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Opportunities
for Women

Sexual and reproductive health and rights (SRHR) interventions in the workplace and women's economic empowerment (WEE): a review of the evidence

WOW Helpdesk Query 5

Final Report

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Request for Support

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Key questions:

- What evidence exists of impact on women's lives (for employees and their families) as a result of interventions providing sexual and reproductive health services in the workplace (e.g. improved health outcomes, economic empowerment, expanded labour rights etc.)?
- What is the evidence that family planning and/or SRH programming/service provision in the workplace can result in returns on investment (ROI) for the employer?
- Is there any evidence that employer-provided family planning and/or SRH services can pose risks to women workers?

Executive Summary

Sexual and reproductive health and rights (SRHR) — including the right to decide if and how many children to have, the right to live free from disease and the right to access confidential, high-quality health services which enable women to control their own bodies — are fundamental to women’s economic empowerment (WEE). Put simply, when a woman’s SRHR are fulfilled, she has more opportunities to pursue economic activity and participate effectively in the workplace. This link between SRHR and WEE is reflected in DFID’s Economic Development Strategy (DFID, 2017), which includes a commitment to increase access to family planning as a vehicle for transforming women’s economic opportunities.

However, whilst decades of research have demonstrated the measurable benefits of investment in SRHR, these are often discussed as separate to women’s economic lives.¹ Consequently, when it comes to SRHR interventions, while the health-related benefits have been well documented, the wider impacts on women’s economic participation have been less explored.

This rapid review aims to help fill this gap by providing a summary of recent evidence on links between workplace provided SRHR interventions and including both WEE benefits for women (section 2) as well as economic and other benefits for their employers (section 3). The report also explores evidence of any potential risks (section 4) which need to be considered for quality, do no harm programming. Finally, the report provides a one page summary of ‘talking points’ (section 5), to help DFID to promote the multiple and economically empowering benefits of SRHR in the workplace to the private sector, international governments and other bilateral and multilateral donors.

Evidence base

The evidence base on links between SRHR interventions in the workplace and WEE is at an early stage in scope and scale, with notable gaps including:

- **The evidence is heavily clustered in the readymade garment (RMG) sector in Asia** — one of the biggest employers of low-skilled women workers globally. Whilst the RMG sector has been investing in women’s health for over a decade, other sectors — including the agricultural sector — are further behind.²
- **Weak evidence of attribution** — SRHR interventions provided in factory settings are often one of a suite of modules included within broader workplace health and wellbeing programmes, making it difficult to attribute — especially non-health related — results to specific components of the intervention.
- **A lack of evaluations which measure impact of SRHR interventions on non-health related outcomes including WEE.**
- **Evidence on the return on investment (ROI) of such interventions is at an early stage,** with few evaluation designs incorporating ROI analysis and a lack of robust data at the workplace level.

¹ For example, women’s health was a notable gap within the gaps and drivers of change identified by the UN High Level Panel on Women’s Economic Empowerment.

² This review found just one evaluation of a workplace-provided SRH interventions within the agricultural sector.

With these limitations in mind, key findings of this review include:

Benefits for women

- **There is strong evidence that workplace interventions which include modules on SRHR related topics** — typically delivered through peer-to-peer training — **can improve SRH knowledge and attitudes.**
- **Evidence on SRH-related behaviours is more mixed**, with stronger evidence of impact where interventions include provision of SRHR services — including free or subsidised SRH commodities — within the workplace, and where interventions adopt behaviour change approaches.
- **Evidence of impact on contraceptive decision-making is also mixed** reflecting deeply entrenched gender norms and cultural barriers, as well as the fact that most interventions do not tend to include women's partners or the wider community.
- **However, there is some evidence that SRHR interventions can impact on gender equitable attitudes and norms** when delivered holistically within a gender transformative curriculum. (Krishnan et al, 2016)
- **Workplace SRH interventions tend to have a much more limited impact on securing SRH rights** — due to an insufficient focus on issues such as gender, women's rights, safe abortion, LGBTI rights and gender-based violence — within the curricula or training. (Bryld, 2014; Hossain et al, 2017)
- Where evidence exists, it suggests that holistic life skills interventions — which include an SRH component — **can positively impact on some aspects of women's empowerment** – including self-esteem, self-efficacy, and changes to women's role in the household.
- In addition, there is evidence of wider economic empowerment related benefits for women including **improved confidence at work, communication skills and career progression.**

