

Original Article

Health-related Quality of Life Among Adult Migrant Garment Workers in Dhaka City

M Z Islam¹, S Ahmed², R N Sarker³, S Farjana⁴, A Akter⁵, S Saha⁶

Abstract

The objective of this cross-sectional study was to assess the health-related quality of life among adult migrant garment workers (age 18-59 years) in Dhaka city. The study was conducted with 400 workers for quantitative research, and two health care service providers for qualitative research. Data were collected during February to March 2009. Data were collected by face-to-face interviews using a constructed pre-tested questionnaire adapted from WHOQOL-BREF. Data were analyzed by applying descriptive statistics (frequency, percentage, mean, standard deviation, range and median) and inferential statistics (unpaired t-test and one-way ANOVA) to examine the relationship between health-related quality of life and socio-demographic characteristics, living and working conditions, and accessibility to health care services. Statistical significance was set as $p < 0.05$.

Keywords: health care seeking, health-related quality of life, migrant, garment workers

Introduction

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.¹ Health is recognized as a fundamental right of all, and migrants are no exception. Dhaka city can be considered as a hub for migrants from all the districts of the country, whose people are in search of a better quality of life.² Quality of life (QoL) is a broad concept which can be defined in many different ways. World Health Organization (WHO) defines QoL (or health-related quality of life) as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns."³ In addition, WHO 2008 stated that an improvement of the health and quality of life is a crucial constituent

The results revealed that 94.00% of workers reported low level of health-related quality of life. The rest were moderate and high, 3.25% and 2.75% respectively. For socio-demographic characteristics, workers' marital status, having family members, income, history of sickness and getting treatment when sick were discovered to have association with health-related quality of life. For living and working conditions, workers' living place, work permit, length of current job and satisfaction on work conditions were significantly associated with health-related quality of life. For accessibility to health care services, perception on difficulty to go to the health facility, crowdedness of the health facility and having health insurance card were found to be associated with health-related quality of life. Further longitudinal researches and policies are recommended to improve access to health care services and higher health-related quality of life for migrant garment workers in Dhaka city.

for the new public health and health promotion.⁴ There are still important populations whose quality of life is rarely assessed, for example, people living in highly stressful situations, such as migrant industry workers. Dhaka city is the focal destination of migrant workers especially of the garment workers in Bangladesh due to the concentration of labor-intensive industries in the city.⁵ Garment industries play a very decisive role in earning for currencies by exporting cloth products in abroad. The garment workers are the major augmented workforce for production of garment products at a low cost in the country.⁶ It is also evidenced that garment workers suffer from health problems including short of hearing and poor vision, headache, urinary tract infection, tuberculosis, and sexually transmitted diseases. Working environment of the garment workers is devoid of proper ventilation, hygiene and sanitation.⁷ The workers have to work for a long period of time in overcrowded condition under huge physical and mental stress to fulfill the preset target of production. The workers have to face humiliation in different forms in their workplace, which make them vulnerable for accidents, injuries and psychological disorders also.⁸ This study intended to measure the health-related quality of life among adult migrant garment workers in Dhaka city of Bangladesh. The study findings will contribute to formulate specific measures to improve health related quality of life of the migrant garment workers and their health seeking behavior for sickness.

Materials And Methods

In this cross-sectional study, the sample size was 400 adult migrant garment workers in the age of 18-59 years, both males and females, who could communicate and agreed to participate. Dhaka city was selected because garment workers from 64 districts of the country migrate in the capital city

