

Companies' Return on Investment (ROI) on investments in women's health in the workplace - an overview of evidence and cases

This report forms part of the joint IFU & DFPA Win-Win Project – How workplace-based investments in women's access to health pay off both for women and companies



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Abbreviations

BSR	Business for Social Responsibility
CSR	Corporate Social Responsibility
DFPA	The Danish Family Planning Association (<i>Sex&Samfund</i>)
FAO	Food and Agriculture Organization of the United Nations
ICRW	International Center for Research on Women
IFC	International Finance Corporation
IFU	Investment fund for developing countries
ILO	International Labor Organization
NCD	Non-communicable diseases
ROI	Return on Investment
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually-transmitted diseases
STI	Sexually-transmitted infections
UN	United Nations
UNGP	United Nations' Guiding Principles on Business and human rights
WASH	Water, sanitation and hygiene-related diseases
WEF	World Economic Forum
WHO	World Health Organization

1 Introduction

1.1 Purpose

This report forms part of the joint the Danish Investment Fund for Developing Countries, IFU and the Danish Family Planning Association, DFPA, project "The Win-Win Project – How workplace-based investments in women's access to health pay off both for women and companies".

The overall purpose of the project is to strengthen considerations to women's health in the workplace further by developing tools and guidelines to support companies in their efforts.

The purpose of this report is to provide an overview of the evidence base particularly on companies' Return on Investment (ROI) when making investments in women's health in developing countries. It presents an analysis of 47 reports on initiatives on women's health in the workplaces and illustrates how such initiatives and their effects are measured.

1.2 Executive summary

The cases displayed in this study illustrate how investments in women's health in the workplace have immediate positive impact on women's knowledge and behaviour related to health, including on nutrition, hygiene practices, reproductive health and family planning, but also on the overall company rate of absenteeism and staff turnover. This indicates that company investments in women's health hold unexplored potential for providing health benefits to women at the same time as creating economic benefits for companies.

Demonstration of ROI thus represents an important vehicle to document both the business benefits from investing in women's health in the workplace and the immediate improvement of women's health. As such, ROI calculations pave the way for integrating health investments in the business strategy as an essential asset and for seeing such investments as pivotal for maintaining or increasing the company's productivity and quality of products, rather than women's health as a *do good* project.

However, only a few studies exist that actually calculate the ROI on initiatives promoting women's health in the workplace. This desk study encompasses a total of 47 peer reviewed articles, surveys and reports, among which seven include a focus on ROI impact, 14 present business cases and 11 provide tools and guidance. The rest includes society cases and social impact. 62 % of the examined documents are focused on health initiatives in developing countries.

Three examples of ROI are presented in this study illustrating initiatives in garment manufacturing in Egypt on health awareness, hygiene and reproductive health, in Bangladesh on training in sexual and reproductive health, and one with an on-site health clinic. These cases estimate rates of ROI to 4:1, 3.3:1 and 3:1 (BSR 2011; USAID 2007; Phulki 2015).

The cases have been supplemented with examples on business cases describing qualitative correlations between investing in women's health and creating business benefits.

This study also reveals methodological challenges related to the calculation of ROI. The examined reports show that the ROI ratio presented in the projects is often based on an assumption of causation between health investments and positive business impacts, e.g. reduced absenteeism and higher productivity. Depending on the chosen assumptions, however, the ROI ratio may vary from 1.33:1 to 13.29:1 in a particular project. This result was demonstrated in the Comfit Composite Knit factory in Bangladesh (Phulki 2015).

This calls for further development and testing of models for ROI calculation and for designing indicators that contribute to creating evidence for ROI in health programs. Apart from absenteeism

and staff turnover – as the most common business impact indicator – reduced overtime and fewer production errors could be applied. In addition, indicators focusing on the well-being of the employee, including anaemia, concentration and exhaustion, hold the potential for generating benefits for business, but these need to be explored further in the context of developing countries.

As part of a way forward, this study points to the need for integrating a strategic business approach into the endeavours of promoting women’s health in the workplace. Today, non-profit organisations and governmental aid agencies are instrumental for the realisation of health projects in the business sector. The CSR agenda, however, could be seen as a driver for engaging companies more actively in protecting and promoting health. The UN Guiding Principles thus represent a framework for assessing the company risk of negatively influencing the health of employees, and the Sustainable Development Goals for target setting. In combination with an ROI approach, this may bring health initiatives to the core of a business strategy at the same time as contributing to society through the creation of shared value.

2 Methodology

2.1 Business and human rights

The analysis in this report is based on a combined business and human rights approach. The human rights based approach is applied in an explorative form, which opens up for the inclusion of perspectives that influence the global agenda on women’s health and promote international standards in the field.

Taking the point of departure in women’s right to health as stipulated in the UN Convention on the Elimination of All Forms of Discrimination against Women, we have thus broadened the perspective by including the Sustainable Development Goals adopted in 2015 as well as prioritized areas in relation to women’s health identified by WHO and UN Women.

A business approach is used as a second parameter. It ensures a business focus on the economic benefits from investing in health initiatives for women, and guides the selection of not only ROI initiatives, but also reports and activities illustrating business cases that document or indicate a positive impact of initiatives promoting women’s health in the workplace.

2.2 Desk review

The review builds on reports and material containing analysis, initiatives, outputs and outcomes from company investments in initiatives promoting women’s health and improving working conditions in developing as well as developed countries¹.

As part of the desk review, a systematic and thorough search of all types of literature relevant to the topics of calculating ROI business cases on women’s health in general and specifically in relation to the workplace, women’s rights to health and economics and business initiatives to promote health among their female employees has been carried out.

The desk review took its offset in a list of 39 reports identified by DFPA before the inception of this study and made available to Carve Consulting. As part of the desk review, a search of literature was performed based on references in reports and surveys on the DFPA list. Additionally, a search was made on academic articles listed in databases, including Academia, the Danish Institute for Human Rights Library, London School of Economics Library and Social Science Research Network and on

¹ The distinction between developed and developing countries is based on the World Bank’s country classification. Low- and middle-income economies are referred to as “developing” while high-income economies (GNI per capita of USD 12736 or more) are categorized “developed” (World Bank 2015; World Bank n.d.).

websites, such as Harvard Business Review. Other material and information was found on websites of international organisations, including ILO, IFC, FAO, UN Women and WHO, the Norwegian Government and non-profit organisations, e.g. the South African CareWorks and Business for Social Responsibility (BSR).

As a result of the search, the DPFA list was supplemented by eight reports. Accordingly, a total of 47 reports and surveys have been studied and form the basis of the analysis in section 3 below.

Most reports have been carried out as part of programs in the participating companies initiated and supported by external actors, such as e.g. BSR. Others are developed by organisations with an overall political purpose, such as the World Economic Forum. Fewer reports are based on academic research and validated methodologies.

Due to the variety in purpose, the content and applied methodologies in the reviewed reports, the reports and the examples listed below, should be seen as illustrating good examples, rather than demonstrating a generally valid causal link between a health initiative for female employees and a specific ROI value.

This is underlined by the relatively short project phases of some health programs. As an example, a BSR project ran over a period of 18 months and was used to demonstrate a 3:1 ROI value. An additional factor is the lack of systematic use of control groups to confirm the results of the project phase.

Another factor that should be taken into consideration when assessing the transferability of the health initiatives and implementation practices to other types of companies, business sectors or geographical regions, is the active intervention from external actors. Thus, the highlighted examples in this report are set up through external intervention and economic support, and not as programs initialized by the companies themselves.

2.3 Categories of health indicators

In order to establish an evidence base for the development of tools and guidelines applicable throughout the world and in all industries and business sectors, a number of categories of health impact and business impact indicators have been developed. The indicators are embedded in international standards, programs and practices.

