

Healthcare Delivery in RMG Factories in Bangladesh: What are the Missed Opportunities?

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About this Working Paper

The purpose of this working paper is to present the current gaps identified in healthcare services and facilities inside of factories in the ready-made garment (RMG) industry in Bangladesh. Basic healthcare facilities and personnel (nurse, doctor) are required by law in factories employing more than 300 workers. The findings described in this paper will inform the design of upgrading programs to build the capacity of on-site clinics and factory nurses. This is part of BSR's "HERproject Health Systems Program" supported by UKaid, which aims to systematically bridge the gap in quality of health information, products, and access to services provided to workers in the RMG industry.

The assessment tools were designed by BSR, the USAID-funded RAISE Health Initiative, Kumudini Welfare Trust, the Centre for Injury Prevention and Research Bangladesh (CIPRB), and Change Associates. These included in-depth interviews with factory management, focus group discussion and one-to-one interviews with factory workers, document review, health facility (factory clinic) tour, and personal observation. The data was gathered by researchers of CIPRB from 10 factories in the Dhaka district from June to July 2014.

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ABOUT HERPROJECT

BSR launched HERproject in 2007 with a mission to increase women's health awareness and access to health services through sustainable workplace programs, an initiative that is now referred to as HERhealth. Thirty-five international companies, over 300 supplier factories and farms, and over 300,000 women workers participate in HERhealth programs across 10 countries in Asia and Africa.

Introduction

The 3 million women working in the garment sector in Bangladesh face myriad health issues that negatively impact their well-being in addition to their productive potential.



The ready-made garment (RMG) industry is Bangladesh's greatest contributor to GDP growth and has played a significant role in the country's improved performance against world development indicators. The industry represents 75 percent of Bangladesh's exports and employs up to 4 million people, 80 percent of whom are women¹. Access to the formal economy through the RMG industry has been economically empowering for many women through stability of employment, some measure of social security, and social acceptability².

However, the RMG industry has grown rapidly in Bangladesh within a context of limited social or physical infrastructure to support it. In particular, occupational health and safety (OHS) are insufficiently protected and managed. The factory fires in Gazipur in October and November 2013 as well as the collapse of Rana Plaza in April 2013, claiming 1,100 lives, are evidence of this³. Continuing low rates of women in managerial positions and the persistence of gender income disparity in the Bangladesh RMG industry likewise demonstrate how economic growth has not led to equitable social upgrading, with women still facing barriers to accessing opportunities, services, and so forth.

Within this context, access to the best attainable healthcare services and products, particularly for women, is a critical gap in the physical and social infrastructure in which the RMG industry operates. Health is critical to the well-being of a person, and it is a basic human right. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more⁴. However, within the RMG industry, 87 percent of

1 Bangladesh Alliance for Worker Safety, <http://www.bangladeshworkersafety.org/>

2 Kaber, N. and S. Mahmud (2004) "Globalisation, gender and poverty: Bangladeshi women workers in export and local markets," *Journal of International Development* Vol. 16(1): 93-109

3 "Bangladesh Clothing Factory Hit by Deadly Fire," BBC News, October 8, 2013. <http://www.bbc.co.uk/news/world-asia-24453165>

4 Health and Development, World Health Organization

According to WHO, Bangladesh has a lower density of nursing and midwifery personnel (0.22 per 1,000 population in 2011) than India (1.71 in 2011), Pakistan (0.57 in 2011), and Sri Lanka (1.64 in 2010).

women employees suffer from ailments and diseases⁵ including malnutrition and anemia, poor hygiene, inadequate pre- and post-natal care, and exposure to infections and illness⁶.

The existing healthcare systems cannot provide full protection to RMG workers because there is a large-scale shortage of qualified healthcare providers in Bangladesh. For instance, the nurse to population ratio is 1:7788 and the doctor to population ratio is 1:4645⁷. It would be nearly impossible to produce a sufficient number of public- and private-sector healthcare providers in the short term. The long working hours of many workers also constrain them from availing external health services during normal operating hours.

