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# Working Women and Health in East Africa's Agricultural Sector

**A Scoping Study for BSR HERproject**

September 2014

www.herproject.org

# About This Report

This report was written by Jean-Baptiste Andrieu, Ouida Chichester, Racheal Meiers, Chloë Poynton, and Lauren Shields, with critical input from Jessica Davis Pluess, Elissa Goldenberg and Matthew Charlesworth. Any errors that remain are those of the authors.

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**ABOUT BSR**

BSR is a global nonprofit organization that works with its network of more than 250 member companies to build a just and sustainable world. From its offices in Asia, Europe, and North America, BSR develops sustainable business strategies and solutions through consulting, research, and cross-sector collaboration. For more information, visit www.bsr.org.

**ABOUT BSR'S HERPROJECT**

HERproject is a global partnership initiative that promotes investment in the empowerment of women working in global supply chains. HERproject is active in 10 countries and has two different programs: HERhealth, which provides health trainings and improves access to health services; and HERfinance, which provides financial management trainings and improves access to financial services. Thirty-five multinational companies support HERproject programs around the world, and these programs have been implemented in more than 300 workplaces. Since launching in 2007, HERproject programs have reached more than 300,000 women.

**ACKNOWLEDGMENTS**

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We would also like to thank the interviewees for their participation and insight. For their protection, we have not named all the individuals we interviewed.

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# Contents

# Executive Summary

A BSR program that provides health and financial education to low-income women in their place of work, HERproject was created in Asia to serve workers in the factory setting. It was expanded to East Africa with a HERhealth pilot in Kenya in 2012.

From the implementation of the pilot in Kenya, we confirmed that low-income women working in the country's agriculture and horticulture sectors were being underserved by community health education efforts, as well as the health services provided at their workplace and in their community. Thus, we found that the HERhealth program was relevant to these particular women beneficiaries; it filled a gap by providing health awareness and services to a vulnerable group.

Our most recent research evaluated the need for and relevance of the HERhealth program for women working in export-oriented sectors in additional countries in East Africa. In conducting this evaluation, we examined a set of research questions focused on health needs in sectors dominated by a female workforce, and we explored the potential to leverage private sector partnerships to address gaps in the provision of health information and services to low-income working women.

This latest research focuses on Ethiopia, Rwanda, and Uganda and reviews the pilot in Kenya. Women's health needs were found to be present in all countries. BSR has determined that Ethiopia holds the most immediate potential for HERhealth expansion, due to commonalities with the Kenya economic context (e.g., a growing floriculture sector with a female-dominant labor force) and the private sector's growing interest in expanding sourcing activities in the country. We identified longer-term opportunities in Uganda and Rwanda, particularly in the tea and coffee sectors, working with smallholder farming cooperatives. To succeed, such expansion would require additional research and an adapted implementation model. We later decided to test a pilot adaptation for the cooperative setting in Kenya. In the future, this pilot could be expanded into Uganda, Rwanda, and/or Ethiopia.

Companies with operations or supply chains in East Africa (including, but not limited to, the countries we examined) will benefit from reviewing this research, in order to better understand women's health needs in the region and the potential benefits of further supporting these needs at work. We recommend that the private sector invests more in and devotes more attention to working women's health in East Africa. HERhealth is one of many programs that companies could participate in.

Despite this study's limitations and the need for further research, we believe the insights captured in this report will contribute to a greater understanding of export industries in East Africa, the status of women in the region, and the potential for business to leverage workplace-based interventions to improve their quality of employment opportunities and empower them.

## Introduction

Africa is experiencing unprecedented growth, but distribution of opportunities remains skewed; and women in particular often gain less from growth. This research sought to examine women's economic participation from the specific lens of health, and to explore how workplace-based health programs, like BSR HERproject, might support the needs of women at work in East Africa, as well as provide bottom-line benefits to businesses operating in the region.

*HERhealth peer health educators, Kenya, 2012*

HERproject programs have historically been implemented in light manufacturing settings (e.g., garment and electronic factories) and mostly in Asia. In 2011, BSR decided to expand the HERhealth program into East Africa. Because this expansion required modifying the program for the agriculture or horticulture settings, we undertook a pilot in Kenya beginning in 2012.

The HERhealth pilot in Kenya was implemented on two farms in the floriculture, fruit, and vegetable industries. Approximately 1,200 women workers were trained on issues like maternal health, preventing sexually transmitted infections (STIs), HIV/AIDS, hygiene, family planning, nutrition, and ergonomics. Impacts observed during the pilot included increased health knowledge, in particular around maternal health, nutrition, and hygiene. HERproject endline surveys suggest that improvements in health knowledge translate into reduced health-related absenteeism, fewer cases of illnesses like dysentery and diarrhea, and a significant decrease in the number of women reporting back pain during work. Other impacts included a boost in worker morale and self-motivation, as well as improved confidence and communication skills of female peer educators. In pilot sites, peer educators show increasing leadership and authority. They were often referred to by their peers and in their communities as "teachers," and one was

even promoted to supervisor as a direct result of the abilities she acquired in the program.

Based on our experience implementing HERhealth in Kenya, we have found that women working in the agricultural export sector were being largely left out of community-based health education programs, and did not enjoy full access to the health services available at work and in their community. HERhealth can play a critical role bridging the gaps among community-based organizations (CBOs), health service providers, employers, and (female) employees.

With support from the Ministry of Foreign Affairs of the Netherlands and the Swedish International Development Cooperation Agency (Sida), BSR decided to expand HERhealth in Africa beyond Kenya. We undertook this research to determine the program's relevance within the region and select additional countries where we could expand.

## Women at Work in East Africa

Africa is experiencing unprecedented growth, with annual gross domestic product (GDP) growth rates topping 10 percent in some countries and exports on the rise. At the same time, distribution of wealth and opportunities remains skewed; and women in particular often gain less from growth. Formal employment opportunities remain limited, and competition for them is fierce, leaving women more likely to remain in the informal sector or within vulnerable seasonal or subsistence agricultural roles. Industries typical of early stages of industrialization (such as the garment industry), which often provide both women and men significant low-skilled employment opportunities, remain nascent due in part to slow infrastructure development and the costs of labor, which are high compared to regions in Asia and Central America. However, some industries are growing rapidly; the horticulture sector in East Africa, for instance, has increased six fold in a single decade, from US$1.51 billion in 2001 to US$9.74 billion in 2011. It is also creating much needed formal employment opportunities. In Kenya up to 2 million workers are employed by the horticulture and floriculture sectors,[i] and women hold many of those jobs.[ii]

Further opportunities exist to improve women's formal, contracted participation in the more common commodity and food sectors, including tea, coffee, and sugar. East Africa's growth and development have made it a more desirable region for corporate supply chains; at the same time, transparent, accountable supply chain management practices have not yet matured. As companies focus on the region, opportunities to create more jobs, improve job quality, and link jobs to gender equality and women's empowerment will increase.

Within this context, we see both the opportunity and need to expand programs such as HERproject within export-oriented sectors in East Africa. Significant general and reproductive health needs exist among working women, whose work schedules often prohibit them from taking advantage of community-based programs and health service providers. Moreover, many gender-related risks, such as discrimination, sexual harassment, and maternity leave violations, are prevalent in workplaces. Programs such as HERhealth, which elevate attention to gender issues within the supply chain, while helping improve health education and access to health services, can help address gaps and raise awareness.

## About the Research

This research was conducted in Ethiopia, Rwanda, and Uganda from May through July 2013. The researchers also assessed the Kenya pilot (completed in

March 2014) to glean lessons learned and to share impact data. This report is intended to provide a contextual analysis of countries where we could possibly extend HERhealth.

The purpose of this study was threefold:

» To assess the relevance of workplace-based women's health and empowerment programs (such as HERhealth) in export sectors in East Africa;

» To prioritize countries or sectors where HERhealth could expand, or where similar investments in women's health and empowerment would be useful; and,

» To increase awareness of women's empowerment and health needs in East Africa among BSR members with operations and supply chains in the region who might take positive action.

The study found that a women's health and empowerment intervention, such as HERhealth, would be relevant and feasible for women working in the horticulture, floriculture, and tea sectors in Ethiopia, Uganda, and Rwanda. However, we identified varying levels of opportunity and feasibility in each country based on the size of its export sectors, women's participation rates in the labor force, its prioritization of workforce welfare, its general workplace environment, and the strength of its civil society.

We hope the broader findings will also be of value to companies operating within these four countries and throughout the region, as they provide insight regarding the health needs of women working in export-oriented sectors, as well as into the potential business benefits of better meeting those health needs at work.

Our "Call to Action" (at the conclusion of the report) provides concrete guidance for businesses to support women's empowerment and health within their supply chains, as well as at a systemic level. This section was also published separately (in a somewhat revised format) as an article in BSR's member newsletter.

## Research Approach

This research was conducted in Ethiopia, Rwanda, and Uganda[1] from May through July 2013. The researchers also assessed the Kenya pilot (completed in March 2014) to glean lessons learned and to share impact data. This report is intended to provide a contextual analysis of countries to which we could extend HERhealth.

### Research Questions

***Empowering women*** *increases their economic, political, social, and/or educational strength and that of their communities.*

We sought to address two research questions within relevant sectors in Ethiopia, Rwanda, and Uganda:

1. *Is there a clear unmet need in health and empowerment outcomes for women workers employed in key export sectors?*
2. *Which countries and sectors represent the most compelling, feasible opportunity for a workplace intervention focused on women's empowerment and health?*

**RESEARCH QUESTION 1: CONSIDERING RELEVANCE**
In order to answer the first research question pertaining to a workplace intervention's relevance to addressing women's health and empowerment in each country, the team needed to assess the following factors:

» **Status of women:** What role do women play in society? What barriers to women's empowerment exist? What barriers to women's employment exist? Does formal sector employment lead to empowerment opportunities?

» **Health outcomes:** Do varied, significant health needs exist for women, including needs related to health knowledge, behavior, and access? Do these needs extend to women who are employed within relevant sectors? Do health burdens limit employment opportunities or women's ability to excel at work?

Information about export industries, the status of women, and health outcomes offers insight into the relevance of a program like HERhealth in a given country or sector.

Based on our findings from a pilot project in Kenya as well as the broader regional scoping, BSR sought to determine which country(s) and sector(s) represented the most compelling opportunities for HERhealth expansion or the introduction of similar workplace-based programs to support women.

**RESEARCH QUESTION 2: ASSESSING FEASIBILITY**
In order to answer the second research question pertaining to the feasibility of expanding HERhealth or similar programs into a country or sector, we built on what we have learned from implementing HERproject globally, as well as specific lessons our pilot implementation in Kenya taught us.

Based on all this data, our analysis considered the following factors:

[1] These countries were selected because they receive aid from the Ministry of Foreign Affairs of the Netherlands and because their women workers have significant unmet health needs, as per Millennium Development Goals (MDG) and UN Development Programme (UNDP) data.

- **Export industries:** The HERproject model relies on workplaces that employ many women on a full-time basis, ideally in working conditions that comply with international labor standards. Export-oriented sectors tend to fit these criteria; thus, we assess their presence, strength, and projected growth in the relevant countries.
- **Women's participation in the labor force:** Because they are the target beneficiary group of HERproject, it is important that a critical mass of women is employed in the workplaces where our programs are implemented. Moreover, it is important that women fill positions that their employer values so that the latter is incentivized to invest in their well-being.
- **Investment in worker welfare:** The links between robust export industries and international buyers who are held accountable to working conditions within their supply chains is an important feasibility factor within the HERproject model, which leverages buyer influence over suppliers to launch workplace interventions. From a feasibility perspective, some commitment to support worker welfare, whether self-motivated or encouraged by international buyers, is an important factor for the success of HERproject programs.
- **Workplace environment:** HERproject, which uses peer-to-peer education to spread information, requires a workplace environment where the members of the workforce connect regularly with one another during the workday. These connections are critical to enabling individuals and groups to transfer knowledge.
- **NGO partners and implementers:** A robust local civil society sector is required to make HERproject a success. HERproject workplace programs are implemented by local NGOs, and with our local partners, we promote ownership of program content and implementation, as well as long-term sustainability and scale.

## Research Methodology

These report findings are derived from desk-based research, engagement with local and international stakeholders, and field visits to each country. Research on the Kenya pilot included a desk review of the country context and pilot program documents, as well as phone and field-based key informant interviews (including of program participants and BSR staff), as well as research on the country context as for the other case studies.

In addition, the HERhealth team made regular visits to Kenya both during the course of the pilot implementation and at the conclusion of the pilot phase. These visits included reviews of the implementation with the local NGO partner; updates with farm management, human resources personnel, and clinical officers at the farm sites; and discussions with worker participants in the program. Reports from these trips and results from discussions with program stakeholders in Kenya are reflected in this research.

Desk-based research for Ethiopia, Rwanda, and Uganda focused on the country context, with particular emphasis on macroeconomic business trends, such as country-level information on export industries, and statistics reflecting the status of women in society as well as their general health in each country. The documents reviewed included studies conducted by government agencies, international NGOs, and local country-based NGOs.

Following this research phase, HERhealth teams then conducted weeklong country visits in Ethiopia, Rwanda, and Uganda to deepen our understanding of

the context of businesses in export sectors and collect in-depth qualitative and quantitative data on the status of women and their health. The field visits were an opportunity to answer questions that remained after the country-level, desk-based research was completed, to visit the factories and farms where women were employed, and to speak directly with women regarding their needs.

Teams visited 13 farms, factories, and cooperatives in the three countries (see Appendix 1 for a list of organizations visited or consulted). During the visits, team members interviewed one or more representatives of senior management and selected female employees for interviews on a randomized basis. The researchers did not intend to collect a representative sample or make statistically significant observations of the female workforce, but rather to confirm and elaborate on assumptions they had reached through their desk-based research and expert interviews, and to provide personal accounts of health knowledge, access to and use of health services, and understand gender relations at home and at work.

Expert interviews and team observations were also incorporated into the field-visit data collection.

**Field Interviews Conducted by BSR, April–June 2013**[2]

| | Stake-holders | Female Workers[3] |
|---|---|---|
| **Ethiopia** | 19 | 12 |
| **Uganda** | 17 | 18 |
| **Rwanda** | 22 | 35 |

Stakeholders in the following categories were interviewed; however, we did not interview representatives from all these categories in each country:

» International NGOs
» Local NGOs
» Trade associations
» Unions
» Farm and factory staff, including management, medical staff, and female employees

## Research Limitations

This study was intended to inform broad-based recommendations to business and specific program decision-making for HERproject. It is not intended to serve as an assessment of the status of women, women's health, or women's labor force participation in the target countries. Rather, it is intended to apply a comparative analysis to a set of diverse factors that impact the feasibility and potential for impact of workplace-based programs, including but not limited to HERhealth.

This report's findings must be considered within the context of the following research limitations:

» **Limited sample:** Field visit research covered only a sample of businesses and women, thereby limiting the extent to which the results can be generalized. However, the data we gathered in interviews confirmed our desk-based research findings; where it did not, our findings were substantiated with reports from local government, international organizations, and NGOs. Finally, it is worth noting that before we expand HERhealth in a country or region, we conduct health needs baseline assessments among a

[2] For a full list of all stakeholders interviewed by country, see Appendix 1.

[3] Primarily conducted via focus group.

random, representative sample in every farm or factory selected to participate in the program.

- **Lack of quantitative analysis:** The teams did not conduct original quantitative analysis, instead relying on statistics and analysis from other organizations. As noted above, we will gather original quantitative data in countries selected for HERhealth expansion before any programs are implemented.
- **Language barriers:** BSR teams relied on translators to engage with many of the women workers. As is common with translation, it is possible that parties may not have fully understood some information or communication. In some cases, managers provided this translation, which may have influenced workers' answers.
- **Relevant public data:** The availability of up-to-date, relevant statistics proved limited; whenever possible, BSR used the latest information; however, in some cases we used outdated data because new information was unavailable.

Despite these limitations and the need for further research, we believe the insights captured in this report will contribute to a greater understanding of export industries in East Africa, the status of women in the region, and the potential for business to leverage workplace-based interventions for more quality employment opportunities to support women's empowerment.

## Putting the Research in Context: The HERhealth Pilot in Kenya

Agricultural exports are a major driver of the Kenyan economy. Horticulture exports, including fruit, vegetables, and flowers, accounted for US$1 billion in earnings in 2013.[iii] Floriculture alone contributes approximately US$500 million to the Kenyan economy each year.[iv] Tea likewise is a major export foreign exchange earner and the largest export product from Kenya, accounting for US$1.3 billion in earnings in 2012.[v]

Since the 1990s, Kenya has emerged as a key horticulture exporter to European markets; it also serves domestic and regional markets. The horticulture export sector is characterized by large producers with commercial farm estates, which sometimes rely on subcontracted growers to meet production targets.[vi] International supermarket retailers play a key role in linking producers to global value chains. These retailers demand that their suppliers implement food safety regulations and meet social and environmental standards, including certifications, such as GlobalGAP (Good Agricultural Practice), Rainforest Alliance, or Fair Trade, for instance. Large horticultural exporters focused on the European market represent job opportunities, including formal employment for women, for an estimated 70,000 Kenyan workers.[vii]

HERhealth programs were first introduced in Kenya in 2012. An appendix to this working paper sets out the methodology and program content of HERhealth programs. The program's pilot phase covered two farms producing flowers, fruit, and vegetables. The two programs delivered health trainings to approximately 1,200 female workers. In addition, male workers at one farm site were informally engaged throughout the program. The pilot farms are located in Naivasha and the Baringo District. Marks & Spencer and Sainsbury's (both U.K. retailers) sponsored their suppliers' involvement.

This section reviews the context of Kenya by examining three characteristics that explain the relevance of a workplace-based intervention focused on health and women's empowerment in the floriculture and horticulture export sector. This analysis provides insight into the factors that contributed to Kenya being a feasible case for HERhealth implementation and describes the impacts of HERhealth observed to date.

### Research Question 1: Unmet Needs in Women's Health and Empowerment in Kenya

Prior to launching the program and the subsequent implementation phase, the initial contextual analysis of Kenya suggested that women's health and empowerment needs to be promoted in the workplace. Several obstacles to gender equality persist in Kenya, including women's home responsibilities, lower education, poor health, and childcare responsibilities.

Although women are less visibly restricted in Kenya than in other countries where HERproject operates, discrimination, traditional gender roles, and widespread gender-based violence represent significant concerns for their status. It ranked 78th out of 134 countries in terms of gender inequality worldwide in the World Economic Forum's 2013 "Global Gender Gap Report."[viii] Several health concerns, including poor nutrition, malaria, maternal mortality and morbidity, and HIV/AIDS, are prevalent among Kenyan women.[ix]

## STATUS OF WOMEN

Considerations: *What role do women play in society? What barriers to women's empowerment exist? What barriers to women's employment exist? Does formal sector employment lead to empowerment opportunities?*

As in other countries in Africa and other regions, Kenyan women shoulder a disproportionate amount of family responsibilities relative to men and face discrimination in society based on entrenched norms and gender roles. Moreover, women bear the double burden expectation that they will take care of children and sick family members, as well as work full time to support their family. In particular, the burden of care on AIDS affected households is mostly carried by women[x].

Gender-based violence, including physical, sexual, and psychological violence, is widespread in Kenya. According to the 2008–2009 Demographic and Health Survey, 45 percent of women in Kenya between the ages of 15 and 49 have experienced physical or sexual violence.[xi] Most of these violent acts are committed by husbands or partners. Sexual violence remains a threat to Kenyan women in the home, workplace, and other places in the community.[xii] In some cases, religious and cultural norms can result in barriers to financial independence and sexual freedom. In some regions, particularly the northern areas bordering Somalia, other practices like female genital mutilation (FGM) and arranged marriages are common.[xiii]

Sexual harassment in the workplace is also an issue on Kenyan farms. Stakeholders during the BSR scoping study in 2010 commented that many women who have jobs face grim working conditions, underpayment relative to men, and rampant sexual harassment.[xiv] A study circulated by Women Working Worldwide in 2002 supported these findings and underscored widespread sexual harassment abuses in farms, particularly by supervisors.[xv] The recent Oxfam and International Procurement and Logistics (IPL) study suggests that anti-sexual harassment policies, welfare committees, and trade unions have helped to reduce incidences of sexual harassment in Kenyan farms, but it still occurs to some extent.[xvi] Women frequently refrain from reporting abuses to authorities for fear of losing a hard-won job and the perceived difficulty of finding another.

## WOMEN'S HEALTH NEEDS

Considerations: *Do varied significant health needs exist for women, including needs related to health knowledge, behavior, and access? Do these needs extend to women who are employed within relevant sectors? Do health burdens limit employment opportunities or women's ability to excel at work?*

BSR's initial scoping study in Kenya highlighted the fact that women in the country face myriad challenges to achieving sexual and reproductive health and rights. Their major challenges are related to HIV/AIDS; maternal mortality, particularly related to illegal abortions; and gender-based violence, including FGM, which remains widespread.

Results from the pilot HERhealth farm program in the Naivasha region of Kenya found the following health needs among the cut-flower female employees at the site:

» The majority of the women had heard of family planning methods, but they had significant misunderstandings about and a lack of awareness regarding modern contraceptives and their proper use. (For example, respondents believed that a diaphragm was a female condom.)

» Average nutritional knowledge was found to be low. (For example, 68 percent could not name foods rich in calcium, and 55 percent could not name

foods rich in iron.) Interviews with workers revealed common practices, including eating dirt to "get vitamins" and reserving high amounts of the household budget for red meat, rather than incorporating healthier foods like local greens into menu planning.

» Women were familiar with the danger signs during pregnancy that mean a doctor should be consulted, but they were unaware of holistic pre- and postnatal care practices.

» Knowledge of HIV was high, but prevention of it was low, and the stigma attached to HIV was significant. In particular, women had a superficial knowledge of HIV, but they lacked context or the confidence to apply it to risk factors in their personal lives. For example, in an STI training with more than 30 women, the team learned that a significant proportion of them had never opened a condom package.

» Knowledge of STIs other than HIV was found to be very low, and as a result, prevention was also very low. Furthermore, interviews indicated that reoccurrence of minor STIs and other reproductive tract infections were high, creating significant risk of pelvic inflammatory disorder (PID) and, therefore, increasing a woman's risk of developing cervical cancer later in life.

» Knowledge and practices related to the prevention and detection of breast and cervical cancer were low—for example, only a third of respondents knew how to perform a breast self-examination.

## Research Question 2: Relevance and Feasibility of Workplace-Based Interventions in Kenya

By expanding to Kenya, we tested whether a program successful in the light manufacturing sector in Asia could be adapted to a new regional and sector context. We selected commercial farms as a setting for the pilot in Kenya given their structural similarities with a factory setting. These similarities include a permanent and semi-permanent workforce (mostly serving under contracts), an industrial farm setting where the workers labor in proximity and interact in shared spaces (such as clinics, canteens, and living quarters), and a group working style where people collaborate and communicate regularly with their colleagues.

The pilot phase also allowed BSR to identify factors like the growth potential of export industries or external pressure for worker welfare programs that contribute to the relevance and feasibility of HERhealth's implementation. We then used these factors to inform our analysis of the three countries we were considering for our expansion.

**RELEVANT SECTORS EXIST FOR PROGRAMS**
Feasibility considerations: *What are the primary export industries, and what is their structure? Does government policy promote growth in these industries? Are exports sold regionally or internationally? Do global buyers purchase directly or through auctions?*

Horticulture and floriculture for both domestic and international consumption, including cut flowers, fruit, vegetables, and more, is growing rapidly, increasing by 15 to 20 percent per year.[xvii] The horticulture export sector is also a major employer in a country with a high unemployment rate; it provides 2 million jobs.[xviii] In 2011, Kenya exported 70,000 tons of vegetables for US$220 million in earnings and 1,000 tons of fruit for US$1.5 million.[xix] The largest exporter of flowers, fruit, and vegetables in East Africa, Kenya is particularly known for producing snow peas, green beans, and baby corn.

Beyond export markets, there is significant production to meet regional and domestic demand in fruit and vegetables. In fact, more than 96 percent of vegetable production in the country is for domestic consumption, and nearly 99 percent of the fruit grown in Kenya is destined for domestic buyers.

Meanwhile, flower exports account for nearly half of the country's horticulture export earnings. Roses, Kenya's primary flower crop, can be grown year-round in the country's mild conditions. Sixty-five percent of flowers exported are sent to the Netherlands, with other buyers in the U.K. (25 percent), and minor sales in Germany, France, and other countries.[xx]

Kenya's horticulture export sector is an important industry for the country with clear links to global value chains. Its primary markets are easily identified as direct buyers (mostly U.K. supermarkets) and flower traders operating through auction houses in the Netherlands. The country's well-developed export sector and strong links to international buyers supported the case for the feasibility of implementing HERhealth.

**CRITICAL MASS OF FEMALE BENEFICIARIES TO REACH**

Feasibility considerations: *Are women employed within export-oriented sectors? Are they employed full-time, seasonally, or on a day-to-day basis? Does their employer value their attendance and retention, or are they considered easily replaceable by unskilled day or seasonal labor?*

The fruit,[xxi] vegetable, and cut flower businesses are major export industries in Kenya and significant employers of women—they represent the majority of workers in the sector. For example, two-thirds of workers in green beans, a major product for export, are women.[xxii] The tea sector is another major employer of women, with women representing 60 percent of employees.[xxiii] In floriculture, women reportedly represent 65–75 percent of workers, a figure supported by findings from HERhealth implementation where women represent 50–70 percent in participating farms.[xxiv] Women are often responsible for tasks, such as planting, weeding, harvesting, and working in packhouses, which are relatively low-skilled but physically demanding jobs. Men, in contrast, often perform activities requiring higher skills, such as spraying and soil fumigation in the crop development unit or construction.[xxv]

Jobs in the horticultural export sector in Kenya offer low wages, yet they provide opportunities for relatively stable and secure employment for women workers. At one pilot farm, workers earn around US$70 per month, or approximately US$2.80 per day for a six-day workweek. However, conditions of employment, particularly around the level of wages and employment security, vary by the farm and product. Generally speaking, flower farms offer higher wages and more permanent contracts to workers relative to fruit and vegetable farms, which have lower wages, less job security, and lower rates of unionization.

Oxfam estimates a living wage for Nairobi (the highest cost of living area in Kenya) to be 12,035 Kenyan shillings per month, or approximately US$120, while the UN sets an absolute poverty line of US$1.25 per day (the equivalent of 6,713 Kenyan shillings per month, or US$67). Wages vary by skillset, with a casual vegetable worker in Nairobi earning on average well below both targets (3,600 Kenyan shillings per month, or US$36).[xxvi] Workers at the higher end of the spectrum, such as contracted vegetable workers, can earn 10,560 Kenyan shillings per month, or US$105.[xxvii] An Oxfam IPL study on the horticulture sector in Kenya found that 30 percent of participants were contracted permanently, 32.5 percent of workers were on short-term contracts, and 37.5 percent were working casually, on a daily or three-, six-, or twelve-month basis.[xxviii]

Workers' rights, including those specific to women, have generally expanded in the past decade, but not without challenges. Government monitoring of enterprises has shown that not all laws are being upheld and that when they are upheld, they cause unintended consequences for women.[xxix] For example, a new maternity leave law, passed in 2008 to align with International Labour Organization (ILO) recommendations, requires employers to provide new mothers 90 days of paid leave. As the law has been implemented, however, some factories have fired pregnant workers or workers who may become pregnant in order to avoid paying for their leave.[xxx] In addition, the government reported challenges in monitoring practices. Both the status of women's health and challenges to workers' rights point to the need for interventions focused on decent and empowering employment, which take gender norms into consideration.

**PRESSURE EXISTS TO IMPROVE WORKING CONDITIONS**

Feasibility considerations: *Are private sector actors interested in investing in women workers? To what degree do factories or farms in the country supply leading multinational companies or other companies concerned with worker welfare in the supply chain?*

U.K.-based retailers were the first corporate sponsors to support HERhealth in Kenya. Marks & Spencer and Sainsbury's (two large supermarkets) source fruit, vegetables, and flowers from commercial farms based in Kenya. Other major multinational brands with suppliers in Kenya include other U.K. supermarkets, Dutch flower auctions and direct buyers, and other European supermarkets. Implementing basic social and environmental standards, certification systems, and food safety requirements is a precondition for Kenyan suppliers to enter the European market. Beyond basic requirements, most companies have CSR strategies that support additional initiatives on social and environmental practices in their suppliers. For example, ASDA/IPL, the largest importer of fruit and vegetables to the U.K., has started a living wage program with their Kenyan suppliers in cooperation with Oxfam.

Overall, buyers sourcing from Kenya are strongly willing to invest in worker welfare and programs like HERhealth. The presence of major multinational brands with CSR requirements indicates that companies and their suppliers are working on environmental and social issues to some extent. Some companies have even moved beyond social compliance to support HERhealth and other initiatives targeting worker welfare. While our experience in private sector recruitment suggests some companies in the sector are still reluctant to go beyond workplace compliance, the Kenyan horticulture sector as a whole represents a leader in the region in terms of investment in worker welfare. This willingness to broach issues like women's health and empowerment made Kenya a solid choice as a pilot country for HERhealth.

**CONDITIONS FOR PROMOTING KNOWLEDGE TRANSFER**

Key considerations: *Do the work environment, workday activities, and productivity demands facilitate worker participation in ongoing trainings? For example, do employees work close to each other or regularly gather at a meeting point, either of which would allow for training outreach without posing an excessive cost burden for the factory or farm?*

Commercial farms in Kenya where HERhealth was implemented are typically organized into production beds grouped closely around greenhouses. Some farms also include packhouses, where fruit, vegetables, or flowers are prepared for transit. Activities in the production beds include planting, removing weeds,

administering agricultural inputs, and harvesting the products. Activities in the packhouse are focused on cleaning, cutting, grading, and labeling the flowers or produce into pieces and adding the appropriate packaging. For green beans, for example, groups of five or six workers stand around a table and divide the work of removing lower quality products, cutting off stems, stacking the beans, and packing them in a box.

The workplace setting of large production farms in Kenya proved conducive to implementing ongoing trainings. Farms that participated in the program had workforce sizes that ranged from 400 to 1,200 workers. They all work in one or nearby locations, making it possible to bring them together for a specific training. The management structure, as in factory settings, allows managers to supervise training logistics and to support the program. In addition, worker assignments to production or packhouse zones made it possible to easily divide workers into groups to allow for dissemination with a smaller number of participants. Finally, given that workers spend most of their days working in close proximity, they naturally communicate with each other, providing an avenue for them to transfer training messages and knowledge informally. Thus, commercial farms generally provided an environment with the necessary conditions to facilitate ongoing trainings, and in fact, they shared some features and organizational structure with garment factories where HERproject has previously succeeded.

**NGO CAPACITY EXISTS TO IMPLEMENT PROGRAMS**

Feasibility considerations: *Is there a robust civil society? Do organizations have the relevant capacity and incentives to carry out the program, and could they do so to private sector standards?*

The HERproject model depends on a local NGO with a high level of professionalism and content knowledge to implement trainings at workplaces. Kenya has a well-developed civil society sector, including NGOs that have experience working with international development actors and other donors that require monitoring and reporting similar to the structure of HERproject. BSR selected the National Organization of Peer Educators (NOPE) to implement HERhealth in Kenya. NOPE is a Kenyan NGO with a background in sexual and reproductive health, and peer education training methodologies. They are responsible for implementing trainings taking place on farms to improve health knowledge, attitudes, and behavior. To support access to health services, NOPE has forged partnerships with the National Health Service, U.S. Agency for International Development (USAID) APHIA-II project, and additional private clinic networks near the participating farms.

NOPE's content knowledge on women's health and peer education proved important to their success in implementing HERhealth. In addition, the experience NOPE had working with international donors (like USAID) laid the groundwork for project management and reporting systems. From BSR's global experience implementing HERproject, in order to effectively implement workplace-based interventions, it is almost always necessary to commit resources to build NGO capacity. Often local NGO partners do not have experience conducting programming in the private sector, and thus advancing their capacity to operate in workplaces is key to making HERproject implementation feasible.

## Findings and Impacts of Two Kenya Pilot Programs

Based on initial impact assessments of the pilot and farm management and buyer feedback, the Kenyan agricultural export sector also represents an appropriate setting for a program like HERhealth. Thus, the workplace setting of

**HERproject Baseline and Endline Assessment Methodology**

HERproject uses a baseline and endline survey to identify gaps in health knowledge at each implementing farm and to measure outcomes of the project. The HERproject implementing partner conducts one-on-one interviews with 7–10 percent of the female workforce of each farm.

The pilot projects in Kenya implemented a 130-question survey with female farmworkers to gauge their knowledge on the following topics: general health, physical health, personal hygiene, reproductive health, family planning, nutrition, ergonomics, HIV/AIDS, STIs, chronic noncommunicable diseases, women's empowerment, and gender-based violence. The results of the baseline survey determined the topics covered during HERproject implementation at the two pilot farms.

Since this pilot phase was conducted, the baseline and endline questionnaires used for HERproject programs have been revised to make them more relevant to low-income workers. In addition, a factory management survey is now used to capture management reflections on general worker health, health facilities, women's empowerment, and employee-management relationships. HERproject began implementing the new monitoring and evaluation tools in Kenya in early 2014.

commercial agriculture farms in Kenya proved conducive to ongoing worker trainings focused on women's health and empowerment, a key lesson from the pilot program. HERhealth saw outcomes in the following areas:

- *Improved worker health knowledge, behavior, and ability to access health services*
- *Returns for business related to decreased rates of absenteeism and turnover and increased productivity*
- *Improved employee-management relations, including increased communication and worker motivation*

Based on our implementation experience in Kenya to date, we believe that HERhealth is seizing a significant opportunity to promote women's health and empowerment in the horticulture sector. Two factors distinguish our approach from other initiatives active in Kenya. First, while other programs address women's health topics, few interventions take place within the workplace context. Working women in Kenya are often outside the scope of other programs, which might use communities as their entry point, for example. Second, though HIV/AIDS knowledge and programming is common within Kenya, a more holistic approach to health is needed. Women participants in HERhealth generally demonstrated an understanding of HIV/AIDS, but they had knowledge gaps in pressing areas like general hygiene, family planning, and nutrition, which have immediate effects on quality of life.

To assess our program's impact, HERhealth measures outcomes for both **women workers** and for **business**. Baseline and endline assessments, along with interviews with worker participants, farm management, human resources (HR) managers, and clinical officers or nurses, contributed to our understanding of project outcomes and taught us lessons that will help us strengthen HERhealth implementation. The outcomes for women and business are presented in the table below.

**Outcomes for Key Indicators on Two Pilots at Kenyan Farms**

| | Indicator | Farm 1 | | | Farm 2 | | |
|---|---|---|---|---|---|---|---|
| | | Before | After | Change | Before | After | Change |
| Health Knowledge | Able to name at least four family planning methods | 49% | 66% | +17 | 40% | 65% | +25 |
| | Able to name more than two risk factors that require a doctor's visit or medical help during pregnancy | 83% | 69% | -14 | 62% | 100% | +38 |
| | Knows how to do a breast cancer self-examination | 32% | 34% | +2 | 62% | 86% | +24 |
| Health Behavior | Missed work due to menstrual pain (pain management knowledge) | 3% | 4% | +1 | 40% | 0% | -40 |
| | