The Risks of Pregnancy and the Consequences among Young Unmarried Women Working in a Free Trade Zone in Sri Lanka

Programmes are needed to lessen the dangers of free trade zones for young women

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The primary health care system in Sri Lanka has an international reputation for its contributions to reducing the rates of infant and maternal morbidity and mortality. These results have been achieved in part through a

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comprehensive system of early identification of expectant mothers, careful follow-up and monitoring, almost universal hospital deliveries, postpartum follow-up for three months after delivery, an effective immunization programme, nutrition supplements and the reporting of infectious diseases. A key to this system is the "public health midwife" (PHM) who identifies pregnant mothers, ensures their regular attendance at maternal and child health (MCH) clinics, makes monthly home visits, advises pregnant mothers on nutrition and health, facilitates hospital admission for delivery and responds to emergencies. They also provide postnatal follow-up of mother and child (Ministry of Health and Indigenous Medicine, 1998).

In a typical rural community, a PHM is responsible for an average of 3,000 families and addresses the needs of 25-30 expectant mothers a year. This article explores the dynamics of a situation in which the demands on the PHM have expanded tenfold, resulting in significant risks to pregnant women and infants. This situation has arisen following the formation of a "free trade zone" (FTZ) associated with the international airport north of Colombo. That FTZ has dramatically increased the population of the adjoining residential communities from about 9,000 to a current population of 70,000. In addition, the transition has changed the sex ratio from an approximately even balance of females to males to a proportion of nine females for every male. Almost all of these women are unmarried and are mostly aged between 18 and 24. The article aims to identify the factors that contribute to a high rate of premarital pregnancies among FTZ workers and the implications of those pregnancies for the effective delivery of services through the MCH system.

Background

Sri Lanka became involved in export processing in 1978 with the establishment of the FTZ in Katunayake, a northern suburb of Colombo. It is now estimated that there are 60,000 workers in that FTZ, of whom approximately 52,000 are women; the overwhelming majority of these are young women between 18 and 30 years of age. The Katunayake FTZ has become a complex ecological niche comprising factories behind high-security walls and fences; dormitories, small buildings and family homes housing women workers; shops and markets which, while providing basic food and supplies, emphasize jewellery, cloth and dresses geared for young women with disposable income; and streets in which large numbers of young and older men loiter, some of whom derive their financial support by "living off" the earnings of young women.

Into this environment have come young women drawn almost exclusively from the poorest sectors of rural villages. They arrive in communities which were traditionally focused on paddy culture and coconut plantations. With the development of the airport and the FTZ, however, the communities are now characterized by industrial effluent, noise and air pollution, a saturated and polluted water table, overcrowding and other unhealthy environmental conditions. The women work in factories that are crowded, poorly ventilated and have limited resources for supporting workers. They live in crowded dormitories with poor living and cooking facilities. They must cope with the continual advances of men who congregate outside the factories and dormitories in bars, dark places and wooded areas to lure, coerce, take advantage of or prey on young women.

This article is based on a two-year study of behaviour among FTZ women and seeks to determine the level of sexually risky behaviour in this population, to identity the social processes that can lead to such behaviour, and to use the results as a basis for the development of effective risk reduction progmmmes. The results of this research show that a small but significant subset of young women in the FTZ are involved in risky sexual behaviour and therefore are in danger of unwanted pregnancy. The article is aimed at examining the consequences of such pregnancies in the FTZ communities in terms of the social implications for the mother, the health of mother and child, and the impact on the health care system.

