Women's General & Reproductive Health
in Global Supply Chains

Business for Social Responsibility

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www.bsr.org

I. Introduction

Women between the ages of 18–25 comprise the vast majority of workers making products for export from the developing world to the developed world. They often work in environments where access to information about reproductive health, as well as critical services, is lacking. This project addressed the need for information and critical services through: 1) researching the health needs of women workers; 2) identifying innovative partnerships between business and civil society to address these needs; and 3) developing information and tools to spur the business community to more fully engage on these issues. The aim is to identify replicate and scale up effective partnerships between business and civil society to improve reproductive health globally.

This project—with generous funding from the David and Lucile Packard Foundation—identified and addressed critical reproductive health needs of women working in global supply chains. This project complements work BSR first began in 2001-2002 with an assessment of the extent of brand and/or supplier programs that addressed women's health in the factory setting and the development of a *Guide for Brands*, which equipped retail companies, suppliers and local civil society partners with a better understanding of the reproductive health needs of supply chain workers.[1]

BSR (Business for Social Responsibility), a 501(c)(3) nonprofit organization with offices in San Francisco, Guangzhou, and Paris employing roughly 50 professional staff, is dedicated to building a more just and sustainable world by working with companies to promote more responsible business practices, innovation and collaboration. BSR works actively toward ensuring that companies respect, promote and monitor human rights around the world. The current project expands on BSR's previous work by revisiting factories and community-based organizations first surveyed in 2001-2002 to gauge impact from tools, training and awareness-raising activities delivered during the first project period. The current round of research also focuses new attention on the integration of health services— particularly HIV/AIDS prevention and reproductive health—as a part of the women's general health programs available in the factory setting.

BSR would like to thank adidas Group, Eileen Fisher, Gap, Inc., Hewlett-Packard, L.L. Bean, Mattel, Microsoft, Nordstrom, Sears, Wal-Mart and others for their participation in facilitating factory visits and providing their views on women's health programs. We would also like to thank Marie Stopes International in Viet Nam and Yayasan Kusuma Buana in Indonesia for their support of our work and invaluable assistance in providing deep national and cultural context.

[1] This report is available on BSR's website at: http://www.bsr.org/CSRResources/HumanRights/WomensHealth_Report.pdf.

Project Methodology

The project assessed the extent of factory-based reproductive health (RH) programs in six focus countries: China, India, Indonesia, Mexico, the Philippines and Viet Nam. The aforementioned 2001-2002 project work included China, India, Indonesia and Mexico; as such, these countries were included in follow-up work to gauge any improvements in programs that address women's health. The Philippines was selected as it is a focus country for the Packard Foundation and lies in close proximity to other focus countries. Viet Nam was selected because of its burgeoning growth in export manufacturing and its growing importance to BSR members as a key sourcing country. It also identified community-based organizations and nongovernmental organizations (NGOs) active in RH and family planning (FP), particularly those programs that aim to integrate RH/FP services and include HIV/AIDS prevention as a component of health services delivery. Apparel and toy factories comprised the largest portion of our industry sector coverage, followed by hard-goods, footwear and electronics.

Prior to carrying out extensive fieldwork in China, India, Indonesia, Mexico, the Philippines and Viet Nam, BSR consulted with a wide range of experts in each country, including the International Labour Organization (ILO), the World Health Organization (WHO) and The Asia Foundation. In addition, many suppliers completed a survey on women's health in their factory before the commencement of fieldwork. BSR staff from San Francisco and Guangzhou, China, along with a senior consultant based in Bangalore, India, then carried out fieldwork in the six focus countries from July–August 2006.

Report Organization

The report is organized by country of focus in order to contrast the economic, cultural and legal contexts for the protection of women workers' health. Within each section we describe the research BSR undertook on major health trends in that country, particularly as they relate to women's reproductive health and the capacity for factory programs to address them. Fieldworkers sought to identify best practice for each country and to verify their conclusions through interviews with female workers. We conclude by offerings recommendations for factory managers in each country to improve the health of women workers within their national context. Detailed reports of the site visits appear at the end of each country section. An Appendix, entitled "Resources," provides information on country-specific NGO, public sector and multilateral organizations that are active in the area of women's general and reproductive health.

