Garment Sector Health Interventions in Cambodia
A Comprehensive Review

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The Evidence Project uses implementation science—the strategic generation, translation, and use of evidence—to strengthen and scale up family planning and reproductive health programs to reduce unintended pregnancies worldwide. The Evidence Project is led by the Population Council in partnership with INDEPTH Network, International Planned Parenthood Federation, PATH, Population Reference Bureau, and a University Research Network.

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The authors are grateful to David Wofford and Bunmey Yat of the WorkerHealth team, who provided insights and support to this analysis from its inception alongside their analysis of stakeholders, through joint discussions, presentations, and through numerous iterations of the analysis.

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### List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AECID</td>
<td>Spanish Agency for International Development Cooperation</td>
</tr>
<tr>
<td>AFD</td>
<td>Agence Française de Développement</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Aid</td>
</tr>
<tr>
<td>BSR</td>
<td>Business for Social Responsibility (BSR)</td>
</tr>
<tr>
<td>BW</td>
<td>Better Work</td>
</tr>
<tr>
<td>CBDC</td>
<td>Widen the Range of Family Planning Choices through Community Based Distribution of Contraceptives</td>
</tr>
<tr>
<td>DA:UYFC</td>
<td>Doctors Alliance Union of Youth Federations of Cambodia</td>
</tr>
<tr>
<td>DFAT</td>
<td>Australian Department of Foreign Affairs and Trade</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>GF</td>
<td>Garment Factory</td>
</tr>
<tr>
<td>GFI</td>
<td>Garment Factory Infirmary</td>
</tr>
<tr>
<td>GFW</td>
<td>Garment Factory Worker</td>
</tr>
<tr>
<td>GMAC</td>
<td>Garment Manufacturers Association in Cambodia</td>
</tr>
<tr>
<td>GSK</td>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td>HFHW</td>
<td>Healthy Food, Health Workplace</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HWHW</td>
<td>Health Women, Healthy Workplace</td>
</tr>
<tr>
<td>IAISRH</td>
<td>Improving Access to Integrated Sexual and Reproductive Health and HIV services for Factory Workers</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>JTF</td>
<td>Japan Trust Fund</td>
</tr>
<tr>
<td>KOTRA</td>
<td>Korea Trade Investment Promotion Agency</td>
</tr>
<tr>
<td>M&amp;S</td>
<td>Marks and Spencer</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoLVT</td>
<td>Ministry of Labour and Vocational Training</td>
</tr>
<tr>
<td>NSSF</td>
<td>National Social Security Fund</td>
</tr>
<tr>
<td>OSH</td>
<td>Occupational Safety and Health</td>
</tr>
<tr>
<td>PACE</td>
<td>Personal Advancement and Career Enhancement</td>
</tr>
<tr>
<td>PMUW</td>
<td>Protections for Marginalized Urban Women</td>
</tr>
<tr>
<td>PRISM</td>
<td>Provider Reflection and Information Sharing Meeting</td>
</tr>
<tr>
<td>PSL</td>
<td>Partnering to Save Lives</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
</tr>
<tr>
<td>RMNH</td>
<td>Reproductive, Maternal and Neonatal Health</td>
</tr>
<tr>
<td>SBF</td>
<td>Sewing for a Brighter Future</td>
</tr>
<tr>
<td>SIFPO</td>
<td>Support for International Family Planning Organization</td>
</tr>
<tr>
<td>SWSC</td>
<td>Safe Workplace, Safe Communities</td>
</tr>
<tr>
<td>TYDA</td>
<td>Techo Youth Doctor Alliance</td>
</tr>
</tbody>
</table>
UNFPA  United Nations Population Fund
USAID  United States Agency for International Development
WE    World Education
WorkerHealth Cambodia Worker Health Coalition Executive Summary
Executive Summary

The Cambodian garment industry is one of the most important contributors to the nation’s economy and accounts for a significant proportion of formal employment of the female labor force. Revenue from garment exports accounts for roughly 80 percent of the national export revenue. As of 2015, there were 837 garment factories (GF) operated under the Generalized System of Preferences (GSP) in the garment sector in Cambodia (Mak 2015). The industry provides formal employment to roughly 700,000 garment factory workers (GFW) (BFC n.d.) of which around 85 percent are women, most of whom are of reproductive age (PSL 2014a). Some estimates suggest that one-quarter of all Cambodian women between the ages of 18 and 29 are working in garment factories (GFs). As the majority of female GFWs are of reproductive age, challenges related to their access to reproductive health (RH) services, including family planning (FP), are particularly important to consider. Recent research has found that 80 percent of female GFWs are not using FP, and 80 percent of these women are under the age of 30 (PSL 2014a).

The Cambodia Worker Health Coalition (WorkerHealth) project, a two-and-a-half-year initiative supported by USAID Cambodia through SIFPO II/Marie Stopes and the Evidence Project, is designed with multiple, inter-related components to increase GFW access to and utilization of health services, particularly provision of high-quality RH and voluntary FP services. One of the hallmarks of the project is that it employs a rigorous Learning Agenda to enable evidence-based decision-making and programming related to the health and wellbeing of female GFWs. As a part of this mandate, the Evidence Project/Population Council (the Council) conducted a comprehensive review of garment sector health interventions/projects in Cambodia during the last five years, with a particular emphasis on RH and FP focused projects.

The review had three main objectives. The first objective was to document the range of garment sector health interventions in order to provide the most recent and up to date documentation of the interventions. More specifically, the second objective aimed to identify best practices and gaps in programming and evaluation. This knowledge is needed to inform the scale-up of promising interventions, minimize duplication of efforts, and ensure efficient use of available resources. The third objective was to draw implications for the WorkerHealth Project, in light of programmatic strengths and challenges of completed and active interventions.

Information on projects under review was collected from October to December 2015 through three methods. The main data collection approach was a desk review of project documents. The consulted project documents included project briefs and summaries, fact sheets, newsletters, baseline reports, and endline reports. In addition to the project documents, the information search included relevant non-governmental organizations’ (NGOs) websites and Google searches for additional project information. Information was also obtained from various stakeholder meetings conducted for the Stakeholder Analysis, a complementary analysis being conducted simultaneously under WorkerHealth. Interventions included in this review all focused on health issues of GFWs as a primary target group, and operated within the last five years (2010-2015).

A total of 21 projects were identified whose characteristics fulfilled the inclusion criteria. Out of these 21 projects, 12 projects remain active, while another nine projects have been completed. Four projects (one completed and three active) were identified after the data analysis was completed in March 2016 and thus were not included in the review. The review therefore analyzed only 17 out of the 21 identified projects, including nine of the 12 active projects.
KEY FINDINGS

- Leadership by a single organization and funding from a single source were common among reviewed projects. However, joint partnership models and collaborative funding were also emerging, especially among recent garment sector health interventions.

- The majority of the completed interventions strategically chose to locate their project sites in Phnom Penh and Kandal province but were not operated at scale, with individual project reaching less than 20 factories and from 14,000 to 25,000 workers.

- The reviewed projects included RH and FP as interest areas, together with other health issues. However, RH and FP issues are not yet receiving sufficient attention to become a primary focus of most projects. RH and FP issues were most often coupled with nutrition and hygiene, general health, and HIV/AIDS.

- Most of the identified interventions employed multiple approaches, rather than a single approach.

- The five main approaches employed by projects in this review included 1) awareness raising and behavior change communication, 2) enhanced service delivery and quality of care, 3) health financing, 4) policy influence, and 5) learning agenda.

- Awareness raising and service delivery were the two intervention strategies used most often, as well as the most commonly combined strategies. However, there was limited use of mHealth innovation as part of awareness raising or service delivery activities.

- Lifting financial barriers to worker utilization of health services was accomplished mostly through the distribution of free health services and products. Innovative health financing strategies to supplement the coming national health insurance scheme for GFWs have not been used.

- Intervention strategies to influence policy at a national level or to produce rigorous evidence of implementation outcomes and experience to inform better project design were not widely adopted by the identified projects.

- A large number of projects have conducted both baseline and endline studies to measure the impacts of their projects. However, the quality of evaluations needs to be improved, since only one completed project used a case-controlled design in its evaluation study.

IMPLICATIONS

- Given the low number of active projects that focus primarily on RH and FP for GFWs, more projects targeting this health issue are urgently needed to meet the need for RH and FP health services in this highly important, female-dominated sector.

- Joint partnership models in terms of leadership and finance should be considered as these pool expertise and resources together. Collaboration among lead organizations and donors would enable future projects to reach wider coverage, adopt more integrated, complementary intervention approaches, and reduce the economic burden on factory management of working with many, uncoordinated health interventions.

- Future projects should support the government’s work to improve worker health. Engaging with the government, especially the Ministry of Labor and Vocational Training (MoLVT), can produce wider impacts through policy influence. Health financing strategies to supplement the National Social Security Fund (NSSF), which is nation-wide and has the potential to produce broader improvement in worker health, is a promising area for collaboration.

- There is an acute need for rigorous monitoring and evaluation of project outcomes and implementation processes to determine what works and does not work, and to inform the design of future garment sector health interventions.
1. Introduction

1.1 BACKGROUND

The Cambodian garment industry is one of the most important contributors to the nation’s economy and accounts for a significant proportion of formal employment of the female labor force. Revenue from garment exports accounts for roughly 80 percent of the national export revenue. The industry provides formal employment to roughly 700,000 garment factory workers (GFW) (BFC n.d.) of which around 85 percent are women (PSL 2014a). Some estimates suggest that one-quarter of all Cambodian women between the ages of 18 and 29 are working in garment factories (GF). Since the majority of female GFWs are of reproductive age, it is particularly important to consider challenges related to their access to sexual and reproductive health (SRH) services, including family planning (FP). Recent research has found that 80 percent of female GFWs are not using FP, and 80 percent of these women are under the age of 30 (PSL 2014a).

There are a number of barriers to female GFWs’ access to quality RH services (PSL 2014a; UNFPA 2014). Those include access to health service providers, factory-related conditions and factors, and workers’ individual characteristics. Garment factory infirmaries (GFI) are often GFWs’ first and nearest point of contact for health services. However, anecdotal evidence suggests that GFWs may be less likely to visit GFIs for RH or FP services due to the perceived lack of confidentiality, low quality of the services, unavailability of certain FP services (e.g. long acting methods), or limited opening hours (PSL 2014a). Public facilities provide a wider range of services, but their working hours are not conducive to GFW work schedules and the GFWs may have a negative perception of their quality. Private clinics could be good alternatives in terms of time but are typically not so for quality of services. In addition to issues associated with health service providers, factories’ internal requirements for certified medical certificates for approval of sick leave prevent workers from accessing certain RH services. A number of other issues, including GFWs’ limited abilities to pay for services, limited knowledge of services available, and transportation costs, hinder female GFWs’ access to and utilization of RH services (UNFPA 2014).

The Cambodia Worker Health Coalition (WorkerHealth) project, a two-and-a-half-year initiative supported by USAID Cambodia, has been designed with multiple, inter-related components to increase GFW access to and utilization of health services, particularly provision of high-quality RH and voluntary FP services. Rather than a single focus, WorkerHealth is structured around several key components: Enabling Environment/Policy, Health Service Delivery and Access, and Learning Agenda. It is co-implemented by two leading institutions in the field of RH and FP. Marie Stopes is responsible for the implementation of the Health Service Delivery component under its SIFPO2 (Support for International Family Planning Organizations 2) Project. The Population Council (The Council) and its partner Meridian Group International, Inc. are responsible for the Policy and Learning Agenda components, under the Council’s global Evidence Project. WorkerHealth presupposes that activities will be more effective and sustainable if they are built on existing structures and programs in Cambodia and thus strategically engages private sector, government, civil society and labor to succeed in improving worker health and supporting the growth and productivity of the garment sector for the long-term.

One of the hallmarks of the project is its rigorous Learning Agenda, which aims to enable evidence-based decision-making and programming that relate to the health and wellbeing of female GFWs. WorkerHealth was designed with a multi-method Learning Agenda to gain a formative understanding of the health and wellbeing of GFWs, particularly with regard to RH and voluntary FP, and to generate and disseminate rigorous evidence on key approaches to improving the health status and health-seeking behavior of GFWs. As a part of this mandate, the Evidence Project/Population Council conducted a comprehensive review of garment sector health interventions in Cambodia during the last five years, with a particular emphasis on RH and FP-focused
THE EVIDENCE PROJECT

1.2 OBJECTIVES

This comprehensive review had three main objectives.

1. **Documenting the range of GF-based health interventions:** This review aims to provide the most up-to-date documentation of garment sector health interventions in Cambodia, particularly capturing interventions conducted during the last five years (2010–2015). The garment sector’s economic and social importance to the country has attracted extensive development efforts, including those related to health. However, there has not been any systematic documentation of these efforts, particularly for worker health. This information is urgently needed to minimize the duplication of programming efforts.

2. **Identifying best practices and gaps in programming and evaluation:** To effectively promote GFW access to and utilization of quality health services, especially RH and FP, it is necessary to understand what works and does not work for improving worker health. This knowledge is needed to inform the scale up of promising interventions, minimize duplication of efforts, and ensure efficient use of available resources.

3. **Drawing implications for WorkerHealth:** More specifically to the project, since WorkerHealth is still in the early stages of implementation, this comprehensive review will inform project intervention design and help navigate the project’s place in the landscape of garment sector health interventions in Cambodia. By identifying best practices in intervention strategies and considering strategies employed by completed GF-based health interventions, this review will support the design and refinement of WorkerHealth strategies to produce maximum impacts on worker health.

