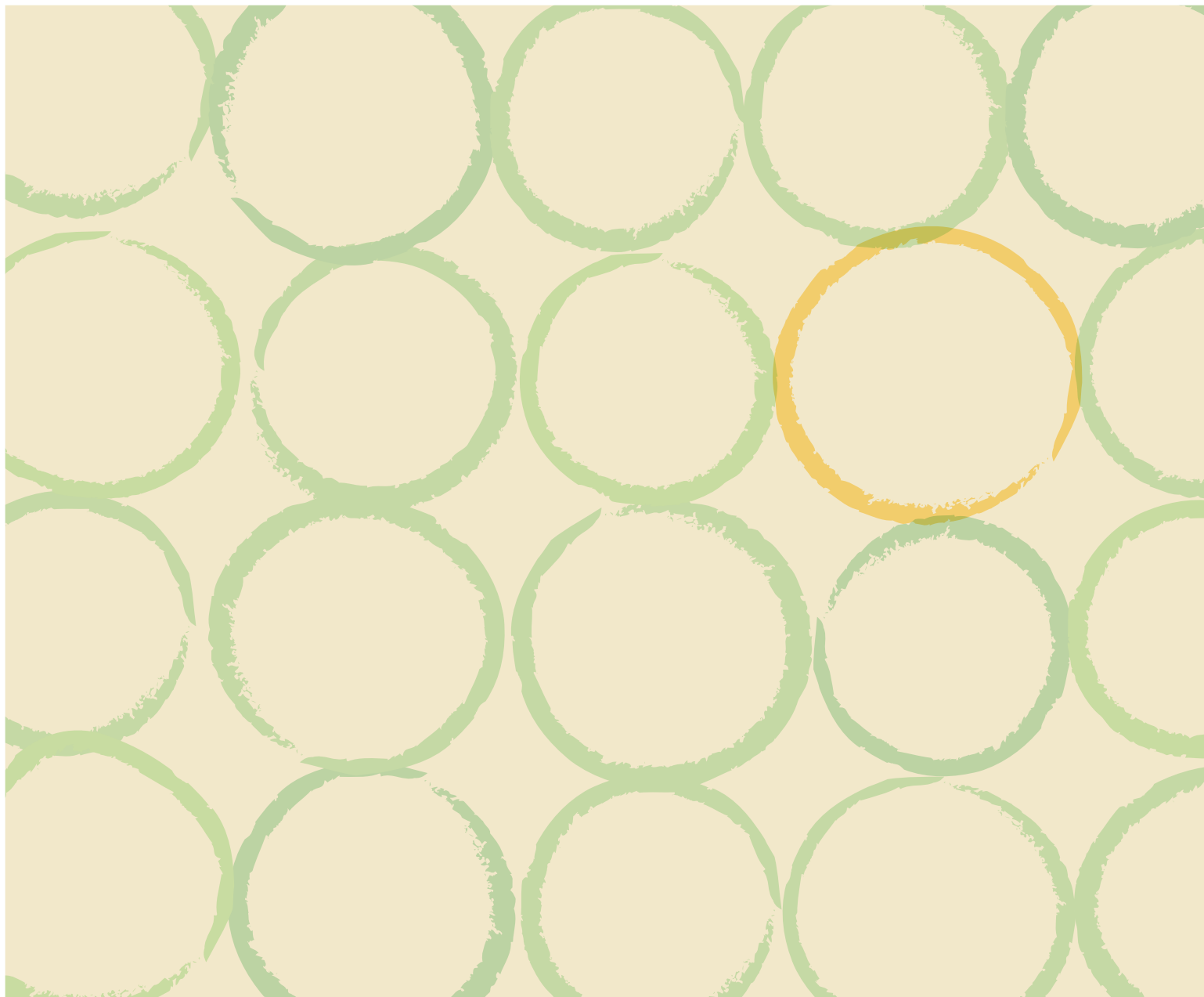


Women's General & Reproductive Health in Global Supply Chains



Business for Social Responsibility

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Note:

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

I. Introduction

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

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

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

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

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

Project Methodology

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

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

Report Organization

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

II. Executive Summary

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

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

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

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

of factories in a certain city or country, or of a certain brand or supplier. The size of factories visited ranged from 124 workers to over 200,000 workers.

Key Findings

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

Reproductive Health

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

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

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

Despite the lack of attention devoted to RH services, many factory managers express—in theory—an interest in RH services, which they define broadly as increased attention to the needs of pregnant workers, access to contraception and family planning services. In addition, the notion of integrated services that include RH and FP services, family planning, nutrition and HIV/AIDS prevention met with understanding and approval. Management typically correlates reduced absenteeism, lower turnover and increases in quality and productivity with healthier women workers. At the same time, many factory managers question the value of investing financial resources in reproductive health programs, as most women workers are young and perceived to be sexually inactive, and because turnover is high. Though trainings in some factories include information on RH, these are not offered regularly, do not involve all factory workers and are quickly sidelined when production pressures take precedence. Factory management views the

trainings as peripheral to overall factory management. One Indian factory visited by BSR in 2002 participated in a multi-stakeholder training initiative (“*Global Alliance*”) but did not continue with trainings after the initiative concluded activities.

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

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

Best Practice in Reproductive Health

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

Since BSR’s initial visit in 2002, one factory in Bandung, Indonesia worked closely with YKB to establish a clinic in close proximity to the factory. All workers and their families receive free treatment at the clinic and costs are covered by the private insurance scheme paid for by the factory. The clinic provides a wide range of health care options—

including RH and FP—and has 7,000 registered patients. Each week the clinic conducts trainings—primarily on reproductive health. In addition, a ‘train-the-trainers’ system has been set up, with forty peer educators trained from among factory workers. Thanks to initial funding from a major retail buyer, the YKB clinic reached the break-even point eighteen months after being set up and is now a self-sustaining facility.

In the Ho Chi Minh City area of Viet Nam, a large brand involved in manufacturing footwear recently contracted MSI to operate a mobile reproductive health service within the existing factory clinic. The mobile RH clinic operates two days per month at the factory to provide gynecological, RH and FP services. Since the mobile clinic began in March 2006, nearly 200 workers have received consultation on a monthly basis. For those potential patients hesitant to use the onsite service due to issues of privacy, MSI also offers a fixed clinic 2km from the factory and promotes this on a factory bulletin board.

HIV/AIDS

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

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

Nutrition

Nutritional concerns vary among factories and countries. While diabetes, hypertension and obesity rank as the top health concerns of women factory workers in Mexico, many

² Fleischman, Janet. “Family Planning, AIDS Care Should Go Hand in Hand.” *The Baltimore Sun* 26 July.2006, natl. ed.: A15.

women workers in China, India, Indonesia and Viet Nam suffer from anemia and gastritis.

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

Our fieldwork suggests that best practice in nutrition involves worker trainings on low-cost and nutritious food, staffing each cafeteria with a nutritionist to plan appropriate meals, providing dietary and vitamin supplements to workers and conducting random checks of meals to gauge quality and nutritional value to ensure valuable micronutrients for safe and healthy childbirth.

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

Education

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

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

Occupational Safety and General Health

The level of health services available inside factories varies widely, from worker trainings in first aid, to part-time nurses and part-time doctors with no diagnostic equipment in a small room, to full-time doctors and nurses staffing a clinic with diagnostic equipment, X-ray facilities and a pharmacy. The majority have only basic first aid response capabilities and dispense only over-the-counter medication for illnesses such as cough, cold, fever and diarrhea. Best practice among factories surveyed include providing an annual check-up for all workers with specific tests for occupational hazards, maintaining individual medical records and following up with the public health care system on specific workers' cases.



Apparel factory in Binh Duong Province, Viet Nam

Recommendations

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

Business Case for RH Services

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

Services Integration

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

Accessibility

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

Nutrition

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

Education

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

- **Proactive Education and Information Sharing:** Since workers are often embarrassed or do not know to ask for information, factories should identify ways to disseminate information easily and discreetly, including posters or brochures posted in semi-private spaces. Proactive provision of information

should not be limited to women workers, however, since male workers can provide this information to their wives and mothers.

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

Departmental Coordination

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

Counseling and Support Systems

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

consideration, which differs from the poor treatment that they generally receive in government-run facilities.

Health Facilities

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

Basic Elements of Effective Factory Health Programs

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

- **Doctor:** General physician available full-time or part-time to all workers. While it is not necessary for the doctor to be a specialist, a female doctor or gynecologist is helpful when the factory has a majority of female workers.
- **Medical Records:** Proper record keeping by maintaining individual medical records (as opposed to sickness or injury log books alone) is helpful in forecasting needs and planning preventive activities.
- **Counseling and Support Staff:** In addition to trained medical providers such as doctors and nurses, workers should be able to talk and receive advice on health issues, either from human resource personnel or from others with specific counseling functions.
- **Annual Health Check-up:** Annual health check-ups for all workers, with specific tests for occupational hazards, can be an effective surveillance tool in furthering preventive care.
- **Dedicated Personnel:** Activities conducted in successful health programs need dedicated personnel to ensure that the activities are planned and designed well, are implemented regularly, are effective and meet the needs of workers. Dedicated personnel could be existing staff or staff specifically hired for this purpose. Regardless, they must be given adequate time to carry out the activities.

Interaction with Government Health Facilities

In India, the Philippines, Mexico and Viet Nam, where government health insurance for workers is mandatory, factories could put more effort into leveraging the public health system and supporting workers through interaction with government hospitals and management. Factories that regularly accompany their workers to government hospitals

for follow-up treatment and develop communication channels with doctors and management at those hospitals find that their workers receive a higher quality of care. Factories are also able to draw on public health care system resources for training and preventive activities.

Collaboration with Government and NGOs

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



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

Plans for Dissemination

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

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

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

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

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

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

III. China

Context

Country Health Situation

China opened up its economy in 1979 and has today become home to the world's largest export-oriented workforce. It achieved a 12 percent share in the global economy in 2004 (on purchasing power parity).³ China's economy expanded by almost 11 percent in the first half of 2006, with growth in the second quarter the highest in over a decade. Industry continues to outpace services on the supply side, and investment remains the main driver of demand.⁴

However, progress in national health has not kept pace with the huge increase in GDP. The total expenditure on health was only 5.6 percent of total GDP in 2003; of this, general government expenditures accounted for 37.4 percent, while private expenditures accounted for 62.6 percent.⁵ In 2005, the average cost of outpatient medical expenditure was RMB126.9 per person (US\$15.95 at US\$1=7.95RMB), which is about 15-20 percent of minimum wage.⁶

China: Health Statistics		
Name	Indicator	Year
Population ¹	1,315,844,000	2004
Life expectancy at birth (male) ¹	70.0 years	2004
Life expectancy at birth (female) ¹	74.0 years	2004
Population with sustainable access to improved sanitation (percentage of population) ¹	50.92%	2004
Maternal mortality rate ²	48.3 (per 100,000 live births)	2003
Infant mortality rate ²	25.5 (per 1,000 live births)	2003
Prevalence of HIV, total (of population ages 15 - 49) ²	0.7%	2002
Contraceptive prevalence rate ¹	84% (married women aged 15-49)	1997
Doctors ¹	15.1 (per 10,000 pop.)	2005
Nurses ¹	10.5 (per 10,000 pop.)	2005

³ World Bank estimates

⁴ *China Quarterly Update*, World Bank, August 15, 2006

⁵ *China Quarterly Update*, World Bank, April, 2006

⁶ Ibid.

Estimated incidence of malignant neoplasms of the female breast, adjusted ²	9.3 (per 100,000 pop.)	2004
Estimated incidence of malignant neoplasms of the cervix uteri, adjusted ²	10.9 (per 100,000 pop.)	2004

Sources: 1 - World Health Organization; 2 - China Ministry of Health, Information Center; 3- Center for Reproductive Rights, www.crlp.org.

Besides the high cost of medical care, lack of adequate sanitary facilities and limited medical insurance coverage are additional hindrances to achieving health for all. According to the Beijing Public Sanitary Information Center, in 2005 only 200 million people in urban areas were covered by some form of medical insurance, which provides limited coverage of RMB30 per person per year (US\$3.78 at US\$1=7.95RMB). In rural areas during the same year, only 21 percent of the population was covered by medical insurance. Because coverage is limited, most people seek medical treatment only for serious conditions and not for minor illnesses. The public's infrequent contact with the health care system makes monitoring and control of outbreaks of diseases, such as avian flu and SARS, a huge challenge for the Chinese government.

In China, the five most common diseases are tuberculosis, hepatitis, diarrhea, gonorrhea and syphilis. Recently the outbreaks of avian flu and SARS have caused the greatest public health concerns.

Based on interviews with factory managers, female factory workers and factory health clinic staff, as well as statistics from Chinese Ministry of Health, the major issues affecting women's health in China include:

- Hepatitis B
- Pelvic Inflammatory Disease (PID)
- Breast cancer
- Cancer of the cervix
- Family planning and reproductive health education
- Childcare for working mothers

In urban areas, women have more channels to learn about health issues and tend to seek medical attention for preventative purposes. In rural areas, the majority of women are still not well educated on health matters and have limited access to quality health care and medicine. They do not seek information and treatment until they are faced with serious illness.

Government and Legal Context

Chinese labor law provides the following benefits to women workers:

- Companies are required to provide female workers with at least 90 days maternity leave.
- Pregnant workers should not work in hazardous positions (defined as "third national category physical stress position").

- Pregnant workers who are over seven months pregnant are not allowed to work overtime or during the night shift.
- Women workers with children of less than one year in age should not be allowed to do hazardous work (defined in the law as “third national category physical stress position”) or work overtime or during the night shift. The same rules apply to nursing mothers.
- Female workers cannot work in mining or other extremely hazardous work (defined as “fourth national category physical stress work”).
- Female workers should not work in elevated heights, low temperature or “third national category physical stress work” during menstruation.

Cultural Context

Economic development in China began in the south. The Pearl River delta and the Chang Jiang river delta are the most industrialized regions. Most of the workers in these regions migrated from rural areas in western China. In 2005, the central government issued Article No. 1, which aimed to balance the population between eastern and western China, as well as between rural and urban areas. Farmers were given incentives to continue practicing agriculture rather than leave their land to work in factories thousands of miles away.

Because of the one-child policy implemented more than 20 years ago that limits the size of families in urban areas of China, many young workers come from single-child homes. The younger generation, which is used to greater affluence than prior generations, is not as willing to work hard and in poor conditions. Factory jobs are not as attractive to this new generation of workers.

Changing migration patterns and the one-child policy have led to a significant shortage of labor in China. The Guangdong Labor and Security Bureau reports that this labor shortage most heavily impacts the garment and electronics sectors.

Worker’s awareness of their rights has increased due to the new generation of workers achieving higher levels of education, the labor department more strictly monitoring factories, brands placing greater emphasis on labor compliance through code of conduct implementation and the media increasing its focus on labor violations. Recent increases in the number of labor disputes evidence the rise in worker awareness. Many employers are improving their labor practices to recruit and retain workers, using measures such as increased wages and benefits, better dormitory facilities and more food choices in cafeterias.

Though working conditions have improved in recent years, employers are still far from realizing the link between employee health and business success, and they have yet to proactively promote health through strategies such as training or health-related activities in the workplace. There are a few leadership factories that are taking progressive steps that are described in the detailed site reports below, but similar efforts are not common across factories in China.

In addition to the lack of efforts by employers, workers are also hesitant to discuss reproductive health in public, since reproductive health issues are considered to be private matters. This aspect of Chinese culture prevents women from seeking information or becoming more actively involved in reproductive health programs.

Research and Findings

Methodology

BSR staff visited seven factories in Southern China to discover the most relevant health issues for women workers and examine how women's health concerns are being addressed in their workplaces and their communities. The field research was supplemented by a review of Chinese labor laws and of the Web sites of government agencies and NGOs (listed in the Appendix).

The seven factories are located in Guangdong Province, which is one of the richest provinces in China and contributes approximately 12 percent of national economic output.

Prior to the factory visits, a questionnaire was sent to each site to collect information about the programs available to address women workers' health. Some respondents filled out the questionnaire during the onsite visit.

Representatives from brands that sourced from the factories visited were present during some site visits.

Site visits lasted from a half day to a full day and included:

1. Discussion with factory management on health programs and policies. Interviewees included but were not limited to general managers, human resources managers, health and safety managers, welfare officers, counselors, consultants, doctors, nurses, other relevant medical and management personnel and representatives from quality and production departments.
2. Factory walk-throughs to observe production processes, as well of observance of safety measures including use of personal protective equipment by workers. One site visit did not include a walk-through.
3. Visits to clinics and infirmaries, and discussion with medical personnel.
4. Interviews with workers, including both one-on-one conversations and group dialogues, were conducted at five of the seven sites. All interviews were located away from the production lines and without management personnel present in order to obtain honest perspectives, to learn about worker awareness of the programs described by management and to determine whether programs were having their intended impact.

Projects Covered

Of the seven factories visited, three were engaged in toy production, three in apparel manufacturing and one in electronics manufacturing. Factories ranged in size from 1000 workers to over 200,000 workers. All factories had more than 80 percent women workers.

Key Findings

Health Facilities

Most factories with more than 500 employees have **onsite infirmaries** that provide diagnosis and simple treatments such as first aid for work injuries or analgesics for colds, fever, diarrhea and stomach ailments. They also perform initial analyses of serious accidents before patients are transferred to hospitals. Onsite clinics are essential in factories because hospital facilities are scarce and usually located far away from the factories.

Hazardous material handling is a big issue in Chinese factories because factory managers lack sufficient professional knowledge. Workers do not receive sufficient training in handling hazardous materials and often choose not to wear **personal protective equipment (PPE)**. Factories often do not provide sufficient PPE due high costs. Those factories that offer training on using PPE and provide correct equipment often have no monitoring and control systems to verify if workers are using PPE.

Common Illnesses

The most common illnesses among all workers are **Hepatitis B, tuberculosis and diarrhea**. Food poisoning is also common. In interviews, workers and medical personnel consistently reported a high prevalence of Hepatitis B and diarrhea. Because both of these diseases are spread through poor hygiene and unsanitary conditions, most factories strictly monitor cleanliness during food preparation in the cafeteria, and cafeteria staff are required have valid health certificates and licenses. Many factory managers train workers to wash their hands before meals and after using the toilet, and they put up posters on hygiene on the production floor. All factory management interviewed agreed that hygiene is fundamental to worker health and linked to productivity.

The majority of Chinese women workers migrate from rural areas to work in factories. They spend frugally on **nutritious food** so they can send more money home to their families for clothing, housing and other living expenses. Most factory cafeterias contribute to inadequate nutrition through stressing the taste of food rather than its nutritional value.

The most prevalent health issues among female workers are **Pelvic Inflammatory Disease (PID), dysmenorrhea and cancer of the cervix**. PID and cervical inflammatory disease often occur in older women who are married or sexually active with men. A lack of knowledge about personal hygiene among migrant workers contributes to

the spread of these diseases. **Cervical and breast cancer** have the highest mortality rate among women in China at 20 per 100,000 women. Detecting cancer early improves the likelihood of successful treatment. Information on risk factors and detecting cancer through self exams and clinical exams needs to be proactively disseminated to women workers, as this is not widely done now.

Outbreaks of diseases such as **SARS** and **bird flu** have also caused concern in recent years.

Care during Pregnancy

There are several benefits for pregnant workers that are mandated by law, but implementation of laws is poor and pregnant workers often do not receive these benefits. Pregnant workers often resign from their jobs and return to their home towns for better health care and child care.

Family Planning

The **one-child policy** makes contraception mandatory for women after the birth of their first child. Local Family Planning Bureaus conduct three to four pregnancy tests per year for each married woman in each factory. Violations of the one-child policy result in serious fines for both the employer and employee. The one-child policy is one of the best-enforced government regulations and is more strictly enforced than regulations on working hours and minimum wage.

HIV/AIDS

Most managers and workers interviewed did not perceive HIV/AIDS as a major health issue for women in China despite a national prevalence rate of 0.7 percent. Workers possess a general understanding of the disease and awareness of preventive methods. Factory management provides little education to workers on HIV/AIDS, in part because most workers are migrants who live in gender segregated factory dormitories, and factory management believes that gender segregation reduces the possibility of workers contracting the disease.

Importance of Leveraging Government and Brand Resources

The **ACFTU** (All China Federal Trade Union, a local government organization), the **Family Planning Bureau** and the **Red Cross Center** promote reproductive health throughout China. The three organizations hold training seminars at least twice a year in each region and invite women factory workers to participate for free. The trainings cover general women's health topics such as adolescence, marriage, pregnancy, menopause, contraception and family planning, as well as prevention of sexually transmitted diseases, reproductive tract infections and HIV/AIDS. The organizations also print and distribute booklets on reproductive health to factories and free family planning tools to the public, and they organize activities such as theme parties, knowledge competitions and free diagnoses.

Some brands also assist factories with health training. As an example, one brand provides a two-year-long program of free monthly trainings on topics such as general health, women's health and HIV/AIDS.

Child Care

Due to the lack of child care in the workplace and the high cost of child care close to the factory, most migrant workers leave their children in their home town. They are unable to perform parental duties and often see their children only once a year during the New Year holiday. Most migrant workers do not regard their jobs as long-term commitments and are prepared to return to their home towns when needed.

Self-Esteem and Empowerment

Women's education levels have improved over the past ten years, as has their self-esteem and sense of empowerment. Women workers desire more income, but they also wish to expand their horizons, gain more knowledge and win the respect of their peers. These desires are reflected in their requests for more **recreation facilities**, such as television rooms, sports facilities, libraries and computer rooms. Women workers also desire to learn more **work skills** that will allow them to take on more varied tasks. Factories are challenged to retain workers: a good working environment is no longer sufficient. Factory management needs to find new ways to satisfy the goals and aspirations of their women workers.

Many of the women workers interviewed said they seldom encountered or were bothered by **sexual harassment** at work, perhaps because most supervisors are also female. The definition of sexual harassment is unclear, so workers may not be able to identify incidents of sexual harassment. They also may not know how to seek assistance.

Who Pays for Health Services?

Basic health services for injuries or minor illnesses are provided at factory clinics free of charge. Few migrant workers are covered by health insurance, so most workers pay out-of-pocket for serious illnesses that require sustained treatment. Most workers do not approach a doctor until their illnesses have progressed to a serious stage.

Education and Prevention

The majority of factories do not provide or plan to provide health related training, particularly on women's reproductive health. High turn over rates, busy production schedules and the fact that most workers are young, unmarried and healthy contribute to factories' lack of motivation to provide preventive health programs.

When factories conduct trainings, either independently or in cooperation with government organizations, participation of workers is limited due to busy work schedules and the large number of workers. Trainings and activities often reach the supervisor level

only rather than the full body of workers. Because little training is offered and because worker education levels are low, workers typically do not understand the issues discussed. There is no system in place to track and measure training effectiveness.

Recommendations for Effective Health Programs

The following recommendations for brands and factories for designing an approach to women's health concerns are made based on the findings above and on review of the critical success factors for factory programs.

- **Factories should work closely with local government agencies and brand customers.** Factories should leverage the resources of local governments and brands, and they should actively partner with the health campaigns provided in their communities. Partnering with existing programs can help to address the obstacles of cost and lack of qualified staff.
- **Factories should change their mindset to regard women's health as their own responsibility.** Factories need to recognize the impact of worker health on productivity and business success. If the motivation for a change in mindset comes from within the factory, health programs are more likely to be successful. Factories should proactively improve working conditions, meet the nutritional requirements of workers and build workers' self-esteem and sense of empowerment. They should also provide training on occupational health and reproductive health, and ensure that personal protective equipment (PPE) is available and utilized.
- **Factories should be more proactive in sharing information and in providing onsite services.** Because information is essential to raising health awareness, information sharing and distribution must be encouraged. Brochures and posters on health related issues can be displayed in production, cafeteria and dormitory areas. Factory bulletins and newspapers are also good places to post health information.

Onsite services are also of great benefit to workers, who typically do not seek treatment until their health problems become serious. An onsite health service could be a clinic, or it could take the form of a partnership with a local hospital or Red Cross Center that provides training, examinations, diagnosis and treatment.

Factories should provide more **recreation facilities**, such as libraries, sports facilities and computer rooms. They should also ensure there are essential facilities such as lactation rooms and child care centers. Efforts to provide sufficient facilities can increase worker satisfaction and increase retention.

- **Factories should offer more frequent, regular health programs and encourage greater worker participation.** Production is still the most important concern for factories, and providing time for workers to attend health programs provides a challenge for most factory managers. Even when a factory partners with local government agencies to conduct onsite health trainings, the participation of workers is often less than 10 percent, and participants are mainly from the supervisor level. Health trainings and programs should be arranged regularly and information about the trainings distributed well ahead of time. Workers should be encouraged to attend, and trainings should be held at a time that is compatible with production schedules.

Detailed Reports of Site Visits

Dongguan, China

Factory Information

The factory is a toy making facility with over **8000 workers**, over 90 percent of whom are female. Turnover is high. Most workers live in the company-provided dormitory.

Recreation facilities include a television room, video room, library, gym, ping pong room, badminton and basketball courts, and a computer room. Women's basketball competitions, a women's dancing group, a health knowledge competition and a debate are held for workers. Annual "Excellent Worker" awards are given to workers who have performed well. A mid-autumn festival party and a Christmas party are held, and workers attend a short offsite retreat once a year. Female workers receive special dinner or meal allowances on Women's Day and Mother's Day.

A **Women's Labor Union** assists with organizing health-related training and activities. The factory works closely with local government agencies in organizing health activities. Its partnership with the local government has become a regional model, and the factory has received governmental recognition for its active participation.

Health Facilities and Issues

The facility has an **onsite clinic** with five doctors on staff that is open 24 hours a day and seven days a week. Consultations and medicines are provided for free. If an employee falls seriously ill, the company donates to cover the employee's medical costs.

In the summer, **herbal drinks** are provided to workers to ease the stress of hot weather.

Reproductive Health

Pregnant workers can obtain free health check-ups from the onsite clinic. The law requires that pregnant workers be exempted from night shifts only after the seventh

month, but the factory does not allow pregnant workers to work the night shift once factory management is apprised of their pregnancy.

HIV/AIDS

Workers are aware of HIV/AIDS and the methods by which it is spread. Free condoms are provided in the clinic, and workers are aware that the condoms are available.

Training

The factory works closely with **local government agencies**, such as the Guangdong Family Planning Office and ACFTU, to organize their training activities.

The factory distributes a variety of **brochures, posters and other written information**, much of it provided by the local government. Some brochures discuss protection from blood-borne pathogens, HIV/AIDS protection, avian flu and the five physiological stages of a woman's life (adolescence, marriage, pregnancy, menopause and post-menopause). Materials are distributed in each dormitory building where workers are free to take them. Posters on general hygiene and health issues are posted in training rooms and cafeterias, and on bulletin boards in the dormitory buildings.

The factory has its own **bi-monthly newspaper**, which features a special section on health education in each issue.

The factory has a training facility called the “**Female Workers' School**” which can accommodate 100 workers at one time. The School works closely with the local Women's Association, the Women's Union and the Labor Bureau to provide trainings twice a year covering health topics such as HIV/AIDS, contraception and family planning, and prevention of reproductive tract infections and sexually transmitted infections. The trainings also cover women's labor rights topics such as working hours, wages and sexual harassment. About 100 female workers participate in each training.

The factory's onsite doctors provide additional trainings for about 300 female workers per quarter.

Not all female workers are able to attend health-related trainings because of their large number and the factory's high turnover rate. All supervisor-level workers participate and are encouraged to educate workers during weekly meetings and daily interaction.

Seminars are held for workers on the difference “between urban life and rural life” and “how to be a modern employee.”

Responsibility and Impact

The factory has initiated many trainings because they feel responsible for the health of their female workers. They believe that healthy workers increase productivity.

Foshan City, China

Factory Information

The factory is a toy making facility with approximately 8000 workers, 75 percent of whom are female. Dormitory facilities are provided for the workers, as is a **computer room** that is well used. During the site visit, the computer room was almost fully occupied.

The facility also provides a preschool where female workers can send their children at lower than normal cost, making it a valued benefit to workers.

Health Facilities and Issues

There is a 24-hour clinic that provides free consultations and medicine to workers.

Factory management visits workers who have been hospitalized or have just given birth. Gifts worth RMB200 (US\$25.12 at US\$1=RMB 7.95) are given to hospitalized workers.

About 400 female workers participate in a special Women's Health Insurance Scheme that covers reproductive tract infections. Participants contribute RMB 10 per year (US\$1.25 at US\$1=RMB 7.95). This scheme was very well received by female workers.

Worker Communication

The company organizes a monthly meeting with 50 workers, chosen randomly by computer, to ascertain the problems of workers and brainstorm about potential solutions. Problems raised in the past include, but are not limited to: the quality of food in the cafeteria and the attitudes of supervisors.

Reproductive Health

Pregnant workers can obtain free health check-ups from the onsite clinic. The law requires that pregnant workers be exempted from night shifts only after the seventh month, but the factory does not allow pregnant workers to work the night shift once their pregnancy is revealed.

HIV/AIDS

Workers are aware of HIV/AIDS and the means by which it is spread. Free condoms are provided in the clinic, and workers are aware that condoms are available.

Training

The facility actively collaborates with local government agencies on women's health issues.

The factory distributes a variety of **brochures, posters and other written information**, much of it provided by the local government. Some brochures discuss protection from blood-borne pathogens, HIV/AIDS protection, avian flu and the five physiological stages of a woman's life (adolescence, marriage, pregnancy, menopause and post-menopause). Materials are distributed in each dormitory building where workers are free to take them. Posters on general hygiene and health issues are posted in training rooms and cafeterias, and on bulletin boards in the dormitory buildings.

The factory has a **training facility** with a capacity of 600 workers at one time. The training facility works closely with the local Women's Association, the Women's Union and the Labor Bureau to provide trainings covering health topics such as HIV/AIDS, contraception and family planning, and prevention of reproductive tract infections and sexually transmitted infections. The trainings also cover women's labor rights topics such as working hours, wages and sexual harassment. After each training, clinic doctors are available for onsite consultations.

Foshan City, China

Factory Information

The facility is a toy making facility with 4500 employees, 90 percent of whom are female. Of women factory workers, roughly half are married and all are on full-time contracts. Dormitory facilities are provided for workers.

Health Facilities

There is a 24-hour **clinic** that provides free consultations and medicine to workers. The cafeteria is focused on good nutrition and provides varied sets of meals from which workers can choose according to their tastes.

Reproductive Health

Pregnant workers can receive **free health check-ups** from the onsite clinic. The law requires that pregnant workers be exempted from night shifts only after the seventh month, but the factory does not allow pregnant workers to work the night shift once their pregnancy is revealed. Workers who are more than five months pregnant are given supplementary milk with meals and receive extra 30-minute breaks in the morning and afternoon.

Training

The facility actively collaborates with local government agencies on women's health issues.

The factory distributes a variety of **brochures, posters and other written information**, much of it provided by the local government. Some brochures discuss protection from blood-borne pathogens, HIV/AIDS protection, avian flu and the five physiological stages

of a woman's life (adolescence, marriage, pregnancy, menopause and post-menopause). Materials are distributed in each dormitory building where workers are free to take them. Posters on general hygiene and health issues are posted in training rooms and cafeterias, and on bulletin boards in the dormitory buildings.

The facility has offered **training** on women's hygiene and health care, including prevention of breast cancer and cancer of the uterus.

Newly hired workers are provided with training, including role play scenarios, on **sexual harassment** that instructs them on identifying harassment, reacting under different circumstances and reporting instances of harassment to supervisors and managers. Factory management believes that sexual harassment must be clearly understood and prevented so that the workforce, which is 90 percent female, will feel comfortable at work and so that there are no unhealthy workplace practices that can affect workers psychologically.

Textile Alliance Apparel, Dongguan, China

Factory Information

Textile Alliance Apparel is a relatively large apparel factory with 5100 workers. About 90 percent (4200 workers) of their workforce is composed of women aged 18–25 years, 33 percent of whom are married. Annual turnover is average at roughly eight to ten percent. Corporate social responsibility, or benefiting shareholders while also benefiting society and environment, is one of the company's five core values.

Health Facilities and Issues

There is a small onsite clinic that provides free consultations and medicines. The clinic has room for one bed, a desk and a medicine cabinet. Clinic staff reported during interviews that most workers see them with very minor ailments. Workers with serious medical concerns are referred to the local hospital. Half of the workers are covered by medical insurance, while the rest are covered by accident insurance that does not cover illnesses.

Reproductive Health

Pregnant workers can register at the onsite clinic. The primary reproductive health complaint workers raise at the clinic is menstrual cramps.

HIV/AIDS

HIV/AIDS is included in an annual training conducted by the local government's Family Planning Office. Married women are more aware than unmarried women of HIV/AIDS and its methods of transmission.

Training

The factory **trains newly hired workers** on factory policies, rules, customers' requirements, quality, safety and first aid, but there is less focus on training for women's health issues and HIV/AIDS.

The local government's **Family Planning Office** conducts trainings on women's general health, family planning and HIV/AIDS prevention annually. About 500 to 600 workers attend this training.

Factory management stated that they use a character from a popular **television** show (Da Chang Jing) to promote the female spirit of independence, strength and ability to persevere. The character was chosen because factory management felt it would resonate with the 90 percent of female workers that are between the ages of 18 and 25. The character's message is spread through bulletin boards and the factory newspaper.

The company does not have a method in place to measure the impact and effectiveness of trainings conducted.

Interviews with Workers

Four workers were interviewed at this factory.

Two workers of those interviewed were 5-7 months pregnant and just under 30 years of age. One of these women lived in the dorms with her husband, while the other lived offsite. Both were somewhat concerned about their nutrition during pregnancy, and both bought milk to supplement their diets. One worker had worked at Textile Alliance Apparel for three years, and the other had worked there for six years. Both experienced morning sickness during the first trimester but were able to work around it. Both registered at the medical clinic when they became pregnant. They confirmed that they are not required to work overtime after seven months of pregnancy. One worker was a floor manager who earned between RMB 1700-1800 per month (US\$214-\$226 at US\$1=RMB7.95), and the second worker was a line worker earning RMB 1300-1400 per month (US\$163-\$176 at US\$1=RMB7.95). The factory had a library, but the library did not have any books on pregnancy in its collection. The two workers have access to the internet for researching health issues, but they stated there is typically a long line to use a computer in the computer room. They do not have insurance to cover the costs of childbirth and cannot use the free clinic for delivery since the clinic focuses on treating injuries such as machine burns and cut fingers. Only one of the women could accurately answer questions about AIDS and how it can be transmitted. Both women stated that they had learned about AIDS someplace outside of work. Only one of the two women said that she reads the posters and flyers that the factory puts up on women's health. Both women plan to return to the factory to work after they give birth to their children. Both women believe that there are some women who become pregnant before marriage, but neither of them had any further information on the topic.

Two of the workers interviewed were not pregnant and had been at the factory for less than a year: one had joined in February 2006, and the other had joined in December 2005. One worker was 18 years old, and the other was 22 years old. The 22-year-old worker, born in Anhui, married this year after coming to the factory to work. She was not required to have a health check before marriage. She was given three days of marriage leave and chose to take 15 days of unpaid leave as well. The 18-year-old worker is neither married nor involved with someone, though she reported that some of her colleagues have boyfriends that they met through family or friends, but not through their jobs at the factory. Both of these women were asked if male workers receive a disproportionate amount of attention from female colleagues because of the high female to male ratio, but both replied that they did not. Both of these women work for eight to nine hours per day and make about 1,100 RMB a month (US\$138 at US\$1= RMB7.95). Both workers live in the dormitories; they reported traveling in groups and staying close to the factory in order to ensure their safety. The dormitories have a 10:30 pm curfew. Both workers felt that sexual harassment was not an issue in or around the factory; they agreed that the major crime that happens on the premises is mobile phone theft. They believe that there may be some women who get pregnant before marriage, but neither of them had any further information on the topic. Both reported frustrations at work, particularly wishing that they could understand new tasks faster. Both reported having a specialty in the production process. One worker did not know about HIV/AIDS. The other worker knew of the existence of HIV/AIDS but suggested that it is transmitted through eating with a person who is infected.

Foxconn, Shenzhen, China

Factory Information

Foxconn is one of the largest information technology factories in China, contributing one-fourth of China's technology exports. The factory has a total workforce of 232,000, 46.5 percent of whom are female. Only 6 percent of factory employees are married. The Foxconn facility provides nine clinics and a sports center, as well as a number of libraries, gymnasiums, television rooms and training rooms.

There are ten business districts in the factory compound, each employing between 10,000–50,000 workers. Each district has its own product lines and clients, and its own human resources (HR), legal and finance teams. Central HR, legal and finance departments coordinate with the teams in each business district to provide shared services.

Health Facilities and Issues

A government hospital, the Shenzhen No. 2 People's Hospital, is located inside the factory compound. The hospital has approximately 50 doctors and nurses organized into departments of internal medicine, surgery, gynecology and emergency care.

At Foxconn, health issues are managed by the Health Department, a division within the central human resources (HR) department that coordinates with the HR teams in each business district.

The incidence of SARS has encouraged development of health programs at the factory. Emergency plans were put in place to address the spread of contagious diseases. Foxconn routinely disinfects the production floor each month to prevent the spread of diseases. A worker recently contracted measles, and in response the facility was disinfected three times a week to ensure containment. The factory has also set up arrangements for quarantining sick workers.

Reproductive Health

The names, work positions, pregnancy dates and expected dates of childbirth for pregnant workers are recorded. Pregnant workers' positions are evaluated for suitability according to legal requirements, and less hazardous positions are assigned when necessary. Pregnant workers are not required to work over time and cannot work during the night shift when they reach seven months. The factory provides free health check-ups for pregnant workers, as well as two lactation rooms for workers who are nursing.

HIV/AIDS

Workers are free to attend a weekly video screening on HIV/AIDS in the health education room. HIV/AIDS is also covered in other health trainings, described below.

Nutrition

A manager at one of the larger cafeterias stated that the cafeteria offers a certain number of meat dishes, vegetable dishes and soups at each meal, and it manages its offerings based on worker preferences and dietary needs.

Training

Printed materials on topics such as hygiene during menstruation, pregnancy tests, nutrition, psychological issues, skin care, reproductive tract infections, family planning and HIV/AIDS are posted on the bulletin boards on the production floor and in female dormitories.

Trainings by the local Family Planning Office are offered once every quarter, and the factory's onsite doctors conduct monthly trainings on topics such as female physiology, family planning methods, pregnancy and post-natal health care.

Since 2003, the factory has organized an annual event entitled "Women Care, Celebrate March 8—Women's Day." The factory invites local family planning officials to deliver lectures on women's health, provide free consultations, conduct special sports games and carry out pre-natal tests. The event has been well received by female workers, though only 20,000 workers in total have participated in the three years the event has been organized.

Responsibility and Impact

There is no measure of the impact the factory's health programs make on productivity, absenteeism, illness rates or other factors.

However, Foxconn strongly believes that a good environment can increase productivity, and that basic knowledge and good health are important for female workers to work well and be productive. The number of female workers is increasing, so the factory plans to cultivate master trainers to establish a larger-scale women's reproductive health training that will reach more female workers. Production and training time provide a substantial challenge to establishing a larger-scale training, as does the fact that health awareness and thus responsiveness to new programs is low among workers.

Zhong Shan Jazzing Knitting

Zhong Shan Jazzing Knitting is an apparel manufacturing company in the Pearl River Delta with a workforce of approximately 1000 (typical of a mid-sized facility). Approximately 63 percent of the workforce is female; 20-30 percent of the workforce is married. All employees have full-time contracts. There is no clinic or medical staff onsite.

The factory does not have its own health training program in place, but a brand that sources from the factory has offered monthly health trainings for the factory's workers since 2003. These trainings are conducted by Verite, a local NGO, and they will continue for two more years. For example, six trainings for 100 participants have been held on general health, women's health, personal hygiene and HIV/AIDS.

The company asks workers to attend a yearly lecture on family planning held by the local Family Planning Office.

Guangzhou Excellent Jade

Excellent Jade is a manufacturing facility with roughly 2,200 workers, 70 percent of whom are female. Roughly half are married. The factory has not conducted any women's health trainings onsite, though some workers were sent to participate in a lecture on health offered by the local Red Cross Center at end of 2005. The factory does have a clinic and doctor onsite.

Factory management expressed in interviews that there is insufficient time to organize trainings and that female workers are reluctant to discuss reproductive health publicly. In lieu of conducting trainings, factory management encourages workers to consult with the onsite doctor about reproductive health concerns.

The factory does not provide a cafeteria or dormitory. Health-related printed materials, such as posters on HIV/AIDS, were not visible on the bulletin boards during the site visit; the bulletin boards contained only production charts and sample drawings.

IV. India

Context

Country Health Situation

India is home to one-fifth of the world's population and faces challenges in providing its residents with basic health care, clean drinking water, sanitation, roads, electricity and education. It possesses the world's tenth largest economy⁷, with a Gross Domestic Product (GDP) that is expected to grow by 6.5-7 percent by the end of 2006. However, its economic gains are offset by its huge population, as well as extreme disparities in income, serious regional differences and vast gaps in infrastructure and services between urban and rural areas.

The information technology, telecommunications, business process outsourcing and manufacturing (apparel and consumer goods) sectors have grown at strong rates in recent years, and this has contributed to an expanding middle class with growing spending power. Still reducing poverty remains India's greatest challenge, with an estimated 390 million out of a total population of 1.1 billion living on less than \$1/day.⁸ Progress has been made in basic social indicators such as birth rate, literacy and enrollment in primary school. The birth rate is down to three children per woman from six children per woman in the 1960s. Enrollment in primary school reached 82 percent in 2005 from 68 percent in 1992. Male adult literacy has increased to 68 percent from 62 percent in 1990, and female adult literacy has increased to 45 percent from 36 percent in 1990⁹. However, infant mortality, maternal mortality, malnutrition and access to trained medical staff still remain far from adequate, as the following table illustrates.

India: Health Statistics		
Name	Indicator	Year
Population ¹	1.1 billion	2005
Life expectancy at birth (male) ¹	61 years	2004
Life expectancy at birth (female) ¹	63 years	2004
Population with sustainable access to improved sanitation (percentage of population) ²	30%	
Population with sustainable access to an improved water source (percentage of)	86%	2002

⁷ *India Country Brief*, World Bank, July 2005

⁸ Ibid.

⁹ Ibid.

population) ²		
Percentage of births attended by skilled attendant ¹	42.5%	2000
Maternal mortality ratio adjusted (per 100,000 live births) ²	540	2000
Infant mortality rate ²	63 (per 1,000 live births)	2003
Prevalence of HIV, total (of population ages 15 - 49) ¹	0.4% to 1.3%, (2,200,000 to 7,600,000 persons)	2003
Contraceptive prevalence rate ¹	48.2% (married women aged 15-49)	1999
Male-female ratio of AIDS cases ¹	5.1	2005
Doctors ¹	6 (per 10,000 pop.)	2005
Nurses ¹	8 (per 10,000 pop.)	2005
Midwives ¹	4.7 (per 10,000 pop.)	2004
Community Health Workers ¹	0.5 (per 10,000 pop.)	2004
Other Health Workers ¹	7.6 (per 10,000 pop.)	2005
Dentists ¹	0.6 (per 10,000 pop.)	2004
Population undernourished (% of total) ²	21%	2000-2002
Children underweight for age (% below 5) ²	47%	1995-2003
Estimated incidence of tuberculosis cases ¹	168 (per 100,000 pop./year)	2004

Sources: 1 - *World Health Report 2006 – Working Together for Health*. World Health Organization, Geneva. 2 - *United Nations Human Development Report*. 2005. United Nations, New York.

India leads the world in new tuberculosis cases annually (168 per 100,000 population per year). According to UNAIDS, 5.7 million people are living with HIV/AIDS in India; this represents 13 percent of global prevalence, second only to South Africa. Because of India's large population, even a small increase in prevalence can greatly increase the global burden of the disease. Six Indian states are thought to have prevalence rates of over one percent: Karnataka, Tamilnadu, Maharashtra, Andhra Pradesh, Manipur and Nagaland. This project visited factories in Karnataka (Bangalore) and Tamilnadu (Chennai).

Government and Legal Context

In the 1950s, the Indian government began establishing a network of primary health care centers, sub-centers and community centers in rural and urban areas. The network now reaches each area of the country, but health facilities are poorly staffed and ill equipped. A strong bias towards population control and limited concern about preventive care guided the network through its establishment.

The government's reproductive health policy focuses on safe motherhood, child survival, access to contraceptives, prevention and treatment of reproductive tract infections and sexually transmitted diseases (especially HIV/AIDS), screening and treatment of cancers (uterine, breast and cervical), effective nutrition among vulnerable groups, prevention and treatment of gynecological problems and services for adolescents. The government's general health policy focuses on elimination of communicable diseases such as malaria, tuberculosis, leprosy and HIV/AIDS and treating non-communicable diseases such as blindness, cancer, diabetes, iodine deficiency and mental health problems.

Total expenditure on health as a percentage of GDP was 4.8 percent in 2003.¹⁰ Of this total, only 24.8 percent was government expenditure, with the remaining 75.2 percent being private expenditure.¹¹ This level of private spending is one of the highest in the world and reflects the poor quality and inadequacy of government health facilities. About 97 percent of private expenditure on health comes from out-of-pocket expenses paid by those who can least afford it. Poor families often go into debt to cover medical expenses. The per capita expenditure on health at international \$ rate is \$82.12.

The following benefits are provided to workers as required by law:

- **Social Security and Health Insurance:** Workers earning less than Rs. 7500 per month (US\$163 at US\$1 = Rs. 46) receive Employee State Insurance (ESI), a government-run social security and health insurance program¹³. ESI contributions are made at the rates of 1.75 percent of wages from the employee and 4.75 percent of wages from the employer. Benefits provided by ESI include sickness and maternity leave, and access to a network of ESI Hospitals and Dispensaries that provide free treatment. ESI is applicable only to the organized sector, and it provides benefits to about 30 million workers, of which only about 1.3 million are women.¹⁴
- **Maternity leave** of 12 weeks can be taken either before or after delivery. Pregnant workers can request to be exempted from arduous or standing work for the month prior to six weeks from their due date. Discrimination against pregnant women and dismissal during pregnancy are prohibited.¹⁵ Pregnant workers are prohibited from taking up hazardous work¹⁶. Female workers cannot work between 10 pm and 5 am.
- A factory with more than 30 women workers must provide a functioning **child care center** with a trained attendant for children up to six years of age. The attendant is responsible for keeping the child care center clean and sanitary.¹⁷

¹⁰ Core Health Indicators, World Health Organization Statistical Information System, WHOSIS 2006. Data from 2003.

¹¹ Ibid.

¹² Ibid. The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries.

¹³ <http://esic.nic.in>

¹⁴ From website of Employee's State Insurance Corporation <http://esic.nic.in>

¹⁵ Maternity Benefits Act, 1961

¹⁶ Factories Act, 1948

¹⁷ Factories Act, 1948

- Women who have infant children in the child care center must be allowed two breaks of 15 minutes each for **breast-feeding** in addition to regular breaks.¹⁸
- There should be at least one **first aid box** for every 150 workers. Personnel trained in first aid should be available during all working hours.¹⁹
- Factories with more than 500 workers must have an **ambulance room** with full-time trained medical staff.²⁰
- Factories with more than 500 workers must have a **Welfare Officer**.²¹
- A factory with more than 150 workers should provide a separate **lunch room** for workers to partake of meals.²²
- On **sexual harassment**, a Supreme Court ruling states that all companies must have a policy on sexual harassment, a grievance procedure involving a sexual harassment committee and training for all employees on the policy and the procedure.²³

Cultural Context

The majority religion in India is Hinduism (80 percent), while Muslims make up about 14 percent of the population and the remaining 6 percent includes Sikhs, Christians and other religious groups. There are 23 recognized official languages, several other languages that are widely spoken and over 2000 dialects. Separatist movements have simmered since the country gained independence from Britain in 1947, and religious and ethnic conflict frequently strike the largest Indian cities and centers of industry.

Women have traditionally been subservient to men and worked in household and agricultural labor, with little access to education or the public sphere. As migrant laborers began to leave rural areas for the cities in search of work, women also began seeking jobs outside of the home to supplement family income. A family with both sons and daughters would usually spend scarce income to educate the son and send their daughters to work. Factories with a majority of women workers exist mostly in the south, where it is now accepted that women work outside of the home. In north India, which is still extremely conservative, women do not generally work outside of the home. Most workers in manufacturing facilities in the north are male migrants from poorer states in eastern India, such as Bihar, Orissa and West Bengal.

Women workers may leave their homes to take jobs in the cities and stay in rented housing far from their parents' home, but this does not indicate that they are empowered or able to make independent decisions. Often, working women stay with relatives in the city or with others from the same village. They rely on their parents or other family members to make decisions for them such as which jobs are suitable or who they should marry. Most of their savings are sent home with little kept for personal expenses. Their

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

²³ *Visaka vs. State of Rajasthan*

education level is generally up to 10 years of schooling, and they may be the first generation of women to work outside of the home. Even after marriage, women may have responsibility for their homes, jobs and children but have very little decision-making power.

Indian society is very conservative, and single women and men are not expected to be sexually active, regardless of their religion or language group. This expectation makes it difficult to discuss reproductive health, sexually transmitted diseases, HIV/AIDS and contraception with single workers and often leads to misinformation and confusion. Among married women, there is a willingness to discuss reproductive health and contraception because of the Indian government's historical focus on family planning. Most women in the cities choose to have a tubectomy operation after the birth of their second child. Intra-uterine devices are a popular method of contraception for those who want to delay having a second child and are easily available free of charge at primary health centers. Generally women do not use contraceptives prior to their first conception, and they often conceive soon after marriage. Condom use among men is low, though condoms are available at drug stores and primary health centers. Condoms or other contraceptives are generally not made available at the workplace, though medical staff at a workplace facility will give contraceptive advice and information when asked by workers.

Research and Findings

Methodology

The study examined five factories and one community-based project in India to discover the most relevant health issues for women workers and examine how women's health concerns are being addressed in their workplaces and in their communities. Of the six sites, four had been previously visited in 2001–2002 during BSR's earlier study on Women's Health in the Global Supply Chain; during the same time period, a different facility of a fifth company was also previously visited. Impacts and progress since the previous visits are recorded in the Detailed Reports of Site Visits. Field research was supplemented by a review of institutional reports on India and other research on issues affecting women workers in Indian factories. We also reviewed Indian labor laws and Web sites for government agencies and NGOs, the latter of which are listed in the Resource Appendix.

The sites visited for this research are located in three of India's largest cities: Delhi, Bangalore and Chennai.

- **Delhi** is the capital of India and has a population of 14 million. It is both the political capital and a center of manufacturing and information technology, along with neighboring satellite towns. Some of the poorest states in India surround it, and migrant laborers who are mostly male pour in from these

neighboring states, including Rajasthan, Uttar Pradesh, Bihar, Jharkand and West Bengal to the further east.

- **Bangalore**, with a population of seven million, is popularly known as India's "Silicon Valley" because it is home to many leading information technology, business process outsourcing and bio-technology companies. It is also a leading center for apparel production, along with Chennai and Delhi. Most of the workers in this region are female migrants from poorer parts of Karnataka, the state that Bangalore is located in, as well as the neighboring state of Tamilnadu.
- **Chennai**, with a population of 6.5 million, is a major center of heavy manufacturing, information technology, business process outsourcing and apparel production. Most of the workers in the apparel industry here are women from Chennai and surrounding areas of the state of Tamilnadu.

Prior to the factory visits, a questionnaire was sent to each site to collect information about the programs available to address women workers' health. Some respondents filled out the questionnaire during the onsite visit.

Representatives from brands that sourced from the factories visited were present during some site visits.

Site visits lasted from a half day to a full day and included:

- 1) Discussions with factory management on health programs and policies. Interviewees included but were not limited to general managers, human resources managers, health and safety managers, welfare officers, counselors, consultants, doctors, nurses, other relevant medical and management personnel and representatives from quality and production departments.
- 2) Factory walk-throughs to observe production processes, as well as observance of safety measures including use of personal protective equipment by workers. Visits were also paid to cafeterias, dormitories, recreation facilities, waste-water plants and other facilities at each factory.
- 3) Visits to clinics and infirmaries, discussions with medical personnel and sample reviews of medical records, where maintained.
- 4) Visits to affiliated medical facilities, such as offsite clinics established by the factory for workers and the local community, often in collaboration with an NGO.
- 5) Where time permitted, health and other facilities (including clinics and child care centers) provided by the local government, industry association or private providers were visited for comparison with factory-provided facilities.
- 6) Interviews with workers and union representatives, where relevant. Interviewed workers were mostly women from all age groups. Pregnant workers were interviewed if present. Interviews were conducted in local languages by the researchers without the use of a translator. The interviews were conducted in settings such as the clinic, the child care

center or a conference room. In some cases representatives of management were present. The goal of the worker interviews was to determine the extent of worker access to health facilities and worker understanding of health issues such as HIV/AIDS, as well as identifying needs that were not being filled. Information gathered was not verified with company records or discussed with management. The interviews are produced verbatim in the Detailed Reports of Site Visits, though some names of people and places may not be accurate. Interviewees were selected to represent the typical age, level of education and marital status of workers at each factory, as well as typical understanding of reproductive health issues and access to services. A total of 22 factory workers and 12 women in the community project were interviewed.

Except for a sample review of one or two medical records or injury log books, no extensive record review was carried out.

Printed information from the factory was collected where relevant and included annual reports, newsletters, posters, reports and presentations on health, blank medical record forms, blank referral letters, employee handbooks and copies of collective labor agreements.

Projects Covered

The five factories visited were engaged in apparel manufacturing and ranged in total size from 40,000 workers (spread through 40 factories) to 3600 workers (spread through three factories). The five factories visited ranged in size from 1150 to 2000 workers. The Detailed Descriptions of Site Visits report on company wide facilities and services. Of the factories visited, four are located in Bangalore and one in Chennai. All of the factories have more than 80 percent female workers in the age group of 18–45, with an average age of 25. An estimated 50 percent of the female workers are married. The average level of education is 10 years of schooling, but among older workers, who are more skilled, the average level could be as low as the 5th grade level.

The community project works in an area in Delhi with 25,000 residents.

Key Findings

Health Facilities

The onsite health facilities of factories visited can be divided into three types:

- 1) Factories that only provide **diagnostic and referral services**, with **minimal medication** given to provide symptomatic relief. Antibiotics and tetanus injections are not given, for example, and workers are referred to the nearest private or ESI hospital in case of sickness or injury. The factories surveyed provided at minimum a part-time doctor, though some provided a team of doctors that rotate between different factories of the same company. A full-time

nurse is required by law for factories with over 500 workers. Medical records are usually maintained in sickness log books; individual medical records are not maintained.