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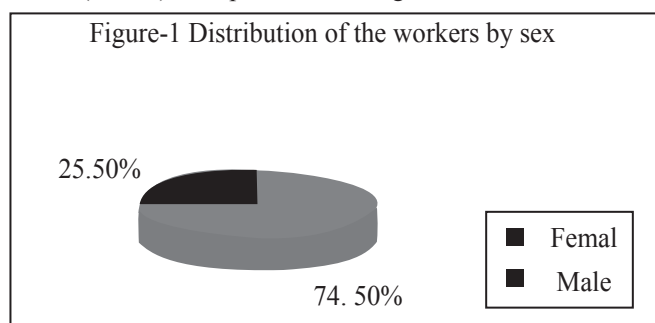
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to work in the garment factories. Five garment factories were selected purposively and all adult migrant workers in the garments had an equal opportunity to be selected. There were a total of eighty workers from each garment in this present study. Data were collected by face-to-face interview through the use of validated pre-tested questionnaires and WHOQOL-BREF which was translated into Bengali. The WHOQOL-BREF comprised of 4 domains - physical health, psychological health, social relationships, and working environment - in 26 questions. In terms of QoL measurement, the scores were categorized into 3 groups: 1) low level with the range of 26–60 scores; 2) moderate level with the range of 61–95 scores; and 3) high level with the range of 96–130 scores⁹. Data were analyzed by applying descriptive statistics (frequency, percentage, mean, standard deviation, range and median) and inferential statistics (unpaired t-test and one-way ANOVA) to examine the relationship between dependent and independent variables.

Results

Among all 400 migrant garment workers, the study revealed that females (74.5%) were dominant than their counterpart males (25.5%) as depicted in the Figure-1.



Majority (63.5%) of the garment workers were in the age group of 18-30 years followed by 28.4% were aged 31-46 years and the rest 8.1% were in the age group of 46-59 years as depicted in the figure-2.

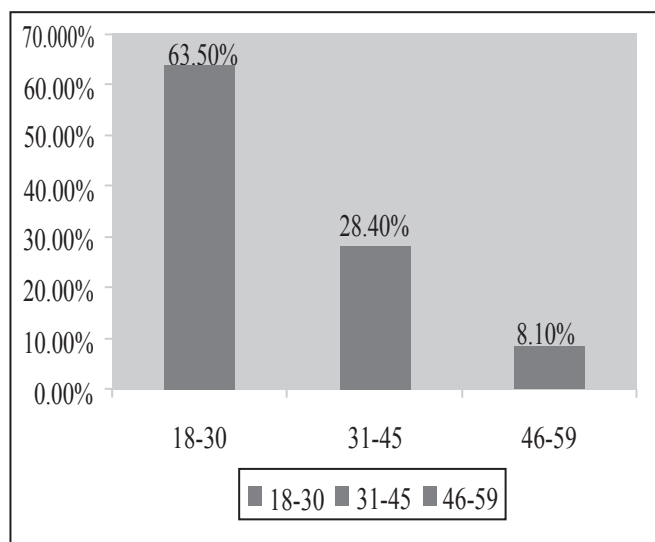


Figure-2: Distribution of the workers by age group

Regarding educational qualification, the study revealed that majority of the workers (42.00 %) had primary level followed by 33.0% had secondary level and only 2.75% workers had higher secondary level education (Figure-3).

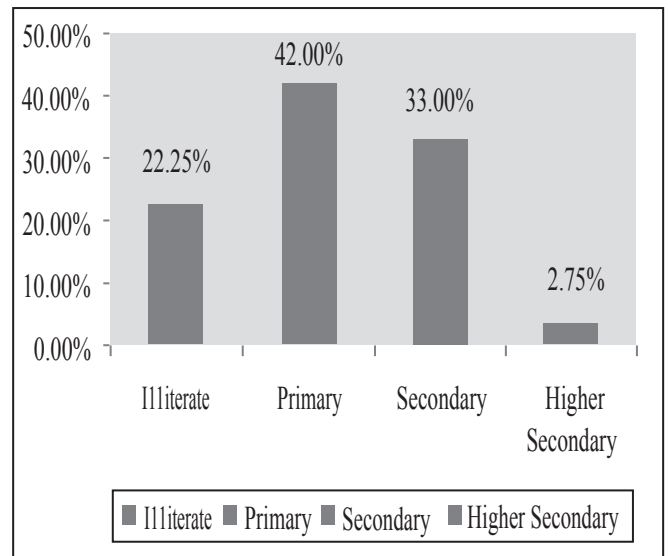


Figure-3 : Distribution of the workers by education

Among the all the garment workers, most of the m had a low level of quality of life (94.00%) followed by moderate (3.25%) and high (2.75%) levels of health-related quality of life, respectively (Table-1).

