is yet to become a topic under ethical trading practices, as we noted earlier in this report, the large number of female garment workers mean that lack of SRHR could become an issue anytime. It thus has an indirect cost for the buyers which should make them interested to co-invest with their suppliers on ensuring SRHR for the female workers. Through this model the investment on SRHR could come from the top of the value chain rather than from the bottom.

Correlation between productivity improvement and market strengthening: Increased investment from factories on SRHR means that there is reduced risk of the buyers getting exposed to negative publicity. This in-turn ensures that their customers are not switching to competing brands. Thus investment from the buyers on ensuring SRHR in their suppliers' factory can potentially translate to brand loyalty which strengthens the rationale for the buyers to sustain investment on the provision of SRHR in the RMG sector in Bangladesh. This eventually could lead to sustaining investment on SRHR from both the factories side and from the buyer's side. Figure 8 illustrates the contribution of SRHR and the transformative change in investment in SRHR that could be brought forward through inclusive business models.

Figure 8: Contribution of SRHR in the RMG Value Chain: The Interconnectedness between Factory Level Productivity and the Market



3.3 Opportunities in the RMG Value Chain for Promotion of SRHR

There are several entry points in the RMG Value Chain through which SRHR interventions can be undertaken. The theory of change explains both the connections between early, immediate and long-term outcomes amongst the stakeholders of the industry. Having mentioned that, this section will analyze the existing opportunity for promotion of SRHR at different points and with different actors in the RMG value chain.

Female Workers: The government has imposed a minimum wage of Tk. 5300 per month for each worker; from the FGDs conducted during the study, it can be denoted that including over time the average minimum wage rate of workers is around Tk. 8000-10,000 per month. The adjusted wage rate is expected to influence the workers' purchasing capacity. However, detailed analysis of the income and expenses of the workers suggest that the workers can hardly make any savings on their income. In this scenario it is striking that during our field investigation we found a trend among workers in using premium quality beauty products that include brands like Dove (soap) and Veet (hair removal cream). Besides, the workers did not report expenses on SRHR products or services like contraceptives and hygiene products. From these accounts it can be deduced that the workers will have to compromise part of their expenses on consumables for SRHR.

From our findings we can deduce a relationship between worker's age and their attitude towards SRHRS. Younger workers (aged 18-25) appear to be more responsive to addressing socially critical issues such as SRHR. They are not withdrawn under the societal taboo of SRHR and its' shyness. Our interviews with several health welfare officers within the factory denote that young female workers' are comfortable to discuss their SRHR needs and concerns. The factories have Welfare Officers and in many cases, these officers have been working with the factory consistently for many years. This creates a stronger bond between the workers and the officers and can potentially be one of the entry points to initiate the interface between SRHR and the factory management. Health welfare officers in some cases are seen to be working as a peer trainers and master trainers for the workers. They take leadership in promotion, training and conversation sessions with the workers regarding general health concerns.

Purchasing power of the female RMG workers

Unmarried female workers: Our FGDs with the individual garment workers in the RMG sector reveals that the average monthly salary of the individual workers, including overtime, ranges from Tk. 8000-10,000. This figure fluctuates monthly in accordance to the number of hours dedicated for over-time depending on the demand for goods and the production capacity of the factories. A segregation of their income, relative to their spending indicates the phenomenon that purchasing power itself may not be the primary cause of the lack of SRHR involvement in their lifestyle.

Approximately 33% of their income is diverted to house rents, which encompasses of Tk. 3000-3500 per person per month. The houses are facilitated with a shared common kitchen and toilet, and no verandah space. The unmarried garment workers share the rooms with 3 or 4 other female garment workers, in which case, the house rent is shared. Other than this major expense, food takes up around 27 % of their income, which is about Tk. 2500- 3000 per person per month. The workers reside nearby their work stations and hence, have no additional travel or commuting costs as most of them walk to work and back. According to the interviews with the workers, their medical costs are almost close to nothing.

However, it is mentionable that, the female garment workers dedicate approximately 5% of their monthly income, which is Tk. 500 on average per person per month on consumption of consumer products such as shampoo, lotion, face wash, talcum powder and etc. Interviews with the female individual workers suggest that they are not interested to purchase SRHR products and services. According to them, 'lack of necessity' concerning SRHR products and services create significant reluctance towards its consumption.

As mentioned previously, the female workers have easy access to available jhut or rags at the factory premises. This is free of cost and moreover, does not involve any time consuming and costly activities such as washing or cleaning. They have mentioned jhuts and rags to be of 'one time use'. This aspect may create significant disincentive for the female workers in consumption of SRHR products and services. For any additional SRHR issues, home remedies and traditional healer have gained much popularity amongst the female workers.

Given the income, expenditure and consumption patterns of the female workers, our triangulated findings portray that they do acquire a stable purchasing power and interest towards consumption of consumer products. Luxury clothing has also been highlighted by the workers in special occasions. However, they lack keen interest of consumption of SRHR commodities.

Married female workers: FGDs and in-depth interviews with the married groups of male and female garment workers reveal that the average monthly household income, inclusive of overtime and festival bonus is Tk. 17000-18000. This figure fluctuates monthly in accordance to the number of hours dedicated for overtime depending on the demand for goods and the production capacity of the factories.

The married working couples spend an estimated 30% of their monthly income on house rent, which is about Tk. 5000-6000 per household per month. This is primarily since they have no room sharing opportunities. They reside in one small room, with a disconnected common kitchen and toilet facility.

A common practice within the garment worker's communities is to leave the infants in an informal day care service, normally with known women of the neighborhood who keeps many of the neighborhood children during working hours. This informal day care service costs a minimal of Tk. 2000 per child per month which is approximately 11% of their total income. This figure appears to be too high and needs further investigation for validation. Additional food supplies and clothing of the infant takes up roughly 8% of the joint income comprising of Tk. 1500 per child per month of their monthly household income.

In cases where the couples have teenage children they leave the infants in their care. In many instances, it has been reported that the mother in-laws of the couples are brought to the urban areas from the villages to assist in cooking and taking care of the children. Many couples have stated to send their children to the

villages to live with their grandparents. These aforementioned aspects of childcare may additionally increase spending amounts in the family up to Tk. 4000-4500 per month; this consists of a striking 23% of their total income. Schooling expenses, food and accommodation expenses of the slightly older child/children create demanding circumstances within the household constituting an estimation of 11% of the total income, which is Tk. 2000 per child per month on an average.

As mentioned in the above segment, travel and medical costs affiliated in their lifestyle are at its minimal. Although, it has been revealed that childcare related medical costs have sporadic occurrences which consists of Tk. 1500 per month on average depending on the severity of the disease. This portion of expense is stated to be approximately 8-10% of their monthly income, although this does not have occurrences regularly.

Nevertheless, additional costs encircling the consumption of consumer products are widely prevalent amongst the married couples. It is striking that given the increased expenses of child care, food, accommodation and additional logistics, the workers spend roughly 6% of their joint income which can range up to TK. 700-1000 per month on consumer products. This amount is significantly high compared to their earning spectrum which reflects the worker's consumption behaviors. In-depth interviews, further reveal that they are prone to purchasing high end products and have keen interest in buying expensive products such as Lux body wash, Sunsilk shampoo, and even, in some instances Veet hair removal cream.

Interestingly, on the contrary, it can be triangulated from our interviews that married couples have significant SRHR needs and related costs, such as purchases of pills, condoms, injections and etc. However, they do not account or address these relevant purchases as costs, or costs related to SRHR.
It is observable that the workers function in a very rigid income and expenditure structure. Moreover, their preference towards costlier, yet good quality products further impede their capacity to make ends meet. Since the external costs are significantly relevant in their lifestyle (for instance the costs related to child care or accommodation), the only medium of incorporating SRHR products and services within their purchasing basket is through cutting down on these expensive luxury items. Then only the workers can save up for directing their purchasing decisions towards SRHR products and services.

It can be further highlighted that frequently used consumer product related expenses can be assessed through a private sector intervention. However, a thorough assessment related to the expenses on consumer products used by female RMG workers is required to clearly understand their purchasing behaviors and patterns.

Husbands of married female workers: Interviews with husbands of workers reveal that they usually go to the doctors themselves on behalf of their wives to discuss sexual and reproductive health related issues. However, this cannot be taken as the general behavior of the male in the RMG sector. Husbands working in the factories undergo certain trainings and have positive peer influence, which facilitates their positive attitude towards SRHR. FGDs and In Depth Interviews (IDI) with married female workers reveal a similar story- the husbands who works in the factories are more understanding and are aware about general SRHR issues that include family planning methods andmenstruation management. However, case studies reveal that there are still gaps that need to be mitigated by creating provision for training for the husbands of the workers. A challenge in this context would be to reach out to the husbands who are not employed in factories. Following are two cases on the role of husbands in supporting their wives on SRHR.

Role of Husbands in the Provision of SRHR for the female workers

Case 1

Mohammad Imran Ali: Mohammed Iman Ali, aged 33, works in Hop Lun factory, located inside EPZ. He is an experienced and highly skilled worker in the cutting and finishing unit. Iman Ali is married and has 2 children- a son and a daughter. When asked about his wife's SRHR related issues, he mentioned that he himself bought a 'pregnancy test kit' from the pharmacy on behalf of his wife; this had been suggested to him by his cousin, an MBBS doctor. Iman Ali is well concerned about his wife's health related issues hence he often consults his cousin for on issues related to menstrual hygiene and menstrual irregularity (on behalf of his wife). As soon as his wife was confirmed to be pregnant, he accompanied her to avail health services and diagnosis from Nari O Shishu Shashthya Kendra till 6 months into her pregnancy. During her 8th month, he suggested an ultrasound for her, after which, he sent her back to the village for child delivery, to be undergone through traditional birth attendants.

Iman Ali is aware that his wife uses rags from the factories however he has never heard that it can be harmful for her health. He has also heard about nutritional requirements especially during the time of pregnancy and has shown interest in procuring products from the pharmacy. He is aware about natural methods for family planning but is not aware about use of contraceptives or family planning methods.

Case 2

Mohammad Raju: Mohammad Raju has a recently born, one month old baby. He is 28 years old and is currently working as a senior packer and operator in Hop Lun. Raju mentions that he does not use any kind of birth control contraceptives such as condoms, injections or birth control pills. However, he is well aware about menstrual hygiene and encourages his wife to use sanitary napkins, mainly Senora (a premium brand), which he has mentioned suits his wife well.

He buys the product himself on behalf of his wife, and has clear knowledge regarding the price and availability of the product. Previously when his wife missed her menstruation date he accompanied her for a diagnosis which later confirmed her to be pregnant. During her pregnancy he made sure he conducted ultrasound on regular intervals as suggested by the doctors at Nari O Shishu Shashthay Kendra. He bought iron and calcium tablets for his wife during the time of pregnancy accordingly, as prescribed by the doctors. Later, he sent his wife back to the village for delivery 3 months before the baby's due date.

Raju was not comfortable with traditional birth attendants and home remedies for child delivery, thus his wife had a C-section in a hospital in the Barisal district of the country. He further states that his friends had suggested an 'early delivery syrup' for his pregnant wife but he did not use it as he thought it to be harmful for her.

Factories: The human resource structures in the factories were found to be well structured, which, if effectively utilized, can support successful promotion and adoption of SRHR initiatives. The factories that were visited during this research had multiple floor managers, line managers and supervisors designated for every production channel in the different floors.

The human resource structures of the factories in addition include a doctor and a nurse in the in-house medical center of the factories. These medical centers are critical for promoting SRHR initiatives since these centers are a direct point of contact with the workers. The medical centers in the factories are being used to a certain degree as service point for SRHR provision. Most of the workers during our in depth interviews and FGDs have revealed that they visit the in-house doctors for immediate relief from abdominal pain caused by menstruation. They occasionally go to the doctor for excessive bleeding or any menstrual or vaginal discomfort. However, the workers suggested that they are not comfortable in discussing issues with male doctors and usually engage the female paramedics for consultation. Review of the complaint record sheet in the medical centers revealed that there are no fields related to SRHR issues. Discussion with the doctors also revealed that factory medical centers are still pre-dominantly used to check for improper use of sick leave. The doctors also suggested that the workers are more comfortable consulting the pharmacies rather than the doctors.

All the factories (20) that we visited for investigation had at least one medical doctor and a paramedic, while few had more than one doctor and several paramedics. All of the factories who have incorporated SRHR have revealed that absenteeism has reduced drastically along with a leap in productivity rates. The factories also associated investment on SRHR to reduction in migration. This was further validated in the validation workshop where the participants were asked to identify the immediate impact of SRHR in the RMG value chain. Apart from this, the factories that have invested on improving their sanitation and toilet facilities and on distribution of low cost sanitary napkins to the workers reported a cost savings of around TK 200,000 (around USD 2500) every month which they had to spend on cleaning the sewerage line which would frequently clog due to the dumping of rags by female workers in the toilets.

It should be noted that the female workers belong to the lowest tier in the factory staff hierarchy. The upper tiers are dominated by male with exception the health welfare officers which is dominated by female. Line supervisors, who are the immediate contact point for the workers are mostly male. This to certain degree restricts the workers from using the medical centers as a contact point for SRHR since the workers have to take permission from the line supervisors before they can leave the sewing line to consult the doctors. The compliance officers in the factories are also primarily male and it was evident in our interviews that the female welfare officers had better understanding of the SRHR issues of the female workers. Some of the progressive factories in our interviews reported that they attempted to promote female workers as line supervisors but found that the female workers were not comfortable with the role. They eventually had to switch to male line supervisors. In this regard, training and awareness session for the male line supervisors, compliance officers and the HR manager of the factories could potentially have positive influence on provision of SRHR for the female workers.

'Line supervisors, who are the immediate contact point for the workers, are mostly male. This to certain degree restricts the workers from using the medical centers as a contact point for SRHR since the workers have to take permission from the line supervisors before they can leave the sewing line to consult the doctors.'