Benefits for employers

- There is **reasonably strong evidence that workplace wellness interventions** – which either focus on or include a component on SRH – **may produce quantifiable business benefits in the form of reduced absenteeism, sick leave and late days, reduced staff attrition and increased productivity.**
- **Evidence of ROI is more limited due to gaps in data quality at the factory level** (Bryld et al, 2014; PWC, 2016; Yeagar, 2011) **and a dearth of evaluations of workplace SRH interventions undertaking ROI analysis.** In the few examples where robust analysis has been undertaken, results range from £6-£63 ROI for every pound spent.
- In addition, **there is qualitative evidence of wider benefits for employers including improved quality of work, employee satisfaction, and reputational gains.** If quantified and tracked, such benefits could account for significant additional savings.

Risks

There are a number of risks associated with employer-provided SRH interventions which need to be carefully mitigated as part of quality and do no harm programming:

- **Poor quality implementation and insufficient attention to SRH rights** in particular due to pressures of productivity and limitations on time.

- **Breaches of confidentiality and privacy** which may result in termination of contract or even deportation in some contexts.
- **Coercion** — especially in contexts where national labour and domestic laws and regulations fail to sufficiently address women’s SRHR in the workplace, there is a risk that employers may use interventions to coerce women to make certain SRH decisions.
- **Backlash.** There is a risk that such interventions — especially which challenge cultural norms around SRH — may risk creating backlash from partners and the wider community.

1. Introduction

Workplace health promotion interventions — including those providing SRHR information and services — are increasingly being recognised as beneficial for both employees and employers. (Baicker, Cutler, & Song, 2010; Baiker et al, 2010; Rongen et al, 2013)

The RMG sector is often seen as a offering important potential for women’s economic and social empowerment. However, its’ predominantly female workforce — a large proportion of which are internal migrants — often have low levels of awareness on sexual and reproductive health, rights and services and are particularly vulnerable to unwanted pregnancies and unsafe abortion (Hossain et al, 2017). These women workers often face multiple barriers to accessing SRHR services including: time restraints; language barriers; high cost of services; and bias or discrimination (Marin, 2013). As a result, they experience poorer SRH outcomes and often have to take time off work resulting in a loss of income. This ultimately impacts on their employers — including factories, brands and retailers — through an increase in absenteeism and a loss of productivity (Battle and Hemrin, 2017).

This rapid review summarises recent evidence³ from published articles, academic journals and grey literature gathered through internet searches and from international experts⁴, on links between SRHR interventions in the workplace and benefits for employees including women and their families (section 2), ROI for employers (section 3) as well as potential risks (section 4).

Interventions included in this review are usually paid for by the buyers (e.g. Walmart) rather than the employers (i.e. factories), many of whom also have wider corporate engagements to support women’s empowerment. Whilst this report acknowledges that in most cases, employers are obliged to provide health clinics on site — which may or may not provide SRH-related services — these initiatives are rarely evaluated.

It is important to note that workplace wellbeing programmes typically try to address multiple needs of women through comprehensive approaches which include a suite of modules of which SRHR is one of many (in addition to areas such as general health and nutrition, financial skills, communication skills and gender etc.). These approaches both help to ensure maximum benefit from women’s time spent off the factory floor, and may make it easier to address more sensitive issues such as gender and SRHR by including these alongside less sensitive issues such as financial and time management. However, from an evaluation point of view, this makes

³ Sources from the last 10 years were included in this review.

⁴ Julia Battle (CARE Cambodia), Christine Svarer (WOW programme), and Marat Yu (BSR).

it difficult to attribute (particularly non-health) benefits to a particular part of the intervention. With this limitation in mind, the following sections provide a summary of the evidence.

2. Impact on women’s lives

This section explores evidence around the impact on women’s lives as a result of interventions providing sexual and reproductive health services in the workplace.

