

WORKING MOMS

Behaviors and Barriers to Accessing Maternal
and Child Health Services for Women Working
in Factories in Cambodia



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Abbreviations and terms

Term	Description
ANC	Antenatal care: The care of a pregnant woman and her unborn baby throughout a pregnancy. Such care involves regular visits to a medically qualified health professional such as a doctor or midwife, who performs abdominal examinations, blood and urine tests, and monitoring of blood pressure and fetal growth to detect disease or potential problems and treat them promptly
CDHS	Cambodian Demographic and Health Survey
CG	Caregiver
Continuum of Care	The continuum of care is one of the key program strategies recommended by WHO, to reduce maternal and newborn deaths and improve maternal and neonatal health and wellbeing. It consists of a continuum of health services and counselling for mothers and newborn that begins in early pregnancy and continues up until the end of the post partum period.
FGD	Focus Group Discussion
FW	Factory Worker
GDP	Gross Domestic Product
IDI	In depth interview
ILO	International Labour Organization
KAPB	Knowledge, attitudes, practices, beliefs
MNCH	Maternal, newborn and child health

Neonatal death	A newborn death during the first 4 weeks of life
OPD	Outpatient department
Post partum period	The period from the birth of the baby until six weeks (42 days) after delivery
Skilled Birth Attendant	Outpatient depart A medically qualified provider with midwifery skills (midwife, nurse or doctor) who has been trained and are proficient in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. ment
UNFPA	United Nations Population Fund
VHSG	Village Health Support Group
WHO	World Health Organization

Introduction

In the last two decades Cambodia has made commendable progress in reducing maternal and child mortality. The under-five child mortality rate declined, from 83 deaths per 1,000 live births in 2005 to 54 in 2010 and 35 in 2014. The maternal mortality ratio decreased from 472 per 100,000 live births in 2005 to 206 in 2010 and 170 in the most recent 2014 Demographic and Health Survey (CDHS). In addition there has been a significant increase in uptake of antenatal care, delivery with skilled birth attendant and post partum mother and newborn care. Despite the improvements, the neonatal mortality rate has not enjoyed the same gains: unchanged at 28 deaths per 1,000 live births in 2005 and 2010 reducing to 18 per 1,000 live births in CDHS 2014.

Currently, neonatal deaths account for more than half of all under-five deaths in Cambodia and there are significant health disparities between urban and rural populations (CDHS 2014). Neonatal mortality in rural areas is more than two times the urban rates (at 23 and 10 respectively). Differentials in mortality by province are also substantial.

The study site, Kampong Tralach district, is situated in Kampong Chhnang province, one of the provinces with high neonatal mortality rate in the country (27/1,000) in 2014 (CDHS 2014). At the time of the study design, the province reported just 60% of women having a skilled assistant at their most recent delivery. There was concern that the rise in the number of women working in the garment factories in this province may be contributing to this poor coverage data.

Cambodia has enjoyed a relatively stable political situation for the last two decades with significant economic growth characterised by increased work opportunities in the construction, garment and tourism industries. As of March 2015 there are 640 registered garment and shoe factories operating in Cambodia, employing 607,000 workers by mid-2015 (ILO 2015), majority of whom are women from rural areas. It is estimated that the garment factory sector alone generates 15% of GDP. In 2013, there was a 22% rise in exports from the garment industry totaling US\$5 billion, expanding by over 25% in 2014 (UNFPA 2014).

In contrast to ten years ago, when factories were situated in the suburbs of Phnom Penh, there is an increasing trend to locate factories in rural areas. While this provides opportunities for rural women to access paid work, it also creates challenges for their role as caregivers. The changes extend to older rural women who have become the main caregivers of their grandchildren.

Kampong Chhnang province, where the study site Kampong Tralach district is situated, has an approximate population of 169,286 with 88,027 women and 18,317 children under five years. Kampong Tralach is the site of nine factories with a combined workforce of approximately 25,000 women.

It is estimated that one in three women aged 18-25 are currently employed in the garment factory industry in this district. Women working in the factories come from Kampong Chhnang province and also migrate from surrounding provinces such as Kampong Cham, Kandal, Battambang and Kampot. Most of the women from other provinces rent temporary accommodation in Kampong Chhnang province and return home for short periods during national holidays. Although there are health clinics in the factories, they only provide basic first aid services. Pregnant women or women with reproductive health problems are referred to government health facilities.