Note:

BSR publishes occasional papers as a contribution to the understanding of the role of business in society and the trends related to corporate social responsibility and responsible business practices. The views expressed in this publication are those of its author and do not necessarily represent the views of BSR or its member companies.

BSR maintains a policy of not acting as a representative of its membership, nor does it endorse specific policies or standards. BSR is a not-for-profit membership organization that seeks to create a more just and sustainable global economy by working with the business community.

II. Executive Summary

In developing economies, women account for a disproportionately large percentage of the workforce engaged in manufacturing for export markets. In the apparel, footwear and toy sectors, factories with greater than 80 percent women workers are the norm. In an environment of heightened brand awareness of social and environmental compliance, corporate responsibility and risk mitigation, a focus on women's health in the global supply chain led Business for Social Responsibility (BSR) to carry out 34 factory- and community-based visits in six countries in Asia and the Americas: China, India, Indonesia, Mexico, the Philippines and Viet Nam. Our aim was to assess the status of women workers' general and reproductive health and offer recommendations for future factory- and supplier-led initiatives that improve the general and reproductive health of women workers. Such initiatives are not only good for workers and communities, but also good for business, as women's health issues are known to affect factory productivity, worker absenteeism, turnover and quality.

The breakdown of number and types of factories is given below:

Total Number of Site Visits by Country and Sector (July–August 2006)							
	Apparel	**Toys**	**Hard-Goods**	**Electronics**	**Footwear**	**Community-Based Project**	***Total Site Visits***
China	3	3	-	1	-	-	7
India	5	-	-	-	-	1	6
Indonesia	2	1	-	-	1	1	5
Mexico	-	2	-	1	-	2	4
Philippines	2	-	3	-	-	-	5
Viet Nam	4	-	-	-	1	1	6
Total by Sector	***16***	***6***	***3***	***2***	***2***	***1***	***34***

BSR conducted twenty-nine factory visits comprised of the following industry sectors: apparel (16); toys (6); electronics (2); footwear (2); house-wares (2); and a bicycle manufacturer (1). Site visits were also made to five community-based projects (local NGOs), bringing the total number of factory and NGO site visits to thirty-four. BSR gained factory access by soliciting project participation from our membership base of more than 250 Global 1000 companies. Brand owners then requested that factories operating within target industry sectors and regions participate. In most cases, BSR then communicated directly with factory management to arrange site visits. In roughly half of the factory visits, brand representatives accompanied BSR staff and consultants. All factory visits were pre-arranged by BSR; no visits were impromptu. Participating brands chose the supplier factories that participated; as such, we can only report on the circumstances in these facilities, which may or may not be representative of the majority of factories in a certain city or country, or of a certain brand or supplier. The size of factories visited ranged from 124 workers to over 200,000 workers.

Key Findings

Below is a summary of the major findings across the six focus countries on women's general and reproductive health in the factory setting, including a discussion of best practice in occupational safety and general health, training, nutrition and HIV/AIDS.

Reproductive Health

A widespread lack of awareness about general and reproductive health persists across the factories and geographies surveyed.

The majority of female workers are unmarried and young (18–25 years old), and factory management perceives them to be healthy, culturally conservative and thus not prone to sexual activity prior to marriage. This assumption on the part of factory management creates a barrier to moving forward with better services. Women workers in the developing world are often reluctant and uncomfortable asking questions or seeking advice in public settings about reproductive health, contraceptives and family planning. Many factory managers question the value of investing financial resources in RH programs, partially due to their assumptions about sexual activity, and partially because turnover is high, so the return on investment is seen as minimal. Because of this, reproductive health issues receive scant attention, though the need—evidenced through candid interviews with factory workers and discussions with local NGOs that address RH issues—clearly exists.

Many factory managers question the value of investing financial resources in RH programs because turnover is high and most women workers are young and perceived by factory management to be sexually inactive and not in need of RH services.

Despite the lack of attention devoted to RH services, many factory managers express—in theory—an interest in RH services, which they define broadly as increased attention to the needs of pregnant workers, access to contraception and family planning services. In addition, the notion of integrated services that include RH and FP services, family planning, nutrition and HIV/AIDS prevention met with understanding and approval. Management typically correlates reduced absenteeism, lower turnover and increases in quality and productivity with healthier women workers. At the same time, many factory managers question the value of investing financial resources in reproductive health programs, as most women workers are young and perceived to be sexually inactive, and because turnover is high. Though trainings in some factories include information on RH, these are not offered regularly, do not involve all factory workers and are quickly sidelined when production pressures take precedence. Factory management views the trainings as peripheral to overall factory management. One Indian factory visited by BSR in 2002 participated in a multi-stakeholder training initiative ("*Global Alliance*") but did not continue with trainings after the initiative concluded activities.