2.1 SRHR knowledge and attitudes

There is strong evidence that workplace interventions, which include modules on SRHR related topics typically delivered through peer-to-peer training, can improve women workers’ SRHR knowledge and attitudes. In addition, there is some limited evidence that such initiatives may have wider benefits for workers’ families as participants share knowledge they have learned with their wider family (ICRW, 2013). Evidence includes:

BSR’s HERhealth methodology

The HERhealth intervention uses capacity building and workplace strengthening to improve health-related knowledge and behaviours and access to health services and products for low income working women. Delivered over 18 months via peer educators through a series of workplace trainings, the content — tailored to local contexts — includes menstrual hygiene, sexually transmitted infections (STIs), HIV/AIDS, nutrition, family planning (FP), early detection of breast and cervical cancer, and occupational health and safety (OHS).

Source: Hossain et al, 2017

- A 2017 mixed-method evaluation of Business for Social Responsibility’s (BSR) **HERhealth intervention** (see box) in Bangladesh (including both a pre and post quantitative study of female workers in 10 factories and a qualitative study with factory managers, service providers, implementing partners and peer-educators) found a positive impact on some aspects of SRH knowledge including around menstruation, STIs and HIV/AIDS, and pregnancy risk factors. For example, the evaluation found a 15% increase in knowledge of pregnancy risks and a 47% increase in those who had heard of STIs in intervention factories between baseline and endline. Furthermore, the high levels of knowledge observed in post-intervention factories at baseline suggest this knowledge may be sustained beyond the intervention. (Hossain et al, 2017)

- **The Women in Factories (WIF)** training programme — an initiative of the Walmart Foundation’s Women’s Economic Empowerment (WEE) Programme — includes health and nutrition among core training modules developed by CARE International (in addition to functional literacy and personal finance; communication; gender, social status and relationships; and leadership). Although the programme did not include a core focus on SRHR, a randomised controlled trial (RCT) in seven factories in Bangladesh and India with 831 endline respondents found an impact on women factory workers attitudes towards birth spacing with a significant long-term reduction in agreement with the statement “I think there is no harm in getting pregnant again soon after giving birth” for women workers both with and without supportive supervisors. However, the evaluation found no impact on sanitary napkin usage. (Babbitt et al, 2017)
- A 2016 mixed-method impact assessment of **CARE’s Sewing For A Brighter Future project** in Cambodia — including a relatively small sample of 142 participants including 72 who had taken part in at least

one training session and 70 participants who had not taken part in the intervention — found an increase in some SRH-related knowledge. The intervention which included peer-to-peer sessions including a module on SRH, was associated with a 20% increase in women who could name at least one contraception method; a 22% increase in ability to identify at least two risk behaviour related to HIV/AIDS; and a 36% increase in knowledge about sexually transmitted infections (STIs). However, there was no impact on myths and misconceptions towards contraceptive use with more respondents who had undergone the intervention having misconceptions about the side effects of modern contraceptive methods than the control group. (Open Institute, 2016)

The impact of these workplace interventions on improving awareness of and realisation of SRH rights is more limited. Evaluations of BSR's HERproject and HERhealth programmes (2014; 2017) have found a limited impact on securing SRH rights due to insufficient engagement with rights-based issues such as gender, women's rights, safe abortion, LGBTI rights and gender-based violence within the curricula or training. However, when curricula is comprehensive and tackles such issues, it can improve women's awareness of their SRHR. For example:

- A qualitative assessment of a **youth peer-led intervention for women who work in factories across Nepal's Kathmandu Valley** found evidence that the project increased female workers' knowledge of SRHR-related topics which improved their overall health and relationships. From 2011-2012, Ipas together with local partners implemented a series of classes in Kathmandu factories using a comprehensive curricula covering human rights; sex and gender; relationships and violence; anatomy; puberty; menstruation; pregnancy; contraception and safe abortion. *'After taking the classes, women displayed greatly improved knowledge of safe abortion methods and where to obtain services — and also an increased comfort level with the idea that a woman has the legal and moral right to abortion if facing an unwanted pregnancy.'* (Ipas, 2013)

2.2 SRH Service uptake

Given the sheer numbers of women employed by the RMG sector, such workplaces have the potential to reach significant numbers of women with family planning products and services (who otherwise may lack access), thereby helping to achieve international family planning goals, such as FP 2020⁵.