Government health staff and community health workers in Kampong Tralach district report that women who work in the factories do not access health services during pregnancy, delivery and the post partum period, often only attending one antenatal visit and then not returning for further care.

The reasons for the low uptake of services is unknown. It is assumed that the women do not want to risk a cut in wages due to taking time off work, or that they lack awareness of the national workplace policies relating to pregnancy and maternity leave. Health care workers in Kampong Tralach reported that even though the health facility remains open on Sundays to accommodate the factory workers work schedule, there is a low uptake of services.

Up until now the situation of pregnant women working in factories in Kampong Chhnang province has not been studied, and minimal research has been conducted about the health seeking behavior of pregnant women working in other factory settings in Cambodia. An ILO study (2011) in eight 'model' factories, six in Phnom Penh and two in the provinces, found that although most of the factories were compliant with the maternity leave policy, there were issues around lack of awareness of factory workers about how benefits were calculated; challenges for taking the one hour breast feeding break; lack of child care facilities and workers' fears of losing their job if they extended leave beyond the 90 days maternity leave. Time for antenatal care visits although not required by the labor law, was allowed in some factories.

This research attempts to understand the health practices and influences for health seeking decisions of pregnant women and women with children from 0- 23 months who work in factories in Kampong Tralach district, by identifying the gaps between current and optimal maternal and newborn care practices and learning about what contributes to these gaps; identify support and barriers for optimal practices (at the level of the individual and family, the community and the health services); and describe the informational, social, cultural or economic barriers to access health services faced by women working in factories in Kampong Tralach district. The findings from the formative research will be used to inform national policies and strategies to increase access to maternal and child health services for women working in factories in Cambodia.

Research aim and objectives

Aim

To contribute to improved maternal and newborn health care for women (and their children) who work in factories in Kampong Tralach district.

Objectives

1. To describe the knowledge, beliefs, practices and health seeking behaviors of pregnant women and women with children 0- 23 months working in factories in Kampong Tralach related to pregnancy, delivery and the post partum period.
2. To identify the key enablers and barriers to access to MNCH services during pregnancy, delivery and the post partum period for women working in factories in Kampong Tralach district.
3. To describe community and household beliefs and practices regarding care for women during pregnancy, delivery and the post partum period and identify support systems and influences on factory women's health seeking behavior and health practices

Methods

Qualitative methods were chosen to explore the factors contributing to low utilisation of health services for women who work in the garment factory industry of Kampong Tralach.

Qualitative methods are best applied when the enquiry focuses on complex phenomena, and they allow rich and detailed exploration of meanings, motives and patterns. Multiple methods (observation, in depth interviews and focus group discussions) were employed to ensure rigour; through cross checking data from different sources. Multiple informant groups were included in the study: pregnant women and women with young children who work in factories, women who work in the factories but who are not pregnant, care givers of young children of mothers who work in the factory, village leaders, health care workers, and factory owners. This approach allowed the inclusion of multiple perspectives.

The study was undertaken as part of a capacity development program for World Vision staff from five countries in South East Asia. Twenty-seven currently working World Vision staff participated in a qualitative training and data collection workshop, held in Kampong Chhnang from July 14-24, 2015. Over two days (18-19th July) 12 teams visited 12 villages to undertake the data collection. Interviews with caregivers, village leaders and health care workers were conducted on the Saturday, and the following day, when factory women have their one day off a week, interviews and focus group discussions with factory working women were held. During the following week two factories employing a total of 5,000 women in the district were visited (Table 1).

Methods

Table 1 Study participants

Description	Number
Pregnant women and women who have a child 0 – 23 months who work in a factory	22 women who work in factories, 10 currently pregnant 12 who have young children aged less than 2 years
Women of reproductive age who work in factory	6 focus group discussions involving 55 women
Village leaders	12
Key caregiver of young child in household with woman working in factory	12 (10 grandmothers and 2 fathers)
Health centre staff – one midwife or health worker from six health centres	6
Factory managers	2
	Total: 109 participants

The study was approved by the National Ethics Committee for Health Research, Cambodia. All participants gave informed consent prior to the interviews and FGDs.