Buyers: Increasing number of buyers is opening local offices in the country which can be leveraged to increase awareness and interest amongst the buyers. After the tragic casualties of Rana Plaza and etc., the demand for interventions from the buyer's has increased significantly as a damage control scheme to create and maintain the image amongst the consumers. Some buyers are escalating their SRHR participation through introducing innovative solutions, such as help lines and call centers for reporting abuse, violence, sexual harassment, fire or any unforeseen predicament in the factory. The leading buyers in Bangladesh have been participating in the BSR-HER project and the Impact Business for Benefit and Workers (BBW) project. However, the number of factories involved in the interventions has not been revealed or reported by the respondent, hence the number is unknown. They thus have good understanding about social investment for business return. It is thus expected that they would buy-in the Inclusive Business model if the impact of good SRHR practices on business health is demonstrated with evidence.

Some of the brands like Tesco are already engaged in limited scale on their own. Tesco for instance is undertaking a training program targeting 5 factories for 2014-2015 to reach out to 400 workers directly and 8000 workers indirectly on the topic of personal hygiene. Tesco has got a charity committee in UK which is currently undertaking a project to provide free

sanitary napkins to school children. Such initiatives suggest that the buyers are keen to invest on such agenda like SRHR. It was also revealed during our investigation that the buyers would be interested on issues investment on which could fetch returns that would value to the organization's annual report targeting its shareholders. However, a key challenge would be to shift the buyers' perception of SRHR from being a CSR issue to being a business issue which is further discussed in chapter 5.

Consumers: According to the respondents, EU consumers are more responsive towards social issues like worker's health and are expected to have favorable response, for instance increased brand loyalty, as a result of investment from the buyers to their suppliers on ensuring worker's health and SRHR. The phenomenon of increased brand loyalty can be measured and reviewed through the Global Index on Brand Loyalty Measurement.

US consumers are reported to be more driven by price and are less interested on social issues. However, they too have responded to the call for increased safety standards for the workers following the Rana Plaza and Tazrin Garments tragedy. Consumer driven campaigns like Clean Clothes Campaign (CCC) are being undertaken in several countries to increase pressure amongst the buyers and factories on ensuring worker's health and safety. However, there appears to be a gap on initiatives in promoting good practices amongst the consumers which could create a positive image of the industry amongst the consumers. Even though it is understood that worker's health and safety is a responsibility of the buyers and their suppliers and it should not be taxed to the customers, since SRHR goes beyond the regular mandate under OHS compliance, there is a need that the customers join the movement to promote SRHR amongst the female workers by contributing in both cash and kind.

Snapshot: Evidences of Inclusive Business Models adopted by the RMG Factories in Bangladesh

DBL Group is one of the pioneers in adopting inclusive business models on SRHR for the female workers. The company currently procures sanitary napkins from ACI at wholesale price of TK 31 and sells to the workers for TK 10. The company thus provides TK 20 as subsidy on each pack sold. The products are sold through the fair price shop 'Bandhan' located in the factory premise. According to the management of the factory, since it started to invest on sanitary pads in 2011, the factory observed remarkable improvements in reducing absenteeism and migration. The current migration rate of the factory is 2.8% against industry average of 10%.

However, to what degree the reduction in absenteeism and migration could be attributed to SRHR is an issue since the factory currently sells about 600 units of sanitary pads. The management is reportedly considering making the purchase of sanitary pads mandatory for the workers. DBL also has a pharmacy inside the factory that sells contraceptives. However, this is not promoted actively since there is a risk that this will be seen as the factory promoting free sex amongst its workers. Other initiatives identified during our investigation include production of low cost sanitary pads by Babylon Group that also supplies the products to other factories.

The case of DBL and Babylon is widely acknowledged by the RMG factories and buyers and we found a keen interest amongst our respondent factories to adopt similar strategies. However, it should be noted that the factories are yet to adopt such practices for other SRHR issues which includes safe abortion, pre natal and post natal care etc. which are and is expected to be addressed through referral systems.

3.4 Opportunities for Promoting SRHR in the RMG Value Chain through the Actors in the Business Enabling Environment

BGMEA and BKMEA: Bangladesh Garment Manufacturers and Exporters Association (BGMEA) was established in 1983 with an aim to ensure a congenial business climate for sustainable growth in the apparel industry. It is one of the largest trade bodies in the country representing the readymade garment industry, particularly the woven garments, knitwear and sweater sub-sectors.

BGMEA's role in the development of the RMG sector has become far more important in recent years due to unrests related to accidents in factories and worker's wage. So far BGMEA has mobilized unprecedented support and commitment to improve working conditions and workplace safety in the RMG industry of Bangladesh. A number of national and international commitments have been made after the tragedies, including National Plan Action (NAP). BGMEA also joined hand for the formation of Accord on Fire and Building Safety formed by European brands and retailers, and Alliance for Bangladesh Worker Safety formed by North American brands and retailers.

An interview with officials of BGMEA suggests that they are eager to incorporate the idea of SRHR. BGMEA officials recognize SRHR as a critical issue with respect to the health of the female workers; however this component is persistently being unnoticed and disregarded. Both BGMEA and BKMEA have experience in managing health projects in collaboration with development partners that include United Nations Population Fund (UNFPA), Engender Health and GIZ. Several projects have already been undertaken and are on the process of being launched (further detailed in chapter 4) and could be leveraged by SNV for the promotion of SRHR through the trade bodies.

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Buyers' Forums: The buyers are not formally organized in Bangladesh. However, there are several informal groups of EU and US buyers. One of these forums, which is called 'Buyer's Forum' represents about 83 of the buyers in Bangladesh. Our interview with the sitting chair of the forum revealed that the forum could potentially stimulate SRHR schemes, if, the degree to which lack of SRHR is causing health risk to the workers is presented with evidence.

Snapshot: Trade Bodies in the Provision of SRHR

BGMEA currently operates 12 health centers that are servicing factories that do not have internal medical centers. Of these three are in the Gazipur, Savar, Konabari clusters where the SNV pilot will be implemented. According to BGMEA they have a budget of about BDT 20 lacs (USD 26,000) for the operation of 12 health centers. This comes down to about USD 2000 per factory. Through the factories free medicines are being provided to the workers on general health care. BGMEA has arrangement with the Department of Family Planning, Ministry of Health (MoH) from which it receives about 12000 pcs of condom and 2000 strips of Shokhi Bori (pills) that are to be distributed for free to the workers. Engender Health, an international NGO, is supporting this program. BGMEA also plans to undertake a policy dialogue on introducing better hygiene practices in about 40 factories under a new project called Changing Gender Norms.

BGMEA previously worked with UNFPA to provide awareness training to mid level managers of factories for the promotion of gender equity, prevention of HIV/AIDS, ensuring safe motherhood and promotion of family planning concepts. BKMEA has a social compliance audit and grading system of factories which can also potentially involve criteria related to SRHR. BKMEA is working closely with German Agency for Technical Cooperation (GIZ) on compliance.

The review of the activities undertaken by BGMEA suggests that even though they are engaged on several programs and projects, the scale is limited and their engagement has been primarily on managing time-bound projects. There is a scope to strengthen BGMEA's capacity to develop systems such that they could build on their experiences and provide long term support to the factories on the issues related to workers' health and SRHR. One such idea that was shared by BGMEA officials is the introduction of a compliance certificate to the factories which will adopt SRHR into their good practices. This certificate can be a potential incentive for factories to accommodate SRHR in their business practice since it will allow them with certain business benefits.

Government of Bangladesh: RMG in Bangladesh, till now has been under the jurisdiction of the Ministry of Commerce (MoC) and Industry however, quite recently the responsibility has been surpassed to the Ministry of Jute & Clothing. This shift would have an implication on the Ministries' buy-in and commitment to issues like SRHR because of the activities related to transition. The project might not get enough traction with the Ministry in the first year.

The Ministry of Health (MoH) through the Directorate General of Family Planning (DGFP) is engaged on strengthening service delivery for family planning which includes the provision of free commodities and long term and short term family planning methods. The Government is currently prioritizing long term methods like intrauterine device (IUD) and implants since according to the government short term methods are found ineffective (condom dropout rate is reported to be 47% while dropout rate for impacts is just about 8%). However, the workers do not usually go to the public health centers and the registered NGO facilities where the commodities are made available and the services are provided due to time constraint and requirements for paper work. DGFP could be partnered with and strategically linked with BGMEA and a health NGO so that the commodities and services are more accessible to both male and female workers. This is further detailed in chapter 6.

Financial service providers: A very interesting idea that was proposed by a director of one of the respondent factories was to engage the financial service providers on investment in some of the activities that may include behavioral change and communication campaign. It was shared with us that the private banks account for at least 21b dollars of transaction of the RMG industry and it would be of their interest to spend the 5% reserve fund that the banks are supposed to spend on CSR activities (as per Bangladesh Bank regulation) on issues in the RMG sector that includes SRHR.

Donors: Donors have their own agenda in fulfilling the goal of sustainable SRHR provision within the RMG sector in Bangladesh. By 2025 Bangladesh is set out to be a mid-income country and once that is achieved donors will start to limit their actions in Bangladesh. Therefore there is an incentive for donors to implement a sustainable SRHR practice within the RMG value chain. The major donors operating with respect to SRHR in the RMG sector in the country include EKN, UNFPA, International Financial Corporation (IFC)/ International Labor Organization (ILO), Swedish International Development Agency (SIDA), Riksforbundet for Sexuell Upplysning (RFSU), Asian Development Bank (ADB), World Bank, EU/ European Commission (EC), Department For International Development (DFID), Gesellschaft für Internationale Zusammenarbeit (GIZ), WHO, Oxford Committee for Famine Relief (OXFAM) and USAID (Macdonald, 2013). EKN, SIDA, and USAID are the primary donors in the RMG sector.

Chapter 4: SRHR Service Provision System for the Female RMG Workers

The service provision system in the RMG sector in Bangladesh is multi layered and complex. It involves public, private and NGO sector stakeholders who mostly work in collaboration with each other even though some of the services are being provided in isolation. It also involves informal providers like peers and micro and community level providers like pharmacies. The factories themselves are also critical to the provision of the services through the medical centers within the factories. An important point to note is that the micro level providers are dependent on the macro level providers like pharmaceuticals, NGOs, government and private sector commodity suppliers for the service delivery. We can thus identify four systems of service provision:

4.1 Factory and Community Level Service Provision

We have observed 3 immediate points of contacts by the RMG workers in the SRHR service provision value chain. At the very core of the system are the workers. To receive SRHR commodities such as the medicines for menstrual pain, excessive bleeding, trivial maternal complicacy etc. - the factory workers mostly go to the factory in-house doctors and nurses. The in-house medicine centers within the factories, with the help of doctors and nurses, cater to the immediate needs of the workers. Hence, the first point of contact within the factories with regards to SRHR issues is the factory in-house medical centers.

The secondary point of contact for the workers is the pharmacies. The growth of communities around the factories led to the proliferation of pharmacies in production clusters like Gazipur and Savar. The female factory workers either, personally attend the pharmacies after working hours, or send their husbands (which are prevalent in the majority of the cases) for SRHR needs. The pharmacies, thereby, play a very critical role as they are at the initial point of contact between the workers and their SRHR availability.

Thereafter, if the SRHR issue is not resolved, the workers consult the private, NGO or government medical centers situated in the garments clusters. This, we can say, is the third point of contact between the SRHR service provision and the RMG workers. The factories in a majority of the cases create referrals with these private medical centers and clinics. SRHR issues which are more severe and cannot be met by the factory medical centers are referred to the local medical centers. The factories have a 'link'with these medical centers through which the SRHR patients receive a marginally or substantial subsidy (depending on the factory strategic planning) on the cost of their treatment.

4.2 NGO and Project Driven Service Provision

The NGOs have direct and indirect means of intervention. They connect the pharmaceutical, donors, government regulatory bodies like BGMEA through creating service provision in and around the factories. The NGOs intervene in the medical centers inside the factories; additionally, they link the factories with the medical center outside the factories. They also make available the services and products from the pharmaceuticals into the factories and around the factories. On the flip side, in the public sector, the NGOs distribute the family planning methods available to the workers provisioned by the government. In many instances, the SRHR provisions go beyond the factories, onto the communities through peer educators and trainers. The informal service providers existing within the service provision system are also tapped by the NGOs. Thereby, we can see that the NGOs are the critical stakeholders within the SRHR service provision value chain in the RMG sector.

Most interventions undertaken by the NGOs comprises of peer training or master training programs. These master trainers in turn relay the sessions to additional

Snapshot: Factory and Community Level Service Provision for SRHR

For our research, we have extensively visited the private hospitals, medical centers, clinics and pharmacies to assess the services that are being provided. Our findings reveal that there is rising demand for health services in the RMG industrial clusters. This stimulated the growth of large number of pharmacies, private hospitals and clinics in the clusters. Over the past few years private clinics have mushroomed drastically catering primarily to the RMG workers. The investigation undertaken to identify the reasons are very interesting. Findings from our in depth interviews and FGDs, suggest that the workers are reluctant to take health services within the factory premises since they fear to be seen by their peers. This is primarily due to the existing social taboo regarding SRHR. Women want to maintain secrecy with regards to SRHR issues, and hence, prefer going to a doctor outside the vicinity of the factory where no one will identify her, in case the SRHR issue gets critical. In order to be compliant the factories are linked with an external referral hospital (private/public) which provides the workers with subsidized rates of service provision.