Evidence of impact on SRH-related behaviours including demand for and uptake of services is more mixed. There is stronger evidence of impact where interventions include provision of SRH services (including free or subsidised commodities) within the workplace, and where interventions adopt behaviour change approaches. For example:

⁵ An outcome of the 2012 London Summit on Family Planning where more than 20 governments made commitments to address the policy, financing, delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies and donors pledged an additional US\$2.6 billion in funding. <http://www.familyplanning2020.org/>

- A 2017 quantitative assessment⁶ of **CARE’s Chat! Programme** (see box) — which employs an innovative behaviour change approach to improve SRH outcomes for almost 25,000 female garment factory workers in Cambodia — found that use of modern contraception and utilisation of SRH services among sexually active women garment factory workers doubled from 24% to 48%, and 9% to 20% respectively between 2014 and 2016. Knowledge of abortion also increased by 39% between baseline and endline (from 8% to 47%). Both knowledge and behaviour indicators were significantly higher among those participating in multiple elements of the intervention, compared to just one. (Battle and Hemrin, 2017)
- A 2016 evaluation of a 14 month pilot (from Feb 2014 – April 2015) of the **Worker Well-Being Initiative** of Levi Strauss & Co. (LS&Co.) and the Levi Strauss Foundation (LSF) in Egypt, which aimed to strengthen workplace-provided SRHR services through expanding the role of nurses, developing clinical quality standards and practices, and integrating management systems and oversight of health functions, found a high level of service uptake with 91% of the 97 women surveyed at endline reporting to have used the factory clinic for SRH services in the previous six months. Furthermore, data from focus groups with women workers indicated that as a result of the intervention, women felt more comfortable accessing services and discussing sensitive SRHR issues with nurses (Evidence Project, 2016)
- A 2016 annual review of the **Health Access and Linkage Opportunities for Workers (HALOW)** project implemented over 12 months by M&S, CARE and GSK and supported by DFID’s Business Innovation Facility (BIF) programme working with 7,700 RMG workers in factories in Bangladesh found that the intervention — which included subsidised SRH products and services provided through a mobile clinic once a month — increased those using sanitary napkins from 20% to 65%, and by the end of the one year pilot 2,100 workers had registered to receive free family planning services. The project focused on improving health care access for RMG workers and educating workers on eight key basic health issues – including family planning - through a peer

Chat! A behaviour change SRHR approach in Cambodian factories

CARE, Marie Stopes International and Save the Children in partnership with the Cambodian Ministry of Health (MoH) is empowering 24,236 factory workers working in 33 garment factories in Phnom Penh and Kandal provinces, through *Chat!* (Nov 2017 – present) an innovative behaviour change package that addresses sexual and reproductive health through a **teach, engage, and challenge** model:

- (1) Short, activity-based sessions that cover communication and consent, contraception, STIs, and safe abortion in a comfortable space;
- (2) Video dramas featuring characters in a garment factory to engage workers’ emotions as they relate to their everyday challenges; and
- (3) An interactive mobile application that challenges workers to improve their understanding of key topics. Facilitators are armed with relevant knowledge to correct misconceptions, and a referral directory with options for quality services near the factories.

Source: Battle and Hemrin, 2017

⁶ Conducted in December 2016-January 2017 in three factories with 244 workers (95% of confidence level and 6% margin error) and numbers were compared with the baseline assessment in four factories with 909 workers in August 2014. Workers of reproductive age (18-49 years of age) were selected from lists of workers supplied by the factories, using random number generation, with proportional numbers for each factory.

education model delivered by trained ‘health champions’, ⁷while also upgrading the clinics available on-site at the factories. (PWC, 2016; CARE, 2016)

- The 2011 evaluation of **HERhealth** (see page 6) in Pakistan and Egypt found 82% of workers took actions to improve their health based on information received from peer educators: 55% improved personal hygiene practices; 38% improved menstrual hygiene; 38% improved nutrition practices; and 7% began using family planning or changed family planning methods. (Yaeger, 2011)
- A mixed-method evaluation of the 2014-2017 SNV pilot of the **Working for Women Initiative** in Bangladesh – which implemented inclusive business models in 20 factories designed to improve demand for and uptake of SRHR services for more than 30,000 workers — found the proportion of respondents accessing family planning from on-site clinics increasing from 0.8% to 11.3%. However, in all sites, private pharmacies continued to be the preferred provider of family planning methods. In total, 10 different inclusive business models for provision of SRHR services were implemented with all models including provision of awareness raising sessions for RMG workers including on SRHR issues, but some variation in the type of services offered. Whilst some of the models provided products at low prices with on-site counselling services, others implemented health insurance schemes for the RMG workers in which premiums were contributed jointly by SNV and the partner factories. (SNV, 2017:2018)

⁷ 241 Health Champions (126 female and 115 male) were trained as peer educators and ‘go-to’ information points for fellow workers.