Methodology

Data collection for the research was carried out using qualitative and quantitative methods. The first, exploratory stage involved key informants, group discussions and observation. Key informants were visited in the field and interviewed. They were drawn from all categories of people relevant to the subjects under investigation and included factory managers, boarding house landlords, shopkeepers, transport providers, health service providers (belonging to both allopathic and traditional medicine disciplines), public sector officers from national and local administrations, local police, religious organizations, representatives of non-governmental organizations (NGOs) in the area and the male partners of working women. Group discussions were held with PHMs, village officers (*grama niladhari*), three-wheel taxi drivers, female workers and female schoolteachers. Subsequently, systematic observations were carried out in the boarding houses, streets and bazaars, in which both the physical aspects of these environments and people's behaviour were observed and carefully recorded. PHMs were enlisted as interviewers and data collectors and were

given three days of training on qualitative interviewing. Since they had direct and official access to boarding houses, they were asked to meet landlords and residents and collect information on their behaviour. They were also instructed to collect specific cases of women workers whose situations in the communities were difficult. Over a four-month period, case histories of 40 working women with problem situations were collected.

The information collected in the exploratory stage became the basis for the development of a self-administered questionnaire for the second phase of the research. For sample selection, the research area was divided into three geographical units depending on the number of working women living in those areas. These three units were categorized as the heavy concentration area (adjacent to the factory complex), medium concentration area (0.5 to 1.5 km from the factory complex) and low concentration area (1.5 to 3 km from the factory complex). The boarding houses were enumerated and 30 were selected using stratified random sampling. The stratification was on the basis of the size of the boarding house (small, medium and large) and sex of the residents (mixed versus female only). Once the boarding houses were selected, all residents present at the time of the research team's visit were considered part of the sample. A total of 1,162 women responded to the questionnaire, generating 775 complete questionnaires. Analysis of the demographic characteristics of the questionnaires that were only partially completed indicated no significant socio-demographic differences between those women who had and those who had not fully completed the questionnaire.

The third stage of data collection involved the maternal and child health records of the PHMs for their respective divisions. Nine PHM divisions are incorporated into the service delivery area of the District Director of Health Services for the communities associated with the FTZ. Of these, five divisions overlap with the three *grama niladhari* divisions (the smallest administrative division in the country) in which data collection for the sample of female workers was carried out. PHMs are required to maintain a system of mothers' cards, which monitor the pregnancy and care of expectant mothers. The research team collected all mothers' cards maintained for the five divisions, amounting to 1,205 pregnancies registered for one calendar year from 1 July 1995 to 30 June 1996. The cards were collected at the end of 1997 so that all pregnancies during the research period would have been fully resolved. Of these pregnancy records, 270 were randomly selected for analysis. The information collected from the cards included: mother's age, mother's age at time of sexual union, mother's occupation at the time of the pregnancy, parity, the number of visits to the MCH clinic, number of times the PHM met the mother in her field visits, and the outcome of the pregnancy.

A member of the research team visited the two MCH clinics in the study area held every other week and identified expectant mothers coming in for services who were willing to discuss their situation. The researchers conducted an in-depth interview to collect information on the woman's origins, her experiences on arrival at the FTZ, how she met her partner, problems in the relationship with the partner, the nature of the pregnancy and other aspects of the woman's story. A total of 30 women were interviewed by this method.

Results

Premarital sexuality in the FTZ communities

The great majority of women in the FTZ work long hours, walk home quickly and in groups for protection, cook a meal in their tiny rooms and go to bed, repeating the same schedule day in and day out. Some young women thrive in the relative freedom of the FTZ communities, avoiding the constraints and dictatorial demands of parents, and may develop lasting relationships. A subset of women, however, seek and maintain active relationships with their female and male peers, which involves shopping, entertainment and activities outside the factory and residence. From the questionnaire sample, 29.5 per cent of the women report having female friends who often have been in the FTZ longer, and are involved in risky behaviour (alcohol use, living with a man, having sexual relationships). These friendships provide the young women with the knowledge, motivation and initial feeling of security they need in order to begin involving themselves in the FTZ communities outside their residence.

Among the women in the questionnaire sample, 25 per cent reported having a "boyfriend". The boyfriend concept is not a feature of traditional Sri Lankan culture. It implies that young, unmarried women choose a man independently of parental approval and are alone with him without supervision. While a few middle and upper class young women may espouse the idea, such a relationship is virtually unheard of among poor young women in rural Sri Lanka. In the qualitative interviews, many women believe these men to be their fiances whom they will eventually marry.