The IDI and FGD guides were developed with reference to the literature review and addressed each of the study objectives. The question guides followed the themes and sub themes outlined in Table 2.

Table 2 Major themes and subthemes

Theme	Subtheme
Factory Working conditions	<ul style="list-style-type: none"> - General conditions (wages, hours of work, overtime, permission for leave, time off,) - Maternity leave provisions - Special provisions during pregnancy - Special provisions for childcare - Positive aspects of work (autonomy, empowerment) - Negative aspects of work (pressure on overtime, personal safety) - Rural versus urban factory work conditions
Health care facilities	<ul style="list-style-type: none"> - Access (distance, cost, opening hours) - Health care centre services - Other providers (private, referral hospitals)
Childcare provisions	<ul style="list-style-type: none"> - Choice of carer - Childcare arrangements (length, where, payment arrangements) - When children are ill and need health care services
Child nutrition	<ul style="list-style-type: none"> - Initiation of breastfeeding and prelacteal feeding - Breastfeeding - Complementary feeding
KAPB Pregnancy, delivery and during the postpartum period	<ul style="list-style-type: none"> - Health knowledge - Traditional practices - Change in behaviours - Delivery site - Hospital stay - Postnatal visits check-ups

All interviews except one factory manager interview were recorded. Field notes were also taken. In the following four weeks all recordings were translated and transcribed into English. The transcripts and field notes were summarised and coded against the primary themes in table 2, and deductive and inductive analysis conducted.

The following presents the preliminary findings of the analysis.

Findings

The findings are presented according to the themes listed in Table 2.

I. Factory working conditions

All participants in the study described a consistent working routine. Women worked six days a week, beginning each day at 7am, had a one hour lunch break between 11am and 12midday, and the standard working day finished at 4pm. Factories offered regular overtime shifts until 6pm, and while factory managers said working overtime was voluntary, all factories workers in the study felt obliged to stay until the later time when requested. The overtime pay bonus was a significant incentive and there were difficulties in travelling home as, when overtime shifts were requested, the mass transport options of the mototrucks did not leave until after the overtime shift.

Once women suspected they might be pregnant they went to the health centre and received a certificate confirming their pregnancy and the expected date of delivery. Factories gave certain privileges and concessions to women with this certification including: time off each month for antenatal check ups (variable between different factories); the ability to leave 15 minutes earlier at lunch time and at the end of the day to avoid the crowds; a seat in the cab or a plastic chair in the transport, so women could sit down between factory and home; and maternity leave for three months. Factories give pregnant women a different coloured scarf to wear that allows them to claim these privileges. The requirement for health centre certification to access these privileges meant that women were more likely to have early and regular antenatal care.

They are given one hour and half for going to ANC check up. But sometimes women have to take a whole day off because it takes more than one hour and half to go to the health centre for ANC and they need to wait there too. (FGD 3)

If we don't go to the health centre, then we wouldn't have the paperwork to prove that we are pregnant, and it would be hard to get permission, and also this way, the factory will take care of us better, like when we leave our work in the evening, they will ask us to leave separately. (FGD 1)

When women return to work after delivering, the factory, by law, is required to provide 30 minutes twice a day for a woman to be released from work without penalty to breastfeed her baby. Factories with more than 100 workers are required to provide a breastfeeding room for this purpose, and to provide child care facilities for factory workers' children aged 18 months – 2 years (ILO 2012). In practice taking up the breastfeeding time was rarely done, with one respondent mentioning just one family doing this at the factory where she worked. None of the mothers or caregivers interviewed described making use of this provision. The reasons given were the difficulty in babies being brought to the factory, including the distance and difficulty of finding transport, and the reluctance to have a young baby being transported to and from a factory twice a day in temperatures that may reach 40 degrees Celsius.

I've never been in that room because this is for breastfeeding and there needs to be a father or a grandmother to bring the child to the mother for the breastfeed. They give one hour for breastfeeding. For me, because my house is too far away, I never bring my baby. (Factory worker (FW) mother, village 3)

Despite the long hours and difficulty managing the work when pregnant or as mothers of young children, most respondents in the study appreciated the opportunity to work. Women valued the opportunity to earn a wage, and the borrowing power a regular income provided.