In the majority of factories surveyed, reproductive health equates to little more than paying greater attention for pregnant workers. Partially in an effort to comply with legal regulations,

pregnant factory workers are generally shifted to less strenuous work after their sixth or seventh month of pregnancy and are permitted to take more frequent breaks when needed during the day. They are reminded to either visit local hospitals for regular check-ups throughout their pregnancy or provided with check-ups at the factory clinic, depending on the capacity of health services at a given facility. Factories that represent best practice in their sector and country provide mandatory monthly health check-ups and training for pregnant workers, as well as free nutritional supplements, separate uniforms or identity cards, separate lines in the cafeteria, mandatory shifting to seated work throughout pregnancy and permission to leave work early. In Viet Nam, for example, women workers are entitled to five months of paid maternity leave under the country's Labour Code.

Factory- and community-based access to reproductive health services remains a neglected issue for women workers along the global supply chain. Though notable strides have been made since our initial report in 2002, women workers still do not have consistent access to quality information and services pertaining to antenatal and postnatal care, safe abortion, HIV/AIDS prevention and treatment, and early diagnosis and treatment for breast and cervical cancer. Though the emphasis in the focus countries is beginning to shift away from population control, factory trainings on occupational safety and health might briefly touch on HIV/AIDS prevention and the use of contraceptives, but rarely do trainings sessions take a comprehensive approach to RH. Bulletin boards, which post useful information on a wide variety of topics, including RH, remain a key source of information for workers, but the quality of posted information is often inconsistent. An approach that integrates RH into existing factory trainings and information outlets is needed.

Best Practice in Reproductive Health

Of the facilities studied, the Yayasan Kusuma Buana (YKB) Clinic in Bandung, Indonesia and Marie Stopes International in Ho Chi Minh City (MSI), Viet Nam provide a wide array of RH services, either onsite or via mobile clinics. These two programs reach a large number of women workers and provide a degree of privacy and confidentiality essential to successful and lasting interactions with women workers. Both are highlighted in the Indonesia (pg. 86) and Viet Nam (pg. 180) sections of this report.

Since BSR's initial visit in 2002, one factory in Bandung, Indonesia worked closely with YKB to establish a clinic in close proximity to the factory. All workers and their families receive free treatment at the clinic and costs are covered by the private insurance scheme paid for by the factory. The clinic provides a wide range of heath care options—including RH and FP—and has 7,000 registered patients. Each week the clinic conducts trainings—primarily on reproductive health. In addition, a 'train-the-trainers' system has been set up, with forty peer educators trained from among factory workers. Thanks to initial funding from a major retail buyer, the YKB clinic reached the break-even point eighteen months after being set up and is now a self-sustaining facility.

In the Ho Chi Minh City area of Viet Nam, a large brand involved in manufacturing footwear recently contracted MSI to operate a mobile reproductive health service within the existing factory clinic. The mobile RH clinic operates two days per month at the factory to provide gynecological, RH and FP services. Since the mobile clinic began in March 2006, nearly 200 workers have received consultation on a monthly basis. For those potential

patients hesitant to use the onsite service due to issues of privacy, MSI also offers a fixed clinic 2km from the factory and promotes this on a factory bulletin board.

HIV/AIDS

Awareness of safe sex practices seems to be superficial in the factories surveyed, and misinformation regarding the risks and consequences of unsafe sex is widespread. Though many women workers have heard of HIV/AIDS, they take neither the risk of contracting HIV nor prevention training seriously as the notion of their spouse or partner having a sexual relationship outside of their own is often unthinkable. Again, factory management does not view HIV/AIDS as a priority because most women workers are young and unmarried and not perceived to be sexually inactive. In some factories in China, management did not consider HIV/AIDS to be of concern because most of the women workers are migrants who are far from families and living in gender segregated dormitories. Across all focus countries, HIV testing in the factory setting is rare, though MSI and YKB both offer this service. Among factory management interviewed, the notion of young, migrant workers aged 20-25 being at risk for HIV/AIDS is extraordinary.