From a preliminary screening of reports and material encompassed by this review, a total of 16 health-related indicators were found and applied on the 47 relevant documents (see Annex 1). However, the indicators were subsequently grouped into six categories as illustrated in table 1, inspired by four Sustainable Development Goals (SDGs):



Health indicators	Connection to the Sustainable Development Goals
1. Nutrition & Anemia	SDG 2 – includes a focus on nutrition
2. Sexual and Reproductive Health, SRH	SDG 3 – includes the issues of reducing maternal mortality, ending epidemics of HIV/AIDS and other communicable diseases, ensuring access to health care services, family planning and information.
3. Non-communicable diseases, NCD	
4. Sexually-transmitted diseases, STD	
5. Gender-based violence, GBV	SDG 5 - includes ending discrimination and violence against women as well as access to sexual and reproductive health and rights.
6. Water, sanitation and hygiene-related diseases, WASH	SDG 6 - includes a focus on access to water and adequate and equitable sanitation and hygiene for all.

Table 1. Health Indicators and their connection to the SDGs

See Annex 2 for a detailed overview of the relevant SDGs and their targets.

Lastly, the categories reflect prioritized areas within women’s health made by WHO as explained in the WHO Guidelines: maternal, reproductive and women’s health². The categories are also aligned with the focus areas regarding women’s health promoted by UN Women³.

2.4 Design of business impact indicators

Indicators used for monitoring and measuring the business benefit of investments in women’s health in the workplace pursue an overall purpose of profitability. Investments are thus guided by the business interest in maintaining satisfaction with their products among consumers and business partners, and should have a directly transferrable positive economic impact on the business. Pursuing the same purpose, most companies are engaged in activities that aim at increasing work performance by supporting the well-being and stability of their employees.

As expectations to the social responsibility of companies, CSR, and their engagement in local communities and societies, in which they run their operations, are increasing, and followed by legal obligations to report on their CSR activities, many companies initiate projects and programs with a social or human rights focus. For companies who look beyond philanthropy, a business driven approach to women’s health in the workplace provides an interesting approach with its combination of business and CSR.

Based on this perception of business interests and social responsibility, and the findings of health indicators in the examined reports, two sets of business impact indicators have been designed. One set of indicators reflects the business interest in work performance or presenteeism – and represents direct business benefits. The other has the employee in focus, monitoring her well-being, and creates indirect business benefits.

The indicators are listed in table 2 below.

Direct business benefit	Indirect business benefit
Absenteeism	Anemia
Employee turnover	Concentration
Productivity	Exhaustion

² The guidelines are available at http://www.who.int/publications/guidelines/reproductive_health/en/

³ For further information, see <http://www.unwomen.org/en/what-we-do>

Quality	Lack of health-related knowledge
Stability	Well-being

Table 2. Direct and indirect business benefit

2.5 Small scale survey

With the purpose of demonstrating good examples of workplace initiatives, Carve Consulting has contacted 26 companies with operations in developing countries within industries characterized by a high representation of female employment.

Apart from 19 large and medium sized listed Danish companies, six multinational companies and one small company based in Kenya were approached and invited to present their activities or results from investments in women's health. The companies were contacted by e-mail or telephone. The outcome of the small scale survey is presented in section 4.

The companies are listed in Table 3 below.

Danish C20 companies	Other Danish companies	Multinational companies	Other companies
Carlsberg	Arla	Biogen Idec	Ruby Cup
Chr. Hansen	B&O	DuPont	
Coloplast	Bestseller	H&M	
FLSmith	Danfoss	IKEA	
ISS	Grundfos	Royal Copenhagen (Fiskars)	
Maersk	LEGO	Tata	
Maersk Oil and Gas	NNE		
Novo Nordisk	Rockwool		
Novozymes			
Pandora			
William Demant			

Table 3. Participants in small scale survey

3 Desk review

3.1 Documents

This desk review maps and describes existing studies and evidence on ROI and women's health in the workplace in developing countries. It also includes studies from developed countries if these are seen as valuable or inspirational beyond their geographical sphere.

The desk study encompasses descriptions of output and outcome of initiatives on promoting and protecting women's health and rights in the workplace conducted by companies, NGOs, multilateral organizations, aid agencies and social actors. The material covers published articles and reports.

A total of 47 documents were reviewed and categorized according to their type of impact:

- ROI: the document contains evidence where companies have calculated the actual return on investment
- Business case: the document presents one or several cases of reported business benefits resulting from an investment in women’s health in the workplace
- Society case: the document provides information on macro-level, and contain information on societal impacts from public or private sector investment in women’s health in general
- Tools: the document provides guidance on how to plan and implement health initiatives in the workplace and/or measure business benefits
- Others: the document does not match any of the above categories

As illustrated in figure 1, nearly half of the reviewed documents contained information on ROI or presented a business case about investing in women’s health.

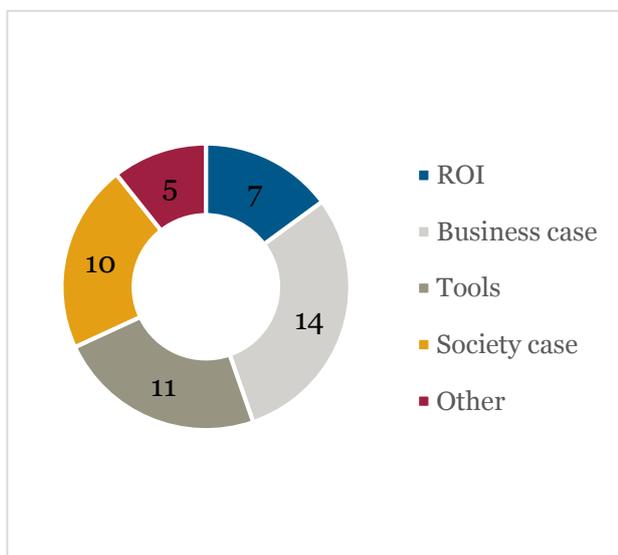


Figure 2. Categorization of the reviewed articles (No.)

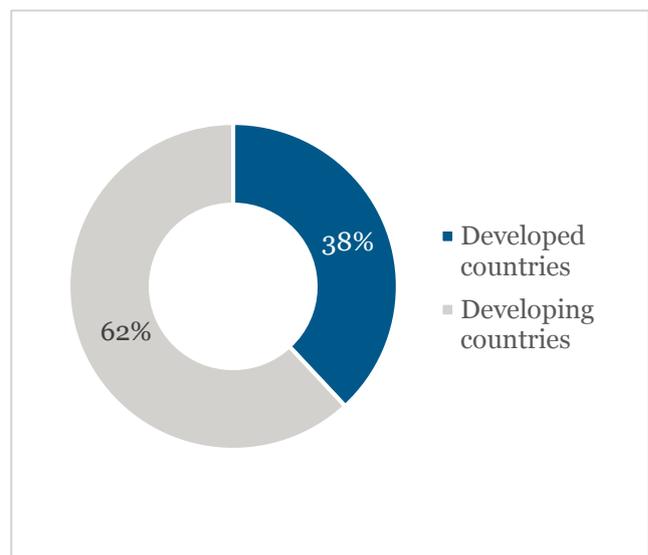


Figure 1. Geographic location of ROI/Business cases (%)

Figure 2 breaks down the 21 documents that were categorized ROI or business case to illustrate the percentage of cases taking place in either developing (62 %) or developed countries (38 %).

The 21 documents that contained evidence on ROI or business benefits were subsequently screened, applying a number of predetermined indicators to explore what type of health initiatives are common at the workplace, and what kind of business benefits are considered to be a result of investments in health. The results are explained in section 3.2 Health initiatives and business benefits.

Even though those documents categorized “society case” do not present concrete evidence from a company-level perspective, they do contain strong arguments in favour of a significant and positive societal impact when the public or private sector invests in women’s health.

The 11 documents categorized as “tools” provide guidance on how to plan and implement health initiatives in the workplace and/or measure business benefits and are explored further in section 3.5.

3.2 Health initiatives and business benefits

The results presented in this section are based on 21 documents and include cases from both developing and developed countries.