- 2) Some factory clinics provide **diagnostic, referral and early treatment** services, including antibiotics in case of illness. They also provide basic suturing and tetanus injections in case of cuts or other injuries. Medical records are maintained for all workers who visit these clinics. Medical providers provide patients with prescriptions for medicine and appropriate tests that must be scheduled at either ESI or private hospitals. The medical providers can also discuss with treatment options when workers return with test results.
- 3) Other clinics are able to provide a full range of **preventive, diagnostic, referral and treatment** services. The five factories visited offer several examples of best practice. One of the factories provides a welfare center with a central child care center, and a health center with a general physician, a pediatrician, a gastric specialist, a general gynecologist, a senior gynecologist and an ENT specialist. All of these doctors are available two to three times a week. In addition to basic laboratory facilities that can perform blood and urine testing, a pharmacy is available and sells medicines at cost. Individual medical records are maintained. Two of the five factories surveyed provide annual health check-ups, including checks for specific occupational hazards. Results from annual health check-ups are used to identify areas for treatment and preventive activities.

Improving Access to and Quality of the Government Health Care System

One of the factories has made a considerable effort to improve its workers' access to the **government ESI system**. Most medical care providers and workers deride the ESI clinics for being poorly equipped and staffed, but the four designated **medical officers** of this factory, which has approximately 11,000 workers, work through the ESI system to ensure that their workers receive good service. Every worker sent to ESI is given a detailed **referral letter** explaining the nature of illness and next steps. A medical officer also visits the ESI dispensary or hospital to talk with specific doctors about treatment options. If the worker needs a level of treatment that is not available, the medical officer takes the worker to the next level of hospital within the ESI system. The factory has at times paid for treatment of a worker in a private hospital and later requested **reimbursement from ESI**; this strategy has worked well for serious illnesses and emergencies. The factory reports that workers take less leave now when they visit the ESI hospital because they are treated more quickly. The factory also has a pediatrician from ESI provide **free check-ups** to workers' children at the company child care center. The factory's efforts with ESI are successful because it has dedicated personnel to work with the ESI hospitals and because the factory is willing to intervene **financially** when needed and apply for reimbursement. By law, factories are not exempt from making ESI contributions if they provide alternative health services.

Common Illnesses

The most common illnesses among workers are **upper respiratory tract infections** (coughs and colds), **anemia** (also common in general population), **gastritis** and **bronchitis**. **Tuberculosis** is also a serious health issue in India, the country with the highest number of new cases per year at 168 per 100,000 population; considerable numbers of tuberculosis cases are reported in the factories visited for this study. Factory medical providers attribute the prevalence of bronchitis to the high incidence of fibers workers breathe in apparel factories. Medical providers attribute gastritis to worker eating habits, including skipping breakfasts, taking long breaks between meals, consuming starch-filled foods without enough green vegetables and not drinking enough water. Women workers are especially afflicted by anemia and gastritis. Other less common ailments included **dehydration** and **arthritis**.

Common reproductive health concerns include **dysmenorrhea** and **reproductive tract infections** such as **white discharge**, or leucorrhea, which is estimated to affect as many as 70 percent of married women in one of the projects visited. The causes of these ailments vary, but **lack of personal hygiene** is a common reason given by health care providers. Problems with **menstruation**, including irregular periods or excessive bleeding and pain, are also commonly cited. Most women in factories still use cloth products for menstrual protection, but factories are encouraging them to use sanitary napkins by selling them in the clinics. The cloths used by female workers are often scraps retrieved from the factory floor.

Care during Pregnancy

Four of the five factories surveyed provided **monthly check-ups** in the factory clinic to workers during pregnancy. Two of the factories make these check-ups mandatory. All four factories maintain **ante-natal cards**, though some are more detailed than others. In one of the five factories, pregnant workers are required to move to **lighter work**, while in the other four, pregnant workers can request a move to seated work. None of the factories provided **uniforms** or other means of identifying pregnant workers, likely because workers in India generally do not wear uniforms. Two factories provide **iron**, **calcium** and **folic acid** tablets to pregnant women, and another factory provides these tablets to pregnant women and also to any others who need them, including menopausal and anemic women. In one of the three companies that provide iron, calcium and folic acid tablets, the supplements are only provided in the company-wide clinic and not in individual factory clinics.

The community project also provides a monthly check-up, ante-natal cards and iron, calcium and folic acid tablets to pregnant women.

Family Planning

All of the five factories surveyed provided advice on **contraceptives**. Two of the five factories obtain free contraceptives, including IUDs and contraceptive pills, from the government Primary Health Center that they can then provide to workers. Neither of

these two clinics has condoms available, but workers do not ask for them. A factory gynecologist inserts IUDs on patients' requests.

HIV/AIDS

One of the five factories reported three instances of **HIV/AIDS** among workers out of a total worker population of 11,000. Only welfare officers and medical officers were aware of the HIV status of these workers; the information was not shared with other factory workers, staff or management. The welfare officers and medical officers took the workers to local NGOs for pre-test counseling, testing and post-test counseling. One worker was shifted to packing from ironing. All three HIV positive workers were not yet in need of anti-retroviral treatment. A medical provider in a second factory said she suspected that there were four or five male workers and one female worker who were HIV positive, but she has not followed up with them or heard more from them. A welfare officer with this second factory also suspects that there may be two workers with HIV/AIDS in this factory.

With regards to **education on HIV/AIDS**, four of the five factories held annual awareness activities on World AIDS Day (December 1st) in collaboration with local NGOs. One of the factories was considering training for caregivers to limit the spread of HIV/AIDS through needle pricks and similar means. Medical providers reported that very few workers inquire about HIV/AIDS.

When questioned about HIV/AIDS, most **workers** had heard of the disease. Most workers knew that HIV/AIDS can be sexually transmitted but knew of no other transmission methods.

Child Care

Factories with more than 50 women workers are required by law to provide **child care centers** with a trained attendant for workers' children less than six years of age. All of the factories had child care centers, though one factory's child care center was not being utilized. Three of the factories had used their child care centers to **access mothers** and provide **training on proper nutrition**. All of the child care centers provide **supplemental food**, and one of the child care centers provides meals and snacks. Three of the five child care centers provide **medical check-ups** for children, and one of the child care centers also provides immunization. All of the child care centers encourage breast-feeding and use of tumblers rather than bottles. Child care services are free at all factories except for the factory where the child care center is combined with the welfare center; this latter service charges a nominal fee.

Who Pays for Health Services?

Services are provided for **free** in four of the factory clinics. The factory that has a welfare center charges a nominal fee for consultations in the belief that workers will value services more if there is a cost. One factory without extensive medical facilities pays for the first visit of its workers to a **local private clinic for follow-up care**. The five

factories make ESI contributions, and service in ESI hospitals is free for covered workers. The five factories pay for treatment of **medical emergencies** that occur at work. Four factories also pay for emergencies that occur outside of work, such as heart attacks, but this happens on an ad hoc basis and outside of a consistent policy. Most workers go to **private clinics for emergency medical care or for minor ailments** and to the **ESI for planned medical procedures**, such as child birth or treatment of chronic illnesses.

Education and Prevention

Education and awareness raising activities include:

- 1) **Train-the-trainer programs**, in which a small group of workers are trained on specific health issues, including reproductive health, self esteem, HIV/AIDS and nutrition. This small group then trains larger groups of workers. Train-the-trainer programs are in place at three of the five factories. However, it can be difficult to take time from production to organize trainings. Individual interactions between trained workers and others have been more effective in disseminating information And at the factories and at the community project.
- 2) Trainings are conducted by the **company doctor, nurse or welfare officer**, or by an **invited NGO or hospital**. These trainings are easier to organize since they typically target a specific group, such as pregnant workers or mothers of children in the child care center, but time pressure remains an issue. All five factories provide these trainings. Training topics include basic health topics such as nutrition, hygiene and reproductive health, as well as self esteem, ergonomics, cancer detection, stress release, behavior for supervisors and “soft skills,” such as communication and public speaking.
- 3) **Health “camps”** seek to highlight a particular health issue through various means over a set period, usually one day. Highlighted issues have included HIV/AIDS awareness on World AIDS Day (December 1st), eye and vision awareness, blood donation, diabetes and ENT camps.

The majority of trainings, regardless of the type, are held during working hours at times of low production. Some trainings are held towards the end of the day so that part of the training is during paid time and part occurs after the end of the work day. Factories have used classroom style sessions as well as custom made audio programs recorded in a professional studio, and films and posters to disseminate information.

Mandatory training on first aid, fire safety and job safety are provided periodically to workers, as required by law or by brands. Four factories hold induction trainings for new workers that covers health and safety issues.

Worker Communication

Factories that used varying means to communicate with workers generally had a better chance of making improvements on worker health. In the Indian context where women workers are hesitant to broach issues of reproductive health, **access to trustworthy individuals** made women workers more amenable to receiving and acting on

reproductive health information. A trusted individual could be a **welfare officer, medical officer, nurse, doctor, internal trainer from a train-the-trainer program, counselor** or **human resources manager**. Women workers valued receiving expert information, but receiving it from a known and trusted source was more likely to affect their behavior than more distanced sources such as films or external experts. Community members at the community project also expressed that they valued the **counseling** they received more than they valued the diagnosis or treatment. They also valued being spoken to **politely** and given the information they requested.

Impact

Three of the five factories stated that health programs had a **positive impact on absenteeism**, while two companies felt that absenteeism had not been reduced. One factory felt that emphasis on health and safety had contributed to reduced injuries. Factories cited the needs to **build loyalty among workers, retain workers** and **practice moral responsibility** over improving productivity as reasons for making health and safety efforts. Factories did not feel that health programs had an impact on productivity apart from reduced absenteeism and turnover.

Recommendations for Effective Health Programs

The following recommendations for brands and factories for designing an approach to women's health concerns are made based on the findings above and on review of the critical success factors for factory programs:

- **Factory clinics should focus their efforts on primary and basic medical interventions.** Primary and basic medical interventions are more effective in the factory setting than in specialized care because workers generally seek treatment from a private or ESI hospital when faced with more serious medical conditions.
- **Surveillance activities, such as annual health check-ups, must be conducted for all workers, along with tests for specific occupational hazards.**
- **Health care facilities must be located at a short physical distance from the factory, and workers must be allowed to leave the production line to visit health care facilities.** If a clinic is located far from the factory, workers are reluctant to take the extra time to go to the clinic, even if transportation is provided. Workers are less inclined to visit the clinic if the line supervisor or production manager is not amenable to allowing them time for clinic visits.
- **Factories with an integrated approach to women's health generally see more effective results.** Women workers are concerned about the welfare of their children, husbands and other family members, thus a factory that provides transport facilities, child care and advice on proper nutrition will see a greater

improvement in health than factories that only provide diagnostic and treatment services, however advanced they may be. Child care centers have also proved to be a useful access point for educating women workers about their own health.

- **Counseling and support systems should be provided.** Women workers value being able to talk to someone about personal problems that may include domestic violence, alcoholic husbands, concerns about children's education or financial worries. They are more likely to raise troubling issues on reproductive health and seek advice and treatment when they know an individual or group that they trust.
- **Coordination between different functions within the factory is important in ensuring improvements to health.** Clinics and medical service providers cannot function in isolation. There must be periodic and systematic coordination and sharing of information between medical service providers, human resources, production, cafeteria management, dormitory staff and senior management. For example, deficiencies in nutrition can be reduced through sharing of information between doctors and cafeteria management, or if workers are dehydrated, line supervisors and production managers must be informed that workers need to drink more water during the work day. All departments must be made aware of the importance of worker health and access to health facilities.
- **Worker training on health issues requires long-term commitment from factory management.** While it is relatively easy to initiate a train-the-trainer program or invite an external expert organization to provide training, ensuring that workers know about and attend the training in sufficient numbers is more difficult. Good training attendance requires sustained efforts from management to keep workers informed about the training and encourage workers to make time to attend.
- **In the Indian context, family planning is emphasized in public health campaigns; factories can offer more.** Contraceptives are available for free from primary health centers, and a few factories that are proactive in providing access to contraceptives have successfully included these free contraceptives in their services. Having a female doctor on the clinic staff for factories with majority women workers is also helpful.
- **Factories should emphasize nutrition more during trainings and individual counseling to improve worker health in the long-term.** Most ailments of workers, such as anemia and gastritis, stem from poor nutrition and eating habits.
- **Factories in India cannot be exempted from ESI payments that give workers access to ESI benefits and services, but factories can make efforts to**

successfully using the system and supporting workers through active interaction with ESI hospitals and management.

- **Maintaining individual medical records can guide management in forecasting worker needs and planning preventive activities.**
- **In addition to doctors and nurses, factories need dedicated personnel who can focus on planning, outreach and implementation of health programs.** Existing staff, such as doctors or welfare officers, may be able to take on these roles, but their additional responsibilities must be recognized and they must be given sufficient time to carry out activities.

Detailed Reports of Site Visits

Ambattur Clothing Company, Chennai, India

Factory Information

Ambattur Clothing Company (ACL) is a Chennai-based apparel manufacturing company with nine factories employing about 5000 workers. Eighty percent of the workers are women. The average worker age is 26, and the age range of workers is 18–45 years. Average worker education is middle to high school level, or 8–12 years of schooling. The factory has recently started to ask for a minimum of 12 years of schooling, or education at the higher secondary level. An estimated 50 percent of the workers are married.

The company also has a factory in Bahrain composed of mostly female Sri Lankan workers. This factory employs about 1000 workers and has an ambulance room with a doctor and a nurse.

A few of ACL's factories have recently been certified to Social Accountability 8000 (SA8000). One of the factories is in the process of being certified for Worldwide Responsible Apparel Production (WRAP), a consensus standard on social compliance promoted by the American Apparel Manufacturer's Association. The minimum wage in the area where this factory is located is Rs. 2222 per month (US\$48 at US\$1=Rs. 46).

Turnover at ACL is 3 percent, against an industry average in Chennai of 5 percent. The general manager of human resources feels that turnover is still quite high. Absenteeism is about 8–10 percent, which is normal for this industry. An attendance bonus is offered if workers take only one day off per month, and about 60 percent of workers receive this bonus. Workers are given a merit increase every year, and internal promotions are encouraged.

Factory buses drop workers close to their homes, and up to a distance of 10 kilometers from the factory.

Improvements and Impact since 2002

The factory was visited in 2002 as part of BSR's earlier project on Women's Health in the Global Supply Chain. It has since consolidated its operations so that all of its factories are in one location. The **number of workers has increased by 20 percent**, from 4400 workers in 2002 to 5500 workers in 2006. Over **80 percent of workers are women**, as before. The company has a **welfare center** with one of the most comprehensive health service programs provided in a factory setting in the apparel sector in India that includes visiting specialists, a laboratory and a pharmacy. Developments described in this section are detailed further in other sections of the description of this site visit.

The **child care center** continues to provide services. Interviewed workers valued the child care center and felt that it was one of the best benefits at the company. Workers reported that children who had visited the child care center behaved better when they joined school, and that school teachers had commented.

Every factory has an **internal trainer**, who is selected from among the workers and trained on health and safety, self-esteem and other aspects of worker well being. There is a weekly meeting of all the Internal Trainers of the company to discuss issues.

Following the success of the welfare center, ACL **invited two nearby factories to share the services of ACL's welfare center** with their workers, but these factories have chosen not to send their workers to the premises of ACL. ACL management is considering a **takeover of the local manufacturer's association's hospital and child care center** (Ambattur Industrial Estate Manufacturer's Association, or AIEMA) to share with other factories in the area. This proposal is under consideration by AIEMA and the government department that owns the land on which the AEIMA facility is located. The proposal is unique and indicates confidence on the part of the company that their health strategies have worked, which has led to a willingness to share their expertise.

Turnover at ACL is 3 percent, compared to an industry average in Chennai of 5 percent. The general manager of human resources feels that turnover is still high but attributes the reduction to the facilities provided to workers, including health facilities.

The company has been very successful in **integrating health, nutrition and educational goals into basic child care services**. The level of holistic care that children in the child care center receive ranks as industry best practice. The company has also been successful in securing the participation of mothers and fathers in actively improving the health of their children through better hygiene and nutrition, as well as internalizing better practices for themselves.

From worker interviews, however, it seemed that **single workers** benefited less from the welfare center. Single workers generally use basic health services and rarely see specialists. Workers mainly seek care for chronic ailments (such as anemia or gastritis) and minor illnesses such as coughs and colds. When they have a more serious medical condition, such as tuberculosis, they generally seek treatment from a private or ESI hospital.

Worker Communication

Each factory has an **internal trainer** selected from among the workers who is trained on health and safety, self esteem and other aspects of worker wellbeing. The internal trainer focuses full time on training and is removed from the factory floor. Every factory also has a **welfare officer**, as required by law. The largest factories have **human resource managers**. Workers are encouraged to approach management with any issues.

Kavila is the welfare officer at a factory with 2000 workers. She has been with the factory for 1.5 years and joined after completing her graduate education. Each day she performs a walk-through of the factory and is approached by workers with complaints. Most complaints relate to production problems, such as learning a difficult style. Kavila usually sorts issues out in the moment. Sometimes workers return after taking days off and discuss personal issues that caused them to take leave, such as marital abuse or domestic violence. The main health problems workers report are headache and back pain. Sometimes the husbands of female workers do not want their wives to work. Lunch is provided in the factory for Rs. 10/meal (US\$0.21 at US\$1=Rs. 46).

Mrs. Manimekalai is a full time internal trainer and has been with ACL for 24 years. She earns Rs. 10,160/month (US\$220 at US\$1=Rs. 46). The unit she works in has 1050 workers. She has undergone three months of training in fire fighting and first aid as well as one week of behavioral training. She has also completed two months of human resources training. Every Friday there is a meeting of all the internal trainers of the company to discuss issues.

Health Facilities and Issues

ACL has built a **welfare center** with a child care center, a full-time doctor, visiting specialists, nurses, a pharmacy and a laboratory. Visiting specialists include a pediatrician, a gastric specialist, a general physician, a senior gynecologist and an ENT specialist. The visiting specialists are available two to three times a week. Patients are referred to nearby hospitals as necessary. If an illness is occupational, the factory pays for treatment.

The welfare center requires an **annual registration fee** of Rs. 2 per worker (approximately US\$0.04 at US\$1=Rs. 46) and charges a fee of Rs. 2 for each consultation with a general physician and Rs. 10 (US\$0.21 at US\$1=Rs. 46) for each consultation with a specialist. Laboratory services and medicines are provided at cost. Management believes workers will value the service more if they must pay for it. A general physician is available full time to workers from 9:00 am to 5:00 pm, during the

same hours the factory is open. The welfare center handles minor complaints and refers major complaints to the ESI. Employee medical records are maintained by the welfare center.

Outpatient services at the welfare center include **diagnosis, laboratory testing (blood and urine), IV (drip), tetanus injections and immunization**. Antibiotics can be obtained at cost from the pharmacy. Iron, calcium and folic acid tablets are given to all patients who need them, including pregnant, menopausal and anemic women.

The **registered and licensed pharmacy** maintains proper storage facilities for medicines. There is an incinerator in the welfare center where medical waste is incinerated twice a week.

The welfare center is located within one kilometer of all of ACL's production units, and a **bus** to the welfare center is available to workers. Workers need to request permission from their supervisor to take the bus. It can take 15–30 minutes to reach the welfare center.

The **general physician**, Dr. Subbalakshmi, sees about 7–12 patients per day and about 275 patients per month. Male workers come with issues similar to those of the general male population, including **fever, injuries and infections**. Female patients mainly raise complaints of **dysmenorrhea** and **gastritis** due to not eating properly in the morning before coming to work. Dr. Subbalakshmi feels that women workers are now more aware of the need to eat well before leaving for work in the morning. Workers are also aware of low cost, iron rich foods. Relatively few patients come to see the specialist doctors, which Dr. Subbalakshmi believes is because their clientele is a workforce and, unlike the general public, is in a state of relatively good health. When workers become seriously ill, they tend to visit the ESI or private hospitals.

A **leprosy camp** has been conducted with a skin specialist. Nine cases of leprosy were detected and cured.

Eighteen cases of **tuberculosis** were detected and cured through an 18-month treatment course.

The factory has donated funds to establish an **eye hospital**. The clinic also conducts an eye camp for workers. Workers who require **glasses** are given Rs. 200 to cover the costs (US\$4.30 at US\$1=Rs. 46). The factory is reimbursed for this expense from the **Government's Labor Welfare Fund**, towards which it contributes Rs. 7 per worker per month (US\$0.15 at US\$1=Rs. 46).

Workers are given **health tests based on occupation** to screen for occupational hazards. For example, electricians and mechanics are given audio tests, while workers in the laundry unit are tested for jaundice.

The company has contributed Rs. 50 million (US\$1,080,000 at US\$1=Rs. 46) towards the **rebuilding of a government hospital** in tsunami-hit Nagapattinam. A U.S. brand which sources from ACL contributed an additional Rs. 5 million for the rebuild (US\$108,000 at US\$1=Rs. 46). The hospital is expected to be completed in December 2006.

ACL has access to a **private 22-bed hospital** nearby that is run by the Rotary with funding from the British Renny Abraham Tanker Foundation. The hospital was established about 10 years ago, and since then 25 companies in Ambattur (including ACL) have contracted with the Rotary Hospital to provide services for their workers. ACL may form a new collaboration with the Rotary Medical Center to provide a greater array of health services to their workers. The Rotary Hospital provides 24-hour outpatient facilities and has three full-time doctors and 12 part-time visiting doctors. IT provides general medicine, treatment of injuries, dental services, pediatrics, gynecology, orthopedics, eye care, dialysis and ENT services. The hospital also has a full maternal and child clinic, with facilities to perform deliveries. The facility receives about 60–70 patients per day and charges Rs. 30 per visit for general patients (US\$0.65 at US\$1=Rs. 46) and Rs. 60 per visit for gynecological patients (US\$1.30 at US\$1=Rs. 46).

The **child care center** attends over 60 children and is managed by a staff of over ten, including trained teachers. On the day of the site visit, 69 children were present. The center's maximum capacity is 150 children. An additional 18 children attend during school holidays. Three Montessori-trained supervisors oversee a staff of eight helpers and two cooks. The supervisors assess the children for their ability to concentrate and maintain records.

Up to 15–20 children may sleep in one room at the child care center. The youngest child at the center is eight months old. Feeding bottles are not used in the child care center; children are fed with bottles or tumblers. Thus far no breastfeeding mothers have left children with the child care center.

The child care center is open from 7:30 am to 7:30 pm. Lunch, milk and refreshments are provided to the children. A nominal charge of Rs. 25 (approximately US\$0.50 at US\$1=Rs. 46) is charged per child per month. Children can be kept in the child care center until they reach six years of age.

A **pediatrician**, who was formerly director of the government children's hospital, visits the child care center three days a week (Monday, Wednesday and Friday) to conduct health check-ups, provide immunizations and advise child care center staff on hygiene, nutrition and health. Each child receives an initial health check-up, and mothers are counseled on nutrition and health. Health check-ups are given every three months and include screening for anemia. A record of medicines given to each child is maintained. An immunization camp is conducted every month to ensure that children receive correct immunizations on time. The pediatrician is a volunteer and has been for the last two years.

Reproductive Health

Dr. Saroja Ramanathan is a gynecologist who visits the clinic three days a week. She is a retired former professor at the Madras Medical College. She sees about 20 patients a month. The main reproductive health issues her patients bring to her include **dysmenorrhea** and **white discharge**. She also sees cases of **gastritis** and **vomiting**. She has conducted **pap smears** for about 45–50 women of over 35 years in age, though no instances of cervical cancer have been found. She provides advice on **contraception**, though demand is limited, and she inserts IUDs if a patient brings one with them. Most women in India have a tubectomy performed after their second child birth, for which the ESI provides 45 days of leave. Dr. Ramanathan administers hormone tablets to women who need to postpone their menstrual cycle. She believes that due to work pressures, women do not spend enough time on their own health.

During **menstruation**, women workers are provided with clean cloths for hygiene material and are asked to take sick leave if necessary. Requests for leave are usually channeled to the supervisor through the line helper.

The company requires **pregnant workers** to perform **light work** and encourages them to take **maternity leave** at least seven to ten days prior to delivery. **Breast-feeding** is encouraged through educational programs. The names of workers in the advanced stage of pregnancy (past seven months) are sent to factory managers. A van is available to transport pregnant workers who need emergency medical care. The medical center maintains a medical history card for pregnant workers who receive check-ups.

The general manager of human resources, Mr. Rajendran, noted that he asked the ESI doctor to provide funding to a worker who was diagnosed with cancer so she could access a specialty private hospital, the Adayar Cancer Institute. The ESI doctor said it would not be possible, though the designated ESI hospital (General Hospital) had a shortage of chemotherapy treatment available. The factory chose to spend about Rs. 2 lakhs for the treatment of this worker at the Adayar Cancer Institute.

HIV/AIDS

A local NGO, Nalamdhana, conducts **awareness raising programs** on World AIDS Day, December 1st at the factory sites, at which the organization distributes pamphlets and posters, and organizes role plays. No cases of HIV/AIDS have been reported as yet.

Training

Pregnant workers receive individual counseling from clinic staff and participate in lectures and seminars on pre-natal care and proper nutrition. They are compensated for time spent in seminars. A pamphlet that is distributed to pregnant workers contains pictures illustrating pre- and post-natal care and appropriate nutrition. This pamphlet is available in both Tamil (a local language) and English. Male workers may bring their

wives to the training with permission from the human resources personnel at their facility.

Sexual harassment training is provided to all supervisors. This training is required, and employees are compensated for time spent in training. The company provides written guidelines to explain ACL's policy against sexual harassment, its disciplinary procedure, its complaint mechanisms and how to conduct an audit on the issue. The guidelines are available to employees through the personnel department, and workers are trained on using the complaint mechanism. The guidelines are available in English and Tamil.

Health camps are held on issues such as **eye care, diabetics, and prevention of polio and hepatitis B**. The camps are held intermittently for a day or half a day and include vaccination and awareness campaigns. Specific health issues are raised based on occupation. For example, **ENT camps** are held for mechanics and housekeeping staff who work in high noise areas, and fabric checkers receive specific eye tests to ensure that they maintain good eyesight. Workers attend the camps during working hours and are compensated. An annual "Nutrition Day" is held to spread awareness, especially among pregnant workers.

Supervisors receive **behavioral training** on developing interpersonal skills and on proper workplace behavior. The training is held intermittently and conducted by an external consultant (Nirmala Nandakumar of Continuing Education). It is held during working hours, and supervisors are compensated for their time. Every supervisor is trained biennially.

The company has developed an **audio health training for workers** in which takes the form of a **song** that is played to workers during their lunch break. (Music is played continuously in all of ACL's factories.) The song was professionally recorded in a studio with professional singers.

New workers who have no prior experience receive **work skills training** during their first 45 days. They are then given a half-day "soft skills" training by the same consultant that conducts behavioral training for supervisors.

Trainings on **first aid, fire safety, use of personal protective equipment** and other training in occupational health are given periodically.

Responsibility and Impact

ACL invited two nearby factories to share the services of the welfare center because it was successful, but the factories have not wanted to send their workers onto ACL's premises. ACL management is considering taking over the management of the local manufacturer's association's hospital and child care center (Ambattur Industrial Estate Manufacturer's Association, or AIEMA). ACL's proposal is under consideration by AIEMA and the government department that owns the land the AEIMA facility is located on. ACL's will relocate their entire child care center to the AEIMA center if the proposal is accepted.

The AIEMA child care center has 35 children between 1.5 to 5 years of age, and it is open from 7:30 am to 7:30 pm. There are three ayahs and three teachers that conduct kindergarten classes. The children bring their own snacks, though lunch provided by the child care center. The Tamil language is compulsorily taught, and no medical care is provided. Care for each child costs Rs. 500 per quarter, paid by the companies whose employees use the services.

Interviews with Workers

Workers at Immunization Clinic, Welfare Center:

Meena Sandhya works in the Stores and has a six-month-old daughter, Abirami. She delivered her child in a private hospital. She began leaving her daughter in the child care center one week ago, since Meena's grandmother has returned to her village. Meena leaves the baby at 8:25 am and does not leave food for the child because the child care center provides food. She finds the child care center a helpful service.

A male machine operator whose wife also works at ACL reported being unable to come to the immunization clinic. Their baby is 1.5 years old and has been attending the child care center for 1.5 months. He has worked at ACL for nine years. Their baby was born at the ESI hospital.

C. Ramesh Kumar is 26 years old and has been with ACL for eight years. For the past four years, he has worked as a tailor. His two-year-old son Rahul has been attending the child care center for one week. Their older daughter was in the child care center for two years and now goes to school. He rides a bicycle to work. His wife had a tubectomy operation, and they do not plan to have more children.

Pratibha has been with ACL for nine years and has been a button fixing machine operator for the last two years. She earns Rs. 3400/month (US\$74 at US\$1=Rs. 46). Her daughter Manjuri is 1.5 years old and was born in the ESI hospital. Her daughter has been going to the child care center for the last six months. Pratibha lives nearby and travels to work with her husband on his motorbike. She feels that the distance between the factory and welfare center is a problem, as travel time can be up to half an hour each direction. Sometimes she travels by an auto (three wheeled vehicle).

Workers at the Factory:

Shanti has worked at ACL for 10 years and earns Rs. 3600/month (US\$78 at US\$1=Rs. 46). She is a button machine operator. She has two children, aged 3.5 years and 1 year. Her younger child goes to the child care center, and her older child is in school. She values the services of the child care center and feels that children who go to the center grow and develop better than children who stay at home.

Selvi is 24 years old and works in the cutting section as a sorter. She earns Rs. 2800/month (US\$61 at US\$1=Rs. 46). She has a five-year-old son and a two-year-old daughter. Her daughter has been going to the child care center for one year. She comes

to work by the company bus. Her youngest child was born at the ESI hospital in Ainavaram, and she is satisfied with the level of care there. She been to the clinic for her daughter's health only and not for her own health. Her husband does not work. She finds the child care center an extremely helpful service that feels like her "mother's home."

Dharani is 19 years old and has been at ACL for 1 year. She is a feeding helper, and this is her first job. She been treated at the ESI hospital for an irregular menstrual cycle. She has never been to the clinic.

Arvind Mills, Garment Exports Division, Bangalore, India

Factory Information

The factory visited is a **shirt making facility** with **1150 workers**, of which over 80 percent are women. The company produces 175,000 pieces a month and has 10 lines. The women workers range in age from 19–40 years, with the majority falling between 19–28 years. About 50 percent of the workers are married. The facility was established three years ago. The Arvind Exports Division in Bangalore has a total of 3600 workers distributed between this factory and three others.

The factory operates in **two shifts**: the morning shift from 8:30 am to 5:00 pm and the night shift from 5:30 pm to 2:00 am. There is a staggered lunch break, and each worker receives an additional 30-minute break. Women do not work the night shift, which is staffed only by about 150 men in the finishing, cutting and sewing sections.

The **minimum wage** in this area is Rs. 2310 per month (US\$50 at US\$1=Rs. 46). The average wage is Rs. 3000 per month (US\$65 at US\$1=Rs. 46). The factory provides a lunch allowance of Rs. 182 per worker per month (US\$3.95 at US\$1=Rs. 46). An **attendance bonus** of Rs. 300 per month (US\$6.50 at US\$1=Rs. 46) is given to workers who take only one day off of pre-approved leave. About 50 percent of workers receive the attendance bonus. Workers are given **free transportation by bus** to drop-off points near their homes. There are 96 staff members in the factory, including line supervisors. Five of the line supervisors and quality control staff are women, while the rest are men.

Turnover is about 10 percent, and absenteeism is about 5 percent. **Absenteeism** has come down considerably from 10–12 percent. At its lowest point, absenteeism was 2.5 percent.

Workers must have been through **10 years of schooling** to be hired, or they must be older workers with substantial experience. Workers with no experience are trained for a week (if they will be helpers) to a month (if they will be tailors).

The **child care center** accommodates about 25 children from four months to three years in age. The factory encourages parents to place children older than three years in school.

A full time teacher and two attendants manage the center. The children are given milk, biscuits and infant foods, and the mothers also provide foods.

There is a **cafeteria** where meals cost Rs. 10 per meal (US\$0.21 at US\$1=Rs. 46). Food is prepared offsite by a licensed caterer and brought to the cafeteria for serving.

There are four **human resource personnel** in the factory, including a welfare officer. Human resources conducts a one-hour induction program for new employees on their first days. This training covers company regulations, including salary, benefits and health and safety regulations.

About 90 percent of workers have **bank accounts**, and the remaining 10 percent will be shifted to bank accounts shortly. Salaries are remitted once a month.

The company was visited in 2002 as part of the earlier project on Women's Health in the Global Supply Chain, though a different factory was visited at that time. The facility visited in 2002 has shifted toward production for the domestic market, so a different, export-focused facility was visited for the current study.

Improvements and Impact since 2002

In 2002, the company had conducted a day-long training on self-esteem. This training has been discontinued.

The company now has a common doctor who visits the four factories of the company in rotation and has a holistic perspective on health problems of workers because she sees them regularly. She has a strong focus on care for pregnant workers, as well as improved nutritional and hygiene standards in the child care center.

The human resources manager feels that **productivity** has improved and **absenteeism** has been reduced through their measures to promote health. He has not seen any major injuries requiring stitches in the last six months. Minor injuries requiring dressing occur about once a week.

Worker Communication

There is a **suggestion box** for workers. The factory recently dismissed three supervisors in response to reports that a supervisor had harassed workers by shouting and touching improperly. There is a companywide policy on sexual harassment that applies to this factory and to others. Workers have complained that they have been denied attendance bonuses because they did not write a leave letter prior to taking leave.

The **welfare officer** walks around the factory two to three times a day to talk to workers. She holds a Master's degree in social work and previously worked at another garment factory before joining this factory two months ago. Workers generally approach her about production problems and worries about not being able to meet targets. They also

discuss personal issues such as marital problems, alcoholic husbands or discord with their in-laws. The most common health concern she hears of is stomach pain during menstruation; she advises workers with this complaint to see the nurse or doctor. She checks the lunch boxes of the children in the child care center and advises the mothers on what food to pack. She also conducts the monthly meetings of the Health & Safety Committee, the Cafeteria Committee and the Sexual Harassment Committee. There have been no instances of harassment since the three supervisors were dismissed three months ago.

Health Facilities and Issues

The factory makes **ESI** deductions and payments. The nearest ESI hospital is in Bommanahalli, about 10 kilometers away. The factory has a medical room with a full-time nurse and a part-time doctor. A taxi is available at night to take workers to the nearest hospital for emergencies.

The **medical room** gets about 25–30 patients per day. The most common ailment is **upper respiratory infections**, such as coughs and colds. Other ailments include **chronic headache** (usually due to poor eyesight), **sinusitis** and **kidney problems** (due to taking too many analgesics). Several married women are likely **anemic**; the doctor does not have the equipment to perform a blood test but can guess from their symptoms. When the doctor encounters a severe case of anemia (defined as below 8 g/dl), she contacts the Human Resources department. She writes a referral letter to the ESI hospital and advises the patient to ask the hospital for free iron and vitamin tablets.

The doctor also sees several cases of **gastritis** per day. Gastritis can be caused by eating too much spicy food, timing meals erratically, not drinking enough water and waiting too long between meals. She advises workers with gastritis to eat more frequently and drink about 3–4 liters of water per day.

Women workers see her with **psychological problems**, such as abusive husbands or family medical problems. She recommends NGOs, including the organization Spandana for alcoholism, which these women can visit for counseling for themselves, their husbands or their children. She writes prescriptions for treatment for family members or recommends tests that they can take for issues such as infertility.

The clinic provides **basic analgesics** and **no antibiotics, suturing or tetanus injections**. In case of a workplace emergency, the factory takes the worker to the nearest hospital for further treatment and pays for services.

Annual health check-ups are not provided for workers.

The doctor conducts a **monthly health check-up** for the children in the child care center and advises mothers on proper nutrition and immunization. One or two of the babies in the child care center are breast-fed.

If the doctor suspects that a worker may have **tuberculosis**, she asks the worker to be tested. If the worker has an open case of tuberculosis, they cannot return to work. If the worker has a closed case, they can return to work. The doctor counsels workers appropriately on proper medicine and nutrition.

The factory recently gave a grant of Rs. 25,000 (US\$544 at US\$1=Rs. 46) to a worker to have a brain tumor removed. The worker had stopped working at the factory years ago. In another case, the company provided Rs. 250,000 (US\$5435 at US\$1=Rs. 46) for a worker's treatment at a private hospital.

The factory is planning to join the industrial estate association, which will give them and their workers access to a proposed hospital and firefighting services.

The doctor and human resources talk by phone to discuss cases and do not have regular monthly meetings.

Reproductive Health

All **pregnant women** have mandatory monthly check-ups. A separate file is maintained for pregnant workers. The doctor prescribes calcium, iron, folic acid and other tablets as necessary. She also advises them on tests that should be performed, such as blood tests and ultrasounds, and she provides referral letters for the next doctor they will see. The workers must then decide whether to visit a private clinic or the ESI clinic. She educates them on proper nutrition during and after pregnancy. At the time of our site visit, there were about 13 pregnant women working at the factory.

Unmarried women commonly complain about **dysmenorrhea**. The doctor explains that dysmenorrhea is a normal part of menstruation, and she recommends pain killers. She sees commonly cases of white discharge, especially among married women. This discharge usually indicates an infection due to poor hygiene, especially after intercourse. The doctor visits all of the company's in rotation. She has worked with the company for six months. She has convinced women workers to use sanitary napkins rather than cloth during menstruation; she feels that now about 70 percent of the women in this factory are using sanitary napkins. Sanitary napkins are available for sale at the clinic for Rs. 2 each (US\$0.04 at US\$1=Rs. 46).

She provides advice on **contraceptives** but does not dispense them. If a worker would like to postpone conception by 6–8 months, she advises that they use oral contraceptives, and if they would like to postpone conception by 1–2 years, she advises that they use an IUD. A new Japanese-made IUD has very few side effects. She generally does not recommend intravenous contraceptives because of side effects. Male workers never ask her about condoms.

The doctor is approached by women who report “accidental pregnancy,” where conception occurs soon after marriage and the worker wants to **terminate the pregnancy**. Workers marry young, at the age of 19 or 20. Within 50 days of conception,

the doctor can prescribe a tablet to terminate the pregnancy; after 50 days, she recommends surgery. She first counsels them to continue with the pregnancy and advises on next steps only if they are certain they would like to proceed with termination.

A consultation with a private doctor on pregnancy-related matters costs about Rs. 30-50 (US\$0.65–\$1 at US\$1=Rs. 46). Delivery in a private hospital in the region costs Rs. 5000–6000 (US\$109–\$130 at US\$1=Rs. 46). The more expensive hospitals charge up to Rs. 15,000 (US\$326 at US\$1=Rs. 46) for a normal delivery and Rs. 25,000 (US\$543 at US\$1=Rs. 46) for a cesarean delivery.

HIV/AIDS

Management recognizes a need to hold a training on HIV/AIDS. A training is planned for later in 2006.

Training

The doctor leads a training every month for pregnant workers on pre-natal care and proper nutrition. She gives a lecture to the mothers of children in the child care center regularly and has given a lecture on nutrition to about 300 workers. Trainings are usually held at the end of the day after 4:00 pm, so the lines that need to participate are given warning and complete their targets by 4:00 pm. Trainings usually last until 5:30 or 6:00 pm. The company plans to have monthly trainings and health camps, starting with an eye camp in September, a training on reproductive health (including HIV/AIDS) in October and a blood donation drive in December.

First aid training is given to 30–60 workers every year; the law requires that 20–30 workers be trained for a factory of this size. A fire drill is conducted once a year, and 30 workers are trained every six months on firefighting. Workers trained in first aid and firefighting are given special name tags.

Responsibility and Impact

The human resources manager feels that productivity has improved and absenteeism has been reduced through health promotion measures. In the last six months, he has not witnessed any major injuries requiring stitches. Minor injuries that require dressing probably occur once a week.

Interviews with Workers

Radha is 22 years old and has worked as a tailor at the factory for 1.5 years. She has completed 10 years of schooling, and this is her first job. She earns Rs. 3200 (US\$70 at US\$1=Rs. 46) per month. She takes a bus for about 20 minutes to reach the point where the company bus picks up workers in Hosur. She lives with her parents and her younger brother, who is studying in college. She sometimes has headaches or stomachaches during menstruation and goes to the company medical room for medicine. She brings lunch from home. She is aware of HIV/AIDS and believes that it is a disease transmitted

through “blood” and “illicit relations.” She received this information from television and was also informed about HIV/AIDS when she joined the company.

Manjula has worked at the factory for one year and two months, and she is 19 years old. She has completed 10 years of schooling and earns Rs. 2300 per month (US\$50 at US\$1=Rs. 46) as a helper. She walks to the pick-up point for the company bus every morning. She has visited the company doctor a few times for headaches, body aches and fevers and has taken the medicine the doctor gave her. She has not consulted with any doctors outside of those at the factory medical room. She lives with her brother, who also works in a factory, and she pays Rs. 850 (US\$18 at US\$1=Rs. 46) as monthly rent. She sends Rs. 2000 (US\$43 at US\$1=Rs. 46) home every month. She brings her lunch to work and has also bought her lunch at the cafeteria before; she reports that the food there is quite good. She does not have a television at home and spends her free time doing household chores. She would like to get married in a few years and believes that her parents will arrange a marriage for her. She does not have any problems with her supervisor.

Padmavathi is 18 years old and has worked for the last three months as a sleeve checker. She has completed 10 years of schooling, and this is her first job. She earns Rs. 2400 per month (US\$52 at US\$1=Rs. 46) plus a lunch allowance of Rs. 182 per month (US\$3.95 at US\$1=Rs. 46). She lives with her two older sisters, one of whom is married. She feels comfortable approaching the welfare officer, who she knows, with any problems. Her father has passed away, and her mother does not work. She would like to learn tailoring and become a sewing operator in the future. She has no knowledge on HIV/AIDS. She does not wish that the factory would provide additional health facilities.

Jyothi is 23 years old and has worked in the factory as a tailor for four months. She is a widow with a three-year-old baby. Her husband was a truck driver who passed away in an accident. Her parents live in a village in a nearby district. She had to quit her previous job in another apparel factory when she had to take one month of leave to look after her baby. She earns Rs. 3000 per month (US\$65 at US\$1=Rs. 46) and has completed 10 years of schooling. She brings her lunch with her to work or eats at the cafeteria on days when she is not able to bring her own food. She saw the factory doctor when she had a headache and needed to rest for an hour before going back to work. When she goes to a private doctor for herself or for her son, she pays Rs. 20 per visit (US\$0.07 at US\$1=Rs. 46). She walks to the bus pick-up point every day. Her sister lives close to her. She does not think there are any additional facilities needed in the factory, and she is happy with the work atmosphere. The supervisors are easy to talk with, and she does not have a problem approaching them with a request. She also feels comfortable talking to the welfare officer, who is often on the production floor.

Nirmala is 37 years old and has been working in the ironing section for three months. She previously worked at another apparel factory for six years, but she quit because the factory was far from her home and she was required to work excessive, unpaid overtime. She has two children: a son who is in college and a daughter in school who stays with her

parents in her village. Her husband works as a security guard. She had a tubectomy operation after the birth of her second child. She is happy at this factory because there is a bus to bring her to work and she has never been asked to work overtime in her three months here. Were she to take a private bus, it would cost her Rs. 10 (US\$0.21 at US\$1=Rs. 46) each direction. She completed 5th grade and married at the age of 17 in her village. She earns Rs. 3000 per month (US \$65 at US\$1=Rs. 46) plus Rs. 182 (US\$3.95 at US\$1=Rs. 46) in lunch allowance. She has made full attendance for the last three months, so she expects to receive the attendance bonus. She receives a half an hour break for lunch. Her husband earns Rs. 4000 per month (US\$87 at US\$1=Rs. 46). She is happy at the factory and knows she can talk to the welfare officer about any problems. She has never been to the factory doctor with an ailment. A private doctor near her home can charge between Rs. 100–200 (US\$2-4 at US\$1=Rs. 46) for a consultation. She has no knowledge of HIV/AIDS.

Gokaldas Exports (GE), Bangalore, India

Factory Information

Gokaldas Exports (GE) is an apparel manufacturing company with 40 facilities in Bangalore that employ approximately 40,000 workers. It is one of the largest apparel manufacturers in India and recently went public. Eighty percent of its workers are female, and all of its workers are full-time employees. Turnover at Gokaldas Exports matches the industry average at about 25 percent. An attendance bonus of Rs. 300 per month (US\$6.50 at US\$1=Rs. 46) is achieved by about 20 percent of workers.

The company has a written health and safety policy that is communicated to workers during an initial orientation. The policy is also displayed on factory notice boards. Every facility has its own labor department and welfare officer and shares in a company-wide compliance department.

The factory visited employs 1800 workers, of which 70 percent are female. A welfare officer is available onsite, as is a labor officer that oversees compliance. Turnover is approximately 200 workers per month, or approximately 11 percent. Lunch is provided at the cafeteria at Rs. 9 per lunch (US\$0.19 at US\$1=Rs. 46). Working shifts are from 9:00 am to 5:30pm. Lunch breaks are given in three batches beginning at 12:45 pm. The child care center had no children at the time of the site visit and had 15 places available.

Improvements and Impact since 2002

The company was visited in 2002 as part of the earlier project on Women's Health in the Global Supply Chain, though a different factory operated by the company was visited in 2006 than in 2002.

Gokaldas Exports has doubled in production capacity and worker strength since 2002, with the total number of workers in all facilities increasing from **19,000 to 40,000**. Over

80 percent of workers are female. The company also **went public** with an Initial Public Offering (IPO) in 2005.

In 2002, the company was a participant in the **Global Alliance**, a global, multistakeholder initiative to assess worker needs and provide training and skills building in areas such as health, self esteem and finances. Two of the company's facilities received supervisory and worker level training through this initiative. The Global Alliance project has since ended, and the company has not continued with the training process.

Since 2002, the company has established a **clinic** in an area where a number of its factories are located. The clinic is staffed by a full-time doctor who sees about 65–75 patients per day. The company is planning to open a second clinic in another area where several of its factories are located. Further details of the clinic follow in this site report.

Human resources management feels that health measures for workers have had no effect on productivity. Turnover remains high and absenteeism remains the same. Management would invest more in health programs if there concrete examples of improved productivity due to health facilities.

Worker Communication

Feedback can be passed through **welfare officers** and other management personnel who are accessible to workers. Factories also have suggestion boxes.

Kamala is the welfare officer at this factory. She has been with the company for six months and joined after completing her Masters in social work. Workers approach her with questions on how to take ESI leave or access Provident Fund savings. Some workers also approach her about personal problems, such as marital discord or husbands who have left them.

Health Facilities and Issues

All workers are covered by **ESI**. **Pregnant workers** take a mandatory 90 days off right before delivery that are covered by ESI.

Every factory has a **nurse and sick room**. Four doctors rotate between different factory clinics; they visit each clinic three times a week. The doctors perform age and fitness certification of workers.

The company has a **clinic** located close to a large number of its factories and not attached to an individual factory. The clinic can be accessed by all company workers and serves a total of **14,000–15,000 workers**. If workers become ill or are injured during working hours, a company ambulance transports them to the clinic. After working hours, workers may travel to the clinic themselves or take family members with them. The clinic has been in operation for about 1.5 years. Prior to its establishment, workers

were sent to a private hospital at the company's expense. The company plans to open a second clinic in a different area that will benefit about 5000 additional workers.

Dr. Dakshyani has been with the clinic for 1.5 years and works there full time. She is assisted by a nurse, Sister Padma. Dr. Dakshyani serves patients from over 35 GE factories in the Peenya area that employ 15,000 workers total. She sees 65–85 patients per day, about 20–25 of whom arrive before lunch.

According to Dr. Dakshyani, health problems among male workers include:

Nutritional disorders:	<ul style="list-style-type: none"> ▪ Anemia
	<ul style="list-style-type: none"> ▪ Dehydration, due to not drinking enough water while at work
	<ul style="list-style-type: none"> ▪ Malnourishment
From these nutritional disorders stem a number of disorders due to a weak immune system:	
Respiratory system:	<ul style="list-style-type: none"> ▪ Bronchitis, an occupational hazard due to dust and fiber in apparel fabrics. The welfare officer also reported many cases of bronchitis in the factory.
	<ul style="list-style-type: none"> ▪ Asthma
Gastro-intestinal system:	<ul style="list-style-type: none"> ▪ Gastritis, from mild to severe. Workers eat rice and sambhar (lentil soup) for all three meals and seldom eat green, leafy vegetables. They also take tea on empty stomachs.
	<ul style="list-style-type: none"> ▪ Diarrhea and dysentery, the latter of which is seasonal
	<ul style="list-style-type: none"> ▪ Mouth ulcers
	<ul style="list-style-type: none"> ▪ Urinary tract infection, leading to abdominal pain
	<ul style="list-style-type: none"> ▪ Kidney stones
Cardio-vascular system:	<ul style="list-style-type: none"> ▪ High blood pressure
	<ul style="list-style-type: none"> ▪ Low blood pressure
	<ul style="list-style-type: none"> ▪ One case of heart attack, as well as cases of heart disease in the initial stages
Accidents in factories:	<ul style="list-style-type: none"> ▪ Cuts, for which the doctor performs suturing in the clinic
	<ul style="list-style-type: none"> ▪ Crush injuries
	<ul style="list-style-type: none"> ▪ Pieces of needle embedded in fingers
	<ul style="list-style-type: none"> ▪ Button injury cases, where the button is embedded in the finger
General:	<ul style="list-style-type: none"> ▪ Functional cases of convulsions

Dr. Dakhshyani has seen an increase in cases of **arthritis** due to **calcium deficiency (osteoporosis)**. Arthritis used to set in at the age of 45 or above, but she now sees more cases in patients at the age of 35 or above.

She also sees cases of **bioderma**, **skin rashes** and **itching** caused by dust and fabric fibers.

The doctor conducts **diagnoses** for all illnesses and gives **needed medication**. When she joined the clinic, only basic pain killers were stocked, but she has expanded the medicines available to include antibiotics and other commonly needed medicines. She provides multivitamins to patients who need them. The factory ambulance rooms stock 8–10 basic medicines. Dr. Dakhshyani purchases medicines at the stock rate, which is about 50 percent less than the market rate. Multivitamins are purchased loose, as this is less expensive. About Rs.20,000 per month (US\$435 at US\$1=Rs. 46) are spent on medicines for the clinic, and Rs. 55–60,000 per month (IS\$1305 at US\$1=Rs. 46) are spent on medicines for the ambulance rooms.

Dr. DAKshyani is not required to provide treatment to **family members** of workers, but she will see family members if workers bring them to her. About 50 percent of patients bring family members, including parents, sisters, brothers, spouses and children.

She maintains a **file** for all workers who visit the clinic.

There are no testing facilities at the clinic. If tests are required, the doctor provides a prescription that workers can take to the ESI or private clinics. Workers are often reluctant to have tests performed, but they do come back to her for follow-up after tests. She reports that many workers do not have ESI cards and have complained to her that they do not receive good treatment at ESI facilities. She does not insist that they go to ESI for tests or other procedures.

No specific disposal for medical waste exists; it is disposed of with the general garbage.

The doctor's main contact with the company is through the human resources general manager. The doctor is not in contact with the ambulance room staff of individual factories, including nurses and doctors. She is aware that the factory welfare officer provides trainings for workers on HIV/AIDS and Hepatitis B but has never attended the trainings or been involved with the curriculum. The factory nurses talk with her informally about health issues.

The main obstacle to improving health, Dr. Dakhshyani believes, is that a single person such as herself cannot do much. The factories and human resources departments need to become more active in serving worker health needs. She believes that investing in health does improve cost efficiency and reduces the time workers spend on leave. She credits the company for providing her with the facilities and medicines she has requested. She

initially asked the company about further training for herself but has not heard back from them or followed up specifically on her question.

Savita is a **nurse** who has been working in the **ambulance room** of the factory for two years. The ambulance room is open during the same hours as the factory (9:00 am to 5:30 pm). She has completed a three-year diploma in nursing. She sees 70–80 patients per day, starting at 10:00 am. Female workers complain most often about leg and body pain. She sees 3–4 work-related injuries per day. She also sees many cases of dysmenorrhea. She provides workers who have work-related injuries with dressing but no sutures. She sees many cases of loose motion due to unhygienic food, which the workers acquire from street vendors. She provides pain killers and antibiotics, and for more serious cases, she takes notes of vital signs and then sends the patients to the clinic. The seriously ill or injured patients who are sent to the clinic are supposed to be accompanied by a doctor or nurse, according to company policy, but not all factories follow this rule.

Reproductive Health

Dr. Dakshyani sees the following ailments among female workers who visit her clinic:

- **White discharge or leucorrhea:** About 70 percent of married patients and 30 percent of single patients have this ailment.
- **Irregularity of menstrual cycle.**

She stocks **contraceptives** that the Primary Health Centre provides for free. She does not stock condoms, and male patients do not ask for them. She inserts Copper Ts (IUDs) for women workers.

The doctor conducts **ante-natal check ups** for pregnant workers, though not all pregnant workers come to her. Some of the pregnant workers may instead be going to the factory ambulance rooms. She gives out **iron, calcium** and **folic acid tablets** in the clinic, which she believes the factory ambulance rooms do not provide. Calcium tablets are not provided to pregnant workers.

Individual factory clinics conduct **monthly check-ups for pregnant workers**. An **Ante-Natal Care (ANC) Card** is maintained for pregnant workers. Pregnant workers are given **ANC trainings** once a month that include topics such as maternal and child health, the importance of immunizations and menopause.

Most workers in the factory use cloths rather than sanitary napkins at the time of menstruation. The factory clinic used to stock sanitary napkins and sell them at Rs. 2 each (US\$0.04 at US\$1=Rs. 46), but this practice has ceased. The doctor talks to workers when they come to the clinic about personal hygiene.

HIV/AIDS

A few workers inquire about HIV/AIDS. Dr. Dakshyani suspects that there are 4–5 male workers who have tested positive for HIV, though no one in the factory is either aware or certain of this. She also believes that there is one woman who is HIV positive who has not yet informed anyone, including her husband. The doctor is not aware if any of the people who may be HIV positive are seeking treatment yet. The welfare officer at the factory also suspects that one or two workers may have HIV/AIDS but is not sure.

To the company's knowledge, no worker has died from AIDS.

Government agencies have spoken to workers with regards to HIV/AIDS. On World AIDS Day (December 1st), an outside agency conducts trainings and raises awareness of HIV/AIDS at the factories.

Training

First aid training is provided to workers by a local hospital in collaboration with the Red Cross. Pregnant workers receive training once a month on safe motherhood and care of infants.

Periodic trainings on specific topics are organized by the four doctors who visit the factory clinics. Three trainings have been held for factory workers on menstruation, maternal and child health, and menopause. Each training accommodates 200 workers. The system followers in the factory send the workers to the trainings, which are held during working hours. Workers are compensated for their time.

The company was a participant in the Global Alliance Program for workers and, through the program, held extensive trainings for workers and supervisors on issues such as health and self-esteem. Company participation in the program ended two years ago.

The company is considering participation in a multistakeholder initiative that will provide training for worker's committees. Existing committees include the Health and Safety, Cafeteria and Works Committees.

Responsibility and Impact

Human resources management feels that health measures have had no effect on productivity. Turnover and absenteeism remain high. Factory management would invest more in health programs if there were concrete examples of improved productivity due to health facilities and programs.