The men with whom the women become involved are for the most part not permanent residents of the FTZ communities. They include male workers in the factories, members of the armed forces stationed at Katunayake to guard the airport, men who have moved to the zone with other women to avoid problems in their home communities, and tradesmen and taxi drivers who serve

the FTZ communities but live with their wives and families a long way from the zone. The men may be married (and often hide that fact) or unmarried. The case histories collected by the research team indicate that most men profess love and long-term commitment in return for a sexual relationship. The familial, social and cultural constraints that would be present in the villages are absent in the FTZ communities, so these men are free to conduct a sexual relationship, then move on to other women or disappear entirely. A woman who has been loved and left must deal with the disappointment of a lost relationship, made even more extreme if she has taken the man home to her family and announced an engagement. There will also be concern over her loss of virginity and the consequent reduction in her marriageability.

In Sri Lanka, as in many parts of South Asia, it is not easy to collect valid survey data on the sexual relationships of young unmarried women. In this study, risky sexual activities were measured by a number of questions in the questionnaire, including ones which asked about involvement in the following: a sexual relationship (12.8 per cent), oral sex (0.9 per cent), getting pregnant (2.7 per cent), having an abortion (1.4 per cent), having a relationship with a married man (2.6 per cent), and having penetrative sex (2.6 per cent). A positive response to any of these questions was classified as involvement in risky sexual behaviour. Of the 775 respondents, 16 per cent were involved in at least one of these activities.

There is considerable motivation for young unmarried women to under-report sexual activity; therefore, it might be supposed that the actual figure could be somewhat higher. However, as the interrelationships of sexual behaviour are examined in association with other variables, consistent patterns are established which suggest that the group having and the group not having sexual relationships have been reasonably accurately defined. The questionnaire data confirm that there is a significant relationship between having women friends involved in risky behaviour and for the respondent to have a boyfriend ($p < 0.00l$). As one indicator of involvement in the world outside the dormitory and the workplace, 29.8 per cent of women reported attending musical evenings (music and dancing with large numbers of young men and women attending). Having women friends involved in risky behaviour ($p < 0.00l$) and having a boyfriend ($p < 0.001$) are both significantly related to attending musical evenings.

Pregnancy and lost relationships

Men frequently promise long-term commitment and marriage, and as a result some young women get involved in unprotected sexual activity.

However, serious problems start when they tell their partner that they are pregnant. Although the women want to get married and settle down, the men often abandon them and disappear or sometimes force them to seek abortions. The relationship may continue with the same man after the abortion, or he may abandon her a while later. If she is abandoned, the need for a male relationship leads her to repeat the process, namely, getting friendly with another man and perhaps getting pregnant again. However, after the first experience, a woman may feel she is smarter and can pick a man who will stay with her. The qualitative data provide a perspective on how becoming pregnant affects the relationships between young women workers in the FTZ and their boyfriends (all names are pseudonyms):

Ramani, aged 21 years, came to work in the FTZ and began to meet the same man each day on her way to work. He proposed that she become his girlfriend and she accepted. They went out for musical evenings with other women who also had boyfriends and very soon moved into a rented room. Within three months she conceived. When she told him she was pregnant, he moved out and found another woman who moved in with him.

Chandani, aged 28 years, being the eldest, decided to work in the zone to support her family. At first she travelled to work from home about 20 km from the FTZ, but later she moved to a boarding house. There she met a young man and developed a relationship. After some time she conceived and she went to Colombo to get an abortion The man went with her to the abortion clinic. After the abortion, he started avoiding her. She learned that he is a married man.

Rangika, aged 26 years, was brought to the FTZ by a relative of her stepfather. She was left in the room of another relative. He promised to marry her and they began to have sex. She conceived after eight months and had an abortion. After the abortion, he began spending less time with her. She learned that he was having a relationship with another young woman.