A key issue with factory and community level service provision is unsafe MR which is said to be undertaken at a lower cost in smaller and newer clinics and hospitals. An interview with Chandra Apollo Hospital reveals that MR is the most commonly demanded service by the garment workers. In most cases, patients are said to 'walk-in', without any notification or referrals from the factories about their pregnancies.

number of workers during lunch breaks and lean periods of production. However, one mentionable fact is that the monitoring and evaluation of such provision undertaken by the peer and master trainers are not always well documented. Some NGOs take continual feedback from the trainers by maintaining a track record system; while others pay are yet to adopt a 'follow up'scheme.

Marie Stopes, Reproductive Health Service Training and Education Program (RHSTEP) and Community Health Clinic (CHC) are the major NGOs working on service provision and awareness generation amongst the RMG workers. Growing Up Safe and Healthy Project (SAFE) and Netherlands University Foundation For International Cooperation (NUFFIC) are two programs that aim to carry out some extensive research of SRHR in order to supplement and complement the existing programs. SAFE program, funded by Netherlands, have 5 implementing partners which support them to promote SRHR through reducing violence against women and girls. It highlights women's right to choices and consent with regards to marriage, sex and child bearing. Other than these, there are peer education programs which are widely prevalent within the garment premises as components of larger programs or as individual programs. The peer education is further extended to sharing sessions held amongst the workers to initiate discussion on SRHR related concerns more explicitly.

Some of the programs identify the potential linkages amongst the stakeholders and integrate the actors together to attain more viable and sustainable outcomes related to SRHR. SAFE program establishes strong networking links between the legal services providers, reproductive and sexual health service providers, human rights and women's advocacy, research institutions and Bangladesh's Ministry of Women and Children Affairs (MoWCA). Link Up, is another project that works to stitch together stakeholders in order to make service provision for accessible to the female workers. Marie Stopes is the clinical partner for the Link up project, HIV/AIDS and STD Alliance Bangladesh (HASAB) operates with regards to SRHR awareness creation and provision of training, Alliance for Cooperation and Legal Aid Bangladesh (ACLAB) intervenes in enhancing service provision and Population Council undertakes research and monitoring of the project.

Better Works Program, implemented by ILO operates to ensure a holistic and well-integrated compliance in the factories; this project incorporates health as multidimensional and critical component. Comprehensive Sexual and Reproductive Health Services for Working Girls is another project funded by RFSU and is implemented by Population Service Training Center (PSTC). This project highlights the SRHR attributes to health concerns and works to ensure the enhanced health benefits and service provision of the female workers. A very similar project to the above is the Reach Out project which is funded by the EU and implemented by Bangladesh Rural Advancement Committee (BRAC), Marie Stopes Clinic and RHSTEP. Reach Out focuses on SRHR of the urban females by creating Community Health Welfare Officers to support women during pregnancy and delivery. The project additionally, aims to create awareness and training in the communities where the female workers reside; along with improving the knowledge and treatment practices of the informal providers and traditional healers who are often visited by the female workers.

Even though the NGO service provision system can be a potential threat to inclusive business models, it is evident that the factories, buyers and commodity suppliers will have to work with the NGOs to reach out to the factories since the NGOs have already created a service delivery system and have the institutional knowledge that could be leveraged. This is evident from the existing cases of engagement between the NGOs and the private sector.

Snapshot: Initiatives that are being undertaken by the NGOs that aim to engage the buyers and factories on investment and management of the interventions

Phulki, a local NGO is operating a helpline branded as 'Amader Kotha.' The helpline is funded by Alliance and is primarily mandated to address OHS. The helpline is also mandated to report on sexual harassment cases. Marie Stopes and SMC are independently operating helplines/call centers on SRHR but these are targeted for the general population. Benefit for Business and Workers (BBW), funded by groups of buyers and DFID and managed by Impact, is targeted towards improving the Human Resource (HR) practices in the factories such that benefit to the workers lead to benefit to the businesses. The training costs are borne jointly by DFID (50%), buyers (25%) and factories (25%).

BSR-HER project is the largest of the programs which is being undertaken with direct funding from the buyers in addition to development partners. Launched in 2010 in Bangladesh by a local organization 'Change Associates', the project is currently working with 17 brands that includes the likes of M&S, UNICLO, PRIMARK, George, Timberland. HER project conducts a baseline study at the inception of the work with the factories. It was shared with us that one such baseline study revealed that about 70-75% of the workers were suffering from chronic RTIs.

HER project aims to reach out to 50 factories by end of 2015. The project uses the concept of peer training model to reach scale. Peer trainers called 'Shasthya Shakhis' are trained to provide counseling and advisory support to other workers. As exit strategy BSR- HER project plans to support the factories to develop a one year post project action plan. The participating factories are engaged for 15 months and it costs about USD 5000 per factory for the implementation of the activities.

Besides, Change Associates has developed a health facility standard grading system in partnership with MeridienCanda. It is also introducing a nurses training program in partnership with Kumudini, a renowned NGO working on health and training and education of nurses and paramedics.

4.3 Private Sector Service Provision

The private sector is a critical stakeholder in the provision of SRHR for the RMG workers. Even if there is demand for low cost solutions among factory workers there has to be abundant supply of products so as to satisfy the need. Therefore it is important that private sector comes up with product bundle to serve the market of female factory workers. Secondary literature review along with the affirmation of interviewers within the private sector reveals that there are various interventions undertaken with regards to SRHR. Private sector provision has facilitated improved health standards amongst the RMG workers, especially shedding light on female health. To strengthen and sustain the provision of SRHR in the industry private sector linkages are necessary.

4.4 Public Sector Service Provision

Public sector provision for SRHR was not systematically assessed in this study. However, investigation was conducted to determine the impact of government policies on the private and NGO provision of SRHR services and products. A key conclusion from the investigation was the fact that (i) the garment workers do not usually visit public health facilities for SRHR related issues and (ii) the distribution of free commodities and family planning methods by the government has implication on the retail market and private market for these commodities. This maybe primarily because the government provision in SRHR commodities makes the market less beneficial for the private sectors, thereby decreasing the number of product suppliers in total. On the other hand, the majority of the pharmaceuticals serve the government institutions which create a disincentive for them to produce for the retail market. Besides, since the public service system is targeted towards the population in general, it does not systematically target the RMG workers. These issues are further detailed in chapter 5.

Snapshot: Private sector in the provision of SRHR for female RMG workers

ACI: Advanced Chemical Industries (ACI) Consumer Products Limited has designed a branded sanitary napkin specifically targeted towards the lower income segments of the population. Savlon Freedom Popular, sanitary napkin, marketed at the retail price of TK 36 (USD 0.40) is for the consumers with an income range of Tk. 5000-6000/month (USD 80-90 per month). According to ACI, as majority of the companies serve the high end consumers, there is an extensive scope of service provision in the low end markets. Savlon Freedom Popular is unobtainable in the outlets. ACI primarily distributes the products through Memorandum of Understanding (MoU) with the RMGs and the NGOs, approximately selling 40,000 packets per month to 18-20 factories. According to officials in ACI, the sale of the sanitary napkins has had a steady growth since the inception of the business model 6 months ago. However, it requires increased focus, and awareness creation amongst the stakeholders. The contribution from ACI till now is limited to sanitary napkins but it can expand to a wide variety of areas like personal hygiene, medicines related to SRHR and etc. For instance it has introduced a new pregnancy test kit at the retail price of TK 18 (USD 0.23) targeting the customers at the lower income households.

SMC: The Social Marketing Company (SMC) is the market leader on distribution of family planning products and according to the respondents it holds 38% of the total contraceptive market. The company has several brands that reach out to different segments of the population- from the bottom of the pyramid to the higher income population. The company has recently introduced a new brand of sanitary napkin 'Joya' which is marketed at the retail price of TK 55 (USD 0.70) per pack. According to SMC this brand addresses the concern of quality of some of the sanitary napkins that are being marketed by different brands as well some of the RMG factories which are producing low cost sanitary napkins on their own. SMC also operates the Blue Star program for family planning with funds from USAID. According to SMC many of the Blue Star providers are located in the Gazipur and Savar clusters where the most of the garments are located. SMC could strengthen their Blue Star Program in these clusters and create more providers if need be to serve the female workers.

Square Consumer Products Limited: Square holds 80% of the total sanitary napkin market in Bangladesh. The company has extensive experience on behavioral change communication campaign for raising awareness on the use of sanitary napkins to reduce the rate of cervical infection which is said to be about 97% amongst the women in Bangladesh. Square specifically reached out to 2.5 million school girls in Bangladesh to raise their awareness on the use of sanitary napkins. The company markets the sanitary napkins at premium price (USD 1.10 per pack) and says the price can be afforded by the garment workers. Square is reluctant to subsidize their products and claims that it effects sustainability. Square also operates a help line which provides advice on menstruation hygiene. It also worked with ICDDR'B on marketing a large sized sanitary pads which could help detect post-partum hemorrhage for child birth at home by informal providers.

Chapter 5: Constraints in Promoting SRHR in the RMG Value Chain in Bangladesh

From our study we could identify five sets of challenges that are restricting the provision of SRHR in the RMG value chain. While some of these challenges are specific to one actor of the value chain, some of it spreads across the value chain and involve multiple stakeholders. These challenges can be classified under the following categories:

- Social, cultural and behavioral barriers
- Work place barriers
- Accessibility, affordability and quality of service barriers
- Investment barriers and
- Capacity, knowledge and skills barriers

It should be noted that these challenges are all interconnected and one leads to the other.

5.1 Social, Cultural and Behavioral Barriers

Our findings suggest that even though the NGOs have had undertaken rigorous intervention on raising awareness amongst the workers on SRHR issues, the awareness is yet to translate into usage and practices amongst the workers. A key barrier to this is the social, cultural and behavioral practices that are yet to be addressed. The social, cultural and behavioral barriers that are yet to be overcome include the following:

Messages don't spread out through word of mouth since sexual health is considered a taboo: Since sexual health is considered a social and cultural stigma and taboo; the messages received by the workers do not spread via word of mouth, which is key to spreading community and society wide adoption of good practices.

Husbands are yet to be effectively targeted to make them aware of the SRHR needs of their wives: For the married women, the husband is a critical influence on ensuring sexual health; our interviews with husbands revealed that they lack proper knowledge on use of family planning methods, risk of cervical infection due to improper hygiene practices etc. Programs are yet to reach out to the husbands at scale for them to disperse this and be able to incorporate SRHR practices within the culture.

Peers and communities exert a negative influence on the workers; programs are yet to find effective means of engaging peers and communities along with workers in the work place: Workers community, which includes their peers and neighbors are not reached out by the programs; therefore, the workers who are trained are not supported by practices and knowledge by their peers and community members; programs are yet to reach out to the communities. Even though the factories and NGOs acknowledge this barrier, they are yet to find a cost effective and efficient model to reach out to the communities of the workers at the same time

Lifestyle of the workers makes them vulnerable to Sexually Transmitted Diseases (STDs); but they are not willing to take service from formal providers: The doctors and paramedics who were interviewed reported of workers (both male and female) having multiple partners. The lifestyle of the workers thus makes them vulnerable to STDs. But the workers did not acknowledge of such lifestyle in our interviews. The issue of prevalence of STDs and its risk amongst the female garment workers thus go unaccounted for. Pharmacies are the key providers of advice on family planning methods and drugs for treatment of STDs. It was also found that many of the pharmacies in RMG clusters are providing unsafe MR services. Since the pharmacists lack the qualification to provide such services; the workers are exposed to serious health risks;

Time needed to instigate behavioral change: It takes years to translate awareness into behavioral practices and therefore it is essential that a common message is spread across all the media and contact points through which the workers receive message on sexual and reproductive health; the programs are operated in isolation; even though campaigns on use of family planning methods and contraceptives are being undertaken by the government and development partners nationwide, this is yet to be complemented by coordinated interventions at factory and community level.

5.2 Work Place Barriers

Findings reveal challenges at the workplace that restrict the workers on adopting good practices even if they are aware. This includes

Limited flexibility in work hours restrict the workers in availing service from the formal providers: The widespread popularity of the pharmacies can be related to the long working hours at the factories which restrict the workers from attending medical centers and qualified doctors, as the medical centers are closed by the time the workers are free. The ultimate option for the workers is to avail the medical center facilities on Fridays (Weekend) and in many instances there are long queues which discourage them.

Fear of exposure limits the use of the medical centers in the factories as consultation point: The medical centers within the factories are yet to become the consultation point on SRHR. The workers are reluctant to discuss SRHR issues with the doctors (also, the factory in-house doctors) even though many of the factories have female doctors. Female workers fear that they might get exposed to their peers and thus try to avoid discussion and consultation on the issue within the factory premise.

Large number of workers in the factories makes dissemination of knowledge a challenge: The factories employ large number of workers. A typical mid-sized factory unit has around 2000 workers of whom roughly 1500 are female. Since all these workers cannot be brought out of the factory for training at the same time, NGOs and factories developed the peer training and master training model. This model assumes that the peers or master trainers will train other workers and over time all the workers will receive the message. The model does not address the issue of the peer trainers migrating to other factories and the strategy to reach out to new workers who are joining the factories on a continuous basis.

Dependency on external support limits the capacity of the factories to address SRHR issues in the work place: The factories are yet to have their own system in place to provide continuous service to the workers and remain dependent on satellite clinics and training programs undertaken by the NGOs. Most factories are not willing to provide access to the NGOs because of concerns related to NGOs instigating unrest. Therefore, most of the factories have remained out of the reach of the existing programs on SRHR.

Power relations; domination of male staffs in the hierarchy: The female workers are in the low tier of the staff hierarchy. The staffs having decision-making roles which includes the line supervisors, health welfare officers, compliance managers are primarily male. The high-level factory staffs (for instance the general managers), directors of the factories are also primarily male. Further to that most factories have male doctors. Even though the male respondents of the study were found to be aware of the issue of SRHR and showed their eagerness to champion interventions, female staffs were found to be more knowledgeable of the cases of the workers. SNV in this context needs to explore the possibility of supporting the factories in adopting HR strategies that could attract more involvement of female in the key positions. In addition to that, the male staffs need to be trained on SRHR issues and their solutions so that they could effectively champion the provision of SRHR in their respective factories.