Interviews with Workers

Malar is a layer in the cutting section and is 45 years old. She was brought to the clinic by ambulance during the site visit with severe pain in her head and neck. After two days of clinic care she went on leave, and during her leave she returned to the clinic on her own for a follow-up visit. She was happy with the care received from the doctor.

Mamta is 17 years old and joined the factory less than a month before the site visit. She has completed high school (12 years of schooling) and holds a diploma in fashion designing. She visited the factory clinic with nausea. She was satisfied with the health facilities at the factory.

Hasina is 35 years old and has worked at the factory for four months. She has four children: three daughters and one son. Her husband runs a fruit-selling business. Hasina is still new to the area and has not yet obtained an ESI card. She visited the factory clinic with a headache. She was happy with the level of care received.

Gokaldas Images (GI), Bangalore, India

Factory Information

Gokaldas Images (GI), founded in 1979, is one of the oldest apparel manufacturing companies in Bangalore, with approximately **11,000 workers in 20 factories**. About 85 percent of its workers are women between the ages of 19–45, though most are between 25 and 30 years of age. Of the 20 factories, seven employ over 1000 workers each. The minimum wage in the Peenya area, where most of GI factories are located, is about Rs. 2310 per month (US\$50 at US\$1=Rs. 46).

The company was visited four years ago during BSR's prior study. At that time, it was considering hiring medical officers in collaboration with an external organization, the St. John's Medical College, an action it has since taken.

Child care centers are attached to each factory. There are 20–25 children in each of the child care centers. Trained staff manage the centers, and there is a ratio of one staff person per 20 children. Children are between four months and three years in age. Mothers attend a monthly meeting where they are given lessons on preparing low cost meals that they later prepare and send with their children for lunch. The children are given 200 grams of milk twice a day. Once a week they are given idli (rice cakes) and eggs. Children below the age of one are given ragi malt. Mothers are encouraged to breastfeed and are allowed to come to the child care center every two hours to breastfeed. Bottles are not used; children are fed with a tumbler or spoon. Child care center attendants receive annual training to refresh their knowledge and skills.

Some children come to the child care center after school. In summer 2006, a camp was organized for 78 children from a number of child care centers. Participants were transported by bus to a government school that was rented by the company. The children were taught crafts and dancing, the latter of which was taught by local youths who used to loiter near the factory gates and were invited to teach. These local youths felt empowered by the experience. Dances and exhibitions of craft items were displayed in a program at the end of the camp.

Improvements and Impact since 2002

Gokaldas Images has **grown about 20 percent in worker strength** since 2002, with the total number of workers increasing from 9,000 to about 11,000. In 2002, the company formulated plans to hire medical officers and to collaborate with St. John's Department of Community Health, a leading medical school and community health organization in India. The following steps have been taken over the past four years:

- The company has hired four doctors as **medical officers**, including a **chief medical officer**. In addition to providing medical services, the medical officers have served as **effective liaisons with ESI** and promoted health education.
- The company has partnered with **St. John's Department of Community Health**, Bangalore to conduct **annual health check-ups** for its workers and in **training peer educators**.
- There is a **medical committee** consisting of the **managing director, medical officers, nurses, welfare officers** and **staff from St. John's Medical College**. The managing director feels that the services of a public health professional may also be needed.

Welfare officers, who speak with workers when they return from leave, report that **sickness absenteeism** has been reduced. Absenteeism was previously about 7 percent total, with 3 percent due to sickness. Workers did not know how to use the ESI system; they used to take four days leave to visit the ESI hospital but now take about two days leave.

Turnover is now 4–6 percent, a reduction of about 1 percent over the last four years. Workers tend to transfer within units rather than leave the company.

GI has not conducted an internal evaluation of the impact of its health programs on health of workers. Sumir Hinduja, the managing director, feels that the health programs have achieved about 50 percent of their goals, with **emergency care intervention** programs as the most successful and the **train-the-trainer system** performing the least effectively. He reports that **annual health check-ups** uncover major ailments but follow-up care is lacking.

Worker Communication

There are nine women **welfare officers** who rotate between the 20 factories. Charlotte is a senior welfare officer who covers 1500 workers at various factories. Workers approach her with problems such as marital discord, alcoholic husbands and harassment by their husbands and in-laws. She refers health issues, including reproductive health issues, to the clinic. Workers also come to her with concerns about ESI details and procedures, the methods for accessing Provident Fund (or social security benefits) and worries about children's education and school admission.

Suggestion boxes are placed in all factories. Workers are also encouraged to approach their supervisor or any member of management. The company publishes a **quarterly newsletter** in the local language (Kannada) that is distributed to workers.

Each factory has a **Grievance Committee** through which management interacts with workers.

Health Facilities and Issues

The 20 factories of GI have their own **ambulance rooms** with full-time nurses. The nurses hold three-year general nursing diplomas.

There are four doctors, known as **medical officers** that are overseen by a **chief medical officer** named Dr. Sudhamani. The four doctors rotate between factories. By law, factories with more than 250 workers must have a nurse available in the ambulance room, and factories with more than 500 workers must have a part-time doctor.

The practice of having medical officers available began through medical check-ups for children in the child care center. Gradually mothers began to also seek medical advice. A survey of four factories revealed a need for more comprehensive health services. Outside agencies, including ESI and an NGO named Parivar Seva Sansthan, had previously provided these services. It was decided that services could be provided onsite as well.

The **ambulance rooms** receive about 20–50 patients per day, depending on factory size. Many workers visit during their lunch hour but may arrive as early as opening time. Among male workers, the main health issues reflect those of the general population and include **gastritis** and **respiratory tract infections in the winter**. Among **women workers, anemia, gastritis, pelvic infection, RTI and menstrual problems** are common. **Medical files** are maintained for all workers.

The ambulance rooms provide **diagnostic and referral care**. GI medical officers also work to **maximize the ESI system for worker benefit**. Every referred patient receives a detailed referral letter describing the illness and prescribing next steps. A medical officer accompanies the patient to the ESI Hospital in Rajajinagar and follows up on specific issues with the ESI Director. ESI does not limit the amount paid to primary beneficiaries, a fact which most factory health providers are not aware of (dependents are limited to Rs. 100,000 per year (US\$2175 at US\$1=Rs. 46). Dr. Sudhamani has managed to obtain Rs. 140,000 (US\$3050 at US\$1=Rs. 46) from ESI for one worker to travel to an out-of-town specialty hospital for a bone marrow transplant. She was also able to secure cancer treatment through ESI for another worker at a specialist hospital because the treatment was not available in Bangalore.

When a worker has a **health emergency**, they are sent to the ESI hospital. If the ESI hospital is not able to provide treatment, the patient is sent to the next referral hospital. A medical officer from GI visits the patient in each of these hospitals. If the medical officer determines that adequate care is not being given, they take the patient to the next

level of private hospital, which may or may not be immediately covered by ESI. If ESI does not immediately cover costs, the company pays hospital fees. After treatment is complete, the medical officer applies to ESI for reimbursement. Earlier reimbursement checks from ESI were sent directly to workers in their own names, and these workers did not return the amount to the company, but a medical officer now requests reimbursements in the company name. In some cases, a medical officer has convinced ESI promise a private hospital in writing that ESI will reimburse for treatment costs. Reimbursements may be made at the ESI rate, which are usually 60–70 percent of charges in private hospitals.

Padma, a 29-year-old worker who was at the ambulance room during the site visit, had breast cancer. She was to be operated on during the following week at a private specialty hospital.

When workers visit ESI for **routine treatment**, they return with **copies of reports and prescriptions for inclusion in their medical files at the factory clinic**.

The chief medical officer reports that GI workers receive **better treatment from ESI staff** because ESI staff knows that the medical officers will follow up. Some workers telephone the chief medical officer from the ESI hospital and ask her to speak directly to a doctor. Some case officers at ESI facilities call her on behalf of workers from other factories to ask for help with specific processes. She is a member of the **Vigilance Committee of the ESI**.

The managing director of the company, Sumir Hinduja, feels that the company's ability to use the ESI system and respond in cases of emergency has been the most **successful aspect** of the health program since it was initiated four years ago.

The company's **Medical Committee** consists of the managing director, medical officers, nurses, welfare officers and staff from St. John's Medical College, now a technical partner in the project. The managing director feels that the services of a public health professional may also be needed.

Annual health check-ups are conducted by the medical officers with assistance from 7–8 doctors from the St. John's Community Health Center. Both teams spend 4–5 days covering each factory. Records are maintained by the medical officers. The managing director feels that improvements could be made in detecting diseases and ensuring preventive care is performed.

Reproductive Health

The main reproductive health complaints and needs brought to the clinic include **menstrual problems (excessive bleeding, pain, irregular periods), information on contraception, white discharge, infertility and laparoscopy**.

The clinic stocks **contraceptives** from the Primary Health Center. The medical officer inserts IUDs and conducts ovulation tests. The clinic advises on types of contraception and sends workers to ESI facilities for tubectomy and other procedures. Most women use cloth rather than sanitary napkins during menstruation. Sanitary napkins are available for purchase from the clinics. Welfare officers are trying to educate women workers to use sanitary napkins rather than cloth.

All **pregnant workers** are given **monthly check-ups** and have a detailed file, or **ante-natal card**, at the clinic. The medical officers refer workers to the ESI hospital for tests. Workers return to the clinic with test results and prescriptions for inclusion in their files. Pregnant workers are given calcium, folic acid and iron tablets.

A medical officer has convinced a **pediatrician** from ESI to visit the child care centers monthly to examine the children free of cost. Health check-ups are given to the children in child care centers once every three months.

HIV/AIDS

Workers would like more information on HIV/AIDS, particularly if they have a family members that is affected. The factory has had three known instances of **HIV positive workers**; one worker's brother was infected and sought health services at a factory clinic. All known cases of HIV/AIDS have been detected either through blood donation camps or through workers visiting the clinic with test results. HIV status in all of these cases was not shared with anyone in the factory where the worker was employed, including management. Only the welfare officers and medical officers were aware of these workers' HIV positive status. The workers were taken to local **NGOs for pre-test counseling, testing and post-test counseling**. One worker was shifted to packing from ironing. In all cases, the patients are not yet in need of anti-retroviral treatment.

World AIDS Day (December 1st) is celebrated with awareness programs organized by the Freedom Foundation that include role play, posters and booths. Many workers contribute money to the foundation. GI is considering trainings for caregivers (nurses, welfare officers and doctors) to ensure that the disease does not spread through needle pricks or injuries. If this training is held, the Freedom Foundation will organize it.

Training

A **train-the-trainer model** is in place for health education trainings. Medical officers, human resource staff and wellness officers receive training, as do 3–4 peer educators per factory. Training is held **once a month** and is organized by outside experts such as the St. John's Department of Psychiatry. Topics include **cancer detection, ergonomics, HIV/AIDS** and **hygiene**. Additional trainings for workers are supposed to be held monthly but in reality happen every two months because of production pressures. Trainings are limited to 30–40 workers and are held in the clinic at the end of the day. The factory pays the worker for one half hour, and each worker contributes half an hour of their time.

A recent example of training for medical officers, human resource staff, wellness officers and peer educators was led by the director of the Regional Occupational Health Center, Bangalore Medical College, who was invited to discuss **ergonomics** by the Chief Medical Officer. The director provided photos of good and bad posture and agreed to provide an audit every six months free of charge.

A **meditation class** has been held after hours, and workers enthusiastically stayed late to attend it.

The Karnataka State Commission on Women has provided training on **sexual harassment** for supervisors.

All workers are trained on the **health and safety policy at the time of induction**. There is an **emergency medical policy**.

All factories provide training on **first aid and fire safety** as required by law and by brands.

Responsibility and Impact

Welfare officers, who speak with workers when they return from leave, report that **sickness absenteeism** has been reduced. Absenteeism was previously about 7 percent total, with 3 percent due to sickness. Workers did not know how to use the ESI system; they used to take four days leave to visit the ESI hospital but now take about two days leave.

Turnover is 4–6 percent and has been reduced by about 1 percent over the last four years. Workers transfer within factories, rather than leave the company.

GI has not conducted an internal evaluation of the impact of its health programs on worker health. Sumir Hinduja, the managing director who has been instrumental in initiating the health program at GI, feels that the health program has achieved about 50 percent of its initial goals. He is most satisfied with the **emergency care intervention**, which saved lives and helped factory workers to receive better care from the ESI system. The train-the-trainer system, one of the company's preventive care initiatives, has not been training workers directly as often as he would like. The annual health check-ups, a preventive care initiative, uncover main ailments but follow-up and long-term treatment are lacking. He supports the program because he feels the company has a moral responsibility to promote worker health and is less concerned about potential gains in productivity.

He believes that the law should allow companies to provide health coverage through private insurance rather than through ESI, which does not provide value for service. He thinks ESI can continue to provide leave and other administrative functions but should

allow competition in the actual provision of health services rather than improve its own services.

Interviews with Workers

Leelavati is 40 years old and has worked with GI for eight years. She was in the checking department but now works in the store. She had a chronic medical condition involving muscle pain that required many months of treatment. She took about nine months of leave, part of which was paid for by ESI. She has spent Rs. 23,000 (US\$500 at US\$1=Rs. 46) of her own money on treatment. She is happy at GI, as they accommodated her need to take time off for treatment and moved her to a less strenuous job.

Padma is 29 years old and has recently rejoined GI. She worked for a different unit earlier but quit when her mother died and she needed to take leave. She lives in a hostel far away and takes two buses to get to work. She was recently diagnosed with breast cancer. Dr. Sudhamani, the chief medical officer, accompanied Padma to the ESI hospital and ensured that she received chemotherapy treatment. Padma was scheduled to have surgery in a private hospital at the time of the site visit. Dr. Sudhamani is requesting that ESI pay for the surgery and has got the hospital to send a letter to ESI requesting reimbursement of Rs. 50,000 (US\$1086 at US\$1=Rs. 46) for the procedure.

Sonal Garments, Bangalore, India

Factory Information

Sonal Garments is an apparel manufacturing company with 14 factories in Bangalore that employ 7000–8000 workers. The factory visited employs **1350 workers**, of which 55 percent are female. This factory manufactures both knits (20 percent of output) and woven fabrics (80 percent of output). Handwork such as embroidery is outsourced.

The factory was certified by **Social Accountability 8000 (SA8000)** from 2002 to 2005 and is now seeking recertification.

Factory hours are from 9:00 am to 5:30 pm, and there is only one shift. Lead time for orders is typically 90 days but can be as short as 10–15 days. The factory is about six years old. The average worker wage is Rs. 2600 per month (US\$57 at US\$1=Rs. 46), and minimum wage in that area is Rs. 2300 per month (US\$50 at US\$1=Rs. 46). The average female worker's age is between 26–17. Women workers range in age from 18–32. About 50 percent of women workers are married.

Turnover is the same as the industry average of 20–25 percent. The factory manager believed that turnover was slightly higher for men than for women. An **attendance bonus** of one day's wages per month is achieved by about 20 percent of workers. Both male and female workers take high amounts of leave and may take 2–4 days without explanation. **Normal daily absenteeism** is 10–15 percent. Workers sometimes take leave

when the factory is filling an order for a difficult style, such as with heavy flannel cloth, and they return when they think the style will be finished.

The **cafeteria** provides subsidized lunch of Rs. 8 per meal (US\$0.17 at US\$1=Rs. 46). Food is prepared offsite and onsite. There are separate rooms for raw and cooked food. There are three iterated lunch breaks of 20 minutes each. There are no other breaks during the day, though workers are free to go to the restroom or to the cafeteria for tea. Most workers bring their own lunch.

The factory provides a **child care center** with a full time attendant and teacher. The child care center has 12–15 children under the age of three and has been functioning for four years.

An **internal audit** is held every three months. Every six months, management reviews compliance efforts. There is a central compliance team for all factories, as well as a personnel officer in each factory.

The factory has a policy and procedure, as well as a committee, on **sexual harassment**. Leela, the welfare officer, chairs the committee meetings. So far there have been no reported incidents of sexual harassment.

Worker Communication

Complaint books and boxes are available on the shop floor. The factory receives few complaints.

The law requires a **welfare officer** for every 500 workers. Leela, the welfare officer, has been with the company for 4.5 years. She holds a masters in human resources and welfare. She performs daily factory rounds for 2–3 hours. Workers approach her during her rounds and also in her office. Most worker problems are simple issues, such as running out of glasses by the water container. Some workers ask for the procedure to apply for ESI leave or Provident Fund benefits. Leela provides information raises issues with the supervisor or manager when necessary.

Health Facilities and Issues

All workers are covered by **ESI** for sick leave, maternity leave and hospital and pharmacy access. The ESI pharmacy is located close to the factory. The nearest ESI hospital is in Rajajinagar, about 8 kilometers away.

An **ambulance room** onsite is staffed by a full-time nurse and a part-time doctor. Dr. Srinivas has worked at the clinic for three years, and the nurse, Sister Ranjitha, has worked there for a year. The clinic is open during the same hours as the factory (9:00 am to 5:30 pm). The doctor is available daily for a few hours and can come in during emergencies because he has a private practice nearby. He sees about 10–25 patients everyday. Most patients come after 10:00 am and during their lunch breaks.

The ambulance room provides **diagnostic and referral services**. Pain killers and fever reducers, such as Paracetamol, are provided, but antibiotics are not. Only non-reactive injections, such as B-Complex, are given because there is no refrigerator to store reactive vaccines. Calcium and iron tablets are not provided because management believes ESI should provide them. Injuries are treated with dressing, and tetanus injections are not available. A medical waste service comes once a week to clear waste such as used syringes.

The factory has an agreement with a local **nursing home (small clinic) for follow-up care**. The first visit to the nursing home is paid by the factory. Payments are made directly to the nursing home upon submission of bills.

Male patients' main health complaints are **pains, gastritis, running nose** and **allergies**.

Most **workplace injuries** are needle pricks or cuts. The most serious injury in the last three years occurred when a worker was taken to a nearby hospital with a heart attack. Another worker with low blood pressure was taken to a nearby hospital because they required a drip.

The doctor would like to see more facilities in the clinic, particularly a refrigerator to store reactive injections, such as tetanus injections. He would also like to provide emergency medicine and calcium and iron tablets.

Reproductive Health

Female patients complain about the same health issues as male patients, plus **anemia** and **menstrual problems (dysmenorrhea)**. The factory clinic refers patients to the gynecological department at the ESI hospital or the private nursing home for further treatment. The clinic provides pain killers and medicines to stop excessive menstruation.

A **pregnant worker** informs her supervisor of her pregnancy. The worker can then decide if they would like to move to seated work on the ground floor. Pregnant workers can obtain leave through ESI. The clinic refers pregnant workers to the hospital for monthly check-ups but provides tablets for morning sickness during the first two months. Iron and calcium tablets are not provided at the clinic. About 25 percent of the women in the factory use sanitary napkins during menstruation, while the rest use cloth.

No contraceptives or family planning services are provided. Workers are shy to ask about contraceptives and family planning, and if a worker does have questions the doctor refers them to the ESI hospital.

HIV/AIDS

There have been no known cases of HIV/AIDS in any of the Sonal factories. The doctor provided a training on reproductive health, including HIV/AIDS. Women workers are shy to ask about HIV/AIDS, and men do not ever ask about HIV/AIDS.

Training

A one-day **induction training** is provided for new workers, as is a one-day refresher training every six months. The welfare officer conducts the induction training. All workers are trained on firefighting and fire drills by a private provider, Brilliant Services. First aid training is provided every two months by St. John's Ambulance Services. All first aid-trained workers wear a badge.

Most new workers have prior experience. Sonal has a training center offsite for workers who need **training in job skills**. Inexperienced workers receive 45 days of training. Sonal has access to the Apparel Training Design Center (ATDC) in Peenya that is managed by the industry association.

Training on health issues is provided to workers monthly by an external social compliance consultant and the doctor. Trainings accommodate 300–400 workers (both male and female together) and are held in the cafeteria using a microphone. Trainings last for an hour and are held during the second half of the working day, during low production periods. Workers are compensated for their time. Topics include:

- Pre-natal care
- Post-natal care
- HIV/AIDS and use of contraceptives
- Hygiene
- Detrimental habits, such as chewing tobacco
- Water purification at home

The welfare officer believes there should be more trainings and that the same issue should be repeated twice (for example, HIV/AIDS).

Responsibility and Impact

The factory management feels that tailors are a scarce commodity in Bangalore and that they need to inculcate a sense of belonging among workers so they stay loyal to the firm. Management feels responsible for the health of workers and believes that the health facilities they provide help to retain workers. However, they do not think that workers recognize the merit of non-financial benefits. Workers appreciate salary increases but do not give credit to health facilities.

Interviews with Workers

Kavita has worked with Sonal for five years. She does writing (marking) in the cutting section. She is married with two children, aged seven and three years. When she had her second child, she was working at Sonal and took the full 90 days leave that ESI covers. She delivered at the ESI hospital and felt she was well cared for there. She was provided with seating in the cutting section during her pregnancy. She lives in nearby Laggare, and her husband is a driver. She takes a lunch break at 1:45 pm. She takes her children to the ESI hospital for routine care and to private doctors near her home in case of

emergency. She is aware of worker committees and knows what sexual harassment is. She earns Rs. 3300 per month (US\$72 at US\$1=Rs. 46).

Nafisa does numbering in the cutting section. She has worked with Sonal Garments for a little over a year. She is not aware of any of committees for workers. She earns Rs. 2600 per month (US\$57 at US\$1=Rs. 46). She completed the 7th grade.

Lalitha is a helper in the stitching department and has been with Sonal Garments for two years. She earns Rs. 2300 per month (US\$50 at US\$1=Rs. 46). She completed the 12th grade and traveled from outside Bangalore to work. She lives with her aunt and uncle nearby and walks to work, which takes her 15 minutes each way. She is aware of the worker committees and does not have any unfulfilled problems or needs.

Bhagya is eight months pregnant. She is a helper in the ground floor performing seated work but used to be a tailor. When she informed her supervisor that she was pregnant, he asked her to move to seated work. She is 21 and was married in August 2005. She lives in Leggere, an hour's walk away according to Bhagya and 20 minutes according to the welfare officer. Her husband works as a loader in the Bisleri factory, which packages mineral water. She is from Tumkur and completed the 10th grade. Prior to working at Sonal, she worked at another factory in Bangalore but she thinks this factory is better. She earns Rs. 2300 per month (US\$50 at US\$1=Rs. 46). She will probably work for another week and then take leave. She goes to the ESI hospital in Rajajinagar and receives iron and calcium tablets there. She is not taking any supplemental food. She is happy with conditions at Sonal.

Swaasthya Community Project, New Delhi, India

Swaasthya is an NGO based in New Delhi that has worked in the urban low income area of Tigri since 1994 to improve reproductive health through women's micro-credit self-help groups, adolescent girls' groups and community marketing of contraceptives. Its programs are designed, implemented and managed by members of the community. Swaasthya plays the role of catalyst and has gradually handed over other roles to the community. The Swaasthya project was also visited by BSR in 2002.

Tigri has approximately 25,000 residents, most of which came from poorer states in northern and eastern India in search of work. It is a "resettlement colony," where residents were resettled by the government from slums where they were illegally occupying land. The residents are considered low income but not below the poverty line. Most women are stay-at-home mothers. This is an extremely patriarchal society. Even within the home, women have to follow the dictates of their mothers-in-law and sisters-in-law (the wife of husband's older brother), who live in the same house. Men work as street vendors or in factories around Delhi. School enrollment is high. The nearest government hospital, Safdarjang Hospital, is about 15 kilometers away.

Swaasthya has five employees in Tigri who are local community members and earn an average monthly salary of Rs. 2500 (US\$54 at US\$1=Rs. 46). Dr. Geetha Sodhi, the founder of Swaasthya, believes that the project's employees should be paid for their services so they take their employment with the seriousness of a paid job. Swaasthya has a staff of seven at its Delhi office. The Tigri-based staff go to the Swaasthya office twice a month for guidance meetings, and Swaasthya office staff come to Tigri once a month for a general meeting. Office staff also visit informally 2–3 times a week.

Improvements and Impact since 2002

Swaasthya has continued to operate five programs that are designed, managed and implemented by paid community members:

- Health clinic with weekly mobile van from another NGO, Population Fund International
- Women's Governing Council
- Women's Self-Help Groups (savings and loans)
- Social Marketing Depots (for contraceptives and feminine hygiene materials)
- Adolescent Development Center

Two evaluations have strived to provide concrete measures of the impact of Swaasthya's work in Tigri, as detailed below in this site report. One evaluation was focused on the adolescent program, and the other compared Swaasthya's women's programs to those of a government pharmacy and a private clinic using a survey tool. BSR interviewed a number of Tigri community members during the site visit to further determine the effectiveness of Swaasthya's programs. Swaasthya has also been chosen by the Francois Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health to participate in a study on reproductive health and women's empowerment, so further data on effectiveness will soon be available.

With time the clinic has established itself in the community. Women are choosing to have less children and are more proactive about immunization. Many women bring other female family members to Swassthya.

The Women's Governing Council, Mahila Panchayat, has confronted initial skepticism from men in the community and from police, both of which claimed that the council had come to "break up families." Such comments continue but are less frequent. The Panchayat has resolved a number of cases and council members are proud of its results.

The social marketing depots have encouraged women to become more open about discussing reproductive health concerns. Many mothers also want their daughters to learn skills from Swaasthya and send their daughters to pick up materials from the Swaasthya clinic, whereas earlier they would not have sent adolescent girls outside of their homes for errands. In the future, women would like the depots to be more self-sufficient and be able to turn a profit.

Girls who have participated in the adolescent development program report better communication with their parents and are more confident about expressing themselves. Mothers understand that Swaasthya is helping their daughters take first steps toward dealing with issues, such as family planning, that the girls must face later in life.

The self help groups are running successfully. Self help group members feel empowered by having their own money and not having to ask their husbands for money to make small purchases.

Clinic

A clinic has been set up in the rented ground floor of a house, for which rent of Rs. 3000 per month (US\$65 at US\$1=Rs. 46) is paid by Swaasthya. A van from Population Foundation of India (PFI) with a doctor and nurse visits the clinic every Wednesday from 10:00 am to 3:00 pm. The Swaasthya employees register each patient, who pays Rs. 10 per visit (US\$0.21 at US\$1=Rs. 46) to consult with the doctor. Medicine is provided for free. The doctor and Swaasthya staff provide counseling on health issues.

Most patients come during pregnancy, for treatment of reproductive tract infections and sexually transmitted infections, for family planning services or for illnesses such as cough, cold, fever and diarrhea. Many come to immunize their children, since Swaasthya provides immunization cards. Every Wednesday about 45–55 patients visit the clinic. Patients are referred to Safdarjang Hospital for deliveries or more extensive medical care. Records for each patient who visit the clinic are maintained on an individual card, and records for pregnant women are maintained on a separate ante-natal card. This is the only clinic in the Tigri area.

The mobile van from Population Fund International visits the slum area of Naglamachi, which is further out, once a week. The van receives about 30 patients per visit.

With time the clinic has established itself in the community; now, women bring their daughters-in-law and sisters-in-law for family planning advice and services. Women used to have four children but, since costs of living and education have increased, most women only have two children. Women used to raise 4–5 children without immunizations, but now they bring all their children for immunizations. According to Tigri-based staff, reproductive health problems are being brought into the open, and women are not shy to visit the clinic and seek treatment.

Women's Governing Council

There are 10–15 members of the women's governing council, or Mahila Panchayat, which has been functioning for the past eight years. The Mahila Panchayat's goal is to raise awareness of laws that protect women and establish community-based paralegal cells. It has been recognized by the government's Delhi Commission for Women. All staff members have been trained by Swaasthya. Most cases it sees involve domestic

violence, divorce, dowry, teasing, harassment by neighbors or property disputes. It settles compensation outside of courts, retrieves bridal gifts or dowry, ensures rights of women in domestic violence situations and acts as liaison with the police.

The Mahila Panchayat meets from 3:00 pm to 5:00 pm every Wednesday at the clinic. It charges Rs. 10 (US\$0.21 at US\$1=Rs. 46) for each case it takes, but women who cannot afford to pay are still aided. Most cases involve marital discord, alcoholic husbands and domestic violence. The Panchayat usually sends a summons to the husband. If he does not appear, the Panchayat members go to the complainant's house and provide counsel. Some complainants join the Panchayat after their cases have been successfully resolved. Cases are generally solved quickly. The police are brought in for cases involving serious injury. The Panchayat has had two recent cases of murder.

Men in the community, as well as the police, were initially skeptical of the Mahila Panchayat's efforts and claimed that the council had come to "break up families." Panchayat members still hear such comments when they make house visits. Some members were themselves victims of domestic violence and were beaten up when they initially joined, but they persevered and now freely participate. They have even brought the Panchayat into their own family altercations. Panchayat members are happy with the results of their work and glad to be able to resolve cases.

Social Marketing Depots

There are 13 social marketing depots in Tigri, all run by women from their homes. These depots stock sanitary napkins and condoms at cost, and women in the neighborhood are aware of the service. Swaasthya provides the materials for sale and gives 35 percent of the proceeds to the women who manage the depots. Initially, Swaasthya gave 25 percent of proceeds to the depot managers and 10 percent of proceeds to the Swaasthya staff who visited the homes for follow-up, but depot managers were given the opportunity to receive the full 35 percent of proceeds if they came to the clinic themselves to pick up materials, which all of them chose to do. The depot managers feel their service is useful because young women are too shy to go to the shops to buy sanitary napkins. About 25–50 napkins are sold every month at the cost of Rs. 2 (US\$0.04 at US\$1=Rs. 46 each). Men do not visit the depots, but Swaasthya has provided condoms in local shops, such as tailor and pan (betel nut) shops. BSR visited one tailor shop, but the owner complained that his stock had not been replenished in many months and demand was high. He did not want to go to the center himself to replenish stocks because he was not being paid for his service. Men used to run depots, but they stopped because they felt that it interfered with their jobs (often managing shops).

Susheela, one of the most successful depot managers, feels that women are now more open about discussing problems and coming to her. Susheela has two daughters, aged 16 and 12. She says that mothers want their daughters to learn skills from Swaasthya. Now they send their daughters to pick up materials from the Swaasthya clinic, whereas earlier they would not send adolescent girls outside of their homes for errands. Women are more forthcoming with their problems. In the future, they would like the depots to be more self-sufficient and make more profit. For example, perhaps depots could make their own sanitary napkins.

Self Help Groups

There are 15 self help groups (SHGs) that have been functioning for eight years. Each group combines savings into a common pool that can be accessed by any of the members. Each SHG sets up its own rules based on member consensus.

Initially, members were contributing Rs. 50 each per month (US\$1.08 at US\$1=Rs. 46), but now they contribute Rs. 100 each per month (US\$2.17 at US\$1=Rs. 46). Each SHG has a secretary, a deputy Secretary and a treasurer, who opens the bank account. Any members can deposit money, but only the three officers can make withdrawals. When a member wants to take out a loan, they approach the three officers, who evaluate the request. The officers communicate decisions to the group during monthly meetings or informally, as they all live close by. The officers also keep Rs. 4,000–5,000 (US\$87–\$108 at US\$1=Rs. 46) with them for emergencies that arise at times when officers cannot go to the bank.. The officers are not fixed, and anyone who is interested can be selected by consensus.

Loans are mostly requested for weddings, home and jewelry purchases or other capital expenditures. Some loans are requested to pay the monthly electricity bills. Loans are repaid in installments of Rs. 10, 12 or 15. Interest of 1 percent is charged; as a comparison, banks or money lenders charge 5 percent interest on loans. The group can give a waiver for a few months to a member that cannot afford to return a loan immediately. In one case, a group waived interest payments for six months. Loan amounts range from Rs. 5000 to Rs. 25,000 (US\$108 to US\$540 at US\$1=Rs. 46).

Tulsi has been an SHG member and Mahila Panchayat member for eight years. Initially, her family resisted her choices, and she was physically beaten up for joining. She involved the police in her sister-in-law's problems, and gradually her family began to recognize the usefulness of the Panchayat and the SHG. At first her family thought that the officers of the SHG would steal her money. She insisted that she wanted to contribute and promised to leave the group if her money was stolen. Her group now has Rs. 80,000–90,000 in their bank account (US\$1739–\$1956 at US\$1=Rs. 46). She took a loan of Rs. 15,000 for her husband to secure a job (US\$326 at US\$1=Rs. 46). Earlier there were 17 members, but now there are 12, as a few members moved out of Tigri. The members feel empowered by having their own money and not having to ask their husbands for money to buy small things like a sari or chappals. They are prepared to give loans to a sub-group of 2–3 women or even to one woman to start a business, but so far this has not happened.

Gayatri is also a member of an SHG. Out of 13 members in her group, eight have taken loans.

Bhavani is another SHG member. Her group has 13 members, and eight have taken loans. The loans typically range from Rs. 5,000–10,000 (US\$108–\$217 at US\$1=Rs. 46), but the largest loan was for Rs. 12,000 (US\$261 at US\$1=Rs. 46). Loans are returned in installments of Rs. 500 to Rs. 1000 per month (US\$11 to \$22 at US\$1=Rs. 46).

All SHG members stated that they want to use the saved money to learn a skill and engage in a trade such as tailoring, candle making or being a beautician. Swaasthya staff said that the problem was not teaching these women skills but marketing their products. Swaasthya staff have taught women candle making, but sales of their products were good only at the time of Diwali (a yearly festival).

The SHG members are prepared to give Rs. 50 per month (US\$1.08 at US\$1=Rs. 46) each to Swaasthya to help run the clinic if Swaasthya funding should stop.

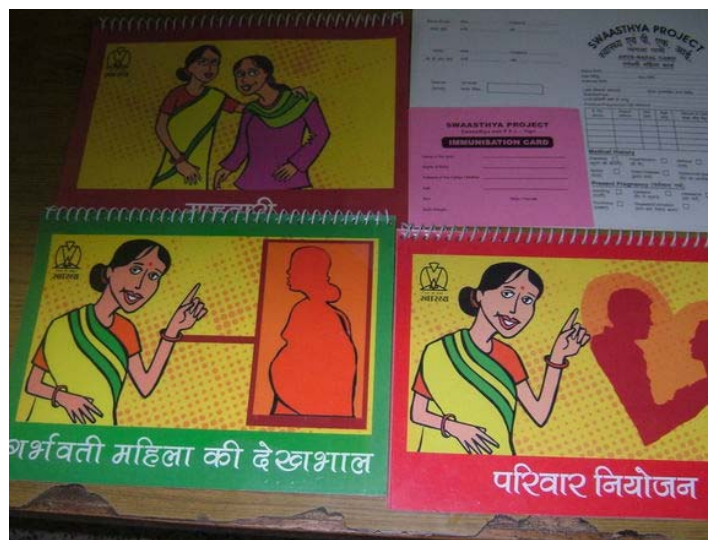
Adolescent Development Center

Swaasthya initiated an adolescent development program because it found that adolescent girls in Tigri have very little communication with parents or other adults. Discussion of sex is strictly taboo, and a lot of misinformation and myth exists, mostly from television and films. There have been cases of pre-marital sex, usually unplanned and unprotected. Coercive and exploitative sexual activity also occurs due, to fear of social stigma. Harassment of teenage girls through lewd comments is common and forces many girls to stay indoors.

A group of 10–15 young girls meets once a week at the Swaasthya for discussions around reproductive health, sexual self-expression and self esteem. These meetings are open to all

adolescents in the area. Ten girls have been trained as peer educators. Peer educators possess training materials and decide for themselves how to engage their peers either through daily interactions or more formally through trainings at the clinic.

Girls who have participated in the program report that they have better communication with their parents, especially their mothers, and they are more confident about expressing themselves. Before participating in the program, they were blamed for dressing provocatively and being teased by neighborhood boys, but now mothers who attend discussions at Swaasthya understand that teasing can happen to anyone and that their daughters cannot be blamed. The mothers understand that the program helps girls take first steps towards confronting issues that will come up later in the girls' lives, such as family planning.



Swaasthya also organized the Kishori Jagrithi Samithi, or Girls' Development Forum," a permanent forum that discusses harassment of women ("eve-teasing") and serves as a grievance redress mechanism. It meets every Friday and has 15–20 members. The members are not fixed, and it is open to the full community.

Impact and Progress

Two evaluations have been carried out recently of the Swaasthya programs. These evaluations were focused on cost efficiency of the adolescent program and effectiveness of the women's programs, the latter of which was carried out by the Indian Ministry of Health. Swaasthya has been selected by the Francois Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health to participate in a study on reproductive health and women's empowerment.

The evaluation found that the adolescent program provided a low-cost model that was easily replicable. Swaasthya found that its intervention increased knowledge levels and positive perspectives. Participants gained a greater ability to make decisions and received

greater social support. The study further found that time had to be invested in bringing groups together to cause cultural change, rather than just simple increases in knowledge. Parents are an instrumental part of the process. The study concluded that knowledge should be imparted on a frequent basis, while groups will continue to gain in strength and do not need outside inputs.

The evaluation of the women's programs by the Indian Ministry of Health compared Swaasthya's programs with the programs of a government pharmacy and a private clinic. Four hundred women residents of Tigri were covered in the survey, which was conducted in February 2006. The survey inquired why Tigri residents choose the Swaasthya clinic over the private clinic and the government pharmacy. Respondents cited familiarity with the doctors at the Swaasthya clinic and the fact that the staff make them feel comfortable and speak to them politely. They also receive answers to their questions at the Swaasthya clinic. At the government pharmacy, the staff were reportedly rude to patients and do not give information.

The final reports from the evaluations were not ready at the time of our report writing, but the following data was shared by Swaasthya during the site visit:

Indicators	Tigri residents who have been exposed to Swaasthya programs	Tigri residents who have not been exposed to Swaasthya programs	Delhi	India
Use of modern methods of contraception	72.9%	57.4%	-	-
Condom use	21%	-	18.2%	7.2%
Percentage of women who underwent a full ante-natal care program*	89%	-	-	32.8%
Percentage of pregnant women who had a health check-up in the first trimester	61.3%	-	-	33%
High knowledge on reproductive health	43.6%	21.8%	-	-
Percentage who sought treatment for reproductive tract infections	36.3%	18.8%	-	-

*Full ante-natal care program consists of three check-ups, tetanus injection and 90 days iron and folic acid supplements, as defined by the government's Nutritional Family Health Survey.

Survey participants preferred to receive family planning services at locations that also offered other health services. They deemed the dignity of the individual to be important and preferred to visit clinics where they are treated well and spoken to politely. They prefer providers who take the time to provide counseling, rather than distributing medicines like the Swaasthya clinic. Lastly, they are prepared to pay up to Rs. 20 per visit (US\$0.43 at US\$1=Rs. 46) rather than the current Rs. 10 per visit (US\$0.21 at US\$1=Rs. 46) for services at the Swaasthya clinic.

V. Indonesia

Context

Country Health Situation

Indonesia has recovered steadily from the Asian economic crisis of 1997 and ended 2005 with overall GDP growth of 5.9 percent, the highest in nine years.²⁴ The country has witnessed extensive political changes in the last decade, with the peaceful election of the current President Susilo Bambang Yudhoyono in 2004 marking significant movement towards democratic reform.

Indonesia has also made considerable progress in basic development indicators in the last few decades. Infant mortality has decreased from 118 deaths per thousand births in 1970 to 35 deaths per thousand births in 2003, and life expectancy has increased from 48 years to 66 years over the same period.²⁵ However, as the country returns to pre-crisis levels of economic growth and prosperity, incidence of non-communicable diseases, such as diabetes and cancer, is increasing, as is incidence of infectious diseases, such as tuberculosis. Vast differences exist between different regions and the 17,000 islands that make up the country, which spreads across three time zones. In some provinces, infant and child mortality rates are among the lowest in Asia.

Indonesia: Health Statistics		
Name	Indicator	Year
Population ¹	222.8 million	2005
Life expectancy at birth (male) ¹	65 years	2004
Life expectancy at birth (female) ¹	68 years	2004
Population with sustainable access to improved sanitation (percentage of population) ²	52%	
Percentage of births attended by skilled attendant ¹	66.3%	2002
Maternal mortality ratio adjusted (per 100,000 live births) ²	230	2000
Infant mortality rate ²	31 (per 1,000 live births)	2004

²⁴ *World Bank Country Briefing 2006*, Jakarta, Indonesia

²⁵ *Ibid.*

Contraceptive prevalence rate ¹	60.3% (married women aged 15-49)	2003
Prevalence of HIV, total (of population ages 15 - 49) ¹	0.0% to 0.2%	2003
Doctors ¹	1.3 (per 10,000 pop.)	2003
Nurses ¹	6.2 (per 10,000 pop.)	2003
Midwives ¹	2 (per 10,000 pop.)	2003
Community Health Workers ¹	0 (per 10,000 pop.)	2003
Other Health Workers ¹	1 (per 10,000 pop.)	2003
Dentists ¹	0.3 (per 10,000 pop.)	2003
Population undernourished (% of total) ²	6%	2000–2002
Children underweight for age (% below 5) ²	26%	1995–2003
Estimated incidence of tuberculosis cases ¹	245 (per 100,000 pop./year)	2004

Sources: 1 - *World Health Report 2006 – Working Together for Health*. World Health Organization, Geneva; 2 - *United Nations Human Development Report*. 2005. United Nations, New York.

Indonesia is third in the world in incidence of tuberculosis at 168 per 100,000 population per year.

There are about 170,000 people (0.1–0.2 percent of the population) living with HIV/AIDS; UNAIDS views Indonesia as a country with a concentrated epidemic, since most HIV positive people are injecting drug users and female sex workers. The highest prevalence rates are in the provinces of Jakarta, East Java, West Java, Bali, Papua, West Kalimantan, North Sumatra, North Sulawesi, Irian Jaya and Riau.²⁶

Government and Legal Context

Indonesia had a strong network of public health facilities from the 1960s until recently, and this network enabled the country to improve its basic health indicators. Primary health centers, known as “Puskesmas,” and community health centers, known as “Posyandu,” functioned throughout the country. However, the new government has decentralized control over health facilities, and management of these facilities is passing to provincial and local governments. Local governments have increased their share in total public health spending from 10 percent prior to decentralization to 50 percent in 2001 as national government responsibilities have been passed down.²⁷

Reliance on private health services has increased. Total expenditure on health as a percentage of GDP was 3.1 percent in 2003,²⁸ but expenditure by the government on health as a percentage of total expenditure on health was only 35.9 percent, with the remaining 64.1 percent being private expenditure.²⁹ About 74 percent of private

²⁶ UNAIDS and United Nations Development Program (UNDP), www.youandaids.org

²⁷ *World Bank Country Briefing 2006*, Jakarta, Indonesia

²⁸ Core Health Indicators, World Health Organization Statistical Information System, WHOSIS 2006. Data from 2003.

²⁹ Ibid.

expenditure on health comes from out-of-pocket expenses. The per capita expenditure on health at international dollar rate is \$113.³⁰ In most areas of Indonesia, the private sector accounts for more than two-thirds of ambulatory care, more than half of hospital contacts and 30–50 percent of all deliveries, the latter compared with approximately 10 percent a decade ago.³¹

The government's reproductive health policy focuses on mother and child health, safe pregnancy, and motherhood and infant growth. Health education and promotion is also emphasized. Policy on communicable diseases revolves around tuberculosis, malaria and HIV/AIDS.

The following benefits are provided to workers as required by law:

- **Social Security:** All workers are eligible for JAMSOSTEK, or Social Security benefits, which are managed by the government. JAMSOSTEK consists of four parts: 1) Occupational accident, 2) Life Insurance, 3) Retirement Benefits and 4) Health care services for worker and his or her family. The first three parts are compulsory, but if an employer can prove that health services equal to or better than those provided by JAMSOSTEK are being provided for workers then they are exempt from paying for government health care services. The JAMSOSTEK organization nominates hospitals to provide services to workers covered by JAMSOSTEK.
- **Maternity leave of 12 weeks** is provided, including six weeks prior to the due date and six weeks after delivery. In case of miscarriage, women are given 1.5 months off. Pregnant workers cannot work between 11:00 pm and 7:00 am if it will be harmful to their pregnancy. Employers are obligated to arrange and allocate work appropriate for pregnant workers, without reducing their rights and entitlements. Discrimination against pregnant women or dismissal during pregnancy is prohibited. Breastfeeding mothers must be provided a suitable location and breaks for breastfeeding during working hours.³²
- Women workers are allowed to take two days of **menstrual leave** per month.³³
- Workers may take **extended leave of up to twelve months** in case of chronic illness such as tuberculosis, provided they have appropriate medical certification. They receive full pay for the first four months, 75 percent pay for the next four months and half pay for the last four months.
- **First aid facilities and workers trained in first aid** must be available during working hours.³⁴
- Any **accidents** must be reported within 48 hours to the Ministry of Manpower.³⁵

³⁰ Ibid. The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries.

³¹ *World Bank Country Briefing 2006*, Jakarta, Indonesia

³² Manpower Act No. 13, 2003

³³ Law No. 1 of 1951

³⁴ Law 1/70 and Minister of Manpower Regulation No. 7 of 1964

³⁵ Law 1/70 and Minister of Manpower Regulation No. 7 of 1964

- Employers with more than 50 workers must employ a **safety manager**. Employers with more than 100 employees must appoint a **health and safety committee**, with representatives from both employers and employees.³⁶
- **Health education and periodic health examinations** must be provided.³⁷
- **Disabled or incapacitated workers** must be **rehabilitated**.³⁸
- While the law does not specifically mention “**sexual harassment**,” there is a provision against “indecent behavior” or “crime against decency” (kesopanan) that can be used in filing a complaint and in termination.³⁹
- A Ministry of Manpower Decree released on May 6, 2006 **prohibits discrimination against persons who have tested positive for HIV/AIDS**. The decree bans employers from conducting HIV tests during recruiting or in compulsory medical check-ups. HIV tests can only be performed with the written agreement of the worker. If a worker needs an HIV test, the employer must provide counseling before and after the test is conducted. Any information obtained from counseling activities, HIV tests, medical treatment and care, and other related activities must be kept confidential like any other medical records.

Cultural Context

The Indonesian population is approximately 88 percent Muslim, 8 percent Christian, 2 percent Hindu, and 1 percent Buddhist or other religions. Indonesia is the world’s most populous Muslim-majority nation, with a total population of 222 million. However, there are strong Hindu and Buddhist influences in the country that remain from ancient Hindu kingdoms in different parts of the modern-day country. Indonesia has been tolerant of different religions and has assimilated various cultural influences that are reflected today in the Indonesian language, customs and practices.

There are more than 300 ethnic groups across Indonesia’s 17,000 islands, and each group has its own language and culture. The Indonesian language, which is taught in schools across the country, is the binding factor. During the Suharto regime (1965–1998), the majority Javanese and Madurese people were made to migrate to the sparsely populated islands of West Kalimantan, Sulawesi and Western New Guinea, and this migration resulted in ethnic clashes between the indigenous communities of those islands and the settlers.

There is a sizable Chinese community of between 6– 7 million, or about 4 percent of the population. During the reign of former President Suharto, the Chinese community was persecuted for alleged communist links and prohibited from cultural expressions such as publicly using Chinese characters, teaching Chinese in schools, celebrating festivals such as the Chinese New Year or using Chinese names. In May 1998, in the last year of the Suharto era, riots erupted in cities with large Chinese populations; Chinese-owned shops

³⁶ Law No. 1 of 1970

³⁷ Law 1/70 and Minister of Manpower Regulation No. 7 of 1964

³⁸ Law 1/70 and Minister of Manpower Regulation No. 7 of 1964

³⁹ Article 281, Criminal Code and Minister of Manpower’s Decree No. Kep-150/Men/2000 as amended by Minister of Manpower’s Decrees No. Kep-78/Men/2001 and No. Kep-111/Men/2001

were looted, and people of Chinese descent were attacked. A large number of ethnic Chinese chose to emigrate overseas. Since then, there has been a relaxation of laws prohibiting use of Chinese language and traditional customs have been revived, including celebrations and use of Chinese names. During Suharto's regime, a few Chinese-owned conglomerates amassed wealth, and the general perception in Indonesia is that the Chinese are economically better off than other Indonesians.

Muslims in Indonesia broadly follow two orientations: "modernists," who follow traditional teachings of Islam but also embrace modern learning and concepts, and the predominantly Javanese "traditionalists," who follow religious scholars and attend religious schools. Although Indonesia has a majority Muslim population, it has been a secular state since independence from the Dutch in 1945. At times some Islamic organizations have advocated the adoption of sharia law by the state, but the large Islamic organizations, the Nahdlatul Ulama and the Muhammadiyah, have resisted this change.

All workplaces have prayer rooms and provide for modified working hours during fasting at the time of Ramadan. Most workers in manufacturing facilities have completed 10 years of schooling (or junior high school). The female adult literacy rate as a percentage of male literacy is 90 percent; overall adult literacy is 87.9 percent.⁴⁰

Single women are not expected to be sexually active. While women receive information on sexually transmitted diseases through television and radio campaigns, they are not provided counseling on reproductive health issues or contraceptives through the public health system. Married women are better informed. Most women in the factories marry in their mid 20s and do not use contraceptives until after the birth of their first child. Intravenous contraceptives seem the most popular, followed by oral contraceptives. Very few women use IUDs, and condoms are rarely requested. Contraceptives are available in public and private hospitals. Because of relatively high levels of literacy, women are open to discussing reproductive health issues and do not hesitate to share information during discussions in factories.

Research and Findings

Methodology

BSR staff visited seven factories in Indonesia to discover the most relevant health issues for women workers and examine how women's health concerns are being addressed in their workplaces and their communities. Field research was supplemented by a review of institutional reports and other research on issues relevant to women workers in Indonesia, as well as of Indonesian labor laws and of the Web sites of government agencies and NGOs (listed in the Appendix).

⁴⁰ Figures for 2003 from *United Nations Human Development Report*, 2005

Of the four projects visited, two were previously visited in 2001–2002 as part of BSR’s earlier study on Women’s Health in the Global Supply Chain. Impact and progress since the previous visit are recorded in the individual factory reports. Also provided is information gathered during a meeting with a reproductive health NGO, Yayasan Kusuma Buana (YKB), that partners with one of the factories.

The factories visited were located in industrial areas around Jakarta and in Bandung, both on the island of Java. Jakarta has a population of 9.5 million and is the political, commercial and manufacturing center of Indonesia. It is surrounded by industrial areas, and most workers are migrants from Sumatra, other parts of Java and other parts of Indonesia. Bandung has a population of about 2.5 million and is a center of apparel production.

Prior to the factory visits, a questionnaire was sent to each site to collect information about the programs available to address women workers’ health. Some respondents filled out the questionnaire during the onsite visit.

Representative of parent companies or brands were present during some site visits.

Site visits lasted from a half day to a full day and included:

1. Discussion with factory management on health programs and policies. Interviewees included but were not limited to general managers, human resources managers, health and safety managers, welfare officers, counselors, consultants, doctors, nurses, other relevant medical and management personnel and representatives from quality and production departments.
2. Factory walk-throughs to observe production processes, as well as observance of safety measures including use of personal protective equipment by workers. Visits were paid to cafeterias, dormitories, recreation facilities, waste-water plants and other facilities.
3. Visits to clinics and infirmaries, discussions with medical personnel and sample reviews of medical records where maintained.
4. Visit to affiliated medical facilities, such as offsite clinics.
5. Where time permitted, facilities provided by the local government, industry association or private providers were visited to compare with factory-provided facilities such as clinics or child care centers.
6. Interviews with workers and with union representatives, where applicable. Interviewed workers were mostly women of varying ages, including pregnant workers when present. Interviews were conducted in Indonesian and interpreted by a brand representative or by company staff. The interviews were held in settings such as the clinic or a conference room. In some cases, representatives of management were present. The worker interviews aimed to assess worker access to health facilities and worker understanding of health issues such as HIV/AIDS, as well as determine unfulfilled needs. Information gathered was not verified against company records such as payroll records, and it was not discussed with management. Accounts of interviews are reproduced verbatim, though some

names of persons and places may not be accurate. Interviewees were chosen to be representative of the average worker in the factory (including age, level of education and marital status) and the average worker's understanding of reproductive health issues and access to services. In Indonesia, a total of 20 workers were interviewed in four factories.

Except for a sample review of one or two medical records or injury log books, no extensive record review was carried out.

Printed information from the factory was collected where available to inform the study. Samples collected include annual reports, newsletters, blank medical record forms, blank referral letters, employee handbooks, posters, reports and presentations on health and copies of collective labor agreements.

Projects Covered

Of the four factories, two were engaged in apparel production, one in footwear production and one in toy manufacture. Two factories are located in Bandung and two are located around Jakarta. The number of workers at each factory ranged from 38,000 workers (with 15,000 in the specific production unit visited) to 3,300 workers. All factories had majority women workers, ranging from 80–95 percent. The average worker age is 25, and the average education level is nine years of schooling. An estimated 50–60 percent of workers are married. An estimated 50–60 percent of the workers are married.

Key Findings

Health Facilities

In Indonesia, companies are exempt from making payments to the government's health insurance program (JAMSOSTEK) if they can prove they provide facilities equal to or better than JAMSOSTEK's facilities. All four factories were exempt from making JAMSOSTEK payments for this reason. Factory services include:

- Onsite clinics for workers. Some clinics had a full-time nurse and a part-time doctor with diagnostic and referral capacities, while others had full-time nurses, general physicians, a part-time dentist, a laboratory, X-ray facilities and a pharmacy, as well as diagnostic, testing, treatment and referral capabilities.
- Private insurance, which gives workers access to outside hospitals .
- Offsite clinics. One factory collaborated with a health-focused NGO to establish a clinic off factory premises that is also available to the community. This clinic is covered by private insurance.
- Annual check-ups. Three of the four factories provide annual health check-ups, the findings of which form the basis for treatment and preventive activities. Health check-ups also scan for occupational hazards; for example, eye check-ups are provided for checkers. The factories maintained individual health files, though one factory only maintained files for workers who visited the clinic.

Additional services workers requested included more extensive health coverage and more services, such as ultrasounds for pregnant workers in company clinics. Workers also requested that family members be allowed clinic access.

Common Illnesses

The most common illnesses among workers are **upper respiratory tract infections (coughs and colds)**, **gastritis** and **hypertension**. Medical health providers attribute incidence of gastritis to the fact that most workers do not eat breakfast before coming to work.

There is a public health campaign against **tuberculosis** in Indonesia, which ranks third worldwide in the number of new cases per year at 245 per 100,000 population. A considerable number of tuberculosis cases were reported in the factories. All factories participate in the public health campaign and provide a long-term treatment course for workers with tuberculosis.

Dysmenorrheal (painful menstruation) is common among women workers, while reproductive tract infections are uncommon.

Nutrition

All four factories provided at least one free meal per shift, and this has had a beneficial impact on worker health. There are fewer cases of gastritis, anemia and fainting at work. Most factories started offering free meals after the Asian financial crisis of 1997. Meals are periodically checked for quality and nutritional value, and one of the factories has a nutritionist on staff. One factory provides all meals for free.