3.2.1 Health initiatives

The reviewed documents reveal a number of different indicators relevant for the measurement of health impact of business investment on female workers or other groups of women. Figure 3 illustrates the type of health initiatives that were identified in the 21 ROI/Business case documents.

Initiatives related to non-communicable diseases, nutrition and gender-based violence were each identified seven times. Initiatives related to sexually-transmitted diseases and WASH-related diseases were identified eight and nine times, respectively. Finally, initiatives related to reproductive health were, by far, the most common theme in the reviewed documents. It should be noticed that each reviewed document may contain one or several health initiatives, and therefore, the number of identified initiatives does not match the number of reviewed documents.

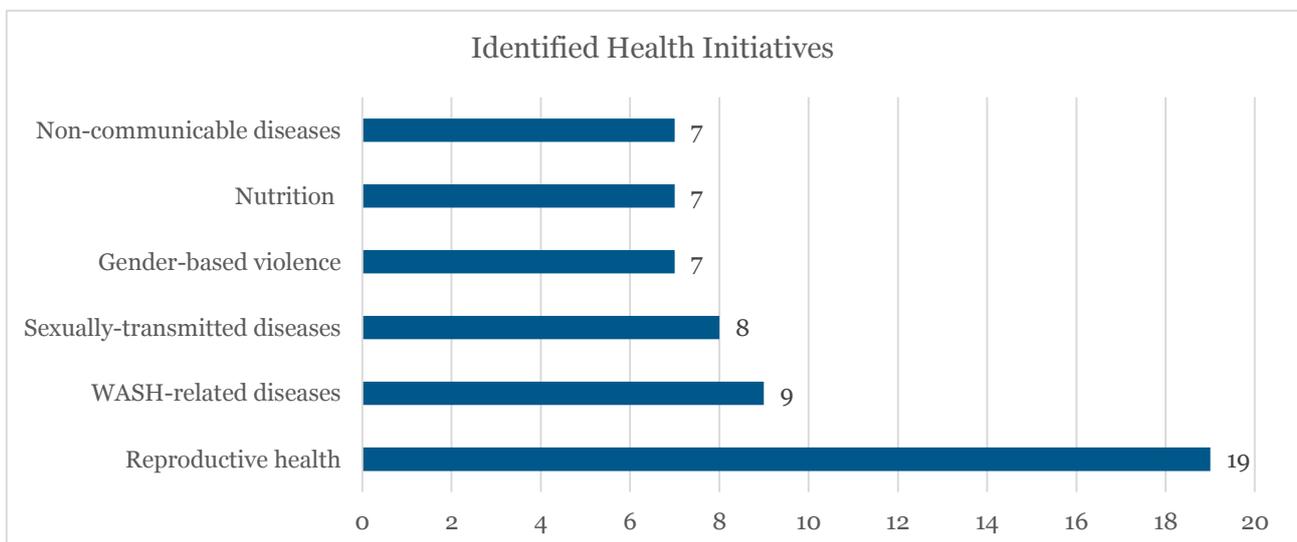


Figure 3. Identified health initiatives

The six categories illustrated in figure 3 encompass a total of 16 health-related indicators. The documents are distributed across the categories as follows:

<p>Category: Gender-based violence (GBV)</p>
<p>Indicators:</p> <ul style="list-style-type: none"> • sexual harassment • violence against women
<p>Result: The total number of documents exploring the impact on gender-based violence is 7, among which 4 focus on violence against women and 3 on sexual harassment.</p>

Category: Non-Communicable Diseases (NCD)
Indicators: <ul style="list-style-type: none"> • cervical cancer • diabetes • knowledge of diseases, symptoms and prevention
Result: The documents on non-communicable diseases show 7 initiatives, covering 2 on cervical cancer, 2 on diabetes and 3 on disease knowledge (symptoms and prevention).

Category: Nutrition
Indicators: <ul style="list-style-type: none"> • anemia • nutrition
Result: Bad nutrition is a root cause for many health related issues and diseases, and 7 documents study the connection between nutrition and work performance.

Category: Reproductive Health
Indicators: <ul style="list-style-type: none"> • access to family planning • information on access to contraception • maternal health • menstruation • reproductive health • safe abortion
Result: The largest number of documents on women’s health related initiatives in the workplace focuses on reproductive health. Thus, 19 studies pursue this angle. Among these, 3 address overall issues of reproductive health, 6 address maternal health, 6 focus on access to family planning, 2 on contraception, none on safe abortion, and 2 on menstruation.

Category: Sexual Transmitted Diseases (STD)
Indicators: <ul style="list-style-type: none"> • HIV/AIDS • sexual transmitted infections
Result: Studies on STD amount to 8, and include 5 documents on HIV/AIDS and 3 on sexual transmitted infections.

Category: Water, sanitation and hygiene related diseases (WASH)
Indicators: <ul style="list-style-type: none"> • hygiene • access to water and sanitation
Result: The interrelationship between WASH-diseases and work performance is the subject of 9 studies, including 6 on the impact of hygiene and 3 on access to water and sanitation.

3.2.2 Business benefits

The 21 reviewed documents show a preference for using indicators reflecting business benefits directly linked to profit. Thus, absenteeism and productivity are used in most studies, i.e. 16 and 15 respectively, to demonstrate the direct positive economic impact of women's health initiatives.

The company's staff turnover rate is used as an indicator in nine cases. The turnover rate cannot be directly linked to the bottom line without further calculations on the economic value attached to an employee, including both direct and indirect costs. As many factors influence the choice of an employee to resign or for management to dismiss the person, the linking of this indicator to benefits from health programs requires management to disclose their approach to ROI calculations and integration of specific indicators and specifications in a baseline survey.

Quality and stability are other indicators used to measure the benefits from an improved health situation of a specific person or group of employees. These indicators are not easily transferrable into direct economic benefits, and are only used three and one time respectively as indicators in the examined studies.

The application of each indicator in the examined documents is shown in figure 1. The figure illustrates reported cases of positive business effects (*Effect QUAL/QUAN*), described either in qualitative or quantitative means, as well as actual ROI calculations (*Effect ROI*).

The picture drawn from application of indicators across the examined studies seems to suggest a business driven human resource or health risk approach to employee health. Thus, measuring absenteeism, productivity and staff turnover is predominant in the documents, whereas much less attention is given to indicators that would unveil negative physical or mental impact with the employees or their well-being.

Looking at studies on US based companies, a different pattern appears. In these studies, focus is on general wellness or the positive experience from engaging in health promoting activities, but also more specifically on negative experience from e.g. back pain and hypertension. Such sets of

indicators are used in combination with indicators with a direct business benefit, including absenteeism, presenteeism or underperformance and health care costs (World Economic Forum 2012; Bertera).