1.3 METHODOLOGY

**Inclusion Criteria**

Completed programs were eligible for inclusion in this review if they met the following three criteria:

1. **Focused on health and wellbeing of GFWs broadly.** Programs needed to be health-focused but did not need to be restricted to only RH and FP.

2. **Focused on garment workers.** Programs focused on GFWs as the major target group.

3. **Operated within the last five years.** The interventions operated within the past five years (2010–2015), regardless of their starting date of implementation.

**Data and Information Sources**

The review was based on data collected from October to December 2015, from three main sources.

1. **Documents produced by projects.** The consulted documents included project briefs or summaries, fact sheets, newsletters, baseline reports, and endline reports.

2. **Online search.** In addition to the project documents, the information search included relevant non-governmental organizations’ (NGOs) websites and Google searches for additional project information.

3. **Stakeholder meetings:** The review also gathered on information from meetings with various stakeholders held as part of the Stakeholder Analysis, a complementary analysis conducted parallel to this review.
One limitation to note is that some projects had considerably more available information than others, making the analysis presented here more detailed and nuanced for some projects than others. Some projects did not have significant publicly available information about their implementation, and confidentiality related issues prevented additional information from being shared for the review. In these cases, analysis was based on publicly available information.

1.4 STRUCTURE OF THE REPORT

This report presents findings of the review, organized into eight sections.

Following the Introduction, Section 2 provides an overview of the leadership, time frame, funding source, and coverage of reviewed projects. Section 3 discusses thematic focus areas of reviewed projects, with an emphasis on RH and FP themes. Section 4 delves more deeply into intervention approaches of identified projects by additionally highlighting under-represented approaches, which may warrant special attention from future garment sector health interventions. Section 5 focuses on program evaluations of identified projects to assess the current state of evidence on the effectiveness of projects under review. Section 6 analyzes the strengths and challenges of reviewed projects, in terms of intervention and evaluation, and presents conclusions from the program review. Based on the identified programmatic strengths and challenges, Section 7 discusses how WorkerHealth fits into the current field of garment sector health interventions, particularly RH and FP, in light of the identified programmatic strengths and challenges. Finally, Section 8 outlines important recommendations for future garment sector health interventions in Cambodia.
2. Project Overview

This section provides an overview of the leadership models, funding sources, and coverage or scope of the projects under review.

A total of 21 projects were identified that fulfilled the three inclusion criteria, of which 12 remain active and nine are completed. Four projects (three active and one completed: SPG, HWHW, HFWH, and 3rd SBF) were identified after the data analysis was completed in March 2016, and thus were not included in the review. The review therefore analyzed only 17 of the 21 identified projects, including nine active projects. A complete list of projects identified by this study are included in Table 2.1.

### TABLE 2.1 LIST OF PROJECTS REVIEWED BY YEAR OF IMPLEMENTATION

<table>
<thead>
<tr>
<th>NO.</th>
<th>PROJECTS</th>
<th>LEAD ORGANIZATIONS</th>
<th>TIME FRAME</th>
<th>FUNDERS</th>
<th>OBJECTIVES OF PROJECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HealthWorks&lt;sup&gt;1&lt;/sup&gt; HealthWorks Program</td>
<td>Reproductive Health Association of Cambodia (RHAC)</td>
<td>2012–Present</td>
<td>Marks and Spencer (M&amp;S)</td>
<td>1. To devise a methodology to improve the health of employees in garment factory suppliers of M&amp;S. 2. To institutionalize a process for long-term sustainability for improving health and preventing disease, using existing infrastructure and minimizing costs.</td>
</tr>
<tr>
<td>2</td>
<td>SWSC Safe Workplaces, Safe Communities</td>
<td>CARE</td>
<td>2013–2016</td>
<td>UN Trust Fund to End Violence Against Women through UN Women</td>
<td>To reduce GBV and SH in Cambodian workplaces and communities.</td>
</tr>
<tr>
<td>3</td>
<td>Kamako Chhoeun Outstanding Workers</td>
<td>Better Work (BW)</td>
<td>2013–Present</td>
<td>---</td>
<td>To educate garment and footwear workers about labor rights, occupational safety and health (OSH), and personal health.</td>
</tr>
<tr>
<td>4</td>
<td>PSL Partnering to Save Lives</td>
<td>Marie Stopes, CARE, Save the Children, Ministry of Health (MoH), and Australian Department of Foreign Affairs and Trade (DFAT)</td>
<td>2013–2018</td>
<td>DFAT</td>
<td>To save the lives of women and newborns in Cambodia through improved quality, access, and utilization of reproductive, maternal and neonatal health (RMN) services through a partnership approach.</td>
</tr>
<tr>
<td>5</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; HERproject HERproject + nutrition: 2nd Phase</td>
<td>Business for Social Responsibility (BSR) &amp; BW</td>
<td>2014–2016</td>
<td>Brands or GFs</td>
<td>To increase women’s health awareness and access to health services through sustainable workplace programs.</td>
</tr>
<tr>
<td>6</td>
<td>PMUW Protections for Marginalized Urban Women</td>
<td>CARE</td>
<td>2014–2017</td>
<td>DFAT</td>
<td>The overarching goal of PMUW is that marginalized urban women in Cambodia, especially female migrants working in garment factories and hospitality/tourism industries, have improved protections from gender-based violence (GBV) and sexual harassment in the workplace and outside work settings.</td>
</tr>
<tr>
<td>NO.</td>
<td>PROJECTS</td>
<td>LEAD ORGANIZATIONS</td>
<td>TIME FRAME</td>
<td>FUNDERS</td>
<td>OBJECTIVES OF PROJECTS</td>
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<tr>
<td>7</td>
<td>Healthcare Improvement Project²</td>
<td>Res. P Co.</td>
<td>2015-2017</td>
<td>LG Electronics, Korea Trade Investment Promotion Agency (KOTRA), Daewon Pharmacy and Huons, factory owners, TYDA Volunteers, and Doctor of Alliance of Union of Youth Federations of Cambodia (DA.UYFC)</td>
<td>To provide health screening and education services to reach GFWs who lack time, knowledge about health, and money to go to hospitals and clinics by using a project medical bus.</td>
</tr>
<tr>
<td>8</td>
<td>WorkerHealth Cambodia Worker Health Coalition</td>
<td>Population Council (Evidence Project) &amp; Marie Stopes</td>
<td>2015-2020</td>
<td>United States Agency for International Development (USAID) &amp; Brands</td>
<td>To ensure that female garment workers have greater access to quality health services that meet their needs and improve their reproductive health and voluntary use of family planning.</td>
</tr>
<tr>
<td>9</td>
<td>2nd IAISRH Improving the access to integrated SRH and HIV services for factory workers: 2nd Phase</td>
<td>RHAC</td>
<td>2016-2018</td>
<td>International Planned Parenthood Federation (IPPF)</td>
<td>1. To provide SRH to GFWs through RHAC's clinic services. 2. To build the capacity of 30 factory clinics to provide selected quality RH services to their factory workers.</td>
</tr>
<tr>
<td>10</td>
<td>HWHW Healthy Women, Healthy Workplace³</td>
<td>CARE</td>
<td>2016-2019</td>
<td>GlaxoSmithKline (GSK)</td>
<td>1. To improve the knowledge, behaviors, and choices of factory workers in relation to sexual, reproductive and maternal health and nutrition. 2. To build the capacity of frontline health workers and increase the responsiveness and effectiveness of the existing health system in addressing the needs of garment factory workers. 3. To influence policy dialogue and priorities surrounding adolescent health through contributing to the development and implementation of effective standards of care within and outside the factories.</td>
</tr>
<tr>
<td>11</td>
<td>HFHW Healthy Food, Healthy Workplace³</td>
<td>CARE</td>
<td>2016-2019</td>
<td>The Children’s Place</td>
<td>1. To improve workers’ nutrition-related knowledge, steer positive eating habits and empower them to make healthy choices. 2. Create an enabling environment to support workers’ access to healthy, hygienic and nutritious food by working with food vendors and factory teams.</td>
</tr>
<tr>
<td>12</td>
<td>3rd SBF Sewing for a Brighter Future (SBF): 3rd Phase³</td>
<td>CARE</td>
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<tr>
<td>NO.</td>
<td>PROJECTS</td>
<td>LEAD ORGANIZATIONS</td>
<td>TIME FRAME</td>
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<td>OBJECTIVES OF PROJECTS</td>
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<td>------------------------</td>
</tr>
<tr>
<td>13</td>
<td>PACE</td>
<td>CARE</td>
<td>2008–2013</td>
<td>GAP Inc.</td>
<td>To improve women’s personal and professional opportunities while building a more skilled workforce.</td>
</tr>
<tr>
<td></td>
<td>Personal Advancement and Career Enhancement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Health Insurance Project for Garment Workers</td>
<td>Gret (a French development NGO), Garment Manufacturers Association in Cambodia (GMAC) and Ministry of Labour and Vocational Training (MoLVT)</td>
<td>2009–2012</td>
<td>AFD, GFs, GFWs</td>
<td>To introduce voluntary social health insurance for the garment sector that addresses the needs of both workers and employers.</td>
</tr>
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<td></td>
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</tr>
</tbody>
</table>
2. To promote women’s participation in workplace-level decision-making.  
3. To create pre-induction and post-factory employment opportunities. |
|     | Social Protection and Gender³ | | | | |
| 16  | 2nd SBF | CARE | 2010–2014 | Levi Strauss Foundation | 1. To increase worker knowledge, access, and use of health-related information and services for SRH, HIV/AIDS, food hygiene and nutrition, and maternal and neonatal health.  
2. To increase worker access, knowledge and use of financial services (i.e. savings and remittances).  
3. To improve working conditions by improving GFWs’ and managements’ understanding of labor law. |
|     | Sewing for a Brighter Future (SBF): 2nd Phase | | | | |
| 17  | Life Skills | World Education (WE) | 2012 | International Labor Organization (ILO) | To provide fundamental life skills to workers to support a healthy, balanced lifestyle and increased productivity. |
|     | Life Skills Training Program | | | | |
| 18  | CBDC | RHAC | 2012–2015 | UNFPA | To increase the modern contraceptive prevalence rate in five Operation Districts (OD) of Takeo Province, especially improving access to IUD services at health centers (HC) and referral hospitals (RH). |
|     | Widen the Range of Family Planning Choices through Community Based Distribution of Contraceptives | | | | |
| 19  | 1st HERproject | RHAC | 2013–2015 | Brands | To increase women’s health awareness and access to health services through sustainable workplace programs. |
|     | HERproject: 1st Phase | | | | |
| 20  | 1st IAISRH | RHAC | 2013–2015 | Japan Trust Fund (JTF) through IPPF | 1. To provide SRH to GFWs through RHAC’s clinic services.  
2. To build the capacity of 30 factory clinics to provide selected quality RH services to their GFWs. |
|     | Improving the access to integrated SRH and HIV services for factory workers: 1st Phase⁴ | | | | |
2.1 Leadership Models

In order to understand how completed interventions were coordinated and managed, and how relevant stakeholders worked together to improve worker health, this review explored projects’ leadership models.

The review found that there were two models of project leadership – sole leadership and joint partnership, with sole leadership being more common. Out of the 17 projects, 11 projects were led by single organizations. Six projects were operating under the joint leadership of two or more organizations (two HERprojects, Health Insurance Project, PSL, Healthcare Improvement Project, and WorkerHealth). This joint leadership model was adopted by two completed and four active projects, suggesting that this leadership model is becoming more popular, which may be explained by the model’s potential strengths. Joint leadership may foster better collaboration among lead organizations, support program implementation through leveraging the comparative advantages of partner organizations, allow for more efficient use of resources, and reduce burdens to factory management caused by participating in health interventions.

The review found that there are three leading organizations implementing garment sector health interventions in Cambodia: CARE (five projects, including the newly signed), RHAC (four projects), and BFC/BW (two projects).

2.2 Funding

Information on funding sources provides insights into the extent to which GFW health issues are a concern for various groups of stakeholders, particularly donors. Similar to the information on project leadership models, funding information also reveals the current state of collaboration among donors. The review found significant complexity in the funding models of the completed and current garment sector health interventions in Cambodia, with projects receiving support, both monetary and non-monetary, from various sources.
The reviewed projects received funding from a number of sources. Bilateral and multilateral donors are the largest source (11 projects), followed by brands (7 projects) and factory management (3 projects). Garment workers themselves also contributed in an initiative to improve their own health outcomes (1 project). Despite no relation with the garment industry, a private firm also joined the project to improve worker health through donations of their medicine products. The high representation of bilateral and multilateral donors and brands suggests that improving workers’ health is both a business issue and a shared development concern.

- Bilateral and multilateral donors: 11 projects
- Brands: 7 projects
- Factory management: 3 projects
- GFWs: 1 project
- Private firm: 1 project

Project funding was provided either by individual donors or collaboratively by multiple donors. Out of the 17 projects, 12 projects (six of which were completed) received funding from a single source. Five projects, two completed and three active, operated under collaborative funding. Single-source funding was more likely to come from bilateral and multilateral donors, while buyers/brands were more likely to provide funding in conjunction with other donors.