Care during Pregnancy

All four factories provided **mandatory monthly check-ups** during pregnancy in the factory clinic. All four factories maintain **ante-natal cards**, though some are more detailed than others. It is mandatory that all factories move pregnant workers to **seated work** when their pregnancy is known. Three factories prohibit pregnant workers from **working the night shift**, and two factories provide a **different colored uniform** for pregnant workers. One factory provides a “**Pregnant Worker ID Card**” that lists of the worker’s due date and prohibited types of work during pregnancy. Three factories provide **iron, calcium** and **folic acid tablets** to pregnant women and, of the three, one factory also provides dietary supplements, such as milk and soya. Two factories with large numbers of workers have **separate lines in the cafeteria** for pregnant women. In one factory, pregnant workers are **allowed to leave five minutes before the end of the shift** to help them avoid departing crowds. Most of the women interviewed said that they would prefer that their child be raised at home by their family or a caregiver.

Anemia and **hypertension** are common among pregnant workers. One factory reported cases of bleeding during pregnancy that resembled that of the general population. Many workers see a **midwife**, as midwife facilities are usually close to their homes and

convenient. Midwives are trained nurses who are authorized to perform deliveries, though there have been instances of midwives not moving the patient to a hospital for a difficult delivery. One factory reported several cases of **infant mortality** after difficult deliveries or due to lack of knowledge on infant care.

Family Planning

The four factories provide contraceptives through their clinics, including the factory that had an offsite community clinic. The most common contraceptives are intravenous and oral contraceptives, which are covered by insurance. IUDs are not popular. Condoms are rarely requested, though some clinics stock them.

HIV/AIDS

There have been **no reported cases of HIV/AIDS** in the factories visited. A nurse at the community clinic suspected a person in the community (not a factory worker) may have died of AIDS, but she does not know of any cases with certainty.

The four factories have included **education on HIV/AIDS** in health and safety trainings, either during induction trainings or during other trainings by company medical providers or invited NGOs. One factory has launched an AIDS Awareness Program with the goals of educating 10–15 percent of its workforce of 9,500 as well as the local community. Medical providers reported that only a few workers ask questions about HIV/AIDS.

When questioned about HIV/AIDS, most **workers** had heard of it. Some stated accurately that it was transmitted through sex and blood transfusions, but some did not know how it was transmitted or have any further information.

Who Pays for Health Services?

All services provided in company clinics are **free**, except for certain types of intravenous contraceptives that two factories charge for. Outside services in designated hospitals are covered by private insurance that factories provide. Private insurance also covers spouses and up to three children. One union member complained that insurance coverage did not cover the costs of child-birth and forced workers to pay about 75 percent out-of-pocket. Other workers seemed satisfied with the coverage provided. A few workers utilized government hospitals or community health centers (PUSKESMAS) for delivery and other health services such as immunization. Many women traveled to their home towns for delivery, and these women typically used PUSKESMAS.

Education and Prevention

Education and awareness raising initiatives were of two types:

1. **Train-the-trainer programs**, where a small group of workers are trained on specific health issues such as reproductive health, self-esteem, HIV/AIDS and nutrition. This small group then trains larger groups of workers. Such programs

exist in three of the factories. One factory also trains peer educators for the larger community.

2. **Training conducted by the company doctor, nurse, a specially invited NGO or medical experts** are held periodically and often target a specific group, such as pregnant workers. All four factories provide this training, and topics have included basic health issues like nutrition, hygiene and reproductive health, as well as specific health issues like tuberculosis, cancer detection and pap smear tests, stress release, HIV/AIDS, dengue fever and avian flu.

Trainings are held after working hours and are not mandatory. Some health care providers would like to have greater attendance and are willing to work more closely with factory management to make better attendance a reality. In addition to classroom style sessions, Factories have used classroom-style sessions, custom-made audio “Talk Shows,” flyers, posters, newsletters, interactive computer stations and custom-made video programs recorded in a professional studio onsite to disseminate information.

Mandatory training on first aid, fire safety and job safety are provided periodically, as required by law and by brands. All four factories provide induction trainings for new workers that cover health and safety topics.

Worker Communication

Factories that provided various means of communication with workers had a better chance of making health improvements. Three factories allowed **face-to-face meetings** between workers and senior management and, in one case, with the company president. Workers find the meetings useful for raising issues and getting answers and clarifications. All factories are unionized, and **union representatives** are often approached by workers with concerns, some of which relate to health facilities and services. Two factories had **individual counselors** available to workers; at one factory, counselors were trained personnel from human resources, and at the second factory workers were trained to be counselors through the Global Alliance project detailed below. The counselors have been useful but are not the sole means of communications with workers. Additional means of communication have included a **hotline for workers, computer kiosks where questions can be posed to management** and **newsletters**.

Impact

All four factories felt that health programs had a positive impact on absenteeism and had reduced turnover and injuries. All of the factories cited a reduced incidence of tuberculosis and were satisfied with their participation in the public campaign against the disease. They marked improvements in worker stamina and nutrition since they began to provide free meals.

Building employee loyalty was cited as an important reason for embarking on health programs. Two factories claimed to be motivated by moral reasons rather than improved productivity, though they did note improvements in productivity through reduced

absenteeism and turnover. These factories felt it was difficult to attribute an increase in productivity directly to investment in health but would find such a study helpful.

Recommendations for Effective Health Programs

The following recommendations for brands and factories for designing an approach to women's health concerns are made based on the findings above and on review of the critical success factors for factory programs:

- **Basic and advanced medical services need to be provided through company clinics.** Workers in Indonesia rely on factory clinics and designated hospitals covered by company-provided insurance for most health needs. Some of the costs of operating clinics with more advanced facilities can perhaps be covered by private insurance.
- **Surveillance activities, such as an annual health check-up, must be conducted for all workers,** along with specific tests for occupational hazards.
- **Health care facilities must be located close to the factory, and workers must be allowed to leave the production line to visit health care facilities.** If a clinic is located far from the factory, workers are reluctant to take the extra time to travel to the clinic even if a bus is provided. Line supervisors and production managers should be amenable to workers taking time to visit the clinic, lest workers become disinclined to use health services including routine medical check-ups or ante-natal check-ups during pregnancy that workers may skip if production pressure is high.
- **Factories with an integrated approach to women's health see more effective results.** Women workers are concerned about the welfare of their children, husbands and other family members. A factory that provides information on nutrition, hygiene, general health issues and seasonal illnesses sees a greater improvement in health than factories that only provide diagnostic and treatment services.
- **Coordination between different functions within the factory is important in ensuring health improvements.** Clinics and medical service providers cannot function in isolation, so periodic and systematic coordination and sharing of information and findings between medical service providers, human resources staff, production managers, cafeteria management, dormitory staff and senior management is necessary. For example, deficiencies in nutrition can be corrected through information sharing between doctors and cafeteria management. All departments must be made aware of the importance of worker health and access to facilities.

- **Training on health issues requires long-term commitment from factory management.** It is relatively easy to initiate a train-the-trainer program or invite an external expert to provide training, but ensuring that workers know about and attend trainings in sufficient numbers requires sustained efforts from management. Management should also encourage workers to make time to attend.

Detailed Reports of Site Visits

PT Dewhirst, Bandung, Indonesia

Factory Information

PT Dewhirst produces apparel in its factory in Bandung. The factory currently has **4996 workers**, 90 percent of which are female. Most are full-time employees. When women workers take maternity leave, they are replaced by contract workers, who receive all the benefits of full-time employees. The average worker age is 25 but ranges from 18–50. About 60 percent of workers are married. The average worker stays with Dewhirst for nine years. One hundred percent of production goes to Marks & Spencer.

The factory operates in **two shifts**, one from 6:00 am to 2:00 pm with a lunch break at 10:00 am, and one from 2:00 pm to 10:20 pm with a lunch break at 4:00 pm and a lunch/prayer break at 6:00 pm. The cafeteria provides free lunch, while tea and snacks are available for purchase. The minimum wage for the region is Rp. 710,000 per month (US\$78 at US\$1=Rupiah 9000).

The factory has a waste water treatment plant, where all waste is treated. Production is organized in three units. There is also a laundry. Warehouse, cutting and packing are organized centrally. There is one supervisor for every 35 workers, and supervisors total 180, of which 150 are women.

Daily **absenteeism** is about 4.2 percent, of which 1.2 percent is due to maternity leave. Illness is the main cause of absenteeism.

The factory has hired **42 disabled workers** through the Central Disabled Rehabilitation Council in Bogor. These workers come from all over Indonesia. The factory aim to have 1.5 percent of workers come from the disabled community.

The factory has a policy and procedure on **sexual harassment** that is communicated to all workers.

The factory is certified to the UK-based **Ethical Trading Initiative standard**.⁴¹

⁴¹ www.ethicaltrade.org

Improvements and Impact since 2002

The factory was visited in 2002 as part of BSR's earlier project on Women's Health in the Global Supply Chain. The factory has expanded its facilities since 2002 and has slightly increased its number of workers from 4300 to almost 5000.

The factory now provides **private health insurance** through Medica Pratama, in lieu of JAMSOSTEK. Medica Pratama has a higher standard than JAMSOSTEK, so the factory is exempt from paying into JAMSOSTEK. Medica Pratama provides up to Rp. 450,000 (US\$50 at US\$1=Rupiah 9000) in treatment including Rp. 100,000 (US\$11 at US\$1=Rupiah 9000) for childbirth, and it covers inpatient and outpatient, maternity, dental and eye care. It also provides coverage for spouses and up to three children. Basic visits are free.

A **partnership with Yayasan Kusuma Buana (YKB)**, an NGO focused on reproductive health education and services, was in planning during 2002. The partnership was launched in September 2003 with the establishment of a YKB **clinic** funded by Marks & Spencer. The clinic is covered by Medica Pratama and operates just outside of the factory premises in a rented building. Operational expenses are covered by Medica Pratama and from fees that workers pay. All workers and their families are covered, and community members who do not have insurance may pay a small fee for services.

The clinic provides general health care, mother and child care, dental services, family planning (including counseling) and low level surgery with local anesthesia. The clinic has registered **7000 patients**, most of which are women and 90 percent of which are PT Dewhurst workers and their families. The clinic sees about 50 patients a day. There has been an **increase in utilization rates** by those covered by the insurance scheme, from **8.3 percent** when the clinic was first established to **17 percent** in the first five months of 2006.

Initial funding from Marks & Spencer and reimbursements from the insurance provider helped the clinic to **reach break-even point** 18 months after establishment, and it is now **self-sustaining**.

The YKB clinic conducts trainings every Wednesday, generally on reproductive health issues. The number of workers attending ranges from 9 to 30 per session, and the average number of participants per month is 96.

Forty peer educators were trained from among staff and workers during one week in 2003. However, there has been no time since then for them to train others. Peer educators are willing to conduct trainings, but other workers do not want to stay at work after their shifts to attend.

Impact of Health Programs

Factory management feels there has been improvement in **productivity** since they expanded health efforts. Absenteeism and turnover have been reduced. Women workers

take leave if a family member is sick, so they should be educated on health to help them care for and educate their families.

Factory management and staff report a **reduction in tuberculosis** cases. In 2004, 12 employees were diagnosed with tuberculosis and were successfully treated. In the first half of 2006, six cases were detected.

Infant mortality continues at the high rates observed in 2002. Over the last three years, the rate has been 1.5 percent, compared to a national figure of 31 per thousand live births, or about 3.1 percent. The human resources manager believes that the new mothers do not know how to care for their babies. Midwives often do not send patients to the hospital for difficult deliveries. The factory is encouraging husbands to take a more active role in caring for pregnant spouses and infants.

The YKB Clinic has been successful in **providing services** and **reaching sustainability**. However, the **trainings** have not been well advertised and **attendance remains low** at between 9– 30 workers. The training schedule does not seem to be on display. The clinic staff believes that information from supervisors is not reaching workers, and they would like to see the number of participants increase. Interviewed workers said they would like to attend trainings but are unable to do so because the trainings are held after working hours and they cannot spare the time. The clinic was most popular with **married women**, who visited it for family planning services or during pregnancy. The clinic staff finds it difficult to obtain information from workers because of their low level of education (nine years of schooling) and feel that staff needs to spend more time with workers.

Worker Communication

There is a **majority union**, the SPN, representing the workers. Workers are encouraged to approach supervisors and other members of management with concerns.

Health Facilities and Issues

The factory provides **Medica Pratama, a private insurance scheme** with a higher standard than JAMSOSTEK, to all workers. This exempts the factory from making JAMSOSTEK medical payments. Medica Pratama provides up to Rp. 450,000 (US\$50 at US\$1=Rupiah 9000) in treatment, including Rp. 100,000 (\$11 at US\$1=Rupiah 9000) for childbirth. It also covers inpatient, outpatient, maternity, dental and eye care, and it covers spouses and up to three children. The basic consultation is free.

Grade II Government Hospitals provide free services, while higher grades charge for services. If a worker has no insurance, a consultation with a doctor and medicine will cost about Rp. 15,000 (US\$1.60 at US\$1=Rupiah 9000). There is a **PUSKESMAS** near the hospital, but it reportedly does not provide good service.

There is a **clinic** inside the factory that is open during working hours and has one general physician and two nurses on staff. The doctor is available from 8:00 am to 5:00 pm, and the nurses are available during working hours for both shifts. The clinic provides **diagnosis and basic treatment**, including antibiotics. Injections are not provided. Workers are sent to the Medica Pratama clinic for further tests or treatment, including tetanus injections. For injuries, dressing is available but sutures are not. The doctor is the only person authorized to certify a worker to take leave of more than six months, so workers return to see her after having tests performed. The clinic sees about 200 patients a day. The most common illnesses are **gastritis, body pains and upper respiratory tract infections such as coughs and colds**. Workers generally come to the clinic for work-related ailments or ailments that affect them during working hours. For more serious or long-term illnesses, they visit the Medica Pratama clinics and hospitals. On the day of the site visit, there were two workers at the factory clinic with a headache and earache.

The company provides an **annual health check-up** for all workers, which is administered by a doctor from YKB in addition to the factory doctor and nurses. The check-up includes a physical examination, complete blood count, urine test and X-Ray. It focuses on high risk areas in health, such as tuberculosis. Workers who are found to be **anemic** are sent to Medica Pratama clinics for **iron tablets**. In the past, about 20 people were diagnosed with **tuberculosis** and were given six-month-long treatment; they are all fully cured now. Even when workers are **long leave**, they must check in with the doctor monthly to verify that they are taking medicine.

Yayasan Kusuma Buana (YKB) Clinic

The YKB Clinic is **covered by Medica Pratama**. It was created with initial funding from Marks & Spencer and operates outside of factory premises in a rented building. Operational expenses are covered by Medica Pratama and from fees that workers pay. All workers and their families are covered, and community members who do not have Medica Pratama pay a small fee for services.

The clinic provides **general health care, mother and child care, dental services, family planning and low level surgery with local anesthesia**. They do not have a laboratory. There are two general physicians and one dentist, and hours are Monday through Friday from 8:00 am to 7:00 pm and Saturday from 8:00 am to 2:00 pm. One nurse and midwife work in shifts, and there are three support staff. The doctors also work in shifts, one from 8:00 am to 2:00 pm and one from 2:00 pm to 7:00 pm. The dentist visits three times a week from 2:00 pm to 5:00 pm.

The clinic has **7000 registered patients**, most of whom are women. Ninety percent of the patients are either employees or family members. Utilization rate of those covered by the insurance scheme at PT Dewhirst was 15.3 percent in 2005. The clinic sees about 50 patients a day.

Following is a **schedule of fees** for community members without insurance as well as a list of services covered by Medica Pratama:

Service	Type	Cost in Indonesian Rupiah	Cost in US\$ (US\$1=Rupiah 9000)	Covered by Medica Pratama
Intravenous Contraception	3 month (DP Progestin)	12,500	\$1.40	Yes
	3 month (DP Provera)	15,000	\$1.65	Yes
	1 month (Cyclofem)	15,000	\$1.65	No
Oral Contraceptives		Free	Free	Yes
Condoms		Free	Free	Yes
Intrauterine Device (IUD)	Insertion	70,000	\$7.80	No
	Removal	35,000	\$3.90	No
Implant (Contraceptive)	Insertion	125,000	\$13.90	No
	Removal	70,000	\$7.80	No
Pap Smear		40,000	\$4.50	No
Immunizations (Children)	BCG	15,000	\$1.65	Yes
	DPT	10,000	\$1.15	Yes
	Polio	6,000	\$0.70	Yes
	Measles	20,000	\$2.25	No
	Hepatitis	20,000	\$2.25	No
Ante-Natal Care	Pregnancy Test (Urine Test)	10,000	\$1.15	No
	Tetanus injection during pregnancy	10,000	\$1.15	No

The YKB clinic is **self-sustaining**. In the first year of operation, payments from health insurance providers alone were insufficient, but in later years the clinic became able to manage on insurance payments and fees.

The main health complaints at the clinic are **upper respiratory diseases (cough, cold and fever)**. There are about 50 cases of **tuberculosis** between the community and workers, and these patients are currently in treatment.

PT Dewhirst ensures that workers visit the YKB clinic; in return, the YKB clinic provides good services. The PT Dewhirst human resources manager visits the clinic

weekly or calls. A **monthly report** to PT Dewhirst lists the number of patients, most common illnesses and trainings held.

The YKB Clinic operates out of rented premises with room upstairs for training. They are planning to build their own premises to expand services and have bought land nearby. Expanded services would include deliveries, baby day care, a pharmacy and a laboratory.

Reproductive Health

Pregnant workers are required to visit the factory clinic for a monthly check-up that examines weight, blood pressure and other vital signs. Check-ups are not required by law, but the factory makes check-ups mandatory for maternity leave. The clinic provides calcium, iron and folic acid tablets. After five months, pregnant workers may not work the night shift. Many women go to **midwives** for their deliveries that are covered by Medica Pratama. About 66 percent of births in Indonesia are attended by a skilled attendant.

The law requires that women take **maternity leave** 1.5 months before and 1.5 months after childbirth, but in reality, if the pregnancy is going well a woman may wait up to one week prior to delivery. The factory is considering establishment of a day care center.

Infant mortality is high. Over the last three years, the rate has been 1.5 percent; the national figure is 31 in 1000 live births, or about 3.1 percent. The human resources manager believes new mothers do not know how to care for their babies. Midwives often do not send patients to the hospital for difficult deliveries. The factory is encouraging husbands to take a more active role in caring for pregnant spouses and infants.

The factory clinic does not provide **contraceptives**, but it does provide advice. Previously workers obtaining contraceptives for free from the PUSKESMAS, but now they obtain them from the YKB clinic for a nominal fee.

The YKB clinic sees cases of **dysmenorrhea** and occasional cases of **reproductive tract infection**. They also see cases of **diarrhea** and **gastro-intestinal disorders**, some cases of **bleeding during pregnancy** and less than 10 **miscarriages** per year.

There are 79 workers registered for three-month doses of **contraceptives** and 46 workers registered for monthly doses. Four people from the community are also registered at the clinic for contraceptive doses. A small number of women request condoms but often do so when their period is late. About two patients a year request IUDs. No patients have requested implants.

The YKB Clinic provides **counseling services** on reproductive health issues.

HIV/AIDS

The YKB staff provides information on HIV/AIDS, though no patients have specifically

requested information. The clinic staff suspects that one person in the community around PT Dewhirst died of AIDS after having diarrhea for three months. The person's family is currently doing well.

PT Dewhirst covers HIV/AIDS during its induction training. The company would like to hold trainings at the posyandu on health topics, including HIV/AIDS.

Training

A half-day **new worker orientation** covers company regulations and policy, including health and safety. Skills training is given on the job. If a worker is inexperienced, he or she begins in trimming or other low skill jobs.

The factory clinic offers **trainings**, typically focused on reproductive health issues, in cooperation with the YKB Clinic every Wednesday. The number of attendees 9–30 per session, with the total participants per year ranging between 60–100. The schedule of training topics is: **1st week—General Health, 2nd week—Pap Smear, 3rd week – Dental health and 4th week—pregnancy.** Specific topics include **pre-natal care, tuberculosis and HIV/AIDS.** The training schedule does not seem to be displayed anywhere in the factory. The clinic staff believes that supervisors are not disseminating information about trainings to workers. The Supervisor claims that workers were informed, but at least one worker states that she was not informed. The clinic would like to see the number of participants increase. Dewhirst staff are also trying to cover reproductive health issues in the new worker orientation.

Forty peer educators were trained from staff and workers during one week in 2003, but there has been **no time** since then for the peer educators to train other workers. Workers choose to go home after work and do not want to stay for trainings. Another NGO offered weekly health and safety trainings in 2003, but these trainings stopped in 2004.

PT Dewhirst has also received a donation from Medica Pratama for YKB to conduct trainings, and Medica Pratama has been asked to assist with educational activities, including discuss of health issues such as avian flu.

YKB doctors occasionally visit PT Dewhirst to lead trainings after working hours. PT Dewhirst management would like to collaboratively provide trainings with the local Posyandu rather than in the factory.

The YKB Clinic staff visit the **local community** three times a month. Sometimes the community is invited to the clinic, but usually they hold health trainings within the community in a local school or mosque. About 50 people attend each training. The community trainings cover geriatric issues since the community includes many older adults.

Interviews with Workers

Jis is 24 years old and in the eighth month of her first pregnancy. She is in the cutting section and does her work standing up, but will be taking her maternity leave soon. She has been visiting the clinic every month for check-ups. She has been taking calcium and iron tablets from the clinic. She will see a midwife for delivery and plans to have her aunt look after her baby.

Yuyu is a 26-year-old label machine operator who is married and has a five year old girl. She has worked at PT Dewhirst for 2.5 years, and this is her second job. She has visited the factory clinic for ulcers and body aches. She is from the Bandung area and lives about 25 kilometers from the factory. Her younger sister looks after her baby. If the factory were to provide a child care center, she would not use it because she prefers that her baby be at home. She has not used contraceptives for 1.5 years and would like to have another child. She does household chores and watches TV in her spare time. She is aware of HIV/AIDS, which she learned of from television and radio programs. She knows what sexual harassment is and terms it as “sodomy and touching” (based on interpreter’s words). Her wages are about Rp. 800,000 per month (US\$89 at US\$1=Rupiah 9000). A private doctor would charge Rp. 30,000–50,000 (US\$3.30–\$5.50 at US\$1=Rupiah 9000) for a consultation and medicine.

Neni is a sewing operator who has worked for PT Dewhirst since 1995. She is 27 years old and married two months ago. She has completed junior high school (nine years of school). She had dengue fever six months ago and went to a nearby government hospital for treatment. The cost was covered by Medica Pratama, and she took leave for two weeks to recover. She has never been to the YKB Clinic. When she has minor ailments such as colds, she visits the factory clinic. She also sees her family doctor, who is covered by Medica Pratama. She is aware of HIV/AIDS and how it is spread. She is also aware of sexual harassment and terms it as “rape, child molestation and unwanted touching.” She is aware of contraceptive options and cited intravenous contraceptives, the pill and inserts under the skin as contraceptive options. She does not currently use contraceptives and plans to use them only after the birth of her first child. She attended a training on pregnancy and child care a year ago in the factory. She has not been able to attend any of the trainings at YKB because they are held after work and she is busy.

Siti is 26 years old and has worked at PT Dewhirst for seven years. She works in the sewing section, stitching collars. She has been married for six years and has a five-year-old daughter. Her husband works in administration in another company. She lives half an hour away from the factory. She receives free contraceptive injections from the YKB Clinic that are covered by Medica Pratama. She has never attended health trainings at the YKB Clinic; her supervisor selects which workers can attend trainings, and though she would like to go, she has not been able because of the limited number of spaces. She has visited the clinic for headaches and toothaches. She is aware of HIV/AIDS, which she has heard of on the radio, and she says that it can be spread by “intravenous” transmission. She says that sexual harassment is “sodomy and rape.” Her daughter is

looked after by her mother. If the factory provided a child care center, she would not want to leave her daughter there and would continue to keep the child at home.

Arini is a trimming operator who has worked at PT Dewhirst for three years. She is 25 years old and unmarried, and she lives in a rented house close to the factory. She comes from the region of Cilacap and has completed twelve years of schooling plus a one-year diploma in computers. She saves her salary and does not want to marry yet. She has visited the factory clinic for ulcers and a cold. She also went to the YKB clinic for treatment of her ulcer and is happy with the treatment she received. She was chosen to attend one of the YKB trainings but had overtime that day and could not attend, though she would like to attend a training sometime. She is aware of HIV/AIDS. She terms sexual harassment as “improper treatment of women” and thinks that it is unlikely to happen in the factory; if something happens she will report it to her supervisor. She does not use contraceptives, though she is aware of different contraceptives (injections, pills, IUDs) available and will see the doctor when she needs them. In her free time she participates in religious activities and discussions.

Suryana has been the full-time union chair of the majority SPN **union** since 2004. He has worked with PT Dewhirst for eight years and was previously a supervisor. He is 43 years old and married with three children. His wife does not work outside the home. Union elections are held every three years, and the union meets once a month. The Union Board consists of seven members, including three women. He believes the factory clinic and YKB are good, but he wants more say in the selection of the service provider. He thinks that preventive activities are important since workers work long hours.

Rini is a Supervisor who is on the **union board**. She reports there were several complaints against the previous health insurance provider, Nayaka, which prompted the change to Medica Pratama. Several pregnant women utilize the YKB clinic. The clinic does not provide ultrasound scanning services though Rini thinks it should. The clinic has told workers that ultrasounds are not necessary and are only required if pregnancy is not proceeding well. All pregnant women workers interviewed want ultrasounds and are paying out of pocket to have them. Rini is seven months pregnant and will take leave starting in the eighth month. She has been pregnant eight times and has four children. She used IUDs and intravenous contraceptives in the past but still got pregnant. When she used condoms in addition to contraception, conception was prevented. Once her baby is born, she plans to have a tubectomy. She is 28 years old and has been with PT Dewhirst for seven years. Her husband runs his own business. There have been trainings on reproductive health, nutrition and time management during her tenure. She feels there should be more trainings for pregnant workers. She has attended one training at the YKB clinic on tuberculosis, and it was useful. She believes that lung diseases are increasing. She thinks that milk can be given as a supplement for health. She would like equipment on the shop floor that clears dust and fibers from the air. She does not know if there are fees to attend the YKB clinic. Most workers see a midwife for delivery, but she will see a doctor. She would like a child care center and would send her child there; she believes a child care center would help breast-feeding mothers.

Responsibility and Impact

Factory management feels that **productivity** has improved since expanded health efforts came into effect; **absenteeism** and **turnover** have been reduced. Women workers take leave when their family members are ill, so it is important to educate them on health so they can look after their family as well as themselves.

PT Dewhirst staff reported a reduction in **tuberculosis** cases: 12 employees had in 2004 that were successfully treated, compared to six thus far in 2006.

When YKB staff first began to hold **health trainings**, few workers asked questions. Now workers have many questions. The clinic staff feels that houses in the community are cleaner now, though the large number of new workers makes it difficult to gauge program effectiveness.

The Puskesmas is doing little to promote health. **Poor communication between government agencies** makes it difficult to get permission to conduct community trainings, but the factory has managed to secure permission. Because the average worker education level is nine years, clinic staff find it difficult to obtain information from workers. The YKB clinic staff would like PT Dewhirst to spend **more time educating workers on health topics**.

Yayasan Kusuma Buana, Jakarta, Indonesia

Yayasan Kusuma Buana (YKB) is a Jakarta-based NGO established in 1980 that seeks to strengthen the private sector's role in family planning, reproductive health care and community development through community services, research and health education. YKB has a staff of over 100 spread throughout Java (Jakarta, Bandung, Semarang and Surabaya) and North Sumatra and attempts to deal with health comprehensively. Its main programs areas include adolescent reproductive health, sexually transmitted diseases and HIV/AIDS.

Health Issues

Women often come to work without eating breakfast, which can lead to anemia and stomach pain. Women also suffer from occupational hazards, such as skin disease and exposure to excessive noise.

Oral and intravenous contraceptives are popular. Tubectomy is not as popular, and condom use is very low. The government is trying to promote the use of condoms to prevent the spread of sexually transmitted infections.

There is now a Ministry of Manpower regulation that prohibits discrimination against and dismissal of HIV positive persons. The number of HIV/AIDS cases is increasing, management is more interested in preventive activities such as training workers. If a

worker is suspected of having HIV/AIDS, pre-test counseling and post-test counseling are required. By law the process must be kept confidential, but this is not always possible, because when more money is spent on one worker for tests and counseling, others in the factory ask why. Most women do not inquire about AIDS, though midwives often educate them.

Discussion of YKB's services follows.

Clinics

YKB maintains four clinics around Jakarta and one in Bandung (Rancaekek), next to PT Dewhirst.

They have classified the communities they serve into four categories: "pre-welfare," or below the poverty line and unable to pay for any of their services, plus "welfare 1," "welfare 2" and "welfare 3." The classification is based on surveys that ask questions such as how many meals a patient eats per day and what recreational facilities they can access. Pre-welfare patients receive free clinic services, while welfare, 1, 2 and 3 patients pay a fee. Patients beyond Welfare 3 can afford to see a specialist at a private clinic. Pre-welfare patients need a letter from the *kampung* (community) head to certify that they should receive free services. They also receive free food supplements and contraceptives. The clinic fees are higher than what JAMSOSTEK clinics charge but lower than private hospitals.

A midwife is available for deliveries, though an on-call doctor is available for emergencies. Each midwife is a trained nurse who undergoes an additional two years of midwife training. The Jakarta clinics see about 60–70 patients per day. The clinics provide education, immunization and early diagnosis services. YKB has a mobile X-Ray van which was donated by a company. They also offer tuberculosis screening and pap smears. They do not provide treatment for HIV/AIDS. One clinic offers laboratory services. Some clinics that are located close to areas where drug use is common see cases of HIV/AIDS.

The clinics were started in 1981 and are self-sustaining. Each clinic took about five years to break even, except the Rancaekek Clinic, which broke even in two years.

The Rancaekek Clinic was created with funding from Marks & Spencer and is located just outside the PT Dewhirst compound in Bandung. Workers and their family members can visit. There are about 7000 people registered with the clinic. They are covered by private insurance in place of JAMSOSTEK. YKB is reimbursed from the insurance company for Dewhirst workers. Other community members pay a small fee for services.

YKB also runs a few *posyandus* using volunteers from the community.

Training

YKB received a grant from Family Health International that covers their operational costs. YKB thus offers trainings to companies for free and asks only that the company provide the venue, workers and time. Initially it was time-consuming to convince companies to let them train workers, but now there is a lot of demand. They first approach senior management with a presentation and then move to peer education among workers. They offer health camps and drawing competitions for children. Some companies have since taken over the education process. For example, a steel company runs training programs on its own and invites YKB to observe. YKB has also worked with NIKOMAS, a footwear manufacturer. In total, YKB has worked with about 300 factories from various sectors including machinery, aviation, chemicals and steel.

Many factories now ask for HIV/AIDS training. YKB also provides train-the-trainer programs to disseminate information among larger numbers of workers. YKB works with human resources teams, unions, and environment, health and safety (EHS) committees.

Working with Companies

Companies cannot spare time from production, but they have begun to realize that their bottom line suffers when workers fall sick.

Evaluations of project success need to be performed over a long time frame. Successful projects are perceived as sustainable and are eventually taken over from YKB by factories. About 50 companies have taken over management of their health projects. They have formed core teams to disseminate information and developed their own information, education and communication materials.

Every year a national event organized by YKB, the Ministry of Manpower and the International Labor Organization honors companies that have made exemplary efforts in health. Companies honored include BP, Unocal, Krakatau Steel, Gajah Tunggal and Standard Chartered.

PT Fit U, Bandung, Indonesia

Factory Information

PT Fit U is an apparel manufacturing facility in Bandung that was established 26 years ago. It has **3300 workers**, of which 90 percent are women. The average age range is 18–25, and there are few workers above 40. 68 percent of workers are full-time employees, and 32 percent are contract workers. All workers have equal access to health facilities at the factory. About 50 percent of workers are married. Average education is junior high school, or nine years of schooling.

The company's specialty is tops. Typical turnaround times are between 30–45 days. The factory follows a **shift system**. The morning shift is from 6:00 am to 1:45 pm, with a lunch break from 10:00–10:30 am. The afternoon shift is from 2:00 pm to 11:00 pm,

with a meal break from 6:00–6:30 pm. Workers in the afternoon shift also take a tea break at 3:15 pm. There is also a middle shift from 8:00 am to 5:00 pm. Two prayer breaks are given per shift. Most workers live in the Bandung area. Workers who finish the **night shift** at 11:00 pm are **dropped home** by 100 mini-buses. Each mini-bus holds about 13 workers, and the factory pays for this service. There are 1500 workers during each shift.

The **minimum wage** for the region is Rp. 710,000 per month (US\$79 at US\$1=Rupiah 9000), and the average wage is Rp. 930,000 per month (US\$103.30 at US\$1=Rupiah 9000).

Turnover is below 1 percent. Before the monetary crisis of 1998 turnover was 3 percent, but now jobs are scarce and competition fierce. **Absenteeism** is about 2 percent per day.

Lunch is provided for **free** in the cafeteria and consists of rice, vegetables and meat. The workers do not cook at home in the morning and instead buy street food on the way to work. The factory began to provide free lunch after the 1998 monetary crisis. In 2000, there were five workers a day who fainted from hunger, but now that number is one or none a day. There are three cafeterias. Food is cooked outside by a caterer and brought to the factory.

There is a **child care center** for children of workers that was set up in 2002. There are about 15 children during the morning shift and about 20 during the evening shift. The mothers send milk with their children, and meals are provided for Rs. 3000/day (US\$0.35 at US\$1=Rupiah 9000). Sick children are taken to the clinic. There is one caregiver for every child in the center.

A **workers' cooperative store** is available onsite, with groceries available at cost. About 50 percent of workers use the store. Workers are given credit at the store that is deducted from their wages.

Three units of the company were certified to **Social Accountability 8000** (SA8000).

There is a **library** on the premises that is open to all workers, who may take books home. About 20 workers visit per day during breaks or after their shifts.

The company provides land and facilities for a **Textile School** established in collaboration with the University of Bandung. The school provides **scholarships for workers' children** to attend.

Worker Communication

Workers are encouraged to approach human resources personnel and management with any issues.

The factory was a participant in the **Global Alliance**, through which several **counselors** were trained among workers. The counselors continue to counsel workers as volunteers. There are also personnel officers available to workers to discuss issues, and there is a well-utilized **grievance box** for anonymous complaints that range from supervisor conduct to insufficient water supplies to cleanliness of toilets and the cafeteria menu. Management follows up with cafeteria staff, supervisors and others as appropriate. In a few cases, there have been repeated complaints about the same supervisor, for reasons such as shouting at workers. These supervisors have resigned.

Workers also have a weekly **FKK** (Indonesian acronym) “**fact to face**” **meeting with the president** to discuss any issues. One worker is selected randomly each week to meet with the president, with no other management representatives present.

Workers are represented by the **SPSI union**, to which a majority of workers belong. There is a collective bargaining agreement. Meetings of the union board are reported in an action log and posted for all workers. Health and safety are covered in factory regulations, as required by law.

Health Facilities and Issues

The factory provides **private health insurance** to workers, and this exempts the factory from paying into JAMSOSTEK. The private insurance covers each worker, their spouse and three children in four hospitals in Bandung.

There is a **clinic onsite** with a doctor available daily from 12:00–3:00 pm as well as a full-time nurse. The doctor is a female general physician. The director of human resources and one of the human resource managers talk to the clinic daily in person or by phone, and they meet with the doctor once a week. If the doctor has needs, she contacts the HR director.

The nurse in the clinic sees about 50 patients a day. Most workers come during their break time between 12:00–3:00 pm. There is one nurse on duty per shift. The main health issues for women are upper respiratory infections (colds and coughs), gastritis, stomachaches, fevers, eye infections and hypertension. Antibiotics are provided when needed, and iron tablets are available for anemic workers, with pregnant anemic women given priority. The clinic does not have a refrigerator, and tetanus injections are not available. Tetanus cases are only referred to outside hospitals if the patient has severe injuries. The clinic is considering providing injections.

When workers are referred to an outside hospital, the doctor **follows up with the hospital**. Workers return to the clinic with records from the hospital. In case of emergency, workers are taken to a hospital and costs are covered by the factory, as in the case of one worker who had an asthma attack.

The clinic provides **diagnosis** and **long-term treatment**. A six-month treatment course is provided for **tuberculosis**; there have been less than 10 cases in the factory that have

all been cured. One tuberculosis case was referred to an external hospital; private insurance covered costs. Tuberculosis treatment was formerly provided by the government hospital, but now the treatment is provided at the clinic.

Reproductive Health

Dysmenorrhea is the main health complaint that brings female workers to the clinic. There are few reported instances of reproductive tract infection. Sanitary napkins are provided when needed; most women use sanitary napkins at home as well.

Pregnancy tests are free at the clinic. If pregnant, workers are shifted compulsorily to seated work. A clinic file is maintained to track their progress. Maternity leave of three months is given by law: 1.5 months are taken prior to delivery and 1.5 months are taken after delivery. If a pregnancy is unhealthy, the factory encourages the worker to take more time after delivery. Pregnant workers receive monthly training on ante-natal care. Exercise classes are also conducted for pregnant women after their shift, though these classes are not compulsory.

The clinic provides **pills and intravenous contraceptives**. More than 1000 women are registered for intravenous contraceptives given every three months. The clinic does not provide IUDs, though the nurse believes some workers get them elsewhere. The clinic charges Rp. 20,000 (US\$2.25 at US\$1=Rupiah 9000) for a one-month course of intravenous contraceptives and Rp. 10,000 (US\$1.15 at US\$1=Rupiah 9000) for a three-month course. The Puskesmas charges Rp. 15,000 (US\$1.65 at US\$1=Rupiah 9000) for similar intravenous contraception. The clinic was established in 1997 and has provided family planning services since 2004. Worker health records are maintained.

Aryani has been with PT Fit U for five years and works in the payroll department as part of the support team. During the Global Alliance project, she was trained to be a counselor. She walks around the production floor daily during working hours so workers can approach her with issues. Workers raise concerns about the physical work environment, family planning options and other reproductive health concerns such as HIV/AIDS and whether “normal couples” such as themselves are susceptible to HIV/AIDS. Workers also discuss unsatisfactory sexual relations with their husband due to impotence or sexually transmitted infections. Some single workers ask about contraceptive use and typically claim the information is for their relatives, though it may be for themselves. Single women sometimes ask about the dangers of sexual relations with married men. Aryani provides advice to the best of her knowledge and sends women to the clinic doctor as needed. To her knowledge, none of the single women are sexually active.

HIV/AIDS

A small number of workers have asked the doctor how HIV/AIDS is spread. Workers hear about HIV/AIDS from peers and from television. HIV/AIDS is also covered the factory trainings. So far there have been no reported cases of HIV/AIDS in the factory.

Training

New workers receive a one-week **orientation** that is conducted by human resources staff. The orientation covers factory regulations such as health and safety.

When the factory participated in the **Global Alliance** project, an NGO, CIDIKARA, was contracted in 2005 to provide training to workers. **Sixty workers** were trained as peer educators, and training was provided to them three times a week. The training was given after the morning shift for morning shift workers and before the evening shift for evening shift workers. Topics covered included nutrition, health and safety, finance and self esteem. The training program continued after the Global Alliance project ended, with support from the factory. The peer educators educate workers through a **radio “talk show”** that is broadcast in the factory and cafeteria during lunch break twice a week. The peer educators also train workers directly each month on health and safety topics.

Mandatory trainings on **first aid**, **fire safety** and **safety on the job** are provided periodically to workers.

Interviews with Workers

Elin is 37 years old and unmarried, and she has worked in the packing and finishing section for the last six years. She has visited the clinic for stomachaches. She has never had a work-related injury, and she likes the cafeteria food. She earns Rp. 710,000 per month (US\$79 at US\$1=Rupiah 9000), not including overtime and bonus. She eats a breakfast of rice and bread at home before coming to work. She lives with her sister, and they cook together in the morning before going to work. She takes the mini-bus home from work at night. In the morning she rests and does household chores. She has participated in an FKK meeting with the president and brought up issues like late food delivery. She also asked receive her paycheck in cash rather than through the cooperative, but the president explained to her that it is better in the long run for all workers to have the cooperative. She is aware of HIV/AIDS and sexual harassment. She is one of the workers trained by CIDAKARA during the Global Alliance project. She has discussed some of the issues from the training with a friend and has talked on the radio “talk show.”

Yaesy is a 26-year-old worker pregnant with her first child. She has been with the company for six years and previously worked in ironing, but now she is doing folding in a seated position. She works during the middle shift, from 8:00 am to 5:00 pm. She is seven months pregnant and has been visiting the factory clinic for monthly check-ups. She is due in October and will be visiting a referral hospital that her insurance covers for the delivery. She would like to hire a caregiver for her child after delivery. If she were to see an outside doctor, it would cost Rp.50,000 per visit (US\$5.55 at US\$1=Rupiah 9000) for the consultation and medicines.

Nani has worked in the cutting section for the last two years and carries cloth from cutting to different parts of the factory. This is her first job, and she is single. She is from another part of Indonesia and rents a house on her own. She has visited the clinic for routine ailments such as a headaches, coughs and colds. She is aware of HIV/AIDS and how it is spread. Her salary is Rp. 710,000 per month (US\$79 at US\$1=Rupiah 9000), not including overtime and bonus. She buys nasi (rice) and roti (bread) in the morning on her way to work. She sends part of her salary home to her family. She has five siblings. Sometimes she likes the cafeteria food, but on other days she dislikes it. She is aware of HIV/AIDS and knows that AIDS is caused by the HIV virus. She believes that HIV/AIDS is spread through intravenous injections, kissing and sexual intercourse. She is also aware of sexual harassment. She has attended the weekly FKK meeting with the president and has raised concerns about cafeteria food, water supply and cleanliness.

Ojang (male) has worked for PT Fit U for 16 years in the warehouse department. He is part of the 16-member **union board**, which meets once a week and has five women members. The union would like to see better clinic facilities and would like the clinic facilities to be extended to workers' families. Only about 50 percent of out-of-pocket health costs are covered by the factory. For example, if the cost of a visit is Rp. 30,000 (US\$3.35 at US\$1=Rupiah 9000), only Rp. 15, 000 (US\$1.70 at US\$1=Rupiah 9000) is covered by the factory; the fee of Rp. 30,000 includes medicine. Workers also need better coverage for childbirth. Currently, they receive reimbursement of Rp. 75,000 (US\$8.35 at US\$1=Rupiah 9000), but the actual cost of delivery is Rp. 400,000 (US\$44.45 at US\$1=Rupiah 9000). The company needs to make more efforts to combat upper respiratory diseases and increase the number of calories given for lunch in the cafeteria. The monthly attendance bonus is Rp. 20,000 per month (US\$2.25 at US\$1=Rupiah 9000), but the union wants it increased. The union is now renegotiating the collective bargaining agreement, which happens every three years. Ojang is 35 years old, and his wife is six months pregnant. She also works at PT Fit U. His basic pay is Rp. 850,000 (US\$94.45 at US\$1=Rupiah 9000), which does not include bonus, overtime and other allowances.

Responsibility and Impact

Management believes that investments in health have had a positive impact on productivity. The factory conducts surveys of about 100–200 workers at a time to collect information.

Factory management reports a decrease in the number of workers fainting during work. In 2000, about five workers fainted each day, but now there are either one or no workers who faint each day. Management attributes the reduction to the free meals provided and to the fact that more workers eat breakfast before coming to work. Workers are more willing to use masks and other personal protective equipment, as they are aware of the dangers of not using protective equipment.

The nurse believes that incidence of upper respiratory tract infections and gastritis has been reduced, as has tuberculosis. More sophisticated medical equipment, such as

sterilization and injury treatment equipment, would be useful. There are about 20 injuries a year, or an average of two injuries every month.

A counselor trained by Global Alliance feels that workers are more confident about speaking with supervisors and in public. The counselor feels that workers can become leaders and organizers due to higher self esteem.

Metro Jakarta, Indonesia

Factory Information

The factory is a toy making facility with **9500 workers**, 95 percent of which are women between 18–30 years. The average worker age is 25. Most workers have completed high school (12 years of schooling), which is the minimum qualification. There are 300 supervisors, 95 percent of which are women. The production unit is air conditioned.

The factory works in **three shifts**, from 1) 7:10 am to 3:30 pm, from 2) 3:40 pm to 11:10 pm and from 3) 11:10 pm to 7:10 am. Each shift has a 30-minute meal break and additional breaks for prayer. Workers on the night shift are dropped close to their homes by factory buses. About 50 percent of workers are married. No childcare facilities are provided.

The factory employs up to 2800 **contract workers** during peak season. Most of the production is in-house, with manufacturing of accessories outsourced. Subcontractors are audited at the preproduction stage and once annually. The audit team consists of 3–4 persons, and audits usually take 1–2 days.

The factory has 0.5 percent **turnover** every month. **Absenteeism** is about 5–6 percent, which is normal for the area. Absenteeism figures here include pre-approved leave, such as annual leave and maternity leave. Leave due to sickness is estimated at less than 1 percent.

Minimum wage in the area is Rp. 820,000 per month (US\$91 at US\$1=Rupiah 9000).

There are 240 management staff in the factory. New workers participate in an **orientation** on the factory's operating principles, including health and safety. The orientation is conducted by human resources, of which there are 31 personnel.

The factory has operated more than 47 million hours without a lost day due to injury (since mid-2004) and has been **recognized by the Indonesian government for its safety record**. Several safety features are built into manufacturing processes, such as machines with two-hand operation and scissors that are attached by rope to the sewing machine.

All workers, including contract workers, have **bank accounts** and are paid by direct deposit.

The **cafeteria** provides one free meal per shift. Each meal consists of rice, sambal, tofu, meat and fruits totaling about 1000 calories. This is the recommended allowance for a person working in light industry. Those working in heavy industry need about 1400 calories per meal. There is a menu committee overseeing the selection and nutritional value of meals. The committee randomly measures caloric value and content of meals. In addition, food can be purchased from different vendors. The caterer is certified by the department of public health, and staff in the cafeteria are given specific annual health check-ups. Workers during the night shift are given milk.

There are **three dormitory buildings which house nearly 6000 workers**. Each worker pays a nominal fee of Rp. 65,000 per month (US\$7.22 at US\$1=9000 Rupiah). There are 32 workers in each large room, and each worker is provided with a cot, mattress, locker, light and fan. The factory provides a television and telephone in each room. Workers are responsible for keeping their bedrooms and bathrooms clean. No visitors are allowed after 9:00 pm. Workers walk back from the factory, which is about a kilometer away. Security guards escorted night shift workers back to the dormitory. In case of rain, workers are taken back to the dormitories by bus. Public phone booths are available, and there is a beauty salon and boutique. A karaoke room offers free karaoke. There is a “chit chat” session for workers with management every two weeks. Movies, chosen by the majority, are shown every Friday night in the recreation room. A library equipped with 15,000 books on various subjects lends workers books, and a convenience store sells them groceries. A computer room with several computers provides workers internet access and a chance to learn new skills. There are also skill development classes conducted by human resources personnel on cooking, computers, hair dressing and beauty treatments. The dormitory matron provides counseling. Sports facilities for basketball and soccer are provided. There is a dedicated training and communications manager in the human resources department.

There is a company-wide **sexual harassment** policy and procedure that is implemented by the factory. There have been no reported instances of sexual harassment.

Workers can contribute to arrange a bus to travel to their hometowns for **Ramadan**.

All workers, including contract workers, have bank accounts and are paid by direct deposit. There is a **savings and loan cooperative** from which workers can take loans between Rupiah 900,000–1.3 million (US\$100–144.44 at US\$1=9000 Rupiah).

There is a **gymnasium** onsite with nominal fees of Rp. 50,000 per month (US\$5.55 at US\$1=9000 Rupiah).

During the recent Yogyakarta earthquake, the factory provided **aid and transportation by bus** for about 100 employees with family in the earthquake zone. Employees made

donations after the earthquake, which the factory matched. After the December 2004 tsunami in Aceh, employees contributed Rp. 50 million (US\$5555.55 at US\$1=9000 Rupiah), which the factory **matched**. Rupiah 500,000 (US\$55.55 at US\$1=9000 Rupiah) has been collected thus far for victims of the recent Java tsunami.

The factory organized volunteers to assist with the **Special Olympics** in Jakarta in September 2006.

Worker Communication

A **computerized kiosk** on the production floor allows workers to pose questions to management. Answers are available for all to scroll through. The computer also displays information on health, production and amenities available.

There is a “**chit chat**” **session** between workers and management every two weeks. The general manager of the facility and the human resources manager are the only management representatives present. About 60 workers are selected randomly by computer to attend the one-hour meeting. Questions are often related to production or to medical facilities, such as where a specific treatment is available.

Production problem or other problems on the production floor, such as a supervisor abusing workers, can be taken to the next level manager. If the problem is not resolved, workers approach the human resources office located on the production floor. When a worker goes to the clinic for treatment, the doctor telephones their supervisor and informs the supervisor how long observation or treatment will last so supervisors are aware of how much time will be lost.

Health Facilities and Issues

The company provides **private insurance** for workers and thus does not make JAMSOSTEK health payments. The private insurance gives workers access to six hospitals and seven clinics in the vicinity. The local Puskesmas is poorly equipped, so few workers use their services. The company holds a monthly **medical provider gathering** with hospital representatives for workers. The meeting is held from 11:00 am to 1:00 pm and covers seasonal illnesses and whether services are properly provided. Factory management stresses the importance of not giving too many medicines.

By law, a worker who is injured at work or suffers from an occupational hazard is eligible for **2.5 times the minimum wage as compensation**.

There are **four clinics** onsite with outpatient facilities that were established when the factory was built in 1992. Services are provided for free. The clinics have X-ray facilities and basic laboratory facilities for testing blood and urine. Local anesthesia can be provided for suturing of minor wounds and injuries. Tetanus injections are available. Five beds provide space for observation and recovery. There is a midwife on staff. A pharmacy stocks basic medicines and antibiotics.

The clinics are open 24 hours and see a total of 200–300 patients per day among all four facilities, or 75–100 patients per clinic per day. Dependents may visit the clinic; about 40 percent of patients are family members of workers. A total of 12,500 people are registered with the clinics, including staff and family members. Immunization is provided to children, including BCG, DPT, polio, measles and hepatitis vaccinations.

The **most common illnesses** are **upper respiratory infections**, **gastro-enteritis** (from not eating properly prior to coming to work) and **dysmenorrheal**.

When workers are sent to an **external hospital** for treatment, the clinic staff **follows up**. The clinics are also prepared for emergencies, and last year two baby deliveries were performed in the clinics.

A **survey of workers** is administered annually to gauge the effectiveness of clinic services. So far one survey has been completed. Workers reported wanting access to an ultrasound machine.

An **annual health check-up** is conducted for workers, with specific tests for occupational hazards. Anemic workers are given iron tablets. Detailed medical records are maintained. The clinics also conduct pre-employment health check-ups.

In 2005, there was a 45 percent increase in the number of patients who visited the clinic. The clinic developed an “evidence-based” medicine list advocating the rational use of medicine.

In preparation for the recent **bird flu** scare, the company has purchased 10,000 doses of Tamiflu for treatment. A six-month treatment course is provided for tuberculosis.

Reproductive Health

At any given time, there are 300–400 **pregnant workers** in the factory. There is a **separate line** for pregnant workers in the cafeteria, and pregnant workers are allowed to leave work **five minutes early** to avoid crowds. Pregnant workers **cannot work the night shift** (11:00 pm to 7:00 am). Workers whose pregnancies are progressing well and would like to take extended unpaid maternity leave after delivery are permitted to do so under a written agreement. Pregnant workers have a **different uniform**, a blue smock, to distinguish them from other workers. They are shifted to **seated work**.

Training is conducted for pregnant workers quarterly and covers pre-natal and ante-natal care. The trainings are held after working hours, usually in the afternoon, and are not mandatory. Pregnant workers receive **calcium**, **folic acid** and **iron tablets**. No dietary supplements are given in the cafeteria. Most pregnant workers deliver in the **hospital** and not with a midwife. A normal delivery at a private hospital costs about Rp. 1,500,000–2,000,000 (US\$167–\$222 at US\$1=Rupiah 9000) if the worker has no

insurance. There have been instances of low birth weight babies. The clinic does not have statistics on infant mortality. The clinic is not aware of any instances of miscarriage.

Workers above the age of 35 are encouraged to have **pap smears and breast cancer tests** regularly.

About 50 women visit the clinic per day for three-month intravenous **contraception**, and 20–25 visit each day for the monthly intravenous contraception. The clinic provides IUDs, which few women request. The clinic does not stock condoms for contraceptive purposes but does provide them as part of an anti-HIV/AIDS campaign. Very few men ask for condoms.

Sanitary napkins are available for free, but most women bring their own.

HIV/AIDS

There have been no reported cases of HIV/AIDS in the factory. Workers are trained periodically on the disease and how it is spread. Several staff members have trained to be voluntary peer educators.

The International Labor Organization (ILO) and the Indonesian Ministry of Manpower have a program on AIDS awareness and prevention. The Bekasi district, where the factory is located, is second in the country in number of HIV/AIDS cases, mainly because of the large number of narcotics users. The Bandung district has the highest number of cases of HIV/AIDS. As in other countries, there are higher instances of the disease among truck drivers. The United States Agency for International Development (USAID) has funded a project for the distribution of condoms, and Family Health International distributes brochures for raising awareness.

Training

The factory has its own **studio** where **recordings** are made by staff and workers on different aspects of factory life, including health and safety. Programs on HIV/AIDS have been produced and broadcast through the factory and dormitories.

Health talks are held on basic health issues and are targeted toward employees and 50 percent of dependants in the community. Health talks for pregnant women are held every quarter at the factory and in the community. Health talks on reproductive health are held every quarter in the factory and dormitory. A health talk on seasonal illnesses, the “Mothers and Child Talk Program,” is held every quarter in the factory and community for workers and their families. A total of 34 health talks were held in 2005.

Health awareness programs are held on priority topics in health such **tuberculosis**, **HIV/AIDS** and **stress release** and include **awareness campaigns**, **testing** and **treatment**. Awareness programs are conducted through talks, flyers and video broadcasts. The tuberculosis awareness program consists of a health talk in the factory and

community plus flyers, announcements on the notice board, videos on the disease, tests at the onsite clinic and six-month treatment at the clinic where needed. In 2005, four trainings on tuberculosis were held in the community and three were held in the factory and dormitory; eleven campaigns with video and flyers were conducted. A total of 1664 cases of tuberculosis were detected in the community and factory in 2005.