Within this context, we see enormous potential to better leverage factory-based nurses and on-site clinics to bridge some of these gaps and efficiently link RMG sector workers, especially women, to the health products and services that they need. Right now, that potential is not being realized. This study sought to identify the gaps in human capacity, operational management, and company policy that are causing these resources to go underutilized.

About the Research

BSR's HERhealth program has demonstrated the power of providing women's general and reproductive health education in the workplace to transform individual lives, workplaces, and communities. The HERhealth workplace training model has been highly successful in increasing the health knowledge and access of female factory workers and delivering business efficiencies and cost savings to participating factories.

A key aspect of HERhealth is to fully utilize the existing structures of RMG factories to better promote and maintain the health of all workers, especially that of the female workforce. Through our experience in implementing HERhealth in more than 50 factories in Bangladesh since 2010, we know that workplaces can play a critical role in meeting workers' unmet health needs. However, we have also observed shortcomings in the qualifications and skills of nurses, as well as in the utilization and operations of on-site clinics.

While companies and other stakeholders are currently focusing on improving the RMG industry's infrastructure, initiatives have yet to emerge to make full use of existing resources, such as factory nurses and clinics, to improve the social and economic well-being of workers. As factories are renovated or built anew, the opportunity should not be lost to add or improve clinic facilities and improve other facilities directly connected to health, such as toilet and canteen facilities. Capitalizing on these opportunities can bring long-term and sustainable benefits in workers' health and business performance. It can also advance the human development and poverty reduction benefits of the RMG sector.

With the support of UKaid, BSR is working with international buyers, factories, and Kumudini Welfare Trust in Bangladesh to enhance factory nurses' competences and upgrade on-site clinic facilities. This research seeks to assess and identify gaps in qualifications and performance of factory-based nurses and clinics. The findings of the research will inform a pilot nurse training program and

⁵ Ibid

⁶ Akhter S, Salahuddin AFM, "Health and Occupational Safety for Female Workforce of Garments Industries in Bangladesh," *Journal of Mechanical Engineering*, Vol. ME 41, No. 1, June 2010

⁷ Kabeer, N., "Health and Occupational Safety for Female Workforce of Garment Industries in Bangladesh," 2010

an advisory service for upgrading factory clinics that BSR and partners will launch in Bangladesh in January 2015.

Research Approach

Hypothesis and Research Questions

We believe that workplaces can fill a gap in meeting workers' unmet health needs—particularly women's health needs—if they provide on-site access to qualified nurses and primary-care clinics. Factory nurses and clinics provide great potential because:

- The legal infrastructure already exists. Bangladeshi law stipulates that RMG factories have an on-site clinic with one or more full-time nurse⁸;
- Nurses are on-site and therefore more accessible to workers than off-site practitioners;
- Nurses are in constant direct contact with the workers and therefore have increased potential to promote preventive care through health education, counseling, and treatment.

Through this research, we set out to assess the current gaps in the knowledge, skills, and service provision of nurses, as well as the facilities and management of on-site clinics in Bangladesh. Specifically, we sought to answer three main questions:

- What are the qualifications, experience, expectation, competences, and potential of factory nurses in providing healthcare services to the workforce?
- What are the main performing and underperforming areas of factory clinics?
- What is the role of management and corporate leadership in protecting and promoting workers' health?

Methodology

BSR, in partnership with RAISE Health Initiative, Kumudini Welfare Trust, the Centre for Injury Prevention and Research Bangladesh (CIPRB), and Change Associates, conducted a gap assessment study of on-site healthcare services and facilities in the RMG sector in Bangladesh.