Joint partnership models have been implemented in various forms. A number of projects were co-funded, with different sources funding different aspects of project implementation. For example, establishment of the Health Insurance Project was funded by Agence Française de Développement (AFD) in Cambodia, while operation was funded by factory management and workers through co-payment for health insurance products (BFC 2009). Similarly, the impact evaluation study of BFC’s Nutrition Project was funded by AFD in Cambodia, while the cost of project implementation was covered by other sources. The Healthcare Improvement Project received financial support from LG Electronics Company, KOTRA, and factory management, while Hebron International NGO hospital, TYDA Volunteer and DA.UYFC provided in-kind support by seconding medical staff to work for the project, and Daewon Pharmacy and Huons donated nutrient and high blood pressure medicines (Rep. P Co. 2016).

Multiple funders also took turns financing different phases of project implementation. The 1st HERproject was funded entirely by brands, while the 2nd HERproject was funded by brands and factory management. Brands paid for new factories that were added to the project in the second phase, while factories that had participated in the first phase (with funding from brands) contributed their own funding to participate in the second phase.\(^1\)

Different donors took primary or secondary roles in supporting project implementation as well. The operation of WorkerHealth is completely funded by USAID. However, the project is committed to engaging brands, industry, and labor to support policy changes and interventions. Brands, industry groups and factories were particularly expected to contribute ‘in-kind support’ (e.g. time for participation), ‘indirect support’ (e.g. brand leverage to enable research and health service activities to be done in factories), and ‘direct support’ (e.g. direct funding to program interventions).

Based on the information of project coverage, a few funders seem to be key players in garment sector health interventions in Cambodia during the last five years. Japan Trust Fund, through its support for 1st IAISRH, is the largest donor for completed projects. The 1st IAISRH was the largest completed project, reaching up to 30 factories with an estimated 68,000 workers (RHAC 2015a). DFAT and USAID seem to be the two largest, active donors. DFAT supported PSL and PMUW. PSL covers only 12 factories, but its impact could reach

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\(^1\) Personal communication with BFC program officer, February 2016.
beyond these factories since the project works to produce nation-wide policy impacts. The overarching goal of PMUW is to support marginalized urban women in Cambodia, including garment workers, to benefit from improved gender-based violence and sexual harassment protections in the workplace and outside work settings (CARE n.d.). USAID supports WorkerHealth, which aims to reach over 40,000 workers at 35 factories. Various brands, including GAP Inc., Marks and Spencer, and Levi Strauss, are also active in supporting garment sector health interventions included in this review.

2.3 COVERAGE

This section provides an analysis of project coverage, including 1) project location and setting and 2) numbers of factories and workers reached, to summarize the coverage and reach of completed and active projects.

2.3.1 Location and Setting

The majority of the projects in this review chose their implementation sites strategically to reach a wider coverage of workers. Phnom Penh, with the highest density of garment factories in Cambodia, was selected by 15 projects as the only or one of the project locations, followed by Kandal province, which was selected by seven projects. Eight projects chose other provinces. A number of projects had locations in multiple provinces.

While it is logical to concentrate interventions in Phnom Penh and Kandal provinces, based on their high concentration of GFs, this has resulted in other provinces with GFs (e.g. Kampong Chhnang, Kampong Speu, Kampong Cham and Sihanouk Ville) having limited access to external assistance to improve worker health. This exclusion implies that there could be high unmet needs for RH and FP services among GFWs in those provinces, which needs to be considered.

Most projects were implemented in factory compounds. Sixteen projects held their activities inside the factories, of which seven projects also had activities outside of the factories. One project operated completely outside the factory setting (Kamako Chhnoeum Project). Of the seven projects implemented both inside and outside the factory, four projects remain active, suggesting that projects are expanding beyond the factory setting in their efforts to successfully and effectively improve worker health. Focusing interventions only inside factories might not be sufficient, since some barriers to worker access to and utilization of health services are associated with factors external to the factories (e.g. the socio-economic environment in which the workers live, health service providers, and some relevant national policies).

From this analysis, it is clear that the general design of garment sector health interventions is still centered around Phnom Penh and Kandal, and within the factory setting. Although trends are emerging toward implementing interventions to locations (provinces) other than Phnom Penh and Kandal and beyond the factory compound, the shift is not yet significant. This is to be expected, as projects try to make strategic use of their limited resources. Future projects may need to consider this coverage gap.

2.3.2 Factories and Workers Reached

Regardless of their implementation approaches (i.e. awareness raising or service delivery), the identified projects were largely small in scale. The majority of the projects covered less than 20 factories (Figure 2.1) and reached between 14,000 to 25,000 GFWs (Figure 2.2).

Three projects operated at a larger scale. The 1st IAISRH covered 30 factories, reaching an estimated 68,000 workers. RHAC aims to reach up to 40 factories in the 2nd IAISRH project. WorkerHealth aims to have a direct reach of 40,000 workers from 35 factories (WorkerHealth, 2015). However, it is possible that WorkerHealth's

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2 Personal communication with RHAC CHW, 2016
impact will reach beyond those factories, through the commitment to work with key stakeholders to promote national policies affecting factories and the industry, and with the GIS-enabled hotline and referral service.

Overall, the analysis of project leadership, funding sources, and coverage suggests that there is increasingly a shared understanding, though not yet widespread, among various industry stakeholders of the need to work collaboratively to achieve greater success improving worker health. Joint leadership is beneficial, as it brings lead organizations together in a collaborative instead of competitive manner. Moreover, it allows projects to adopt multiple, integrated and complementary approaches based on the expertise of individual organizations. For factory management, well-coordinated projects help reduce economic losses associated with their participation, which is often in the form of lost worker time. Finally, greater and pooled resources enable lead organizations to expand their coverage, operate at economies of scale and reach a larger number of beneficiaries.
3. Thematic Focus Areas

This section presents analysis of the projects’ thematic focus areas in health, with a special focus on RH and FP. **Section 3.1** assesses the extent to which garment workers’ RH and FP issues have been specifically addressed by interventions in this review. In addition to that, **Section 3.2** provides information on other areas of focus in health covered by the reviewed projects in order to enhance an understanding of the contribution made by the identified interventions.

The review found that the majority of projects included in the review solely focused on health issues, while only a few included non-health related themes combined with a health focus. Among the projects included, a majority focused on RH & FP (14 projects). Other themes that were covered included nutrition and hygiene (6 projects), general health (4 projects), HIV/AIDS (4 projects), financial services/literacy (3 projects), labor working conditions (2 projects), life skills (2 projects), gender-based violence (GBV) and sexual harassment (2 projects), and workplace skills (1 project). Projects that covered non-health related themes did so in combination with health related themes.

Out of the 17 projects, 11 projects addressed more than a single issue. The distributions of completed and active projects addressing multiple issues were relatively the same (6 completed projects, 5 active projects), suggesting that multifaceted focus has been a norm among the garment sector health interventions.

### 3.1 INCLUSION OF RH AND FP

Since this Comprehensive Review has a special focus on RH and FP issues, this section provides information on how extensively RH and FP issues have been integrated into the completed and active projects that address health issues of garment factory workers.

The review found that 14 out of the 17 projects included RH and FP either as primary themes (“RH and FP primary projects,” six projects) or as secondary themes (“RH and FP secondary projects,” eight projects) (see **Table 3.1**). It is not surprising that RH and FP were common topics among the garment sector health interventions, since around 85 percent of GFWs in Cambodia are women and a majority are of reproductive age. These women come from rural areas where access to good quality information about RH is limited. Furthermore, migrating to urban

<table>
<thead>
<tr>
<th>PROJECT FOCUS</th>
<th>COMPLETED PROJECTS</th>
<th>ACTIVE PROJECTS</th>
<th>TOTAL</th>
</tr>
</thead>
</table>
| RH and FP primary | Total = 3  
• 2nd SBF  
• 1st IAISRH  
• CBDC | Total = 3  
• PSL  
• WorkerHealth  
• 2nd IAISRH | 6 |
| RH and FP secondary | Total = 4  
• PACE  
• Life Skills  
• 1st HERproject  
• Health Insurance Project | Total = 4  
• 2nd HERproject  
• HealthWorks  
• Kamako Chhnoeum  
• Healthcare Improvement Project | 8 |
| Non-RH and FP | Total = 1  
• BFC’s Nutrition | Total = 2  
• PMUW  
• SWSC | 3 |
| Total | 8 | 9 | 17 |
areas puts women in a disadvantaged position since they are no longer able to receive family or community support and are more vulnerable to sexual exploitation, often resulting in unwanted pregnancies and sexually transmitted infections.

Out of the 14 projects that included RH and FP, only six projects included them as primary themes. The other eight projects coupled RH and FP with other issues. The most common coupling was between RH and FP and nutrition and hygiene (5 projects), followed by general health (4 projects), HIV/AIDS (4 projects), financial services/literacy (3 projects), labor working condition (2 projects), life skills (2 projects), and workplace skills (1 project).

However, when RH and FP were not the primary themes, they seemed to receive relatively limited attention in the projects. For example, RH and FP altogether were one of the three topics covered by the hotline quiz of the Kamako Chhnoeum project, one of the five training topics of the Life Skills Training project, one of eight training topics of the PACE program, and one of many health counselling topics addressed by the Healthcare Improvement Project.

### 3.2 Other Areas of Focus in Health

In addition to RH and FP, the reviewed projects also focused on other issues. Nutrition and hygiene have received continued interest from donors, and were the sole focus or were combined with other issues in completed and active projects. The focus on nutrition and hygiene makes sense, as they remain critical health issues, particularly for female Cambodian GFWs, who were often reported to faint during working hours due to malnutrition.
Some projects were designed to improve the general health of GFWs. The services provided include, for example, health screening on cholesterol, vital signs, body composition, Hepatitis B, liver function, and kidney function. Health education counseling on hygiene, nutrition, reproductive health, and other topics was also a part of services delivered in some projects.

The focus on HIV/AIDS in garment sector health interventions is changing, as none of the active projects work on HIV/AIDS. This absence of interventions might reflect the improved HIV/AIDS knowledge of garment workers, as well as the evolving nature of HIV prevention and care in the health sector. Development partners, including the government and NGOs such as CARE, have been working on HIV/AIDS with garment factories for more than 10 years.

The emerging focus on GBV and SH as a new theme could reflect an evolution in thinking about GBV and SH. While HIV/AIDS and GBV are interconnected, the completed garment sector health interventions chose to focus only on HIV/AIDS. This could be explained by the early misconception of HIV/AIDS organizations and by socially tolerant behaviors towards GBV (Duvvury & Knoess 2005).

It is also important to note that non-health related issues such as financial services or literacy, life skills, workplace skills and labor or working conditions were also addressed by some projects included in this review in conjunction with health-related issues. Financial literacy and services improve workers’ ability to manage their own finances and to reduce the costs of sending remittances home, which would ultimately lead to increased savings and financial security. A combination of financial literacy and health knowledge building promotes workers’ personal development. Improving workers’ awareness of labor rights and good working conditions is to increase their capacity to demand proper compensation in case of lay-off.

Overall, completed and current garment sector health interventions have been quite diverse in terms of thematic focus areas in health that were covered. RH and FP have been integrated in garment sector health interventions for a long time, and is likely to remain a primary health concern for GFWs, who are predominantly women. Similarly, nutrition and hygiene are likely to continue as critical health issues for GFWs, as reflected in the high representation in both completed and active projects. Attention to HIV/AIDS, however, appears to be diminishing possibly due to general reduction in development assistance for this issue as well as the evolution in how HIV/AIDS is addressed. At the same time, GBV and SH are emerging as a new topic to be addressed for GFWs.
4. Intervention Approaches

This section analyzes the intervention approaches the identified projects adopted to improve GFWs’ access to and utilization of health information and services. Specifically, this section examines what intervention approaches were adopted by the completed projects, if those approaches varied by the project’s thematic focus, and which approaches have become obsolete or recently emerged.

4.1 OVERVIEW OF APPROACHES

In total, five main approaches were identified that were employed by the completed and active garment sector based health interventions in Cambodia in the last five years (see Table 4.1). In order of most to less frequently adopted, they are:

1. Awareness raising and behavior change communication (“awareness raising”) (15 projects)
2. Improving service delivery and quality of care (“service delivery”) (12 projects)
3. Health financing (7 projects)
4. Influencing policy (4 projects)
5. Documenting evidence (2 projects)

<table>
<thead>
<tr>
<th>APPROACH</th>
<th>COMPLETED PROJECTS</th>
<th>ACTIVE PROJECTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RH and FP Primary</td>
<td>RH and FP Secondary</td>
<td>Non RH and FP</td>
</tr>
<tr>
<td>Awareness raising</td>
<td>Total = 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2nd SBF</td>
<td>• PACE</td>
<td>• 1st IAISRH</td>
</tr>
<tr>
<td></td>
<td>• 1st IAISRH</td>
<td>• Life Skills</td>
<td>• 1st HER-project</td>
</tr>
<tr>
<td></td>
<td>• CBDC</td>
<td>• Health Insurance Project</td>
<td>• IAISRH</td>
</tr>
<tr>
<td>Service delivery</td>
<td>Total = 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2nd SBF</td>
<td>• Health Insurance Project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1st IAISRH</td>
<td>• BFC’s Nutrition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CBDC</td>
<td>• 2nd IAISRH</td>
<td></td>
</tr>
</tbody>
</table>
4.2 MULTIPLE APPROACHES

In addition to the multifaceted thematic focus, identified projects tended to employ multiple strategies. Out of the 17 projects, 11 projects delivered their project activities through more than one approach. The remaining six projects used only a single intervention approach.