Kanchana, aged 25 years, came to the zone when she was 21. A young man in the FTZ started pursuing her. In the beginning she didn't like him but she finally agreed to have him as her boyfriend because she started to be pestered by another man. She introduced him to her patents as her fiance. After this they regularly visited her home and had sex. They moved into a rented room and within three months she had conceived. When she told the man he said not to

worry because they would be marrying soon. A week later, he went to work as usual but never returned. She does not know his home address. She told her mother, who said she should continue to work as long as possible and come home for the delivery.

Sunitha, aged 29, comes from Kandy. Her mother died early and her father, who was an alcoholic, remarried, and she was looked after by her grandmother and aunt. She was educated only up to grade 6. In order not to be a burden to her relations, she came to work in the zone. For four years she had no problem; then she met a young man from the armed services. She told her aunt; she took him to her house as her fiance. They had a sexual relationship, but did not use contraception. They discussed their future marriage and decided she should work abroad to earn money for a house. Soon after arriving in Kuwait she found she was pregnant and her employers sent her back. She was scared to see her aunt and immediately went to the boarding house in the FTZ community where she had lived before going abroad. Her fiance was gone. She was told that he was transferred to the eastern part of the country. After further enquiries, she learned that he is married and has two children. She contacted the PHM and through her, a religious organization that arranges adoptions.

Estimated pregnancies in the FTZ communities

There are an estimated 52,000 unmarried women in the FTZ communities between the ages of 18 and 30. From the questionnaire sample, 16 per cent of the women reported that they were involved in risky sexual behaviour. Extrapolating this figure to the broader population gives an estimate of 8,320 women in the FTZ communities who were having risky sex. While this figure still represents a minority, it is well above the rates identified by Silva and others (1997) for a comparable urban poor community in Kandy.

An NGO in the area conducts menstrual regulation for an average of 2,250 FTZ women workers annually. Analysis of the PHM records shows that the communities in the FTZ study area recorded 2,410 pregnancies, of which 2,179 were those of FTZ workers. Because little overlap is expected between menstrual regulations and the frequencies recorded by the PHMs, the two figures can be summed to give an estimated 4,429 pregnancies in total. The NGO has also indicated that a significant number of women seek abortions through private practitioners. Therefore, it can safely be estimated that there are at least 5,000 pregnancies annually. This annual pregnancy rate is consistent with the estimated number of FTZ workers at risk of conception.

Coping with pregnancy in the FTZ communities

The cases quoted above indicate that one of the major contributing factors to a lost relationship is breaking the news to the boyfriend that the woman is pregnant. Since few of the women knew about family planning and there was little report of the use of contraceptive methods, premarital pregnancy is clearly likely among the sexually active. For a young pregnant FTZ worker, the options are clear. She can marry her partner, return to her home village, seek an abortion, give the child up for adoption, rear the child as a single mother in the zone, or abandon the child. But for some women, even these options are not all available. A young unmarried woman with a child in Sri Lanka faces social ostracism, economic difficulties and problems in finding housing and a supportive environment. She is frequently barred from working in factories, is cast out of the dormitory and is unable to return to her parents' household or her village. In these circumstances, her efforts, whether to bring the pregnancy to term or seek an abortion, are fraught with social, economic and emotional difficulties.