5.3 Accessibility, affordability and service quality barriers

Even though the female workers live in communities and places close to health centers and service providers, there are accessibility barriers that limit the provision of SRHR services and products for the workers. Additional to accessibility, affordability and quality of the product and services act as an obstacle for many women in incorporating SRHR initiatives. This includes:

Lack of interest amongst the factories to provide access to the NGOs: There is general lack of interest amongst the factories to give access to the NGOs. Interview with several NGOs have highlighted this issue repeatedly. Due to the issue of accessibility most projects and NGOs end up engaging the same factories on different initiatives which lead to silo effect and limit scale. Officials at a NGO called Phulki have highlighted the fact that, in order to convince the factories to permit the project intervention, Phulki had to undergo several sample training sessions. Furthermore, Phulki had to chase the factory management through series of phone calls and emails, which often go by unanswered.

Workers do not get the products when they need it: Commodity suppliers and pharmaceuticals reach out to the point of service and product delivery, for instance, the pharmacies and medical centers. Since sexual health is seen as a taboo, workers do not purchase the products directly or try to avoid retail and health checkup points that are known to them. NGOs working on SRHR attempted to address this challenge through satellite clinics from where free commodities can be availed by the workers. But this is a superficial system. The workers will purchase the drugs and commodities when they need it but not when it is made available to them. Therefore, the commodities that are made available in the satellites do not lead to sustainable access and usage for the workers.

Workers barely have savings; SRHR is yet to be considered as an essential expense head: Review of workers' income and expenses suggest that they barely have savings. Nonetheless, it is striking that significant percentage of their income is spent on consumables and to certain degree on luxury products. SRHR was not reported by the workers as an expense head. This suggests that SRHR issues like menstruation hygiene, use of contraceptives etc. are not accounted for as a regular need. The project's interventions will have to generate interest amongst the female workers to compromise some part of their expenses on luxury products to accommodate for regular expense on SRHR needs.

Commodity suppliers and pharmaceuticals are dependent on NGOs to reach out to the workers: The commodity suppliers, for instance the suppliers of sanitary pads, reported that they need to engage with NGOs to be able to reach out to the factories since they do not have the manpower to reach out to the factories systematically which the NGOs do. On the other hand, reach of NGOs has remained limited within the scope of time bound projects. There is a scope to promote long term business relationship between NGOs and commodity suppliers which could in turn ensure accessibility of the commodities and the services to the workers. This channel is evolving but is yet to be established.

The expense and quality of SRHR products and services: The rags that the garment workers use are widely available in the factories and that too for free of cost. This acts as a disincentive for the workers in buying sanitary napkins, which has a significant cost involved since not all the pharmacies have low-cost napkins available. FGDs with the female workers reveal that a few of them are satisfied and accustomed to using the rags and are reluctant to shift to sanitary napkins. A few respondents have mentioned the availability of low quality condoms in the pharmacies and public hospitals that induce burning and itching after usage, which is why they are reluctant to use it. Female workers have complained about the birth control pills that cause nausea, headaches and tastelessness. There are no other substitutes or variety to choose from.

Government intervention on free distribution of family planning products and methods limit the retail market presence of the private sector: Family planning commodities such as injectable, condoms, pills and supplementary long term family planning methods are provided by the Government for free. This makes the market less lucrative for private sector business and pharmaceuticals. Thus there are a limited number of suppliers for contraceptive commodities. Most pharmaceuticals serve the institutional markets (both private and public) and do not have the incentive to serve directly to the retail markets. Although recently, there are a few pharmaceuticals that produce low cost affordable hygiene products like sanitary napkins; however it is generally pursued as a CSR initiative by the companies other than a business case.

5.4 Investment Barriers

While family planning is addressed through public health system and is regarded as a public health concern, STDs, UTIs etc. remain within the domain of the private health systems. In this context, to ensure sustainable provision of SRHR for the workers, it is essential that the factories, buyers and service providers invest on developing a system that is self financed and self sustaining. There are several challenges that restrict the factories, buyers and service providers to invest on SRHR for female workers. This includes

Drive to invest on OHS compliance limits capacity of the factories to invest on SRHR: Factories are currently driven by compliance to OHS. They are making significant investment on Occupational Health Safety (OHS). According to some respondents the factories are investing USD 250,000- 300,000 on OHS due to regulatory pressure from Accord and Alliance which are working on building safety and fire safety. In this context, there is a threat that investment on provision of SRHR for the workers will not be seen as a priority

Most factories are yet to be aware of business gains from investment on SRHR: Even though factories which have invested on SRHR for the workers have reported of significant improvement on rate of absenteeism, migration and productivity, the evidence is yet to be systematically collected and disseminated. Most factories therefore are not aware of the business benefits that could be gained through investment on SRHR for the female workers

Buyers take SRHR as CSR issue; yet to promote and adopt SRHR for the purpose of business gains: The investment decision of the factories is driven by the buyers. Buyers consider SRHR as a CSR issue. CSR projects often struggle to reach scale since these are seen as good to have or add-ons. SRHR needs to be positioned as a business issue more than a social issue so that both the factories and buyers are driven by business interest to invest on developing long term capacity of reducing risks to workers health due to lack of SRHR. This would require creating an evidence base on (i) the business return of investment on SRHR and (ii) the risk to worker's health due to lack of SRHR which exposes the factories and buyers alike to crisis that were unfolded following Rana Plaza and Tazrin Garments tragedy.

Interventions by buyers, factories and donors are mostly ad hoc and not strategic: The interventions that are being undertaken are mostly short term and time bound and have remained limited to the scope of the workers and factories that are directly reached out to. Models that could drive industry wide adoption and good practices are yet to be in place.

Drive to ensure price competitiveness leads the factories to invest on initiatives that could ensure long term gains: The factories are businesses and the entire industry is driven by price competitiveness. The motive of the factories is to be profit maximizers and cost minimizers. The standard practice in the industry is to get engaged in intense competition to secure their market status by offering the best value to the consumers, thereby, the buyers' and their brands. As a result of that, they fail to claim the premium from the consumers. Additionally, though some consumers are sensitized towards workers health welfare, a majority of them are price sensitive. If the consumers could be convinced to pay a marginal premium, the entire value chain, especially the workers could benefit in terms of SRHR and beyond. In all instances, the global consumers are typical consumerist individuals acquiring cost-effective strategies. They are seen to be sensitive to brand design and price over the source and strategy of production.

Donor mandate is not conducive to the promotion and adoption of inclusive business models: NGOs are driven by the donor agenda and subsequently invest on strategies to satisfy the donor's mandate. Our review suggests that the mandates have so far remained limited to assessing the outreach and scale of the programs, for instance number of workers that have been trained on SRHR issues with donor fund, number of workers that receive SRHR services and products because of donor fund, number of factories that have provision of SRHR services and products. Such indicators do not report the health of systemic and sustainable change since it does not record the systems that are put in place for continuation of the services. Such indicators include, number of factories that have put in place an SRHR service provision system for the workers, number of service providers that have invested on developing products and services that can sustainably address the SRHR challenges in the RMG factories, number of buyers that are investing on SRHR needs of the workers. The donor's mandate thus creates disincentives for the NGOs to develop sustainable models.

Disconnect between the workers and the consumers make it difficult to translate good practices for the workers to business gains: Illustrated earlier in this study, the consumers are high up in the RMG value chain. They are remotely connected to the workers and are hardly aware of their needs if not instigated by widespread media coverage which is often led by tragedies rather than achievements. The consumers are thus yet to become an influence group. However, there are campaigns that aim to connect the consumers with the workers. For instance, the Clean Clothes Campaign (CCC) is such an initiative which is dedicated to improving the working conditions and supporting the empowerment of workers in the global RMG industry. CCC has been established in 1989 and has assisted in ensuring fundamental rights of workers through increased education and mobilization of consumers, lobbying companies and the government and directly offer support for the workers to fight for their rights and demand a better working environment. Working in an alliance of 16 EU countries, CCC works with women's rights, consumer advocacy and poverty reduction. The scope of incorporating SRHR in the mandate of CCC needs to be explored though.

5.5 Capacity, Knowledge and Skill Barriers

Sustainable solutions require capacities- human, infrastructural, technical; that could sustain the service provision on SRHR. Since the investments have not been channeled for long term capacity building needs of the buyers, factories and the service providers, each of these entities lack critical gaps in their capacities which restrict sustainable provision of SRHR for the female workers in the RMG value chain. This includes:

Factories are yet to have an internal system that could tackle SRHR issues sustainably: Because of the existing supply driven service delivery model the factories are yet to develop an internal system that could address SRHR issues sustainably. This includes in-house capacity for training and awareness raising, sustainable linkage with service providers and commodity suppliers, regular monitoring of workers' health and SRHR issues, work place facility for personal hygiene etc.

Limited knowledge and awareness amongst the buyers on the degree of prevalence of SRHR issues amongst the workers has limited their investment on capacity to promote SRHR in their supply chain: The buyers are yet not aware of the degree of prevalence of SRHR problems amongst the workers, they are yet to have the policies and support mechanism in place to tackle SRHR issues of the workers in addition to OHS

NGOs are critical to SRHR service and commodity delivery; but they are yet to build their human and technical capacity on sustainable solutions: Although the NGOs are increasingly working with the value chain actors such as the factories and buyers and are heavily investing on issues such as measuring Return on Investment (ROI) due to interventions, there is still a lack in understanding the social benefits leading to business benefits and the strategies that could engage the value chain actors for scaling up and sustainability. The NGOs in general needs to understand and internalize the concept of inclusive business models for addressing SRHR issues of the workers and adopt it as their practice area.

Trade associations are yet to become facilitator of inclusive business models to tackle social and health issues of the workers: Trade association lacks the knowledge and technical expertise in delivering SRHR related service and commodity; they do not bear the capacity of acting as a facilitator. There has to be strategic partner or a consortium, through which advise, management, advocacy, policy design and monitoring and evaluation of SRHR initiatives can be undertaken by the trade associations.

Donors are yet to embrace inclusive business models as mandate to tackle SRHR: The donors mandate with respect to addressing SRHR issues need to evolve to support development and widespread adoption of inclusive business models. However, this would require buy-in to the evidence base on social benefits leading to business gains which can eventually lead the donors to incorporate such models in the mandate of the projects.

models promoted by the project.

Chapter 6: Strategic Recommendations

The pilot project would need to take a multi-stakeholder approach to tackle the challenges in the provision of SRHR for the female workers in the RMG value chain. Furthermore, since the challenges are inter-related, it is essential to ensure that the interventions are not seen in isolation. This chapter provides details on the following:

- Intervention Strategies: Strategic interventions that should be undertaken by SNV to address the challenges through inclusive business models. It should be noted that capacity building and advocacy are taken as intervention areas and therefore these are not presented separately.

- Operational Strategy: Time series presentation of the proposed interventions; potential partners and their roles in the intervention

- Knowledge Management and Communication Strategy: Systematically capturing the knowledge and communicating the lessons learnt to the stakeholders across the lifetime of the project to ensure continuous engagement of the stakeholders and buy-in to the

6.1 Intervention Strategies

In chapter 5, we summarized the key constraints in the provision of inclusive business models for the provision of SRHR for the female RMG workers and classified them under five- social, cultural and behavioral barriers, work place barriers, accessibility, affordability of quality barriers, investment barriers and capacity, knowledge and skill building barriers. These barriers are interconnected and therefore call for holistic strategy to resolve the challenges. It should also be noted that while the social and behavioral barriers and the work place barriers are related primarily to the workers, the accessibility barriers, investment barriers and capacity barriers are primarily related with the SRHR service providers, regulators and facilitators. Thus, interventions that addresses the capacity, investment and accessibility barriers are expected to contribute to the solution of the work place barriers and social and behavioral barriers.

The interventions that we are recommended can thus be classified in three categories- (i) capacity building, advocacy and action research on IB. It should be noted that action research in this context refers to pilot interventions. These three strategic intervention areas are interconnected and should not be implemented in isolation (figure 7). Within each of these strategic areas we are recommending SNV to undertake the following specific interventions that can potentially address the specific challenges within the broad category.

Action Research/Pilot: We are proposing the following interventions as action research or IB pilots:

i. Support factories to develop innovative models for provision of SRHR to the workers: This intervention would aim to strengthen the in-factory provision of SRHR by addressing the challenges related to effective use of the medical centers for consultation. This intervention would aim to leverage on the existing structure of Worker Participatory Committee (WPC) and welfare officers in the factories, the induction trainings that are organized for the new workers and the training service capacity of the factories. This intervention would also aim to stimulate innovations on business models for the provision of SRHR. This may include scale up of the existing models of distribution of low cost sanitary napkins and introduction of innovative models like introduction of health cards for the workers which could eventually be used as a health monitoring tool and voucher for redeeming subsidized services. The business model may also involve innovation in partnership between factories, service providers, commodity suppliers and buyers so that the business model could be financed and sustained directly by the value chain actors.