To prepare the gap assessment, BSR engaged with a number of stakeholders in Bangladesh to i) understand the medical education market and operating environment of factory nurses; ii) gather recommendations and feedback on potential partners, and iii) secure initial buy-in to the nurse training and clinic upgrading program. Key stakeholders included representatives from:

- » University/research institutions—BRAC Institute of Global Health, BRAC JP School of Public Health, and The International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) for technical advice, particularly on the educational/training market in Bangladesh.
- » International organizations—World Health Organization (WHO) and International Labour Organization (ILO) Better Work.

⁸ Section 44 (4), Factories Act, 1965 (No. 4 of 1965), "In every factory wherein five hundred or more workers are employed, there shall be provided and maintained an ambulance room or dispensary of the prescribed size containing the prescribed equipment or similar facilities, in the charge of such medical and nursing staff as may be prescribed." <http://www.ilo.org/dyn/natlex/docs/WEBTEXT/47346/65073/E65BGD01.htm>

- » Dutch, Danish, and Swedish Embassies.
- » Bangladesh government—Professor Shah Monir Hossain, former director general of health services, Ministry of Health and Family Welfare (MOHFW).
- » Private sector—Bangladesh Knitwear Manufacturers and Exporters Association (BKMEA) and Bangladesh Export Processing Zones Authority (BEPZA) as well as international buyers sourcing from Bangladesh.

Ten factories were selected to participate in the assessment. They were nominated, rather than selected randomly, given the need for buy-in and support by the factory management, and the extensive use of both workers’ and managers’ time in answering the surveys. To identify factories, BSR invited international member companies to nominate their supplier factories to join the assessment. All of the factories were Tier 1 suppliers to foreign buyers, and therefore were subject to a minimum of annual social compliance audits. None of the factories who participated were current or past participants in HERhealth programs, though some had participated in other health interventions delivered by NGOs.

Group	Number interviewed
Workers	390 individual interviews 10 focus groups
Factory management representatives	30 (general management, welfare, HR)
Factory nurses	14 (including paramedics)
Other stakeholders	15 (doctors and medical assistants)

Data was gathered through assessments conducted in ten factories from June to July 2014. All participating facilities were located in Dhaka division. The number of workers in the factories participating in the assessment ranged from 1,700 to 4,000, and about 80 percent of the workers were female. A total of 390 people were interviewed, including 256 females (65.6 percent) and 134 males (34.4 percent). Workers were selected by the factory management for interviews, and they had the right not to participate in the assessment.

The standard assessment typically consisted of an opening meeting with factory management, followed by in-depth interviews with factory management staff and selected supervisors and factory workers, focus group discussions with factory workers, policy review, facility tour and direct observation.

Limitations

Findings of this assessment should be interpreted in light of the following limitations related to representation and the robustness of the data.

The sample size of the factories was small, with only 10 participating facilities. A number of them also belong to larger supplier groups, and therefore may have equal or better infrastructure, policy, and personnel vis-à-vis their counterparts in Bangladesh. The limited sample size combined with the quality of some of the factories included may bias the data toward more positive conclusions than may be generalized throughout the Bangladeshi RMG sector.

Participating factories were generally cooperative. However, one particular factory posed several limitations and management was present in all workers’ interviews and focus group discussions, which could have influenced the responses. To overcome that, our researchers triangulated the data from various

sources through different means. The same specific findings were explored through structured interview, in-depth interview, and focus group discussion with different stakeholders in the factory (e.g., management, workers, and healthcare service providers), as well as through direct observation and relevant document review.

Regardless of these limitations, we believe that the information we obtained provides valuable insights related to the research questions we posed.

We believe further research on this topic is critical, and encourage other organizations and companies to conduct additional studies.

Study Findings

The gap assessment identified five main gaps in the healthcare system available at RMG factories: (1) Nurses lack necessary skills and qualifications to perform their job optimally; (2) Insufficient attention is given to health education and promotion of women's health issues; (3) Clinic facilities require upgrading to better serve health needs; (4) Factories' healthcare management systems require strengthening; and (5) Health staff are insufficiently prepared to respond to emergencies. Further details of the findings are discussed below.