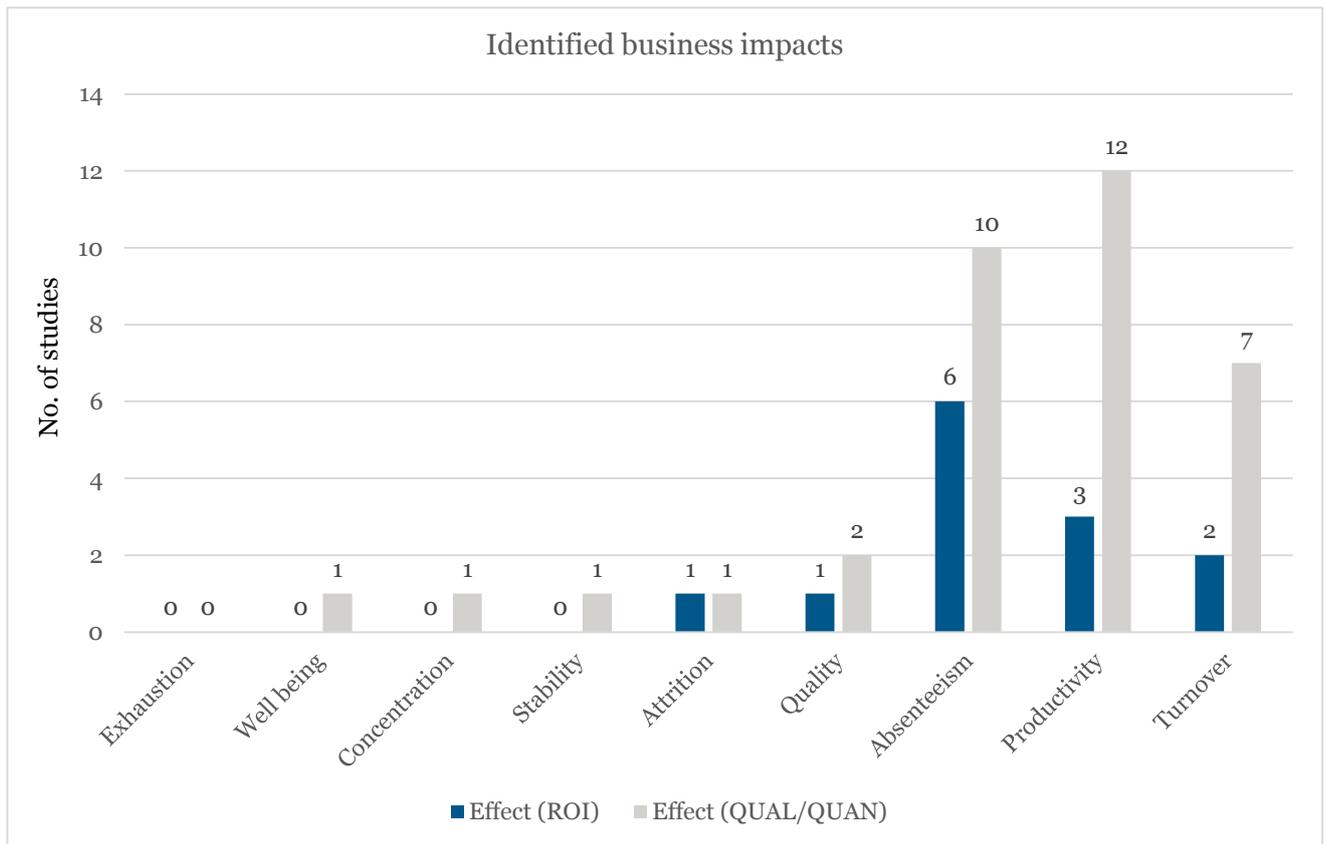


Figure 4. Business benefits (qualitative and/or quantitative measurements) and ROI

3.3 Examples on return of investment (ROI)

The desk study identified few cases where return on investment (ROI) has been calculated. Out of 10, only three are conducted in a developing country context.

All cases from developing countries were carried out in the garment manufacturing industry, which is highly depending on female workers for production. The cases showed that participating businesses had 44 - 84% female employees. The background and ROI of these cases are described in the following. Supplementing examples of ROI are from cases in the USA, many of which focused on employee well-being and health services related to increasing health expenses of companies related to non-communicable diseases.

EXAMPLE 1

HERproject has taken a number of initiatives in cooperation with businesses (Garment Manufacturing in Egypt)

The initiative is focused on improving women worker's overall health awareness including hygiene and reproductive health. The immediate health impacts included 82% of the workers taking actions to improve their health based in information received from peer educators⁴, through improved

⁴ Peer education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their peers. Peer education is the teaching or sharing of health information, values and behaviour in educating others who are in similar position, in this case worker to worker.

personal hygiene practices, improved menstrual hygiene, improved nutrition and use of family planning or changes in family planning methods (BSR 2011).

Results

The study found that absenteeism was reduced by 8.3% and turnover among female workers reduced by 6.4%. Based on these results, a *ROI of 4:1* in form of reduced absenteeism and turnover rates were calculated. The factory management further underscored the possible multiplier effects related to productivity, stating that the decrease in production error rates could account for significant additional savings (Yeager 2011).

Calculating ROI	
APPLIED METRICS	
Costs: <ul style="list-style-type: none"> Start-up costs of the clinic Clinic operational costs 	Return: <ul style="list-style-type: none"> Saved turnover cost per employee Saved cost of training a new employee Productivity gains from reduced, healthier and happier workers (BSR n.d.)
LIMITATIONS IN DATA AND CALCULATION	
<p>The project identified the following limitations:</p> <ul style="list-style-type: none"> Expected and unexpected events such as cultural holidays, security challenges and civil disturbance impact baseline and end line comparison of productivity data Difficulties in obtaining cost data, such as the valuation of workers' time or error rates Lack of reliable data, due to inadequate data tracking systems and incomplete data availability 	
LEVELS OF CAUSATION	
<p>Return on investment were calculated using different levels of causation between the savings made at the factory and the HERproject intervention. Ranging from a level of causation of 10% to 100%, the ROI shows a variation of 0.74:1 to 7.4:1 - both extremes considered unlikely. Whereas the more likely result from causation of 25%, 50% and 75% is 1.9:1, 3.7:1, and 5.6:1.</p>	

Lesson learned

Lessons learned from the HERproject design includes:

Create a project team

- The team should have representation from human resources, production, factory clinic and union

Engage middle management early

- Introducing the business case argument and the implementation schedule

Select peer educators with care

- Criteria should include personal characteristics as well as tenure with factory

Design training sessions to maximise stability and impact

- Considering peer educator turnover and low education level, it is recommended to parcel the curriculum over six 2.3 hours sessions held every other month, with bi-monthly refresher trainings

Integrate with existing system

- Combine with existing training programs or health programs for efficiency and sustainability

Use creative information sharing

- Peer educators pass on information during scheduled small-group training sessions, new worker orientations, and during work, lunch and travel to and from the factory

Allow flexible training schedule

- Line managers and HR staff work with peer educators and clinic nurses to avoid costly disruptions in production

EXAMPLE 2

Insight Development and Partners in Health and Development (Garment Manufacturing in Bangladesh)

The initiative provided extensive awareness training among factory workers on sexual and reproductive health issues. The aim of the initiative was to create behavioural change that could improve the health of workers and positively impact their productivity, and thus have a positive return on investment.

A baseline survey of knowledge and behaviours related to health was carried out at the inception of the project in selected factories. The project intervention completion at factories was followed up by an end-survey. On most indicators, the comparison of baseline and end-surveys indicated increased knowledge of reproductive health issues (USAID 2007).

Results

Comparison of baseline and end line surveys indicated increased knowledge of reproductive health issues, including:

- Knowledge about menstrual regulation increased from 19% to 62%
- Knowledge about safe menstrual regulation practices increased from 10% to 81%
- Knowledge of key family planning issues increased from 73% to 93%

The following behavioural changes among workers were identified:

- Use of sanitary napkins increased from 10% to 17%
- Prevalence of the use of modern family planning methods increased from 54% to 67%

The study found that absenteeism was reduced by 25% and a reduced production error rate of 9.5%

Assuming a 25% causation, the case provides an estimate of **3.3:1 ROI**, whereas the estimated ROI is 6.6:1 when assuming 50% causation (Phulki 2015).

Calculating ROI	
APPLIED METRICS	
Costs: <ul style="list-style-type: none"> Awareness training 	Return: <ul style="list-style-type: none"> Reduction in absenteeism Reduction in errors in production Increased productivity
LIMITATIONS IN DATA AND CALCULATION	
<p>Given the insufficient baseline data and the short time span of intervention, it is difficult to capture the level of causality between health interventions and increased productivity.</p>	
LEVELS OF CAUSATION	
<p>The ROI strongly varies according to the assumed causality:</p> <ul style="list-style-type: none"> 13.29:1 – upper limit, assumes an unlikely level of 100% causation from the intervention 9.97:1 – assumes a 75% causation 6.64:1 – assumes a 50% causation 3.32:1 – assumes a 25% causation 1.33:1 – assumes an unlikely level of 10% causation 	

Project activities promoting women’s health in the workplace

The activities included:

- Report building with factory management
 - Orientation with factory management
 - Entry point to provide health and reproductive services
- Selection of master trainer and peer educator
 - Master trainers selected from mid-level management staffs
 - 2% of the workers were selected as peer educators
- Train master trainer and peer educator
 - Providing training to MT and PEs
 - MT: 3 hours orientation session
 - PEs: 6 hours session
- Disseminate through MT and PE
 - Team of three trainers (one MT and two PEs) to disseminate the message among workers
 - Each batch consisted of 30 participants
 - The two peer educators from the team would disseminate the messages in follow up sessions at the floor, while they had off tie or free time with less workload

EXAMPLE 3

USAID (Garment Manufacturing in Bangladesh)

The project established an on-site workplace health clinic and provided consultation on workers' reproductive health and family planning status and concerns. Both men and women were counselled on sexually transmitted infections (STI), including HIV/AIDS. Antenatal care and post-natal care were also available.

The on-site clinic recorded a total of 1,145 consultations during the 18-month study period, providing 2,263 treatments or services, 30% of which involved reproductive health and family planning (Phulki 2015).

Results

The study found that a 450 worker factory in Chittagong gained a financial benefit from providing health services to workers, thus at the same time providing an important business case for smaller companies with limited resources for such employee investments. The initiative focussed on providing on-site health services including reproductive health and family planning.

The study found a decrease of 11% in absenteeism in the first year and 18% over the first 18 months, and a 43% decrease in staff turnover in the first year and 46% over the first 18 months.

The study estimated the monetary value of the savings gained from reduced absenteeism and turnover compared to the start-up and operation expenses for the health program, and found a ROI of 3:1 over 18 month of the program.

The study also provides evidence that a small investment to enhance workers' access to health services and health awareness may contribute to an improvement of the workers' behavioural practices and health, and it may also contribute to a significant gain in factory productivity and thus profitability.

Calculating ROI	
APPLIED METRICS	
Costs: <ul style="list-style-type: none"> • Start-up of health clinic • Operation of health clinic 	Return: <ul style="list-style-type: none"> • Reduction in absenteeism • Reduction in staff turnover
CALCULATING ROI	
The ROI was calculated using the following methodology, incorporating both absenteeism and turnover:	
<i>Total savings (absenteeism, turnover) / Total costs (start up and operational costs)</i>	
The one-year ROI was computed in the following way: <ul style="list-style-type: none"> • The factory savings due to reduction in average number of absent days was calculated as: <i>(Average number of days absent in 2004 – average number of days absent in 2005) x (merchandise produced by a worker per day)</i> • Then the factory savings due to retention in average number of new recruits was calculated as: <i>(Average number of new recruits in 2004 – average number of new recruits in 2005) x (cost of training a new employee)</i> • The activity's start-up cost to the factory was calculated, taking into account indirect costs associated with employee and management time • Finally, the clinic operational cost was calculated 	
The results obtained through these computations were used to calculate the ROI:	

<i>(Factory savings due to reduction in average number of absent days + Factory savings due to reduction in average number of new recruits) / (Start up cost + Clinic operation cost)</i> (USAID 2007)
LIMITATIONS IN DATA AND CALCULATION
<p>The project reports the following limitations:</p> <ul style="list-style-type: none"> • Determining the cost of an absent or departed employee • Inconsistency in data – e.g. the number of workers employed and attendance records corresponding to the day-to-day reality in the factory. This is mainly due to the production cycle and that during periods of high production, workers would be asked to work overtime rather than hire more employees • Incomplete attendance and employee turnover records, due to non-formalised employment relations and record to avoid certain legal obligations to workers • No clear demarcation between holidays and monthly workdays, due to difference in status during peak garment production, where public holidays are compensated instead • No well-maintained records for resignations or terminations, often employees quit without giving notice or while on leave
LEVELS OF CAUSATION
N/A

Inspiration: demonstrating absenteeism

Findings on absenteeism are demonstrated in an older study from the US on health education and health promotion programs. The study adheres to a Health Risk Appraisal scheme and thus focusses on weight control, blood pressure, dental health, stress management and nutrition, and cover both men and women. Evaluating the impact of a comprehensive workplace health promotion program on absences among 43,888 hourly employees, the study found a net difference of 11,726 fewer days of absenteeism over two years at program sites, and an ROI of 2.05:1. (Bertera 1990).

3.4 Business cases based on qualitative indicators

A number of cases exist in the literature describing qualitative correlation between investing in women friendly workplaces, including improved access to health services and business benefits. Improving women’s health represents a business-critical investment that will reap short-term benefits through reduced absenteeism, reduced turnover rates, improved product quality and increased production (BSR 2011; IFC 2013).

Improving general working conditions and minimising negative business impacts

There is a strong link between investing in women’s health and improving working conditions in general. While few companies are focusing on on-site health investments targeting women, many more are looking to the business case for better working conditions and the direct effect on productivity and profitability of companies. The Better Work campaign of IFC and ILO provides evidence from Better Work Vietnam covering 185 factories in the apparel industry of the improvements, which also covers sexual harassment, clinic treatment quality and health services among others. The case shows that factories experience a 5.9% boost in profitability when workers perceive improvements in working conditions. Profitability is 7.6% higher where workers experience a comfortable environment and trusting workplace, and workers in factories with better working

conditions reach their daily production targets up to 40 minutes faster compared to factories with non-improved working conditions (IFC/ILO 2015a). Furthermore, better working conditions were seen to have positive impacts in employee turnover and absenteeism (IFC/ILO n.d.).

Examples of cases providing incentives based on the negative impacts, which neglecting poor practises can have on business, also exists. The Better Work initiative of IFC and ILO provides such a case drawing on experiences from Haiti, Jordan, Vietnam and Nicaragua. It states that prevalence of sexual harassments in factories leads to low production efficiency, increase workforce turnover and likely raises the wages necessary to retain workers. These impacts manifest in reduced profits and companies should therefore have a strong incentive to control an incidence of sexual harassment in their factories (Lin et al. 2014).

Investing in women’s sexual and reproductive health and rights

The HERproject provides by far the largest number of business cases for investing in women’s health based on participating companies in 11 countries including Mexico, Egypt, Bangladesh, China, Vietnam, India and Pakistan. The HERproject demonstrates the power of providing women’s general and reproductive health in the workplace to transform individual lives and deliver business efficiency and cost savings to participating factories. (BSR 2014a).

The HERproject has showed that the factory workplace provides a unique forum for reaching out to women on sexual and reproductive health and rights (SRHR), and that women are able and willing to adapt enhanced knowledge on SRHR to change their practises (Bryld et al. 2014).

The cases show that a number of preventable health conditions and diseases impact workers’ quality of life, reduces their productivity and increases the likelihood of health-related absenteeism. Common health conditions include poor nutrition and anemia, reproductive health, sexually transmitted infections and diabetes. The subsequent business impacts encompass absenteeism and decreased productivity. Through investing in a range of on-site health services and health awareness peer education, participating factories report effects up to 25% reduced poor concentration at work, 11% reduced absenteeism, 33% reduced difficulties in meeting production targets (BSR 2010).

Furthermore, the evaluation of the HERproject found that the use of peer educator mechanism enhanced the degree of comfort in discussing sensitive issues related to sexual and reproductive health, while at the same time keeping the costs low at factory level enabling a perceived ROI (Bryld et al. 2014).

Project activities promoting women’s health in the workplace

Initiatives include awareness raising on general and reproductive health through training and peer educator programs.

Improving health knowledge and access to health service

Investigating the link between health outcomes and business outcomes, a case from the agricultural sector in Kenya showed that health initiatives focusing on improving health knowledge (e.g. breast cancer self-examination) and access to and use of health services had a positive impact on worker’s health in general. A direct outcome related to health behaviour (e.g. pain management knowledge), led to a 40% decrease of missed work due to menstrual pain. The direct effect on business was a decrease of 12-14% of workers missing at least one day in the last six months due to illness, and a decrease of 14-35% of worker’s ability to work and meet targets without being negatively affected by health issues (BSR 2014b).

The business impact is further strengthened through investing in on-site health services. During an audit in a factory providing on-site health services, workers indicated that the availability of the on-site services made them less likely to be absent from their work, more likely to stay in their current job and have a positive attitude toward factory management (USAID 2007)

Project activities promoting women's health in the workplace

Initiatives include on-site health providing reproductive health and family planning services as well as counselling on sexually transmitted infections including HIV/AIDS, and providing antenatal and post-natal care.

Early detection and treatment of cancer

Women in low-resource settings suffer disproportionately from breast and cervical cancer due to lack of detection at an early stage and poor access to quality cancer health services. Major interruptions in workforce participation apply to both women diagnosed with cancer and their caregivers. Cases from factories in Guatemala and Nicaragua providing workplace initiatives such as early detection and treatment of cervical cancer, nutrition programmes, awareness raising on self-examination for breast cancer, and support to employees to transition back to the workplace after leave, show a reduction in health related absenteeism up to 50% (Bupa/UICC n.d.).

Project activities promoting women's health in the workplace

Initiatives include providing general and reproductive health education improving awareness of self-examination

Inspiration: Women's economic empowerment

Health programs for women may be seen as part of a broader engagement in women's economic empowerment. A study in this area suggests creating a business case based on an integrated approach that include inter alia access to and control over reproductive health and family formation, freedom from risk of violence and access to safe employment. It also points towards a need to look across the value chain of the company and identify and acknowledge women not only as employees, but also as suppliers, contractors and distributors, as customers and as members of communities in which companies work. The study claims an inter-linkage between supporting economic empowerment of women and ROI – both for business and society – as well as increased profit and sustainable growth in society, higher input quality and better productivity for companies (ICRW 2014).

3.5 Tools and guidelines

Designing and implementing ROI programs

Guidance on the understanding of ROI and how to measure it, and for creating business cases and exploring the need for health related initiatives for women in the workplace, is found in more examined documents. These documents are all related to the BSR HERprojects.

On the basis of experience and results, an ROI toolkit provides basic tools and background to integrate ROI into the overall health program in a company. The toolkit suggests a mixed methodology that collects both quantitative and qualitative data. Under these headings, the study identifies returns from new savings attributable to the health activities and return from sunk costs, i.e. existing costs. Reduced absenteeism and reduced turnover are part of the former, whereas the

latter cover reduced overtime, fewer production errors, increased output, reduced shipping costs due to missed deadlines, attendance bonuses, training and health insurance payments.

The study stresses the need for ROI processes, and especially the requirement for an ongoing dialogue with management about the applied quantitative data, and the assignment of a monetary value to agreed indicators. In addition, the study points to the necessity for the collection of ROI data to coincide with the introduction of new health programs. It provides a 9 step program for designing and implementing a ROI program, including project management, a baseline survey, data collection, monitoring and analysing data, and the sharing of results (BSR n.d.).

Identifying focus areas for health interventions

In order to ensure the highest outcome of company health initiatives, it is important to map the risks for negative impacts on women's right to health, and assess health needs in the given context. One of the HERprojects provides concrete examples on how to establish women's health needs in the workplace, e.g. by using explorative questions.

Inspiration: establishing women's health needs

Using explorative questions are suggested in a HERproject as a way to establish women's health needs:

- *'Do women have varied, significant health needs, including needs related to health knowledge, behaviour, and access?*
- *Do these needs extend to women employed within relevant sectors?*
- *Do health burdens limit employment opportunities or women's ability to excel at work?*

(BSR 2014b)

Successful implementation

The success of an initiated health intervention at the work place highly depends on the management commitment and a context specific design of the health intervention. The USAID study identifies a number of factors contributing to the success of a workplace health program.

Inspiration: management commitment to health interventions

Three success factors are identified by the USAID in relation to health programs:

1. The factory owner and the line managers are supportive of the on-site health services from the onset, and demonstrate their support through direct encouragement and by example;
2. The health services are designed and implemented in a manner that clearly correspond to the needs and interests of employees; and
3. The health services and factory management respond quickly when concerns about the quality of health services arise.

(USAID 2007)

Seeing that compliance standards can serve as motivators for improved management practises and working conditions, BSR and UL's Responsible Sourcing Group argue for incorporating health indicators into existing workplace assessments, particularly focusing on women's health and well-being at the workplace (BSR 2014c)

Inspiration: Workplace wellness

Based on a workplace wellness approach, a study from the World Economic Forum focusses on ways of keeping employees healthy, irrespective of geographical or business sector context. The background for this study is the existing risk of not meeting the demand for skilled workers, which is related to the ageing of the work force and the increase in chronic diseases, but also to the economic growth. A healthy workforce is thus seen as a moral and business imperative for employers.

In building the business case, the report relies on analyses and surveys demonstrating the costs related to the increase in non-communicable diseases (NCD). An example shows that over the next 20 years NCDs will cost 47 trillion US dollars or 4% of the annual global GDP.

As NCDs will affect the workplace performance and productivity through absenteeism and presenteeism, costs run to as much as 70 million US dollars for lost time and productivity and employer covered healthcare costs and medical expenditure.

Apart from identifying health related costs, the report proposes seven steps to support companies and governments in closing the talent gap, orienteered mainly towards strategic talent planning and people management. Other focus areas are behavioural risks and changing risk related behaviour (WEF 2012).

4 Examples from Danish companies

As part of the small scale survey conducted among 26 Danish companies, the responses showed only three cases of involvement in health related initiatives with women as a target group, but only one directly targeting women in workplaces in developing countries.

Maersk launched a global maternity leave policy in April 2016 with the purpose of reintegrating women after maternity leave. The new policy includes a program allowing a phased reintegration to work for all onshore employees, and a global guaranteed minimum of 18 weeks maternity leave on full pay for all employees.⁵ ROI rates were considered as part of the planning of the project, and linked to a new target of retaining at least 90% of the women going on maternity leave.

A project was initiated by Novo Nordisk in Nicaragua with the purpose of preventing diabetes among pregnant women. The project targeted women working in factories and was carried out in cooperation with management in order to facilitate access to diabetes consultation during work hours for women, who were diagnosed with pregnancy diabetes.

Bestseller is the only company engaged in health projects for women in workplaces in developing countries. They participated in a BSR HERproject involving 12.000 female employees in Bangladesh and included indicators on absenteeism, turnover rates and productivity.

The Bestseller case does not provide other knowledge than the BSR HERprojects integrated in the desk review. Regarding the other cases, one was not targeting the group of women at focus in this study and in the other case, it was not possible to get access to ROI estimates or calculations.

⁵ See more on <http://www.maersk.com/en/the-maersk-group/press-room/press-release-archive/2016/1/maersk-group-introduces-improved-maternity-benefits-worldwide-20160114t073843>

As such, the small scale survey did not provide results or information relevant for the study. It may however indicate the need for anchoring programs concerning investments in women's health in the workplace to company management, as suggested in part 6.

A list of the companies involved in the small scale survey is found in table 3 in part 2.5 above.

5 Conclusions and recommendations

The cases displayed in this study illustrate how investments in women's health in the workplace have immediate positive impact on women's knowledge and behaviour related to health, including nutrition, hygiene practices, reproductive health and family planning, but also on the overall company rate of absenteeism and staff turnover. This indicates that company investments in women's health hold unexplored potential for providing health benefits to women, and at the same time creating economic benefits for companies.

In this light, the application of ROI methodology and calculations represents an important vehicle to demonstrate the effect of investments in women's health in the workplace. ROI thus paves the way for integrating health investments in the business strategy as an essential asset and for seeing such investments as pivotal for maintaining or increasing the company's productivity and quality of products.