Figure 7: Intervention Strategies and Interconnectedness of the Strategies

ii. Support service providers (private sector and NGOs) to develop innovative models to increase and sustain delivery of services and products related to SRHR: Some of the private sector and NGO providers proposed of innovative models for increasing their outreach to the workers. SMC for example showed keen interest to develop a distribution hub system for the workers through which family planning products and services, including hygiene products and contraceptives marketed by SMC could be directly promoted, distributed and retailed to the workers. This intervention would aim to complement the peer trainer/ master trainer model to reach out to more workers more effectively. This intervention would also aim to strengthen facility based provision of SRHR for the workers. It is expected that the innovation would involve new ways of partnership between factories, buyers and service providers (private sector and NGOs) such that the innovation could be financed and sustained by the value chain actors.

iii. Engage buyers to develop innovative mechanisms for promoting SRHR amongst the workers of their suppliers: The buyers' engagement on provision of SRHR is currently limited and is driven by CSR agenda. The impact of the interventions thus remains limited. This intervention would aim to stimulate the buyers to develop innovative mechanisms of promotion SRHR for the workers of their suppliers. This may include helpline/ call centers for SRHR, strategic alliance between buyers and SRHR service providers and commodity suppliers which could allow the factories to avail SRHR related services and products for their workers. This may also include provision of SRHR excellence award jointly by the buyers, BGMEA/BKMEA and the Government of Bangladesh.

iv. Support buyers/NGOs/private sector to develop effective Behavioral Change Communication (BCC) tools for SRHR in collaboration with factories: This intervention would aim to address the critical challenge of reaching out to large number of female workers with the same message on critical issues related to SRHR. This intervention would require engagement of workers, their husbands and partners, relatives and neighbors in the communities. This intervention would also seek to stimulate innovation on use of mobile phones by establishing help lines, broadcasting media, print media and point of sales communication for effective dissemination of information to the workers. It would be essential that the BCC campaign is implemented in conjunction with service and product delivery so that (i) the supply meets the demand and (ii) the BCC campaign is financed by the revenues generated through the provision of services and commodities. The BCC campaign may also involve sponsorship and cross-subsidy as source of fund. The key components of the BCC campaign will be to address the following issues:

- Positively engaging the husbands, family members and in-laws on provision of SRHR for the female workers

- Reducing the discussion barrier between female workers and their peers, line supervisors, Welfare Officer, doctors, nurses and paramedics

- Reducing the discussion barrier between female workers and male actors in the factories and in the service delivery channels

- Reducing discussion barrier regarding SRHR within the communities of the workers such as neighbors, friends, and community leaders, who are key influencing agents in women's decision making process.

The project can consider using BCC tools developed by other projects (either completed or ongoing). The scope for improvement should be kept open though. It is also advisable that the BCC campaign is initiated at a later stage once the service delivery channels are strengthened. This will ensure that the messages passed through the campaigns are translated to demand.

Capacity Building: The following interventions could be undertaken to develop sector wide capacity for adoption of Inclusive Business models:

i. Training support to buyers, factories, NGOs and private sector service providers and commodity suppliers on developing inclusive business models: Inclusive business models require a business model to secure the fund for sustenance of the services. This in turn calls for innovative financing models and partnerships. There are both local and global cases on successful inclusive business models. But the knowledge is not widespread.

It would be essential in the beginning of the project to support the prospective partners of the projects to have clear idea about inclusive business models, its affiliation with SRHR and the strategies that could be adopted to sustain the models.

ii. Facilitate multi stakeholder partnerships for inclusive business solutions to SRHR issues of the RMG workers: It is clear that the inclusive business models would require multi stakeholder partnerships between factories, buyers and NGOs. These partnerships are already in place and are increasingly being adopted. However, a critical challenge is that the factories in general are unwilling to allow the NGOs to conduct activities within the factory premise. This intervention would seek to build capacity of the stakeholders to identify partners and develop and maintain partnerships.

iii. Support stakeholders on promoting inclusive business models to create a better image of the RMG sector in Bangladesh: This intervention would aim to support the project partners (factories, buyers, NGOs and private sector) to document the impacts achieved (both on improving workers' health and on productivity and profitability of the factory) and proactive disseminate the information through local and international media. This would help build a better image of the Bangladesh RMG sector amongst the local and international stakeholders, including the customers and in turn create sustained interest on investment on SRHR.

iv. Training for both male and female actors in the RMG Value Chain on gender roles in the provision of SRHR: Gender segregated roles can be considered for the multiple stakeholders with respect to incorporating SRHR as a part of their business model. As the majority of the factory owners and management staff are males, an extensive training of the factory owners, management and additional staff such as line supervisors, welfare officers and compliance officers will help to increase their capacity, awareness and knowledge to adopt SRHR more eagerly.

Husbands of the female workers, who are identified in this study as one of the key influencers in women's decision-making behavior, should be trained on SRHR needs and practices. While the project could possible reach the worker's husbands who work in RMG factories, it would be difficult for the project to reach the husbands who work outside the RMG industry. Effective strategies to reach out the husbands who work outside the factories could be explored.

The factories can promote SRHR amongst its officials through increased campaigns, newsletters, leaflets, awareness creating info graphs, discussion sessions, commercial ads and etc. The presence of female health welfare officer within the factory premises will help achieve the transformative behavior at a higher and impactful rate.

The buyers who are critical and influential stakeholders within the value chain are mostly males. Extensive training and capacity building on their part is a necessity which will make them increasingly prone towards integrating SRHR in their compliance issues. This will further stimulate SRHR activities further down the value chain.

The scope of these trainings could be expanded to engage staffs from the pharmaceuticals, consumer product manufacturers and from the public sector which were also found to be dominated by male.

Advocacy: It is essential to create sector wide buy-in to inclusive business models and the need for investment on SRHR. The following interventions could be considered to create industry wide awareness and buy-in for investment on SRHR:

i. Study on the SRHR priority needs of the female RMG workers and the lack of SRHR on workers' health: This quantitative study would aim to analyze and document the SRHR priority issues amongst the female workers in the RMG sector and establish the evidence base on the risk of these issues on workers' health. Dissemination of this information could help sensitize the buyers and factories to consider investment on SRHR of the female workers.

ii.Developing stakeholders' awareness about the need and value of investing in SRHR: It is essential to systematically capture the impact that is being achieved by the project and share it with national and international stakeholders to ensure their commitment and buy-in to the investment on tackling SRHR challenges of the workers. This intervention should be carried out throughout the life of the project; however, the intensity would be higher at the end of the project when the results are increasingly evident. Roundtables on thematic SRHR issues, for instance, personal hygiene, MR, family planning, STDs etc. and the scope of inclusive business models could help sensitize sector wide interest on investing on inclusive business models. It would be specifically relevant to raise interest on inclusive business amongst the donors that are engaged on addressing SRHR issues.

6.2 Operational Strategy

Intervention Time Series: The interventions suggested in section 6.1 need to be implemented using a holistic approach. This would ensure depth in impact and scale in outreach. Following is a time series presentation of the recommended interventions. This is a provisionary time series and should be changed as the project learns and adopts new interventions to tackle new challenges or to take advantage of new opportunities.

Table 2: Time series illustration of the recommended interventions

Intervention Area	Intervention	Year 1	Year 2	Year 3
Capacity Building	Training support to buyers, factories, NGOs and private sector service providers and commodity suppliers on developing inclusive business models	→		
	Facilitate multi stakeholder partnerships for inclusive business solutions to SRHR issues of the RMG workers		→	
	Support stakeholders on promoting inclusive business models to create a better image of the RMG sector in Bangladesh			→
Advocacy	Study on SRHR issues of the female RMG workers and the risk of lack of SRHR on workers' health	→		
	Developing stakeholder's awareness about the need and value of investing SRHR	→	→	→
Action Research/IB Pilot	Support buyers/NGOs/private sector to develop effective BCC tools for SRHR in collaboration with factories		→	→
	Support factories to develop innovative models for provision of SRHR to the workers	→	→	→
	Support buyers to develop innovative mechanisms for promoting SRHR amongst the workers of their suppliers		→	→
	Support service providers (private sector and NGOs) to develop innovative models to increase and sustain delivery of services and products related to SRHR	→	→	→

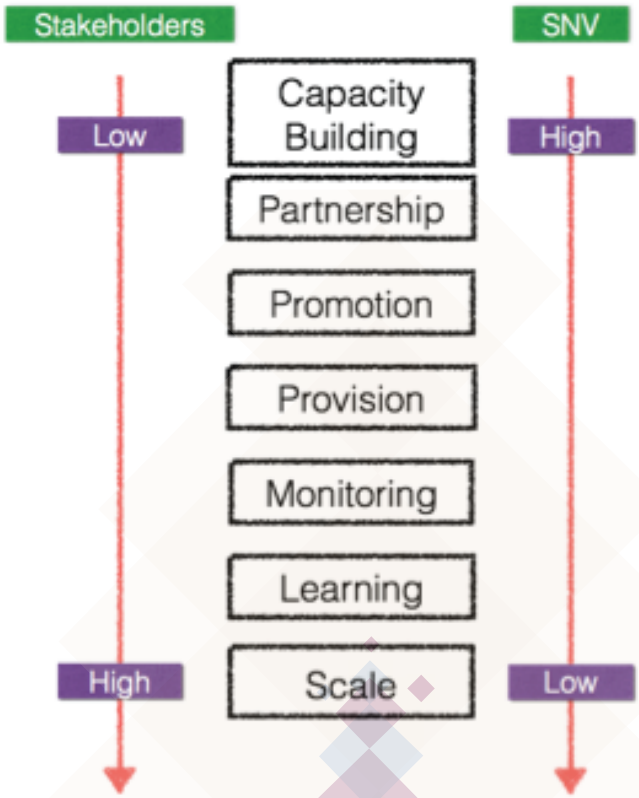
Key Stakeholders and their roles: From the findings of the study we could identify several key stakeholders who should be engaged by the project for intervention management, capacity building and advocacy. The table below summarizes the key stakeholders that should be targeted by the project and their roles in the project.

Stakeholder	Organization	Role in the project
Factory	The project aims to target 10 factories that have more than 2000 workers in the factory unit. Our findings suggest that the capacity of the factories vary with respect to adopting and investing on good practices related to SRHR depending on the size and number of workers. Factories with larger number of workers are expected to buy-in more immediately than factories with lesser number of workers. However, it would also be equally important to target midsized factories that can demonstrate the variability with respect to results. The project can consider ensuring a mix of larger and midsized factories. Also, the service providers are expected to reach out to larger number of factories than the targeted 10 to achieve financial viability for service delivery. It is recommended that the number of factories targeted by the service providers is kept open.	The factories 'role in the project will be primarily on pilot of IB models. However, some of the factories, especially those which have already adopted good practices for ensuring SRHR services for their workers could also act as influence group and could be engaged by the project for capacity building and advocacy.
NGOs	It is expected that the NGOs that are already heavily engaged on SRHR will be engaged by the project. This would help the project to build on the knowledge and experience of these NGOs and reduce duplication of efforts by leveraging on existing interventions.	The NGOs will have roles on piloting IB models, capacity building and knowledge management.
Private Businesses	The private businesses like suppliers or contraceptives and personal hygiene products are yet to be engaged directly and intensively on SRHR for female workers. The project should aim at engaging them more intensively on the design and implementation of the interventions. We identified Square, ACI and SMC as the three key potential partners. The project should also aim to reach out to more such organizations as it matures.	The role of the private sector will be primarily on IB pilot.
Buyers	The buyers will be a key influence group for the adoption of SRHR practices by the factories, NGOs and private sector. The project should aim at engaging both EU and US buyers since we have found variability with respect to interests on SRHR amongst the EU and US buyers. While the project should aim to reach out to the buyers who are more ready to embrace SRHR practices for their suppliers and can act as influence group, organizations like the Buyers' Forum should be engaged to influence larger number of buyers to promote adoption of IB models for SRHR by their suppliers.	The buyers will have role on capacity building, advocacy and IB pilot as explained on the intervention strategy.

Type of Stakeholder	Organization	Role in the project
BGMEA/ BKMEA	BGMEA/BKMEA will have to be engaged from the very onset of the project so that they are aware of the developments and impacts and could act as an influence group to promote SRHR service provision amongst the buyers, NGOs and factories	Advocacy for the provision of SRHR
Donors	It would be highly important for the project to ensure that the donors who are engaged on supporting and funding projects on SRHR for RMG worker are aware of the developments and impacts so that they are interested to adopt similar strategy for their programs. This will help improve the enabling environment for adoption of inclusive business models since the current strategy of direct service provision is a threat to creating interest amongst the NGOs, factories and buyers to invest on inclusive business models.	The role of the donors in the project will be indirect. They are expected to be reached out as an influence group which could potentially support the interventions reaches scale.
Government Agencies	The project could engage relevant ministries. The Ministries' involvement could potentially support government's investment on building a positive image of the RMG sector in Bangladesh amongst the global audience which includes the consumers. Engagement with DGFP could be sought to work out possibility of FP commodities and services provided by the government to reach out to RMG workers more effectively.	The role of the government agencies in the project will be indirect. They are expected to be reached out as an influence group which could potentially support the interventions reach scale.
International campaigns and projects on workers' right	Initiatives like Clean Clothes Campaign (CCC) could potentially facilitate publicity of the inclusive business solutions that are piloted by the project. The project should aim to identify such campaigns and reach out to them with the results and evidence base on impacts so that they could create a positive image of the RMG sector in Bangladesh amongst the global audience. This would strengthen the industries' willingness to invest on SRHR.	The campaigns could play a direct role on the dissemination of the learning of the project and on communication activities that are expected to be undertaken by the project to create international exposure to the impacts that are being achieved by the factories, buyers, NGOs and private sector businesses on issues related to SRHR.

The project's role would be much deeper at the inception of the project. As it matures, the stakeholders are expected to assume more responsibilities and increase their investment on the management of the interventions. Even though it might be difficult for the project to ensure that the IB models piloted would be self-sustaining by the 3rd year of the project, the impacts should suggest a pathway to self-sustenance which is illustrated in figure 8.

Figure 8: Distribution of roles and responsibilities between the project and the stakeholders in an inclusive business model



6.3 Marketing, Communication and Advocacy Strategy

Since inclusive business as a solution to SRHR is a new concept, the marketing, communication and advocacy strategy of the project would be a key to creating sector wide interest to adopt inclusive business models. The project should develop marketing, communication and advocacy strategy at the very onset of the project. This strategy might involve a media usage study to identify the media that would have the most impact on the workers, factories, NGOs, private sector, buyers and donors on the issues related to SRHR and on the impacts that are being achieved by the project.