The analysis showed that when projects adopted only one approach, it was largely awareness raising. This was most common for the completed RH & FP secondary projects. RH & FP primary projects and active projects, on the other hand, tended to implement multiple approaches. Awareness raising and service delivery were the two most commonly combined approaches. This may be because improving workers’ access to and utilization of RH and FP information and services requires the interventions to go beyond merely awareness raising and address other barriers. It also could reflect greater ambition of the active projects and RH and FP primary projects to expand their intervention approaches to achieve greater success.

The number of approaches adopted by each project is independent of its duration. For example, some two-year projects adopted up to three approaches (e.g. Health Insurance Project and 1st IAISRH), while some five-year projects adopted only one approach (e.g. PACE).

4.3 AWARENESS RAISING AND BEHAVIOR CHANGE COMMUNICATION

The awareness raising and behavior change communication (BCC) approach was used 1) to inform workers and factory management staff about health services, information of health care, or the project’s activities and services, and 2) to promote positive or healthy behaviors among workers. The frequent adoption of this approach is unsurprising, as GFWs generally have very low level of education and come from rural areas where access to health information is limited. Notwithstanding the fact that it is already a commonly adopted approach, the need for more awareness raising work was expressed frequently by various stakeholders during the stakeholder meetings. However, while 15 projects engaged in various awareness raising activities, only four
specifically used BCC approaches to bring about positive behavior changes among workers (HealthWorks, SWSC, PSL, and WorkerHealth). The low adoption of BCC could be explained by the relatively short lifespan of reviewed projects, since it can take a minimum of three to five years to achieve substantive behavior changes (Marks and Spencer 2015).

In addition to being a common, stand-alone approach, awareness raising was often coupled with the service delivery approach. This suggests that when health projects employ multiple approaches, the first priority is to enhance workers’ knowledge and promote healthy behaviors, and then improve how health services are delivered.

A number of sub-approaches were employed to raise awareness and promote healthy behaviors among GFWs (and employers in some instances) on health issues (see Table 4.2). The most commonly adopted sub-approach was training (10 projects), followed by peer education (7 projects), health fairs/events (5 projects), mHealth innovation (3 projects), and other sub-approaches (8 projects), including worker outreach, coaching/mentoring, media campaigns, and social marketing.

### TABLE 4.2 EMPLOYED SUB-APPROACHES FOR AWARENESS RAISING AND KNOWLEDGE BUILDING

<table>
<thead>
<tr>
<th>SUB-APPROACHES</th>
<th>COMPLETED PROJECTS</th>
<th>ACTIVE PROJECTS</th>
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</tr>
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<tbody>
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<td></td>
<td>RH and FP Primary</td>
<td>RH and FP Secondary</td>
<td>Non-RH and FP</td>
</tr>
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<td>Training</td>
<td>Total = 3</td>
<td>2nd SBF</td>
<td>1st IAISRH</td>
</tr>
<tr>
<td>Peer education</td>
<td>Total = 1</td>
<td>2nd SBF</td>
<td>1st IAISRH</td>
</tr>
<tr>
<td>Health fairs/events</td>
<td>Total = 1</td>
<td>1st IAISRH</td>
<td></td>
</tr>
<tr>
<td>mHealth</td>
<td>Total = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other sub-approaches</td>
<td>Total = 2</td>
<td></td>
<td>1st HERproject</td>
</tr>
</tbody>
</table>

**TABLE NOTES**

One project might adopt multiple sub-approaches
4.3.1 Training

Training was adopted to improve the health-related knowledge of workers and was the most common sub-approach, used by 10 projects. Worker training is considered necessary for improving workers’ personal and professional lives through the direct provision of knowledge and skills to workers. The conventional practice of directing training to only factory management was not effective for improving workers’ lives for two reasons (ILO 2012a). First, training was delivered to factory management with an assumption that they would transfer the knowledge to their workers. However, this assumption proved incorrect and knowledge was not transferred to workers. Second, training often dealt with topics more related to the quality and quantity of factory work, such as effective management and communication skills, and was less concerned with workers’ personal lives (e.g. health issues).

Among the projects with available information on how trainings were held, three projects - PACE program, Life Skills, and 1st HealthWorks - adopted innovative designs in terms of training time, schedule, and choice of trainers to accommodate the highly structured nature of garment work and improve the effectiveness of the training. During working hours, it is generally difficult to remove a large number of workers from production lines at one time for training.

In order to enhance workers’ personal and professional development and increase skilled workforce for employers, GAP Inc. initiated the PACE program and worked with CARE as the lead implementing organization. CARE conducted Training of Trainers (ToT) for selected staff in the factories. These individuals then shared their knowledge with other workers during lunch breaks, so that the training did not interrupt work schedules. In each factory, the project conducted ToTs for 33 days long (CARE 2014a). The project divided the eight training topics into three modules by their level of relative importance for workers (see Box 1). Modules 1-3 were Core Modules as they lay the foundation for workers’ learning of the other modules, and these modules were delivered in order from one to three. Module 4 was designated a Required Module, and workers had to participate as it taught them how to apply their newly acquired knowledge and skills at their workplace. Modules 5-8 were considered Supplementary Modules for improving workers’ knowledge of topics that affect their personal lives (GAP Inc. 2015).

World Education had a different strategy to make their training widely accessible to workers (ILO 2012a). In the Life Skills Training project, the organization conducted ToTs for a number of staff of the partner organization, but was able to select only eight staff to serve as core trainers for the project. These eight trainers were divided into four teams to deliver training to 125 workers in each of the four selected factories. The training was held outside of working hours, on Sundays from 7:00am to 5:00pm. After training for a few weeks, the trainers phoned participating workers to do post-training test.

In the case of the two RHAC-led projects, training was conducted by the trained factory clinic staff: the 1st HealthWorks program and CBDC project (UNFPA 2015; Marks and Spencer 2015). The projects provided

Box 1

**PACE PROGRAM’S EIGHT TRAINING TOPICS**

**Core Modules**
1. Communication Skills
2. Problem Solving and Decision-Making
3. Time and Stress Management

**Required Module**
4. Hygiene and Sanitation

**Supplementary Modules**
5. Execution Excellence
6. General and Reproductive Health
7. Financial Literacy
8. Legal Literacy and Social Entitlements
training to build the capacity of garment factory infirmary (GFI) staff, to increase their capacity to conduct health communication and education sessions for workers. While this approach might be more sustainable, since the GFI staff are likely to maintain their employment in factories for a long time and could organize as many health education sessions as needed in the factories, it could be more challenging to implement than having the project staff to deliver the health education sessions. As observed in both projects, GFI staff felt reluctant to provide health education to workers at least in the beginning, due to the lack of self-confidence. The HealthWorks program overcame this challenge by continuing to provide on-the-job training, with support from RHAC and Project HOPE staff, until the GFI staff gained confidence to deliver the sessions (Marks and Spencer 2015).

4.3.2 Peer Education

Following training, peer education was the second most employed sub-approach, as it was implemented by seven projects (HIP, 1st and 2nd HER projects, 2nd SBF, PACE, SWSC and WorkerHealth). Peer education was usually used to supplement training: five of the seven projects employed both training and peer education for awareness raising. These two approaches supplemented each other in the sense that the workers selected to receive training or education on selected health topics would then serve as peer educators to disseminate their acquired knowledge to their co-workers, usually in the form of conversation during lunch breaks or during other free periods of time. While the training was often delivered by staff of implementing organizations and in a formal manner, peer education was usually provided by the trained workers and in an informal setting at a convenient time.

The high representation of peer education could be explained by the nature of garment work. Generally, workers have less time outside of working hours to seek out health-related information. It is more convenient and accessible for co-workers to provide them with information during working hours or during breaks. In addition to its flexible nature, the peer education model is particularly suitable for awareness raising in the garment sector due to workers’ low absorption capacity for new information and the high turnover of workers (BSR 2011). Being less educated or illiterate often limits workers’ ability to absorb new information when they just hear it once (e.g. during a single training session). Peer educators can help reinforce the messages to workers at any time they interact with each other, and this helps maintain the information sharing inside the factory despite the high turnover of workers.

However, different projects had different outcomes with peer education. Peer education was considered effective in raising workers’ awareness about the health insurance scheme of HIP project, which is less medically technical, it was gradually replaced by ‘resource centers’ by CARE due to several reasons. While training could accommodate relatively large number of workers per time, peer education could reach only very limited numbers of workers. Thus, it is really a burden for peer educators if they want to reach a large number of workers. Furthermore, health messages delivered through peer educators could be altered as peer educators themselves might not be clear enough about the content. The high turnover in garment sector also put peer education approach in an unfavorable position. Compared to the resignation of workers, the resignation of peer educators cause a greater loss to the project. In replacement of peer education, CARE has started to establish ‘nurse-staffed resource centers’ in some garment factories. The resource centers were displayed with health education materials and videos where workers could visit during lunch breaks. There was the provision of a nurse staying standby for one hour a day in each resource center for workers’ inquiries. Since some health topics are too sensitive for workers to discuss with anyone else, the resource centers might be helpful for workers to locate the information they need by themselves.

WorkerHealth takes an innovative approach through implementation of the “WorkerHealth Champion” model to remedy gaps in the peer education model. In the WorkerHealth Champion model, a group of workers in each factory are selected to receive training from the WorkerHealth project team and then work as WorkerHealth
Champions, whom other workers can consult — informally at a time that is convenient to both parties — regarding RH and FP issues and services. WorkerHealth Champions are also authorized to refer workers for RH or FP services from WorkerHealth-partnered private providers whose quality has been assured. Names and photos of WorkerHealth Champions are posted at various places inside factories so workers can easily identify and reach out to the Champions.

4.3.3 Health Fairs/Events

Health fairs and events have gained popularity as a way to reach large numbers of workers with information at one time (1st IAISRH, HealthWorks, Health Insurance Project, WorkerHealth, and 2nd IAISRH). The 1st IAISRH project held 30 health fairs during lunch hours inside their target factories to inform workers about project vouchers for free services at RHAC clinics. During the health fairs, the project distributed 22,241 single page hand-outs/fliers with lists of RHAC clinics and services available in those clinics (RHAC 2015a). During their health fair days, the Health Insurance Project used creative BCC materials such as leaflets with cartoons picturing workers in their daily lives at the factory and songs explaining the project’s health insurance scheme to workers (BFC 2009). WorkerHealth organizes their health events in the form of mini concerts in factories and mega concerts in worker communities, as a BCC strategy to improve workers’ knowledge, access and utilization of RH and FP services.

4.3.4 Mobile Health (mHealth) Innovations

The Global Observatory for eHealth (GOe) defines mHealth as “medical or public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices” (WHO 2011). mHealth ranges from the use of simple mobile technology, such as voice or text messages, to more complex functionalities like general packet radio service (GPRS), third and fourth generation mobile telecommunication (3G and 4G), global positioning system (GPS), and Bluetooth technology (WHO 2011).

mHealth initiatives have gained popularity across the globe with evidence that they could help strengthen health care systems, especially in developing countries. The initiatives make use of mobile technology to tackle myriad constraints, such as shortages of health professionals, costs associated with services and transportation, lack of reliable sources of health information, large rural populations, and under-resourced health care systems (WHO 2011). The second global survey on eHealth found that out of 112 countries participating in the survey, 83% used at least one mHealth initiative in their country (WHO 2011). The majority of these employed four or more types of mHealth initiatives. The most frequently used mHealth initiatives around the globe are health call centers, toll-free emergency hotlines, mobile telemedicine, appointment reminders, community mobilization, treatment compliance, patient record systems, patient monitoring, health surveys, surveillance, awareness raising, and decision support systems (WHO 2011).

Of the projects in this review, only three (all active) used mHealth to raise awareness of health and non-health issues and promote positive behavior changes among garment workers. The use of IVR by BFC’s Kamako Chhnoeum Project allows garment workers to get answers to their questions by just making a call free of charge and following the IVR dialogue via their telephone keypad to participate in a quiz. On the call, workers are asked to select one of the three topics they want to answer: 1) salaries and allowances, 2) occupational safety and health, and 3) personal health (abortion and hormonal contraceptives). The information content of the quiz is already prerecorded into the system. If workers provide a wrong answer, the system informs them of the correct answer. At the end of the quiz, workers are asked about which factory they work at and to leave a comment. To encourage more participation from workers, the project conducts a “lucky draw” of the call-in numbers every month. The project is still active under partial support from Levi Strauss Foundation and Dallas Cowboys Merchandising Ltd. After one year of implementation, the project received 42,973 valid calls (calls where callers stayed on the line to answer at least one question), and 30% of those callers selected the personal
health topic. There are some challenges to adopting IVR in garment sector projects, whether or not related to health. The Kamako Chhnoeum Project reported two challenges in particular (BFC 2014). First, many workers could not identify their own factories. Second, workers gave vastly different ratings to their factory's performance on the three topics.

WorkerHealth uses various mHealth strategies to deliver its Call To Action (CTA) messages, aiming to promote positive behavior changes related to RH and FP among workers. The strategies include mobile voice messaging, playing CTA messages on audio playlists, videos, and LCD screens in workplaces, Facebook posts, an electronic referral application for mobile phones, and a GIS-equipped call center. The call center will be used as a central resource for health information and referrals provided to workers by trained staff.