2.3 Gender equitable attitudes and norms

Deep seated harmful gender inequitable norms and attitudes may act as a significant barrier towards both SRHR and WEE. *‘Workplace programmes also can simultaneously reach men and women and offer a neutral venue for discussions related to gender norms and expectations’* (Krishnan et al, 2016). This review finds some evidence that when delivered holistically within a gender transformative curricula, employer-led workplace SRHR interventions can impact on gender equitable attitudes and norms. For example:

- A 2016 quasi-experimental evaluation of **Namagaagi Naave** (*‘It’s our life, it’s our responsibility’*) (see box) intervention – a participatory intervention to promote gender equity in garment factories in Karnataka State, India – found that after 12 months the intervention group survey respondents expressed greater gender-equitable attitudes, were less likely to report intimate partner violence (IPV) to be acceptable, less likely to associate alcohol use with positive outcomes, and were more knowledgeable of IPV and alcohol-related support services. (Krishnan et al, 2016)
- A 2013 ICRW evaluation of the **GAP Inc’s Personal Advancement & Career Enhancement (P.A.C.E.) programme** (see page 11), found evidence of shifts in women’s ability to address GBV, with a 133% increase in Chinese female workers who felt highly capable to reprimand a man’s inappropriate behaviour on the street (12% vs. 28%). (ICRW, 2013)

Namagaagi Naave (NN) workplace programme

The NN intervention used the workplace context to address the intersections between gender norms, IPV, alcohol use, and SRH. The overall goal of the NN activities was to promote individual and collective responsibilities to understand and challenge prevailing harmful gender and social norms and related adverse reproductive and sexual health outcomes.

The intervention included four issue-based campaigns (each lasting six days) over a 10-month period at the workplace. The campaign messages drew on the content of evidence-based interventions including Yari Dosti and Bell Bajao, which were adapted to the local context. Each campaign was implemented using static information displays (standees and posters) and interactive methods such as street plays, experience-sharing, and one-to-one interactions. In addition, BMST partnered with NGOs that provide support services (including reproductive and sexual health services) to offer these services on a periodic basis at the workplace and through referrals.

Source: Krishnan et al, 2016

Evidence of impact on contraceptive decision-making is mixed reflecting deeply entrenched gender norms and cultural barriers, as well as the fact that most interventions do not tend to include partners or the wider community. For example:

- An evaluation of CARE’s **CHAT! Programme** (see page 8) found complete confidence to discuss contraception with partners doubled between baseline and endline (24% - 50%) and complete confidence to refuse sex with partners almost trebled (17% - 50%) (Battle and Hemrin, 2017)
- By contrast, a 2014 theory-based evaluation of BSR’s **HERproject** (see box) (including a desk review and qualitative data collection in four Bangladesh garment factories and Kenyan flower farms) found that although married women felt more able to discuss family planning with their husbands, this had no influence on contraceptive decision-making due to deeply entrenched cultural norms limiting women’s ability to influence family planning decision-making in Bangladesh, and the fact that the intervention only targeted women, not their partners. (Bryld et al, 2014)

2.4 Empowerment-related outcomes

Evidence around non-health related benefits of SRH workplace interventions is much more limited with this rapid review confirming that most evaluations fail to measure impact on broader empowerment outcomes. However, where evidence exists, it suggests that holistic life skills interventions can positively impact on some aspects of women's empowerment including self-esteem, self-efficacy, and household decision-making. In particular:

- The 2013 ICRW multi country evaluation of **GAP Inc's Personal Advancement & Career Enhancement (P.A.C.E.) programme** (see box) found a significant impact on self-esteem (49%) and self-efficacy (150%). The evaluation also found that these changes impacted on women's role in the household. In Bangladesh, the evaluation found a nearly six-fold increase in P.A.C.E. participants who felt family members highly respected their opinion (13% vs. 72%), and a more than four-fold increase in women who said their family would look to them for advice (17% vs. 74%). (Nanda et al, 2013)
- An RCT of the **WIF programme** found that the training (which included a module on health and nutrition see page 6) in the short and long term positively impacts whether a woman's family helps with housework and childcare, and in the long term whether she helps decide how the family income is spent. However, the evaluation found no direct impact of the training on women's confidence (Babbit et al, 2017)

The P.A.C.E. Programme

P.A.C.E. is a comprehensive learning programme which has reached over 65,000 women in 12 countries since 2007. Women participating in P.A.C.E. receive 65 – 80 hours of life skills education followed by enhanced technical training that helps them become more effective at work and improve their personal lives. General and reproductive health is one of the nine modules – in addition to gender roles, communication, and leadership skills etc.