To disseminate such integrative perspective on ROI, there is a need for developing tools and guidance on ROI methodologies, including specific indicators and calculation schemes. On the basis of the cases analysed in this study, the following three recommendations stand out as key to moving investments in women's health in the workplace from a *do good* agenda into a strategic business agenda.

A need for additional ROI cases

Few studies exist that have actually calculated the ROI related to women's health. Furthermore, the ROI ratio is often based on assumptions of causation between health investments and positive impacts on e.g. productivity. In order to determine the level of causation and provide strong ROI evidence, more studies and well-documented business cases are needed.

One example of the significance of the assumption on causation is shown in the Comfit Composite Knit factory. Here, a significant increase was found in the productivity in a garment factory, gained through reduction in absenteeism and a reduction in errors in production, as a result of the Nirapod project. The ROI for this particular project varies significantly depending on the assumed causation of the gain from increased acceptable quality production (i.e. reduced error), and hence the company value of this results (ROI 1.33:1 assuming 10% causation to ROI 13.29:1 Assuming 100% causation).

Recommendation

There is a need for designing and testing models of ROI calculation, including assessments of the assumptions used for such calculations, and studies of their application in practice by companies with operations in developing countries.

A need for additional business impact indicators

Most of the identified cases are focused on ROI related to indicators such as absenteeism and staff turnover. However, the potential of exploring ROI related to effects on productivity and reduced

error rates are evident. Studies suggest that the focus on absenteeism and employee turnover rates in the calculation of ROI might be too narrow to capture the true value of investing in women's health.

The management in two of the factories investing in women's health, the Comfit Composite Knit factory and the Ismailia factory, stated the investments had several non-quantifiable business benefits.

In the Ismailia case, the management stressed that, apart from the direct effects of reduced absenteeism and turnover rates used in the ROI calculation, additional multiplier effects related to the productivity and reduction in error rates could account for significant additional savings. Furthermore, management found that from a reputational perspective, other buyers' clients had taken notice of the HERproject during visits or audits.

Also, indicators focusing on the well-being of the employee, including anemia, concentration and exhaustion, hold the potential for generating benefits for business, but needs to be explored further in the context of developing countries.

Recommendation

Additional indicators should be tested in a company setting, such as reduced overtime, fewer production errors, low concentration and anemia. Subsequent studies on the indicators as means of achieving increased output in the calculation of ROI should be initiated.

Baseline survey

A proper and well-established baseline is a precondition for evidence-based studies on ROI. Currently, few studies have been carried out with a baseline on employees and a production baseline. This affects the accuracy and validity of existing ROI calculations.

Recommendation

Set-up and maintain consistent records on employee data, including:

- Number of workers employed
- Attendance records with clear indication on overtime hours, public holidays and leave
- Employee turnover records, including records for resignation without giving notice

Additionally, cost rates need to be established concerning:

- Cost data including valuation of workers' time or error rates
- Cost of an absent or departed employee

6 Discussion: a way forward

As concluded in part 5, there is a need for additional cases that demonstrate ROI effect and for additional indicators. On a practical level, there is a need for establishing a baseline survey with consistent records of employee data, before embarking on measuring ROI effects of health initiatives for women in the workplace.

However, the further development of company-based health initiatives and tools for measuring the ROI effect may also call for structural adaptation. Hence, the picture that can be drawn from the examined studies shows that linking the ROI approach to health initiatives for women is suggested

mainly by international and non-profit organisations, and aid agencies. Often, these actors are also involved in carrying out activities and health programs within the companies.

As catalysts for change, such external interventions are instrumental and should be further deployed as part of international aid and investment programs. At the same time, however, it is of major importance to create genuine ownership within company management to such programs, and to ensure that they are embedded in the company's strategy, culture and practices.

Strengthening the CSR perspective

Anchoring programs on ROI on women's health in the workplace presents an opportunity for the company to link the initiatives to their CSR strategy and – under that umbrella – their efforts to protect and promote women's rights to health, employment, inclusion and empowerment.

By doing so, companies can build their rationale for engaging in women's health in the UN Global Compact and in the Sustainable Development Goals. Moreover, this contextualisation opens for applying existing tools and guidelines for human rights risk assessment and for identification of internationally acknowledged health targets and indicators.

The CSR perspective is also a driver for linking health initiatives to the business interest in productivity, stability and quality, and thus integrate results and benefits from health initiatives into the overall business model and strategy. Thus, it paves the way for management to disclose their management approach to women's health in the workplace.

ROI and risk assessment

Before embarking on programs on ROI on health initiatives for women, companies applying a CSR perspective may use the UN Guiding Principles (UNGPs) to assess their risk for negatively impacting women's right to health.

Carrying out a due diligence process would thus help identifying and assessing actual and potential adverse impacts caused or contributed to by the company itself, or through products or services by its business relationships (OHCHR 2011; OHCHR 2012). Based on this insight, the company can initiate needed and relevant health programs and demonstrate how they protect and improve health conditions or prevent or mitigate the risk of illness, exhaustion or lack of concentration. Accounting for how they address adverse impact is part of the UNGP due diligence process, and may contribute to the baseline need for the ROI calculation.

From this perspective, the human rights risk assessment and an ROI approach to health initiatives may be seen as interlinked and mutually benefiting. This points to a way forward for integrating ROI in the planning of CSR activities in the companies – to the benefit of both women and business.

Creating shared value

The interest in ROI calculations of health initiatives for women in the workplace may also be combined with a shared value approach in creating value for business and society (Porter & Kramer 2011).

Thus, an emerging discussion is related to the ability of companies to positively impact the health of women and children, using their strategic advantages while generating value for the company. The concept of 'shared value' is the cornerstone of this discussion, and a number of good cases exist where companies created shared value by reconceiving products and markets; redefining productivity in value chains; and strengthen local clusters (PMNCH 2012). The literature further presents processes and tools for companies to implement strategic investments in women's health (BSR 2011). The introduction of the concept of shared value should be seen in the light of an increasing number of

companies looking towards the Sustainable Development Goals, to tap companies CSR efforts into broader global development trends.

This avenue presents a core argument for further developing the methodologies and indicators to demonstrate ROI on women's health in the workplace.