Everything is good for me to work here because it helps me so much especially on economic front. I can receive a salary and I can borrow money from others, then I can return when getting my salary. (FW mother young child, village 3)

An emerging theme during the research was the differences between the conditions of working in Phnom Penh and in factories sited in rural districts such as Kampong Tralach. A number of women had experience of working in the capital, and discussed their perspectives on the two working sites. Both interviews with factory managers also touched on this theme.

Factory owners stated that the workforce required additional training compared to workers in the city as the pool of experienced workers was smaller, but as most workers were local residents there was also greater stability in the workforce. The implications of this difference between working in the capital and in more rural settings are expanded in the discussion below.

In Phnom Penh, workers come from different places; but here workers come from one province only. Second, in Phnom Penh there are more factories and more unions, which is a contrast from here. Third there is more competition for workers in Phnom Penh. In Phnom Penh, workers spend more than in the provinces. I believe we have better conditions here and we are more stable than Phnom Penh. (Factory manager 2)

2. Health care facilities

The local health centres were the preferred provider of antenatal care and delivery care, and in contrast to what was expected when this study was designed, all women knew about the importance of antenatal care and most were receiving at least the WHO four visits during pregnancy. Many described regular monthly check ups. Factories varied in their accommodation of pregnant women requiring check ups. Most allowed a one-two hour break, and others located far from the health centre, allowed a half to one day break for the visit.

The half or one day release incurred a salary deduction, but was permitted, in contrast to leave without prior permission. Difficulties arose if the health centre staff forgot to sign the pregnancy registration card, as then women had no means to certify their visit, and without it they received an additional pay penalty.

It's difficult to get the medical report when women need to go for ANC. Sometimes the health care providers do not write on the mother's card so it's hard for the factory to give permission to them. (Factory manager 1)

Health centre staff in some facilities recognised the limited time working women had for their check ups and would provide their check ups before those of non factory working women during weekday clinics, to minimise the waiting time.

Sometimes it is very crowded at the health centre, and then the staff say they will ring the factory about our being late. This is because we may be waiting for a long time, or if it is very crowded. It is not just a matter of going and getting a check up, we need to wait. Both villagers and workers go there, but when we tell the health centre staff that we are the workers they understand and we have our check ups first. (FGD 1)

Most women, however, elected to go to the health centre on their day off (Sunday), and health centres provided antenatal service to factory women on this day, in between attending to any women in labour. Two of the midwives suggested that the Sunday ANC service for factory working women resulted in a difficult additional work load for health staff. Midwives are posted alone on weekend shifts and have to manage seeing the outpatient ANC clients while also caring for any women who may have presented in labour. With the very high proportion of women who work in factories residing in the district, the Sunday ANC visits on this current ad hoc basis is unlikely to be sustainable.

Usually on the weekend days I have hard work because if many labor women come I have to keep OPD patients waiting for a while and give priority to laboring women, but if it is a working day we have many staff to help so I only work as midwife in delivery room. (Midwife HCI)

Women generally described the health workers as friendly and the services acceptable. Government services were the preferred providers for antenatal care and delivery care, however private providers, regardless of the additional cost, were preferred for the care of sick children. Stock out of drugs was described by many women, and there were reports of abusive treatment of women during labour. One husband stated that poor patients received poorer care.

I was angry with her [her daughter]... She did not pay attention. I hit her and the birth attendant hit her too. After delivery the baby cried a lot. (Grandmother, caregiver 5)

When my wife delivered, we gave the midwife 30,000 Riel. Now I don't know what the patient is meant to pay. If we bring the poor card the service is free; however, the nurses don't want us to bring it as they will earn nothing. Moreover, patients with that card do not get much attention from the midwives. (Husband, caregiver 8)

3. Childcare provisions

When women return to factory work, family members are the preferred childcare providers. Across all women who participated in the study, grandmothers and fathers were the first choice of all participants. Grandmothers were the preferred option with many women mentioning their confidence in a grandmother's care, which was perceived to be better than a father's care.