PSL’s Chat! Contraception package was developed to increase workers’ knowledge, confidence, and awareness so that they are empowered to take control of their lives and make healthier choices. The package includes training sessions, videos, and a mobile game. Workers receive short, targeted activity-based training sessions providing key information and building confidence on communication, contraception, sexually transmitted diseases, and safe abortion. Workers are also shown engaging dramas featuring characters in a fictional garment factory, which allow workers to relate to real health challenges and decisions. In their free time, workers can take an interactive mobile phone quiz that challenges them to demonstrate and improve their understanding (CARE 2017).

4.3.5 Other Sub-approaches to Awareness Raising

The projects under review also adopted a few other sub-approaches to raise awareness of workers or factory management staff. Those sub-approaches included, such as, worker outreach, coaching, media campaigns, and social marketing.

Worker outreach was implemented by the two HERprojects and SWSC to increase workers’ awareness and participation in the projects. The PACE program used mentoring to provide feedback and key messages to at least 70 supervisors and line leaders (CARE 2014a). Media campaigns were also used in the SWSC project (CARE 2015a).

In addition to the mHealth strategies, WorkerHealth uses other sub-approaches to deliver their CTA messages, both inside and outside factories. Inside the factories, the CTA messages will be delivered to workers through GFIs, WorkerHealth Champions, and workplace announcements. The Quality Network of external service providers, including providers from public, private and NGO facilities, will also take part to deliver the CTA messages to workers.

4.4 IMPROVING SERVICE DELIVERY AND QUALITY OF CARE

Efforts to enhance service delivery and quality of care were adopted by 12 projects, making service delivery the second most commonly adopted approach. While this approach was integrated into all of the RH and FP primary projects, it was used in only three RH and FP secondary projects and one project that did not include RH and FP. Four of the nine projects adopting this approach remain active. The majority of projects (11) coupled this strategy with other approaches, most often awareness raising. Only BFC’s Nutrition project implemented the service delivery approach alone.

The fact that the service delivery approach was most frequently used by RH and FP primary projects and usually with the awareness raising approach indicates that the RH and FP primary projects have invested more in improving workers’ access to and utilization of RH and FP services than the RH and FP secondary projects. This suggests that unless RH and FP are the key focuses of the project, the project may not be able to allocate
enough resources to actually improve service delivery. It could also suggest that raising workers’ awareness alone is not sufficient to improve uptake of RH and FP services, since workers also face constraints associated with service delivery. Interventions, thus, need to tackle those constraints as well.

In order to improve service delivery and quality of care, completed interventions employed a few sub-approaches including training and capacity building of service providers (9 projects), improving referral systems (6 projects), expanding the provision of services (7 projects), and monitoring the quality of drugs and medical staff (4 projects) (see Table 4.3).

4.4.1 Training and Capacity Building of Service Providers

Health service providers, just as GFWs, need awareness raising and capacity building around health issues. Training is the most frequently employed approach to build the capacity of health service providers, including GFI staff and external service providers, to provide better quality services, and was used by eight projects (completed and active). The continued popularity of training suggests that lead organizations and donors find this sub-approach useful for building the capacity of service providers.

PSL, one of the projects implementing this approach, aims to improve health service delivery through capacity building for GFI staff. In order to identify areas for capacity building, the project conducted GFI assessments, coordinated by the Municipal Health Department (MHD), Operational District (OD) and Maternal and Child Health (MCH) focal points. Results of the GFI assessments will inform PSL about the capacity building needs of the GFIs under the project (PSL 2014b).

| TABLE 4.3 SUB-APPROACHES ADOPTED TO IMPROVE SERVICE DELIVERY AND QUALITY OF CARE |
|----------------------------------------------------------|-----------|-----------------|-----------------|-----------------|-----------------|
| SERVICE DELIVERY STRATEGIES                             | COMPLETED PROJECTS |                        |                       | ACTIVE PROJECTS | TOTAL |
|                                                         | RH and FP Primary | RH and FP Secondary | Non RH and FP       | RH and FP Primary | RH and FP Secondary | Non RH and FP | TOTAL |
| Training and capacity building for service providers    | Total = 3         |                        |                       | Total = 3       |                   |                   | Total = 2          | 9 |
|                                                         | • 2nd SBF         |                       |                       | • PSL            |                   |                   | • PMUW            |   |
|                                                         | • 1st IAISRH      |                       |                       | • Worker-Health  |                   |                   | • SWSC            |   |
|                                                         | • CBDC            |                       |                       | • 2nd IAISRH     |                   |                   |                   |   |
| Improving referral system                              | Total = 3         |                        |                       | Total = 3       |                   |                   |                   | 6 |
|                                                         | • 2nd SBF         |                       |                       | • PSL            |                   |                   |                   |   |
|                                                         | • 1st IAISRH      |                       |                       | • Worker-Health  |                   |                   |                   |   |
|                                                         | • CBDC            |                       |                       | • 2nd IAISRH     |                   |                   |                   |   |
| Expanding the provision of services                     | Total = 2         | Total = 1             |                       | Total = 1       |                   |                   |                   | 7 |
|                                                         | • CBDC            | • Health Insurance    |                       | • Worker-Health  |                   |                   |                   |   |
|                                                         | • 1st IAISRH      | Project               |                       | • 2nd IAISRH     |                   |                   |                   |   |
|                                                         |                   | • BFC’s Nutrition     |                       |                   |                   |                   |                   |   |
| Monitoring quality of drugs and medical staff           | Total = 1         | Total = 1             |                       | Total = 2       |                   |                   |                   | 4 |
|                                                         | • 1st IAISRH      | • Health Insurance    |                       | • Worker-Health  |                   |                   |                   |   |
|                                                         |                   | Project               |                       | • 2nd IAISRH     |                   |                   |                   |   |
Like factory workers, it is difficult for GFI staff to participate in lengthy trainings. RHAC’s 1st IAISRH project tried to address this problem by creating three 5-day training shifts, so the GFI staff could choose a session that fit with their work schedules. Despite this flexibility, only 23 out of 30 factories were able to send their staff to the training, for a few reasons. First, there was only one staff in the infirmary, and thus the staff could not be away for one whole week. Second, the training conflicted with other scheduled factory visits, such as factory audits and visits of officers from ministries. The project, therefore, recommended future workplace training for the GFI staff be spread out over a month, with one day a week for training, and that it be conducted in collaboration with MoLVT (RHAC 2015a).

The 1st IAISRH training was accompanied by regular monitoring visits to GFI staff in order to assess their improvement, using a standard checklist. The checklist was used to assess several performance indicators, such as changes in the services provided by GFI staff, counseling, referral and health education for workers. One lesson learned from this experience is that the future standard checklists should outline clearly what is to be monitored, how information should be validated, and what kinds of information sources are needed, instead of depending on the perception of GFI staff (RHAC 2015a).

In the 1st HealthWorks program, in partnership with Project HOPE, RHAC supplemented the program’s training with mentoring (Marks and Spencer 2015). In total, the project delivered eight training sessions to GFI staff. The trainings covered clinical topics, maternal health education, HemoCue for anaemia, and BCC. The GFI staff were reluctant in the beginning to conduct health education sessions for workers. However, after on-the-job training, which provided plenty of opportunities for them to practice, and mentoring from RHAC and Project HOPE staff, the GFI staff gained confidence to conduct the health education sessions by themselves. While the 1st IAISRH recommended spreading the training over a month to maintain participation of the factory infirmary staff, the 1st HealthWorks program recommended that future projects issue certificates to the GFI staff after training, as an incentive to maintain their commitment.
Training was also provided to external service providers, as in the cases of the 2\textsuperscript{nd} SBF, SWSC and PMUW projects. The 2\textsuperscript{nd} SBF project trained food vendors in hygiene and nutrition, so that they could provide quality food to factory workers (CARE 2012). The SWSC and PMUW projects trained frontline police, local civil society organizations and officers from relevant ministries on how to respond to GBV and SH cases (CARE 2015a; CARE 2015b).

Building on the training design of both 1\textsuperscript{st} IAISRH and 1\textsuperscript{st} HealthWorks projects, WorkerHealth developed a more comprehensive training and capacity building model for their targeted health service providers inside and outside factories. Before delivering the training, the project will conduct basic health and FP service assessments of providers to identify areas for improvement. The GFI staff and contracted external health service providers will then receive training courses to build their capacity. The GFI staff will be visited at six-month intervals for quality assurance, while the contracted external health service providers will receive quarterly quality assurance and on-the-job coaching visits. These visits will ensure that the external providers maintain high quality care, and in doing so, secure their place in WorkerHealth’s quality assured network of service providers. Moreover, both internal and external service providers will be invited to attend ‘provider reflection and information sharing meetings’ (PRISM), conducted semi-annually, to reflect on their experience serving workers and to receive technical support on RH and voluntary FP counseling and service delivery.

4.4.2 Improving Referral Systems

Five RH and FP primary projects, three completed and two active, aimed to increase workers’ access to and utilization of quality RH and FP services by improving referral systems. This suggests that donors and programmers of RH and FP primary projects consider improving referral systems as a key strategy to improve workers’ uptake of those services. The absence of this strategy among RH and FP secondary projects might imply that those projects are not able to dedicate the necessary resources and effort to improve referral systems, especially in terms of coordination among the project staff, GFI staff, and external service providers. PSL and WorkerHealth are the two active RH and FP primary projects that are implementing this strategy.

Among projects implementing this strategy, there were varying degrees of effort to improve referral systems. For garment factories, the referral systems in the 2\textsuperscript{nd} SBF and PSL projects were focused on sharing information about external service providers (CARE 2012; PSL 2014b). On the other hand, the 1\textsuperscript{st} IAISRH and CBDC projects shared information on free health services in their referral work (UNFPA 2015; RHAC 2015a). In the 1\textsuperscript{st} IAISRH project, workers could request vouchers from GFI staff to use free health services at RHAC clinics (more discussion on how the vouchers worked in this project appears in Section 4.5). Similarly, in the CBDC project, community based distributors (CBDs) and GFI staff were trained on how to provide FP education in the community and factories, respectively, and refer women in need of intrauterine devices (IUD) or other FP methods for free services at health centers (HC) or referral hospitals (RH).

Incentive structures are required to make referral system work. Research conducted on the CBDC project indicates that CBDs became passive when they no longer received per diem and travel allowances for their attendance at CBD monthly meetings (UNFPA 2015). RHAC staff had difficulty ensuring that CBDs attended monthly meetings and submitted their reports on time. Some CBDs and GFI staff did not actively provide FP education or refer new clients for IUD services at HCs. In addition, some HCs would not provide IUD services on Sundays, and some HC midwives did not offer IUD services, despite the demand. Findings from the same study on the project found that HC staff did not offer IUDs partly because they lacked confidence and partly because the system of income sharing in the HC was not properly defined and created disincentives. RHAC has been working with HC staff to address this issue by improving fee management for IUD provision and have been able to improve the quality of care in some HCs (RHAC 2015b).
WorkerHealth’s referral strategy aims to improve referral systems at WorkerHealth factories through mHealth innovation. Workers are referred to providers in the Quality Network through three referral agents: GFIs, WorkerHealth Champions,3 and a hotline. With GIS mapping, the three channels locate providers that are most convenient and matched to workers’ needs through GPS assisted systems. Referrals are provided through an SMS-based system. WorkerHealth also supports the referral of workers to the Quality Network providers through transportation vouchers (details of this scheme provided in Section 4.5).

### 4.4.3 Expanding Service Provision

Another strategy to improve workers’ access to and utilization of health services is to expand the hours and/or locations for service provision. Research examining the health-seeking behaviors of workers illustrate that the majority (85%) of health services are sought through private clinics or hospitals in Cambodia. This is congruent with worker concerns around the lack of client focus and confidentiality of GFIs. Most of the projects employing this service expansion approach were RH and FP primary projects and were already completed. The relatively low adoption of this sub-approach is likely because it is logistically challenging to negotiate with external service providers to expand their service provisions beyond what they usually do. The GFIs will automatically become a part of the projects upon the factory management’s formal partnership agreement, but private providers might not be interested in participating in an intervention if it involves critical changes to their normal service delivery approach, with few economic returns.

The 1st IAISRH project’s referral system only connected GFIs to RHAC’s own clinics, so there were fewer challenges in expanding service provision (RHAC 2015). However, RHAC faced much stronger challenges in getting HCs and their midwives to provide additional IUD services, especially on Sundays, under the CBDC project (UNFPA 2015). The HIP project worked with many HCs and hospitals to extend their working hours for garment workers in Phnom Penh (BFC 2009). Instead of letting medical staff to handle the workers by themselves, the project placed hostesses at the contracted health facilities to welcome workers when they are sick and address any complaints the workers might have.

Instead of coordinating with external service providers to make health services more accessible to GFWs, the Healthcare Improvement Project brought health services closer to GFWs through their mobile medical bus. The objective of the project is to remove time and financial barriers to worker access to and use of health services. The bus was equipped with specialist doctors and medical equipment, such as biochemistry analyzer and hematology analyzer, to provide health screening services to workers. The bus was parked inside the factory compound during service delivery to GFWs, and the project coordinated with factory management to ensure that all employees of participating GFs could get health screening services on the bus (Rep. P Co. 2016).

WorkerHealth is expanding service provision to GFWs through the establishment of the Quality Network. The network covers the catchment areas surrounding the garment factories and high density worker residential areas. Participating providers sign a Memorandum of Understanding (MoU) with the project as an entry point to the network, and receive several benefits to incentivize them to offer services under the WorkerHealth project. Quality assessment is conducted with each provider, followed by training and clinical skills development on RH and FP counseling and service delivery skills. The project also aims to conduct on-going RH and FP quality assurance through on-the-job coaching visits to ensure that the network providers maintain high quality levels of care. The providers, together with GFI staff, are also invited to attend semi-annual PRISM meetings to reflect on their experience of serving workers.