Gap 1: Nurses lack necessary skills and qualifications to perform their job optimally

All ten participating factories had at least one nurse on duty in the clinic. Six of them were diploma nurses and the other four were paramedics, having received only basic training.

Our findings suggest that factory nurses are not performing their job optimally. First, nurses were found to lack formal medical education and qualification—only 60 percent were diploma nurses.

Supply-and-demand factors influenced management's decision to inadequately staff trained nurses in factories. On the supply side, there is a general shortage of nurses in Bangladesh. Nurses in factories usually earn less than their counterparts in the public or private hospitals and, therefore, factories have limited candidates to choose from in hiring⁹. On the demand side, many factories recruit a nurse to meet the compliance requirement, but they are not legally incentivized to hire a qualified nurse or to invest in his or her professional development once hired. There is no specific requirement in the government policy regarding the qualifications level of "factory nurses," and this issue is not currently assessed in national or international compliance assessments.

There was found to be a discernible mismatch between the training received by the nurses and the actual health needs in RMG factories. Nurses learn patient care, patient management, and instructions related to medication prescribed by the doctors¹⁰. They also learn about wound care and other general well-being issues. However, in factory clinic settings, nurses need to prescribe certain medicines and counsel patients on common illnesses. They also need to make informed external referrals for patients because factory clinics don't provide most health services.

Nurses did not wear gloves in **83.3 percent** of examinations. Two-thirds of the nurses did not ask patients' drug history, and **none of them** asked about patients' allergy history.

Despite being widely respected by workers, most nurses had an inadequate standard of patient care and did not fully execute their responsibilities of clinic management. Nurses that only possess a paramedic qualification (40 percent) did not mention that they had any formal training in diagnosing, treating, counseling, and referring skills, services they have to provide regularly. This indicates that nurses will be unable to respond effectively to factory workers' health needs.

Relevant health topic knowledge was also found to be lacking, especially related to sexual and reproductive health. None of the nurses offered any counseling on relevant topics such as personal hygiene, waterborne diseases, and sexually transmitted infections (STI) and HIV/AIDS during our researchers' observations.

⁹ For instance, the starting salary of a factory nurse is between 8,000 and 16,000 taka per month on average (US\$100 to \$200), depending on experience. On the other hand, in a private clinic or other healthcare facility a nurse can start their service at around 20,000 taka per month (US\$250).

¹⁰ "Developing Training Systems for Health Workers in Bangladesh," Catalyst, 2012, with updated data from the Bangladesh Nursing Council:
[http://bnmc.gov.bd/cmsfiles/files/Web%20for%20NI%20NC%20List%202026_1_14\(1\).pdf](http://bnmc.gov.bd/cmsfiles/files/Web%20for%20NI%20NC%20List%202026_1_14(1).pdf)

Most nurse contracts do not stipulate responsibility for the workforce's personal health issues: 40 percent of the nurses interviewed do not have a job description. Instead nurses often only provide first-aid services and basic symptomatic care. Furthermore, on-site nurses are not well adjusted to function optimally in factory settings because they lack critical general and reproductive health knowledge, capacity to deliver counseling and referrals, and understanding of health record systems¹¹.

Having a nurse in place is both a statutory and a corporate code compliance requirement. Nurses have the potential to make significant contributions to improve the health of a largely underserved group, as well as benefit factories' bottom line by driving down absenteeism and turnover and improving workplace environment and compliance standards. Properly trained nurses can also complement other health initiatives undertaken by the factory, such as health promotion campaigns.

Gap 2: Insufficient attention is given to health education and promotion of women's health issues

70 percent nurses interviewed said that menstrual pain was one of the top five reasons for female workers to visit the factory clinic.