Table-1: Health-related quality of life among workers (n=400)

Quality of Life Scores (Level of Total QoL)	Number Percentage	Number Percentage
Low	376	94.00
Moderate	13	3.25
High	11	2.75
Statistics	Mean ± SD = 78.90 ± 9.72, Range = 44 – 103, Median = 79	

The study depicted that married workers constituted 49.50% and nearly half (48.00%) of the workers had one to two family members and majority of the workers (32.50%) had duration of work between four to seven years. The largest group of the workers (46.25%) had monthly income Tk.3,000-4,000. In respect of living conditions, 366 (91.50%) workers were living in rented room. When analyzed by one-way ANOVA with statistical significance at the level of p<0.05, workers' marital status, number of family member living, duration of work, education level, monthly income and types of house showed significant associations with health-related quality of life (Table-2).

Table-2: Relationship between health-related quality of life score and workers' characteristics, and living condition analyzed by One-way ANOVA (n=400)

Variables	Number	Percentage	Score (QOL)	SD	p-value
Marital Status					0.017
Single	187	46.75	78.08	9.70	
Married	198	49.50	80.06	9.20	
Widow, Divorced, Separated	15	3.75	73.93	14.12	
Number of Family Member					0.018
None	45	11.25	77.36	9.31	
1-2	192	48.00	77.88	9.92	
>2	163	40.75	88.55	9.39	
Duration of Work					<0.001
<4	139	34.75	76.02	9.95	
4-7.99	130	32.50	79.74	9.47	
≥8	131	32.75	81.14	9.03	
Education Level					<0.001
Illiterate	89	22.25	80.88	9.24	
Primary	168	42.00	77.22	9.62	
Secondary	132	33.00	78.04	9.78	
HighSecondary	11	2.75	87.91	8.36	
Monthly Income (Tk.)					<0.001
3,000 - 4,000	185	46.25	70.30	10.05	
4,000 - 6,000	155	38.75	75.78	12.96	
6,000-8,000	50	12.50	77.34	10.25	
8,00-10,000	10	2.50	81.52	7.20	
Type of House					<0.001
Lodging in work compound	16	4.00	89.50	7.41	
Rent	366	91.50	78.32	9.42	
Others	18	4.50	81.39	12.09	

For the data of workers' own sickness, 147 (36.75%) had experienced sickness in the past four weeks. Among those who experienced sickness, 120 workers (81.63%) received health care services. Among 141 workers who had difficulty to go to health facilities, the reasons were found to be buying medicine from drug store, being mild sickness, no time to go to health facility and ignorance. When analyzed by unpaired t-test with statistical significance at the level of $p < 0.05$, respondent's sickness within past four weeks, receipt of health service, difficulty to go to the health facility, crowdedness of the health facility and life insurance status showed significant associations with health-related quality of life (Table-3).

Table-3: Relationship between health-related quality of life score and workers' characteristics and health care seeking (Analyzed by unpaired t-test)

Variables	Number	Percentage	Mean	SD	p-value
Workers' Sickness in The Past Four Weeks (n=400)					<0.001
Sick	147	36.75	76.38	8.84	
Not sick	253	63.25	80.37	9.93	
Workers' Receipt of Health Service (n=147)					0.001
Yes	120	81.63	77.48	8.27	
No	27	18.37	71.48	9.75	
Difficulty To Go To Health Facility (n=141)					0.002
Difficult	122	86.53	78.30	7.73	
Easy	19	13.47	71.89	10.10	
Crowdedness of the Health Facility (n=141)					0.003
Most of the time	113	80.14	78.46	8.05	
Some of the time	28	19.86	73.29	8.34	