The strategy could adopt a phased approach so that it can capitalize on the learning of the project. For instance, the first phase of the project is expected to be dedicated on creating interest about SRHR issues and inclusive business models amongst the stakeholders. At this stage the strategy should be to organize events that could create direct interaction between the stakeholders. Once this is achieved, the project will have to ensure that the stakeholders are informed about the progress and achievements. At this stage, tools like newsletters could be more effective. As the impacts become evident, the project should start investing on developing documentaries, case studies, and best practice models for widespread dissemination of the knowledge.

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Annex 1:
List of Respondents

I. Factory Owner and Management

Respondent	Type	Factory	Position	Contact	Gender
Amarul Hossain	Factory Management	Hop Yick (Bangladesh) Ltd.	Quality Inspector	Mobile: -01755552604	Male
Asela Fernando	Factory Management	Bando Design Limited	Executive Director	Email:asela@bandodesign.com Mobile: 01967241517	Male
Ashique Ferdous	Factory Management	Hop Yick (Bangladesh) Ltd.	Senior Manager HR	Email: ashique.ferdous@hoplunbd.com Mobile: -01755552604	Male
Aysu Mehbuba Rahman	Factory Management	Far East Knitting & Dyeing Industries Limited	A.G.M. HR & Compliance	Email: mehbuba@fareastknit.com Mobile: 01730045473	Female
Harun OR Rashid	Factory Management	Impress-Newtex	Manager- HR/Admin & Compliance	Email: harun.rashid@impress-newtex.com Mobile: 01780464046	Male
Hedayet Hossain	Factory Management	Comfit Composite Knit Limited	Senior Manager (Admin)	Email:hedayetcckl@youthbd.com Mobile: 01619995010	Male
Ifterkhar Ibne Zahid	Factory Management	NewAge Group	Officer (HR/Admin/CoC)	Email: iftekhar@newage-group.com Mobile: +8801713438930	Male
IndrikaJayasekara	Factory Management	Winter Dress Limited	General Manager-production	Mobile: 01711218080	Male
Ishtiaque Ahmed Patwari	Factory Owner	Knit Plus Ltd.	Managing Director	Email: ishtiaque@knitplusltd.com Mobile: 01711542844	Male
Kauser Ali	Factory Owner	Comfit Knit Compliance	Chief Executive Officer		Male
Lt. Col. Md. Humayun Kabir (Rtd.)	Factory Management	Square Fashions Ltd.	General Manager-Compliance, HR & Administration	Email:hkabir@squaregroup.comMobile:01711428935	Male
Md. Abdul Hadee	Factory Management	FCI BD LTD/ Talisman Ltd	Chief Operating officer	Email: hafee@fcibd.com Mobile: 01713436017	Male

Respondent	Type	Factory	Position	Contact	Gender
Md. Abul Hashem Patwary	Factory Management	DBL Group	Assistant General Manager Human Resource Department	Email: hashem@dbl-group.com Mobile: 01730043905	Male
Md. Jiaur Rahman	Factory Management	South East Textiles	Unit Sr. Manager, HR, Admin & Compliance	Email: jiaur@icl.bdrmg.com Mobile: +8801755629782	Male
Md. Kawsar Ali	Factory Management	Comfit Knit Composite Limited	CEO	Mobile: 01619995010	Male
Md. Mahfuzur Rahman	Factory Management	DBL Group	Deputy General Manager Compliance	Email:mahfuz@dblgroup.com Mobile: 01713148846	Male
Md. Mashumul Kabir	Factory Management	BIRDS GROUP	AGM -HR, Admin and Compliance	Mobile: 01686148414	Male
Md. Rafiqul Islam	Factory Management	Interstoff	DGM -Admin, HR & Compliance	Email: rafiq@icl.bdrmg.com Mobile:01730728073	Male
Md. Rezaul Karim	Factory Management	Norban Comtex Ltd	AGM (Admin HR & Compliance)	Mobile: 8801755511655, 8801687092335	Male
Md. Shafiqul Islam	Factory Management	DBL Group	BSS, MSS, MBA (HRM) Manager, HR & HRIS	Email: shafiqul@dbl-group.com Mobile: 01755587248	Male
Md. Shariful Hasan	Factory Management	Winter Dress Limited	Senior Manager-HR, Admin & Compliance	Mobile: 01711218080	Male
Md. Shariful Islam	Factory Management	Giant Group	Manager- HR & Compliance	Email: shariful@giantbd.com Mobile: 01678006309	Male
Md. Shoriful Islam (Shameem)	Factory Management	Dressmen	AGM (Admin HR & Compliance)	Mobile: 8801712982817	Male
Md. Touhidul Islam	Factory Management	Divine Group	AGM -HRD, Compliance & Admin	Email: touhid1973@gmail.com Mobile:01730009374	Male
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Mohammed Zahidullah	Factory Management	DBL Group	General Manager - corporate	Mobile: 01755587248	Male
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Syed Ashraful Islam FCMA	Factory Management	Shanta Group	Chief Executive Officer	Email: syedashrafulislam@gmail.com Mobile: 01713008720	Male
Tipu Sultan	Factory Management	Hop Yick (Bangladesh) Ltd.	Manager HRA	Mobile: 017555552604	Male
Zahir Al Mamun Khan	Factory Management	Liberty Fashion Limited	GM, HR and Compliance	Email: mamun@liberty-bd.com Mobile: 01678646104	Male

II. Factory Doctor

Respondent	Type	Factory	Position	Contact	Gender
Dr. Ahsaduzzaman	Factory Doctor	Winter Dress Limited	Doctor	Mobile: 0177825	Male
Dr. Farzana Yasmin	Factory Doctor	DBL Group	Factory Doctor	Mobile: 01755587248	Female
Dr. Farzina	Factory Doctor	South East Textiles	Factory Doctor	Mobile:01730728073	Female
Dr. Golam Mortaza Khan	Factory Doctor	Far East Knitting & Dyeing Industries Limited	Doctor	Mobile: 01715159222	Male
Dr. Mohammad Amit Chaudhury (Salam)	Factory Doctor	Impress-Newtex	Doctor	Mobile: 01911117887	Male
Dr. Mohammed Abedul Hoque (Rakib)	Factory Doctor	Square Knit Fabrics Limited	Medical Officer, Compliance, HR & Administration	Email: rakib4me@yahoo.com Mobile: 01730327001	Male
Dr. Sair Uz Zaman	Factory Doctor	Giant Group	Factory Doctor	Mobile : 01197341611	Male
Kulsum Akhter	Factory Doctor	Comfit Knit Composite Limited	Doctor/Medical Assistant	Mobile: 01619995010	Female
Md. Imran Hossain	Factory Doctor	Comfit Knit Composite Limited	Doctor/Medical Assistant	Mobile: 01619995010	Male

III. Welfare Officers

Respondent	Type	Factory	Position	Contact	Gender
Afsana Parul	Welfare Officer	South East Textiles	Welfare Officer	Mobile:01730728073	Female
Bilkis Akhter	Welfare Officer	Impress-Newtex	Welfare Officer	Mobile: 01914073213	Female
Lovely Akhter	Welfare Officer	Flamingo Fashion	Welfare Officer	Mobile: 01678006309	Female
Mitu Akhte r	Welfare Officer	Comfit Knit Composite Limited	Welfare Officer	Mobile: 01619995010	Female
Monowara Yasmin	Welfare Officer	South East Textiles	Welfare Officer	Mobile:01730728073	Female
Ms. Nahida Akhter (Nahid)	Welfare Officer	DBL Group	Manager, Compliance, Women Health Programme Initiatives	Email:nahida@dbl-group.com Mobile: 01755587244	Female
Rina Nasrin	Welfare Officer	Far East Knitting & Dyeing Industries Limited	Welfare Officer	Mobile: 01715159222	Female
Rokeya Akhter	Welfare Officer	South East Textiles	Welfare Officer	Mobile:01730728073	Female
Rokhsana Parvin	Welfare Officer	Flamingo Fashion	Welfare Officer	Mobile: 01678006309	Female

III. Line Supervisors

Respondent	Type	Factory	Position	Contact	Gender
Abu Jafor	Line supervisor	Shafi Processing Industry, under Giant Group	Line supervisor	Mobile: 01678006309	Male
Arifuzzaman	Line supervisor	Giant Group	Line supervisor	Mobile: 01678006309	Male
Md Hali Hawladar	Line Supervisor	Comfit Knit Composite Limited	Line Supervisor	Mobile: 01619995010	Male
Abu Jafor	Line supervisor	Shafi Processing Industry, under Giant Group	Line supervisor	Mobile: 01678006309	Male
Arifuzzaman	Line supervisor	Giant Group	Line supervisor	Mobile: 01678006309	Male
Md Hali Hawladar	Line Supervisor	Comfit Knit Composite Limited	Line Supervisor	Mobile: 01619995010	Male
Abu Jafor	Line supervisor	Shafi Processing Industry, under Giant Group	Line supervisor	Mobile: 01678006309	Male
Arifuzzaman	Line supervisor	Giant Group	Line supervisor	Mobile: 01678006309	Male
Md Hali Hawladar	Line Supervisor	Comfit Knit Composite Limited	Line Supervisor	Mobile: 01619995010	Male

IV. Service Provider/NGO

Respondent	Type	Factory	Position	Contact	Gender
QuaziSuraiya Sultana	Service Provider-NGO	RHSTEP	Executive Director	Email: qssultana@rhstep.org Mobile: +8801711538107	Female
Mahbubul Haque	Service Provider-NGO	RHSTEP	Program Coordinator	Mobile: +8801712241804	Male
F. M. Mostaqu e	Service Provider-NGO	Population Services and Training Center (PSTC)	Executive Director	Email: pstc78@gmail.com Mobile: +8801713000437	Male
Jasmin Hossain	Service Provider-NGO	Narimaitree	Program Coordinator	Mobile: +8801191627995	Female
Kazi Rezaul Hassan	Service Provider-NGO	Narimaitree	HR Officer	Mobile: +8801914276834	Male
Salma Parvin	Service Provider-NGO	Phulki	Project Manager	Mobile: +8801718060291	Female
Suraiya Haque	Service Provider-NGO	Phulki	Executive Director	Email: phulki@phulki.org Mobile: 01713062020	Female
Rosey Hurst	Service Provider-NGO	IMPACT	Executive Director	Email: rosey@impacttlimited.com	Female
Dr. Altaf Hossain	Service Provider-NGO	BAPSA	Director	Mobile: 8801720132013	Male
Md. Mahfuzul Bari Chowdhury	Service Provider-NGO	HASAB	Team Leader SRHR	email: bari@hasab.org mobile: 01786500910	Male
Ms. Jui Shams	Service Provider - NGO	HASAB	Coordinator - Peer Education SRHR	email: jui@hasab.org mobile: 01727238822	Female
Nazneen C. Huq	Service Provider	Change Associates	Executive Director	Email: nanzeenhuq@change-bd.org Mobile: +8801819229093	Female

V. Pharmaceuticals and Toiletries

Respondent	Type	Factory	Position	Contact	Gender
Farzana Hossain	Toiletries	Advanced Chemical Industries (ACI)	Product Group Manager Consumer Brands	Email: farzanahossain@aci-bd.com Mobile: +8801713099833	Female
Malik Mohammed Sayeed	Toiletries	Square Toiletries	Head of Marketing Square Consumer Products	Email: malik@squaregroup.com Mobile: +8801713049395	Male
Md. Ikramul Hasan Kenedy	Pharmaceuticals	Renata Limited	Head of Im Business and Health care Products		Male
Toslim Uddin Khan	Pharmaceuticals	Social Marketing Company (SMC)	General Manager, Program	Email: toslim@smc-bd.org	Male
Farzana Hossain	Toiletries	Advanced Chemical Industries (ACI)	Product Group Manager Consumer Brands	Email: farzanahossain@aci-bd.com Mobile: +8801713099833	Female
Malik Mohammed Sayeed	Toiletries	Square Toiletries	Head of Marketing Square Consumer Products	Email: malik@squaregroup.com Mobile: +8801713049395	Male
Md. Ikramul Hasan Kenedy	Pharmaceuticals	Renata Limited	Head of Im Business and Health care Products		Male
Toslim Uddin Khan	Pharmaceuticals	Social Marketing Company (SMC)	General Manager, Program	Email: toslim@smc-bd.org	Male
Farzana Hossain	Toiletries	Advanced Chemical Industries (ACI)	Product Group Manager Consumer Brands	Email: farzanahossain@aci-bd.com Mobile: +8801713099833	Female

VI. Regulatory Bodies

Respondent	Type	Factory	Position	Contact	Gender
Dr. Mohammed Sharif	Regulatory Bodies	Directorate General of Family Planning (DGFP)	Director (MCH-Services) & Line Director (MCRH)	Mobile: 01819313861	Male
Dr. Md. Moinud din Ahmed	Regulatory Bodies	Directorate General of Family Planning (DGFP)	Line Director Clinical Contraception Services Delivery Program	Email: drmoin09@gmail.com Mobile: 01712157103	Male
Steven Kruit	Regulatory Bodies	Buyer's Forum	General Manager		Male
Farzana Sharmin	Regulatory Bodies	BKMEA	Sr. Deputy Secretary (Compliance)	Email: complianceofficer2@bkmea.com Mobile: 01712577027	Male
WgCdr (Retd) Md. ZaglulHayder	Regulatory Bodies	BGMEA	Additional Secreatry (Admin & HR)	Email: info@bgmea.com Mobile: 01817044677	Male
Md. AdburRazzak	Regulatory Bodies	BGMEA	Sr. Assistant secretary	Email: healthproject@bgmea.com.bd Mobile: 01712942878	Male
Ehsanul Fattah	Regulatory Bodies	BGMEA	Secretary General	Mobile: 011990092145	Male
K.M Delwar Hossain	Regulatory Bodies	Bangladesh Center for Social Compliance	CEO	Mobile: 01863500179	Male
Aminul Islam	Regulatory Bodies	Labor and employment Generation Ministry of Labor	Deputy Secretary	Email: aminul1962@gmail.com	Male