Although the majority of workers in the factories were women, health-related activities such as workers' orientation, counseling, and health promotion campaigns were mainly focusing on occupational health and safety (OHS) and general well-being, with less attention given to women's health issues. It also appeared nurses were underutilized in these efforts as most of the health promotion assignments were taken up by welfare officers.

All interviewed factories conducted orientation for new employees and periodically organized health promotion campaigns. However, among the workers who said they had received health information when they joined the factory (86.7 percent, n= 390), the majority of them reported that they mainly received information on occupational health and safety (94.1 percent of respondents, n=390), and hygiene and cleanliness (54.6 percent of respondents, n=390); only 3.8 percent of them (n=390) received information on family planning.

Recurrent health promotion campaigns were also mainly on OHS, fire safety, and general well-being. And access to information through health promotion campaigns is not necessarily linked to enhanced access to health services or products (such as sanitary napkins and family planning products, or referrals and counseling).

Promoting healthy behavior among the workforce through trainings, health counseling, basic treatment, and referrals for services has a tremendous impact on women's health, as HERhealth has already demonstrated in Bangladesh. Factory nurses have wide access and acceptability among the workers. If they possess professional knowledge and skills, especially on topics important for the workers and hardly addressed through the existing promotional campaigns such as women health issues, they can play an instrumental role in promoting health both in their capacity in the clinic *and* as members of factory health committees.

Gap 3: Clinic facilities require upgrading to better serve health needs

42 percent of the workers who visited the clinics expressed their satisfaction with the present service quality of the clinic.

Acknowledging some negative outliers, as well as the limitations of our factory sample, clinics were found to comply with primary care expectations with regards

¹¹ World Health Organization, Health Systems in Bangladesh. <http://www.ban.searo.who.int/en/Section25.htm>

to patient privacy and confidentiality, lighting and ventilation, furniture provision, instrument stocking, and medicine stocking.

However, facilities assessed were found to have areas that could be easily improved with some investment. In particular the following areas were found to require improvement in most assessed clinics: facility cleanliness, client safety, client record-keeping, providing basic reproductive healthcare services, providing health education, and publically posting information about service hours and services available. These insufficiencies are at least in part attributable to the nurse's lack of skills in maintaining quality standards and in understanding that clinic management responsibilities fall under their role as a healthcare provider.

Since factories already have in place health facilities and health providers that are often under-used and under-managed, they represent one of the main sunk costs for many factories. Improvements to health services mean that the factory is getting more impact from its existing investment in health.

Upgrading clinics should go beyond the physical facilities. HERhealth's experiences in India, Egypt, and Haiti show that effective clinic operations and quality of care provision are also dependent on operational excellence of clinics, and this requires prioritization by factory management. For example, an integrated clinic upgrade plan will seek to achieve both short-term (e.g., regular restocking of medicines) and medium- to long-term objectives (e.g., stand-alone budget line on health, policy on healthcare product provisions, etc.).

Gap 4: Factories' healthcare management systems require strengthening

Strong management systems and policy creates an enabling environment and accountability to improve the provision of responsive and reliable healthcare services in factories. All of the factories assessed had health-related policies, such as a health and safety committee, and had expressed commitment to support health in company goals and operations. Factories scored very high in inventory management and grievances mechanisms related to health. The majority of factory nurses and doctors also took precautions to protect the confidentiality of patients.

Although all of the factories included in the study have documented policies, these policies were not well communicated to workers. As a result, most of the workers interviewed were not aware of the policy and/or clinic services provision. For example, health information was not reaching every worker, either because workers did not join the new staff orientation (13.3 percent, n=390), or they were not aware of any health campaigns in the factory (12.8 percent, n=390). Effective management systems also depend on effective processes and practices that lead to open, two-way communication with workers. Workers need to be aware of policies, and they should have opportunities to make suggestions of ways they can be improved.