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3 The roles of WorkerHealth Champions are to provide correct information about WorkerHealth and SRH and FP, referral electronic messages/SMS to workers, and information about the quality assured network to workers.
4.4.4 Monitoring Quality of Drugs and Medical Staff

Quality of drugs and medical staff is another factor affecting quality of health services. Three projects monitored the quality of drugs and medical staff, often with the expansion of service provision, but less frequently with the improvement of referral systems probably due to logistical challenges as discussed earlier.

The projects that monitored the quality of drugs and medical staff included the 1st IAISRH project, HIP, and WorkerHealth (planned). The 1st IAISRH project conducted its own regular monitoring visits by using the standard checklist (RHAC 2015a). As a pilot health insurance scheme of the NSSF, HIP was well-positioned to coordinate with public service providers and was able to monitor the quality of drugs and medical staff at their contracted public health facilities (BFC 2009). WorkerHealth will conduct monitoring visits to GFIIs every six months for quality assurance and to external health service providers quarterly, plus on-the-job coaching visits. The external health service providers need to maintain their level of performance to stay in the project’s Quality Network.

4.5 HEALTH FINANCING

Seven projects worked to remove financial barriers to worker uptake of health services. Four projects remain active, only two of which are RH and FP primary projects (WorkerHealth and 2nd IAISRH).

Out of the seven projects, three employed common health financing models, specifically health insurance (HIP) and paid vouchers for health services (1st and 2nd IAISRH) (see Table 4.4). WorkerHealth aims to intervene in health financing through a transportation subsidy scheme and engagement with health financing policy through potential work with the NSSF on its national health insurance scheme. The other three projects implemented health financing through lifting financial barriers for workers by directly providing free services or products. The CBDC project provided free IUDs and other FP methods at HCs and RHs. The HealthWorks
project provided workers with free iron supplements and anti-parasitic drugs and FP services at GFIs of the participating factories. HIP distributed free medicine and supplements to GFWs in their participating factories.

The current collective efforts of government and development partners to develop the national health financing policy clearly indicates the need to remove financial barriers to quality health services for workers as well as the general population. However, health financing was an underrepresented strategy among the active projects, which could be explained by the following reasons:

- It may be more costly to implement health financing projects than other approaches.
- It may be more challenging to ensure that impacts are sustainable. Lessons from the 1st IAISRH project suggest that delivering free health services through vouchers may not be sustainable. Certain financing mechanisms, e.g. social marketing, discounting rate for services, donor funding, and cost sharing between factory management and workers, are likely to ensure better effectiveness and sustainability of programs. Yet, getting employers and workers to share the costs, even at discounted rates, is difficult to implement. The willingness and ability of workers to pay is extremely low and employers may be resistant to bearing a significant proportion of the costs (e.g. of health insurance).
- Donors as well as lead organizations might be reluctant to implement health financing schemes until information of the national health insurance scheme under the NSSF has been fully released, so they can align their strategies with the national scheme and ensure there is no duplication of effort.

Some important information on the NSSF scheme is worth noting. The scheme started in May 2016 with some GFs in Phnom Penh, Kandal and Kampong Speu as the initial locations. The health benefit package provided by the scheme is comprised of medical care, victim transportation in case of emergency, funeral transportation service and daily allowance for the non-working period because of sickness. The scheme will cover a wide range of health services, including RH and FP, with some exceptions. GFWs cannot make a claim from the scheme unless the period of sickness is certified as seven days or more. While the scheme will cover the costs of health services, it will not cover transportation costs to seek those services (MoLVT 2016). The cost of the insurance premium is likely to be equally shared by factory management and GFWs.

WorkerHealth has designed its health financing component to tackle various obstacles workers face to accessing quality health services, using a variety of channels:

- The project is implementing an interim ‘transportation subsidy system’ to cover workers’ transportation cost to their preferred Quality Network facility. Considering the limited coverage of transportation costs under the upcoming NSSF, WorkerHealth is piloting a transportation subsidy system that will complement the national scheme. In addition to the subsidy scheme, the project expects to work closely with the upcoming NSSF on the accreditation of the project’s network providers.
- The project also aims to work with the network providers to offer discount prices to workers for RH and voluntary FP counseling and services.

The PSL project also implements health financing but not in their work with garment factories (PSL 2014b).

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4 According to the Prakas on Health Insurance Services issued by MoLVT on March 2016, the 16 excluded medical services are: 1) free medical treatment stipulated in public health policy, 2) dental care (cleaning, filling, crown or bridge), 3) treatment and sex transsexual surgery, 4) organs transplantation (one marrow, kidney, liver, health and pancreas…), 5) artificial insemination in case of infertility, 6) self-treatment, 7) cosmetic surgery and medical implants, 8) contract lens and eye-laser treatment, 9) treatment of alcoholism or drug abuse, 10) infertility treatment, 11) artificial globe ocular operation, 12) cardio vascular surgery, 13) chronic diseases, 14) hemodialysis, 15) thalassemia, and 16) chemo therapy for cancer treatment (MoLVT 2016).
4.6 INFLUENCING POLICY

Influencing policies, either by improving existing policies or developing new policies, is clearly an emerging approach, since none of the completed projects under review had implemented this strategy as an intervention component. Only four active projects work on policy: PMUW, SWSC, WorkerHealth, and PSL. Among the RH and FP primary and secondary projects under review, WorkerHealth and PSL are the only two projects that work on health-related policy changes in the garment sector, since PMUW and SWSC focus primarily on GBV and SH. Although various stakeholders have been actively engaged in policy dialogue on the health of garment workers and other sector-related issues at an organizational level (through participation in various technical working groups), there is limited policy engagement at the project level. This new trend of project-level engagement in policy suggests that general garment sector interventions, not necessarily those focusing on health, are moving beyond immediate changes in workers’ knowledge or small scale expansion of service delivery towards broader policy changes to ensure sustainable and larger scale impacts for the industry as a whole. There were a few sub-approaches adopted by the reviewed projects to promote policy changes.

4.6.1 Supporting Stakeholders in Policy Development and Practices

The first sub-approach aims to provide support to stakeholders in policy development and practices.

Through the PMUW project, CARE worked with the Ministry of Women’s Affairs and other government agencies to support employers in the hospitality and garment sectors to implement locally appropriate and low cost GBV and SH workplace policies and mechanisms. The support extended beyond the factory settings to reach the Commune Council, which received assistance to work with employers, landlords and other key stakeholders to increase protection against GBV and SH in communities (CARE 2015b).

While the objective of the PMUW project was to mobilize authorities to realize, acknowledge and implement their responsibilities, the SWSC project went one level deeper to work with business partners and the general public to reduce the risk of GBV and SH for women in workplaces and communities. The project successfully supported the SAFE Working Group to adopt Standard Sexual Harassment Guidelines for garment factories, and contributed to the government’s endorsement of sub-decree 194 and approval of the 2nd National Action Plan to End Violence Against Women. CARE provided inputs to the National Action Plan on the need to recognize beer promoters as formal workers and expand the coverage of awareness raising on violence against women beyond the domestic setting to the workplace and community (CARE 2015a).

PSL supports health facilities to meet and maintain MoH standards, including facility assessments, infection control, equipment and materials, and workplace safety and security for midwives. PSL also supports MoLVT on various policy efforts, including the development of factory infirmary guidelines.

Similarly, the WorkerHealth project is implementing several activities related to policy development and practices for sustainable RH and voluntary FP services in garment factories. First, the project is working to establish or expand health financing policy options that are available to factory workers. Second, with assistance from MoH, the project is supporting MoLVT and other NGO partners to develop new national policies and related protocols or procedures for garment factory infirmary standards, licensing, registration, and continued oversight and professional development of factory infirmary staff. However, since policy change is a long-term process and requires seizing opportunities as they arise, the project will remain open to new evidence from research and interventions to direct its engagement in policy changes.

4.6.2 Creating an Enabling Environment for Policy

The second sub-approach aims to promote links between stakeholders to create an enabling environment for policy dialogue and change.
This sub-approach was adopted by two projects: SWSC and WorkerHealth. The SWSC project created an enabling environment by connecting various stakeholders, including ministries, police, local authorities, and private sector, to create a platform for collaboration and coordination (CARE 2015a). The WorkerHealth project is doing the same by engaging key industry stakeholders, such as brands/buyers, factory owners and workers, to create an enabling environment for health in the garment industry. The project emphasizes the collective influence of major brands that source garment products from factories in Cambodia on the health practices of factories and the policy development of relevant ministries.

### 4.6.3 Advocacy

Three projects (PMUW, SWSC, and WorkerHealth) have engaged in advocacy as a third sub-approach to promote policy changes.

One of the key activities of PMUW project was to advocate with apex bodies representing various industries, including the garment sector, to have GBV and SH policies in the workplace (CARE 2015b). SWSC took a different approach to engage in advocacy work through capacity building. The project provides advocacy training to the management team of the Solidarity Association of Beer Promotion (SABC), so that they have enough capacity to present and defend themselves in front of high-level stakeholders (e.g. relevant ministries). The project also creates opportunities for the SABC to speak on the issues they face in various settings and to make their voices heard.

WorkerHealth takes an evidence-based approach to advocacy by offering a range of policy options and translating evidence on the most promising practices for Cambodia, based on research, policy mapping, and experience, to promote policy changes by government, labor, donors, brands, and factory owners.

### 4.7 DOCUMENTING EVIDENCE

Although all of the reviewed projects have included some research or data collection, only PSL and WorkerHealth include a Learning Agenda to inform evidence-based programming on worker health. More discussions on the research aspect of the reviewed projects can be found in Section 5.

Under its Learning Agenda, PSL documented evidence on several learning priorities. These include technical harmonization across the PSL partnership, non-emergency referral systems at the community/health facility level, and improving access to RMNH information and services for garment factory workers (PSL 2014b).

The Learning Agenda component of WorkerHealth is fully devoted to informing evidence-based programming and policy development related to worker health. The strategies employed are as follows:

- Documenting and synthesizing formative evidence on worker health, particularly for RH and FP and living conditions, and disseminating it to key stakeholders to facilitate their program design and policy development. Validating the Return On Investment (ROI) tool, in partnership with UNFPA, which measures the relationship between the investment in RH and FP and workers’ productivity.

- Rigorously documenting the implementation process of the WorkerHealth model by providing information on perceptions of beneficiaries, health service providers, and intervention implementers on successes and challenges regarding improving female workers’ access to high quality RH and FP services. For maximum reach and impact, the findings of this process evaluation study will be disseminated locally and globally, through materials that are tailored for different industry, development partner, government, and donor stakeholders.

- Contributing to the sustainability of high quality research in Cambodia by strengthening the capacity of a national research institution to undertake implementation science activities on worker health programming.
The WorkerHealth Learning Agenda was developed to address a number of identified gaps:

- There is a lack of synthesized learning on efforts to improve worker health. As identified in this review, at least 17 projects have addressed health-related issues in the garment sector during the last five years. However, there has not been any systematic documentation of the learning from these projects in terms of what has been done so far and what works or does not work for improving worker health.
- There is a paucity of rigorous evaluation on the effectiveness of past interventions, which is necessary for informing scale-up. Research in the reviewed projects has mostly been limited to baseline and/or endline studies. Only two projects were able to employ statistical sampling techniques in their study, let alone more rigorous evaluation methods. This paucity significantly reduces the power of existing evidence on the effectiveness of implemented interventions.
- The garment sector presents a challenging environment for programmatic and policy work. Effective programs and policies, thus, need to be fueled by the right knowledge and evidence. Preliminary discussions with various stakeholders in the garment sector identified several issues requiring rigorous studies, including the national health standards, health financing, and the relationship between the health and productivity of workers.

### 4.8 UNDER-REPRESENTED APPROACHES

This review has shown that garment sector health interventions in Cambodia during the last five years have employed extensive approaches and sub-approaches, which are also commonly used in garment sector health interventions in other countries. Although some traditional approaches were significantly represented in the included projects, newer more innovative approaches were observed to be under-represented.

- No significant use of innovative mHealth strategy in awareness raising and enhanced service delivery approaches: The reviewed projects have devoted substantial resources on awareness raising and building the health-related knowledge of workers, followed by enhancing service delivery and quality of care. However, the use of mHealth as a sub-approach in BCC and health service delivery is less visible. Only two three active projects – WorkerHealth, PSL and Kamako Chhnoum – employed mHealth strategies. Interventions in this review not only used mHealth infrequently to support awareness raising as well as BCC and enhanced service delivery, but also used just a few of the many mHealth strategies available. The second global survey on eHealth reported a number of mHealth initiatives adopted around the globe, including health call centers, toll-free emergency, emergencies, mobile telemedicine, appointment reminders, community mobilization, treatment compliance, patient records, information, patient monitoring, health surveys, surveillance, awareness raising, and decision support system (WHO 2011). These strategies have great potential to be applied to the work in this field.
- Shortage of innovative health financing schemes: Cambodia has been actively implementing a myriad of health financing schemes, tackling both supply and demand side barriers, for poor and vulnerable populations in the public health sector, but attention and efforts to specifically expand the practices to the garment sector have only been made recently. Several schemes have been implemented to address supply side issues, such as user fees and exemption systems. However, only the upcoming NSSF health insurance scheme has the potential for direct, strong impact on garment workers’ access to and utilization of health services. Although six identified projects included health financing in one way or another, only two have potential to produce sustainable impacts. The HIP project implemented health insurance as a pilot project of the upcoming NSSF, suggesting that the impacts of the project could continue. WorkerHealth aims to contribute to the strengthening national health financing-related programs through engagement on learning and
evidence based policy development and programming, with a goal to have sustainable impacts. However, WorkerHealth is the only active project slated to focus on health financing policies, indicating a need for more health financing programs.