Source: www.gap.com/pace

In addition, there is evidence of wider economic empowerment related benefits for women including **improved confidence at work, communication skills and career progression**.

- The **P.A.C.E. programme** in Asia is associated with a 119% increase in self-reported work efficacy⁸ and 100% increase in workplace influence⁹, with factory supervisors also corroborating these perceived self-reported improvements. Interviews with women workers provided some more nuance to interpret these findings with respondents reporting that they felt more confident to work as part of a team, discuss challenges with their supervisors, communicate with and help their colleagues. Women workers who took part in the programme – which included a focus on leadership and communication skills – were more likely to advance in their careers. (Nanda et al, 2016)

⁸ Defined as meeting production targets on time; assuming greater responsibilities at work; and confidence to resolve a problem at work.

⁹ Defined as timeliness of arrival for work; ability to communicate with supervisors about work conflicts; and guiding peers when they make a mistake.

3. Benefits for the employer

Companies – in particular RMG companies – have invested in women’s health with significant business gains. This section explores the evidence that SRH interventions in the workplace can result in returns on investment (ROI) for the employer.

3.1 Quantifiable benefits

Globally, there is evidence (mainly from the US) that workplace wellness programmes can yield significant benefits for employers (Baiker et al, 2010; Rongen et al, 2013). For example, a 2010 Harvard meta-analysis (of US companies) found a USD \$3.27 return on investment (ROI) for every dollar spent on wellness programmes. (Baiker et al, 2010).

This review finds reasonably strong evidence from the Global South that workplace wellness interventions – which either focus on or include a component on SRH – may produce quantifiable business benefits in the form of reduced absenteeism, sick leave and late days, reduced staff attrition, and increased productivity. However, evidence of ROI is more limited due to gaps in data quality at the factory level (Bryld et al, 2014; PWC, 2016; Yeagar, 2011) and a dearth of evaluations of workplace SRH interventions undertaking ROI analysis. Evidence of quantifiable benefits for employers includes:

- A 2011 evaluation of the **HERproject** in Pakistan and Egypt (see page 6) found that three out of the four factories experienced reductions in absenteeism and female staff turnover following the intervention. As a result, in one factory in Pakistan where data was sufficient to undertake an ROI analysis, this represented a ROI of USD\$4 for every dollar spent. (Yeagar, 2011) These findings are further corroborated by qualitative findings from other assessments of the HerHealth methodology (Hossain et al, 2017; Bryld et al, 2014 etc.) where stakeholders including factory owners, management and women workers themselves reported a significant impact on absenteeism, staff turnover and improved productivity.
- The 2017 RCT evaluation of the **WIF programme** in Bangladesh and India — which included a training module on health and nutrition — found that productivity for female employees rose by 5% and tardiness reduced significantly, with the number of days women workers arrived late reducing from 45 to 17 per month. The evaluation concluded that the foundational training pays for itself in 1.7 months in terms of cost savings for the employer. (Babbit et al, 2017)
- An assessment of CARE’s **CHAT! Programme** in Cambodia (see page 8) found that on average factories saw 6% less turnover, 24% less leave without permission, with 6% more workers reaching productivity targets after the behaviour change intervention. (Battle and Hemrim, 2017)
- An ROI assessment of a six month pilot of the **HALOW** programme in Bangladesh (see page 8) found that on average factory efficiency improved by 15% compared to baseline. Whilst sick days overall increased during the intervention period, there was a downward trend in the latter half of the intervention. The gains in efficiency were associated with a strong positive ROI over the intervention period in both factories of ranging from a £6 to £63 ROI for every pound spent. However, the summary report of the assessment notes that whilst full attribution to the SRH intervention is assumed, it is likely that efficiency and quality are in fact influenced by much broader factors. (PWC, 2016)

3.2 Wider benefits

In addition to the evidence presented above, this review finds some (mostly qualitative) evidence to suggest that there may also be significant wider — often non-quantifiable — benefits including improved quality of work, employee satisfaction, and reputational gains, which may be more important for management than more quantifiable measures.