Abortion

The qualitative data provide insights from the perspective of women who chose to seek an abortion:

> **Nilanti** did not have her period for two months. She had a pregnancy test and it was positive. She was unmarried so she and her boyfriend sought an abortion. Her boyfriend's friend told them about a clinic in a town about 50 km from the FTZ. The fee was Rs. 200 (US$l = 85.5 Sri Lankan rupees) because she had the abortion after the second month. The doctor gave her an injection and asked her to wait outside until she had pains in the abdomen. When she told the doctor she had pains, she was taken inside and asked to lie on a bed. He inserted some drug to dissolve the foetus. Then he opened up her womb and her period started. The whole procedure took 10 minutes. After this she was given medicine for fever, abdominal pain and excessive bleeding. She was told to go home as quickly as possible. When she returned to the boarding house, she started bleeding heavily. The following day she went to the factory but found it difficult to work. She then took leave for two days and went back to work afterwards.
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> **Pavitra** missed her period and she told the landlord, with whom she had had a sexual relationship. He gave her a soft drink with eight

analgesic tablets mixed in it (a commonly available analgesic is sometimes used as a crude abortifacient). She drank the mixture and that resumed her periods.

Sunita went to a private clinic and the doctor put some drug inside her womb. Then she was taken into the operating theatre and something else was inserted and she began bleeding. Then the doctor asked her to go home soon and advised her that, if she bled too much, she should get admitted to the nearest hospital and not tell where she had the abortion. She was given a prescription to buy some vitamins. After three or four days, her bleeding subsided and she went to her home village and then later to the boarding house. She did not tell anybody about the abortion.

Premarital pregnancies and the MCH system

There are seven PHMs for the nine divisions in the FTZ study area. Taking into account the figures given for total pregnancies, it can be assumed that each PHM on the average will have 712 FTZ women workers becoming pregnant in their service areas. The figures from the NGO referred to above and the data from the PHMs indicate that approximately 56 per cent of the women have an abortion, with 44 per cent bringing their pregnancies to term. Therefore, each PHM will have the responsibility for 309 expectant mothers and their infants. This number is in sharp contrast with the 25-30 pregnancies that a PHM would handle in a typical rural area. Faced with these overwhelming numbers, the PHMs report the following:

- PHMs have difficulty knowing the identities of the women in their service area because of the constant in- and out-migration of the FTZ population.
- The social stigma of pregnancy for unmarried women means that many are reluctant to identify themselves to health officials.
- FTZ women workers are unaware of their pregnancies and of the services needed and available for their pregnancies because of a lack of education and awareness.
- PHMs are overwhelmed and unable to carry out case-finding activities because of the large number of pregnancies in addition to their other activities.
- PHMs depend on hearsay from other workers or from landlords and then track down the pregnant women.

- Many women who bring their pregnancies to term have considered abortion as an option in the first half of their pregnancy and do not seek prenatal services until they finally commit to having the child.
- Women who leave the area to return to their village or another location are lost to the FTZ PHMs, resulting in a further delay in connecting with the MCH system.

Characteristics of pregnant women in the FTZ

The mothers' cards maintained by the PHMs represent the only hard data available on women who have been monitored during their pregnancies. Of the 243 pregnant women obtained from a random sample of mothers' cards maintained by the PHMs of the area from 1 July 1995 to 30 June 1996, 42.3 per cent were below the age of 24. This figure may be compared with the national figure (Department of Census and Statistics, 1994) which indicates that the average age of women at first pregnancy to be at least 27 years, or one year after the average age of women at marriage. Of the total sample, 139 (60 per cent) of the FTZ women gave up employment at the time of pregnancy, presumably hoping to resume work after delivery. Only those women who have children and are pregnant for the second or third time and those who have really given up employment, at least for a substantial period of time, are considered as not employed.

The great majority of women in the FTZ communities are unmarried. The relatively small number of married women are from indigenous families or are workers who subsequently married and remained in the communities. However, because 61.5 per cent of the women who received MCH services reported that they were married, it is likely that these women wanted to avoid admitting that they were pregnant outside marriage, or that their marriage occurred after conception.