Because my baby is with my mother I don't have to worry about her, and can focus on my work. If I worried about my daughter my work performance would be low and I would be blamed. (FW mother 3)

I leave my baby with her grandmother or her father. With her grandmother is better, she is warm and more confident than her father. It would be better to care for the babies ourselves. (FW mother 4)

Women mentioned the option of paying a non family member but only one participant in our study used this option, and she described it as expensive and a last resort. The payment for childcare equates to 20% of the total base salary a factory worker receives.

I hired someone in my neighbourhood, because my mother lives too far away. It's difficult. It costs 100,000 Riel [US \$25] a month. (FW mother 6)

The availability of childcare at the larger factories, for children aged 18 months-3 years, was described by many women. All stated that they would not trust the factory to look after their child. This view was also expressed by one of the factory managers, who stated that by law, factories with more than 100 workers have to provide crèche services. In his factory, where over 4000 women worked, the crèche was empty and the assigned childcare staff were working on the factory floor instead.

The workers tell us that they don't want to bring their small children. Our workers are afraid that nobody will look after their children and they don't want anyone other than relatives to care for their children (Factory manager 2)

Amongst the caregivers interviewed, there was a range of views expressed– from being a willing caregiver keen to assist a young family set themselves up economically, through to a feeling of having their old age hijacked, by being forced to full time care of another family member.

Let me tell you this, I have taken care of five grandchildren already. Frankly speaking I took care of them since they were very young. Even this last girl also, but I am sick now. (Grandmother, caregiver)

4. Child nutrition

The recommended nutritional advice for newborns and infants is for exclusive breastfeeding to commence within one hour of birth and continue until a child reaches the age of six months, followed by the addition of appropriate complementary feeding. For the women in our study the focus of enquiry was on the conditions for exclusive breastfeeding and the ability to provide appropriate complementary foods. For nearly every woman in the study, breastfeeding was not exclusive; with widespread reporting of both prelacteal feeds and additional substances in the first six months. The complementary feeding was a particular concern with inadequate variety in the reported intake of many young children.

For all respondents, returning to factory work triggered the cessation of exclusive breastfeeding. For some women this occurred when the baby was less than three months old. Other mothers stated that they deferred returning to work until their child was taking complementary foods. Many mothers described returning to work and then stopping if the alternative feeding arrangements didn't work. For those mothers who returned to work, all mentioned the significant expense of buying formula.

After three months [post delivery] my friend went back to work. You know what, her infant got diarrhoea which lasted for 17 days, because the formula milk is not suitable for the baby. Then she changed the milk brand but it still didn't work out so she quit the factory, and came back to look after the baby. (FGD 2)

While waiting for his mother to return from factory work we feed him formula milk, mostly he drinks formula milk...quite an expenditure, he finishes one can in just three days, one can for 24,000 Riels [USD \$6, one-two days salary equivalent]. (Father of a three month old)

Caregivers of young children were asked to describe a 24 hour recall of the food consumed by the child in their care. Amongst the 12 caregivers, five described meals that were either inadequate in quantity or variety, or age inappropriate. One father was giving porridge to a three month old, while one grandmother was restricting a two year old to milk only. Three of the grandmothers stated that fear of diarrhoea was the reason for providing a diet that was limited to porridge only, for children between 6-12 months of age.

I : So the white porridge is for the whole day from morning until evening?

CH : Yes, I heat the porridge. I do not give anything else because I am afraid she might get diarrhoea. (Grandmother of 12 month old)

5. Knowledge, attitudes and practices during pregnancy, delivery and in the postpartum period

A striking feature of the study was the widespread knowledge of the importance of regular antenatal check ups, and the value of a facility based delivery. Village leaders, grandmothers, factory managers and all the women involved in the study spoke of this as an established and routine way to manage a pregnancy. Those women working in factories were likely to report to a health centre early in their pregnancy. Women described danger signs during pregnancy, the need for a good diet, and the importance of taking iron supplementation. Yet many traditional beliefs and practices during pregnancy and delivery were also described. Traditional beliefs included practices that may be harmful; for example, some food restrictions during pregnancy, and the widespread practice of steaming and heating women after the delivery.

Deliveries took place at the health centre, or at the hospital if there were any complications. Women stayed in hospital up to three days after the delivery, ample time for postnatal care and breastfeeding advice. Yet many women described prelacteal feeds and withholding of colostrum, both poor newborn care practices. The other concern was the frequent description of multiple injections in the post partum period.