VII. Brands/Buyers

Respondent	Type	Factory	Position	Contact	Gender
Hamza Habib Hasan	Brands/Buyers	Primark	Ethical trade Executive		Male
Lindse Block	Brands/Buyers	PRIMARK	Ethical Trade Controller, Global Project	Email: lblock@primark.co.uk Mobile:+919582555060	Female
Md. Hasan Uz Zaman	Brands/Buyers	Target USA	Manager- Social Compliance (Bangladesh, India & Pakistan)		Male
Md. Abdul lah Al Mamun	Brands/Buyers	DK Company	Compliance Co-ordinator	Email: mamun@dkcbd.com Mobile: 01712097988	Male
Mashuda Begum	Brands/Buyers	Tesco	Senior Manager, Ethical Trading	Email: mashuda.begum@tescobd.com Mobile: 01730728787	Female
Qumrul Hasan Pathan	Brands/Buyers	INDITEX	Compliance Manager	Email: qumrulhp@itxtrading.com Mobile:01777709102	Male
Zahid Ghauri	Brands/Buyers	Walmart	Regional manager	Mobile 01755606049	Male
Md. Hasan -Uz-Zaman	Brands/Buyers	TargetUSA	Manager-Social Compliance	Email:hasan.zaman@target.com Mobile :01755582236	Male
Montashir Nahid	Brands/Buyers	Debenhams	Ethical Compliance Manager	Email: montashir.nahid@debenhams.com Mobile: 01678521701, 01715110325	Male

VIII. Pharmacies

Respondent	Type	Factory	Position	Contact	Gender
Mr. Assaduzzaman	Pharmacies	Assad Pharmacy	Pharmacist	Bypile	Male
Mohiuddin	Pharmacies	Fatema Pharmacy	Retailer	Bypile	Male
Dr. Barun	Pharmacies	Barun Medical Centre	Owner	Bypile	Male
Mohiudin	Pharmacies	Farzana Medical	Retailer	Bypile	Male
Dr. Md. Iqbal Hossain Gazi	Pharmacies	Gazi Medicine Corner	Proprietor	Mobile: 01912232560	Male
Monir Hossain, NasiruddinMollah	Pharmacies	Molla Medicine Center	Retailer	Mobile: 0172667918	Male
Mr. Assaduzzaman	Pharmacies	Assad Pharmacy	Pharmacist	Bypile	Male
Mohiuddin	Pharmacies	Fatema Pharmacy	Retailer	Bypile	Male
Dr. Barun	Pharmacies	Barun Medical Centre	Owner	Bypile	Male

IX. Medical Service Providers

Respondent	Type	Factory	Position	Contact	Gender
Dr. Rina Talukder	Medical Service Provider	Population Services and Training Center (PSTC)	Doctor	Mobile: 01711547980	Female
Imrul Hasan Khan	Medical Service Provider	Marie Stopes Bangladesh	Team Leader, EKN Project & General Manager- Program, Advocacy & Capacity Development	Email: imrul.khan@mariestopesbd.org	Male
H M Asaduzzaman	Medical Service Provider	Marie Stopes Bangladesh	General Manager - Services	Email: asad@mariestopesbd.org Mobile: +8801731254249	Male
Dr. Umme Hany	Medical Service Provider	Marie Stopes Bangladesh	Manager Program Development	Email: hany@mariestopesbd.org Mobile: +8801715127862	Female
Momtaz Begum	Medical Service Provider	Marie Stopes Static Clinic	Paramedic	Mobile: 01849118186, 01750114114	Female
Dr. Mohammad Hussain Choudhury	Medical Service Provider	Marie Stopes Bangladesh	General Manager - Services & Team Leader DFID Urban Health Project	Email: mhc@mariestopesbd.org Mobile: 01819213357	Male
A.B.M Khokan Mondal	Medical Service Provider	Pauper General Hospital	Chairperson	Mobile: 8801712869809, 8801683631732	Male
Md. Rafiqul Islam	Medical Service Provider	Centre for Women & Child Health	CEO	Mobile: 8801714007134	Male
Md. Moslem Uddin	Medical Service Provider	Chandra Apollo Clinic	Managing Director	Mobile: 8801715181159	Male

X. FGD Respondents - Female Workers

Name	Age	Marital Status	Children	Name of Factory	Designation	Years of Experience
Majeda Begum	20	Married	1	South East Textiles	Sewing Operator	1.5
Minara Begum	21	Married	1	South East Textiles	Sewing Operator	5months
Reshma Begum	19	Married	1	South East Textiles	Sewing Operator	5months
Mosammat Marium Akhter	25	Married	1	South East Textiles	Sewing Operator	6months
Mosammat Farida Begum	20	Married	2	Comfit Knit Compliance Limited	Tailor	2 years
Anjuman	24	Married	2	Comfit Knit Compliance Limited	Senior Supervisor	10 years
Rasheda Beg um	20	Married	0	Comfit Knit Compliance Limited	Finishing	1 years
Lipi	22	Married	0	Hoplun Yick	Sewing Operator	8 years
Aisha	24	Single	0	Hoplun Yick	Jr. Quality Inspector	3 years
Halima Khatun	24	Married	1	Hoplun Yick	Sewing Operator	6 years
Akhi A khtar	24	Single	0	Hoplun Yick	Assistant Supervisor	10 years
Arifa Akhtar	26	Married	pregnant	Hoplun Yick	Sr. Sample Maker	11 years
Rahima KhatunShefali	28	Married	1	Hoplun Yick	Sr. Worker	11 years
Rumana Parvin	26	Married	1	Hoplun Yick	Machine Access ories	12 years

Hena Akhtar	24	Single	1	Hoplun Yick	Sr. Worker	10 years
Noyon Moni	23	Married	0	Hoplun Yick	Jr. Sewing Operator	5 years
Nipa Akhtar	26	Married	1	Hoplun Yick	Cutting Operator	5 years
Sainur Begum	25	Married	1	Hoplun Yick	Sewing Operator	6 years
Rina Akhter	23	Married	1	Hoplun Yick	Jr. Operator	3 years
Fatema Begum	23	Married	1	Hoplun Yick	Sewing Operator	10 months
Morsheda Begum	25	Married	2	Hoplun Yick	Sewing Operator	3 years
Laily	26	Married	1	Interstoff	QC inspector	6 Years
Fatema	32	Married	2	Interstoff	Packaging staff	3 years
Morsheda	30	Married	1	Interstoff	Senior operator	10 years
Shanjida Parveen	21	Married	0	Interstoff	Finishing Assistant	1 years
Anowara	21	Married	2	South East Textiles	Sewing Operator	3 months
Parvi n Begum	21	Married	0	South East Textiles	Sewing Operator	1 yearr
Farzana Akhtar	20	Married	pregnant	South East Textiles	Sewing Operator	3 months
Sheuli	35	Married	3	Comfit Sewing	Sewing Operator	4 years
Shilpi	25	Married	2	South East Textiles	Sewing Operator	3 years
Lucky Akhter	21	Unmarried	0	DBL	Junior Operator	2.5 years
Beauty Rani	22	Married	0	DBL	Sewing Operator	9 years
Julekha	22	Married	1	DBL	Finishing section	9.5 years
Shima Begum	21	Married	1	DBL	Finishing	2 years
Toslami Nasreen	23	Unmarried	1	DBL	Junior Operator	2.5 years
Monowara	20	Unmarried	0	DBL	Finishing section	3 years
Yasmin Ara	24	Married	1	DBL	Sewing Operator	4 years
Akhlima Begum	25	Married	2	DBL	Finishing section	7 years
Jahanara Khatun	22	Unmarried	0	DBL	Sewing Operator	1.5 years
Rubina Begum	19	Married	0	South East Textiles	Jr. Sewing Operator	3 months
Shirin Akhter	20	Married	0	Khan Garment	Junior Operator	2 years
Mosammat Rehena Begum	21	Married	1	South East Textiles	senior sewing operator	10 years
Nahar	22	Married	1	Khan Garment	Junior Operator	2 years
Nasima Khatun	19	Unmarried	0	Khan Garment	Sewing operator	1.5 years
Khodeja Khatun	28	Married	0	South East Textiles	Assistant Supervisor	10.5 years
Moni	22	Married	0	South East Textiles	Sewing operator	7 years
Shafi a Akhta	27	Married	0	Khan Garment	Machine Accessories supervisor	7 years
Jasmin Begum	21	Married	2	South East Textiles	QC inspector	6.5 years
Shiuli Nasrin	23	Married	1	South East Textiles	Finishing section	4 years
Arju Begum	19	Married	0	Khan Garment	Junior Operator	3.5 Years
Rena Begum	19	Married	1	South East Textiles	Sewing Operator	3 months

XI. Female In-Depth Interview Respondents

Name	Age	Marital Status	Children	Factory Name	Designation	Years of Experience
Josha Akhter	21	Single	0	South East Textile	Sr. Operator	10
AnjumanAra	24	Single	1	DBL	Master trainer	3.5
DipaKhatun	26	Married	0	South East Textile	Junior Operator	4
Shirina	30	Married	2	Khan Garments	Sewing Operator	4
HosneAra	22	Married	1	South East Textile	Packaging	1

XII. Husband'sIn-Depth Interview Respondents

Name	Age	Marital Status	Children	Factory Name	Designation	Years of Experience
Harun ar Rashid	27	1	Comfit Garments	Quality control	4	Harun ar Rashid
Md. Shaharul Islam	25	1	Khan Garments	Quality control	8	Md. Shaharul Islam
Ronju Mia	23	0	Impress Garments	Packing	2.5	Ronju Mia
Ershad Ali	25	1	Comfit Garments	Operator	3	Ershad Ali
Md. Raju	28	1	Hoplun Limited	Package and finishing	3	Md. Raju

Annex 2: Question

QUESTION GUIDE SET: BUYERS

Name of Organization	:	
Name of Respondent from organization	:	
Designation	:	
Gender	:	Female ◯ Male ◯
Location	:	
Phone Number	:	
Date	:	
Interviewer	:	

1. How many factories do you work with in Bangladesh? How do you select your suppliers? Please explain the supplier selection policy.

2. Do you have any policies that the factories you are affiliated with, must comply to? Such as any welfare programs?

3. If yes, why do you want factories to be welfare compliant?

4. When implementing such programs do you partner with any NGO's? If yes which one/ones?

5. In the welfare programs, what are the primary areas you focus on?

6. Is SRHR a part of the welfare programs you focus on?

7. Within these SRHR service provisions, do you exclusively provide SRHR awareness, training and activity workshops?

8. Is there any funding amount you designate for this SRHR program intervention?

9. If yes, to what degree do you depend on your own source for SRHR program intervention?

10. To what degree do you depend on external sources for SRHR program intervention?

11. How do you market your socially responsible business attitude to your clients?

12. Will you give preference to factories which provide SRHR initiatives?

13. Have you ever designed and deployed any program specifically for SRHR?

14. If yes, what is the reason behind designing such a program?

15. Will you be interested in sharing your program design?

16. Will you be interested to cooperate in designing a sustainable SRHR inclusive business model in the RMG value chain?

17. According to you, what could be your role in the sustainable SRHR inclusive business model?

18. Will you pay a premium to factories which will implement SRHR inclusive business in their business process?

19. Is there any impact of good practices/welfare activities in your business?

20. What could be the strategy to promote good practices among consumers?

QUESTION GUIDE SET: SRHR PRODUCT AND SERVICE SUPPLIERS

Name of Organization	:	
Name of Respondent from organization	:	
Designation	:	
Gender	:	Female ◯ Male ◯
Location	:	
Phone Number	:	
Date	:	
Interviewer	:	

1. Background of the company (year established; type of commodities/ services produced/ supplied; customers/ clients/ market share in their respective category)

2. What SRHR related product or services are you currently offering in the market? Note: Specify the SRHR services/ products to the respondent)

3. Who is your target market for the SRHR commodities? How do you reach the target market? (please probe: for instance: institutional buyers, retail market, ifinstitutional whether it is NGO or government or donor funded projects)

4. Have you ever considered tapping the low end markets, for example, the female garment factory workers, for the provision of SRHR supplies? (this question is valid if the organization is yet to target the low end market)

5. Are you affiliated/ were you affiliated with any donor funded programs? If yes, please get details on their engagement with the program me.

6. Do you continue SRHR service provision once the projects terminates? If yes, how do you fund and manage these services?

7. What are the obstacles you encounter/ encountered while providing SRHR services to the female factory workers? / What do you think would restrict you in achieving your targets on promoting SRHR products/ services to the RMG workers?

8. What are the factors which will motivate you to develop more products for RMG workers? (Try to find out how the project could add value to their existing initiative)

9. According to you, what kind of technical/financial/ monitoring support do you require to extend you market to the low end garment workers?