Pregnancy outcomes

The options for women carrying their pregnancy to term include staying in the FTZ communities or leaving the area. The mothers' cards indicated that, of the 243 pregnant women, 105 (44.5 per cent) of them were lost to the PHMs because the women had left the area or could not be located (table 1). They left, generally, between the fourth and eighth month of their pregnancy. Of the 138 women whose pregnancy outcome was known, over 85 per cent had a live birth, 6.5 per cent had a stillbirth and 9 per cent reported a spontaneous abortion. The national figure for stillbirths is 1.92 per cent, and the

Table 1. Location of pregnancy outcomes in Katunayake Free Trade Zone

Location of outcome	Frequency	Percentage
Stayed in the FTZ community	138	56.5
Left the area	105	44.5
Visiting parents	17	
Leaving the area permanently	54	
Missing	34	
Total	**243**	**100**

district in which the FTZ communities are located reported a stillbirth rate of 1.3 per cent. Consequently, the FTZ workers show a stillbirth rate almost five times higher than that of the general population in the district. The rate of spontaneous abortion in this population is over four times higher than the national rate of less than 2 per cent (Ministry of Health and Indigenous Medicine, 1998). An explanation for this heightened rate of spontaneous abortion may be the poor living, working and nutritional conditions experienced by women in the FTZ.

MCH utilization

The mothers' cards pmvided information on the utilization of MCH services once a pregnancy was identified by the PHM. Generally, a pregnant woman is required to visit a prenatal clinic at least six times in order to get a normal admission for delivery in a government hospital. Failure to have at least six prenatal visits would preclude getting admission except as an emergency case. Table 2 shows that these women made an average of only 2.6 visits to the prenatal clinic, which is extremely low by national and district standards. It

Table 2. Number of visits by pregnant women to the MCH clinic in Katunayake Free Trade Zone

Number of visits	Frequency	Percentage
1	23	9.5
2	108	44.4
3	60	24.0
4	38	15.6
5	14	5.7
Total	**243**	**100**

was extremely rare for one of these women to visit the clinic on her own initiative. The PHM, after receiving the information about a pregnancy either from a boarding housemaster or mistress or from some other source, had to track down these women and force them to register at the clinic. Once registered, most women visited the clinic on the appointed day, although in many cases, they had to be reminded with a visit to the home or in the field or by someone else. However, the great majority of women did not follow up with subsequent visits and the PHMs were mostly unable to follow up with a residential visit.

The average number of times the PHM met the woman in the field or at her home, at 0.23 visits, is much lower than called for in the PHM guidelines, which stipulate at least one visit a month after conception has been confirmed. The great majority of women (82 per cent) received no visits at all, and only just over 5 per cent received two visits. No woman was visited more than twice. Frequently, the PHM visited and the women were not at home. A standard comment, as recorded on the mothers' cards, is that the woman had gone to the factory to work.

Conclusion and implications

This article has described the factors and processes that can result in risky sex for young women workers in the Katunayake FTZ and the consequences of unwanted pregnancy. The limited knowledge of poor rural women coming into the FTZ combined with their desire for increased opportunities in life expose them to manipulation by men who turn the women's income and sexuality to their advantage (Hettiarachchy, 1992, 1994, 1998). The result for these sexually active women is frequently negative in terms of the loss of the relationship and/or unwanted pregnancy. Consequently, many of them are cast adrift from the cultural mainstream of Sri Lankan rural society and endure cultural, economic and social rejection. To make matters worse, the health care system, despite its favourable MCH reputation, is completely unprepared to deal with the magnitude and complexity of the needs of these young women workers.

FTZs will continue to be part of Sri Lankan social and economic life; young, unmarried women from poor rural villages will continue to migrate to FTZs seeking a better life. As a result, the negative consequences of risky sex, lost relationships, unwanted pregnancies, hazardous abortions and single parenthood will increase, thus overwhelming an inadequate and unprepared reproductive health and MCH system. The results in this article point to the need to formulate and implement programmes to lessen the dangers of FTZs

for Sri Lanka's young women. These progmmmes should include: newcomer orientation, health and education campaigns, expansion of existing primary health care and reproductive health care services and the organization of women workers' associations with support from NGOs. The elements of this action plan include the following:

Outreach to dormitories: The dormitory strategy for collecting questionnaire data showed that the best method of engaging women is to conduct meetings and activities at the dormitory residences. The first step would be to select a cluster of large dormitories close to the factory complex to pilot initial programmes.