This issue is related to accountability. If factories had effective communication structures to reach workers on health policies, responsibility of healthcare providers, and other workplace programs, and collect workers' feedback regularly, factories would be able to evaluate the impact of their investments in workers' health, and respond to workers' emerging health needs in a more timely manner.

Effective management systems require not only policies but also committed leadership who take actions to integrate health into an enterprise's goals, values, and operations. That might include setting annual health plans and targets, conducting periodic reviews of the implementation status of health policies, and having a separate budget line for workers' health and well-being.

Only 20 percent of the clinics had sanitary napkins, and none had educational materials on treatment and prevention of STDs and HIV/AIDS, family planning, reproductive health, or gender based violence.

80 percent of the factories have code statements which include commitments to workers' health and well-being beyond the legal minimum.

Nurses in two factories spoke about a training on building collapse accidents organized by BGMEA, but could not recall the details on training contents and issues addressed.

Gap 5: Health staff are insufficiently prepared to respond to emergencies

After the Rana Plaza tragedy, collaborative initiatives such as the Alliance¹² and the Accord¹³ are working with the industry to safeguard workers safety. So far the focus has been on infrastructural upgrade, training on hazard prevention, and reporting of observed risks (through help lines). Health response systems in factories—another important component in times of disasters—have yet to be properly equipped to manage emergencies. Nurses interviewed pointed to a lack of necessary medical equipment, and 80 percent of them believed that training could enhance their performance.

As of now, factories rely heavily on external service providers, i.e., contracted hospitals and health centers, to handle emergencies, and there is a clear need to provide training on immediate responses.

Factories can be better equipped in emergency management by training their health staff regularly and more effectively on issues like triage. Once equipped with adequate knowledge and skills, the factory will also be able to hold their health staff accountable for emergency procedures, knowledge management, and promotion of emergency preparedness among the workforce. Factories will also be better prepared to deal effectively with an emergency situation such as a fire.

Conclusions

The gap assessment study confirmed the missed opportunities in the RMG sector related to already existing healthcare resources in factories and their potential to make a significant contribution to improve workers' well-being.

Moreover, all participants in the assessment, from management to healthcare service providers, as well as factory workers, expressed the need for professional training of healthcare service providers to ensure better health for all in the factories.

Overall, we found that factory nurses were underutilized and insufficiently prepared, and that clinics were insufficiently stocked and not professionally managed. Nurses were underqualified and insufficiently trained to effectively attend to the needs of women and men working in the assessed factories. Although the majority of workers are women, women's health concerns are not prioritized and nurses are often not trained to attend to their specific sexual and reproductive health needs. Health staff could also be further trained on emergency management to improve preparedness and to help train workers on procedures.

Cleanliness and functionality of the factory clinic environments were found to have room for improvement. In particular, nurses should be trained to manage the clinic, and factories can make some targeted investments to upgrade the facilities and stocked products. Better health management systems would also contribute to more clarity on roles and responsibilities of health staff and communication on policies and services to the workforce.

¹² Alliance for Bangladesh Worker Safety.

¹³ Accord on Fire and Building Safety in Bangladesh.

In a country where health-system infrastructure is lacking, improving workplace clinics and factory nurses' capacity can make significant contributions to improve the health of a largely underserved group while at the same time produce business returns. Low-income women workers are particularly disadvantaged due to long work days that allow limited time to seek medical assistance.

The potential for nurses (of various professional background) and on-site clinics to bridge the gap in health service infrastructure is not being realized. Health staff and facilities are often one of the main sunk costs in factories, so it is smart business to find ways to better leverage these required resources. Moreover, investing in workforce well-being is proven to have direct business benefits related to reduced absenteeism and turnover and increased productivity. It also has other less quantifiable impacts such as improved workplace environment, improved worker-employer relationships, and better reputation with clients.