The goal for the **HIV/AIDS** awareness program is to cover 10 percent of the worker base (1000 workers) and reach 15 percent (1500 workers). The awareness program is conducted by several staff members who are trained as **voluntary peer educators**. Peer educators go into the community to conduct awareness sessions on HIV/AIDS, usually in a common community hall in a building complex with several employees. A game called “wildfire” is played, where participants hold hands to denote spread of AIDS. They follow the “ABC” doctrine—“A” for “abstinence,” “B” for “be faithful” and “C” for “condom use.” The awareness program has been held once a quarter for a few years. Awareness sessions are held during weekends or weekday evenings from 6:30 pm to 9:00 pm. Brochures are distributed within the factory and at community awareness sessions. About 300 people have attended the sessions in total. Trainings have been held in the factory and dormitory as well. In a dormitory session, some female workers had questions on how HIV/AIDS was spread, including if it can be spread through kissing. In addition to HIV/AIDS, workers asked about seasonal illnesses such as influenza or dengue fever. Flyers and videos are also used to spread information. A similar program is conducted on stress management.

The factory plans to coordinate with government public health services to build capacity of other factories in the area of health, starting in 2006.

The factory would like to initiate train-the-trainer programs among workers. The goal is to train 5–10 percent of workers as trainers.

Training on **first aid, fire safety, fire drills** and **occupational safety** are conducted periodically.

Responsibility and Impact

The general manager believes that health programs have had a positive impact on productivity, though the factory offers health programs because it is the “right thing to do.” By having their own clinic, workers are assured of consistent service, do not have to travel long distances for healthcare and are healthier in the long run. The factory has preventive measures in place for epidemics, such as bird flu or SARS. A direct co-relation has been found between facilities provided and retention. Most workers want to stay longer, though younger women do leave to get married. There are considerable costs associated with running the clinic: one visit to the factory clinic costs the factory about Rp. 30,000 (US\$3.35 at US\$1=Rupiah 9000). A visit to a private clinic costs Rp. 76,000 (US\$8.45 at US\$1=Rupiah 9000).

Pou Chen, Serang, Indonesia

Factory Information

Pou Chen is a Taiwan-based company with manufacturing facilities in Indonesia, Viet Nam and China. Its Indonesian footwear factory is in Serang, close to Jakarta. The factory in Serang has a total of about 38,000 workers, of whom **17,343** are attached to the production unit visited. Over 80 percent of workers are women (15,351), the majority of whom are aged 20–30 years. Forty percent of workers live in factory-provided dormitories. Most workers are from the island of Java, where Serang and Jakarta are situated, though some are from the neighboring island of Sumatra.

There are 33 blocks of **dormitories**. Each room holds eight workers and has a common bathing area. Toilets are shared among larger groups of workers. Workers are given a cot and storage facilities. Cooking facilities are not provided; all meals are provided at a common cafeteria. The kitchen has a full-time nutritionist and cooks who regulate the nutritional content of meals. Every meal consists of rice, vegetables, tofu and meat. The counters and storage shelves in the kitchen are made of stainless steel. Cafeteria workers undergo specific health checks annually.

Turnover is 1.7 percent, which is normal for the area and industry. The average length of employment is 12 years. A probationary period of three months is provided by law. Workers might choose to leave after this time because the job is their first, because they are unable to adjust to the work routine, because they are homesick or because they must return home to assist their family or get married early.

New workers without experience are trained in a **training center** on the third floor of one of the office buildings for 3–4 days. The workers are then posted to the shop floor for simple manual work before moving to more skilled tasks. The minimum wage in the Serang region is Rp. 796,000 per month (US\$88.45 at US\$1=Rupiah 9000). The average wage is Rp. 1,100,000 (US\$122 at US\$1=Rupiah 9000), including overtime and seniority allowance.

The facility has its own **wastewater treatment plant**, and water is recycled for reuse.

There is a **library** onsite with magazines, fiction and books on maternal, child and reproductive health. The library is well frequented and sees over 200 visitors a day.

The company provides **bus shelters within the compound** so workers can take public transportation from inside and do not have to walk to the main gate. During **Ramadan holidays**, the company charts buses to transport workers to their hometowns and back to the factory.

The factory is **unionized**, with SPN (Serikat Pekerja Nasional) as the majority union. The collective bargaining agreement is negotiated every three years and is posted in both

Bahasa and Mandarin (for the management staff, many of whom are from Taiwan) on notice boards throughout the facility.

There are 45 people on the factory's **human resources team**, 22 of which deal with brands' social compliance requirements.

Workers are **paid in cash**. Workers from at the supervisor level and above have bank accounts to which their salaries are deposited directly. The factory **does not levy fines on workers for production defects**.

The factory maintains its own full time **fire brigade**, with a fire truck and 40 firefighters spread among three shifts. This brigade assists the local community in times of emergency. The factory undergoes a **fire drill and evacuation twice a year**, per Indonesian regulations and brand requirements.

The factory has **donated for disaster relief** during recent natural disasters that have struck Indonesia, including the tsunami of December 2004, the Yogyakarta earthquake and the tsunami in Java. The factory provides scholarships for workers' children. It has received **awards** from the **provincial government for best Safety Committee and best Labor Union**. It has also received an award from the **Indonesian President** for best **"Female Employees Caring Programmes."**

Impacts and Progress since 2002

The Pou Chen facility has **expanded in operations and number of workers**, from approximately 8000 workers in 2002 to over 17,000 workers in 2006. Its health program has mostly kept pace through expansion of its clinic facilities.

There is now a large, two storied clinic within the compound that is open 24 hours and has three consultation rooms, one dental service room, one midwife service room and two emergency rooms, as well as nine medical beds and 31 beds for observation of up to eight hours. The clinic has 44 staff, including eight general practitioners, one dentist, one midwife, fifteen nurses and four pharmacists. Detailed medical records are maintained by computer, including results from annual health check-ups. The clinic serves all 38,000 workers of Pou Chen Indonesia, including other production units.

While there has been an **expansion of physical infrastructure and medical staff**, equal effort has not been put into **training or raising awareness on health issues**. Several workers did not know about HIV/AIDS or sexual harassment. Union members mentioned a supervisor who was disciplined for becoming angry with a worker who took a long time to return from a routine clinic visit. Management needs to ensure that the different departments understand the **need to promote worker's health and the importance of clinic and other factory initiatives**. **Coordination between different functions** is important in ensuring health improvements. Clinics and medical service providers cannot function in isolation.

A representative of senior management of the Pou Chen Group feels that the health facilities have helped to **improve productivity**. Workers are healthier, and the number of injuries has been reduced. Absenteeism is about 3 percent per day, but of that, **sickness absenteeism is less than 1 percent**. From January to June of 2006, there were 24 **injuries** recorded; this is a **reduction** over previous years.

Worker Communication

The factory has a **monthly “heart to heart” meeting** with computer-selected groups of 60–70 workers to discuss issues of concern. Workers cannot nominate others to go in their place, and the meeting is held during working hours. A vice director, the head of human resources and the factory manager attend. Most issues raised relate to production, including why just one truck transports materials between buildings. Answers to questions are posted on the notice board.

Suggestion boxes are kept unobtrusively on the shop floor, but they do not receive many suggestions. A telephone hotline for workers to report issues is more popular.

The **worker care stations/counseling centers** in the factory and dormitory are open from 8:00 am to 5:00 pm and 3:00 pm to 9:30 pm, respectively. The worker care station has water, light refreshments and counselors available. Nofi is a counselor at the worker care station and is part of the social compliance team. She has been a counselor for the past four years. She sees about two workers per day that seek her out specifically and an additional three per day that drop in. Many workers come to the worker care station to read magazines during breaks. A supervisor recommendation is required to talk with the counselor during working hours. Most problems workers bring to her are related to production or personal issues such as financial problems including the need to take a loan and children’s education. Some workers complain that they do not want to work the night shift because it is too cold; these workers request a transfer.

The company has a **monthly newspaper** and a quarterly **special edition magazine** for workers.

There is a **Worker’s Credit Society**, where workers pool savings and provide loans.

Health Facilities and Issues

The factory does not make JAMSOSTEK payments because the onsite clinic provides comparable health services. It provides coverage through a **private insurance scheme**, Mitra Kesehetakan Jaya (MKJ). MKJ provides access to five hospitals in the area plus two maternity clinics for pregnant workers. All employees receive coverage, and families, including spouses and up to three children, receive limited coverage. The PUSKESMAS has a poor reputation, and the Posyandu is not active. In case of emergency, workers can show their Pou Chen ID cards at any MKJ hospital for treatment, which will later be reimbursed by the factory.

A two story, 1674 square feet **clinic** in the compound is open 24 hours and has three consultation rooms, one dental service room, one midwife service room and two emergency rooms. There are nine medical beds and 31 beds for observation of up to eight hours. The clinic has 44 staff, including eight general practitioners, one dentist, one midwife, fifteen nurses and four pharmacists. Detailed medical records are maintained by computer and include results from annual health check-ups. The clinic serves all 38,000 workers of Pou Chen Indonesia.

The **annual health check-up** includes a physical examination, blood and urine tests and an x-ray. Specific tests are conducted for different occupational hazards. Workers may be sent to one of five referral hospitals for follow-up. Patients who are referred to or taken into hospitals are monitored by clinic or factory staff four times a week. A worker with a chronic disease, such as arthritis, may be given a new job profile to accommodate physical limitations.

The **pharmacy** stocks 134 types of medicines that include National Registered Essential Medicines (DOEN).

Clinic staff receives **regular training** on First Aid, Basic Trauma Life Support (BTLS), Advance Trauma Life Support (ATLS) and Advance Coma Life Support (ACLS).

The clinic has **two ambulances** with drivers trained in first aid and radio communication equipment. The ambulance is sometimes used for emergencies in the community.

About 300 workers daily visit the clinic, with most arriving before noon. About 130 patients per day come from the production unit visited. Patients come from 8:00 am to 11:00 am and from 2:00 pm to 4:00 pm. Basic medicines and antibiotics are available. According to ISOS, an international NGO, the percentage of workers who visit the clinic from this unit is 0.78 percent, which is low compared to standard attendance of 1.5–3 percent.

The most **common illnesses** are **upper respiratory diseases**. Body endurance is low, and workers contract illnesses that are prevalent in the community. **Pharyngitis** is common, as are **gastritis, anemia, hypertension, dermatitis** and **skin allergies**.

The factory has a **tuberculosis prevention program** and provides treatment for detected cases. In 2005, 72 persons received treatment.

Reproductive Health

The clinic provides **family planning services**. In the month of June 2006, there were 86 women registered for intravenous contraceptives and 34 women were registered for contraceptive pills. There were no requests for IUDs or condoms; most women who use contraceptives choose the intravenous method or the pill. No workers have asked about other contraceptive methods.

Pregnant workers are prohibited from working with chemicals, standing for long hours and performing heavy work. They cannot work the night shift and are shifted to seated work. Special identity cards are issued so pregnant workers can be easily identified, and these cards contain medical details such as due dates and medical restrictions. They also wear a different color apron. There is a separate line for pregnant workers in the cafeteria. Pregnant workers are provided with additional food supplements such as milk, soya and vitamins. Pregnant workers are given calcium, folic acid and iron tablets at the clinic. Lactameal is given to pregnant workers as an incentive to join a compulsory monthly training that covers ante-natal and post-natal care and is held during working hours. Pregnant workers are required to visit the clinic for monthly check-ups. Simple pregnancy tests are also available at the clinic. Last year there were 36 cases of miscarriages among approximately 800 pregnant workers; this is low compared to the community. Anemia and maternal hypertension (pre-eclampsia) are common.

Several cases of morning sickness have been reported among pregnant workers. Most pregnant workers go to a **midwife for delivery**. There is no data on infant mortality among workers' children. **Dysmenorrheal** is common, but reproductive tract infections and sexually transmitted diseases are rare.

One of the nurses in the clinic has worked there for the last five months and is a trained midwife. She has seen about 300–400 pregnant workers during that time, including 10 cases of bleeding, premature birth or miscarriage. She believes that women are tired in the first trimester but continue to lift materials and perform heavy work. The number of bleeding cases is not high, but she believes that it must be reduced. They advise patients in these cases to take leave and rest at home. If the patients still do not improve after taking leave and rest, they are referred to the hospital. She believes that premature births occur when women walk long distances, are tired or have sex late in pregnancy. She refers patients with dysmenorrheal to the doctor and patients with serious ailments, such as a tumor in the uterus, to the hospital.

HIV/AIDS

Once a year, training and presentations on HIV/AIDS are offered. Posters are put up during lunch breaks. A nurses in the clinic believes that workers are uncomfortable talking about HIV/AIDS and thus do not ask about it. HIV/AIDS is also covered in general trainings on health and safety.

There are no known cases of HIV/AIDS in the factory.

Training

All new workers attend an **orientation** on factory rules and regulations, the collective bargaining agreement and brand requirements. Workers regularly receive training on safety (fire, use of chemicals and industrial hygiene), waste collection and separation, and occupational health. First aid training is provided by the Red Cross annually. One of

each thousand workers is trained in first aid and has a safety sign on their ID card. Pregnant workers receive specialized training on pre-natal care.

The factory contracted with **ISOS**, an international NGO, for one year to provide training on health and safety to company and clinic staff. **Yayasan Kusuma Buana (YKB)** has also conducted trainings on health.

Articles on health topics, including HIV/AIDS, appear in the **company newspaper and magazine**.

Interviews with Workers and Union Representatives

The union committee consists of 25 members that represent all 38,000 workers at Pou Chen. There are four members from the unit visited: two male and two female representatives. Rahmat is the chair of the committee and has been with Pou Chen for 13 years. He has been with the union full time since 1994. Previously he worked in the warehouse and is now responsible for general affairs of the union. Harun and Samsolo are also on the union committee and have been with the factory for 13 years each. Samsolo is responsible for worker welfare and the savings cooperative. Earlier there were four women on the committee, but two female representatives left the factory. They plan to expand the number of members on the union committee in the next elections in 2007 to better represent the large number of workers.

The factory has recently opened a new production unit for a new brand, and an additional 2000 workers will be hired immediately with 7000 total in the future; the union representatives feel that the current clinic facilities are not big enough to accommodate the new workers and need to be expanded. They have no complaints about clinic services and feel that the clinic is able to serve all workers, though some workers may not be taking medicines properly, and some may feel that outside doctors have a better “touch” than doctors in the clinic. There are some workers who only visit the factory clinic. The private medical insurance through MKJ is good and covers most health related expenses. There is also an army hospital close by that provides good service and is covered by MKJ.

Pregnant workers are sent to the clinic for routine check-ups on certain days by their unit, though they are free to visit the clinic for emergencies. During the site visit, a pregnant worker waited over an hour for a routine visit because of long lines. When she returned to work, her supervisor became angry that she had taken so long for the check-up. She complained to the union, and they raised the matter with the central office. The supervisor was issued a warning letter to ensure that they understand the importance of the worker’s routine monthly ante-natal check-up. Union representatives noted that pregnant workers often have long waits when they visit the clinic for their routine monthly check-ups; perhaps there should be more than one midwife available.

The union representatives stated that the cafeteria facilities could be improved by including rest and recreational facilities that would particularly benefit workers who do

not live in the dormitory. Cafeteria meals may be meeting nutritional requirements, but they often do not meet worker tastes. The cafeteria was recently moved far from the factory buildings and is inconvenient for workers, especially when they are fasting during Ramadan.

Union workers also noted that the dormitory facilities have improved in the last few years. Previously, 12 workers shared a room, but two years ago policies were changed so that eight workers now share a room. Lastly, one more worker care center should be established for workers, and there need to be more counselors in the centers.

Danny is seven months pregnant and has worked in the sewing section at Pou Chen for four years. This is her first pregnancy. Her husband also works at Pou Chen as a mechanic. She has been married for over a year. She lives two kilometers from the factory and is taking calcium tablets from the clinic. She plans to return to her hometown for her delivery, which will be at a government hospital. She will take maternity leave after her eighth month. Her mother will return with her to care for her baby. Even if Pou Chen provided a child care center, she would not leave her baby there. She is aware of HIV/AIDS and believes that it is related to sex. When she was asked about sexual harassment, she stated that it is to “make love by force” (may be a literal translation). She does not think that sexual harassment can happen in the factory. She will register for intravenous contraceptives after the birth of her child.

Senatun is six months pregnant and works in the sewing section. She is 23 years old, and this is her first pregnancy. Her husband is a mechanic at Pou Chen. She has been married for seven months. She has visited the clinic every month for regular check-ups with the obstetrician. She attended the training for pregnant workers three times and she learned about the importance of taking vitamins during pregnancy. She will visit the government hospital in Serang for her delivery. She has not yet decided who will take care of the baby after birth, but she may hire a caregiver. If the factory were to provide a child care center, she would use it. She is aware of HIV/AIDS and believes that it is contracted through “free sex.” She does not know anyone with HIV/AIDS. She terms “sexual harassment” as when a “man forces sexual relations on you.” She does not believe that sexual harassment can happen at the factory. She plans to use intravenous contraception after birth. When she wants to visit the clinic, she must talk to her supervisor and obtain a letter from the administration department. It is a five-minute walk from her building to the clinic. An ambulance can be arranged through the security guard in case of emergency. She reports that injuries are rare in the factory.

Herlina Wata has worked in the sole-making section for eight months. This is her first job, and she completed senior high school (12 years of schooling) in 2003. She is 21 years old and stays in rented housing. She has been married for two years. Her husband works on the neighboring island of Sumatra in a factory in Palembang. She visited the clinic during the site visit because of painful menstruation and wanted to take menstrual leave. She has visited the clinic just once before. She is aware that HIV/AIDS is a disease but knows nothing further. She does not know what sexual harassment is. She has not

yet used contraceptives but may use them after the birth of her first child. She would like to have a baby. She is not aware of different contraceptive options.

Helmiati has been working at Pou Chen for one year. She is 22 years old and single. She has completed high school, or 12 years of schooling. Her take home pay is about Rp. 1,400,000 (US\$156 at US\$1=Rupiah 9000). She works in the punching machine, which creates eyelets for shoe laces, and has a friend who was injured by this machine, but she is not worried about being injured. She is from Palembang on the neighboring island of Sumatra and lives in the dormitory. She does not know the meaning of “HIV/AIDS” or “sexual harassment.” She visited the clinic when she had influenza, but she did take time off because her case was not serious. She does not want additional health services. She wants to return to her hometown and marry but she does not know when.

Sanua has worked at Pou Chen for seven years. She applies solvents to the soles of shoes before affixing them to uppers. She has always used an applicator and mask. She has never had any health problems from the primer or glue. She has been married for four months and does not have any children. She is 24 years old and has completed junior high school, or nine years of schooling. She is from the local area, and her husband is a bus conductor. Her wages are about Rp. 700,000 per month (US\$78 at US\$1=Rupiah 9000). She visited the clinic when she had a cold; she saw a doctor and was given medicine. She believes that HIV/AIDS has to do with “relations” and cannot say more. She does not know what sexual harassment is. She does not want more health services in the factory.

Responsibility and Impact

A representative of senior management of the Pou Chen Group feels that the health facilities have helped to improve productivity. Workers are healthier, and the number of injuries has been reduced. Absenteeism is about 3 percent per day, but sickness absenteeism can be attributed to less than 1 percent. From January to June of 2006, there were 24 injuries recorded; this is a reduction over previous years.

VI. Mexico

Context

Country Health Situation

Mexico is established as a middle-income country. It has the highest per capita income in Latin America but still faces huge gaps between rich and poor, north and south, urban and rural. The 1994–1995 financial crisis thrust millions of Mexicans into poverty, and NAFTA has not brought the economic growth that was anticipated, in part due to increased competition from emerging economies in Asia.⁴²

The state of healthcare in Mexico reflects its position between developing and developed countries. Total health spending accounted for 6.5 percent of GDP in 2004, more than two percentage points lower than the average of 8.9 percent in OECD countries but higher than most developing countries. Mexico ranks below the OECD average in terms of health spending per capita, with spending of US\$662 in 2004 (adjusted for purchasing power parity), compared with an OECD average of US\$2550. Between 1999 and 2004, health spending per capita in Mexico increased in real terms by 5.5 percent per year on average, a growth rate slightly higher than the OECD average of 5.2 percent per year.

The majority of health spending in Mexico comes from private sources. This stands in contrast to other OECD countries, with the United States and Mexico as the sole exceptions. Mexico has the second lowest public share after the United States at 46.4 percent of health spending paid from public sources in 2004. While this represents an increase from 40.4 percent in 1990, it remains well below the OECD average of 73 percent in 2004.

Obesity rates have increased in the past two decades in all OECD countries, although there remain notable differences across countries. In 2004, the latest year available, the prevalence of obesity among adults varied from a low of 3.2 percent in Japan and Korea to a high of 30.6 percent in the United States in 2002. The obesity rate in Mexico, based on self-reported data, stood at 24.2 percent in 2000 and is second only among OECD countries to the United States. The time lag between the onset of obesity and increases in related chronic health problems such as diabetes or asthma suggests that the rise in obesity that has occurred in Mexico and most other OECD countries will have substantial implications on the future incidence of health problems and related spending.⁴³

⁴² The World Bank, Mexico Country Brief

⁴³ OECD Health Data 2006, *How Does Mexico Compare*

Healthcare in Mexico is largely linked to employment or provided through private means. The private sector provides health services to approximately 12.3 million predominantly upper middle class citizens out of a population of 107 million. Approximately 38 million Mexican citizens look to social security to address their health needs. Social security-related services, however, are available only to those who are employed. Various public sector institutions provide some kind of coverage to an additional 9 million citizens, while the Mexican Health Department cares for approximately 14.5 million persons. Over 22 million Mexicans, or 20 percent of the population, are estimated to have no access to healthcare.

Mexico: Health Statistics		
Name	Indicator	Year
Population ¹	107,029	2005
Life expectancy at birth (male) ¹	73.2 years	2005
Life expectancy at birth (female) ¹	78.1 years	2005
Population with Adequate Sanitary Facilities ¹	77%	
Maternal mortality rate ¹	65.2 (per 100,000 live births)	2003
Infant mortality rate ¹	19.7 (per 1,000 live births)	2003
Contraceptive prevalence rate ²	68.4% (married women aged 15-49)	1997
Prevalence of HIV, total (of population ages 15– 49) ²	0.3%	2003
Male-female ratio of AIDS cases ¹	5.1	2001
Doctors ¹	15.6 (per 10,000 pop.)	2000
Nurses ¹	10.8 (per 10,000 pop.)	2000
Dentists ¹	1.0 (per 10,000 pop.)	2000
Estimated incidence of malignant neoplasms of the female breast, adjusted ³	26.4 (per 100,000 pop.)	2002
Estimated incidence of malignant neoplasms of the cervix uteri, adjusted ³	29.5 (per 100,000 pop.)	2002
Prevalence of overweight among adult population (of females 20-74 years) ³	52.5%	2000

Sources: 1 - Pan American Health Organization, Area of Health Analysis and Information Systems (AIS). *Health Situation in the Americas: Basic Indicators 2005*. Washington, D.C.; 2 - World Development Indicators database, April 2006; 3 - Pan American Health Organization, Health Analysis and Information Systems Area. *Regional Core Health Data Initiative; Technical Health Information System*. Washington D.C., 2005.

The **Instituto Mexicano del Seguro Social** (IMSS) is a governmental organization that attends to public health, pensions and social security in Mexico. The social security system, which covers workers in the formal economy, is comprised of several institutions, each funded by contributions from employers, employees and the government. IMSS is the largest organization in the system, compared to other organizations that focus on and serve about 80 percent of the covered population. Workers in the informal economy may purchase coverage as well.

IMSS operates its own hospitals, clinics, pharmacies and other medical facilities and also contracts for the use of some facilities. Benefits include general and specialist care, surgery, maternity care, hospitalization or care in a convalescent home, medicines, laboratory services, dental care and appliances.

The quality of service at IMSS facilities is reportedly uneven and depends greatly on the location. Workers complained that there are long waits at some facilities and that some medications are in short supply.

The major issues affecting women's health in Mexico, based on interviews with factory managers, infirmary physicians, female factory workers, a women's health clinic and a faith-based, labor rights organization include the following:

- HPV and cervical cancer
- Breast cancer
- Diabetes
- Hypertension
- Obesity
- Family planning and reproductive health education
- Domestic violence prevention
- Childcare, especially for single mothers

There is a general feeling that women, as well as the population at large, are not well educated on health matters, have limited access to quality health care and medicine and do not regularly seek medical attention for preventative purposes.

Government and Legal Context

Mexican labor law provides some benefits related to women's health, particularly for pregnant workers. Companies are required to:

- Protect pregnant women from performing tasks that would cause danger to the woman and her baby, including reassignment to less strenuous tasks and limiting work to daytime hours. Every chemical that is used for production must be examined for toxicity and the risks it poses to workers through exposure. Pregnant workers must be informed if a chemical or process poses a threat to her health or the health of her child, and management must ensure that she is

immediately transferred to a safe position. Each position in the production line should be classified as safe or unsafe for pregnant workers to assist management.

- Pay pregnant women maternity leave of six weeks before delivery and six weeks after delivery. Women retain their employment and rights under their labor contract during this period of leave, which may be extended if it is impossible for the woman to return to work due to postnatal recovery. During the maternity leave, if the employer has registered the employee with IMSS for 30 of the preceding 52 weeks she receives payment of her salary directly from IMSS as a subsidy and her employer has no obligation to pay.⁴⁴ The employee will receive 50 percent of her salary if she takes an extension beyond the 12 weeks; IMSS helps to subsidize this extension.⁴⁵
- Allow new mothers two extra 30-minute paid breaks to breastfeed their infants.⁴⁶
- Provide enough chairs for pregnant women to sit down.⁴⁷
- The IMSS provides nursery services for children of workers from 43 days to 4 years of age.⁴⁸

The law provides for joint management and labor committees to set standards and assume responsibility for workplace enforcement in factories and offices. The committees are required to meet at least monthly to consider workplace needs, and they must file copies of their minutes with federal labor inspectors.

Cultural Context

To understand the challenges to addressing women's health in Mexico, understanding of the cultural context in the country is needed, including both the "machista" attitudes towards women and the conservative and religious mindset that is prevalent in a predominantly Catholic country.

Women in Mexican society have traditionally served as the principal family caretaker and have only recently begun working outside the home. While the dual responsibility adds incremental health and family complications for working women, women's health needs remain largely underserved by the system. Women often bear the most responsibility for family planning and childcare, yet they face issues such as domestic violence and lack of self empowerment. The traditional view of the woman's role should be contrasted with the fact that the majority of the factory workers are female and are viewed as more reliable and safe workers.

The Catholic religion has a strong presence in communities and among NGOs and community health organizations, thus it holds great influence on women's health in Mexico. Mexico is 89 percent Catholic, and the church's influence manifests itself through conservative attitudes towards sexual health. Methods to prevent pregnancy and

⁴⁴ Social Security Institute. Articles 101, 102

⁴⁵ Torriente, Anna. Mexican and U.S. *Labor Law and Practice*. National Law Center for Inter-American Free Trade, 1997.

⁴⁶ Constitution of Mexico. Article 123(A)(V). Mexican Federal Labor Law. Article 170.

⁴⁷ Mexican Federal Labor Law. Articles 170, 172.

⁴⁸ Social Security Law. Article 206.

sexually transmitted diseases are often not publicly communicated. Women are often afraid or uncomfortable when asking for health information. While there are many single mothers, single women are often hesitant to report pregnancies for fear of being ostracized.

The cultural context differs by region within Mexico. Southern Mexico tends to be more religious and conservative, and the availability of information and opportunity to ask questions on prevention is more limited there. The largest pharmacy in Guadalajara does not even sell condoms. By contrast, the border towns, especially Tijuana, have more American influence. Tijuana is much more open and liberal, and more willing to discuss issues of women's health.

Research and Findings

Methodology

BSR staff visited three factories and two non-profit organizations in Mexico to discover the most relevant health issues for women workers and examine how women's health concerns are being addressed in workplaces and communities. The field research was supplemented by a review of Mexican labor laws, institutional reports on Mexico and other research, and the Web sites of government agencies and NGOs (listed in the Appendix).

Prior to the factory visits, a questionnaire was sent to each site to collect information about the programs available to address women workers' health. Some respondents filled out the questionnaire during the onsite visit.

Brand or parent company representatives were present during all site visits.

Site visits lasted from a half day to a full day and included:

1. Discussions with factory management on health programs and policies. Interviewees included but were not limited to general managers, human resources managers, health and safety managers, welfare officers, counselors, consultants, doctors, nurses, other relevant medical and management personnel and representatives from quality and production departments.
2. Factory walk-throughs to observe production processes, as well as observance of safety measures including use of personal protective equipment by workers. One site visit did not include a walk-through.
3. Visits to clinics and infirmaries, and discussions with medical personnel.
4. Interviews with workers, including both one-on-one conversations and group dialogues, were conducted at two of the three sites. All interviews were located away from production lines and without management personnel present in order to obtain honest perspectives, to learn about worker awareness of the programs described by management and to determine whether programs were having their intended impact.

Projects Covered

Sites in three cities were visited:

- **Monterrey** is located in the state of Nueva Leon and is the third largest city in Mexico. It is about two hours from the border city of Laredo in Texas.
- **Guadalajara** is Mexico's second largest city and is located in the state of Jalisco. Guadalajara and surrounding areas form a major center of electronics manufacturing in Mexico; 80 percent of exports from Jalisco are electronics.
- **Tijuana** is a border town just below California and has a young and transient population. There are over 700 maquiladoras in Tijuana, many of which work in the consumer electronics sector. Unemployment in the city is less than 1 percent, which results in a highly mobile, competitive labor force. Tijuana tends to be more liberal than the rest of conservative, Catholic Mexico.

To supplement our factory visits with a broader perspective from workers and the community, we visited two local NGOs. Centro de Reflexión y Acción Laboral (CEREAL) is a faith-based labor rights advocacy group and a project of Fomento Cultural y Educativo A.C. (Cultural and Educational Promotion A.C.). It provides legal assistance, labor rights training and organizational support for workers' groups, and it researches working conditions in different productive sectors in the country and promotes public awareness campaigns on working conditions. CEREAL produced a report in June 2006 entitled "New Technology Workers: Report on Working Conditions in the Mexican Electronics Industry." BSR's discussions with their team provided information from female workers in a large number of electronics factories.

The second visit was to COMFAM, a women's clinic in Guadalajara that offers affordable prevention and treatment services for women who lack access to IMSS services. The clinic offers Pap tests and other screening services, as well as programs for self empowerment, family care, literacy and exercise. COMFAM takes a holistic approach to health and is an example of a service provider for the poor communities in Mexico, many members of which comprise the labor force for the country's factories.

Key Findings

Health Facilities

Onsite infirmaries provide treatment and first response to workers in cases of occupational illness or injury that range from cuts and scrapes to serious accidents that require hospitalization. Infirmaries provide a workspace for medical staff, patient areas for examinations and supplies. Infirmaries should be located where employees' daily routines will intersect with them. Employees may be afraid to enter infirmaries if they do not have a pressing health problem, which makes preventative care promotion challenging. Infirmaries should be perceived as a resource for every worker's well-being rather than as a place for sick people.

Health monitoring of workers for exposure to **hazardous materials** is crucial to alert management of needed changes for worker protection. If pregnancies are unknown or unreported to supervisors, pregnant women and their fetuses may be at risk of hazardous chemical exposure, which may cause birth defects or miscarriages.

Common Illnesses

The most prevalent women's health issues are **cervical cancer, obesity, diabetes** and **hypertension**. These conditions can be prevented through proper nutrition or, in the case of cervical cancer, Pap screening. The need for greater information on early prevention and detection is apparent.

Cervical cancer is a leading cause of mortality among women in Mexico and was consistently named in interviews as the biggest health problem facing women workers. It is also highly preventable through conducting timely Pap tests to discover pre-cancerous changes in the cervix. Because it is recommended that women undergo a Pap test once a year, infirmaries should offer this service to their workers rather than have workers make appointments at IMSS. As a baseline, women workers should be provided with information on prevalence, prevention and treatment options. Prevention information on STDs and nutrition is essential, as cervical cancer is linked to HPV and risks are increased by obesity.

Breast cancer is also a leading cause of mortality among women in Mexico. Detecting breast cancer early improves the likelihood of successful treatment. Information about risk factors and how to detect this disease through self and clinical exams should be proactively disseminated to women workers.

High blood pressure, or **hypertension**, was commonly cited among women workers and can lead to undesirable health complications. Maintaining records of blood pressure for workers is one way that medical staff can help workers take charge of their health. Hypertension can be managed through changes in diet, exercise and weight management. Employers can assist employees by providing information about nutrition and the benefits of an active lifestyle.

Medical staff know that **poor nutrition** is a high risk factor for the workforce because a large number are **overweight** and have relatives who are **diabetic** or **hypertensive**. Medical staff often discourage dieting for aesthetic purposes and provide workers with information on improving health through better nutrition.

A focus on **self-esteem and self-empowerment** encourages women workers to take ownership of their health and proactively seek health services from a variety of sources. This focus can also provide women with the courage to seek assistance with sexual harassment or domestic violence. IMSS, factory medical staff and community clinics can help empower women to take charge of educating themselves about their own health.

Information must be made available about current health risks and options. Factory management can assist by providing information and motivation to workers.

Sexual harassment continues to be a problem in the workplace. In the majority of cases, low level supervisors act inappropriately toward subordinates, but sexual harassment also occurs among production line workers. Women are often afraid to report cases for fear of retaliation. Policies protect workers from retaliation in some workplaces, but workers may not be aware of the policies, or they may not believe policies will be enforced. Management can educate workers about the policy and provide information on enforcement and who to contact when there is a problem.

Care during Pregnancy

While many benefits for pregnant workers are mandated by Mexican law, unwanted, undetected or unreported pregnancies are common. It is crucial for women workers to have affordable access to pregnancy tests and to feel comfortable informing their employer when they discover they are pregnant so they can be reassigned to safer job responsibilities if necessary. Management can facilitate a solution through communication and trust-building. Pre-natal care, including regular checkups with medical professionals, a healthy diet and stress and movement management, should be available to women workers to improve the well-being of the mother and the development of the fetus. Workplaces are legally required to provide a comfortable space where mothers can pump and store breast milk. Enabling mothers to breastfeed their children at work, when feasible, is an example of best practice.

Family Planning

Contraception is a sensitive topic in Mexico. Attitudes about contraception vary. Many recognize the importance of contraception in avoiding unwanted pregnancies, but others do not condone contraceptive use. Sensitivities to various contraceptive methods differ, with injections and pills being the most acceptable methods. Condoms are more controversial because, though they can prevent some sexually transmitted diseases, they are perceived as enabling casual sex. Every employer must determine whether to offer contraceptives to workers and which methods to make available, while keeping in mind cultural sensitivities and the impact of unplanned pregnancies on workers.

HIV/AIDS

Most managers and workers did not perceive HIV/AIDS to be a major health issue for women in Mexico, despite AIDS being the sixth leading cause of death among women aged 15–44.⁴⁹ There was a general feeling that information about the disease is being communicated through public campaigns, but there still appears to be a lack of awareness. More effective education about HIV/AIDS and STDs in general is needed. While management of all three factories recognized the importance of STD education

⁴⁹ UNICEF Mexico, <http://www.unicef.org/mexico/programas/vih.htm>

and prevention, they also recognized the cultural challenges of implementing effective programs and maintaining a “wholesome employer” reputation.

Child Care

Women workers do not leave their family responsibilities behind when they enter the factory floor: the well-being of their children is never far from their thoughts. When problems in securing care for their children arise, they may become distracted, miss shifts and lose their jobs. Child care is especially a problem, due to the high percentage of single mothers in Mexico.

Who Pays for Health Services?

Most workers depend on IMSS to cover costs of health care or visit government dispensaries run by the Ministry of Health. Since treatment is generally sought only after illness has set in, and few preventive activities are undertaken, costs of private healthcare are generally covered by the worker with no compensation.

Education and Prevention

Mexican workers **do not have a culture of preventative medicine**, nor do they visit doctors for regular checkups. Medical care tends to be focused on acute treatment. Any approach to women’s health will face a challenge of changing this overall mindset, especially among young people who tend to ignore medical information and believe that “it cannot happen to them.” The factories surveyed have implemented awareness programs on general health and specific health issues, supported by diagnosis and treatment activities where needed. Specific services provided during such campaigns include vision tests, diabetes tests, medications for parasites and vaccinations for influenza, hepatitis B, tetanus and rubella.

Worker Communication

Mexico has specific **cultural sensitivities** distinct from other manufacturing regions. Multinational companies should give local management freedom and flexibility to develop programs based on **local culture**. Cultural sensitivities, including attitudes towards women, religion and sexual relations, differ among regions within Mexico, and the most successful programs adapt to these nuances. Such localization must be balanced with strong company values to support decision making.

Impact

Improved recognition by factories of the business case for health programs:

Anecdotal evidence suggests Mexican employers increasingly recognize that the health and safety of workers is a driver of business success, and thus many are transitioning from basic occupational health and safety to address broader health problems among their workforce. Costs can be kept minimal through partnerships with government institutions, and benefits include increased productivity, reduced absenteeism, better

recruitment and retention of workers, improved product quality and reputation in the community as an employer of choice.

Recommendations for Effective Health Programs

The following recommendations for brands and factories for designing an approach to women's health concerns are made based on the findings above and on review of the critical success factors for factory programs.

- **Factories should identify ways to disseminate information that can be accessed easily and discreetly.** One factory distributes pamphlets to workers at orientation and has brochures on a display stand outside the infirmary so that women do not have to ask. Success is greatly enhanced through a push, rather than pull strategy, as workers are often embarrassed or do not know to ask for information. Proactive distribution to all workers has incremental benefits to the community, as male workers can provide the information to their wives and mothers. Since many major health issues for women in Mexico are preventable, a focus on information and awareness building is essential.
- **Large factories should make prevention and health screenings convenient by providing them onsite when possible.** While information is important, Mexico does not have a culture of health prevention, and many workers will not take the necessary steps to follow up on information received. The provision of medicine at the infirmary is seen as a huge benefit, as many workers do not have the time or money to visit the pharmacy. One factory has close relationships with a local laboratory that comes onsite and offers services during a specific week or as needed (for example, when a group of workers request a specific service).
- **Factories should hold regular and frequent health campaigns for workers.** If campaigns are voluntary, many workers will choose not to attend unless they are in a location where workers are already congregating, such as the cafeteria. Because Mexican factories experience high turnover, health campaigns that occur annually only reach a small percentage of the population. The objectives of campaigns are to change attitudes of workers, and such a change requires repetition and frequency. One factory addressed health topics with workers on a monthly basis by creating displays between the factory entrance, cafeteria and production area to ensuring that workers were aware of campaigns.
- **Multinational companies should support factory initiatives, instilling company values and guidelines but allowing flexibility for local managers to design programs that are tailored to worker needs and take into consideration cultural and socioeconomic sensitivities.** The success of localized programs can be enhanced by providing opportunities for input and feedback from workers and establishing worker committees or health

representatives so that programs are supported by peers and not just management. One factory had a number of committees dedicated to various health issues, such as health and wellness, which meet on a monthly basis with formal participation by committee members throughout the factory.

- **The cost of many factory programs is minimal because they are tailored from government or community programs.** Such partnerships make providing information and services to workers easier while improving the overall business case for the programs. As an example of best practice, one factory's infirmary stocked many medications at no or reduced cost through partnering with the local branch of IMSS.

Detailed Reports of Site Visits

Monterrey, Mexico

Factory Information

The city of Monterrey in the state of Nueva Leon. Monterrey is the third largest city in Mexico and an important industrial center. The factory visited in Monterrey produces children's toys which are manufactured, assembled and packaged at the factory, then shipped by truck to the U.S. market. The border city of Laredo, Texas, is about two hours drive from Monterrey.

The factory covers 860,000 square feet and employs around 2000 workers, including cleaning subcontractors and security guards. Among the more than 1000 operators who work on the production lines, 72 percent are female, and the average age is 22. The average seniority of operators is less than one year. Among the 350 technicians, including forklift drivers and other maintenance workers, only 7 percent are female. Of 140 administrative staff, 28 percent are female, though this percentage has grown from only 10 percent several years ago.

The majority of employees are between the ages of 19–30 years old. Night workers are more likely to be older employees, and there is less turnover among workers on the night shift. The factory uses temporary contracts to manage the size and composition of its workforce because it does not have the production volumes necessary to employ a permanent workforce. Ninety percent of operators have temporary contracts that end after the peak production season. Only 100 out of 1000 temporary operators become permanent operators in any given year. Most workers hold contracts from April through October, although 70–80 percent of operators in a given year are return workers.

In the off-peak season beginning before the winter holidays, many operators attempt to find retail employment after their contracts end.

Turnover is a challenge for the factory, which finds the highest turnover rates during the peak season and among operators. The facility's human resources management administers an exit survey to identify causes of turnover. Survey results reveal that, among workers leaving the factory, 37 percent were employed for less than one month and 39 percent were employed for between one and two months. Management has plans to address high turnover through:

- Investigating the provision of onsite or nearby child care
- Performing more in-depth interviews with workers who have left
- Offering more permanent employment options

There are challenges associated with a temporary workforce in providing health information, training and services.

Management employees are aware of the factory's values. There are posters that list the factory's values located in prominent areas of the factory, including on the production floor and in front of the cafeteria. The factory values are perceived as a way to determine the right decisions to make. The factory requires safe and fair treatment of employees, environmental protection and respect for cultural, ethnic and philosophical differences amongst employees. These values are visible throughout the factory, and management states that they are a useful management tool.

The factory is investigating options to provide onsite child care because it recognizes that child care is a major cause of turnover and absenteeism. The government will subsidize a child care center on a per child basis.

There is a zero tolerance policy for sexual harassment, and the topic is addressed annually during one of the company-wide monthly safety meetings.

Worker Communication

Supervisor meetings are held weekly to address health and safety issues. One focus of the meetings has been preventing accidents by keeping aisles clear so that collisions among workers and forklifts are avoided. Through the meetings, supervisors are kept informed of when incidents occur and ways to avoid them.

Self Esteem and Empowerment

The factory has a female motivational speaker speak at the factory about self respect and self empowerment.

Health Facilities and Issues

The factory has an **infirmary onsite** in a central location. The infirmary is staffed 24 hours a day and seven days in a week. The staff includes a doctor and four nurses. The doctor is available onsite during the day shift, as well as during the night shift once a month. Nurses are available onsite during all shifts. Almost 50 workers visit the

infirmery per day for a variety of reasons, including treatment of migraines, blood pressure tests and contraceptives.

When a worker is assigned a task that requires them to work at height above the factory floor, the worker must pass a blood pressure test.

The facility has HSE staff and a system for ensuring the safety of workers in handling hazardous materials and providing personal protective equipment when necessary.

Hypertension: There is a communications campaign the week prior to EHS Week and during EHS Week, with a booth where workers can get their blood pressure checked. Also, prior to working at heights, workers must get their blood pressure checked in the infirmery.

Nutrition, obesity and diabetes: The medical staff in the factory infirmery provides information to workers through bulletins and communications campaigns. Weight records are kept in the infirmery for workers who want assistance in controlling their weight. Medical staff stress the importance of eating healthy and the risks of excessive dieting. Factory medical staff and an external laboratory coordinate during EHS Week on providing workers with blood tests for cholesterol.

Prevention and vaccination for disease: Communication campaigns and vaccinations are provided onsite during EHS Week. The factory partners with IMSS to provide vaccines for tetanus, influenza, rubella and measles. The infirmery provides free oral medication for parasites during EHS Week.

Reproductive Health

The factory has a **pregnancy health care program** that ensures compliance with the law governing the treatment of pregnant workers and goes beyond the law to address aspects of pregnant women's health. Women workers are excused from work to visit the IMSS five necessary times to qualify for the pregnancy leave benefit, and when necessary for the health of the mother and child. Buses that service the factory have seats reserved at the front of the bus for pregnant workers. There are reserved parking spaces for pregnant workers near the entrance to the facility. Every pregnant worker can get a nutritional snack at no cost at the start of every shift. Pregnant workers can also track their weight in the infirmery.

In order to receive the pregnancy leave benefit from IMSS, women workers must have been registered as an employee for the 30 weeks prior to the beginning of the pregnancy leave. It is common practice for facilities to end contracts without consideration of whether pregnant workers may lose eligibility for their pregnancy benefit. To ensure that pregnant workers do not lose their pregnancy benefit, the factory will extend the workers' contracts. This has a tremendous impact because it allows women to continue to have access to health services through IMSS and to continue to have income from the pregnancy benefit.

Breastfeeding: After mothers return to work they are provided with two thirty minute periods during each shift to use a breast pump. A separate room and refrigerator are located in the infirmary for mothers to pump and store their milk.

Family planning: Free contraceptives are available from the infirmary for all workers.

HIV/AIDS

The medical staff at the factory has created a pamphlet with information about how the HIV virus is transmitted and some preventative measures workers can take. The pamphlet is located outside the infirmary on a rack, so there is no need to ask for more information, which some workers may be embarrassed to do. The company does not conduct HIV tests or ask questions in the hiring process.

Training

The factory provides **information and services** related to health for all workers including women, because they believe it is the right thing to do and because there are clear benefits to the factory. These include the benefits from being an employer of choice in Monterrey, reduced turnover among operators, reduced risk of accidents and illness, higher quality products, a more productive workforce and lower payments to Social Security.

The specific approaches taken by the factory are led by **local management**. Although the corporate values are evident at the facility and provide an enabling context for decision making, the specific programs offered and even the general commitment to workers and women's health are an outgrowth of the initiative taken by local management. Their focus on the well-being of workers, women and pregnant women in particular comes from a perspective that can be summed up as "Our business is children." There is an understanding that the costs of the health and wellness programs are justified because better health creates a more productive workforce; demonstrating that management cares about health and safety has a positive influence on worker recruitment and retention, and it benefits the employer's image in the community.

The factory offers ongoing health services throughout the year. Once a year, the facility also hosts an EHS Week that provides a broader range of health services onsite, including information about preventing disease, ways to seek treatment, and screening for certain ailments. External providers of services and the infirmary staff set up booths about various health issues. The booths are located in the dining hall so that all are encouraged to attend, with raffles for participation. During EHS Week, workers can access onsite the following services:

- Vision tests
- Diabetes tests
- Vaccinations for influenza, hepatitis B, tetanus, rubella
- Medications for parasites

Several groups that are responsible for different elements of health and wellbeing at the factory. There is a Safety and Hygiene committee that is led by a nurse and meets regularly to discuss ways to prevent accidents and illness. There is also a First Aid Brigade affiliated with the Red Cross and Green Cross. All the members of the First Aid Brigade receive training for administering first aid. In addition, there is also a Fire Brigade at the factory, but there are no women on the brigade.

The overall training approach can be characterized by a focus on information sharing and awareness building, and less focused on provision of actual services. Each new worker is provided with an IMSS Health Guide at orientation and a variety of information pamphlets are on display and readily available outside the infirmary including information on cervical and breast cancer, osteoporosis and AIDS. Informational posters are also extremely prevalent and visible on bulletin boards and cafeteria tables. Project are designed by IMSS and adapted by factory medical staff.

Cervical and Breast Cancer: Women workers learn about cervical and breast cancer during the EHS week and through the IMSS-PREVENIMSS calendar that is distributed at the orientation for new employees

Responsibility and Impact

The factory has many strong programs that support women's health. There are a number of lessons from their experience:

- Strong, values-based leadership enable programs to be successful.
- Workers often do not know about ways to prevent diseases so communication is needed, especially in communicating the importance of preventative care to young workers.
- Finding the business benefit to improving the health of workers will drive success over the long-term.
- Costs of providing health information and services can be quite low by leveraging established government programs.
- There are competitive advantages in providing a safe and healthy work environment, in terms of improving recruitment and retention, reducing cost, improving product quality and workforce productivity.
- There are limits to the extent of health care services that can be provided in a work environment.
- Offering the same benefits to temporary and permanent workers is required by law.
- Allowing workers to encounter health-related information in a comfortable environment with their peers allows them to overcome fear and anxiety.
- Preventative care is not part of the Mexican culture and this will take hard work to change the mindset. This is especially a problem among young people who don't pay attention to the information already available.
- An open management culture is essential for improving communication.

- There is a large advantage of having local programs based on cultural differences, rather than a consistent, global program mandated by corporate headquarters.

There is also a cost savings justification for prevention activities. By reducing the number of incidents per year, the risk factor assigned by IMSS to the factory decreases. This in turn reduces the required payment to IMSS. Reducing the risk factor over the last four years from 3.05 to 0.62 has saved the factory six million pesos.

Tijuana, Mexico

Factory Information

The Tijuana factory manufactures toys and employs 2944 workers, of which 57 percent are female. Of the 2244 operators, 67 percent are female. Over half the population is under the age of 30 and two-thirds have tenure of less than one year at the factory.

There are two major contextual factors which drive the plant's approach to women's health issues. The first is the culture and values of the company, derived from the overall culture. The company develops programs tailored to the local needs of the factory and its workforce.

The second major factor is the socio-economic context of the city of Tijuana, which is a border town with a young and transient population. There are over 700 maquiladoras in Tijuana, many of which are in the consumer electronics sector. Retention is a big challenge in this highly mobile, competitive labor market. Unemployment in the city is less than 1 percent, with average turnover at 12 percent monthly due to the highly transient population. Turnover is more than 4 percent a week. Thus, the site has not fired or laid off a worker in the past two years. Rather than terminating contracts, they manage seasonal fluctuations through attrition.

Tijuana also tends to be more liberal than the rest of conservative, Catholic Mexico. Women workers interviewed were much more open than in other parts of the country, were willing to talk about birth control and STD prevention, and had all utilized the screenings and services provided. This cultural difference makes it easier to provide information on prevention and more "controversial" issues of women's reproductive health. The population in Tijuana also tends to be younger and less educated. Average education level is 6th or 7th grade, thus women often need support to fill out medical information.

Child Care: After school day care is a challenge, especially with a significant number of single women workers. The factory recently started providing transportation to a local child care facility provided by DIF.

Health Facilities and Issues

Infirmary onsite: There is an infirmary onsite staffed by three nurses and one physician. The infirmary is currently open 24 hours a day, 6 days a week, but will be moving to be 7 days a week. The physician is onsite from 9-6. As the plant is not air-conditioned, one of the biggest problems of occupational health is heat-stroke. The plant has installed additional fans and water stations on the factory lines. The factory provides free medications at the infirmary. And although the factory contributes approximately \$30,000 annually, more than half of the medications and services are financed through the government. The infirmary also provides discounts at a local laboratory for specific services and blood testing.

Weight Control and Obesity: Communication campaigns and weight control testing are being provided by onsite medical staff at the infirmary, and records are kept for employees' reference.

Testing for cholesterol, diabetes, and high blood pressure: Communication campaigns and screenings are conducted. In 2005, 1100 hypercholesterolemia-cholesterol and triglycerides tests, 375 diabetes mellitus examinations, and 6125 hypertension tests were conducted.

Reproductive Health

Pregnancy Health Care: There is a program to identify and support women during pregnancy which includes: reassignment to risk free, morning shift job environment, record keeping of health conditions, no waiting in line for employee services such as cafeteria, extra meal portion if it is required, payroll, buses boarding, and a food basket before child birth. Pregnant women also wear a badge identifying them as pregnant and part of this special program. The culture in Tijuana is more open and accepting of single mothers, enabling this type of visible identification. The objective is to raise awareness of the importance of detection of pregnancy and the proper health care during this period and to prevent exposure to hazards on job activities for women workers. In 2005, a total of 90 employees were included in the program, and in 2006, 116 employees have been included in the program to-date.

Period of Breast Feeding: Communications is provided to all employees at new hire orientation program and posted at infirmary. Employees receive 30 minutes of time allowance twice during the shift for breast-feeding. The feeding could be at the infirmary or off site of the facilities. There is space to pump and refrigerate milk in the infirmary and women also have opportunity to have family member bring child into facility as many live within walking distance. In 2005, 9 female workers used this benefit.

Identification of Cervical Uterine Cancer: Communication campaigns and testing are being provided at the infirmary and conducted by medical staff and government medical institutions (IMSS-ISESALUD). In 2005, 104 cervical uterine cancer test were applied

Breast Cancer Identification: Communication campaigns and testing are being provided at the infirmary and conducted by medical staff and government medical institutions (IMSS-ISESALUD). In 2005, 104 breast cancer exams were applied.

Family Planning: Free contraceptives are available for all employees at the infirmary, communication campaigns and conferences. The objective is to raise awareness of the importance of family planning and the proper use of contraceptive methods among our workforce. In 2005, 1100 doses of contraceptive methods (injection, pills, and condoms) were provided to female workers and in the first six months of 2006, 1400 doses of contraceptive methods were provided. The infirmary also provides information about vasectomies.

Training

The factory's approach focuses on both education/awareness and provision of health services and centers around on partnering with government institutions such as IMSS and ISESALUD to broaden the services offered to employees. This is accomplished through health care campaigns conducted monthly throughout the year, provision of free medicine and health screenings, and an annual Family Day. Projects are designed by the government medical institutions and adapted by company medical staff.

Health care campaigns are held right outside the infirmary, which is in a central area through which all workers pass multiple times per day. Campaigns and screenings include breast cancer, uterine cancer, diabetes, cholesterol and blood pressure as well as family planning, which includes providing information and free oral contraceptives, injections and condoms.

There is also an annual Family Day, held on a Sunday and serving over 1000 workers and their families. This program brings in government institutions to provide health information and screenings, such as vision and dental exams, as well as drug use and fire prevention. The Family Day is widely publicized.

The factory also held a Spring Race in 2006 which promotes an active lifestyle among its workers. The factory management believes that focusing on sports is an important component in the fight against obesity.

The factory management believes that provisions of all these benefits helps attract and retain workers, especially in such a competitive labor market. All programs are voluntary and are available to all employees, from production lines to professional level workers.

Responsibility and Impact

Highlights from factory programs and approaches include the following:

- Services go beyond education and information sharing to actually providing health screenings, services and medicine. This makes such preventative measures

much easier for workers and increases the chance of that workers will take such measures.

- The factory provides regular and frequent information and services through monthly campaigns. This helps change the overall mindset towards prevention, and is especially effective given the high turnover rate.
- The open culture of Tijuana is an enabling factor, as workers are more willing to ask for information.
- Factory management is able to understand the business case for such programs. As most are offered through government partnerships, they do not cost a great deal but result in reduced absenteeism and improved recruitment/retention of workers.

Recommendations to improve the programs include:

- **Transition from pull to push approach:** Currently no information is consistently on display, but written materials and information are available upon request. Some women are still embarrassed to ask questions- and more proactive, discrete dissemination of informational materials would be beneficial. This would include distribution of the IMSS Guide to Women's Health to all new workers and a stand outside the infirmary with information pamphlets.
- **More worker participation:** The factory could increase uptake of voluntary programs by involving workers in planning and communicating such campaigns. This would ensure that campaigns meet the worker needs and also allow communication to be spread through a network of peers.
- Since one of the biggest challenges in Mexico is availability of **medicine**, the factory would like the opportunity to partner with pharmaceutical companies to aid their distribution of essential medicines.
- **Create more effective partnerships with government:** The factory could act as an efficient distribution channel of information and health services to its workers. If government agencies provided more resources such as free vaccines and medications, the health of workers and their families could be improved.

Guadalajara, Mexico

Factory Information

This electronics manufacturing facility is located near Mexico's second-largest city of Guadalajara in the state of Jalisco. Guadalajara and the surrounding areas in the state of Jalisco are a major center of electronics manufacturing in Mexico. In fact, 80 percent of the exports from Jalisco are electronics. There are twelve original equipment manufacturers and fourteen contract manufacturers with a presence in Jalisco.