The most important and alarming finding was the fact that some of the adult garment workers were saving their money while taking the risk of grave consequences of sickness without having life/health insurance status as the workers considered themselves healthy and perceived no need to buy insurance. When the migrant workers became sick, they had to pay out-of-pocket money which lead them into trouble as the medical expenses are generally unpredictable. Analysis by unpaired t-test with statistical significance at the level of $p < 0.05$, length of current job, satisfaction on the work place (sound, light, ventilation, smell, work position and salary), opinion on difficulty to go to the health facility, crowdedness of the health facility, and life insurance status showed significant associations with health-related quality of life (Table-4).

Table-4: Relationship between health-related quality of life score and working conditions (Analyzed by unpaired t-test)

Variables	Number	Percentage	Mean	SD	p-value
Length of Current Job (Year s) (n=400)					<0.001
<3.99	243	60.75	77.11	9.52	
≥4	157	39.25	81.68	9.40	
Sound Condition (n=400)					<0.001
Satisfied	108	27.00	74.62	11.67	
Dissatisfied	292	73.00	80.49	8.38	
Light Condition (n=400)					0.022
Dissatisfied	38	9.50	74.53	12.16	
Satisfied	362	90.50	79.36	9.33	
Ventilation (n=400)					<0.001
Satisfied	80	20.00	74.20	11.32	
Dissatisfied	320	80.00	80.08	8.99	
Smell Condition (n=400)					<0.001
Satisfied	103	25.75	74.52	10.47	
Dissatisfied	297	74.25	80.42	8.98	
Work Position (n=400)					<0.001
Satisfied	93	23.25	75.68	9.22	
Dissatisfied	307	76.75	79.88	9.67	
Salary (n=400)					<0.001
Satisfied	95	23.75	73.32	11.41	
Dissatisfied	305	76.25	80.65	8.43	
Life/health Insurance Status (n=141)					<0.001
Have	25	17.73	71.60	9.48	
Don't Have	116	82.27	78.69	7.55	

Discussion

Among the 400 adult migrant garment workers in Dhaka city, 94.00% had a low level of health-related quality of life, followed by moderate (3.25%) and high (2.75%) levels of health-related quality of life respectively. A study in Phangnga Province, Thailand, using Short Form-12 to assess the health-related quality of life among migrant workers showed that one-third of the migrants' self perceived health status was good.⁹ Another study that used Short Form-36 to assess the QoL of migrant workers in Samut Sakhon revealed that migrant workers had high satisfactory level in physical and mental components of QoL, 49.50% and 50.20% respectively.¹⁰ These studies used other scales rather than WHOQOL-BREF to measure QoL and all were oriented to measure specific circumstances such as physical functioning, role limitations due to physical health problems, bodily pain, social functioning, general mental health (covering psychological distress and wellbeing, role limitation due to emotional problems, vitality, energy or fatigue, general health perceptions.¹¹ Therefore, their results differ with the findings in this present study. Nevertheless, in general, it can be said that workers from current study had low QoL than the previous studies as only 2.75% of them perceived their QoL as high. This may be a consequence of poor health care facilities, less utilization of health care services and poor working environment. Regarding working environment majority of the workers were dissatisfied with sound, light, ventilation, smell, work position and salary, which were statistically significant ($p < 0.05$). On the contrary, the comparative by Thein TL in Thailand found majority of the migrant workers were satisfied with these aspects of working environment. This discrepancy may logically explained by the fact that the present study was conducted in Bangladesh among the migrant garment workers while the comparative study was conducted in Thailand among migrant workers of different manufacturing, seafood processing and fisheries.¹²

Conclusion

It is concluded that longitudinal studies on QoL is preferable for future studies to find out the realistic picture of the migrant garment workers without seasonal variation. Use of health insurance should be promoted and health facilities should be made available in the workplace. Community based organizations should be developed for migrants workers in order to improve their

quality of life and protect their reproductive health and occupational health in the country.

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