I : What did they do after the delivery?

Mother 3 : They gave me an injection and an intravenous perfusion. They gave me injections three times a day. When I came home I was wearing a thick and long cloth and a hat to prevent exposure to the heat... I was drinking herbal medicines and getting injections for ten days from the health care provider.

W : You come back home and you can't heat the fire because it can cause bleeding, from the medication used during the labour. So we follow instruction. We can't do it immediately. We take medicine and drink water for one week and then we start the heating.

I : So do you all practice heating nowadays?

W : Yes we still do that. We are in the countryside. Most people still do that. It can help with the blood system, the veins, and especially when the weather is cold. (FGD 3)

Discussion

The women in this study, working in the garment factories of Kampong Tralach, were accessing regular antenatal care and skilled care at delivery. Many women stayed for three or more days at the health centre after delivery, receiving postnatal care provided by health centre staff. Postnatal care once women were discharged from hospital was limited, with most women reporting no further health check ups once they returned home. These findings support the most recent CDHS survey. The recently published preliminary findings of the 2014 DHS suggest a significant improvement in coverage of key maternal and newborn interventions in Kampong Chhnang Province: 99.5% of women receive at least one antenatal visit; 86.4% receive the recommended four visits, 97.6% of women delivered with SBA in the most recent delivery, and 99.2% of those women received a postnatal check up within two days of their last delivery (CDHS 2014).

There were a number of maternal and infant health risks associated with garment factory work, including poor maternal nutrition, inappropriate and possibly insufficient infant nutrition and early child development. There were also a number of identified benefits of factory work for women and their families. Notably in this one district the presence of 25,000 workers represents an economic injection of millions of dollars each month, in what was previously a rural agricultural based economy. The regular salary allows women to plan and dream of creating an alternative future for their family, and while women were quick to describe the difficulties of factory work, they were also appreciative of the opportunity to earn.

Maternal nutrition

Women work from 7am – 4pm six days a week, with most working the additional two hours overtime between 4-6pm when required. For pregnant women, morning sickness is common and best managed with frequent small snacks throughout the day. Factory rules do not permit eating while working, which means pregnant women have just the one hour lunchbreak during the day. Many respondents described poor eating during pregnancy, of particular concern given the widespread anaemia recorded in this population.

Infant nutrition

A striking feature of the study was the effect of factory work on the ability of mothers to exclusively breastfeed for the first six months. All respondents stated that this was a challenge and that factory work was incompatible with exclusive breastfeeding. The factory provisions were inadequate for rural settings and the large distances between villages and factories meant that bringing a young baby to be fed was not feasible. No mothers mentioned expressing breast milk for use by caregivers, although a recent trial of supporting working mothers to express breast milk in factories in Phnom Penh was not successful, due to a mistrust by women of the storage fridges at work and the difficulties in transporting expressed milk between work and home (Cockroft 2014).

It is notable that the recently published CDHS findings suggest that there is a significant reduction in the proportion of babies being exclusively breastfed (Table 3). Further analysis is required to understand whether these lower rates correspond to increasing numbers of women working in factories.

Table 3 Breastfeeding trends 2010-2014

Year of DHS	EBF at 4-5 months	Not feeding at 2-3months	Not feeding at 4-5 months
2010	59.6	3.2	4.1
2014	50.4	6.6	9.4

Source: Cambodia Demographic and Health Surveys 2010 and 2014

The challenges for infant nutrition extended to the introduction of complementary feeds. Many women who had deferred returning to work while their babies were very young, returned to full time work at the time their babies were needing a more varied diet. Yet many caregivers were reluctant to present any new foods to children in their care for fear of the child having diarrhoea, resulting in many young children receiving inadequate nutrition.

Factory rights

The women in our study were aware of their basic rights regarding maternity leave provisions. Similar to other studies, however, many women were unsure of their exact entitlements and there was some variation in the way maternity leave entitlements were paid out, varying from three months leave without pay; receiving a bonus equivalent to 50% of the salary; to some women receiving a full three months salary. A 2010 ILO study found that compliance on following the maternity law is still patchy.