- Management in factories in Egypt and Pakistan reported significant wider benefits of the **HERproject** including workforce development benefits; enhanced utilisation of existing on site health facilities; improved worker satisfaction with management; improved worker health behaviour; reduced recruitment costs; improved reputation with factory clients; and improved worker cleanliness and hygiene. In particular, ‘error rates’ (mistakes made when making garments) were reported to have significantly improved following the intervention, with each error prevented representing an approximate saving of US\$10. Therefore, if tracked, error rate reductions could account for significant additional savings. (Yeagar, 2011)
- SRHR interventions may also lead to a strengthening of broader on site health facilities and services – with wider health benefits for employees. (Yeagar, 2011; Bryld, 2014)

4. Risks

There are a number of risks associated with employer-provided SRH interventions, some of which are related to any intervention of this type – whilst others concern the specific dynamics of providing such services in women’s place of work.

- **Poor quality implementation and insufficient attention to SRH rights:** Due to the inherent pressures of productivity and limitations of time in most factory settings, even where managers are broadly supportive, implementing partners of BSR’s peer health education model described challenges in persuading management to invest the time necessary to fully implement the model. (Hossain et al, 2017) Given these competing pressures, coupled with contextual cultural barriers, there is a risk that SRH interventions provided in the workplace may be rushed or incomplete, and/or may not be fully comprehensive, with a number of evaluations included in this review noting a limited impact on SRH rights in particular. (Bryld, 2014; Hossain et al, 2017) Specialist SRHR expertise including strong partnerships with quality health care providers are essential to ensure high quality and comprehensive information and services. By framing interventions as broader health and wellbeing programmes (rather than a more sensitive SRHR focused intervention) may help to persuade factory owners and managers, whilst providing an entry point to discuss more sensitive rights-based issues.
- **Maintaining confidentiality and privacy:** Confidentiality and privacy are incredibly important components of quality SRHR interventions, and especially important in the workplace setting where women employees may fear termination of contract due to illness and pregnancy, or in some cases even deportation. Countries like Singapore, Malaysia, and Taiwan require pregnancy and HIV testing, either on a yearly basis or upon renewal of contracts, and those who get pregnant or acquire STIs could be imprisoned or deported. (Marin, 2013) When SRH confidentiality is breached in the workplace, this

may pose significant risks for employees, for example a recent study by Human Rights Watch in Cambodia (2015) found that women workers in the garment industry repeatedly face pregnancy-based discrimination, sexual harassment and denial of maternity benefits. Comprehensive protocols which include an emphasis on confidentiality of services and data must be developed, adhered to and closely monitored in order to avoid any such breaches to mitigate these risks.

- **Coercion:** In some rare cases, especially in contexts where national labour and domestic laws and regulations fail to sufficiently address women's SRHR in the workplace, there is a risk that employers may use interventions to coerce women to make certain SRH decisions. For example, in Sri Lanka, where there is no law regarding informed consent for sterilization, there have been reported cases of forced sterilization of Tamil workers on tea plantations under the guise of a family planning programme. (Balasundaram, 2011) Rights-based approaches, which emphasise voluntary informed consent must be adopted to ensure women's rights are protected.
- **Backlash:** The majority of interventions included in this review focus on women workers, with a limited focus on partners or the wider community outside of the workplace. Programmes which directly challenge social norms (in this case around SRH) can create backlash from partners and the wider community (reference SNs guidance note). Mechanisms to assess, track and address risk are therefore an important part of quality and do no harm programming.

5. Talking points

Drawing on the evidence provided in this review, the following talking points are proposed to help DFID promote the multiple and economically empowering benefits of SRHR in the workplace to the private sector, international governments and other bilateral and multilateral donors.