The facility is a major electronics manufacturing campus with more than thirty buildings and over 8000 workers. The company's services range from design engineering, through manufacture and assembly, to distribution and warehousing.

There are a total of 3552 female employees and 5013 male employees onsite. The average age of operators is 28.

- 45 percent of the Operators are male and 55 percent are female
- 74 percent of the Technicians are male and 26 percent are female
- 73 percent of the Professional staff are males and 27 percent are female

Turnover ranges from below 2 percent for direct workers to an average of 15 percent for contract workers. Absenteeism ranges from 2.5-3.5 percent.

There is a hotline to report **sexual harassment** but there is still a problem of verbal abuse among low-level supervisors.

Health Facilities and Issues

The factory's approach is to identify the health needs of the workers and then put programs in place that address those programs. Factory management identifies three women's health issues as the most important. The first is a general health issue consisting of interrelated conditions: obesity, diabetes and hypertension. The second is a health issue specific to women: cervical cancer, which is a leading cause of mortality among women in Mexico. The third issue relates to sexuality and includes contraception and family planning, reproductive health and the prevention of sexually transmitted diseases. The factory has programs to address these three issues.

All programs are optional and take place during work hours. The facility management understands that it may be difficult for some workers to travel to and from IMSS clinics to access services. Therefore they attempt to bring services to the workers. All the services offered by the factory are available to all workers onsite, regardless of their position or status.

Infirmery onsite: The factory has an infirmery onsite that is staffed 24 hours per day and it has four nurses on staff. The infirmery is located in the same building as the cafeteria, and campus transportation can take workers between buildings helping workers to access the services. At least one nurse is present for every shift in every building. There is also an ambulance onsite.

Hazardous material handling and PPE: The factory has a health and safety management system that includes characterization of the risks to health posed by chemicals used onsite and testing and follow up to measure worker exposure to all workplace risks. These tests include audiometry for exposure to noise, blood tests for exposure to chemicals and spirometry for exposure to dust and vapors. The factory also conducts random drug tests on all employees, including administrative staff.

Nutrition, obesity and diabetes: The factory's approach to this issue includes a program showing female workers how to improve nutrition for themselves and their families. The focus is on how to change habits, prevent or reduce obesity, and reduce the probabilities of developing illness like hypertension and diabetes. Approximately 120 women participated in at least part of this program. The cafeteria coordinator supports the management of meals and the fulfillment of caloric needs. The programs began when workers began asking for advice on eating more nutritional foods. The factory has also welcomed visitors from pharmaceutical companies who have shared their experiences in other companies in improving nutrition. The factory will also perform tests for diabetes if a worker asks for it and will recommend a test if symptoms are apparent.

Prevention and vaccination for disease: The factory runs a vaccination program for influenza and tetanus.

Reproductive Health

Pregnancy Care: The factory complies with pregnancy leave laws. In addition, the facility management audits all personnel agencies that they use to ensure that the agencies are in compliance with laws regarding pregnancy leave. The company allows an hour of breast-feeding time per day for three months or allows workers to leave an hour early. The company does not keep a record of pregnant women and does not ask during hiring.

Cervical cancer and breast cancer: The communications department designs and distributes banners and brochures about the risk factors for cancer and preventative measures. The factory also promotes preventative checkups for cervical cancer by hiring an external laboratory to come onsite every year and make Pap tests available to women workers. 2006 was the third year that these tests were available and 150 women participated in 2005.

Family planning: The medical staff makes information available on different contraceptive methods, including how to choose the best method and the consequences of a non-planned pregnancy. Female workers can also fill prescriptions for contraceptive injections at the infirmary.

HIV/AIDS

In order to overcome resistance to sensitive topics such as sexually transmitted diseases (STDs), the medical staff publicizes health-related events by focusing on less sensitive topics, such as menstrual health. When workers attend, they also learn about sexually transmitted diseases, symptoms, and the ways to prevent infection. This program includes HIV/AIDS prevention topics by providing information on how to use a condom and the importance of preventing casual sexual intercourse.

Responsibility and Impact

Highlights from the factory's programs and approach include the following:

- The factory's nutritional program has resulted in workers changing not only their eating habits but those of their families as well. Participants in the program increased their confidence and their relationships with their coworkers.
- The nutrition program recognizes that dieting can be unhealthy if it is based on caloric deprivation and includes this topic in the program.
- Worker participation: There was an event for all the participants in the nutrition program in order to identify ways to improve it.
- The monitoring of personnel agencies for compliance with pregnancy related laws is a best practice way for the factory to protect the RH of its contract workers onsite.
- Providing access to contraceptive injections onsite provides workers with a convenient way to access family planning services.
- Including more controversial or sensitive topics in the same format as other health information allows workers to feel more comfortable and exposes them to important information they can use to protect their health.
- The focus on preventative health services is an asset, especially given the lack of a prevention ethic among many of the workers.
- Health and safety personal protective equipment supply and provision is managed through an onsite third party vendor. This ensures that all appropriate supplies are available and the medical staff can focus on providing service rather than logistics.
- The factory holds monthly HR Directors meetings that address topics of health and safety.

Recommendations to improve the programs include:

- Provide free condoms to all workers at their request. Recognizing that there may be privacy concerns for some workers, this should be addressed as part of the program.
- Build on the success of the nutrition program by expanding it to include more workers.
- Provide more treatment services for workers while maintaining the focus on preventative care.
- Provide more information to workers in the form of brochures that can be accessed in every building on the most important and sensitive health topics.
- Provide information and programs in public places such as cafeteria to increase participation. For example, the STD information is currently a program during working hours for which employees need to ask permission to attend.

VII. Philippines

Context

Country Health Situation

The Philippines has had robust economic growth for the past five years. The country's GDP growth averaged 4.5 percent in 2000–2003 and increased to 6.1 percent in 2004. Similar to other countries in this study, the Philippines has made improvements in basic health indicators. The infant mortality rate has declined from 57 per 1000 live births to an estimated 27 per 1000 in 2003. Malnutrition for children under five shows only a small decline, from 34.5 percent in 1990 to 31 percent in 2003. Huge disparities between regions and income groups continue: the infant mortality rate among the poorest fifth of the population is 2.3 times higher than the rate among the richest fifth. Life expectancy in the Autonomous Region in Muslim Mindanao is at the national level that was reached in 1970, indicating that the region lags 30 years behind the rest of the country.⁵⁰

Philippines: Health Statistics		
Name	Indicator	Year
Population ¹	83 million	2005
Life expectancy at birth (male) ¹	65 years	2004
Life expectancy at birth (female) ¹	72 years	2004
Population with sustainable access to improved sanitation (percentage of population) ²	73%	2002
Population with sustainable access to an improved water source (percentage of population) ²	85%	2002
Percentage of births attended by skilled attendant ¹	59.8%	2003
Maternal mortality ratio adjusted (per 100,000 live births) ²	200	2000
Infant mortality rate ²	27 (per 1,000 live births)	2003
Contraceptive prevalence rate ¹	48.9% (married women aged 15-49)	2003
Prevalence of HIV, total (percentage of	0.1% to 0.2%	2003

⁵⁰ World Bank Discussion Brief: Improving Health Outcomes, Especially for the Poor. World Bank Group, Manila.

population ages 15 - 49) ²		
Doctors ¹	5.8 (per 10,000 pop.)	2000
Nurses ¹	16.9 (per 10,000 pop.)	2000
Midwives ¹	4.5 (per 10,000 pop.)	2000
Community Health Workers	NA	NA
Other Health Workers ¹	12 (per 10,000 pop.)	2000
Dentists ¹	1.1 (per 10,000 pop.)	2000
Population undernourished (% of total) ²	22%	2000-2002
Children underweight for age (% below 5) ²	31%	1995-2003
Estimated incidence of tuberculosis cases ¹	293 (per 100,000 pop./year)	2004

Sources: 1 - *World Health Report 2006—Working Together for Health*. World Health Organization, Geneva; 2 - *United Nations Human Development Report*. 2005. United Nations, New York. 3 - Center for Reproductive Rights, www.crlp.org.

The Philippines ranks ninth in tuberculosis incidence, among 22 high burden countries. There are an estimated 293 cases per 100,000 population per year. The Philippines is considered a low prevalence country for HIV/AIDS, with an estimated 11,200 people living with HIV/AIDS at the end of 2005.⁵¹ The disease is mostly transmitted through sexual contact, especially among sex workers, who rarely use condoms.

Government and Legal Context

Provision of health services is uneven and has inherent deficiencies. Prices of medicines are high compared to other developing countries, due to a near monopoly in the pharmaceutical industry. Though the government has passed laws to promote generic drugs, structural deficiencies hinder their effective distribution. Preventive measures, such as campaigns against smoking or to promote good diets and exercise, are lacking to stop the spread of non-communicable diseases such as heart and vascular disease, cancer and chronic lung disease. Health care efforts tend to be concentrated around large specialist hospitals that have the best facilities and trained doctors and medical staff, while little effort has been made to improve the network of primary care facilities that could be more effective as a first stop for successful treatment.

The Philippines has a network of primary health centers down to the Barangay (sub-municipal) level. In 1991, the management of these centers was devolved from the National Department of Health to provincial, city and municipal governments under the Local Government Code. Health services have deteriorated since the devolution, due to inability of local governments to maintain previous expenditure levels and fragmentation of the system. In 1995, the National Health Insurance Program was started under the management of the Philippine Health Insurance Corporation (Phil Health) to provide universal coverage through programs for the self-employed and the poor, with the premiums for the latter jointly paid by national and local governments.

⁵¹ UNAIDS Data.

Phil Health has yet to realize its full potential through reaching out to all citizens; under-utilization of benefits by existing members is another problem.

The following benefits are provided to workers, as required by law:

- Workers are eligible for social security, which provides sickness, maternity, disability, retirement and death and funeral benefits. Social security includes employee compensation in case of disability and death.⁵² Contributions from both employer and employee are based on the wage level of the employee.⁵³
- Workers are provided health care services through Phil Health.⁵⁴ Equal contributions are made by the employer and employee based on the wage level of the employee. Phil Health provides for services in nominated hospitals; services are generally free in a public hospital, and workers pay a percentage of the fees in a private hospital.⁵⁵
- Pregnant workers are eligible for 60 days of maternity leave in case of normal delivery, miscarriage or abortion and 78 days in case of caesarian section delivery.⁵⁶
- Discrimination against or dismissal of a female worker because of pregnancy is prohibited.⁵⁷
- Employers cannot require as a condition of employment that a female employee not become married.⁵⁸
- Paid paternity leave of seven days is given to married regular male employees.⁵⁹
- Women are prohibited from working at night, between 10:00 pm and 6:00 am.⁶⁰
- Factories must provide free medical and dental services and facilities based on the number of workers. An annual health examination may also be required.
- Factories that, due to their number of workers, are required to maintain clinics or infirmaries should provide free family planning services to their employees, including but not limited to contraceptive pills and intrauterine devices.⁶¹
- Sexual harassment is prohibited, and workplaces are required to have policies, committees and grievance procedures on sexual harassment. All employees must be trained on policies and procedures. The Anti-Sexual Harassment Act provides a definition of sexual harassment.⁶²
- The Philippine AIDS Prevention and Control Act of 1998⁶³ prohibits mandatory testing for HIV. The Act calls for respect of human rights for individuals living

⁵² www.sss.gov.ph

⁵³ Social Security Act of 1997 - Republic Act No. 8282, Portability Law – Republic Act No. 7699 and Employee's Compensation and State Insurance Fund, Presidential Decree No. 626.

⁵⁴ www.philhealth.gov.ph

⁵⁵ National Health Insurance Act of 1995, Republic Act No. 7875.

⁵⁶ Maternity Leave Benefits, Article 133, Title III, Book III of the Labor Code, amended by Republic Act 7322.

⁵⁷ Maternity Leave Benefits, Article 135, Title III, Book III of the Labor Code.

⁵⁸ Maternity Leave Benefits, Article 136, Title III, Book III of the Labor Code.

⁵⁹ Paternity Leave Act of 1996 or Republic Act 8187.

⁶⁰ Employment of Women, Article 130, Title III, Book III of the Labor Code.

⁶¹ Maternity Leave Benefits, Article 134, Title III, Book III of the Labor Code.

⁶² Anti-Sexual Harassment Act of 1995 or Republic Act No. 7877.

⁶³ Republic Act 8504.

with HIV/AIDS, including the right to privacy and protection from workplace and other discrimination. HIV/AIDS education is integrated into schools, and basic health and social services are provided for individuals with HIV/AIDS.

Cultural Context

The Philippines is an archipelago of over 7000 islands with over 100 ethnic groups. It has absorbed influences from Spain, the U.S. and neighboring China, Indonesia and Malaysia. It has the world's third largest Christian population—92 percent of its 83 million people—and is predominantly Roman Catholic. Many traditions and festivals of Spanish Catholicism are followed. About 5 percent of Filipinos are Muslim and live mostly in the southern Mindanao and Sulu Islands.

Women are not discriminated against in education access. Adult literacy is high—92.6 percent—and the female literacy rate as percentage of male rate is 100 percent.⁶⁴

Because of the influence of the Roman Catholic Church and the conservative mindset of the people, a general lack of awareness exists about contraceptives and STDs, especially among single women. Unmarried women often become pregnant, and single mothers are not ostracized. There is still not enough information available on contraceptives. Married women are better informed but generally do not use contraception until after the birth of their first child. Women normally get married in their mid 20s and immediately have their first child. Oral contraceptives and intravenous contraceptives are the most popular types of contraception, followed by intrauterine devices. Condom use is low. Contraceptives are freely available at public health centers and can be purchased in drug stores. Most women, especially single women, are hesitant to discuss reproductive health.

Research and Findings

Methodology

BSR staff visited five factories in the Philippines to discover the most relevant health issues for women workers and examine how women's health concerns are being addressed in their workplaces and by their communities. The field research was supplemented by a review of institutional reports and other research, Philippine labor laws and Web sites of government agencies and NGOs (listed in the Appendix).

The factories visited are located in and around Manila, the capital. Manila has a population of over 10 million and is the center of commerce and industry in the Philippines. It is surrounded by industrial areas, and migrant workers come from all over the Philippines. Many factories are Chinese- and Taiwanese-owned.

⁶⁴ United Nations Development Program (UNDP), *Human Development Report 2005*

Prior to factory visits, a questionnaire was sent to each site to collect information about the programs available to address women workers' health. Some respondents filled out the questionnaire during the onsite visit.

Representatives from brands were present during some site visits.

Site visits lasted from a half day to a full day and included:

1. Discussion with factory management on health programs and policies. Interviewees included but were not limited to general managers, human resources managers, health and safety managers, welfare officers, counselors, consultants, doctors, nurses, other relevant medical and management personnel and representatives from quality and production departments.
2. Factory walk-throughs to observe production processes, as well as observance of safety measures including use of personal protective equipment by workers. Cafeterias, dormitories, recreation facilities, waste-water plants and other facilities were visited.
3. Visits to clinics and infirmaries, discussions with medical personnel and review of a sample medical record where maintained.
4. Visits to affiliated medical facilities, such as off-site clinics.
5. Where time permitted, visits to facilities provided by the local government, industry association or private providers to compare with factory facilities such as clinics and child care centers.
6. Interviews with workers and union representatives. Interviewed workers were mostly female and represented all age groups. Pregnant workers were interviewed when present. Interviews were conducted in Tagalog and English and were interpreted by a brand or factory representative when necessary. Interviews were conducted in settings such as the clinic or a conference room. In some cases, representatives of management were present. The worker interview aimed to assess the extent of worker's access to health facilities and understanding of health issues such as HIV/AIDS, and to identify unfulfilled needs. Information gathered was not verified with company records or discussed with management, and accounts of interviews are produced verbatim in this report. Some names of persons and places may not be accurate. Information presented is representative of workers in the factory—for example, in age, level of education and marital status—and of workers' understanding of reproductive health issues and access to services. In the Philippines, 27 workers were interviewed.

Except for a sample review of one or two medical records or injury log books, no extensive record review was carried out.

Printed information from the factory was collected when available, including annual reports, newsletters, posters, reports and presentations on health, blank medical record forms, blank referral letters, employee handbooks and copies of collective labor agreements.

Projects Covered

Of the five factories visited, two were engaged in apparel production, one in bicycle production, one in electrical cord production and one in decorative mirror production. The number of workers ranged from 124 to 3000. Two of the factories had majority women workers at above 75 percent, and the remaining three factories had between 35–40 percent women workers. The majority of workers range in age from 25–30. An estimated 50–80 percent of workers are married. The average level of education is 10 years of schooling.

Key Findings

Health Facilities

In the Philippines, all companies make mandatory payments to the Social Security System (SSS) and Phil Health.

- Two of five factories provide additional private insurance (“Health Cards”) that covers certain hospitalization expenses. In one factory, the workers make a small contribution per month for the Health Card that is matched by the factory.
- Minimal diagnostic and referral facilities are provided in four of the five factories. One factory does not have diagnostic services and only has trained first aid workers. Four of the five factories had full-time nurses, and of these four, three had a part-time doctor. One of these three factories has three full-time nurses and a doctor that visits three times a week. The other two have one full-time nurse and a doctor that visits once a week. Two of the four factories with full-time nurses have small partitioned areas with a bed that comprise the clinic. The other two of these factories have a larger room with 2–3 examination beds and desks for consultation.
- Treatment provided ranges from basic analgesics and dressing to provision of antibiotics. Suturing is not performed in any of the factories; workers are sent to nearby hospitals with injuries that need stitches or further care.
- Four of the five factories provide an annual health check-up as required by law based on the number of their workers. Check-ups are conducted by local private or government hospitals and are paid for by the factories.
- Results of annual health check-ups are maintained, but individual medical records are not. Sickness logs and injury logs are maintained.
- One factory has provided three doses of Hepatitis B vaccination to all of its workers during the last three years.
- A few cases of tuberculosis were managed confidentially by the factory that provided Hepatitis B vaccinations. The factory’s doctor provided treatment.
- One factory is air-conditioned.

Additional services most often requested by workers are access to a doctor or dentist, additional financial assistance for medical procedures such as childbirth, and more extensive coverage for family members.

Common Illnesses

The most **common illnesses** among workers are **upper respiratory tract infections (coughs and colds)**, **headaches** and **dizziness**. Women especially suffer from headache and dizziness.

Dysmenorrhea is common. Some cases of **urinary tract infection** are seen among women workers.

Nutrition

All factories have cafeterias where workers may purchase meals at approximately 30 pesos a meal (US\$0.60 at US\$1=Peso 52). One factory provided vitamin supplements to workers, including pregnant workers.

Care during Pregnancy

Two factories provide **monthly check-ups** for **pregnant workers**, though check-ups are not mandatory. One of these two clinics provides **vitamin tablets** while the other can provide prescriptions for **iron, calcium** and **folic acid tablets**, which workers may purchase outside. Separate medical records are not maintained for pregnant workers. In two of the other factories, a nurse advises pregnant women on the importance of the monthly check-up. In the factory with no nurse, no specific advice is given to pregnant women. Pregnant workers can request to be shifted to lighter work or seated work in four factories, while in the last factory, it is mandatory that pregnant workers be shifted to seated work in the packing section. Pregnant workers generally wear **maternity clothes** and not the company-provided uniform (usually a colored t-shirt to indicate the worker's section), so they are easily identifiable. Child care facilities are not required by law; most women interviewed would prefer to have their child raised by family members, usually their in-laws.

Workers had visited **public hospitals for childbirth** (fully covered by Phil Health). A few women visited semi-private or private hospitals, where the cost is partly covered by Phil Health. Most women take their children to the **municipal health center for free immunizations**.

Family Planning

No factories stock and provide contraceptives, but clinic staff provide advice when asked. Medical service providers believe that workers obtain contraceptives free from the primary health centers. The most popular contraceptives are oral contraceptives, followed by intravenous contraceptives. IUDs are not popular. Very few workers ask for condoms. Single workers know little about contraceptives.

HIV/AIDS

There have been **no reported cases** of HIV/AIDS in any of the factories visited.

One factory conducted **training on HIV/AIDS** three years back at the request of a brand, and information on HIV/AIDS is posted on their notice board. Two factories are planning to conduct HIV/AIDS training with the Department of Labor as required by law, because they feel they do not have the required expertise. One factory has a **policy on HIV/AIDS**. One factory nurse reported that some women workers have asked her about HIV/AIDS, mainly to learn how to protect themselves.

When questioned on HIV/AIDS, most **workers had heard about it**. Some stated that it was transmitted through sex and blood transfusions, but some did not know how it was transmitted or have any further information. Some were misinformed and said that it could be spread through touch, shared utensils or using the same toilet seat.

Who Pays for Health Services?

Clinic services are **free**. Services in designated hospitals are covered by **Phil Health** or, in two factories, by company-provided Health Cards. Only workers are covered; their families are not. In most cases, workers visit public hospitals where costs are fully covered by Phil Health. When workers visit private or semi-private hospitals, only part of the costs are covered by Phil Health. For emergencies or child illnesses, workers often visit a **private clinic and pay out of pocket**. Medicines, including nutritional supplements during pregnancy, are not covered by Phil Health. Costs of medicines are **high**.

Education and Prevention

One factory has formed a **responsible parenthood committee** of workers that have been trained by doctors from Phil Health on nutrition, family planning methods and basic pre-natal care. Two trainings by the committee for other workers were held in May 2006 on wellness and nutrition. The trainings were held during working hours, and workers were paid for their time. There are plans for the committee to conduct further trainings.

One factory is planning to hold **training on nutrition** conducted by a major food products company. Another factory is planning to hold a training session on family planning with experts from the municipal health center. Another factory reported holding trainings three times a year on dengue, influenza and other seasonal illnesses.

Mandatory training on first aid, fire safety and job safety are provided periodically to workers as required by law or by brands. Four factories hold **induction trainings** for new workers that cover health and safety.

Worker Communication

Workers can communicate with management through suggestion boxes, speaking with human resource personnel, raising a complaint with the grievance committee, through a worker's cooperative (at two factories) and through a union (at one factory).

Impact

Factories cited various benefits from investment in health programs, including greater worker loyalty, higher retention rates, better relations with workers and better work environments. One factory stated that a study that linked productivity to higher investment in health would make them willing to invest more in health services.

The factory that provided air-conditioning believed that the benefit has improved productivity by 10–15 percent; factory efficiency was previously 45–50 percent but is now close to 90 percent. The costs of providing air-conditioning are high and probably equal to the gains of improved productivity. The factory believes that providing better health facilities will give workers a greater sense of well-being and better cleanliness and hygiene. Good health facilities also help the factory to recruit new workers.

Recommendations for Effective Health Programs

The following recommendations for brands and factories for designing an approach to women's health concerns are made based on the findings above and on review of the critical success factors for factory programs.

- **Factories should provide basic health facilities with access to a doctor, a nurse, basic medicines and referrals to the next level of care**, since private health care in the Philippines is expensive and public health facilities poorly equipped and staffed.
- **More efforts should be made in providing basic health education and training.** Collaboration with external experts from the government, NGOs or health care providers can be useful if expertise is lacking within the factory.
- **Training on health issues requires long-term commitment from factory management.** It is relatively easy to initiate a train-the-trainer program or invite an external expert organization to provide training, but ensuring that workers know about and attend trainings in sufficient numbers is more difficult. Sustained efforts from management can ensure that workers are informed about the training and are given the time to attend.
- **Factories can be more proactive in providing information and contraceptives to workers in factory clinics.** A general lack of awareness on family planning exists in the Philippines, though information and contraceptives are available for free from primary health centers.
- **Surveillance activities such as annual health check-ups must be conducted for all workers**, with specific tests for occupational hazards.

- **Maintaining individual medical records is helpful in forecasting needs and planning preventive activities.**
- **Factories with a holistic approach to women's health see more effective results.** Women workers are concerned about the welfare of their children, husbands and other family members. A factory that provides information on nutrition, hygiene, general health issues and seasonal illnesses sees a greater improvement in health than factories that only provide diagnostic and treatment services.
- **Coordination between different functions within the factory is important in ensuring health improvements.** Clinics and medical service providers cannot function in isolation. Periodic and systematic coordination is needed, as is sharing of information and findings between medical service providers, human resources, production, cafeteria management and senior management. All departments must be made aware of the importance of worker health and access to health facilities.

Detailed Reports of Site Visits

Antiques as Accents, Philippines

Factory Information

Antiques as Accents is a small mirror-making facility in metropolitan Manila. In addition to silver backing, gold and black leafing is used to decorate the glass. There are **124 workers** in the factory, of which 96 are regular employees and the rest are seasonal workers during high seasons. Thirty-eight percent of workers are female. The typical **lead time** for a production order is three to four weeks. The peak seasons are usually January to March and September to October. Female workers are used only in certain parts of the process.

The factory works **one shift**, from 8:00 am to 5:00 pm, with a lunch break from 12:00 pm to 1:00 pm and two 15-minute breaks. The **cafeteria** is run by an external caterer who has the required health permit. About 30 percent of workers bring their own lunch. Lunch at the cafeteria costs Peso 25–35 (US\$0.48–\$0.67 at US\$1=Peso 52) for a meal consisting of soup, fish or meat, a vegetable dish and a beverage. A new caterer was hired a month ago because the quality of the previous caterer's food was poor. The food is cooked in a kitchen on the premises.

Absenteeism and turnover are low. Factory rules state that a worker who is absent for more than three days without informing management can be dismissed. Workers are given five days off per year and 13th month bonus pay.

The current **minimum wage**, effective from August 1, 2006, is Peso 277 per day (US\$5.32 at US\$1=Peso 52).

The factory moved a year ago from another location 200 kilometers away, as the new location was less expensive and had better access to containers. Some workers still live near the previous location and commute daily, while others have moved closer to the new location or are from the local area.

Unskilled workers have generally completed **10 years of schooling**. Skilled workers may have the same educational level but more experience. A completely new worker needs 1–1.5 months of primarily on-the-job training and are initially given less skilled jobs. A one-day orientation for new workers covers factory regulations, including those for health and safety.

The factory has a policy on **sexual harassment** as per the law. No cases have been reported as yet. There is one human resources manager for the factory.

The **production process** for mirrors consists of 1) cutting of glass by male workers, 2) grinding by male workers, 3) finishing by both male and female workers, 4) polishing with red paste by female workers, who are seen as more detail oriented, 5) tracing of design by male or female workers with drawing skills, 6) applying design on the glass by highly skilled male or female workers, 7) inspection by male or female workers, 8) silvering by male workers, 9) mirror backing by male workers, 10) cleaning with cardboard on a spinning wheel by female workers, who are believed to be more particular and 11) final assembly of the finished mirrors by male and female workers. Several of the processes are hazardous and use chemicals such as hydrochloric acid, nitric acid, silver nitrate, zinc dust, copper sulfate, caustic soda and formaldehyde. The factory has made efforts to ensure that workers wear appropriate **personal protective equipment**, including job-specific masks, gloves, aprons and footwear.

Worker Communication

Workers are encouraged to approach management with issues. There is one human resource manager based in the factory.

Health Facilities and Issues

The company makes **social security (SSS) and Phil Health payments** for all workers.

There is **no nurse onsite**, but 10–15 workers are trained in first aid every year. The nearest hospital is one kilometer away, and workers are taken there if treatment is needed. The production supervisor maintains a log of injuries. In 2004, eight injuries requiring hospital treatment were recorded; in 2005, there were eight and in 2006, there were three.

No annual health check-up is provided.

Reproductive Health

There are two or three pregnant women per year, who are generally moved to lighter work. The human resources manager mentions that women are given mandatory training on family planning prior to marriage at the municipal health center. HIV/AIDS is also discussed at this training.

Training

Awareness raising sessions on dengue, influenza and other seasonal illness are held about three times a year.

HIV/AIDS

The company has yet to touch on HIV/AIDS in its trainings.

Interviews with Workers

Jeremy works in the sampling section and has worked in the factory for five months. She earns Peso 277 per day (US\$5.32 at US\$1=Peso 52). She lives in the local area and previously worked in a biscuit factory. She is single and lives with her parents. She states that HIV/AIDS is a “disease transmitted through sex and blood.” She describes sexual harassment as “rape and not being given equal treatment by employers.” She is aware of what contraceptives are but cannot say what she will use if she gets married.

Maris works in polishing and joined the factory two weeks ago. She is 20 years old, and this is her first job. She has completed 10 years of schooling and is still learning on the job. She lives in the area where the factory was formerly located and heard about the company from one of the workers. She commutes for 1.5 hours every day and spends Peso 56 per day (US\$1 at US\$1=Peso 52) on bus fare. She earns Peso 277 per day (US\$5.30 at US\$1=Peso 52). Her family lives in Becol, about 12 hours away by bus. She has younger brothers and sends Peso 2000 (US\$38.50 at US\$1=Peso 52) home every month. She says that HIV/AIDS is a sexually transmitted disease and can also be transmitted through blood. When she falls ill with a cough or cold, she sees the doctor at the public hospital, where consultations are free. She pays for her own medicine, which costs about Peso 150 (US\$3 at US\$1=Peso 52) for cough or cold medicine. She believes that “sexual harassment” refers to “rape.” She is aware that contraceptives include condoms but does not know where to obtain other forms of contraception or what contraceptives are. In her free time, she watches television and does household chores.

Mary Jean is 21 years old and has worked in the finishing section for five months. She lives with her married sister close to the factory and is from Quezon Province, which is about four hours away by bus. She previously worked in a biscuit factory. She does not need to use personal protective equipment on her job. She has seen two colleagues with injuries (cuts from glass) in the last five months. She earns Peso 277 per day (US\$5.32 at US\$1=Peso 52) and sends about Peso 1000 (US\$19.20 at US\$1=Peso 52) home every

month. She takes the jeepney (jeeps with additional seating that provide a common mode of public transport) to work and spends about Peso 7.5 (US\$0.14 at US\$1=52) each way. She eats lunch in the cafeteria and likes the food. When she gets home in the evening, she watches television. She lives with her sister, who has three children age six and younger. Her sister's husband works as a security guard. She has seen programs about HIV/AIDS on television and is aware that it is a "deadly disease transmitted through sex." She does not know what sexual harassment or contraceptives are. When she is ill, she visits a private hospital, since she believes that the standard of care is better. A consultation at a private hospital can cost up to Peso 1500 (US\$29 at US\$1=Peso 52).

Rowena is 19 years old and has worked in the design section for the last six months. This is her first job since completing school. She is paid Peso 265 per day (US\$5 at US\$1=Peso 52) but will earn a higher wage soon because she has just been regularized. She is from a province about eight hours away by bus. She lives in the local area with her cousin, who is also working. She has cuts in her hand from working with glass. She eats lunch in the cafeteria daily and likes the food. She eats breakfast at home before coming to work and lives a 15-minute walk away. She sends about Peso 1500–2000 (US\$29–\$38 at US\$1=Peso 52) to her parents every month. In her free time she watches television at home. Once she was taken to the hospital due to dizziness and fainting at work; she was in the hospital for two hours and then came back to work. She did not have to pay any fees because the factory paid them. Since then she has started to eat breakfast before coming to work. She believes that HIV/AIDS is a "disease transmitted through sex and shared utensils" and sexual harassment means "to be beaten and forced." When asked about additional health facilities she would like, she says that her health is her responsibility and not the factory's; the factory has workers trained in first aid, and that is adequate.

Cecile is 27 years old and has worked in the washing section for one month. Previously she worked in a shopping mall selling ice cream and left when her job ended. She is not married and lives nearby with her parents. She likes her current job and earns Peso 277 per day (US\$5.32 at US\$1=Peso 52). She takes the jeepney to work and spends Peso 50 (US\$1 at US\$1=Peso 52) for the round trip commute. She previously brought lunch with her but now eats in the cafeteria. She has bread and coffee for breakfast before coming to work. She has two younger brothers, who are working. She does not like to see doctors and prefers to rest at home when she is sick. She believes that HIV/AIDS is a "disease transmitted through sex" and does not know other ways in which it can be transmitted. She believes that sexual harassment refers to "first time sex." She would like to have a baby soon after getting married. She is aware of oral contraceptives and condoms and thinks that they can be bought from the drug store. She does not feel ill effects from working with red oxide and caustic soda in the washing section.

Rachel is 55 years old and has been with the factory for 12 years. She is in charge of the leafing section. She worked in the previous location of the factory and continues to live by the previous location. She takes the bus to work every day; it takes one hour and costs about Peso 50 (US\$1 at US\$1=Peso 52) for the round trip commute. She earns Peso 350

per day (US\$6.70 at US\$1=Peso 52), including wages of Peso 300 plus a cost of living allowance of Peso 50. She is a widow and has two children aged 26 and 20 who are studying computer science and human resource management. When she falls sick she goes to the public hospital, where she gets free treatment but pays for medicines. She believes that HIV/AIDS is a “disease transmitted through sex and using the same rest-rooms.” She believes that she has seen an improvement in the safety record at the factory over time, since workers are using more PPE.

Nick has worked in the factory for seven years and was previously in the polishing section. He has worked in the silvering section for the past year. He earns Peso 325 per day (US\$6.25 at US\$1=Peso 52), including a cost of living allowance. He has always used a mask and gloves and has never been sick from working in the silvering section. He lives near the old location of the factory and takes the bus to work. He began working when he was 17 and has completed 10 years of schooling. He is married with a one-year-old baby. He takes his baby to the municipal health center for immunizations. The baby was born at home, and an older neighbor lady with no midwife training assisted with the delivery. He has never been to hospital, and his wife did not have pre-natal check-ups. His wife now takes oral contraceptives that she obtains from the municipal health center. He knows that HIV/AIDS is a disease but does not know how it is spread. His wife has completed high 10 years of schooling and two years of college. He likes working at the factory and is happy with his job.

Roberto is in his late 20s and has worked in the silvering section of the factory for seven years. He earns Peso 425 per day (US \$8.20 at US\$1=Peso 52), including wages of Peso 375 plus a cost of living allowance of Peso 50. His wife also works in the factory in the sampling section. They have a three-year-old child who is looked after by his parents. The baby was born in a public hospital that was covered by Phil Health. When they need to take the baby to a doctor, they visit a private hospital, where they spend about Peso 100 (US\$2 at US\$1=Peso 52) for a check-up and Peso 300 (US\$6 at US\$1=Peso 52) for medicines. They believe that the service in the private hospital is better. When he, his wife or his parents fall ill, they visit a public hospital for treatment. He would like a health check-up every six months to be organized and paid for by the factory. The factory does not provide check-ups. He and his wife are not using contraceptives and would like to have a second baby. They may consider using contraceptives after the birth of their second child.

Smart Shirts, Philippines

Factory Information

Smart Shirts is a shirt making factory based in the former Clark Air Base in Pampang, about two hours drive north of Manila. The company has **3000 workers**, of which 75 percent are female. The majority of workers are between 25–30 years. The minimum working age in the Philippines is 15, but the factory does not hire workers below 18. The oldest worker is about 45 years old. About 50 percent of workers are married. Most

workers are from the surrounding area. The total number of workers also includes about 500 contract workers, who are let go when the peak season ends.

The factory is certified by **WRAP** (Worldwide Responsible Apparel Production),⁶⁵ a global standard of the American Apparel Manufacturer's Association, and undergoes an annual audit to maintain certified status. The WRAP standard covers wages, working hours, health and safety, discrimination, harassment, child labor and forced labor.

The majority of workers have **completed high school**, or 10 years of schooling. They undergo a skills test before being hired, then learn needed skills on the job. There is a half-day orientation training on company rules and regulations.

Absenteeism is about 2.5 percent per day, which is lower than the industry average of about 6–9 percent.

Normal working hours are 48 hours a week, or six days with Sundays off. The factory works in two shifts, one from 8:00 am to 5:00 pm and one from 7:00 pm to 5:00 am. The daytime shift has staggered lunch breaks from 11:30 am to 12:45 pm and from 12:00 pm to 1:15 pm. The evening shift has a break from 11:00 pm to 12:15 am. The factory has an exemption that allows it to operate with women workers during the night shift. Certain functions of the factory, such as the dipping section, operate 24 hours. Finishing often takes place on weekends.

The production unit is one of very few facilities in the Philippines to be **air-conditioned**.

The **minimum wage** is Peso 239.5 per day plus Peso 20 in Cost of Living Allowance (COLA), or a total of Peso 259.5 (US\$5 at US\$1=Peso 52). Some workers will soon receive an additional COLA of Peso 18.50 (US\$0.35 at US\$1=Peso 52) when new rules come into effect. About 60 percent of workers are on piece rate, and they earn an average of Peso 12,000 per month (US\$230 at US\$1=Peso 52). The piece rate is above minimum wage and is computed by the Labor Department based on time and motion studies. Workers are paid twice a month through bank deposits, which all workers have. Workers access their accounts through ATM cards.

There is a **cafeteria**, and meals are cooked on the premises. Lunch costs about 30 pesos (US\$0.60 at US\$1=Peso 52) per meal. A meal is about 35 pesos (US\$0.70 at US\$1=Peso 52) in an outside restaurant that workers frequent. The cafeteria is managed by an external agency, which has a health permit. Cafeteria employees undergo an annual health check-up.

⁶⁵ www.wrapapparel.org

It is mandatory as per the Anti-Sexual Harassment Republic Act 77 & 78 of 1995 to have a policy and grievance procedure on **sexual harassment**; the factory has both. There have been no reported instances of sexual harassment.

On the production floor, workers from different sections wear **different colored t-shirts**.

Worker Communication

There are 22 **human resource personnel** among 97 administrative staff and 320 management staff. **Suggestion boxes** on the shop floor do not see much use. Workers usually discuss problems at the shop floor level and, if the problem is not resolved, they see the next level manager, all the way to top management. The factory has an open door policy, so any worker can approach the next level manager. Most issues that come up are production related.

Smart Shirts has a **majority union**, the Smart Shirts Philippines Inc. Worker's Union. There are over 30 union officials, including representatives from the supervisor level.

Health Facilities and Issues

The company makes **Phil Health** and mandatory **social security system (SSS)** payments for all employees. Phil Health provides access to accredited hospitals and covers 45 percent of costs. Maternal health is not covered by SSS, but it is partly covered by Phil Health.

The company provides a **Health Card**, which covers health costs up to Peso 75,000 (US\$1440 at US\$1=Peso 52), provided by a private health maintenance organization (HMO). The first three months of employment are considered a probationary period during which workers do not receive HMO coverage. Contract workers do not receive HMO coverage.

The **onsite clinic** has three full-time nurses and one part-time general physician who visits the clinic three times a week for two hours each time, from 1:00 pm to 3:00 pm.

The clinic sees about 30–40 patients per day. Many more patients come on Monday because they wait for the clinic to open rather than see a doctor on their own over the weekend. Some workers complain of dizziness due to the pressure and stress of work. Vertigo or imbalance in the ear are common. Many workers come to work early and eat breakfast in the cafeteria.

Sick leave of four days is provided to workers in their second year of service. Workers with three or four years of service are given seven days of sick leave, and workers who have completed five years receive eight days. Vacation leave equals six days, seven days and eight days, respectively, for workers at these levels of service.

There is a **mandatory annual health check-up** that consists of a physical examination and blood and urine check. There are no tests for occupation-specific hazards.

Reproductive Health

Pregnant workers can come to the clinic for a monthly check-up of their own volition. Pregnant workers may request to be moved to seated work. **Maternity leave** is 60 days for a normal delivery and 78 days for a cesarean delivery. Most women come back to work after childbirth, especially those who are paid by piece rate. Day care is not required by law. There are a few unwed mothers in the factory, but this is not considered unusual in Filipino society because of the low use of contraceptives. Pregnant workers on the production floor wear **maternity clothes** and do not wear the factory-provided t-shirts; they are allowed to go first for meals and to leave first at closing time. They can also take **separate breaks** to have a snack. The nurse in the clinic sees a few cases of bleeding among pregnant women. Most women use the HMO for the **monthly pre-natal check-up**. They usually purchase their own calcium, iron and folic acid tablets based on a prescription from the HMO.

Many female workers also complain of **dysmenorrheal**, and there are increasing cases of urinary tract infection. Workers often neglect the illness until it gets worse, and only then do they seek treatment.

The clinic provides advice on **contraceptives** but does not stock them. According to the nurse, contraceptives are available for free from government hospitals. About 50 percent of women use the pill, but intravenous injections are also popular. Very few men use condoms.

HIV/AIDS

The factory is required by law to provide HIV/AIDS awareness training. They have requested the labor department to provide training over the next year. They believe that they do not have the expertise to provide this training themselves.

Training

The **Responsible Parenthood Committee** was formed two months ago with 27 workers from all sections of the factory. Doctors from the HMO were invited to train these workers on nutrition, family planning methods and pre-natal care. Two trainings were conducted by the committee for other workers in May 2006 on wellness and nutrition. Trainings were held during working hours, and workers were paid for their time. The committee will provide further trainings to other workers.

Training on first aid, fire safety and occupational safety are conducted periodically, as required by law and by brands.

Interview with Worker

Anna Liza is 23 years old and has worked at the factory for 3.5 years. She has a one-year-old child and is seven months pregnant with her second child. She has never used contraceptives but may consider them after the birth of her second child. She used the calendar method when she wanted to delay conception. She went to a private hospital for the delivery of her first child that was covered by the HMO plan. A normal delivery in a private hospital would normally cost Peso 15,000 (US\$288 at US\$1=Peso 52). She is aware of HIV/AIDS and believes that it can be contracted if a person has multiple sexual partners.

Responsibility and Impact

The general manager of the factory believes that providing air-conditioning has improved productivity by 10–15 percent. Previously, factory efficiency was about 45–50 percent but has now come close to 90 percent. The costs of providing air-conditioning are high and probably equal to the gains of improved productivity. In the general manager's opinion, providing better health facilities provides workers with a greater sense of well being and better cleanliness and hygiene. When management sees how much dust needs to be removed from the air-conditioning filters, they realize that providing air-conditioning is a good step. They take measures to promote health because they feel they “have to” for the well being of workers. They believe that the benefits package provided to workers is one of the best in the industry, and they receive a lot of support from the company headquarters in Taiwan. For example, a husband and wife who both worked at the factory recently lost their house due to a fire. The head office immediately authorized the factory to provide the couple with financial assistance to rebuild their home. The facilities help the factory to recruit new workers. While there is no shortage of unskilled labor with about 150 applications received for each 20 vacancies, there is a shortage of skilled labor.

Suzette Manufacturing and Trading Company, Philippines

Factory Information

Suzette is a small facility manufacturing toddler's and infant's clothing about two hours drive north of Manila. The factory was built in 2001. There are **300 workers**, the majority of which are women. All workers are employed full-time and are between 25–35 years. Some manufacturing processes, such as embroidery, are sub-contracted. The typical lead time for delivery is two months. Turnover is not very high, and absenteeism is low.

All workers are **members of a cooperative** that allows them to receive dividends based on how well the factory performs. The factory formed the cooperative in early 2004 to give ownership to the workers and improve tenure and productivity. A dividend of Peso 300,000 (US\$5770 at US\$1=Peso 52) is divided among workers once in six months. All workers earn by piece rate. **Minimum wage** in the area is Peso 236 per day plus Peso 20

as a COLA, for a total of Peso 256 (US\$5 at US\$1=Peso 52). Management feels that productivity has improved since the cooperative was formed.

The company also provides for 10 percent **profit sharing** through health insurance, retirement funds and monetary disbursements.

The factory works **one shift** from 8:00 am to 5:00 pm. Lunch breaks of 30 minutes are given in batches from 11:00 am to 12:00 noon. Some workers bring their lunch, and others eat in the cafeteria. Lunch at the cafeteria costs between 25–35 pesos (US\$0.48–\$0.67 at US\$1=Peso 52) per meal, including a beverage.

The company has a policy and grievance procedure on **sexual harassment**.

Worker Communication

A **grievance committee** collects feedback from workers, and a suggestion box accepts anonymous complaints. Complaints against a supervisor are dealt with through the cooperative.

A Christmas Party is held every year.

There is one **human resource person** in the head office of the company and one in the factory. There is a cooperative representative who handles human resources.

The human resources person for the **cooperative** is responsible for time keeping and filing. The cooperative has a board of seven members that meets once a month and on an ad hoc basis. Full meetings of the entire cooperative are held periodically. Issues discussed are often related to production and late shipments. Only minor health problems are raised.

Health Facilities and Issues

Social Security (SSS) and **Phil Health** payments are made for all workers. A full-time nurse and a small sick room with a bed are available as required by law. Workers are sent to a nearby hospital for a pre-employment check-up and when they are sick.

Workers undergo an **annual health check-up**, as required by some brands. The health check-up includes a physical examination and blood, urine and stool tests, and it is conducted in the municipal health center. A copy of the health certificate is given to the company as required by law. Cost of treatment for **emergencies** in the workplace is covered by the factory. Individual medical records are not maintained in the clinic. The clinic provides free medicine, including antibiotics such as Amoxicillin. A shortage of nurses exists in the Philippines as many have left to work overseas. A new nurse was hired the week prior to the site visit, since the old nurse had left. Previous to joining the factory, the new nurse worked as an instructor at a nursing school and also in Singapore.

She reported that the main complaints thus far included **headaches, muscle pain** and **fever**.

The company has a **manual on emergency health care**. There is also an **Environment, Health and Safety (EHS) Committee** that has representatives from operations, administration, human resources and the cooperative.

Workers wear **tee shirts of different colors** depending on their job. Pregnant workers wear **maternity clothes** purchased on their own.

Reproductive Health

Pregnant workers are provided coverage by Phil Health. They take 60 days of maternity leave for a normal delivery or 78 days maternity leave for a cesarean delivery. They seek medical care in public or private hospitals, depending on what they can afford. Phil Health covers costs in a public hospital and partial costs in a private or semi-private hospital.

HIV/AIDS

Information on HIV/AIDS is posted on the notice board. Training on HIV/AIDS was offered three years back in response to a brand's request.

Training

The company is planning to offer training on family planning led by a doctor from the nearby municipal hospital. The nurse has experience teaching, and they hope to have her conduct trainings.

First aid training, which is part of brands' requirements, is provided every six months. A fire drill is conducted twice a year per brand requirements.

Interviews with Workers

Esther is 28 years old and has worked at the factory for four years as a sewing operator. She was married last December and is seven months pregnant. She lives close to the factory and walks to work. She has been visiting the municipal health center for monthly check-ups for a nominal fee. She will be having an ultrasound test next month. She will visit a semi-private hospital for the delivery where 50 percent of the fee will be paid by Phil Health. A normal delivery would cost about Peso 8000 (US\$154 at US\$1=Peso 52) and a Cesarean can cost up to Peso 28,000 (US\$538 at US\$1=Peso 52). She will rely on her mother to care for her baby after delivery. She earns approximately Peso 2000 (US\$38 at US\$1= Peso 52) per week. She would like further financial assistance to pay for the delivery.

Rodafe is 29 years old and has been working in quality assurance at the factory for five years. She has been married for five months and is two months pregnant. She has been

visiting a private hospital for her pre-natal check-ups, where the cost is approximately 200 pesos per visit (US\$4 at US\$1=Peso 52) and is fully paid by Phil Health. She has heard that a normal delivery may cost about Peso 13,000 (US\$250 at US\$1=Peso 52) and that a cesarean delivery may cost about Peso 30,000 (US\$577 at US\$1=Peso 52). She earns Peso 330 per day (US\$6.35 at US\$1=Peso 52). Her husband works as an engineer. Phil Health provides coverage for family members. She is aware of HIV/AIDS and says that it is a “sexually transmitted disease.” She is aware of sexual harassment, which she terms as “unwanted attention,” and is aware of the factory’s policy. She has never used contraceptives but is aware of options, including pills and intravenous injections. She will talk to her doctor about using contraceptives after the birth of her child.

Neilda is chair of the worker’s cooperative and has been with the factory for the last six years. She was elected to the position of chair in 2004. She is 45 years old and single. She is currently the production manager of the factory. All cooperative members receive a dividend every six months. She would like access to a doctor, dentist and annual health check-up in the factory.

Kristina is 43 years old and is the packing supervisor. She has worked in the factory for 12 years and is married with two children aged 15 and 6 years. She sees the nurse when she is not feeling well. She would like the factory to provide an annual health check-up; the workers visit the municipal health center for health check-ups every year with a nominal charge of Peso 30 (US\$0.58 at US\$1=Peso 52) per check-up. A copy of the health certificate is given to the factory as required by law. She thinks that the factory could be better ventilated with more windows or air conditioning. The factory has its own doctor in the Manila head office, which is good. She is aware of HIV/AIDS and says that it is a “sexually transmitted disease.” She believes that sexual harassment refers to “contact with force” and thinks that it is unlikely to happen in the factory. She thinks that the cooperative is a good initiative and says it is “like your business.” She reports that pregnant workers who would like seated work are shifted for the duration of their pregnancy. She had a tubectomy after the birth of her second child. She believes that women who do not have the surgical procedure done opt for use of condoms.

Responsibility and Impact

The factory manager says that good health contributes to a better company environment and better relations with workers. The overall benefits are broader than health alone. If productivity linkages can be proved, management will invest more in health. They need direction and guidance on how to best invest in health.

Taifini Copper and Conductor, Inc., Philippines

Factory Information

Taifini is an electrical wire and cord factory close to Manila. The facility manufactures electrical extension cords for sale to U.S.-based retailers. There are **550 regular workers**,

with an additional 250–300 contract workers during peak season. About 40 percent of workers are women. Most workers are from the local area and have worked for a long time at the factory. The average worker age is 30 years. Those working in the copper department are skilled and have a college degree. More than 80 percent of the workers are married.

The factory operates in **two shifts**, a day shift from 7:00 am to 7:00 pm and a night shift from 7:00 pm to 7:00 am. Two breaks of 30 minutes each are given per shift. Production lead times are typically one month. Turnover is low; while the factory does not have exact figures, they estimate that about five workers leave in a year. Absenteeism is also low.

Minimum wages in the area are Peso 249 per day (US\$4.80 at US\$1=Peso 52). An attendance incentive is offered for not coming late or missing work. The incentive is Peso 300 for the first straight month (US\$5.80 at US\$1=Peso 52), Peso 500 for the second straight month (US\$10.00 at US\$1=Peso 52) and Peso 1000 for the third straight month (US\$19.20 at US\$1=Peso 52). A grace period of 10 minutes helps some latecomers still qualify for the bonus. A performance bonus of Peso 1300 per month (US\$25 at US\$1=Peso 52) is given to high performing workers. All workers are paid by bank deposit twice a month. The factory gives a dividend at the end of the year if it has performed well; last year Peso 500 (US\$10.00 at US\$1=Peso 52) was given to each worker. Groceries are given as a gift at the end of the year for Christmas.

The **cafeteria** is managed by a worker cooperative. Workers are given free rice, and the rest of the meal costs about Peso 25 per meal (US\$0.48 at US\$1=Peso 52). Soft drinks cost an additional Peso 10 each (US\$0.19 at US\$1=Peso 52). The cooperative was formed in 2002 and has an election every year to select their representatives. The cooperative organizes the factory's annual Activity Day.

There are four **human resources personnel**, including a director. There are total of 50 management staff. The raw material consisting of copper wire is imported from Taiwan, but late shipments do not pose much of a problem.

Worker Communication

Workers are encouraged to approach management with issues. Human resource personnel also frequently walk around the production floor so workers can approach them. Feedback is given frequently through the worker's cooperative that runs the cafeteria.

Health Facilities and Issues

The factory makes **Social Security System (SSS) and Phil Health payments** for all workers. A **private health card** provides for hospitalization expenses. The factory and employees each contribute Peso 100 (US\$2 at US\$1=Peso 52) for the health card.

Hospitalization through the health card is in a private hospital that provides treatment for different illnesses plus laboratory services.

A one-room **onsite clinic** has a full time nurse and a doctor that visits every Wednesday for 2–3 hours. The clinic has space for consultation and two beds, and it opens during the day shift. During the night shift, four workers trained in first aid take care of injuries that arise. There is also a trained cadre of firefighting workers. In emergencies, the doctor is called or the patient is taken to the nearest hospital; the factory pays for treatment. **An annual physical examination** is conducted by a local hospital. When patients are sent to the hospital, the doctor provides a referral letter with recommendations for treatment.

Workers have been given three doses of **hepatitis B vaccination** every year for the past three years. Tuberculosis cases, of which there have been only a few, are managed confidentially by the nurse, doctor and human resources director. Gastritis and anemia are rare.

The nurse has been working at the factory for four years. She sees about five patients a day. Most workers come with complaints of **headache** and **dizziness**. She sees several cases of **upper respiratory tract infections** (coughs and colds). Women especially complain of **dizziness** due to the heat on the production floor. She asks them to rest in the clinic for a while and if they do not feel better she asks them to go home. Sometimes she takes them home herself. The clinic provides basic medicines, as well as antibiotics such as Amoxicillin. Dressing of injuries is available, but suturing is not.

In 2006, there have been eight accidents thus far requiring trips to the hospital for suturing. Twenty-seven minor injuries that were treated at the factory clinic were recorded in the injuries log for 2006 thus far.

Reproductive Health

On the day of the site visit, there were about 8–9 **pregnant workers**. Pregnant workers are **compulsorily shifted to seated work**, usually in the packing section affixing stickers. The company doctor conducts a **monthly check-up** for pregnant workers when he visits on Wednesday. **Vitamin tablets**, including **vitamin C**, are given to pregnant women or to any employee in need. Costs of childbirth are covered by Phil Health but not by the private health card.

The nurse sees several cases of **dysmenorrheal**, which she explains is natural. She sees a small number of **urinary tract infections**, especially among women.

Most women ask for **advice** on methods for **family planning**. Most use oral contraceptives, which they believe to have less side effects than intravenous contraceptives. They do not use IUDs. Most rely on the calendar method. They do not ask for condoms.

HIV/AIDS

The human resources director attended a training on HIV/AIDS a few years ago, and they are considering including the topic in their health and safety training. The nurse reports that women workers ask her about HIV/AIDS, mainly to inquire how to protect themselves.

Training

Newly hired employees are given an **orientation** of half a day including topics like health and safety, use of personal protective equipment, accident prevention and safe use of machinery.

At the time of the site visit, the factory was planning a training organized by **Nestle** on nutrition. Family members were to be invited. The training was planned to occur during working hours for three hours, and the clinic was to offer workers or family members individual counseling on nutrition issues during breaks.

Training on **first aid**, **fire safety** and **occupational safety** are conducted as per the law and brand requirements.

Interviews with Workers

Rubina is 35 years old and has worked at the factory for five years. She has a two-year-old child and is seven months pregnant with her second child. For her first delivery, she had a cesarean and took 2.5 months off as allowed by law. She delivered at a semi-private hospital, which was covered partially by Phil Health but required her to pay Peso 8000 (US\$154 at US\$1=Peso 52) in medical fees. She now visits the government hospital for a monthly health check-up, which is free. She obtains calcium tablets and vitamins for free from the hospital, and she plans to use the same government hospital for her next delivery. Her husband is a painter who runs his own business. She did not use contraceptives after the birth of her first child and used the natural calendar method to delay conception. Her mother-in-law looks after her baby when she is at work. She earns a salary of Peso 250 per day (US\$5 at US\$1=Peso 52) and receives an attendance allowance of Peso 300 per month (US\$6 at US\$1=Peso 52) and a technical position allowance of Peso 1300 per month (US\$25 at US\$1=Peso 52). She is aware of HIV/AIDS and says that it is “Acquired Immune Deficiency Syndrome that is transmitted sexually.” She says that sexual harassment is when someone “abuses you without permission.”