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8 Annexes

Annex 1: Health impact indicators and related studies

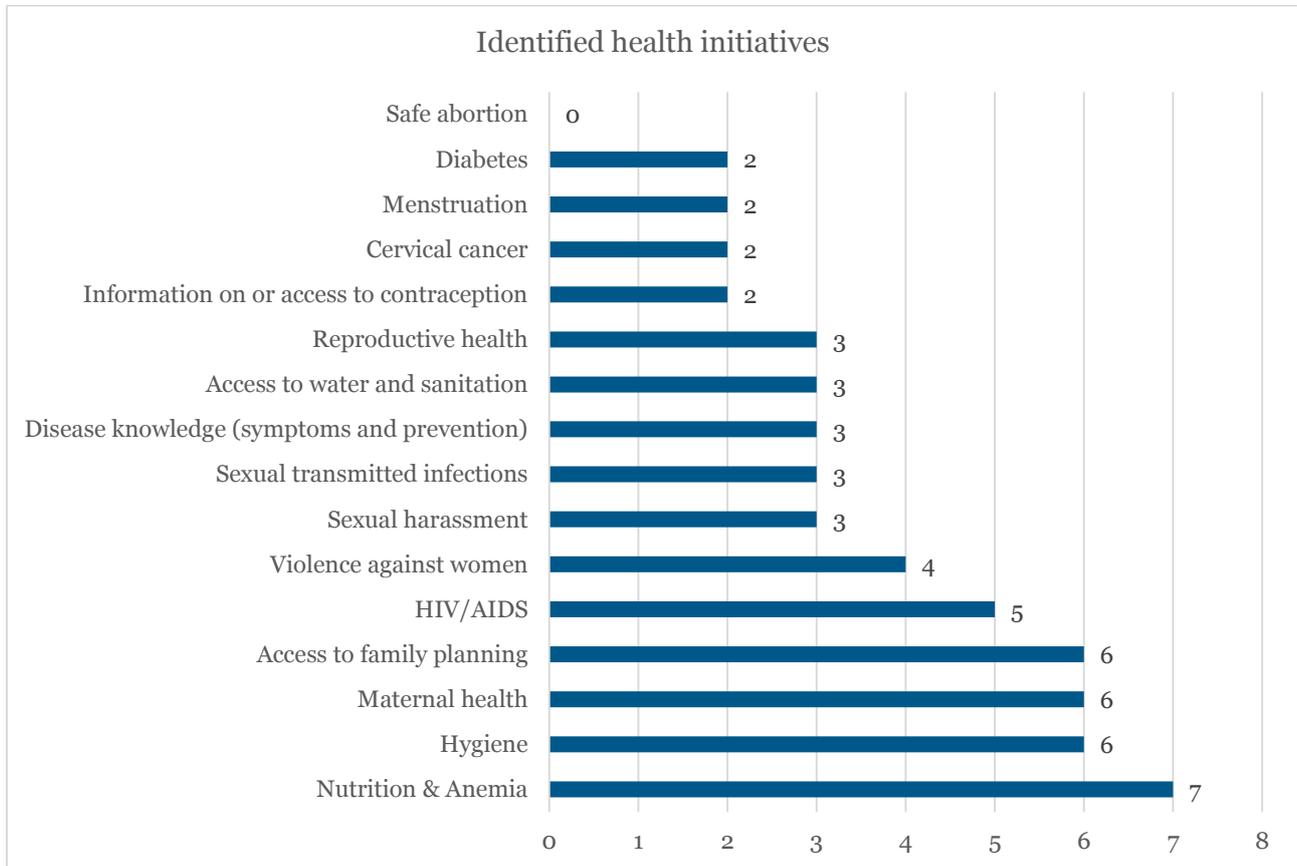


Figure: Identified health initiatives - all categories

Annex 2: Women's health and the Sustainable Development Goals



SDG 2 – End hunger, achieve food security and improved nutrition and promote sustainable agriculture

2.1. End hunger and ensure access by all people to safe and nutritious food all year round

2.2. End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons



SDG 3 - Ensure healthy lives and promote well-being for all at all ages

3.1. Reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.2. End preventable deaths of newborns and children under five years old

3.3. End the epidemics of AIDS, tuberculosis, malaria, and combat hepatitis, water-borne diseases, and other communicable diseases

3.4. Reduce by one-third pre-mature mortality from non-communicable diseases

3.7. Ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8. Achieve universal health coverage, access to quality health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all



SDG 5 – Achieve gender equality and empower all women and girls

5.1. End all forms of discrimination against all women and girls everywhere

5.2. Eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual exploitation

5.6. Ensure universal access to sexual and reproductive health and reproductive

rights



SDG 6 - Ensure availability and sustainable management of water and sanitation for all

6.1. Achieve universal and equitable access to safe and affordable drinking water for all

6.2. Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation

Annex 3: Identified indicators and their sources

Reference	Identified health initiative	Identified business impact	Geographic location
BSR (2006)	<ul style="list-style-type: none"> • HIV/AIDS • Reproductive health • Nutrition & Anemia 	<ul style="list-style-type: none"> • Reduced absenteeism • Improved productivity • Improved quality • Increased turnover 	Developing countries
USAID (2007)	<ul style="list-style-type: none"> • Access to family planning • Reproductive health 	<ul style="list-style-type: none"> • Reduced absenteeism • Increased turnover 	Developing countries
Yeager, R. (2011)	<ul style="list-style-type: none"> • Maternal health • Access to family planning • Information on or access to contraception • Sexually-transmitted diseases • Hygiene 	<ul style="list-style-type: none"> • Reduced attrition • Reduced absenteeism • Improved productivity • Improved quality • Increased turnover • Improved quality 	Developing countries
BSR (2010)	<ul style="list-style-type: none"> • HIV/AIDS • Maternal health • Access to family planning • Information on or access to contraception • Nutrition & anemia • Diabetes • Hygiene • Disease knowledge 	<ul style="list-style-type: none"> • Reduced absenteeism • Improved concentration • Improved productivity 	Developing countries
Bertera, R. L. (1990)	<ul style="list-style-type: none"> • Nutrition & anemia • Disease knowledge 	<ul style="list-style-type: none"> • Reduced absenteeism 	Developed countries
IFC/ILO (2015a)	<ul style="list-style-type: none"> • Violence against women • Sexual harassment • Access to water & sanitation • Hygiene 	<ul style="list-style-type: none"> • Reduced absenteeism • Improved productivity • Increased turnover 	Developing countries
IFC/ILO (n.d.)	<ul style="list-style-type: none"> • Access to water & sanitation • Hygiene • Sexual harassment • Violence against women 	<ul style="list-style-type: none"> • Reduced absenteeism • Improved productivity • Increased turnover 	Developing countries
Lin, X, Babbitt, L. & Brown, D. (2014)	<ul style="list-style-type: none"> • Sexual harassment 	<ul style="list-style-type: none"> • Improved productivity • Increased turnover 	Developing countries
Goetzel, R. Z., Guindon, A. M., Turshen, I. J., & Ozminkowski, R. J., (2001)		<ul style="list-style-type: none"> • Reduced absenteeism • Improved productivity • Improved stability 	Developed countries
Brannon, R. & Orrick, S. (1998)	<ul style="list-style-type: none"> • Access to family planning • Reproductive health • Cervical cancer • Violence against women 	<ul style="list-style-type: none"> • Reduced absenteeism • Improved productivity • Increased turnover 	Developed countries
Phillips, K. E. & Flood, G. (2008)	<ul style="list-style-type: none"> • Maternal health 	<ul style="list-style-type: none"> • Reduced absenteeism • Increased turnover 	Developed countries

Heinemann, L.A., Minh, T.D., Filonenko, A. & Uhl-Hochgräber, K. (2010)	<ul style="list-style-type: none"> Menstruation 	<ul style="list-style-type: none"> Reduced absenteeism Improved productivity 	Developed countries
Wasiak, R., Filonenko, A., Vanness, D. J., Law, A., Jeddi, M., Wittrup-Jensen, K.U., ... Jensen, J. T. (2013)	<ul style="list-style-type: none"> Menstruation 	<ul style="list-style-type: none"> Improved productivity 	Developed countries
IFC (2013)	<ul style="list-style-type: none"> HIV/AIDS Maternal health Nutrition & Anemia 	<ul style="list-style-type: none"> Reduced absenteeism Improved productivity 	Developing countries
Bupa/UIICC (n.d.)	<ul style="list-style-type: none"> Cervical cancer Nutrition & Anemia Access to water & sanitation 	<ul style="list-style-type: none"> Reduced absenteeism Improved productivity Improved well-being 	Developing countries
Phulki (2015)	<ul style="list-style-type: none"> HIV/AIDS Maternal health Access to family planning Violence against women Sexually-transmitted diseases Hygiene 	<ul style="list-style-type: none"> Reduced attrition Reduced absenteeism Improved productivity Improved quality 	Developing countries
Rand Corporation (2014)	<ul style="list-style-type: none"> Nutrition & Anemia Diabetes Disease knowledge 	<ul style="list-style-type: none"> Reduced absenteeism 	Developed countries
Terry, P. E. (2010)		<ul style="list-style-type: none"> Improved productivity 	Developed countries
BSR (2014b)	<ul style="list-style-type: none"> HIV/AIDS Maternal health Access to family planning Sexually-transmitted diseases Nutrition & Anemia Hygiene 	<ul style="list-style-type: none"> Reduced absenteeism Improved productivity Increased turnover 	Developing countries
BSR (2014a)	N/A		Developing countries
BSR (2011)	N/A		Developing countries