- Low adoption of Learning Agenda: A Learning Agenda approach focuses on research, evaluation and evidence-based planning and decision-making in the garment sector. WorkerHealth and PSL are the only two projects integrating rigorous research and evaluation as a key approach. Additional efforts are needed to ensure that documentation of evidence for interventions implemented by other projects is rigorous. One way to do this is to include evidence generation and documentation in the funding proposals for larger projects and including research and learning as a specific intervention approach.
5. Program Evaluation

While it is particularly important to understand the thematic focus areas and intervention approaches, knowledge of the effectiveness of each intervention strategy is equally necessary to inform the design of future interventions. Future projects should build on intervention approaches that have been shown to be effective in improving worker health. To that end, this section examines how well the completed interventions performed in terms of program evaluation. Specifically, the review examined how extensively program evaluation was integrated in the identified projects and how it was conducted.

Impact evaluation is becoming common. Out of the eight completed projects, six projects conducted baseline studies and eight projects conducted endline studies. Among the ten active projects, four projects conducted baseline studies. The high number of projects integrating evaluation research into their project designs suggests that lead organizations understand the importance of evaluation studies to determine project impacts.

However, the quality of evaluation studies is still limited, which casts doubt on the power of the evidence. Only BFC’s Nutrition Project employed a case controlled design in their evaluation study. Five completed projects determined project impacts through “before and after comparison” of outcomes of interest in their target groups, but without a control group (2nd SBF, Life Skills Training, 1st HealthWorks, 1st HERproject and CBDC). The 1st IAISRH project reported their impacts only through qualitative descriptions of current conditions of the outcomes of interest among their target groups (e.g. vouchers and service utilization rate, satisfaction with SRH services provided by RHAC and capacity building for GFI staff). Only the 2nd SBF, WorkerHealth, and PSL projects applied statistical techniques to determine the sample size of their studies.

The reviewed projects’ may have been unable to use a case-controlled design due to lack of data accessibility or financial constraints. Experiences from various projects in this review have shown that it is very challenging to get factory management to participate in the interventions, due to perceived opportunity costs and labor hours lost when workers are engaged in studies. Therefore, it is likely to be even harder, if not impossible, to get factories which are not selected for the interventions to participate in the evaluation studies as control groups, since their participation would create time costs with no perceived benefits. In addition to the logistic challenges, the adoption of case-controlled design is likely to be hindered by the low prioritization of rigorous research in the midst of competing funding priorities.

The fact that the 2nd SBF, PSL and WorkerHealth projects applied statistical techniques to determine the sample sizes for their studies and that some projects are applying principles of before and after intervention designs suggests that there is increasing, though not yet universal, commitment
to improve the quality of evaluations. Evaluation in the garment sector is moving towards better quality, despite the potential constraint of data accessibility for using case-control designs. Thus, projects that apply rigorous evaluation designs will make useful contributions and are likely to receive considerable attention.

In summary, program evaluation is not a new concept among the projects identified by this review, and most seem to have good understanding of the importance of evaluating their interventions. However, the practice is far from perfect. Regardless of their thematic focus areas or implementation status, out of the 17 projects, only one project has employed a case-control design in their evaluation. While there is vast anecdotal information of how these interventions have led to improved worker health, rigorous evidence of their effectiveness is yet to be produced.
6. Conclusions

This section highlights key strengths and challenges of the GF-based health interventions conducted in Cambodia within the last five years. The analysis covers strengths and challenges related to both intervention and evaluation.

6.1 PROGRAMMATIC STRENGTHS

- **RH and FP topic was a focus of most projects.** There has been considerable effort to improve worker health in terms of RH and FP. Of the 17 projects, 14 projects included RH and FP either as a primary or secondary focus.

- **Multifaceted health interventions are becoming the norm.** Among all the 17 projects, only six projects addressed just a single health issue. The other 11 projects addressed more than one health issue, one of which was RH and FP. In addition to RH and FP, nutrition and hygiene was also a common focus of completed interventions. Although there is a relatively long history in Cambodia of work tackling GBV and SH in communities, these efforts have only recently been directed at garment workers as a specific target group. Since some of the thematic areas are related, for example HIV/AIDS and RH and FP, this multi-dimensional focus by projects may increase their effectiveness in improving worker health.

- **Multi-approach strategies are increasingly employed.** Six of the projects adopted only a single intervention approach, while the other 11 projects adopted multiple approaches. This suggests that the GF-based health interventions in Cambodia have gained more capacity in addressing health issues of garment workers through various approaches beyond the awareness raising and knowledge building. It also suggests that future GF-based health interventions could more successfully combine approaches by learning from the multi-approach strategies of the current projects.

- **Joint partnership models are emerging.** Out of the 17 projects, 11 projects were led by a single organization, and six projects operated under the joint leadership of two or more organizations. Joint partnership projects, if managed properly, are desirable for two main reasons. First, they are likely to be more effective than those led by a single organization, since they bring expertise from two or more specialized organizations to the projects. Second, they could reduce fragmentation in efforts to improve workers’ health. Collaboration by multiple organizations also increases the number of factories and workers that can be reached, and allows projects to address multiple topics and employ multiple approaches.

- **Financial support from bilateral and multilateral donors remains visible.** Despite the decrease in development aid to Cambodia, development partners have continued to make financial investments in GF-based health interventions. The WorkerHealth and PSL projects are good examples. This indicates that international donors still consider worker health a priority development issue in Cambodia.

- **Collaborative funding has been increasingly adopted.** Similar to the joint partnership models, the collaborative funding model has very strong, positive implications for the extent to which a project impact worker health. It enables more effective and efficient use of resources, and also improves accountability both among implementers and donors.

- **Research and evaluation are highly valued.** A large number of projects have conducted both baseline and endline studies to measure the impacts of their projects. This indicates their recognition that evaluation studies are necessary to determine the impacts of their projects and draw lessons learned for more effective programming and policy development.
6.2 PROGRAMMATIC CHALLENGES

The reviewed projects also have some challenges, illustrating areas for improvement by future projects. The key challenges this review identified are as follows:

- **Most of the interventions are not operating at scale.** The majority of the projects covered less than 20 factories and reached between 14,000 to 25,000 workers. Either for strategic reasons or due to limited resources, Phnom Penh and Kandal are the only provinces where an extensive number of GF-based health interventions have been implemented. While the other provinces also house garment factories, they were not priority locations for the reviewed projects.

- **Few active projects primarily focus on RH and FP.** Although a large number of projects included RH and FP as a focus area, among the nine active projects only PSL, WorkerHealth and 2nd IAISRH are the RH and FP primary projects. The review has shown that, compared to the RH and FP secondary projects, RH and FP primary projects were more likely to adopt multi-approach strategies to address multifaceted barriers to worker access and utilization of health services. The low number of projects whose primary focuses are RH and FP, however, presents a challenge to achieve greater improvements in worker health in terms of RH and FP.

- **Implementation of innovative health financing strategies is limited in the garment sector.** Although Cambodia has been actively implementing a myriad of health financing schemes tackling both supply and demand side, health financing innovation is limited in the garment sector. Eight projects involved health financing in one way or another, but only two seemed to have the potential for sustainable impacts: HIP and WorkerHealth. The introduction of the NSSF Health Insurance Scheme is, however, an important achievement for the health of garment factory workers in Cambodia and an important development for health financing. Since the NSSF Health Insurance Scheme has been implemented only recently, supportive efforts on innovating health financing from nongovernmental GF-based health interventions may be needed to facilitate the implementation of such an important national health financing scheme.

- **Policy engagement at the project level is still inadequate.** Similar to the health financing approach, the reviewed projects are also limited in terms of policy influence or engagement. None of the completed projects worked on policies, and only four active projects have a policy component. Additional work on policy engagement is clearly warranted, since it has the potential to have industry-wide impacts.

- **Participation from factory management is generally limited.** Only three projects were funded by factory management. Getting cooperation for project implementation from factory management remains challenging, due to competing priorities and costs. Collaboration from factory management, at least in the form of time, is necessary for successful implementation and their financial participation is essential for sustainable impact, especially for health financing, since donor funding frequently ends along with the project.

- **Commitment to improving the quality of evaluation is increasing but still not sufficient.** Although impact evaluation is becoming standard, the quality of evaluations still needs to be improved. Only BFC’s Nutrition project used a case-controlled design in their study. This absence of rigorous evaluation casts doubt on the power of evidence produced by identified projects.
7. Position of WorkerHealth

As noted in Section 1, one of the objectives of this comprehensive review was to analyze how WorkerHealth fits in as an RH and FP primary project in the garment sector. This section discusses the position of WorkerHealth, in light of the identified programmatic strengths and challenges.

- **First project aiming to reach to over 100,000 workers in around 60 factories:** This commitment is very significant for the garment sector, since the majority of reviewed projects covered less than 20 factories and reached between the ranges of 14,000 to 25,000 workers. The use of a hotline as one of the referral mechanisms and the policy component will help the project meet this ambitious commitment.

- **Expanding the joint partnership model:** WorkerHealth will engage diverse stakeholders: In addition to the partnership between Marie Stopes and the Evidence Project as implementing organizations, WorkerHealth aims to engage other stakeholders, such as BFC, brands, industry organizations, factory management, workers, labor groups and relevant ministries.

- **Creating an enabling environment for policy:** The project will work to promote necessary policies, starting with GFI standards, health financing policy, and health service provider quality standards. This Policy component is critical for the garment sector, since only one project (PSL) includes any work on health-related policies in the garment sector.

- **Enhancing health service delivery:** The project will introduce several innovations for enhancing service delivery. Those innovations include establishing the Quality Network of health care providers; strengthening referrals and practices by infirmary staff; using a nurse-staffed hotline with GPS capability and referral; and implementing health financing strategy, in collaboration with the upcoming NSSF, to ensure improved access to health financing instruments and thus better access to health services.

- **Enhancing health service delivery:** The project is introducing several innovations for enhancing service delivery. Those innovations include establishing the Quality Network of health care providers; strengthening referrals and practices by infirmary staff; using a nurse-staffed hotline with GPS capability and referral; and implementing health financing strategy, in collaboration with the upcoming NSSF, to ensure improved access to health financing instruments and thus better access to health services.

- **Documenting evidence of what works:** WorkerHealth is one of three projects applying implementation science, where research is translated into practice through evidence-based programming (PSL and BFC’s Nutrition project are the other two). The value of this approach is most clearly seen in WorkerHealth’s learning agenda. WorkerHealth’s learning agenda priorities correspond to the current knowledge gaps in the garment sector, and WorkerHealth fills critical evidence gaps by documenting implementation process of the WorkerHealth model as lessons learned for current and future interventions aiming to improve the health of female garment workers.
8. Recommendations

This review identified a number of priority actions for current and future garment sector health interventions to consider in order to achieve the greatest impact on worker health, especially on RH and FP. These actions, which build on the programmatic strengths and challenges discussed above, are:

- **Prioritize RH and FP issues:** Despite the fact that the majority of identified projects incorporated RH and FP as one of their thematic focus areas, only three projects currently have a primary focus on RH and FP. Given the substantial share of female workers in the garment sector (around 85%), many of whom are of reproductive age, the lack of active projects working on this health issue is clearly a sign of potential unmet RH and FP needs in this important sector.

- **Promote joint partnership models:** Lead organizations and/or brands should work cooperatively under a coordinated scheme. This could be cooperation of finances, by pooling available resources, or of expertise, by engaging as co-implementing partners. By pooling resources, projects have the potential to reach a larger scale. The majority of identified projects reached less than 20 factories and were centered only around Phnom Penh and Kandal. Collaboration between multiple organizations enables them to leverage individuals’ expertise to adopt multiple, innovative intervention strategies as in the case of WorkerHealth Project. In addition, good coordination among lead organizations reduces potential economic loss for factory management, especially in terms of time lost to project activities, since the GFs would not have to allocate their time to multiple individual interventions working on the same health issues. For this reason, joint partnership models may be helpful in getting support from factory management, which is not the case now.

- **Support government's efforts to improve worker health:** As the review identified, only three projects engage with the government (usually MoLVT and MoH), at a project level to enhance policy. Policy engagement is clearly needed to achieve broader impact, and health financing is one promising avenue for such engagement. The majority of projects under review did not employ innovative health financing strategies to improve worker health. The launch of the national health insurance scheme NSSF presents an opportunity for current and future projects to support the scheme by addressing issues and gaps through innovative approaches that align with the broader scheme. To accomplish this, lead organizations will need more health financing.

- **Document evidence of what works in a rigorous manner:** A significant amount of work has already been done by the identified projects to improve worker health, but the absence of rigorous monitoring and evaluation research design limits the lessons that can be learned. To what extent each intervention strategy works remains to be determined, since only one of the 17 identified projects adopted a case-controlled design in their evaluation study (BFC’s Nutrition Project). This missing information is highly important to inform future intervention designs, as well as GFW-related health policies.
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CARE. 2014a. “Personal Advancement Career Enhancement (PACE).” Fact Sheet. CARE.