Jennifer is 24 years old and has been working at the factory for five years. She has been married for five months and is five months pregnant. Her husband works in the same department. She visits a private hospital for monthly health check-ups. The consultation fees are Peso 250 (US\$5 at US\$1=Peso 52) each time. She buys calcium and vitamin tablets at the cost of 8–9 pesos each (US\$0.15 and \$0.17 at US\$1=Peso 52). She plans to visit the same hospital for delivery. She believes that Phil Health will cover 50 percent of costs if her delivery is normal, but she is unsure how much will be covered in case of a

cesarean delivery. The health card will not cover expenses of childbirth. She lives close to the factory. Her mother-in-law will look after the baby after birth. She will be relying on the natural method to prevent conception after the birth of her baby. When asked about HIV/AIDS, she says that she forgot what the word means. She says that sexual harassment refers to “abuse.” She is happy with the facilities at the factory and does not feel that she needs any more facilities.

Joyce is 31 years old and has worked in the quality assurance department for six years. She is single and comes from a province that is about eight hours away. She bought her own house using a loan from the government. She earns about Peso 15,000 per month (US\$288 at US\$1=Peso 52) and receives a technical allowance of Peso 1300 per month (US\$25 at US\$1=Peso 52) plus an attendance allowance. She says that HIV/AIDS is a “disease spread through sex, injections and maybe kissing but don’t know.” She says that sexual harassment happens if “somebody touches you in private places without permission.” She is aware of IUDs that need to be “placed inside the vagina”; she read about them in a book. She says that sometimes workers receive a shock from the machines even though they are grounded; she feels they need more protection, such as gloves or a rubber mat.

Maryann is 20 years old and has worked in the assembly section for three months. She recently graduated from a four-year college in a different province. She lives in a rented house with two sisters. She earns Peso 249 per day (US\$4.80 at US\$1=Peso 52) and does not earn allowance but does earn overtime. She thinks that HIV/AIDS can be contracted through “pre-marital sex” and “from blood.” She says that sexual harassment refers to “female and male having sex.”

Salvador is 36 years old and has worked in the copper wire department for almost eight years. He has three children aged 12 years, 10 years and 9 months. He had a foot accident last year on the production floor, and the factory took care of treatment. Phil Health provides coverage for his wife and children. He says that HIV/AIDS is “Acquired Immune Deficiency Syndrome that spreads through sex” and does not know any other means of transmission. He believes that sexual harassment refers to “speaking bad words to girls or holding them.” He says that sometimes use of bad language happens in the factory, but it is meant as a “joke.” Neither he nor his wife would like to have any more children, but they do not use contraception. He earns Peso 279 per day (US\$5.35 at US\$1=Peso 52) and receives a production allowance of about Peso 600–1300 per month (US\$11.50–\$25 at US\$1=Peso 52). He would like to have health card coverage for his wife and children.

Responsibility and Impact

Management feels that the most important benefits to investing more in health are that workers are more loyal and turnover is reduced.

United Cycles, Philippines

Factory Information

United Cycles is a cycle manufacturing facility close to Manila. Most parts are imported, and bicycles are assembled and exported to the U.S. and Canada.

There are approximately **300 workers** at the United Cycles factory, of which about 40 Percent are female. Workers range in age from 25–30, and about 70 percent are married. The workforce can increase to 500 during high season at the end of the year when seasonal workers are hired. Workers wear different colored uniforms depending on whether they are seasonal or regular workers. Females are generally given light work that does not require heavy lifting of bicycle parts.

On the day of the site visit, there were 254 workers present. About 50 workers from one department were waiting for a shipment, which was delayed by a typhoon, so they could begin work. Some workers had been given the day off, and some were working in other departments. Production lead times are about 60 days. Production is done in **one shift** from either 7:00 am to 4:00 pm or 8:00 am to 5:00 pm. Lunch lasts for one hour, from 11:00 am to 12:00 noon or from 12:00 noon to 1:00 pm.

Many workers are from different provinces and stay in rented residential facilities near the factory. **Absenteeism** due to illness is estimated at 1–2 percent. **Turnover** is low.

The **minimum wage** in the area is Peso 249 per day (US\$4.80 at US\$1=Peso 52). There is no COLA in the area, though it was recently announced that a COLA of Peso 18 per day (US\$0.35 at US\$1=Peso 52) may be added; the factory is waiting for notification from the Department of Labor before add the COLA to wages. The factory gives a performance incentive of Peso 10–50 per day (US\$0.18–\$0.95 at US\$1= Peso 52), depending on number of years of service and level of performance.

There is a **cafeteria**, and food is cooked onsite. Lunch costs approximately Peso 20–25 per meal (US\$0.38–\$0.48 at US\$1=Peso 52).

Workers are paid by **direct bank deposit** and have access to an ATM machine close to the factory. Workers are paid by the week.

There are two **human resource personnel** under the supervision of the administrative manager.

The company has a policy and procedure on **sexual harassment**, as required by law.

Worker Communication

Workers are free to approach management with issues.

Health Facilities and Issues

All workers receive **Social Security (SSS)** and **Phil Health** benefits. No additional private insurance is provided.

There is a full-time nurse and a small, **basic clinic** with a bed for workers. A doctor visits once a week on Wednesdays from 11:00 am to 1:00 pm, though a doctor's presence is not mandatory at this factory because of its small size. The nurse, Marites, joined the factory two months ago when the previous nurse left. She previously worked in a hospital for six months. She sees about 25–30 patients in a day. Most come to her with **upper respiratory diseases**, such as coughs and colds. Some come to her with **headaches**. Last month one worker had a two centimeter laceration that she dressed at the clinic. She then sent the worker to the hospital for stitches. Basic medicines, but no antibiotics, are provided in the clinic. About once a month there is a worker who needs to rest in the bed at the clinic due to **dizziness**. When the doctor examines the worker, if further treatment is needed he writes a referral slip to the hospital for follow-up.

An **annual health check-up** as required by law is conducted by a private clinic nearby. The check-up includes blood and urine tests and an X-ray. The factory pays for check-ups, as they are not covered by Phil Health.

Reproductive Health

The nurse sees about two cases of **dysmenorrhea** a month and gives patients a pain killer. **Pregnant workers** consult with the nurse, who advises them to have monthly check-ups and take medicine. Most workers obtain **contraceptives** for free from the municipal health center.

Pregnant workers visit the municipal health center, Phil Health covered facilities or private facilities, based on what they can afford. Full **maternity leave** is given for 60 days in case of normal delivery and 78 days in case of delivery by caesarian section.

Training

New workers are provided with a six-hour **orientation**, with the portion on health and safety covering two hours. The factory has conducted three **trainings on emergency response**, in collaboration with the local municipal health center, and it conducts training on avoiding accidents and occupational hazards. Training on **first aid and fire safety** are conducted as per the law and brand requirements.

HIV/AIDS

HIV/AIDS is covered in the nurse's general training on health and safety. A few workers ask her about the disease. The factory has a **policy on HIV/AIDS awareness** to promote prevention. The factory is planning to organize a training by the Department of Labor on HIV/AIDS, tuberculosis and hepatitis.

Interviews with Workers

Marlene is 44 years old and has worked in the factory for the past five years. She was with an affiliate company for three years prior to joining this factory. She is married and has two children aged 19 and 16. Her husband is a tricycle driver. She is from a nearby province. Her husband and children are covered by Phil Health. She works as a supervisor of about 50 workers, mostly women. When she has a pregnant worker under her supervision, she asks them if they would like to move to a seated job. She is aware of HIV/AIDS and says that it is a “disease transmitted from person to person.” She is aware of what sexual harassment is. Her workers talk to her about personal worries, such as children’s education or finances. If there are any problems with remitting salaries, she takes them to the office to help sort the problem out.

Marisale is 33 years old and has worked for four years in the quality control department. She has a nine-month-old baby. During her pregnancy the factory provided her with an assistant. She took extra breaks to have snacks. She delivered the baby through a cesarean procedure in a public hospital that was fully covered by Phil Health; she only paid laboratory fees. However, it was not a very good hospital, with many patients and not enough facilities. Had it been a private or semi-private hospital, only a percentage of the cost would have been covered. Her mother-in-law helps to look after her baby. She takes her baby to the nearby Barangay Municipal Center for free immunizations. Her husband works as a security guard. She is not taking any contraceptives and is relying on the natural method to avoid conception. She would like to have more children but is not sure they can afford it. She is aware of HIV/AIDS.

Flordilisa has worked in the factory for five years and is in the quality control department. She is married and has a two-month-old baby. She returned to her job two weeks ago, after her maternity leave ended. When she was pregnant, she had a seasonal worker as an assistant. She had the delivery in a public hospital. She went to a private hospital for the monthly pre-natal check-up. Each visit cost about Peso 500 (US\$10 at US\$1=Peso 52): Peso 250 (US\$5 at US\$1=Peso 52) for the consultation and Peso 250 (US\$5 at US\$1=Peso 52) for medicines. Her husband is a worker in the same factory. She takes her baby to the Barangay Municipal Center for immunizations. She has never used contraceptives. She would like to postpone having her second child for another five years. She receives minimum wage plus production incentives.

Jennifer is 29 years old, single and has worked in the factory for almost five years. She works in the painting section, putting stickers on the finished parts. She earns Peso 249 per day plus Peso 10 per day as an incentive if she is not late or absent, for a total of Peso 259 (US\$5 at US\$1=Peso 52). She does not receive a production incentive. She lives on her own in a rented house. She is from a different island and has come here to work. When she is sick she goes to the hospital, which is covered by Phil Health. She has been to the company doctor when she has been ill at work. She says that sexual harassment is “when somebody harasses me” and does not say more.

Jeana is 27 years old and has worked in the quality control department for almost five years. She is married with two children, aged three years and two years. Her husband works in the same department. Both her children were born through normal deliveries, and she took two months of maternity leave each time. She went to a private hospital, partially covered by Phil Health, for both deliveries. Her mother-in-law is home and looks after her children. When she was pregnant, she did seated work but did not have an assistant. She earns the minimum wage of Peso 249 per day (US\$5 at US\$1=Peso 52) plus an attendance incentive. She has seen the factory doctor when she was unwell. She says that HIV/AIDS is “sexual.....” and has forgotten what it is. She says that sexual harassment is covered by the law and has to do with “bad words.” She is not sure if she would like to have more children but is not using contraceptives at this time.

Romeo is 26 years old and has worked at the factory for five weeks as a seasonal worker in the warehouse. He is from a neighboring island and is single. He sends about Peso 2000 (US\$38 at US\$1=Peso 52) home every month. Previously he worked for a construction company.

Rigor has worked in the warehouse for five years. He is 26 years old and single, and he is from the local area.

Joel is 22 years old and has worked in the wheel fixing section of the factory for two years. He is single and from the local area. He has been to the clinic and taken medicine when he has been unwell. He has also been to the hospital; the visit was covered by Phil Health. He lives an hour away and commutes by bus. He eats at the cafeteria.

Romeo, Rigor and Joel think that the cafeteria food is okay. They would like additional resting areas with seats, especially during the rainy season. They earn an attendance incentive of Peso 10 per day (US\$0.19 at US\$1=Peso 52) and performance incentive of Peso 10 per day.

Cindy works in the painting section, affixing stickers on finished parts. She is 22 years old and has worked in the factory for about five weeks. She is from the area, and this is her second job. Previously she worked in assembly in an electronics plant but left because her contract ended. She earns Peso 254 per day (US\$4.90 at US\$1=Peso 52) and completed a hotel and restaurant management course at college. She visited the nurse when she was not feeling well, but she has never been to the hospital. She is the second child of four girls; her siblings are still in school. She learned about sexual harassment during the factory orientation and believes that it is when “somebody touches.” When asked about HIV/AIDS, she says that “if two persons have intercourse, it can be transmitted.” She does not know any other way of transmission.

Priscilla is 29 years old and has worked in the framing department for five years as a visual checker. She is from another province on the same island. She earns minimum wage plus Peso 10 (\$.20 at US\$1=Peso52) attendance bonus plus Peso 10 (\$.20 at US\$1=Peso52) production bonus. She also receives an additional allowance of Peso 20

per day (US\$0.40 at US\$1=Peso 52) that only team leaders are eligible for. She has eight workers on her team, all of which are female. She has seen the nurse and factory doctor when she has been unwell. She is single and has a boyfriend but will not say more about him. She does not know what contraceptives are. When asked about HIV/AIDS, she said that “if there is intercourse, it can be transmitted.” She says that sexual harassment is when “when somebody touches me and I don’t like.” When someone on her team is not well, she allows them to see the nurse or apply to take time off.

Janice is 23 years old and has been working in the frame section for two months as a seasonal worker. She is from a different province on the same island. She has been married for one year. Her husband works in the Export Processing Zone (EPZA) as a regular worker. She has a one-year-old baby that her mother-in-law cares for in their hometown. She is taking intravenous contraceptives. Her mother is a midwife and provides her with contraceptives every three months when she goes home. She prefers the intravenous option to the pill, since she may forget to take the pill. She does not want to have another baby for five years. She earns Peso 249 per day (US\$4.80 at US\$1=Peso 52). She says that HIV/AIDS is “contagious” and spread through “contact.” She believes that HIV/AIDS can also be spread through talking. She says that sexual harassment is “if somebody touches your body without your permission.” In her free time, she cooks and does household chores. She goes home to see her baby once a month on a holiday. When she joined she attended an orientation for 1.5 days on issues including health and safety, HIV/AIDS and sexual harassment.

VIII. Viet Nam

Context

Country Health Situation

Viet Nam is a rapidly developing Southeast Asian country with the second highest rate of GDP growth in Asia after China. In 2005, GDP growth hit 8.4 percent, and it is expected to grow at a similar pace in 2006. Over the past decade, GDP has increased by more than 7 percent annually, which has resulted in rapid poverty reduction. The incidence of poverty dropped from 58 percent in 1993 to roughly 29 percent in 2002.⁶⁶ Fueling this growth is Viet Nam's position as the world's second largest exporter of both rice and coffee, and as a leading exporter of rubber, cotton, tea, pepper, cashews and seafood. The apparel and footwear industries continue to grow as a result of a Bilateral Trade Agreement signed with the U.S. in 2001 and Viet Nam's likely accession to the WTO in late 2006. In 2004, Viet Nam exported more than 43 million pairs of shoes to the U.S., making it the fourth largest exporter of footwear to the U.S. market. Viet Nam ranks sixth in the volume of apparel exports to the U.S.⁶⁷ Foreign direct investment (FDI) flows into Viet Nam have mushroomed, reaching US\$3.9 billion in 2005.

According to The World Bank, Viet Nam has reached levels in basic health indicators that far surpass those attained by countries with much higher incomes per capita. Many of these gains stem from a focus on social solidarity and a relatively balanced distribution of income. Nevertheless, a host of social and economic problems threaten the future stability of Viet Nam's meteoric economic rise over the past decade. The emergence of private sector enterprises and subsequent closure of many state-run enterprises have had profound implications for Viet Nam's social protection systems. At present, only 5.6 million of the country's 33 million workers are covered under the state-run social insurance system. In 1995, the government moved to include private enterprises with 10 or more employees in its state benefits system. The International Labor Organization (ILO) has been working with the Vietnamese Government to design and implement a social security system that would extend coverage progressively to excluded sectors and provide support to workers who have become unemployed as a result of the economic transition process.

The shift to a market-oriented economy is widening the rural–urban gap and could threaten future social, economic and political stability. Worker strikes, primarily wildcat strikes in southern Viet Nam at labor-intensive, foreign-invested enterprises, are becoming more commonplace; more than 900 such strikes have occurred since 1995.⁶⁸ High economic growth rates in a small handful of southern and northern provinces force

⁶⁶ UNDP *Human Development Overview*, 2006.

⁶⁷ American Apparel and Footwear Association Annual, 2004.

⁶⁸ ILO/VIETNAM Industrial Relations Project, Online FAW sheet,

workers to migrate to large cities for work, where wages are higher than in their home provinces but insufficient to compensate for the higher cost of living. New health threats are emerging, namely HIV/AIDS, avian influenza and motorbike fatalities, the latter of which Viet Nam averages more than 12,000 deaths per year.⁶⁹

Viet Nam: Health Statistics		
Name	Indicator	Year
Population ¹	84,238,000	2005
Life expectancy at birth (male) ¹	69 years	2004
Life expectancy at birth (female) ¹	74 years	2004
Population with sustainable access to improved sanitation (percentage of population) ³	41%	2002
Population with sustainable access to an improved water source (percentage of population) ³	73%	2002
Maternal mortality ratio adjusted (per 100,000 live births) ³	130	2000
Infant mortality rate ¹	21 (per 1,000 live births)	2004
Births attended by skilled health personnel ¹	90%	2004
Total fertility rate ¹	2.3	2004
Contraceptive prevalence rate ¹	78.5% (married women aged 15-49)	2002
Prevalence of HIV, total (of population aged 15-49) ²	0.3 – 0.9% (150,000 to 430,000 people) ⁷⁰	2006
Ratio of women AIDS cases ²	13.5% ⁷¹	2000
Doctors ¹	5.3 (per 10,000 pop.)	2001
Nurses ¹	5.6 (per 10,000 pop.)	2001
Midwives ¹	1.9 (per 10,000 pop.)	2001

Sources: 1 - *World Health Report 2006 - Working Together for Health*. World Health Organization, Geneva; 2 - *Report on the Global AIDS Epidemic*. UNAIDS. 2006; 3 - *United Nations Human Development Report*. 2005. United Nations, New York.

Government and Legal Context⁷²

The 1992 Constitution of Viet Nam gives every Vietnamese citizen the right to work and other basic civil and economic rights.⁷³ The 1995 Labor Code of Viet Nam

⁶⁹ Asia Injury Prevention Foundation, www.asiainjury.org.

⁷⁰ Although Viet Nam has implemented HIV/AIDS case reporting, the general lack of HIV testing thus far suggests that the actual number of HIV infected persons is much higher. HIV prevalence in the general population is estimated to be approximately 0.4%.

⁷¹ In some southern provinces, the proportion has reached nearly 50%.

⁷² Information for this section provided by the U.S.-Vietnam Trade Council (www.usvtrc.org) and 1995 Labor Code of Viet Nam.

⁷³ Articles 55, 56, 63 and 67.

institutionalized these basic rights. Under the Labor Code, every Vietnamese worker enjoys the following basic rights.

Freedom to Chose Employer

Workers have the right to choose their employer and to enter into one or more labor contracts with one or more employers.⁷⁴

Standard Work Week

The standard work week is eight hours a day or 48 hours a week, minus 30 minutes rest time each day.⁷⁵ Working hours have been reduced to 40 hours per week for the state administrative sector, and other sectors are expected to eventually follow suit.

Overtime Limits & Pay

Workers may not be required to work more than 300 hours overtime per year or four hours overtime on any given day. These limits are among the lowest in South East Asia. For overtime work, workers are entitled to be paid:

- at least 150 percent of his or her normal hourly wage for overtime during the daytime on normal days;
- at least 200 percent of his or her normal hourly wage for overtime during the daytime on weekly days off and on holidays; and
- an additional amount at least equal to 30 percent of his or her normal hourly wage for overtime at night.⁷⁶

Leave, Holidays & Rest

Workers are entitled to:

- Annual leave from 12 to 16 days with pay, and one additional day of leave for each five years of service.
- National and international holiday leave of eight days per year with pay, and paid leave for personal reasons, such as three full days compassionate leave for the death of an immediate relative.⁷⁷
- Paid rest period equal to at least half an hour for workers who work eight consecutive hours. Workers on the night shift are entitled to a mid-shift break of at least 45 minutes with pay and rest of at least 12 hours before being assigned to another shift.⁷⁸

Minimum Wage

Workers are entitled to receive a minimum wage plus statutory allowances, benefits and bonuses. When the cost of living rises, the government may readjust the minimum wage

⁷⁴ Art. 30.

⁷⁵ Art. 68

⁷⁶ Art. 61

⁷⁷ Art. 73, 74 & 78

⁷⁸ Art. 71

to guarantee real wages.⁷⁹ In most provinces, local labor authorities set multipliers that increase the minimum wage according to the worker's seniority and skill level, so almost all workers enjoy a basic wage higher than the minimum.

Bonuses

Workers are entitled to a minimum annual bonus equal to one month's pay if they have worked in the business for one year or more.⁸⁰ Piece work and incentive bonuses may supplement this statutory bonus, but they may not replace it.

Social Insurance

The social insurance regime is compulsory for employers, who bear the larger part of the burden, that employ 10 workers or more. The social insurance regime provides compensation and/or allowances when a worker is ill, pregnant, retired, dies, is the victim of a labor accident or work-related diseases or illnesses, or meets with other hardships.⁸¹

Health Examination & Health Insurance

Workers are entitled to health examinations at least once a year.⁸² Employers are required to contribute an amount equal to 15 percent of payroll to health insurance, to which workers contribute 5 percent of their salary. Workers are issued health insurance cards and may select the health examination and treatment facility of their choice. Workers may be reimbursed up to 100 percent of the hospitalization fee by the health insurance system.

Maternity Leave

Female workers are entitled to four months' maternity leave (five months for most women factory workers) with full pay for their first two children. They are entitled to an extra hour of rest each day for the first full year after giving birth.⁸³

Probationary Periods

Probationary periods for employees may not exceed two months, and compensation during probationary periods may not be less than 70 percent of the standard salary.⁸⁴

Labor Contract Termination

A worker may unilaterally terminate a labor contract without cause; the employer may not.⁸⁵ Even with cause, the employer may not terminate a worker if:

- The worker is ill, has been in a labor accident or has a work-related disease for

⁷⁹ Art 55 & 56

⁸⁰ Art. 64

⁸¹ Art. 140

⁸² Art. 102

⁸³ Art. 114 & 144

⁸⁴ Art. 32

⁸⁵ Art. 30 and Art. 37

- which he or she is undergoing medical treatment;
- The worker is taking annual vacation, personal leave and other cases of leave permitted by the employer; and
- The worker is taking leave because of marriage, pregnancy or maternity leave, or to raise a child under 12 months of age.⁸⁶

Severance Entitlements

In cases where the employer is allowed to terminate a worker, the worker is entitled to severance payments equal to:

- one-half a month's salary for each year of work if the employer goes into liquidation or dissolution; or
- one month's salary for each year of work, with a minimum amount of two month's salary, if the business cuts its staff due to structural or technological changes.⁸⁷

Even when workers terminate labor contracts, they still enjoy the above severance pay entitlement.

Workplace Safety

The Labor Code gives workers the rights to workplace that meets high standards of space, ventilation, lighting, dust, cleanliness, air and freedom from hazardous gases, radiation, electronic fields, heat, humidity, noise, vibration and other hazardous elements.⁸⁸ In dangerous and harmful workplaces, workers must be fully equipped with appropriate means of protection.⁸⁹

Child Labor

The working age is 15 and above. Children under this age may not be accepted for work, except in few positions such as theatrical artists, craftsmen and athletes.⁹⁰ Working time of minors may not exceed seven hours in a day or forty-two hours in a week.⁹¹

Right to Unionize

Workers have the right to establish and join the national trade union in their company, and to elect their representative to the same, wherever there are ten or more employees working for one employer.⁹²

⁸⁶ Art. 39

⁸⁷ Art. 17 & 42

⁸⁸ Art. 97

⁸⁹ Art. 100

⁹⁰ Art. 120

⁹¹ Art. 122

⁹² Art. 7.2

Right to Strike

Workers have the right to strike.⁹³ There were 39 strikes in Viet Nam during the first half of 2006: twenty at foreign-invested enterprises, four at state-owned enterprises and the fifteen at private companies.

Cultural Context

Viet Nam is a relatively small Southeast Asian nation (roughly the size of New Mexico) with a burgeoning population of more than 84 million people, more than half of whom were born after the end of the Viet Nam War in 1975. Eighty-six percent of the Vietnamese population is ethnic Vietnamese (Kinh), while 54 ethnic minorities comprise the remaining 14 percent. The majority of the Vietnamese population is involved in ancestor worship and can be described loosely as Confucian or Buddhist (Mahayana); roughly 10 percent of the population—located primarily in central and southern Viet Nam—is Catholic.

In many ways, Viet Nam represents a leader in Asia on gender equality. Viet Nam performs better than its neighbors in delivering of health and education services to both sexes. Rates of economic participation are nearly the same for women as they are for men, and Viet Nam has the highest percentage of women in Parliament in the Asia-Pacific region.⁹⁴ The degree of gender equality can be attributed in large part to Viet Nam's revolutionary history and the solidarity the trials and tribulations of engaging in protracted warfare engendered. A solid legal and policy framework reinforces the notion of relative gender equality and provides Vietnamese women with rights such as generous maternity benefits (five full months for most women factory workers) and the ability to make reproductive health decisions.

Nevertheless, gender inequalities have not been completely erased. Women are still held to cultural norms that put them at greater health risk than men, such as putting their families first with little thought to their own health. Though women often control family finances and make economic decisions for the family, they are expected to defer to male judgment. Domestic violence, prostitution and trafficking remain persistent problems.

Research and Findings

Methodology

BSR staff visited five factories and one community-based project in Viet Nam to discover the most relevant health issues for women workers and examine how women's health concerns are being addressed in their workplaces and their communities. The field research was supplemented by desk research and numerous conversations with brands, suppliers and NGOs in Hanoi and Ho Chi Minh City.

⁹³ Art. 7.4

⁹⁴ *Viet Nam: Gender Situation Analysis*, Asian Development Bank. Manila, 2005.

BSR worked closely with several brands to gain factory access. In one factory visit, brand representation participated in the visit and traveled from Bangkok to join BSR in Ho Chi Minh City. Dr. Nguyen Bich Hang made the trip to Ho Chi Minh City from her base in Hanoi to accompany us on an all-day factory visit and subsequent stop at a Marie Stopes International (MSI) clinic in Binh Duong Province.

All of the factory- and community-based visits occurred in Binh Duong Province.

- **Ho Chi Minh City** is the economic hub and largest city of Viet Nam. Its population is over 6 million people. It has achieved status as an economic powerhouse driving Viet Nam's expansion as an export manufacturing center, so that two neighboring provinces, Dong Nai and Binh Duong, have benefited from labor shortages in Ho Chi Minh City over the past decade and have undergone rapid economic development as a result.
- **Binh Duong Province** is located north of Ho Chi Minh City and has a population of roughly 1 million people. Along with neighboring Dong Nai Province and Ho Chi Minh City, Binh Duong is a leading destination for foreign direct investment in Viet Nam, with more than 4770 factories as of 2004.

Projects Covered

Of the five factories, three were engaged exclusively in apparel production, one in apparel and toys and one in footwear. The number of workers ranged from 1500–9,200 workers. All factories had an overwhelming majority of women workers, from 62–95 percent. The majority of workers are between 20–25 years old, and slightly less than 50 percent are married. The majority of women workers have at least a ninth grade education (nine years of school), and more than 50 percent have finished high school (12 years of school).

Key Findings

Health Facilities

The factories visited make mandatory payments into the social insurance system. The employer bears the bulk of financial responsibility to the system.

- All factories had an infirmary or sick room onsite. Levels of service varied from a single room with one bed to a facility with multiple beds and a mobile reproductive health clinic about to be licensed to serve as a government clinic so workers would not need to visit the hospital for treatment or prescription drugs.
- Minimal diagnostic and referral facilities were available in four of the factories. No factory clinic was able to provide antibiotics, but all were capable of suturing cuts. All factories had at least a nurse on staff. Four factories had full-time doctors on staff, though the one factory that did not have a doctor on staff had a large worker population.
- Medical records were not kept in any of the factories visited; only logbooks of those visiting the infirmary were kept.
- All five factories sign contracts with local hospitals to conduct annual health check-ups.
- Five cases of rubella occurred in one factory during 2005.
- One of the factories is air-conditioned.

Common Illnesses

The most common illnesses among workers were **upper respiratory tract infections** (coughs and colds), **headache**, **fatigue**, **diarrhea** and **dysmenorrheal**.

Nutrition

Nutrition is a major problem among factory workers in Viet Nam. Women factory workers have a tendency to skip breakfast and eat the free factory lunch. There is a strong inclination to work overtime as often as possible because dinner is provided free of charge to those who do. Anecdotal evidence suggests that the quality and nutritious value of cafeteria meals are questionable and in need of improvement. Many of the factories in other focus countries provided vitamins, but none of the factories in Viet Nam dispensed any type of vitamin supplements.

Care during Pregnancy

No factories provided **monthly check-ups for pregnant workers**, though all stressed they encourage pregnant workers to visit the local hospital for the three antenatal visits proscribed by law. Pregnant workers are automatically shifted to less strenuous work at the start of their seventh month of pregnancy, at which point they also begin a reduced workday—from eight hours to seven hours—with no overtime allowed. Workers generally do not wear clothing to identify a pregnancy, though one factory changed the background of their worker identification badge from blue to pink at the seventh month of pregnancy.

Family Planning

The Marie Stopes International (MSI) mobile reproductive health clinic at the Chi Hung facility in Binh Duong was the only program that provided family planning services. Generally, factory management discounted the notion of providing family planning services, as they deemed their workers too young to require such services.

HIV/AIDS

There are no reported cases of HIV/AIDS in the factories visited. All of the factories had HIV/AIDS prevention posters mounted in the infirmaries, but this represented the extent of prevention activities in most factories. Though training sometimes touches upon HIV/AIDS, there is no formalized training. At the Chi Hung and Chutex factories, MSI has carried out some trainings on reproductive health and family planning that touch upon HIV/AIDS, but this is not the norm.

Recommendations for Effective Health Programs

The following recommendations for brands and factories for designing an approach to women's health concerns are made based on the findings above and on review of the critical success factors for factory programs.

- **Articulate the business case for RH programs.** Across the board, factory managers were interested in further exploring the business case for RH/FP services at their facilities. Though many indicated they would change management practices if the case for RH/FP services was strong, most were not yet convinced of a link between such services and higher productivity/reduced absenteeism.
- **Factories should strive to upgrade basic health facilities.** Large factories should work with Ministry of Health officials to ensure factory health facilities are licensed government clinics that can easily administer onsite care, are reimbursed by the government health system and can prescribe medication.
- **More efforts should be made to provide basic health education, including trainings on RH and FP issues, nutrition and hygiene.** In general, workers do not receive consistently reliable information on health care issues. Trainings on such issues are oftentimes delivered alongside occupational safety and health training and thus their effectiveness is diluted.
- **Dedicated trainings and worker health campaigns should occur at least twice annually to ensure as many workers as possible receive such training.**
- **Factories should identify ways to disseminate information that can be accessed easily and discreetly.** One local NGO indicated that when condoms

are made available at the factory clinic, issues of privacy deter many women from taking them. When condoms are made available in the women's bathroom, however, they disappear quickly. This seems to indicate that privacy and confidentiality are major considerations in providing RH/FP services, including contraceptives for unmarried workers, to Vietnamese women workers.

- **Awareness raising among factory managers on RH/FP issues is key to moving forward.** As almost all factory management interviewed in Viet Nam is male, an appreciation for the benefits of providing RH/FP education to workers is often lacking. In general, factory management viewed their largely young and unmarried female workforce as not in need of such education.
- **Factory and/or industry associations should collaborate to share best practice in addressing women's general and reproductive health issues.**

Detailed Reports of Site Visits

Hansoll Vina Company, Ltd., Binh Duong Province, Viet Nam

Factory Information

Hansoll Vina Company is a South Korean-owned apparel manufacturing company focused on knit tops and located outside of Ho Chi Minh City in the neighboring Binh Duong Province. This factory opened in 2002 with 1000 workers in one factory building. Hansoll Vina now occupies three buildings and employs **5300 workers**, 83 percent of which are women. The majority of female workers are between 23–25 years of age and have completed high school. Roughly 75 percent of workers are from **Viet Nam's central and northern provinces**, with only 2–3 percent coming from Ho Chi Minh City and Binh Duong Province. The remainder come from other southern provinces in the Mekong Delta region.

During the site visit, **125 women workers** were known to be at least two months **pregnant**.

Sewers account for the overwhelming majority of factory employees, though there are more than 300 section chiefs and roughly 100 supervisors. **Seventy percent of the section chiefs and supervisors are women.**

Employee **turnover** at Hansoll Vina is high compared to other factories visited in Binh Duong Province, at roughly 33 percent annually. This is attributed in large part to the young age of women workers who typically get married within the age range of 23–25 years. Factory management did not know the percentage of women workers who are married, as they do not keep records on employee marital status; however, they estimated that roughly 50 percent are likely married.

The **minimum wage** at Hansoll Vina is set at 870,000 VND per month (US\$54.37 at US\$1=VND 16,000). The minimum wage set by the government for industrial zones in Binh Duong province is 790,000 VND per month (US\$49.38 at US\$1=VND 16,000). Workers at Hansoll generally clock enough overtime to increase their monthly income to an average of 1,200,000 VND per month (roughly US\$75 at US\$1=VND 16,000).

Workers begin employment on a three month indefinite contract, followed by an additional indefinite contract of the same length. Upon completion of their second contract, workers automatically receive a “definite” contract for one year. There are no minimum educational qualifications for employment at Hansoll.

Worker Communication

Top-down communication at Hansoll are carried out largely by the human resources manager—a Vietnamese male—and the compliance team, headed by two South Korean males. Eight factory employees make up the human resources and compliance teams.

A comment box is located in the cafeteria for worker comments on factory conditions. The cafeteria, which provides a free lunch to all workers during two lunchtime shifts, is the primary venue at which workers communicate with one another and view public service announcements on a bulletin board on topics ranging from health and safety to nutrition.

In addition to the public bulletin board, workers meet with their line leaders each morning. During this 10-minute meeting, line leaders inform workers of important updates. Sample topics include health and safety, avian flu and changes to the line.

Ms. Bui Thi Minh, a 29-year-old factory employee from Thanh Hoa Province in northern Viet Nam, has worked at Hansoll for one year as a sample sewing worker. She has been married for five years, has a four-year-old daughter and is six months pregnant with her second child. Her husband also works in Binh Duong Province in a furniture factory. Her average monthly wage is 1,000,000 VND (US\$62.5 at US\$1=VND 16,000) without overtime and 1,200,000 VND (US\$75 at US\$1=VND 16,000) if she works four hours overtime three days each week, which equates to a six-day, 60-hour work week. She has lunch for one hour and a 15-minute break each morning and afternoon. She noted that during her current pregnancy, she often feels tired at the end of the day, and that a nap room would be useful for pregnant employees. When she feels too tired, she goes to the factory clinic to rest for 15 minutes. She confirmed that she will switch to a seven-hour work day when she reaches the seventh month of her pregnancy. She stated that she lives 10 minutes away by motorbike from the factory and that she always wears a helmet when in transit. When asked about HIV/AIDS prevention, she confessed she knew very little except what she read in the newspapers, and she felt that she and other workers would benefit from training.

Health Facilities and Issues

Hansoll has **three medical clinics** inside the factory that are staffed by two female doctors, one available full time and the other available four days per week. Hansoll has two full-time nurses in each of its three main factory buildings, for a total of six nurses. Each clinic has 2–3 beds and is stocked with simple medication to treat **minor headaches** (Panadol), **diarrhea, influenza, upper respiratory problems** such as cold and cough, and **menstrual cramps**. No antibiotics are provided. Workers are free to visit the clinic if they do not feel well. If symptoms are serious, workers receive permission from the doctor to visit the local hospital, Army Hospital IV, located roughly 1km away, without forfeiting any wages. The doctor sees between 30–40 workers per day and notes each visit in a log book.

Once per year, Hansoll signs a contract with Army Hospital IV for an **annual check-up for all workers**.

Reproductive Health

The doctor reports regular cases of **dysmenorrhea**, for which a pain killer and rest on one of the clinic beds are recommended. Pregnant workers are reminded to visit the local hospital for one of three visits provided under Viet Nam's social insurance system during pregnancy.

Training

Annual health and safety training, including first aid, is delivered to all line managers and supervisors. Sexual harassment training is also delivered to this group, which educates workers during daily line meetings.

HIV/AIDS

Other than informational material on the public bulletin board and some public health posters on the walls inside the factory clinics, there is no formal training that touches upon HIV/AIDS prevention and care.

Dream Vina Company, Ltd., Binh Duong Province, Viet Nam

Factory Information

Dream Vina Company is a South Korean-owned factory located in Uyen Hung Town, Tan Uyen District in Binh Duong Province. Dream Vina manufactures apparel (knitwear) and toys primarily for North American customers. This factory opened in 2004 and currently employs **2000 workers**, 95 percent of which are female. The average salary at Dream Vina is the minimum wage provided under Vietnamese law: 790,000 VND per month (US\$49.38 at US\$1=VND 16,000) in Binh Duong Province. The age range at the factory is between 18–28 years old, but the average age is much closer to 20

years old. Factory management guesses that 50 percent of workers are married but has no way of verifying this number.

As with other factories visited in Binh Duong Province, normal working hours are 48 hours per week: eight hours per day, six days per week with Sundays off. Workers clock an average of two additional hours per week in overtime. The factory operates on **one shift** only, from 8:00 am to 5:00 pm.

Daily **absenteeism** at the factory is estimated at roughly 7–8 percent, though the exact figure was not known. Factory management strongly agreed that healthier workers reduce daily absenteeism, and thus programs that address women's health issues are valued. That said, the average age of women workers at the factory (roughly 20 years old) means that serious health issues are uncommon.

When asked about the number of **pregnant women** at the factory, factory management did not have a clear answer. A check with human resources revealed that there are 14 known pregnancies under seven months and nine women who are more than seven months pregnant. This is a remarkably low number of pregnancies.

Among the 2000 workers, roughly **90 are line leaders and seven are supervisors, all of whom are female**. There is a **trade union** at the factory, though membership and participation are weak; activities generally include visiting sick workers and those who have recently lost a family member. The union also helps defray travel costs for attending funerals in other provinces and provides small loans for costs associated with medical care and funerals. Membership fees in the union, which cost roughly 5000 VND per month (US\$.31 at US\$1=VND 16,000), are deducted from workers' salaries, which are paid in cash at the end of each month.

Contrary to most factories in Binh Duong Province, **70 percent of workers are local**, with the remainder coming almost exclusively from Phu Yen Province in central Viet Nam. Migrant workers from Phu Yen generally share a 3–4 bedroom house, with 3–4 women workers sharing a small bedroom. Rent per worker costs about 100,000 VND per month (US\$6.25 at US\$1=VND 16,000). Local employees typically live with their families.

Dream Vina's parent company, Dream Inko, has 10 additional factories located in China. Dream Vina is their only factory located in Viet Nam. Factory management noted that workmanship and quality in Viet Nam surpasses quality levels in China, but that productivity remains well below Chinese standards.

Worker Communication

Line leaders deliver information to workers when directed by factory management, though this does not happen on a regular basis. There is a **comment box** located on the factory floor to deliver messages to factory management.

Health Facilities and Issues

Dream Vina has one **sick room** located on the main factory floor that staffed by two nurses. A male doctor is present every Thursday for the full day and makes referrals to the local hospital. The sick room stocks minor pain relievers and does not dispense antibiotics, as it is not an official pharmacy. Nurses at the clinic report seeing roughly 10–15 workers per day for headaches, flu-like symptoms, menstrual cramping and fatigue. Injuries on the factory floor are rare, with finger lacerations due to needle cuts being the most common.

Once per year, a group of **South Korean and Singaporean doctors and missionaries** come to the factory to provide three full days of medical care. During our visit, 17 doctors from Singapore and two traditional medicine specialists from South Korea were providing care, with tables set up in a courtyard between Dream Vina's two factory floors. The same program is in place in all of Dream Inko's China factories.

Reproductive Health

Due to the young age of most women workers at the factory, reproductive health issues are not a focus for factory management, nor do they view the area as a future priority. The cultural notion that Vietnamese women do not have sex until after marriage was cited as the primary reason for a lack of focus on the topic.

Because there are so few pregnancies at this particular facility, factory nurses only noted that they remind pregnant workers to visit the hospital for the three free check-ups allowed during pregnancy under Viet Nam's health insurance scheme. Pregnant workers are allowed to take time off with pay for these visits.

HIV/AIDS

Factory management did not view HIV/AIDS prevention as a priority focus, due again to a perceived lack of relevance to a young pool of female workers who are not yet sexually active. No formal HIV/AIDS prevention training is available, though HIV/AIDS prevention posters encouraging condom use were posted inside the clinic.

Training

Workers obtain healthcare and safety training during their initial factory orientation, which lasts one day. The factory also works with a local hospital to arrange annual health check-ups for all workers. All line leaders receive first aid training annually and convey their learnings to workers during informal line meetings.

Saigon Knitwear, Ltd., Binh Duong Province, Viet Nam

Factory Information

Saigon Knitwear is a Hong Kong-owned and operated facility that is part of the South Ocean Group of Companies. The factory manufactures sweaters for export markets and

produces primarily for North American customers. The factory opened in 2002 and employs approximately **1500 workers** who range in age from 22–25 years; 62 percent of factory employees are women. The **average monthly wage** at Saigon Knitwear totals 1,200,000 VND per month (US\$75 at US\$1=VND 16,000). As is the case with most factories in Binh Duong Province, more than **50 percent of factory employees are from central and northern Vietnamese provinces**.

Saigon Knitwear's daily **absenteeism** rate is 3.5 percent, well below the average in most Vietnamese factories. Despite the low daily absenteeism rate, factory management expressed interest in further reducing this number via improved health services available at the factory. Annual **turnover**, at 6 percent, is also extremely low.

As allowed by Vietnamese labor law, a **trade union** exists at Saigon Knitwear and counts 40 percent of factory employees as members. Dues are 5000 VND per month (US\$.31 at US\$1=VND 16,000) and are deducted from monthly wages.

In the main lobby in the administrative section of the factory building, a full wall was covered with framed Codes of Conduct from each brand for which Saigon Knitwear manufactures sweaters. Among all other factories visited in Viet Nam, this was unique.

Worker Communication

Workers are encouraged to communicate with factory management via an **open door policy**. **Daily line meetings** provide a forum to voice concerns that are conveyed up the chain of command to factory management. A **suggestion box** is available on the factory floor but is rarely utilized.

Health Facilities and Issues

Factory management voiced considerable interest in promoting women's health within their factory, as they view improved health as a key driver in reducing absenteeism and boosting productivity.

A doctor visits the factory's onsite sick room one day per week. During the work week, two full-time nurses staff the office, which contains one sick bed. Antibiotics are not distributed. The doctor reported that patients generally report headaches, stomach problems, menstrual cramps and occasionally fatigue, particularly during pregnancy.

Contrary to the low number of pregnancies at Dream Vina, factory management reports that 7–8 percent of women at its facility are pregnant at any given time.

Reproductive Health

Pregnant workers at Saigon Knitwear are allowed to take paid time off for the three prenatal visits provided under Vietnamese law. When a female worker learns of her pregnancy, she is encouraged to inform her line supervisor who in turn reports her pregnancy to the doctor. At the seventh month of the pregnancy, the worker is

automatically reassigned to a less strenuous task and begins a reduced, 42-hour work week with no overtime.

HIV/AIDS

No formal training is provided on HIV/AIDS prevention. During interviews, women workers appeared uninterested in HIV/AIDS education because they did not feel it was relevant since they were not married (*i.e.* not sexually active), or married and in a monogamous relationship in which such concerns were unwarranted. As was the case in all factory sick rooms and clinics, HIV/AIDS prevention posters encouraging condom use were visible not only in the clinic, but also in other high traffic areas throughout the factory.

Training

All workers receive annual health and safety training, including first aid and fire safety, the latter of which management particularly emphasizes. New employees receive orientation and training during their first month of employment. In the past, Saigon Knitwear has contracted with local hospitals and NGOs to deliver some health and safety training.

Chi Hung Footwear Company, Ltd., Binh Duong Province, Viet Nam

Factory Information

Chi Hung Footwear is a Taiwanese–Vietnamese joint venture located in Di An District, Binh Duong Province. Chi Hung commenced production in 2001 with a 650,000 sq. ft. factory that manufactures sport shoes exclusively for adidas Group. Chi Hung currently employs **9200 workers**, 85 percent of whom are female. In addition, 85 percent of workers are between 20–24 years old. **Average monthly wages** for workers total 1,200,000 VND (US\$75 at US\$1=VND 16,000). The work week is Monday to Saturday, eight hours per day with one hour for lunch and 15-minute breaks in the morning and afternoon. Workers average 1.5 hours of overtime each day, bringing the average number of work hours each week to 57. More than **50 percent of Chi Hung employees are migrant workers from Viet Nam’s central and northern provinces.**

Daily **absenteeism** at Chi Hung is roughly 6 percent, or 552 workers per day. No firm figures were available for annual turnover, though factory management indicated the number is high due to the large percentage of migrant workers who arrive and leave within 2–3 months due to homesickness.

A **trade union** exists at Chi Hung, though membership figures were not available. The director of human resources for Chi Hung is working closely with the union’s executive committee to hire a full-time employee to serve as the factory’s trade union chairman. Factory management views greater interaction with the trade union as a means to enhance worker satisfaction through greater understanding of important issues.

Chi Hung is in the process of obtaining **ISO 14000 certification** and prides itself on continuous health, safety and environment training for its workers.

Health Facilities and Issues

Chi Hung is an example of best practice in the export manufacturing sector in Viet Nam vis-à-vis onsite health services available to employees. An **onsite clinic** is staffed by two full-time doctors, four full-time nurses and one pharmacist. The medical clinic is comprised of three exam rooms, one emergency room and roughly 10 sick beds.

The factory coordinates **yearly onsite employee health checks** and is in the process of becoming a state-licensed health clinic with the capability to fill prescriptions onsite and apply directly to the national health insurance program for reimbursement.

Beginning in March 2006, **Marie Stopes International (MSI)**, a non-profit organization based in the United Kingdom, has been operating a **mobile reproductive health clinic** in the existing medical clinic two days per week. This program is highlighted below.

Reproductive Health: Best Practice

Factory management at Chi Hung Footwear is dedicated to enhancing the reproductive health of its workers. A mobile reproductive health clinic at the Chi Hung factory is managed by Marie Stopes International (MSI) Viet Nam, a United Kingdom-based nonprofit social enterprise with a Viet Nam representative office that is dedicated to providing sexual and reproductive health information and services in nearly 40 countries.

According to Chi Hung factory management, the objective of the MSI mobile reproductive health clinic is to raise awareness of better reproductive health practices. The project includes three core activities:

1. Mobile services two days per month at the factory to provide **gynecological consultation** for workers; 150–200 workers are consulted each month.
2. **Peer educator training** provides reproductive health education to a group of workers dubbed peer educators (PEs) who in turn share the knowledge with fellow workers. Thus far, 40 PEs have been trained; the target number of PEs is one for every hundred workers. Meetings are held monthly among the PEs to provide ongoing training and guidance.
3. **Reproductive health information, education and communication** seminars are provided monthly for about 300 workers.

The main goal of MSI's work with Chi Hung and other adidas Group supplier factories in Ho Chi Minh City and Binh Duong Province is to improve sexual and reproductive health (SRH) among workers. The mobile RH clinic aims to increase the availability and

accessibility of quality SRH information and clinical services for factory workers. Chi Hung and MSI aim to enhance the capacity of factory health staff to provide basic, accurate health information and services to workers. The government openly disseminates health information via newspapers and propaganda posters placed strategically throughout the country, but the quality of information is in question.

Chi Hung Factory Information from MSI

- 82 percent of workers at Chi Hung are female
- 100 percent of workers are at reproductive health ages (15–49)
- Most of the workers are migrants and
 - Have multiple sexual partners
 - High risk of HIV/AIDS infection and STIs
 - Lack basic RH knowledge
- Insufficient RH services provided at the factory clinics and local hospitals
- 70 percent of male and female workers surveyed indicated interest in obtaining RH and childraising information
- Beneficiaries include 9200 Chi Hung factory employees, factory health staff and local residents

Specifically at Chi Hung, MSI has established a sustainable RH clinic to serve factory workers and local residents. RH and family planning (FP) services, including contraception, treatment for STIs and HIV/AIDS, and access to safe abortion, are key project benefits. The establishment of a Peer Educator Network ensures wider dissemination of RH/FP information. The mobile health clinic has convenient opening hours, charges nominal fees for RH/FP services and ensures privacy and confidentiality.

There is a clear need for the MSI clinic as evidenced by the number of patients: on the seven days the mobile clinic has visited the Chi Hung factory, doctors and health personnel from MSI saw more than 300 patients per day.

At the RH clinic, information and services are provided on:

- Contraceptive methods
- Abortion
- STIs and STDs
- Pregnancy care
- Child raising
- Pap smears
- HIV/AIDS

Benefits to the factory include the addition of programs that focus on the long-term health of workers and reduce absenteeism and potentially boost productivity. The programs are known to reduce worker turnover, reduce employee medical costs,

eradicate poverty and hunger in smaller families via FP, and promote better health. For brands, health programs in supplier facilities support corporate social responsibility efforts, differentiate factories from their competitors and create a wider network of stakeholders that increase partner loyalty.

HIV/AIDS

Currently, Chi Hung is participating in the Academy for Educational Development's "SMARTWork" program. **SMARTWork** (Strategically Managing AIDS Responses Together in the Workplace) works to establish workplace HIV/AIDS programs and policies in six countries, and disseminate the lessons from these programs and policies to business groups, labor leaders, government and NGO representatives seeking to catalyze workplace responses. SMARTWork has guided the design and launching of dozens of workplace HIV/AIDS programs and policies at both the workplace and national levels.

In addition to SMARTWork, the MSI clinic at Chi Hung provides a wide range of **HIV/AIDs training and counseling**, as well as access to a **full range of contraception**, including condoms, intravenous and oral contraceptives, and IUDs, **at no fee**. Condoms are also available in the men's and women's bathrooms. Though condoms were previously available at the MSI clinic, the entry way is public and workers were shy about being seen. MSI reports that they cannot restock the restrooms quickly enough; clearly demand went unmet.

Training

New employee education at Chi Hung takes place during an initial one-month orientation that includes training on legal rights under the Vietnamese Labor Code and health and safety issues. Each employee undergoes a two-hour refresher course each July–August during the low season.

Ms. Pham Thi Thuan, 22, has been a sewer at Chi Hung for two years and is from the central Vietnamese province of Nghe An. She and her husband, who works in a ceramics factory in Binh Duong Province, recently had their first child. She was aware of the MSI mobile RH clinic at Chi Hung but had not yet visited. Ms. Thuan noted that her basic salary is 875,000 VND per month (US\$54 at US\$1=VND 16,000) and that she generally gets an additional 100,000 VND per month (US\$6.25 at US\$1=VND 16,000) if she exercises each morning prior to work and does not miss a day of work for the entire month. Together, she and her husband earn roughly 2,000,000 VND (US\$125 at US\$1=VND 16,000). When asked about her monthly expenses, Ms. Thuan noted that she and her husband spend 300,000 VND per month (US\$18.75 at US\$1=VND 16,000) on their apartment and 100,000 VND per month (US\$6.25 at US\$1=VND 16,000) on water and electricity. She receives 12 days of paid annual leave. She noted that she had participated in a training through the MSI Peer Educator program and had learned how to prevent unwanted pregnancy through contraceptive use. She had received information from her line supervisor about the voluntary MSI training.

Chutex International Company, Ltd., Binh Duong Province, Viet Nam

Factory Information

Chutex International Company, located in Binh Duong Province within the Song Than Industrial Zone, manufactures knitwear tops for brands such as Gap, JC Penney, Federated Department Stores, Sears, Kohl's, Disney and Charming Shoppes. Chutex was established in 2002 and employs roughly **5600 workers**, 93 percent of which are women. Chutex is unsure of the exact number of married and single women workers but estimates that less than 50 percent are married. Roughly 80 percent are migrant workers from Thanh Hoa and Nghe An Provinces, both in northern Viet Nam. Ninety percent of workers are between 20–26 years old, and roughly 50 percent are married.

The **average wage** at Chutex is roughly 1,300,000 VND per month (US\$81.25 at US\$1=VND 16,000), including overtime pay. There can be more than one shift during peak seasons, but generally there is one shift from 8:00 am to 5:00 pm, with one hour for lunch and a 15-minute break in the morning and afternoon. Maximum overtime per week is 12 hours; the maximum allowed under Vietnamese labor law is 300 hours per year. **Turnover** at Chutex is roughly 10 percent annually.

Chutex follows Vietnamese labor law in providing employees with five months of **maternity leave**, though the social insurance system is liable for wages during leave—not the factory. Unique to Chutex is their policy of allowing mothers to work seven- rather than eight-hour days until their child is one year old.

Daily **absenteeism** at Chutex is approximately 7 percent, which factory management attributes largely to sickness and “personal reasons.”

Worker Communication

There is a **comment box** on the factory floor and an organized trade union that communicates directly with factory management.

There is a highly useful, informative **bulletin board** located at the entrance to the factory cafeteria that includes materials on RH, FP, avian flu, motorcycle safety and numerous other topics. In visiting the cafeteria during one of two lunch shifts, it was clear that workers take note of the information, as many women and men were reading new postings.

Health Facilities and Issues

There is a **health clinic** at Chutex adjacent to the factory floor that receives roughly 30–40 patients per day, most of whom complain of **headaches, cough, cold and fatigue**,

the latter particularly by pregnant workers. Each worker is allowed to rest for 15–30 minutes without taking sick leave. Clinic staff reported that Monday was the busiest day, with an average of 80 patients. The clinic is staffed by one full-time doctor and three full-time nurses. Factory health staff manages a contract with a local hospital 5 km away that handles employee **annual health check-ups**. Check-ups take place very October and November and take roughly 7–10 days to complete for all 5600 workers.

The factory utilizes a public address system each morning to provide short announcements on important topics, though these announcements are generally limited to factory-specific information and have not yet addressed health issues.

To inform future work surrounding worker health, Chutex recently surveyed 100 workers randomly with a **health questionnaire**. The questionnaire was designed to show that they care, but also to inform future activities. The results were not yet available.

Reproductive Health

MSI has worked with Chutex in the past to deliver trainings on RH and FP, particularly on access to safe abortion. The trainings targeted line leaders and line supervisors, who then delivered trainings to workers under their supervision.

Training

Initial orientation lasts two hours for new employees and focuses on health and safety, including fire safety, first aid, personal hygiene and hazardous chemicals management for employees working primarily in the laundry. Employees in groups of 30–40 are supposed to receive an annual 3–4 hour refresher course led by the human resources and compliance team, but this is not always possible according to factory management. The HR and compliance teams focus first on training supervisors and line leaders. In June to September when peak season is over, trainings often take place during the afternoons as overtime is rare during this period.

HIV/AIDS

MSI has worked with Chutex in the past, as have other local NGOs, to deliver trainings that focus on HIV/AIDS prevention. Factory management noted that these trainings are not regular.