The two factory managers in our study were very clear about, and proud of, their adherence to the law regarding breastfeeding and child care arrangements. Yet, when probed about how they could support mothers of young children through initiatives such as part time work or alternatives, they were not very flexible. The rules regarding breastfeeding time and childcare arrangements are particularly inappropriate for rural factories for which different arrangement may be necessary.

Rural Factory work

The provisions by factories for antenatal check up leave, and the adherence to the legislated maternity leave, breastfeeding and child care arrangements, did not address the situation faced by the women in this study. Even in Phnom Penh these provisions do not always allow working women to continue to exclusively breastfeed (Cockroft 2014). In Kampong Tralach, the distances between the villages where women reside and the factories were significant. Most travelled over 30 minutes by vehicle each way. Consequently, women were more likely to do overtime as the mass transport would not run at the usual finish time. The distance also precluded women from taking advantage of breastfeeding breaks.

In contrast to factory workers in Phnom Penh, most of the women in our study were living in their homes, many with family nearby, and the vulnerabilities that have been well reported for migrant workers in other studies (ILO 2012; Cockroft 2014) were not so apparent amongst the participants of this study.

Limitations

There were limitations to the study. Twelve teams undertook that data collection over two days, presenting some risks of inconsistency. This limitation was managed by having well structured question guides, pre-training in the data collection, and immediate review at the end of each day. As the teams undertook the data collection over one weekend there was limited capacity to refine the tools during the data collection, which risks missing potentially important lines of enquiry and restricts the ability to probe for any newly identified themes. Pretesting the question guide helped to minimise this risk.

Only two garment factories gave permission for visits and interviews and they may not represent the conditions described by many of the women in our study. Both were factories with a strong union presence and may not reflect the conditions in other factories in the district, particularly those not registered with the ILO and consequently not under a similar level of scrutiny.

Conclusion and recommendations

This study focused on the impact of working in garment factories in Kampong Tralach District on maternal and newborn health care services. Factory work provides an important means to economic participation for many women. The legal provisions and consideration for pregnant workers results in women accessing regular antenatal care. Facility based delivery is the established practice in this district. Yet there are some significant poor health consequences for both women and their children resulting from factory work. These include maternal nutrition, infant nutrition and early childhood development concerns. Some of these are amenable to community or local program support, while other initiatives may require legislative action. The summary recommendations include the following:

- Addressing maternal nutrition – legislating for factories to allow pregnant women additional breaks during morning and afternoon shifts to provide opportunities for additional meals to overcome morning sickness and improve maternal nutrition.
- Supporting garment factory workers to receive timely ANC – to avoid the reported delays and difficulty for health workers to see women when they are working alone on Sundays two potential ways forward are identified:
 - . Rostering additional midwives to work Sundays (as dedicated ANC providers) and introducing a flexible working week so midwives who work on Sunday receive a day off during the week
 - . Regular ANC clinics at factories – for larger factories outreach ANC clinics could be a way to minimise time away, and to reduce pressure on weekend ANC care for health care staff.
- Supporting exclusive breastfeeding for six months – explore options such as advocating for job sharing or part time work to allow women to work for a morning or afternoon shift to allow exclusive breastfeeding to continue until a child is six months old.
- Supporting improved introduction of complementary feeds – explore options to support caregivers of children aged 6-12 months, e.g. through caregiver support groups, grandmother clubs or alternatives to enable infants to receive adequate quantity, quality and variety of complementary feeding. This may also be an avenue to assist caregivers to provide child development activities and a stimulating environment for young children

In addition, this study highlighted some gaps in the provision of quality postnatal care, particularly the overuse of injections and poor breastfeeding advice. These concerns are not particular to women working in factories and extend to the quality of the health services, but it is recommended that health workers receive further in-service training about early initiation and support for exclusive breastfeeding.

The study highlighted the importance of continuing to document the situation of women working in garment factories. While many of the concerns of women in this study matched those of previous studies in Phnom Penh, there were some material differences, particularly the fact that most women are not migrants but are living in their home villages, allowing greater opportunity for village based support programs. Yet these women are also living further away from their workplaces, making the current legislation less relevant as families are not in a position to take advantage of either breastfeeding or child care arrangements at the workplace.

It is hoped that the findings of this study can inform those working to improve the maternal and newborn outcomes for women working in garment factories in Cambodia.

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Preliminary Findings

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