1) SRHR are a fundamental building block of WEE

- When a woman's SRHR are fulfilled, she has more opportunities to pursue economic activity and participate effectively in the workplace.
- Holistic life skills programmes including SRHR components can improve women workers' self-esteem, self-efficacy and role in the household. For example:
 - The 2013 ICRW multi country evaluation of GAP Inc's P.A.C.E. programme found a significant impact on self-esteem (49%) and self-efficacy (150%). (Nanda et al, 2013)
 - A 2017 RCT of Walmart's Women in Factories Programme found in the short and long term the intervention positively impacts whether a woman's family helps with housework and childcare, and in the long term whether she helps decide how the family income is spent. (Babbit et al, 2017)
- Women who take part in such programmes may become more confident at work, have better communication skills and be more likely to progress in their careers. For example:
 - The P.A.C.E. programme associated with a 119% increase in self-reported work efficacy¹⁰ and 100% increase in workplace influence¹¹, with factory supervisors also corroborating these perceived self-reported improvements. Women workers who took part in the programme – which included a focus on leadership and communication skills – were more likely to advance in their careers. (Nanda et al, 2016)

2) Workplace provided SRHR interventions could make a significant contribution to international family planning (FP) goals.

- Approximately 70% of apparel production is done by women – often young migrants – who face multiple barriers to accessing SRHR services leading to poor health outcomes and economic insecurity.
- SRHR interventions provided in women's place of work can improve their SRH knowledge and attitudes, and when coupled with free or subsidised services and/or behaviour change approaches, can increase service uptake leading to fewer unintended pregnancies and unsafe abortion. For example:
 - A 2017 quantitative assessment¹² of CARE's Chat! Programme found that use of modern contraception and utilisation of SRH services among sexually active women garment factory

¹⁰ Defined as meeting production targets on time; assuming greater responsibilities at work; and confidence to resolve a problem at work.

¹¹ Defined as timeliness of arrival for work; ability to communicate with supervisors about work conflicts; and guiding peers when they make a mistake.

¹² Conducted in December 2016-January 2017 in three factories with 244 workers (95% of confidence level and 6% margin error) and numbers were compared with the baseline assessment in four factories with 909 workers in August 2014. Workers of reproductive

workers doubled from 24% to 48%, and 9% to 20% respectively between 2014 and 2016. Knowledge of abortion also increased by 39% between baseline and endline (from 8% to 47%). (Battle and Hemrin, 2017)

- A 2016 annual review of the 12 month HALOW project found that the intervention — which included subsidised SRH products and services provided through a mobile clinic once a month — increased those using sanitary napkins from 20% to 65%, and by the end of the one year pilot 2,100 workers had registered to receive free family planning services. (PWC, 2016)
- A 2017 evaluation of CARE’s CHAT! Programme found complete confidence to discuss contraception with partners doubled between baseline and endline (24% - 50%) and complete confidence to refuse sex with partners almost trebled (17% - 50%) (Battle and Hemrin, 2017)

3) There is evidence of quantifiable business benefits in the form of reduce absenteeism, sick leave and late days, reduced staff attrition, and increased productivity which suggests a high ROI for employers.

- Whilst ROI analysis of SRHR interventions is at an early stage in scope and scale, evidence from two different factories in Bangladesh suggests an ROI of £6 to £63 for every pound spent (PWC, 2016).

4) The Ready Made Garment (RMG) sector in particular (compared to other highly feminised sectors) have been investing in women’s health for over a decade with significant gains

- Quantifiable benefits include reduced absenteeism and staff attrition and increased productivity.
- Wider benefits include improved quality of work, employee satisfaction and reputational gains.
- The evidence suggests significant opportunities to think beyond the RMG sector, in particular the agricultural sector which is the biggest employer of women globally.

5) In order to mitigate risks, provide high quality confidential services and do no harm, strong partnerships and referral networks with SRHR providers are needed.

- Ensure curricula and training incorporate rights-based issues such as gender, women’s rights, safe abortion, LGBTI rights and gender-based violence to enable women to fulfill their SRHR.
- When delivered holistically within a gender transformative curricula, high quality employer-led workplace SRHR interventions can also impact on gender equitable attitudes and norms.

6) There is a need to build a stronger evidence base demonstrating the multiple links between SRHR interventions and WEE

- The evidence is heavily clustered in the RMG sector – with more evidence needed from other areas.
- Evaluations of workplace SRHR interventions should integrate measures of WEE and ROI analysis.
- In order to build the evidence base on ROI for employers, more work is needed to strengthen the quality of data at the level of the workplace.

age (18-49 years of age) were selected from lists of workers supplied by the factories, using random number generation, with proportional numbers for each factory.

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