Appendix A: Resources

The following resources were compiled as part of BSR's research into women's health needs. Included are resource organizations specific to the six focus countries of the project: China, India, Indonesia, Mexico, the Philippines and Viet Nam.

China

1) Yunnan Health and Development Research Association

Organizational Overview: Yunnan Health and Development Research Association-YHDRA (originally Yunnan Reproductive Health Research Association, YRHRA) was founded in March 1994 and is the first registered NGO focusing on RH. YRHRA has roughly 186 members, including senior researchers working in the medical and social science fields from universities, research centers and reproductive- and hygiene-focused organizations.

Located in Yunnan, YHDRA convenes regular meetings the first Saturday of each month. YHDRA emphasizes public health services in the rural areas and administers a series of research projects covering traditional culture and health, prevention of venereal disease and AIDS and the rights and health of women.

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Website: www.yhdra.org

2) China AIDS Network (CAN)

Organizational Overview: Founded in 1994, CAN's core members are from the Beijing Union Medical College, and the majority are professionals in academic or public health institutions. This nationwide network also embraces professionals from other disciplines involved in the social and behavioral dimensions of AIDS research.

CAN has conducted HIV/AIDS research projects among taxi drivers, hotel attendants, migrant workers, long distance truck drivers and hotel workers along highways in some cities. Since 1999, CAN has worked to promote HIV/AIDS awareness among commercial sex workers in Hainan and Guangxi. The network also serves as an advisory body to the government on AIDS issues.

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Website: www.china.hivaidsinfo.net

3) China Foundation for the Prevention of STDs and AIDS

Organizational Overview: The Foundation was established in 1988 under the Ministry of Public Health's Chinese Academy of Preventive Medicine to promote research, public education and interventions to prevent and treat STDs and AIDS.

In 2000, the Foundation conducted a pilot, multi-sectoral training program for health and social workers (include staff in the Public Security Bureau, Women's Federation and Youth League) in the Weifang area of Shandong Province. It has hosted the 'Prevention Education Exhibitions' on AIDS and STDs. The publication of International STD and AIDS Information is produced quarterly. The research is conducted on the behaviors of high-risk populations to plan appropriate intervention and educational strategies, and the 'ZOKI Award' was established to fund research on the prevention and treatment of AIDS.

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Email: aids-jjh@163.com

4) The Asia Foundation

Organizational Overview: Since 1999, The Asia Foundation has focused on the rights and roles of working women in China, supporting a series of groundbreaking activities to provide services to migrant women workers, in addition to supporting policy reform dialogues on the rights of women workers. These programs have provided services for more than 250,000 migrant women workers in more than 200 factories in 22 cities and districts along China's Pearl River Delta. Projects fall into four main program areas: education and counseling, occupational health and safety training, HIV/AIDS awareness education, and legal services. Not only have these programs provided direct assistance to marginalized workers, but also they have effectively mobilized government, industry, and the NGO sector to share expertise and resources in support of improved worker conditions. These services are offered free of charge due to the generous support of a variety of funders including the Levi Strauss Foundation, May Merchandising Company, Ford Foundation, First Data Western Union Foundation, and Microsoft Corporation. These distinctive programs have generated participation from all stakeholders in building

community-based, sustainable networks to promote the social inclusion of migrant women workers.

Contact Information:

The Asia Foundation
Suite 1905 Building No.1,
Henderson Center
18 Jianguomennei Avenue
Beijing 100005 PRC
Tel: (86-10) 65183868
Fax: (86-10) 65183869
Email: beijing@asiafound.org

5) China Women's Development Foundation

Organizational Overview: China Women's Development Foundation (CWDF) was established in December 1988, and is a nationwide nonprofit social welfare organization registered under the Ministry of Civil Affairs and approved by the People's Bank of China. CWDF is dedicated to improving women's overall standing, maintaining women's legal rights, promoting the development of women and women's undertakings and collecting funds and materials from domestic and international enterprises and public sector undertakings to support its activities. CWDF actively participates in many social welfare activities including women education, training, poverty alleviation and disaster rescue.

Contact Information:

CWDF
15 Jianguomennei Avenue
Beijing 100730 PRC
Tel: (86-10) 65236597
Fax: (86-10) 65236597
Email: mqjkkc@163.com
Website: www.cwdf.org.cn

6) Women's Studies Institute of China

Organizational Overview: Established in 1991, the Women's Studies Institute of China is a national-level institution specializing in women's and gender studies. Since 1991, WSIC has carried out a number of theoretical and empirical research projects on the history, laws and regulations and policies related to women's issues, as well as comparative studies between China and other countries. WSIC's mandate is to facilitate the formulation and implementation of state laws and policies and promote women's development and gender equality. WSIC has carried out a number of important research projects. WSIC has also sponsored many important national and international symposia concerning women's issues.

Contact Information:

Add: No.15, Jianguomennei Avenue
Beijing 100730 PRC
General Office: (86-10) 85112139
Research Affairs Office: (86-10) 85116304
Information Center: (86-10) 85112147
Fax: (86-10) 65225396
Email: wsic@wsic.ac.cn
Website: www.wsic.ac.cn

7) Migrant Women's Club

Organizational Overview: The Migrant Women's Club is the first organization in China serving "migrant women" who come to the city from the countryside to find jobs. Founded in 1996, it allows migrant sisters working in the city to have a place to call their own.

The most prominent mission of the Club is to empower migrant women for self-protection and management. Its four staff members are from the countryside and were previously volunteers or members of the Club themselves.

Migrant women are a marginalized group within China's new market economy. They are concerned about finding employment, but lack the necessary skills and social resources; they are concerned about their survival, but lack the necessary urban knowledge and social security; they are concerned about their future, but do not know where or how to find a hopeful one. In response to their needs, the Migrant Women's Club aims at upholding migrant women's legal rights, improving their lives, building their capability for self-growth and expanding space for the group's development. To realize these goals, the Migrant Woman's Club has carried out a variety of activities.

Contact Information:

3 Jingyongli, Di'anmen Xidajie
Beijing 100009 PRC
Tel: (86-10) 66163129
Email: bjdgm7788@163.com
Website: www.nongjianv.org
Contacts: Han Huimin, Gao Yueqin, Fang Qingxia and Xu Jing

8) Ford Foundation-China

Organizational Overview: When the Ford Foundation office was opened in 1988, activities were concentrated in three fields: economics, law and international relations. Subsequently, new lines of work were developed in response to China's evolving needs and changing priorities. Programs in environment and development and in reproductive health were added in 1989-90 because of the need to address the chronic poverty affecting remote, under-developed areas, and to promote an integrated approach to

persistent RH problems. The latest development in 2001 involved the introduction of a program on education and culture.

Women's Activism: An office-wide initiative aims to provide institutional and project support for the ACWF and other groups at the forefront of social activism on women's issues. These organizations provide important institutional homes for work on a range of women's and gender issues, and engage in activities designed to provide practical support particularly to disadvantaged women, and to enhance women's access to services, information and to economic and political opportunities. They also work to strengthen awareness of women's rights and play an advocacy role on their behalf.

Women's and gender studies: Work within the Education portfolio focuses on support for the development of an academic field of women's and gender studies. By providing a theoretical basis for work on gender issues, grounded in research and analysis, this component of Ford Foundation support strengthens the ability to integrate gender issues across all our grantmaking activities.

Sexuality and Reproductive Health Program: Ford Foundation's Sexuality and Reproductive Health program responds to the highly diverse social, cultural, political, legal, economic and epidemiological conditions in China, and is focused on the links between socio-economic and political realities and health outcomes. The aim is to help low-income communities and individuals build the human and social assets they need to understand, articulate, and address their sexual and reproductive health needs.

Contact Information:

Ford Foundation-China
International Club Office Building
Suite 501, Jianguomenwai Avenue No. 21
Beijing 100020 PRC
Tel: (86-10) 6532-6668
Fax: (86-10) 6532-5495
Email: ford-beijing@fordfound.org

9) National Center for Women and Children's Health

Organizational Overview: The National Center for Women's and Children's Health (China WCH) of the Chinese Center for Disease Control and Prevention (China CDC) is a State-level professional organization for women and children's health under the aegis of the China CDC. It is the national center for the technical direction of women and children's health care including maternal and child health (WCH/MCH). The mission is: 'to provide scientific data and policy proposals to Chinese government drafting laws, regulations and policies on WCH/MCH; to set technical standards; and to provide guidance for the development of technical services in China's national women and children health care.' Through technical and policy research and with the aim of raising the overall standard of women and children health, WCH carries out related work under

the professional supervision of the Ministry of Health's Division of Primary Health Care and Maternal and Child Health.

Contact Information:

National Center for Women and Children's Health
Chinese Center for Disease Control and Prevention
Tower A, #13 Dong Tu Cheng Road, Chaoyang Qu
Beijing 100013 PRC
Tel: Center Director General (Zhang Tong): (8610) 64298766
Deputy Director General (Wang Linhong): (86-10) 64298136
General office: (86-10) 64295495
Women's Health Care Department: (86-10) 64298634
Children's Health Care Department: (86-10) 64295561
Website: www.chinawch.org.cn

India

1) Community Health Cell (CHC)

Organizational Overview: CHC is a research and training organization based in Bangalore, India whose mission is to raise awareness and promote action on issues of community health. Founded in 1990, CHC has focused on the following:

- Women's health and empowerment through training in rural areas of Karnataka state
- Prevention of water borne diseases
- Anti-tobacco and anti-alcoholism campaigns
- Participation in the national and international campaign on right to health care

Underlying all of its programs is a strong focus away from the individual and towards the role of the community. Hence, the women's health empowerment programs take into consideration their standing in the local communities and the role of their families in promoting better health practices. To this end, male relatives and local officials also participate in the trainings. CHC has also advised companies in Bangalore on health strategies for women workers and is active in several campaigns on health issues.

Products and Services:

- Information and advisory services (Library and Documentation Center at the CHC office)
- Training
- Research and Evaluation

Contact Information:

Dr. Ravi Narayan
Executive Director
No. 359 "Srinivasa Nilaya", Jakkasandra I Main
Koramangala I Block

Bangalore 560034
India
Tel: (91-80) 2553-1518
Fax: (91-80) 2552-5372
Email: chc@sochara.org
Website: www.sochara.org

2) Suraksha

Organizational Overview: Suraksha (“Protection”) is a community-based organization that provides health services in low income areas of Bangalore.

Products and Services: The services that Suraksha provides include:

- Four “Well Woman Clinics” located in the poor slum areas of the city: Serves women of all ages from adolescence to menopause and aims to create awareness about reproductive health, STDs and HIV/AIDS.
- Also provides referral services to needy patients with the linkages that the organization has built with several institutions and hospitals in the city.
- Counseling: Counseling for adolescent girls on sexuality, puberty and related issues for HIV positive individuals and their families; for couples on sexual behavior, fertility/infertility, diseases and family planning; and for sex workers on health, high risk of STDs, HIV/AIDS and condom usage.
- Training: For health workers in the field on how to raise awareness and leadership development.
- Pharmacy: Basic medicines are provided to the community at nominal charges.
- Group meetings: Community level meetings led by staff of Suraksha on issues related to reproductive health, nutrition, STDs, HIV/AIDS, other communicable diseases and community and personal hygiene practices.
- Products include flip charts, posters and brochures. Relevant audio-visual material produced by other institutions and government agencies are also used in the provision of services.

Contact Information:

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Director, Suraksha
#77, Grihalakshmi Layout
2nd Stage, Kamalanagar
Bangalore 560 079
India
Tel: (91-80) 322-3669
Email: suraksha_harini@yahoo.com

3) Sanjivini Trust

Organizational Overview: Sanjivini Trust is a Bangalore based organization that works with urban disadvantaged communities and schools to provide education on health and hygiene.

Products and Services: The services that Sanjivini Trust provide include:

- **School Health Education (SHE):** Counseling and awareness raising on basic health and hygiene, sex education and gender concerns in schools in low income areas (often run by the Bangalore municipality and also known as “corporation schools.”) These services are also offered to other NGOs when required.
- **Health Animators’ Learning and Education (HALE):** Training for service providers (“Health Animators”) on primary health care, with particular emphasis on mother and child health. Training also includes skills in approaching disadvantaged communities and community organization.
- **Child Health and Nutrition (CHAN):** Includes childhood health awareness education to mothers, preparation of nutrient supplements and distribution of supplements in two disadvantaged communities for children under age five.
- **Lobbying and advocacy:** Lobbying government and businesses on women and child health issues including clinical health facilities for women, child rights and public awareness about the rights of the disabled.
- **Products** include flip charts, posters, brochures, puppets, street theater scripts and role-play scripts. Also provided are guidelines for health education programs and education materials tailor made for specific programs. In collaboration with the Belaku Trust, Sanjivini has produced two films on breast-feeding and complementary feeding. They have developed a health manual for facilitators of training programs. Materials are available in English as well as three regional languages.

Contact Information:

Sanjivini Trust
No.57, Langford Road
Richmond Town
Bangalore 560025
India
Tel: (91-80) 2221-2530
Email: vzach@bgl.vsnl.net.in
Contact person: Dr.Veda Zachariah

4) Guild of Women Achievers (GOWA)

Organizational Overview: The Guild of Women Achievers provides counseling and stress management skills to college girl students, women in disadvantaged communities and in a rural area near Bangalore.

Products and Services: Services provided by GOWA include counseling, a mobile clinic, stress management and team building orientation programs, confidence building contests and recognition of women achievers. GOWA also assists organizations in sexual harassment policies in workplace and conducts awareness programs for employees.

Products include guidelines on confidence building for women and self-help books on marriage and starting an enterprise.

Contact Information:

Guild of Women Achievers (GOWA)
8/67 Block I Railway Parallel Road
Kumara Park West
Bangalore 560 020
India
Tel: (91-80) 346-9629
Email: guildachievers@yahoo.com
Website: www.womenachievers.com
Contact person: Ms. Chaya Srivatsa

5) City Clinic and Specialists Center

Organizational Overview: Dr. Shirdi Prasad is a practicing pediatrician who provides individual counseling services and stress management workshops along with a team of six trained counselors.

Products and Services: Dr. Prasad provides individual counseling for children and parents and also conducts training programs on stress management, group dynamics, emotional maturity and leadership development. He has also developed training materials on work life balance in a factory setting.

Contact Information:

Dr. Shirdi Prasad
City Clinic and Specialists Centre
8th Main, 2nd block, Jayanagar
Bangalore 560011
India
Tel: (91-80) 2656-1225

6) Bangalore Medical Services Trust (BMST)

Organizational Overview: BMST manages blood donation campaigns and also provides training and awareness on HIV/AIDS in schools, colleges, truck drivers and industrial workers.

Products and Services: BMST provides the following services:

- Training programs on AIDS awareness, training in testing and counseling AIDS affected patients.
- Training programs in schools and colleges, for truck drivers and for industrial workers on the Bangalore-Hosur Road.
- Volunteer blood donations.
- Products include posters; training modules for counseling, AIDS awareness and sexuality; a

- reference manual for trainers on reproductive health, child abuse, substance abuse, STDs and HIV/AIDS.

Contact Information:

Bangalore Medical Services Trust (BMST)
New Tippasandra Main Road, HAL III stage
Bangalore 560075
India
Tel: (91-80) 2529-3486

7) Mythri Sarva Seva Samithi (MSSS)

Organizational Overview: Mythri Sarva Seva Samithi ("Women's Service Organization") is a community based organization that provides health education and awareness to residents of nine urban disadvantaged areas in Bangalore through field offices and health workers.

Products and Services: Services provided by MSSS include:

- Health education and awareness for residents of disadvantaged communities
- Training for field workers of other NGOs
- Consultancy services to other NGOs and government agencies
- Health and nutrition program for children in disadvantaged communities
- Solid waste management systems for companies, residential associations and urban poor settlements
- Products include posters on health, flip charts and modules on health awareness and eco-friendly
- practices.

Contact Information:

Mythri Sarva Seva Samithi (MSSS)
1300 D 1st cross, 1st Main, HAL III Stage
New Tippasandra,
Bangalore 560075
India
Tel: (91-80) 2527-3941
Fax: (91-80) 2525-5543
Email: msss@vsnl.com

8) St. John's Medical College, Department of Community Health

Organizational Overview: St. John's Medical College is a teaching and community hospital in Bangalore. The Department of Community Health provides outreach programs, health education, research, and training.

Products and Services: The Department of Community Health has conducted occupational health and sickness and absenteeism studies for apparel industries and tea

plantation workers. It has also collaborated with Gokaldas Images, a large apparel manufacturing firm in Bangalore in the establishment of their health system, including curative, preventive and promotional aspects and comprising an annual health check-up, medical officers and training for workers among others.

Contact Information:

Dr. Bobby Joseph and Dr. Arvind Kasturi
Department of Community Health
St. John's Medical College
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Bangalore 560034
India
Tel: (91-80) 2206-5000
Fax: (91-80) 2553-0700

9) Snehadan

Organizational Overview: Snehadan acts as a positive force in addressing the comprehensive needs of the HIV/AIDS patients, by providing testing and counseling. It also provides healthcare to the terminally sick with an emphasis on palliative care. Medical service providers in one of the factories surveyed in Bangalore said that they had taken workers suspected of having HIV/AIDS to Snehadan for pre-test counseling, testing and post-test counseling.

Contact Information:

Fr Johnson Vellachira and Fr Dr. Mathew
Snehadan
St. Camillus Home of Charity, Carmelaram P.O.
Sarjapur Road
Bangalore - 560 035
Tel: (91-80) 2843-9516, 2891-3425

10) Freedom Foundation

Organizational Overview: The Freedom Foundation operates three HIV/AIDS Support and Care facilities in India, in Bangalore, Hyderabad and Bellary (Karnataka State).

Products and Services:

The Bangalore HIV/AIDS Support and Care facility is a 50-bed residential facility with Day Care Centre and Short/Long Stay Home with rehabilitation, counseling and hospice care for HIV positive persons. Food, shelter and medicines are also provided. The facility has also been named as the Ideal low-cost community-based home by the National AIDS Control Organization (NACO). The Freedom Foundation also received the first Commonwealth Award for Comprehensive Care in HIV/AIDS. The Freedom Foundation also conducts HIV/AIDS awareness raising sessions for companies and communities.

Medical service providers in one of the factories surveyed in Bangalore said that they had taken workers suspected of having HIV/AIDS to Snehadan for pre-test counseling, testing and post-test counseling.

Contact Information:

HIV/AIDS Support and Care Center
Freedom Foundation
30, Survey No.17/2
Hennur Village
Bangalore 560043
India
Tel: (91-80) 2544-0135, 2544-3101
Email: freedom@bgl.vsnl.net.in
Website: www.thefreedomfoundation.org
Contact Person: Ashok K Rau
Tel: (91-80) 2526-2924
Email: ashokrau@hotmail.com

11) Nalamdana

Organizational Overview: Nalamdana is a Chennai-based community theater group that uses street theater to raise awareness on health issues. At the end of each one-hour show it conducts discussions to ensure that the message has been understood. An evaluation survey conducted after the show enables the staff to answer queries. Testing cards are distributed on demand, with information on local, authorized health centers. Most of Nalamdana's programs have been on HIV/AIDS, including high-risk sexual behavior, treatment for curable STDs (Sexually Transmitted Diseases) and the use of condoms. Other issues addressed are immunization, general hygiene, cancer screening, alcoholism, drug abuse, women's empowerment, occupational safety, female infanticide and suicide prevention. Nalamdana also creates communication material on the above topics for distribution. One of the factories surveyed in Chennai had invited Nalamdana to conduct awareness raising sessions on World AIDS Day (December 1st).

Contact Information:

Nalamdana
No. 20, LIC Colony
Dr. Radhakrishna Nagar
Chennai 600041
India
Tel: (91-44) 249- 6347
Fax: (91-44) 2235- 2375
Email: nalam@vsnl.com

12) The Rural Women's Social Education Centre (RUWSEC)

Organizational Overview: RUWSEC is a community-based organization close to Chennai that promotes reproductive health through education and behavioral change.

Products and Services: Services provided by RUWSEC include the following:

- Gender training for prevention of violence against women
- Community awareness programs on health
- Community based reproductive health program for women, men and youth
- Health related research
- Life skills training for women factory workers in the urban areas around Chennai
- Products include training materials in English and Tamil on reproductive health.

Contact Information:

Rural Women's Social Education Centre (RUWSEC)
Nehru Nagar, Thiruporur Junction Road, Vallam Post
Chengalpattu
Tamil Nadu 603002
India
Tel.: (91-411) 242-6188
Dr. T.K. Sundari Ravindran

13) Madras Institute of Development Studies

Organizational Overview: The Madras Institute of Development Studies is a government research organization that conducts research on development economics. At the Institute, Dr. Padma Swaminathan has focused her work on occupational health issues and conditions of work. Her work has included a study of working conditions in the knitwear production center of Tiruppur, working conditions for women in Chennai and health outcomes for women workers. She is a source of expertise on women's health and working conditions in manufacturing.

Contact Information:

Dr. Padmini Swaminathan
Professor, Madras Institute of Development Studies
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Chennai 600020
India
Tel: (91-44) 2441-2589, 2441-1574, 2441-2295, 2441-9771
Fax: (91- 44) 2491-0872
Email: padminis@mids.ac.in
Website: www.mids.ac.in

14) Swaasthya

Organizational Overview: Swaasthya is a non-governmental organization founded in 1995 that has developed and operationalized a reproductive health model in a low-income area in Delhi, Tigri (also see main report of study for further information).

Products and Services: Services that Swaasthya provides include:

- Information and education on all aspects of reproductive and related health through special programs for women, men and adolescents including workshops, peer education and school outreach.
- Basic health care services through a clinic including curative (general and child health, management of STDs and reproductive tract infections) and preventive services (ante and post natal care, immunization of children and pregnant women and counseling).
- Community based depots that are managed by local women and men who provide contraceptives and menstrual hygiene materials for sale at their homes.
- Individual follow-up and counseling to women at homes through Swaasthya volunteers and staff.
- Community leadership development through women's self-help groups and councils ("panchayats").
- Products include posters, flip charts, and training materials in English and Hindi on reproductive health.

Contact Information:

Dr. Geeta Sodhi
Director, Swaasthya
G-1323 Chittaranjan Park
New Delhi 110019
India
Tel: (91-11) 2627-0153
Fax: (91-11) 2627-4690
Email: gsodhi@vsnl.com

15) Prerana

Organizational Overview: Prerana is a community-based organization in Delhi that has developed reproductive health and life skills programs for women and adolescents in rural areas close to Delhi. Prerana is an associate of the Washington, DC based Center for Development and Population Activities (CEDPA).

Products and Services: Services that Prerana provides include:

- Reproductive health and family planning information and screening services through a mobile health van and volunteer depot holders who provide contraceptives within the community.
- AIDS awareness programs in schools aimed at sensitizing principals, parents and teachers to the dangers of the spread of AIDS.
- Basic clinical services through onsite clinics in the six villages where Prerana operates.
- Train-the-trainer programs to educate women's self-help groups in the community

- Products include manuals on community mobilization and service delivery, training materials for community health workers, and videos and other materials required for conducting training and workshops on reproductive health and other health issues.

Contact Information:

Ms Vinita Nathani, Executive Director
Prerana
J-332, Sarita Vihar (DDA SFS Flats)
New Delhi 110044
India
Tel: (91-11) 2694-1902, 2694-8876 6941902
Fax: (91-11) 2694-1902
Email: info@prerana.org
Website: www.prerana.org

16) Naz Foundation (India) Trust

Organizational Overview: The Naz Foundation (India) Trust is a Delhi-based national organization that conducts training and awareness programs on HIV/AIDS and also provides care, support and therapy to HIV positive individuals.

Products and Services: Services provided by the Naz Foundation include:

- Training sessions in schools, colleges and companies to raise awareness on HIV/AIDS and also discuss sexuality and reproductive health issues. This includes the Women's Sexual Health Program that is focused specifically on women and allows for the discussion of issues that may not be normally discussed openly.
- Training is also provided for community development organizations and other groups on raising awareness on HIV/AIDS, testing, counseling and care.
- A gay and lesbian support telephone help-line provides counseling and advice on sexual identity and HIV/AIDS.
- Testing and care are provided through a free HIV clinic and collaboration with city hospitals.
- The Trust also maintains a 16-bed Care Home for people living with HIV/AIDS with both inpatient and outpatient facilities.
- Products include training manuals and materials.

Contact Information:

Ms. Anjali Gopalan, Director of Programs
Naz Foundation (India) Trust
D - 45 Gulmohar Park,
New Delhi 110049
India
Tel: (91-11) 2656-7049
Fax: (91-11) 2685-9113

Email: nazindia@bol.net.in

17) Community Aid and Sponsorship Program - CASP/Plan Delhi

Organizational Overview: CASP-Plan Delhi works with children, adolescents and women in low income areas of Delhi in the areas of early childhood care and development, reproductive health, women's empowerment, child rights and advocacy and education. The services and products it provides include:

- Weekly clinic in low income area of Delhi with mobile van and medical service providers from Population Foundation of India that provides diagnostic, treatment and counseling services.
- Awareness generation programs for women on pre and post-natal care, proper nutrition, safe motherhood, immunization and family planning.
- Self-Help Groups for women in low income areas to enable them to learn skills and be economically independent.
- Training for the entire community in HIV/AIDS and sexually transmitted infections (STIs).
- Non-formal education for school drop-outs and encouraging mainstreaming into formal education system.
- Child rights advocacy and Bal Panchayat or Children's Council that is managed by children.
- Products include training materials and services.

Contact Information:

CASP/Plan
66 Tughlakabad Institutional Area
(Near Batra Hospital)
MB Road
New Delhi 110062
Tel: (91-11) 2605-7488, 2605-5889
Fax: (91-11) 2605-8489
Email: cpdelhi.pu@plan-international.org
Website: www.balpanchayat.org

18) Parivar Seva Sanstha

Organizational Overview: Pariva Seva Sanstha provides clinical services and education in the area of family planning and reproductive health through its Parivar Seva/Marie Stopes Clinics. Services provided include:

- Medical termination of pregnancy
- Provision of different types of contraceptives
- Sterilization for male and female
- Patients
- Screening, diagnosis and treatment of Reproductive Tract Infections and Sexually Transmitted Infections, including HIV/AIDS
- Ante-natal and post natal check-up and other gynecological treatment
- Immunization

- Pregnancy test, pap smear test and other laboratory services
- Breast examination
- Infertility care
- Urological and minor surgical problem procedures
- Condom promotion and distribution
- Education programs are targeted at adolescents and youth, high risk groups and companies. Training is also provided service providers and peer educators. One of the companies surveyed in this study used Parivar Seva Sansthan to provide training to its workers on reproductive health.

19) International Labour Organization (ILO), New Delhi Office

Organizational Overview: The ILO is a United Nations affiliated agency that promotes social justice through the establishment of labor rights standards (see list of Global Resources for more information). The New Delhi office of the ILO has a program on HIV/AIDS which includes dissemination of training materials and technical assistance in conducting trainings. The ILO is currently working with several companies in India in developing and implementing internal AIDS awareness programs. The ILO can either directly provide assistance in training activities or suggest NGOs and State AIDS Control Societies in different parts of India that can provide training on HIV/AIDS.

Contact Information:

International Labour Organization
 Sub-Regional Office for South Asia (SRO), New Delhi
 India Habitat Center
 Core 4B, 3rd Floor, Lodi Road
 New Delhi 110003
 India
 Tel: (91-11) 2460-2101-03 Ext. 241
 Fax: (91-11) 2460-1111
 Website: www.ilo.org/hivaidsindia
 Contact Person:
 S. Mohd. Afsar
 Technical Specialist (HIV/AIDS), South Asia and National Program Coordinator
 (HIV/AIDS and the World of Work)

Indonesia

1) Yayasan Kusuma Buana (YKB)

Organizational Overview: YKB is a Jakarta based organization that promotes community action in the areas of reproductive health and family planning, sexually transmitted diseases and AIDS prevention, nutrition, hygiene and sanitation, and narcotics and drug abuse. It has also successfully worked with companies in the electronics, textiles, apparel, ceramics, food and coal mining sectors all over Indonesia.

(See Study Report for further information on YKB and its partnership with PT Dewhirst, one of the companies surveyed in the study).

Products and Services: Services provided by YKB include:

- Health education and information
- Counseling services
- Training (for workers and peer educators)
- Executive brief for top management
- Outreach activities to the surrounding community of the factory
- Health examination and checkups: anemia, worm infection, and blood, urine, x-ray tests
- Health intervention for anemia and intestinal parasite control activities
- Management and provision of health services

Contact Information:

Yayasan Kusuma Buana (YKB)

Jl. Asem Baris Raya A3

Gudang Peluru, Tebet

Jakarta Selatan 12830

Indonesia

Tel: (62-21) 829-6337, 831-2467

Fax: (62-21) 831-4764

Email: ykb-jkt@idola.net.id

Website: www.kusumabuana.or.id

Contact persons:

Dr. Firman Lubis, Executive Director

Email: flubis@rad.net.id

Dr. Adi Sasongko, Director for Health Care

Email: adi.sasongko@gmail.com

2) Perdhaki (Association of Voluntary Health Services of Indonesia)

Organizational Overview: Perdhaki or the Association of Voluntary Health Services aims to improve quality medical care to society through services and coordination among all members. Its priority programs are in the area of primary health care and health unit management. Its staff of 50 includes medical doctors, public health and health management

specialists and senior nurses and midwives. Perdhaki and Atmajaya University have worked in collaboration to deliver health education for women in urban disadvantaged communities in North Jakarta starting in 1996. Perdhaki also provided health education services in factories when the Global Alliance programs were being implemented.

Products and Services: Services provided by Perdhaki include:

- Training on health education and clinic management for health care providers and NGO staff

- Training and technical assistance for peer educators in factories
- Health information and services for broader workers' audiences
- Products include training materials, posters and brochures.

Contact Information:

Perdhaki
 Dr. Felix Gunawan, Executive Director
 Jl. Kramat VI No 7
 Jakarta Pusat, Jakarta
 Indonesia
 Tel: (62-21) 314-0455
 Email: perdhaki@cbn.net.id

3) PKBI (IPPA: Indonesian Planned Parenthood Association)

Organizational Overview: PKBI is an umbrella organization which has programs of family planning and reproductive health counseling. This organization is a member of IPPF (International Planned Parenthood Federation) and has chapters in 26 provinces. IPPA carries out the following activities in the field of reproductive health:

- Empowerment of pre-adolescent and young people with regards to sexual and reproductive health.
- Empowerment of women and their partners on reproductive health and gender equality.
- Promotion of quality reproductive health services.
- Improvement of health and quality of infant and children care under five.
- Promotion of well being of the elderly.
- Organizational enhancement through resources and capacity building.
- Training and technical assistance for peer educators in factories
- Health information and services for broader workers audiences

PKBI was also engaged in providing health education in factories through the Global Alliance.

Contact Information:

Chairman: Prof. Dr. Prijono Tjiptoherijanto
 Indonesian Planned Parenthood Association
 Jl. Hang Jebat III/F3 Kebayoran Baru
 Jakarta Selatan 12120
 Indonesia
 Tel: (62-21) 720-7372, 739-4123, 720-6413, 720-5804
 Fax: (62-21) 739-4088
 Email: ippa@pkbi.or.id
 Website: www.pkbi.or.id

4) PKBI (Indonesia Planned Parenthood Association) West Java

Organizational Overview: IPPA West Java is one of 25 chapters of Indonesian Planned Parenthood Association, headquartered in Jakarta. Since its inception in 1960, IPPA West Java Chapter has been actively involved in the efforts to create responsible families in Indonesia through its main programs:

- Development of a network of services for family planning and reproductive health
- Information Program on HIV/AIDS
- Program for pre-school children

IPPA West Java has six permanent staff assisted by 26 voluntary experts and 276 volunteers across 18 regions in West Java.

Contact Information:

PKBI (Indonesia Planned Parenthood Association) West Java
Jl. Soekarno Hatta No. 496
Bandung 40266
Indonesia
Tel/Fax : (62-22) 756-7997, 751-4332
Email : pkbijb@inosat.net.id
Website: www.pkbi.or.id

5) International SOS (ISOS)

Organizational Overview: ISOS provides emergency medical services through a network of clinics in Indonesia. In addition, it also carries out site surveys to assess medical risk and recovery and base line public health surveys for corporations. For example, it has carried out a survey of footwear factories in Indonesia to assess their capacity to carry out health surveillance, awareness and prevention and to suggest measures for improvements. ISOS was assisted in this effort by the Indonesian Association of Occupational Health and Safety (Asosiasi Hiperkes dan Keselamatan Kerja Indonesia), a professional association of health and safety experts.

Products and Services: Services provided by ISOS include:

- Security advice and evacuation.
- Public and occupational health surveys.
- Remote site medical staffing and management.
- Clinic membership
- Corporate healthcare management
- Insurance hotline services
- Auto assistance services
- Training on specific health issues.

Contact Information:

International SOS
PT. Asih Eka Abadi
Jl. Puri Sakti No. 10, Cipete

Jakarta Selatan 12410
Indonesia
Tel: (62-21) 750-5973
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Contact persons: Dr. Andrew Jeremijenko, Medical Technical Advisor
Email: aeajkt01@internationalsos.com
Francois Keyser, Technical Advisor
Email: fancois.keyser@internationalsos.com
Indonesian Association of Occupational Health and Safety
(Asosiasi Hiperkes dan Keselamatan Kerja Indonesia)
Gedung Pusat Hiperkes
Jl. A. Yani No. 69-70
Jakarta 10510
Indonesia
Tel/Fax: (62-21) 428-7988
Contact person: Dr. Tan Malaka
Email: tan.malaka@internationalsos.com
Website: www.internationalsos.com

Mexico

1) Grupo Factor X, The X Factor

Organizational Overview: Grupo Factor X is a Tijuana women's group which helps factory workers organize for better working conditions and human rights. The maquiladora labor force, primarily made up of young women aged 16-25, has basic needs that are not being addressed either by employers or by government programs. At its women's center, the Casa de la Mujer, located in a working-class neighborhood, Grupo Factor X offers a variety of programs including: support groups for battered women; workshops on how to deal with sexual harassment in the workplace; classes on reproductive, sexual and workplace health; a medical clinic; a legal clinic; assistance in investigating human rights violations in the maquiladoras; and workshops on labor organizing. Workshop participants who choose to go through an entire training program become promotoras, activists who take their new knowledge back to their communities. Through the work of Grupo Factor X, a community of active, empowered workers is emerging.

Contact information: <http://www.maquilopolis.com/collaborators.html>

2) Centro de Estudios y Taller Laboral (CETLAC)

Labor Workshop and Studies Center

Organizational Overview: The first Labor Workshop and Studies Center was established as a center for workers in the maquila plants in Ciudad Juárez, an important maquila zone in Mexico where some 230,000 workers are employed in approximately

400 plants. Because of its importance in reaching maquila workers, two additional centers were established: in Ciudad Chihuahua and Monterrey.

CETLAC's mission is to educate workers about their rights, provide legal assistance designed to promote the development of workers' organizations, and to consistently put forward a different vision of how unions should and can operate in order to lay the groundwork for, and provide technical assistance in unionization.

Contact Information:

Beatriz Luján
Centro de Estudios y Taller Laboral (CETLAC)
Avenida Vicente Guerrero No. 5038
Cd Juárez, Chih.
México
Tel: (52-16) 16-20-73
Fax: (52-16) 16-20-73

3) Centro de Investigación Laboral y Asesoría Sindical A.C. (CILAS)

Organizational Overview: CILAS is made up of a group of researchers who are specialists in diverse subjects related to the world of work and the economy. Members include lawyers, economists, sociologists, administrators, doctors, and unionists who are fully experienced in labor relations and the negotiation processes with companies and institutions. CILAS was founded to contribute to organizing and to carrying out professional analysis, research, specific studies by economic branch, sector or business. It works to actively assess and develop unions. The work is directed by and has been requested by the unions themselves in order to strengthen the participation of the membership of the unions.

Contact Information:

Centro de Investigación Laboral y asesoría Sindical, A.C.
Tabasco 262-402, casi esquina con Insurgentes,
Col. Roma Sur
Delegación Cuauhtémoc
México, D.F.
C.P. 06700
México
Tel: 5207 4147, 5514 7675
Fax: 5207 4147
Email: cilas@laneta.apc.org

4) Centro de Reflexión y Acción Laboral (CEREAL) - Guadalajara

Organizational Overview: CEREAL is a project of Fomento Cultural y Educativo A.C. (Cultural and Educational Promotion A.C.), part of the apostolic works of the Mexican Province of the Company of Jesus, which for the last 35 years has been devoted to educating and organizing Mexican popular sectors. CEREAL provides legal assistance, labor rights training and organizational support for workers' groups; it also carries out

research on working conditions in different productive sectors in the country and promotes public awareness campaigns with regard to workers' situation.

Contact Information:

Contrera Medellin 245
Col. Centro
Guadalajara, Jalisco
C.P. 44200
México
Tel: (0133) 36148095
Email: cereal@iteso.mx
Website: <http://www.sjsocial.org/fomento/>

5) Comité Fronterizo de Obreras (CFO)

Organizational Overview: The main purpose of the CFO is to educate, organize and empower maquiladora workers to improve working conditions and the quality of life for workers in the maquiladoras, especially for women and their families. As a worker-controlled organization that educates, organizes and empowers other maquiladora workers along the Mexican border with the United States, the CFO organizes for the defense of basic human and workers' rights, union democracy, and the protection of the health, life and welfare.

Contact Information:

Ocampo 509-B altos
Piedras Negras, Coahuila
C.P. 26000
México
Website: <http://cfomaquiladoras.org/>

6) ELIGE

Organizational Overview: ELIGE is a youth-led organization in Mexico City that focuses on sexual and reproductive rights. Created in 1996, ELIGE works with young people to promote and defend their sexual and reproductive rights within a human rights framework, and guarantee that they are able to exercise the full range of those rights. ELIGE works closely with MADRE, an international women's human rights organization. In 2001, ELIGE began a campaign to address the crisis of the unsolved murders of over 300 women factory workers in Juarez and Chihuahua, Mexico. In Spring 2005, MADRE is continuing this work by helping to bring two young women from ELIGE to New York City to participate in the Beijing+10 Conference.

Contact information: <http://www.madre.org/sister/Mexico.html>

**7) Federación Mexicana de Asociaciones Privadas de Salud (FEMAP)
(Mexican Federation of Private Health Associations)**

Organizational Overview: FEMAP is an umbrella organization for 44 affiliate organizations throughout Mexico. FEMAP's community health services are at the center of FEMAP's mission. Volunteer health promoters (promotoras) learn to use health information to improve their own family's well-being and empower other women to make similar changes. The promotoras' information, education, and communication services include:

- Breastfeeding counseling to mothers
- Cooking and nutrition classes to improve eating habits
- Adolescent education on reproductive health
- HIV/AIDS prevention, STD prevention, and drug prevention
- Family planning and social marketing of contraceptives

In order to complement its health services, FEMAP added an array of services, such as micro-financing for small enterprises. FEMAP also embraced social entrepreneurship, trying to find innovative ways to produce value for society and, at the same time, generate income. FEMAP has established laboratories, imaging services, factory programs, and pharmacies, all of which can generate revenue to subsidize less profitable community programs.

Contact information: <http://www.femap.org.mx/>

8) Instituto Jalisciense de las Mujeres

Organizational Overview: The Instituto Jalisciense de las Mujeres is a quasi-governmental body created in 2001 by the governor of the state of Jalisco. It was created to promote, to elaborate and to execute the public policies of the state in favor of women. In service of this mission, the Institute conducts research, events and communications campaigns. It also pursues programs that improve women's access to preventative and curative healthcare.

Contact information:

Miguel Blanco No. 883 Primer Piso.
Guadalajara, Jalisco
CP: 44100
México
Tel: (0133) 36583170
Website: <http://www.institutodelasmujeres.com/>

9) Latin American and Caribbean Committee for the Defense of Women's Rights

Organizational Overview: CLADEM, The Latin American and Caribbean Committee for the Defense of Women's Rights, is network of organizations and women throughout Latin America and the Caribbean that are committed to defending women's rights throughout the region. CLADEM's activities include formulating legislative proposals, researching, training, litigating, teaching at universities, informing, communicating and exercising solidarity actions.

Contact Information:

Andrea Medina Rosas or Elizabeth Placido Rios (Co- coordinators for CLADEM Mexico)
Enlace DF : Juarez 29, Tlacopac. Delegación Alvaro Obregón
Ciudad de México
C.P. 01040
México
Telefax: (52-55) 56 61 04 22
Cellphone: (52-55) 26 97 70 38
Email: placidoeli@yahoo.com / andreagdl@infosel.net.mx
Website: <http://www.cladem.org/english/institutional/strategic.asp>

10) Maquiladora Health and Safety Support Network

Organizational Overview: The Maquiladora Health & Safety Support Network is a volunteer network of 400 occupational health and safety professionals who have placed their names on a resource list to provide information, technical assistance and onsite instruction regarding workplace hazards in the 3,000 “maquiladora” (foreign-owned assembly) plants along the U.S.-Mexico border. Network members, including industrial hygienists, toxicologists, epidemiologists, occupational physicians and nurses, and health educators among others, are donating their time and expertise to create safer and healthier working conditions for the one million maquiladora workers employed by primarily U.S.-owned transnational corporations along Mexico's northern border from Matamoros to Tijuana.

Contact Information:

P.O. Box 124
Berkeley, CA 94701-0124
USA
Tel: 510-558-1014
Fax: 510-525-8951
Website: <http://mhssn.igc.org>

11) Mujeres Trabajadoras Unidas, A.C. (MUTUAC)

Organizational Overview: MUTUAC offers legal aid and psychological counseling to working women. The organization investigates, compiles, and disseminates information relevant to the rights of women workers. MUTUAC also offers courses on nontraditional jobs for women in coordination with the Mexican government (e.g. Office of the Secretary of Labor). Scholarships are provided where need is demonstrated. The workshops focus on a variety of issues, including sexual health, domestic violence and developing leadership skills to help women have a greater voice within unions. While union members attend the workshops with no loss of pay, non-union maquila workers attend during the weekends and Mutuac pays for any lost wages.

Contact Information:

President: Maria Elisa Villaescusa Valencia

Coatepec No. 1, Interior 4, Piso 2
Col. Rama, C. P. 067600
Deleg. Cuacuhtemoc
Mexico, D.F. Mexico
Tel & Fax: 5574-6215, 5264-6951
Email: mas@laneta.apc.org

12) Sociedad Mexicana Por Derechos de La Mujer (Semillas)

Organizational Overview: Semillas is a nonprofit organization that finances women's cooperative projects throughout Mexico. From its beginning in 1990, Semillas has financed 237 projects that have benefited to more than 650.000 Mexicans. Semillas directs its social investments to women's organizations that seek to solve social problems over the long-term. Some projects focus on educating women about their labor rights, including in areas such as Tijuana.

Contact Information:

Tamaulipas No. 66
Col. Condesa
Delegación Cuauhtémoc
C.P. 06140
Mexico
Tel: 5553-2900
Email: buzon@semillas.org.mx
Website: <http://www.semillas.org.mx/index.html>

13) Solidarity Center (AFL-CIO), D.F.

Organizational Overview: The Solidarity Center is a non-profit organization that assists workers around the world who are struggling to build democratic and independent trade unions. It works with unions and community groups worldwide to achieve equitable, sustainable, democratic development and to help men and women everywhere stand up for their rights and improve their living and working standards. The Solidarity Center provides a wide range of education, training, research, legal support, organizing assistance, and other resources to help build strong and effective trade unions and more just and equitable societies. The Center's education programs feature training in basic human and worker rights, union skills, advocacy, occupational safety and health, economic literacy, and civic and voter education.

Contact Information:

Solidarity Center
1925 K Street, N.W., Suite 300
Washington, DC 20006
Tel: 202-778-4500
Email: information@solidaritycenter.org

Philippines

1) Community and Family Services International (CFSI)

Organizational Overview: Community and Family Services International (CFSI) provides the following services in the area of reproductive health and HIV/AIDS.

- Capability building
 - Counseling
 - Workshops and training for communities involved in hospitality and tourism, sex workers, military personnel, health care providers and families
- Community Mobilization
- Networking and advocacy
- Information, Education, Communication (IEC) Materials

Contact Information:

2/F Torres Bldg., 2442 Park Avenue

Pasay City 1300

Philippines

Tel: (63-2) 510-1043, 510-1040

Fax: (63-2) 551-2225

Email: cfsi@mozcom.com

Website: <http://www.cfsi.info.com.ph>

Contact Person: Mr. Steven Muncy, Executive Director

2) Family Planning Organization of the Philippines (FPOP)

Organizational Overview: Family Planning Organization of the Philippines (FPOP) provides the following services in the area of reproductive health and HIV/AIDS:

- Capability building and training for men, women and youth
- Community Mobilization of youth
- Integrated and Community-Based Services for men and women of reproductive age, including family planning services and treatment for reproductive tract infections
- Networking and advocacy
- Sustainability and resource generation

Contact Information:

50 Doña M. Hemady Street

New Manila, Quezon City 1112

Philippines

Tel: (63-2) 721-7101, 722-6466, 721-7302

Fax: (63-2) 721-4067

Email: FPOP@ippf.org or fpop1969@yahoo.com

Contact Person: Atty. Rhodora M. Roy-Raterta, Executive Director

3) Health Action Information Network (HAIN)

Organizational Overview: Health Action Information Network (HAIN) provides the following services in the area of reproductive health and HIV/AIDS:

- Capacity building and training for men and women on sexuality and reproductive health
- AIDS Action Asia-Pacific ed., newsletter for health workers
- Training course on research methods for reproductive and sexual health
- Clearinghouse for dissemination of appropriate STD/ HIV/AIDS information through the internet and other means for policymakers, health workers, and other stakeholders
- Training

Contact Information:

26 Sampaguita Avenue
Mayapa Village II
Barangay Holy Spirit
Quezon City 1127
Philippines
Tel: (63-2) 952-6312
Fax: (63-2) 952-6409
Email: hain@info.com.ph
Website: <http://www.hain.org>, www.kalusugan.org

4) Kabalikatng Pamilyang Filipino, Inc. (KABALIKAT)

Organizational Overview: Kabalikat provides the following services in the area of reproductive health and HIV/AIDS:

- Research, development and communication of materials, technical assistance to low-income and semi-literate groups and all levels of health service/product providers
- Capability building, including training on general reproductive health and on HIV/AIDS
- Research community outreach and peer education on HIV/AIDS to registered and freelance sex workers and male customers
- Peer education and counseling
- Networking and advocacy on reproductive health and HIV/AIDS
- Publications include “Teen Ugnayan” and “ARH Research” for youth

Contact Information:

93 Cambridge St.
Cubao, Quezon City 1109
Philippines
Tel: (63-2) 832-1291
Email: kablikat@mozcom.com
Contact Person: Ms. Marilyn Calilung, Executive Director

5) Philippine Business for Social Progress (PBSP)

Organizational Overview: Philippine Business for Social Progress (PBSP) is a private non-profit foundation dedicated to promoting business sector commitment to social development. Organized in 1970 by 50 prominent business leaders, it has since grown to become the largest business-led social development foundation in the Philippines. PBSP provides the following services for companies and NGOs:

- Capability Building and training for companies, NGOs and private groups
- Networking and advocacy with companies and local and international NGOs
- Resource Management
- Manual and curriculum development for companies and caregivers on HIV/AIDS

Contact Information:

Philippine Social Development Centre
Magallanes cor. Real Sts.
Intramuros, Manila 1002
Philippines
Tel: (63-2) 527-7741 to 50
Fax: (63-2) 527-3750, 527-3751
Email: PBSP@PBSP.org.ph
Website: www.pbsp.org.ph
Contact Person: Mr. Gil T. Salazar, Executive Director
Branch Offices: Cebu City & Davao City

6) The Philippine National Red Cross (PNRC)

Organizational Overview: The Philippine National Red Cross (PNRC) which has branches throughout the country has the following services in the area of reproductive health and HIV/AIDS:

- Capability building
 - Counseling – women, youth, children, blood donors
 - Workshops and training for student trainees, professionals/staff, youth, children, Red Cross health volunteers
- Community mobilization – youth and children
- Resource center management – student trainees, professionals/staff
- Voluntary blood donation and services – volunteer donors
- Networking – local organization and agencies international through the Asia Red Cross and Red Crescent AIDS International Task Force
- Publications for student trainees, professionals/staff, youth, children, volunteers
- Advocacy on children and youth issues

Contact Information:

Bonifacio Drive
Port Area, Manila 2803
Philippines
Tel: (63-2) 527-8384 to 90 loc.125 or 155

Fax: (63-2) 527-0858 and 527-6353

Email: elacsina@redcross.org.ph

Contact Person: Mrs. Jelma C. Dela Peña, Director of Operations and Mrs. Evelyn P. Lascina, Community Health and Nursing Service

7) Remedios AIDS Foundation Inc. (RAF)

Organizational Overview: The Remedios AIDS Foundation provides the following services in the area of reproductive health and HIV/AIDS:

- Capacity Building: Hotline project for women, youth and general public, Remedios Hotline 524-0551, Women's AIDS Hotline 524-4427 and face to face counseling for the general public and internet relay chat
- Workshops and Training including post graduate courses for the general public, workplace, students, women, overseas Filipino workers and professionals
- Community Mobilization
 - Mobilization of peer educators among sex workers and in the workplace
 - Peer to peer support groups for youth
- Resource center management
- Anonymous Clinics, Testing and STD Case Management (Remedios Clinic Health Laboratory) for sex workers and the general public
- Anonymous clinic for adolescents
- Networking and advocacy of government agencies, private sectors, legislators, policy makers on the Philippine AIDS Prevention and Control Act of 1998 (Republic Act 8504)
- Information Education and Communication (IEC) Materials and paramedical courses for the general public, women, youth, workplace, sex workers, MSM, paramedical courses
- Shopping mall-based youth centers
- Publications
 - Training manuals and modules on reproductive health
 - Care and support manuals on HIV/AIDS Prevention

Contact Information:

1066 Remedios cor. Singalong Sts.

Malate, Manila 1004

Philippines

Tel: (63-2) 524-0924, 524-4831

Fax: (63-2) 522-3431

Email: reme1066@pldtsl.net

Website: <http://www.remedios.com.ph>

Contact Person: Jose Narciso Melchor C. Sescon, MD, FPOGS, Executive Director

Branch Office: Colonade Mall, Cebu City

Viet Nam

1) IPAS (Viet Nam)

Organizational Overview: Ipas has worked for three decades to increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafe abortion. Ipas's global and country programs include training, research, advocacy, distribution of equipment and supplies for reproductive-health care and information dissemination.

Contact Information:

Room 203, Vn Phuc – Tosero Building, No.2 Nui Truc Street
Ba Dinh District
Hanoi, Viet Nam
Tel: (84-4) 726-0548
Fax: (84-4) 726-0549
Email: ipashanoi@fpt.vn
Website: www.ipas.org

2) Family Health International Viet Nam (FHI)

Organizational Overview: FHI manages health research and field activities in more than 70 countries and works with a variety of government, academic institutions, NGOs, and the private sector. In Viet Nam, FHI uses three main strategies for HIV/AIDS prevention: strengthen the capacity of national and provincial AIDS authorities and local NGOs; develop and expand the coverage of effective behavior change and HIV/AIDS/STI risk-reduction interventions, especially among such vulnerable populations; develop and support the implementation of community-based care and support interventions and materials for people living with HIV/AIDS.

Contact Information:

FHI Viet Nam
30 Ngyuen Du Street, Suite 301
Hanoi, Viet Nam
Tel: (84-4) 943-1828
Email: fhivn@fhi.org.vn
Website: www.fhi.org

3) Center for Education Promotion and Empowerment for Women (CEPEW)

Trains women with management and leadership skills.

Contact Information:

Hanh Thi Vuong, Director,
113 D1 Trung Tu, Ha Noi.
Tel: (84-4) 572-6789
Fax: (84-4) 572-6789
Email: cepew@fmail.vnn.vn

4) World Vision Viet Nam (WVV)

Organizational Overview: WVV partnerships with the Ministry of Health (MOH), the People's Committee (PC), businesses and local communities. World Vision works to improve women's health through a variety of ways including the promotion of water, sanitation and hygiene, sexually transmitted diseases (STDs) and HIV/AIDS prevention and care, and improving access to medical treatment and services. WVV supports activities such as: gynecological examinations and treatment for women; training for mothers, pregnant women and caregivers on reproductive health, nutrition and adequate sanitation practices; nutrition programs; construction and renovation of health centers; provision of medicines and medical equipment.

Contact Information:

4th Floor, HEAC Building
14-16 Ham Long Street, Hanoi, Viet Nam
Tel: (84-4) 943-9920
Fax: (84-4) 943-9921
Website: www.worldvision.org.vn

5) Population Council

Organizational Overview: The Population Council's mission in Viet Nam is to conduct research and trainings on reproductive health and contraceptive choice to provide a greater understanding and awareness of the needs and concerns of Vietnamese women and men. Recent research includes testing new models of HIV prevention among vulnerable populations, including mobile construction workers, young garment workers, disadvantaged youth, and the Khmer ethnic minority. The Population Council assists the Vietnamese government in testing reproductive health interventions and incorporating them into current maternal and child health and family planning policies, programs and research. The current agenda addresses a broad range of reproductive concerns including youth reproductive health, male involvement, reproductive tract infections (RTIs), sexuality, violence, and sexual harassment.

Contact Information:

Population Council (Hoi Dong Dan So)
No 2 Dang Dung Street
Ba Dinh District
Viet Nam
Tel: (84-4) 716-1716
Fax: (84-4) 716-1707
Email: pchanoi@popcouncil.org.vn
Website: www.popcouncil.org

6) Marie Stopes International Viet Nam (MSI Viet Nam)

Organizational Overview: MSI Viet Nam works with the Ministry of Health to provide quality family planning and sexual and reproductive health services in the provinces and the cities of Hanoi and Ho Chi Minh through its network of seven centers and its mobile center teams. Outreach activities include visits to factories, markets, and schools.

Contact Information:

Marie Stopes International Viet Nam
2nd Floor, 1 Nguyen Dinh Chieu Street
Hai Ba Trung District, Hanoi, Viet Nam
Tel: (84-4) 943-9860
Fax: (84-4) 943-9858
Contact person: Ms. Nguyen Thi Bich Hang, Country Representative
Email: hang.bn@mariestopes.org.vn
Website: www.mariestopes.org.vn

7) USAID – President's Emergency Plan for AIDS Relief (PEPFAR)

Organizational Overview: Viet Nam is one of fifteen countries in President Bush's Emergency Plan for AIDS Relief. An interagency team led by the Ambassador provided \$27.6 million in 2005 and will provide \$34 million in FY 2006 to expand integrated prevention, care and treatment programs. In May 2006, PEPFAR launched a campaign to promote voluntary counseling and testing for HIV (VCT).

Contact Information:

American Embassy Hanoi
Lang Ha Street, Hanoi
Viet Nam
Tel: (84-4) 7721500
Fax: (84-4) 7721510