Nevertheless, health care providers in factories—perhaps due to pressure from buyers—are becoming more aware of the need to provide information on HIV/AIDS and on programs in the community that workers could access. Based on our fieldwork, the opportunity to integrate HIV/AIDS prevention training within the framework of existing RH training is one that holds promise, though additional research in a wider range of countries is needed to further explore this linkage. Exploring this linkage makes particular sense as one of the common denominators in contracting HIV and sexually transmitted infections (STIs)—as well as unplanned pregnancies—is unprotected sex.[2]

Nutrition

Nutritional concerns vary among factories and countries. While diabetes, hypertension and obesity rank as the top health concerns of women factory workers in Mexico, many women workers in China, India, Indonesia and Viet Nam suffer from anemia and gastritis.

China, India, Indonesia and Viet Nam experience similar problems with the diets of women workers. While factories in Viet Nam and Indonesia provide free lunches to workers, factories generally do not provide breakfast. Due to lack of time or attempts to save as much of their wages as possible, workers often skip breakfast and work without a solid meal for more than twelve hours. The food served in the cafeterias is usually provided by licensed third-party vendors but is seldom balanced or nutritious. Diarrhea and food poisoning are not uncommon.

Due to lack of time or attempts to save as much of their wages as possible, workers often skip breakfast and work without a solid meal for more than twelve hours.

Our fieldwork suggests that best practice in nutrition involves worker trainings on low-cost and nutritious food, staffing each cafeteria with a nutritionist to plan appropriate meals,

[2] Fleischman, Janet. "Family Planning, AIDS Care Should Go Hand in Hand." The Baltimore Sun 26 July.2006, natl. ed.: A15.

providing dietary and vitamin supplements to workers and conducting random checks of meals to gauge quality and nutritional value to ensure valuable micronutrients for safe and healthy childbirth.

Education

In most factories, annual trainings on first aid, health and safety, fire safety, hazardous chemical management and protective personal equipment (PPE) for relevant positions are delivered to all employees, though compliance teams on several occasions admitted that production pressures sometimes delay such trainings. Training on occupational health and safety is often required by law or by brands under their own codes of conducts or terms of engagement. Most factories surveyed also provided induction training for new workers, which usually touches upon health and safety. The general lack of basic health services hinders the development of more robust RH services and training on important topics such as nutrition, which many factory managers point to as a major cause of worker absenteeism due to sickness.

Factories that have set up mechanisms for communication with workers through counselors, human resources personnel, health care providers, labor unions and factory line supervisors educated in training of trainers programs find a greater degree of success in raising awareness on health issues, due to the availability of multiple channels. Empowerment remains a critical area for future attention. Best practice in training includes 'train-the-trainer' programs for the factory and community, customized audio and video materials, monthly campaigns on health issues and long-term collaboration with external NGOs and public agencies.

Apparel factory in Binh Duong Province, Viet Nam

Occupational Safety and General Health

The level of health services available inside factories varies widely, from worker trainings in first aid, to part-time nurses and part-time doctors with no diagnostic equipment in a small room, to full-time doctors and nurses staffing a clinic with diagnostic equipment, X-ray facilities and a pharmacy. The majority have only basic first aid response capabilities and dispense only over-the-counter medication for illnesses such as cough, cold, fever and

diarrhea. Best practice among factories surveyed include providing an annual check-up for all workers with specific tests for occupational hazards, maintaining individual medical records and following us with the public health care system on specific workers' cases.

Recommendations

The recommendations below for brands and factories to consider when designing an approach for implementing or expanding women's health initiatives in the factory setting are based on general findings across the focus countries and factories surveyed. While there are differences in specific country situations, there are also underlying success factors across countries.

Business Case for RH Services

Without exception, factory management interviewed agrees that improved worker health leads to a reduction in absenteeism due to sickness. Improved worker health impacts productivity and, in the longer term, contributes to reduced turnover rates. Reducing turnover is especially important in the manufacturing hub of Southern China and parts of India, where shortages of skilled labor in the sectors covered are growing. A few factories have recognized this, but wider acknowledgement across sectors and buy-in from factories is necessary to effect real change. It is our conclusion that internal motivation among factory management represents the most effective way by which to successfully promote women's health programs.