Public health midwives: PHMs played a key role in the implementation of the research project and could be a vital means of entry, information and identification of problems and participants. They could be trained to upgrade their roles and thereafter provided with an income supplement.

Identifying change agents: While it would be ideal to recruit women into voluntary roles as programme implementers, the lack of time among working women makes such an approach difficult. Instead, the project would seek to hire young women between the ages of 25 and 30 who have had at least four years' experience of living and working in the FTZ. They would be hired at a salary comparable to what they would earn in the FTZ. They would be trained in their new role as change agents.

Cooperative action in the dormitories: Women in the dormitories were observed to carry out their everyday chores on an individualistic basis. The organization of a cooperative effort could address, for example, the problem of nutrition through joint food acquisition, food preparation and cleaning activities on a rotating basis. Other possibilities for cooperation could include alternatives for disposable income in terms of savings and investment, and recreational activities. However, each dormitory group would select its 'own priorities. Using the change agents, the project would conduct education sessions in the selected dormitories concerning the advantages for the residents of organizing cooperative action. Change agents would be trained in cooperative action by a Sri Lankan government training facility.

Organization of cooperative committees: The success of cooperative action could lead to the organization of specialized committees to address issues on an ongoing basis. Committees of dormitory residents could be organized for newcomer orientation to the FTZ, handling such areas as nutrition, recreation and the alternative uses for disposable income.

Legal and political advocacy: University faculty and advanced students could provide training on workers' and residents' rights. One aspect of this effort could involve registering women to vote in the FTZ communities rather than their home district, so that their voting power could influence the behaviour of politicians and government representatives in the area.

Development of dormitory-based mobile health clinics: A shift in service policy could enable the PHMs to visit dormitories on a monthly basis to examine women with health problems and refer them to regular health delivery systems. The change agents and the health cooperative committee could support the PHMs in their work.

Reproductive health programme: Many of the women workers have poor knowledge of reproductive health and most have never had a gynaecological examination. The programme would utilize the PHMs, the change agents and family planning agencies to provide education and discussion, and referral for reproductive health problems.

Contraceptives: A contraceptive awareness programme could be conducted by family planning programmes and other NGOs to educate women on the alternatives available for contraception. The first step in the training would be to provide information on condoms and their use, accompanied by the distribution of condoms.

Counselling: For many young women, the absence of appropriate advice spells disaster and causes dysfunctional behaviour. The presence of elders and kin who could help to guide young women is very much needed. It may be possible to implement a system of "fictive kin" in which a senior woman, such as a landlady, creates a "surrogate relationship" linked to a small group of young women. Regular visits and group activities could create such a relationship and provide the opportunity to discuss problems and decisions. Professionals in a variety of fields need to be identified as educators and counsellors.

Support systems for pregnant women: When an unmarried woman becomes pregnant her world can collapse, with both the man in her life and her family withdrawing support. Any intervention needs to address a series of issues in terms of assisting the women in their decisions to give birth or to have an abortion, to work or go on leave, to pursue the man or not, to change residence, and many other concerns. The project needs to work with public, non-governmental, and private religious and non-religious organizations to develop a system of support for pregnant women.

In today's global economy, FTZs are a major phenomenon in the process of globalization (Schensul and others, 1994). Their basic structures and functions show great similarities across national systems and regions. Systematic research on the effects of FTZs on women is still inadequate, as are models for effective health promotion and education progmmmes. However, the commonalities among FTZs suggest that generation of knowledge and mechanisms for intervention can have a positive effect not only locally but also for FTZs elsewhere in the world. It is known that the development of these industries makes a significant contribution to the national economy. However, all efforts must be made to ensure that that economic contribution does not come at the cost of the health and well-being of young women workers.

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