CARE. 2014b. “Safe Workplace, Safe Communities.” Phnom Penh: CARE.

CARE. 2015a. “Safe Workplaces, Safe Communities: CARE’s work with marginalized women in Cambodia to reduce gender-based violence.” CARE.


GAP Inc. 2015. “P.A.C.E. Program Overview.”


MoLVT. 2016. “Prakas on Health Insurance Services.”


## Appendix: List of Projects Under Review

### BY YEAR OF IMPLEMENTATION

<table>
<thead>
<tr>
<th>No.</th>
<th>Projects</th>
<th>Year</th>
<th>Lead Organizations</th>
<th>Implementing Partners</th>
<th>Funders</th>
<th>Objectives of Projects</th>
<th>Location</th>
<th>Setting</th>
<th>Beneficiaries</th>
<th>Number of Factories &amp; Workers</th>
<th>Program Evaluation</th>
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<tbody>
<tr>
<td>1</td>
<td>HealthWorks HealthWorks Program</td>
<td>2012–2014</td>
<td>RHAC</td>
<td>No</td>
<td>Marks and Spencer</td>
<td>1. To devise a methodology to both improve the health of employees in garment factory suppliers of M&amp;S. 2. To institutionalize a process for long term sustainability for improving health and preventing disease, using existing infrastructure and minimizing costs.</td>
<td>Phnom Penh</td>
<td>Factory-based</td>
<td>Garment workers, mostly women</td>
<td>7 GFs with 14,507 GFWs</td>
<td>Baseline and end-line (Non case-control design with before and after comparison)</td>
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<tr>
<td>2</td>
<td>SWSC Safe Workplaces, Safe Communities</td>
<td>2013–2016</td>
<td>CARE</td>
<td>Solidarity Association of Beer Promoters in Cambodia (SABC), People Health Development Association (PHD), Ministry of Women's Affairs, MoLVT, and Ministry of Interior</td>
<td>UN Trust Fund to End Violence Against Women through UN Women</td>
<td>To reduce GBV and sexual harassment in Cambodian workplaces and communities.</td>
<td>6 communes in Phnom Penh (Km No. 6, Phnom Penh Thmey, Preak Leap, Chorm Chao, Kakap, Toul Sangke)</td>
<td>Factory-based and community-based</td>
<td>Female garment workers, hospitality and tourism industries, male clients, outlet owners, high school and university students, and police officers</td>
<td>—</td>
<td>Baseline study (—)</td>
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<tr>
<td>No.</td>
<td>Projects</td>
<td>Year</td>
<td>Lead Organizations</td>
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<td>3</td>
<td>Outstanding Workers Kamako Chhnoeum</td>
<td>2013–Present</td>
<td>Better Work</td>
<td>—</td>
<td>—</td>
<td>To educate garment and footwear workers about labor rights, OSH, and personal health.</td>
<td>Hotline</td>
<td>Hotline</td>
<td>Garment workers</td>
<td>Eligible for all workers since it is a call-in approach; 17,542 valid calls from July-Sep 30, 2014</td>
<td>Only quarterly report</td>
</tr>
<tr>
<td>4</td>
<td>PSL Partnering to Save Lives</td>
<td>2013–2018</td>
<td>Marie Stopes, CARE, Save the Children, MoH, DFAT</td>
<td>—</td>
<td>DFAT</td>
<td>To save the lives of women and newborns in Cambodia through improved quality, access and utilization of RMNH services through a partnership approach</td>
<td>Phnom Penh and Kandal for garment workers; Mondulkiri, Ratanakiri and Stung Treng for ethnic women; and additional 17 provinces across the country for FP and safe abortion capacity development</td>
<td>Factory-based and community-based</td>
<td>Ethnic minorities, garment workers, clinical staff</td>
<td>12 GFs with more than 25,000</td>
<td>Baseline study (Non-case-control design with multi-stage sampling strategy)</td>
</tr>
<tr>
<td>5</td>
<td>2nd HERproject HERproject + Nutrition: 2nd Phase</td>
<td>2014–2016</td>
<td>BSR and BW</td>
<td>Cambodia Business Coalition on AIDS (CBCA)</td>
<td>Brands or GFs</td>
<td>To increase women’s health awareness and access to health services through sustainable workplace programs</td>
<td>Phnom Penh, Kandal, Kampong Chhnang</td>
<td>Factory-based</td>
<td>Garment workers and factory staff</td>
<td>15 GFs with 23,200 GFWs</td>
<td>Baseline study (—)</td>
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<td>No.</td>
<td>Projects</td>
<td>Year</td>
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<td>6</td>
<td>PMUW Protections for Marginalized Urban Women</td>
<td>2014–2017</td>
<td>CARE</td>
<td>No</td>
<td>DFAT</td>
<td>The overarching goal of PMUW is that marginalized urban women in Cambodia, especially female migrants working in garment factories and hospitality/tourism industries, have improved gender-based violence and sexual harassment protections in the workplace and outside work settings.</td>
<td>Phnom Penh</td>
<td>Factory-based and community-based</td>
<td>Female workers in GFs and entertainment industries</td>
<td>Number of GFs and GFWs unknown; Direct beneficiaries: 14,000; Indirect beneficiaries: 60,000</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>Healthcare Improvement Project</td>
<td>2015–2017</td>
<td>Res. P Co.</td>
<td>No</td>
<td>LG Electronics, Korea Trade Investment Promotion Agency (KOTRA), Daewon Pharmacy and Huons, factory owners, TYDA Volunteers, and Doctor of Alliance of Union of Youth Federations of Cambodia (DA.UYFC)</td>
<td>Not restricted; 13 provinces including Phnom Penh and Kandal reached</td>
<td>Inside factory</td>
<td>Garment workers</td>
<td>4 GFs with 4,500 GFWs</td>
<td>No</td>
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<td>No.</td>
<td>Projects</td>
<td>Year</td>
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<td>8</td>
<td>WorkerHealth Cambodia Worker Health Coalition</td>
<td>2015–2020</td>
<td>Evidence Project &amp; MSIC</td>
<td>—</td>
<td>USAID &amp; Brands</td>
<td>To ensure that female garment workers have greater access to quality health services that meet their needs and improve their reproductive health</td>
<td>Phnom Penh and Kandal</td>
<td>Inside and outside factory</td>
<td>Garment workers</td>
<td>Around 60 GFs with GFWs up to 100,000</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>2nd IAISRH Improving the access to integrated SRH and HIV services for factory workers: 2nd Phase</td>
<td>2016–2018</td>
<td>RHAC</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>Phnom Penh, Kandal, Kampong Speu</td>
<td>Factory-based</td>
<td>Garment workers</td>
<td>—</td>
<td>N/A</td>
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</tbody>
</table>
2. To build the capacity of frontline health workers to increase the responsiveness and effectiveness of the existing health system in addressing the needs of garment factory workers.  
3. To influence policy dialogue and priorities surrounding adolescent health through contributing to the development and implementation of effective standards of care within and outside factories. | Phnom Penh and Kandal provinces | Inside and outside factories | Garment factory workers, health providers, infirmary staff, factory management | 15 factories | —                     |
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<th>Beneficiaries</th>
<th>Number of Factories &amp; Workers</th>
<th>Program Evaluation</th>
</tr>
</thead>
</table>
| 11  | HFW      | 2016–19| CARE               | —                     | The Children’s Place | 1. To improve workers’ nutrition-related knowledge, steer positive eating habits and empower them make healthy choices.  
2. Create an enabling environment to support workers’ access to healthy, hygienic and nutritious food by working with food vendors and factory teams. | Phnom Penh and Kandal provinces | Inside and outside of factories | Garment factory workers and food vendors | 5 factories | — |
<p>| 12  | 3rd SBF  | 2016–19| CARE               | —                     | —             | —                                                                                      | —                      | —                            | —                                  | —                        | — |
| 13  | PACE     | 2008–13| CARE               | VBNK and Marie Stopes | GAP Inc.       | To improve women’s personal and professional opportunities while building a better skilled workforce | Phnom Penh Factory-based | Garment workers | 4 GFs with 2,080 GFWs | Baseline and end-line (Non case-control design with before and after comparison) |
| 14  | HIP      | 2009–12| Gret, GMAC, MoLVT | No                    | AFD, GFs, GWs   | To introduce voluntary social health insurance for the garment sector that addresses the needs of both workers and employers | Phnom Penh Inside and outside factories | Garment workers | 11 GFs with 8,249 GFWs | —                        | — |</p>
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<tr>
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<th>Implementing Partners</th>
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<th>Number of Factories &amp; Workers</th>
<th>Program Evaluation</th>
</tr>
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</table>
| 15  | SPG      | 2010–2012  | ILO                                                                                | Marie Stopes, Cambodia Business Coalition on AIDS (CBCA), Women Development Center (WDC) in Kampong Chhnang province, International Volunteers of Yamagata (IVY) in Svay Rieng province, and World Education (WE) | Spanish Agency for International Development Cooperation (AECID) | 1. To improve the well-being and health of women workers and enhance gender-responsive workplace policies  
2. To promote women’s participation in workplace-level decision making  
3. To create pre-induction and post factory employment opportunities | Phnom Penh & Kandal | Inside and outside factories | Garment workers                  | 20 GFs with 14,467 workers                           | Project evaluation (qualitative) |
| 16  | 2nd SBF  | 2010–2014  | CARE                                                                              | Cambodian Women for Peace and Development (CWPD), CBCA, Marie Stopes, Credit Mutuel Kampuchea (CMK), MoLVT, and Phnom Penh Municipal Health Department (MHD) | Levi Strauss Foundation          | 1. To increase workers’ knowledge, access and use of health-related information and services for SRH, HIV/AIDS, food hygiene & nutrition, maternal & neonatal health.  
2. To increase workers’ access, knowledge and use of financial services (i.e. savings and remittances).  
3. To improve working conditions by improving GWs’ and managements’ understanding of labor law. | Phnom Penh & Kandal | Factory-based          | Garment workers and (only on labor law) factory managers | 8 GFs (7 in Phnom Penh and 1 Kandal) with 16,000 GFWs | Baseline and end-line (Non case-control design with cross tabulation GFs’ conditions before and after intervention) |
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<tbody>
<tr>
<td>17</td>
<td>Life Skills Life Skills Training Program</td>
<td>2012</td>
<td>World Education (WE)</td>
<td>CWPD</td>
<td>ILO</td>
<td>To provide fundamental life skills to workers to achieve a healthy, balanced lifestyle and increased productivity</td>
<td>Phnom Penh</td>
<td>Factory-based</td>
<td>Garment workers mostly women</td>
<td>4 GFs with 502 GFWs</td>
<td>Baseline and end-line (Non case-control design with before and after comparison)</td>
</tr>
<tr>
<td>18</td>
<td>CBDC Widen the Range of Family Planning Choices through Community Based Distribution of Contraceptives</td>
<td>2012–2015</td>
<td>RHAC</td>
<td>No</td>
<td>UNFPA</td>
<td>To increase the modern contraceptive prevalence rate in five ODs of Takeo Province, especially improving access to IUD services at health centers and referral hospitals.</td>
<td>Takeo (76 health centers and 1,122 villages)</td>
<td>Factory-based and community-based</td>
<td>Community and garment workers</td>
<td>18 GFs with 17,233 GFWs</td>
<td>Baseline and end-line (Non case-control design with before and after comparison)</td>
</tr>
<tr>
<td>19</td>
<td>1st HERproject HERproject: 1st Phase</td>
<td>2013–2015</td>
<td>BSR &amp; BW</td>
<td>CWPD</td>
<td>Brands</td>
<td>To increase women’s health awareness and access to health services through sustainable workplace programs</td>
<td>Phnom Penh, Kandal, Kampong Chhnang</td>
<td>Factory-based</td>
<td>Garment workers and factory staff</td>
<td>10 GFs with 23,889 GFWs</td>
<td>Baseline and end-line (Non case-control design with before and after comparison)</td>
</tr>
<tr>
<td>No.</td>
<td>Projects</td>
<td>Year</td>
<td>Lead Organizations</td>
<td>Implementing Partners</td>
<td>Funders</td>
<td>Objectives of Projects</td>
<td>Location</td>
<td>Setting</td>
<td>Beneficiaries</td>
<td>Number of Factories &amp; Workers</td>
<td>Program Evaluation</td>
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| 20  | 1st IAISRH: Improving the access to integrated SRH and HIV services for factory workers: 1st Phase | 2013–2015  | RHAC               | No                                          | Japan Trust Fund (JTF) through International Planned Parenthood Federation (IPPF) | 1. To provide SRH to factory workers through RHAC’s clinic services.  
2. To build the capacity of 30 factory clinics to provide selected, quality RH services to their factory workers.                                                                 | Phnom Penh, Kandal, Kampong Speu | Factory-based | Garment workers               | 30 GFs with 68000 GFWs (app. 26% of workers were able to avail of the free services from RHAC by using vouchers) | Project evaluation (Non case control design with description of post-intervention conditions of GFs) |
| 21  | BFC’s Nutrition: A pilot project to boost nutrition for Cambodia garment workers | —         | BFC                | No                                          | US Department of Labor & AFD (evaluation)                                | To improve the health and productivity of workers.                                                                                                                                  | —                | Factory-based | Garment workers               | 4 GFs                          | Baseline and end-line evaluation (Non case-control design)                       |
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