Recommendations

Workplace healthcare services in the RMG sector in Bangladesh have the potential to address some of the key issues the country's weak health system faces as well as infrastructure shortcomings specific to the RMG sector. Access to healthcare services and products is a critical gap, especially for women and low-income factory workers. Given that there is an acute shortage of nurses in the country, improving on-site clinics and the qualifications of factory nurses provide an immediate and economical solution to help meet the health needs of this largely underserved population.

Improving the operations and personnel providing health information and services in RMG factories will help enhance the contributions of the sector to more equitable social upgrading. It will also help make one of the most important economic sectors in Bangladesh—and a critically important global sourcing destination for garment manufacturing—more productive and profitable.

Call to Action for Business

Businesses—including global companies, Bangladeshi and foreign-owned factories, and business associations such as the BGMEA and BEPZA—have a key role to play in realizing this opportunity. We suggest four main areas of focus in support of this objective:

- Factories and international buyers adopt a twin-tracked approach to invest in people (appropriately trained nurses) and systems (maintaining sound clinic operations and stocking appropriate health and hygiene products) to improve workplace healthcare systems.
- Factories develop standard policies related to health and well-being of their workforce. In addition, all policies should be well communicated with all of the stakeholders, posted in factory clinics, and provided to workers or clinic clients on request. Specific roles and accountabilities should also be documented and communicated to responsible staff, and management team should be trained on managing workplace health facilities.
- International buyers consider including health-related indicators and clinic assessment areas, e.g., qualifications of nurses, stockpile of medicine, hygiene, patients' recordkeeping, etc., into factory audits and ensure that third-party monitors do the same.
- Collaborative initiatives such as the Accord and the Alliance consider manpower development and healthcare systems building in their subsequent phases of activity to upgrade RMG sector health and safety infrastructure.

Call to Action for Government and Civil Society

Government and civil society have important roles to play to connect workplace-based healthcare systems to community resources. We suggest that they consider the following opportunities:

- Investments are made in a market analysis to further understand this training space, and build up the capacity of nursing institutes to meet the demand. Ninety-seven nursing institutes (including 43 government colleges and 54 private institutions) are offering three-year diplomas in nursing science and midwifery in Bangladesh. Specific training programs at foundational and advanced levels can be developed for *in-service* factory nurses (e.g., those currently employed in factories).

- Nongovernmental organizations that implement workplace-based health programs engage with factory nurses in their programs. In addition to building up their capacity in delivering curative care, efforts also focus on their role on prevention and promotion, as well as integrating their roles into the existing structures, such as health committees, worker participatory committees, etc.
- Government agencies and donor-funded NGOs or health projects consider how to include factory health providers in the capacity building and training which they already provide to public and private health facilities. Developing and strengthening linkages between the public health system and factory health providers would be good for the RMG sector, workers, and the general community.
- The Bangladesh Nursing Council (BNC) looks into the standardization of factory nurse qualifications and training curriculum, and provides clear guidance on the requirement and related competencies.

This study has uncovered significant gaps in the capabilities and performance of factory-based nurses, and the operations of factory-based clinics. These gaps should be filled—not only for legal compliance and to ensure maximum capacity to manage and respond to emergencies, but also to deploy these nurses and clinics in meeting the personal health needs of an underserved population. If women and men working in the RMG sector are healthier, they will be able to earn more, invest more in their future, and share more benefits with their families and communities through remittances. Healthier workers will also be more productive and will support the continued growth of Bangladesh’s RMG sector.

To contribute to this challenge, BSR and partners are designing a training program for currently employed nurses based on the needs identified in this study. The program will be pilot tested in 2015 with 100 nurses. Based on the feedback and evaluation, the training program will be further adapted and scaled up in Bangladesh and beyond.

The clinic facility assessments will be transformed into a working plan for factories interested in upgrading their facilities. This tool will be pilot tested in 15 factories in 2015 and further fine-tuned for wider use in the sector.

If you are interested in participating in, or learning more about, either of these programs, please contact getinvolved@herproject.org.

We look forward to collaborating on this important issue.