10. According to you, what is the Timeline required for extending SRHR products in the low segment markets? (This question is more relevant for product manufacturer/supplier)

QUESTION GUIDE SET: TRADE BODIES (BGMEA, BKMEA)

Name of Organization	:	
Name of Respondent from organization	:	
Designation	:	
Gender	:	Female ◯ Male ◯
Location	:	
Phone Number	:	
Date	:	
Interviewer	:	

1. Do you monitor whether factories are adhering to any welfare programs?

2. What sort of welfare programs are usually run by factories?

3. Do these welfare programs cover SRHR issues?

4. If not, then do you think it is important to address SRHR issues in factories?

5. If yes, how can SRHR be put into the value chain of RMG as inclusive business?

6. What role you can play in enabling factories to provide SRHR?

7. How can factories ensure the credibility of their investment in SRHR?

8. How can factories market their SRHR compliance to buyers?

QUESTION GUIDE SET: LINE SUPERVISORS

Name of the Respondent	:	
Profession/Designation	:	
Gender	:	Female ◯ Male ◯
Name of Organization	:	
Type of Garments	:	Knit ◯ Woven ◯ Others ◯
Total number of workers	:	
Location	:	
Phone number	:	
Date	:	
Interviewer	:	

1. What is your team size/ how many workers work under your supervision?

2. Do you have an existing WORKER'S WELFARE PROGRAM in action? If yes, what is the current program intervention? Do welfare programs have impact on worker's performance?

3. Are you aware of the different components of SRHR? Do you have the inclusion of SRHR programs/products/services within the WORKER'S WELFARE PROGRAM? If yes, then please elaborate the SRHR service provision in details below.

4. What is your role in SRHR interventions of the factory? (for the interviewer: please probe about potential role)

5. What are the problems worker's face that may be addressed by SRHR service provision? Do you see any observable change due to existing SRHR practices in your factory? If no, then why not?

6. Do workers ever reported/shared any SRHR issues to you? If yes, please elaborate what those are. If not, with whom do they share SRHR issues with?

7. Do you have any peer programs in your factory? If yes, how do you think peer programs can motivate the female workers to adopt SRHR services? Do you think peer programs are effective to promote SRHR among workers?

8. (For the interviewer) What could be a prospective model to incorporate SRHR service provision in RMG value chain?

QUESTION GUIDE SET: FACTORY OWNERS/ MANAGEMENT

Name of the Respondent	:	
Profession/Designation	:	
Gender	:	Female ◯ Male ◯
Name of Organization	:	
Type of Garments	:	Knit ◯ Woven ◯ Others ◯
Total number of workers	:	
Location	:	
Phone number	:	
Date	:	
Interviewer	:	

1. When was your factory established? Who are your major buyers?

2. Please brief on any initiative/good practice in place for ensuring workers' welfare, apart from standard labour practices (buyer compliance). When and why did you start such initiatives (Interview Team: please Map initiatives separately, that are factory-driven/buyer-driven/ those from development organization. Also collect materials related to this, if available).

3. Do you have any ongoing or completed SRHR initiative in your factory? If yes, what factors led you to implement such initiative? (For the interviewer, please try to analyze both push and pull factors).

4. How do you think your SRHR initiatives impacted your workers? Did you see any visible change in their performance? If yes what kind of change did you see? How did you benefit from such changes? Do you want to make any improvement on your existing SRHR initiatives? If yes, what kind of improvements do you want to make and why?

5. If you did not have any SRHR initiative in your factory, then please tell us whether you are aware of SRHR initiative? If yes, what kind of SRHR initiatives did you hear of? From where did you hear of such initiatives? Why haven't you implemented such initiative in your factory as of yet? Are you interested to implement such initiative? If yes, why? When do you want to implement such initiative? What restricts your from implementing such initiatives?

6. Would you be interested in subsidizing the SRHR products and services for the benefit of your workers and for long term productivity gain? If not, then please elaborate what obstacles you would encounter in the process.

7. What suggestions do you have to promote SRHR initiative in the RMG sector in Bangladesh?

QUESTION GUIDE SET: DOCTORS

Name of Organization	:	
Name of Respondent from organization	:	
Designation	:	
Gender	:	Female ◯ Male ◯
Location	:	
Phone Number	:	
Date	:	
Interviewer	:	

1. What are the services you offer?

2. How many patients do you see every day? What is the profile of your patients?

3. What sort of complaints is more prominent?

4. Are these diseases related to SRHR issues?

5. What type of SRHR issues RMG workers mostly suffer from?

6. Do you think SRHR training within factories would be an effective medium of educating RMG workers about SRHR?

7. Have you ever provided any training to workers on SRHR?

8. What do you think is the main barrier for workers to adopt hygienic process of SRHR?

9. How can factories contribute in improving SRHR practice by workers?

10. According to you, what are the primary obstacles you encounter while providing the SRHR services?

11. What are the methods in which you overcome these obstacles?

12. Did you take part in any SRHR program/products/ services which is donor funded? If yes, then by which organization?

13. What is the number of workers you cater to in your existing SRHR program intervention?

14. What happens to the SRHR program/product/ services when the donor fund is withdrawn?

_____
_____
_____

15. According to you, do you continue to avail the SRHR program/products/services even after the withdrawal of the donor funds?

_____
_____
_____

16. If the factory owners demand the SRHR product/programs/services even after the withdrawal of donor funds, will you be interested to continue the service provision?

_____
_____
_____

17. Who according to you could be a major enabler to promote the SRHR products/services in the factories? Please explain why you think so.

_____
_____
_____

QUESTION GUIDE SET: SERVICE PROVIDERS

Name of Organization	:	
Name of Respondent from organization	:	
Designation	:	
Gender	:	Female ◯ Male ◯
Location	:	
Phone Number	:	
Date	:	
Interviewer	:	

1. What type of services do you provide? (Try to find out the services related to SRHR; analyze the share of SRHR services within the overall business)

_____
_____
_____

2. Who are your customers who attain these health services? (Also try to find out who are the customers for the SRHR services)? Do you serve the RMG workers? If yes, please explain how?

_____
_____
_____

3. Do you have any arrangement with RMG factories to provide services/ programmes to the RMG workers (related to both SRHR and welfare services)? If yes, please provide details on the programme (for example, area coverage, number of workers served, number of factories served, human resources to provide the service)?.

_____
_____
_____

4. Within these SRHR service provisions, do you exclusively provide SRHR awareness, training and activity workshops?

_____
_____
_____

5. What is the customer response to the SRHR service provisions?

6. Is the SRHR service provision for free? OR Are the customers accustomed to receiving these products and services for free?

7. According to you, what are the primary obstacles you encounter while providing the SRHR services?

8. What are the methods in which you overcome these obstacles?

9. Is the existing SRHR program/products/services donor funded? If yes, then by which organization?

10. What is amount of fund you received for this SRHR program intervention by the donors?

11. To what degree do you depend on your own source for SRHR program intervention?

12. To what degree do you depend on external sources for SRHR program intervention?

13. What is the cost of delivery of the SRHR program intervention?

14. What is the number of workers you cater to in your existing SRHR program intervention?

15. What happens to the SRHR program/product/services when the donor fund is withdrawn?

16. According to you, do factories continue to avail the SRHR program/products/services even after the withdrawal of the donor funds?

17. If the factory owners demand the SRHR product/programs/services even after the withdrawal of donor funds, will you be interested to continue the service provision?

18. Who according to you could be a major enabler to promote the SRHR products/services in the factories? Please explain why you think so.

QUESTION GUIDE SET: WELFARE OFFICERS

Name of Organization	:	
Name of Respondent from organization	:	
Designation	:	
Gender	:	Female ◯ Male ◯
Location	:	
Phone Number	:	
Date	:	
Interviewer	:	

1.What are the welfare programs in your factory?

2. Do you have any arrangement with hospitals to provide services/ programmes for the RMG workers (related to both SRHR and general medical services)?

3. Within these SRHR service provisions, do you exclusively provide SRHR awareness, training and activity workshops?

4. What is the workers response to the SRHR service provisions?

5. Is the SRHR service provision for free?
OR
Are the workers accustomed to receiving these products and services for free?

6. According to you, what are the primary obstacles you encounter while providing the SRHR services?

7. What are the methods in which you overcome these obstacles?

8. Is the existing SRHR program/products/services donor funded? If yes, then by which organization?

9. What is amount of fund you received for this SRHR program intervention by the donors?

10. To what degree do you depend on external sources for SRHR program intervention?

11. What is the cost of delivery of the SRHR program intervention?

12. What is the number of workers you cater to in your existing SRHR program intervention?

13. What happens to the SRHR program/product/ services when the donor fund is withdrawn?

14. According to you, do you continue to avail the SRHR program/products/services even after the withdrawal of the donor funds?

15. If the factory owners demand the SRHR product/programs/services even after the withdrawal of donor funds, will you be interested to continue the service provision?

16. Who according to you could be a major enabler to promote the SRHR products/services in the factories? Please explain why you think so.

QUESTION GUIDE SET: Discussion Guide for Female Factory Workers

Knowledge

Please review the respondent's degree of knowledge on the following aspects of SRHR

Issue	Comments of the respondent	Your assessment on the respondent's knowledge
Personal Hygiene		
Menstrual Regulation		
UTI/ Respiratory Tract Infection (RTI)/STI		
Safe motherhood (Ante Natal Care (ANC), Delivery Care, Post Natal Care (PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Attitude

Please review the respondent's attitude towards the following aspects of SRHR:

Issue	The degree to which the respondent perceives the issue to be important	Your assessment of the respondent's attitude
Personal Hygiene		
Menstrual Regulation		
UTI/RTI/STI		
Safe motherhood (ANC, Delivery Care, PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Practice

To what degree the respondent is availing good practices for the following SRHR issues:

Issue	The degree to which the respondent is adopting good practices	Your assessment of the respondent's practice
Personal Hygiene		
Menstrual Regulation		
UTI/RTI/STI		
Safe motherhood (ANC, Delivery Care, PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Accessibility

Review the degree to which the respondent has access to services and commodities for

the SRHR issues

Issue	The degree to which the respondent has access to these products (source, proximity, on time etc.)	Your assessment of the respondent's access to commodities and services
Personal Hygiene		
Menstrual Regulation		
UTI/RTI/STI		
Safe motherhood (ANC, Delivery Care, PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Availability

Review the degree to which the respondent can avail the services and commodities for the SRHR issues

Issue	The degree to which the respondent has the products and services available (source, proximity, on-time availability etc.)	Your assessment of the availability of the commodities to the respondent
Personal Hygiene		
Menstrual Regulation		
UTI/RTI/STI		
Safe motherhood (ANC, Delivery Care, PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Affordability

Review the degree to which the respondent can afford the products and services

Issue	The degree to which the respondent can afford the products and services	Your assessment of the respondent's capacity to purchase the products and services
Personal Hygiene		
Menstrual Regulation		
UTI/RTI/STI		
Safe motherhood (ANC, Delivery Care, PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Review the degree to which the respondent is satisfied with the services and commodities that she received on SRHR

Issue	The degree to which the respondent is satisfied	Your assessment of the needs of the respondent
Personal Hygiene		
Menstrual Regulation		
UTI/RTI/STI		
Safe motherhood (ANC, Delivery Care, PNC)		
Sexual abuse and harassment		
Safe sex		
Use of family planning methods (contraceptives)		

Other issues:

- Who is the most important provider of SRHR services and products to the respondent?

- What support does the respondent receive from the factory on SRHR?

- What support she intends to receive from the factory on SRHR?

- What are the roles of the husband on SRHR issues? How they should be/ could be engaged for the provision of SRHR services to the workers?

- What are the roles of other family members on SRHR issues? How they should be/ could be engaged for the provision of SRHR services to the workers?

- What are the roles of peers on SRHR issues? How they should be/ could be engaged for the provision of SRHR services to the workers?

- What are the roles of the doctors, nurses and welfare officers in the factory? How these could be improved or used?

- Does the provision of a male doctor within and outside the factory create hesitation or discomfort amongst the workers in discussing/availing SRHR products and services?

- Does the provision of female doctors within and outside the factory encourage them to discuss the SRHR issues more frequently?

- Anecdotal evidence of SRHR problems faced by the respondent:

- Anecdotal evidence of a program support that the respondent received:

- Anecdotal evidence of the benefits the respondent received from the program:

QUESTION GUIDE SET : Husbands of the Female Workers

Name of the Respondent	:	
Age	:	
Marital Status	:	
Number of Children	:	
Profession/Designation	:	
Name of Organization	:	
Type of Garments	:	Knit ◯ Woven ◯ Others ◯
Years of Experience	:	
Total number of workers	:	
Location	:	
Education Qualification	:	
Phone number	:	
Date	:	
Interviewer	:	

1. Did you receive any kind of general training in the factory? Please state what kind of training these are

2. What kind of family planning methods do you use as a husband? Where do you buy these SRHR products from? Do you avail it from the factories?

3. What kind of family planning methods does your wife use? Where does she buy these SRHR products from? Does she buy it on her own? Or do you buy it for her? Does she avail it from the factories?

4. What kind of additional SRHR products and services does your wife need? Where does she buy these SRHR products from? Does she buy it on her own? Or do you buy it for your wife? Does she avail it from the factories?

5. Are you satisfied with the quality of the SRHR products and services? What do you think about the price of the SRHR product and services? Do you think the SRHR products and services are widely available? If not, why?

6. If you have children then answer this question. Did you avail any SRHR products and services during and after your wife's pregnancy (ANC, PNC and Delivery Care)? Where did you avail these SRHR products and services from? Why did you avail the products and services from this place?

7. In your knowledge, where did your wife avail services from during her child birth and delivery time? Did she attend a formal doctor? Did she attend a traditional birth attendant and informal service provision?

8. Did you send your wife to the village during her delivery time or child birth? Why did you do so? Did anyone influence you to do this (in-laws, community leaders, religious leaders)? What kind of products did she receive during her delivery time? Where did she get these products from?

9. Anecdotal evidence of child birth (successful or unsuccessful) faced by the respondent or his wife.

10. Anecdotal evidence of any SRHR related issues faced by you or your wife

11. Anecdotal evidence of a SRHR program/awareness/ knowledge support that the respondent received

12. Anecdotal evidence of the benefits the respondent or his wife received from the program:

13. Anecdotal evidence of workplace harassment and sexual or verbal abuse in the factory, faced by the respondent's wife.

14. Do you feel the need for any SRHR training provided to you from the factories or any external stakeholders? Why is that so?

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