Services Integration

Factories with a holistic approach to women's health generally realize more effective results. This is especially true for women workers who are also concerned about the welfare of their children, husbands and other family members. A factory that provides transport facilities, child care and advice on proper nutrition will witness greater improvement in health than factories that only provide diagnostic and treatment services, however advanced their services may be. Child care centers have also proved to be a useful access point for educating women workers about their own health, though India was the only country surveyed in which factories routinely provide such facilities. The lack of child care centers in the other countries surveyed can be attributed in large part to the unmarried, migrant status of factory workers.

Accessibility

Health care facilities must be easily accessible to workers and permission to leave the production line must be granted when the need exists. If the clinic is located away from the factory, workers are reluctant to take the extra time to go to the clinic, even if transportation is provided to them. Also, if the line supervisor or production manager is not amenable to workers taking time to visit the clinic, workers will be less inclined to do so. This is especially true for routine medical check-ups, such as an antenatal check-up during pregnancy, which workers may tend to skip if production pressures are high. Comparative research on factory- vs. community-based health facilities is required, as privacy and confidentiality remain key variables.

Nutrition

Most worker ailments, such as anemia and gastritis, stem from poor nutrition and poor eating habits. Factories can improve worker health in the long-term by placing more emphasis on nutrition through training and individual counseling, and by providing nutritional supplements and free or subsidized meals, particularly breakfast.

Education

Training on health issues requires long-term commitment from factory management. While less time and effort is required to initiate a train-the-trainer program or invite an external expert organization to provide training, ensuring that workers are aware of and attend the training in sufficient numbers is more difficult. Sustained efforts on the part of management can help to ensure that workers are informed about trainings and have the time to attend.

- **Proactive Education and Information Sharing:** Since workers are often embarrassed or do not know to ask for information, factories should identify ways to disseminate information easily and discreetly, including posters or brochures posted in semi-private spaces. Proactive provision of information should not be limited to women workers, however, since male workers can provide this information to their wives and mothers.
- **Regular and Frequent Health Campaigns for All Workers:** If campaigns are voluntary, many workers will choose not to attend unless they are in a location where workers are already congregating, such as the cafeteria. Because factories often experience high turnover, health campaigns that occur only annually reach a small percentage of the population, so campaigns should occur more frequently. Even if turnover is low, changing worker attitudes requires repetition and frequency. One factory addressed health topics with workers on a monthly basis by creating displays in a location between the factory entrance, the cafeteria and the production area, ensuring that as many workers as possible were aware of the campaign.
- **Locally Tailored Programs:** Companies should support factory initiatives, instilling company values and guidelines but allowing flexibility for local managers to design programs that are tailored to worker needs and consider cultural and socioeconomic sensitivities. The success of such programs can be enhanced by providing opportunities for input and feedback from workers and by having worker committees or peer health representatives that demonstrate worker ownership of health issues. Worker feedback is essential in ensuring that health programs meet their current needs while continually improving to meet anticipated needs.

Departmental Coordination

Coordination between different functions within the factory is important to ensuring improvements in health. Clinics and medical service providers cannot function in isolation. Periodic and systematic coordination and sharing of information and findings between medical service providers, human resources, production, cafeteria management, dormitory staff and senior management remains essential. For examples, deficiencies in nutrition can be remedied through the sharing of information between doctors and cafeteria management; if workers are dehydrated, line supervisors and production managers must be reminded to

instruct workers to drink more water during the work day. All departments must be made aware of the importance of workers' health and access to health facilities.

Counseling and Support Systems

Women workers tend to value the opportunity to talk to someone about their personal problems, which may include domestic violence, children's education and financial concerns. They may seek advice and treatment on troubling RH issues only when they have an individual or group that they feel they can trust. Such trusted counselors could be staff hired specifically for this purpose, or they could include human resource personnel, union members, nurses or others. Workers should have access and frequent communication with counselors on an individual basis. Many of the women workers interviewed state that they value the counseling and advice they receive more than they value medical treatment. They particularly appreciate being spoken to politely and with consideration, which differs from the poor treatment that they generally receive in government-run facilities.

Health Facilities

In Indonesia, where factory clinics are the primary health care provider for workers and are often covered by workers' health insurance, workers prefer more specialized care and facilities. However, in India, the Philippines, Mexico and Viet Nam, where government health insurance is mandatory, workers tend to use the factory clinic as a facility for diagnosis and treatment of chronic ailments (such as anemia or gastritis) and minor illnesses such as coughs and colds. When workers have a more serious medical condition, they generally seek treatment from a private hospital or government hospital that their insurance covers. One factory in India that has arranged for weekly visits to their clinic by specialist doctors found that the specialists did not see many patients when compared to the overall number of visits to the factory clinic.

Basic Elements of Effective Factory Health Programs

While the projects visited had various levels of health systems and facilities, the following represent the basic elements of a successful program:

- **Doctor:** General physician available full-time or part-time to all workers. While it is not necessary for the doctor to be a specialist, a female doctor or gynecologist is helpful when the factory has a majority of female workers.
- **Medical Records:** Proper record keeping by maintaining individual medical records (as opposed to sickness or injury log books alone) is helpful in forecasting needs and planning preventive activities.
- **Counseling and Support Staff:** In addition to trained medical providers such as doctors and nurses, workers should be able to talk and receive advice on health issues, either from human resource personnel or from others with specific counseling functions.
- **Annual Health Check-up:** Annual health check-ups for all workers, with specific tests for occupational hazards, can be an effective surveillance tool in furthering preventive care.

- **Dedicated Personnel:** Activities conducted in successful health programs need dedicated personnel to ensure that the activities are planned and designed well, are implemented regularly, are effective and meet the needs of workers. Dedicated personnel could be existing staff or staff specifically hired for this purpose. Regardless, they must be given adequate time to carry out the activities.

Interaction with Government Health Facilities

In India, the Philippines, Mexico and Viet Nam, where government health insurance for workers is mandatory, factories could put more effort into leveraging the public health system and supporting workers through interaction with government hospitals and management. Factories that regularly accompany their workers to government hospitals for follow-up treatment and develop communication channels with doctors and management at those hospitals find that their workers receive a higher quality of care. Factories are also able to draw on public health care system resources for training and preventive activities.

Mobile RH clinic at footwear factory in Binh Duong Province, Viet Nam

Collaboration with Government and NGOs

Factories should work closely with government agencies and NGOs, including actively partnering with government health campaigns in their communities. Factories alone may lack the expertise and financial resources to organize and train workers, so utilizing existing programs may be more cost effective. Family planning services are one area in which all focus country governments offer a number of programs. Government agencies and NGOs can also be invited to conduct health programs within a factory. Several NGOs interviewed during this study expressed willingness to provide health education to factories, in many cases free of charge, because their costs are often covered by bilateral, multilateral and private donors.

Plans for Dissemination

The research and findings from this report will be disseminated throughout BSR's network to a wide array of stakeholders, including BSR member companies, suppliers in the focus countries, NGOs, donor agencies and relevant government officials.

In September 2006, BSR attended the Clinton Global Initiative in New York City and committed to expanding our current work on RH in 2006-2007. For more information on our commitment, please visit the BSR website at www.bsr.org.

In October 2006, findings from this research will be discussed at a Health Services Roundtable event in New York City hosted by the David and Lucile Packard Foundation and the Global Business Coalition on HIV/AIDS (GBC). BSR also featured an article titled "A Focus on Women's Health in Global Supply Chains" in the Fall 2006 edition of *Leading Perspectives*, BSR's own quarterly publication that is circulated to more than 3,000 subscribers.

In November 2006, project findings will be presented and discussed during a panel discussion at the BSR Annual Conference in New York City. Dr. Don Lauro from the David and Lucile Packard Foundation, Ms. Nguyen Thi Bich Hang from MSI in Viet Nam, Dr. Adi Sasongko from YKB in Indonesia and at least one major brand will participate on the panel.

Prior to the conclusion of project work in October 2006, BSR will also produce and make available a *Guide for Brands* that will be disseminated primarily to suppliers in the six focus countries and translated into local languages. This *Guide* represents a practical, abridged version of the full report that will aim to provide factory management with an overview of the issues, recommendations and best practice examples.

We will also feature the project and findings via the BSR website, BSR's Ethical Sourcing Working Group, through the *BSR Weekly* email updates and through relationships with industry initiatives and other interested parties.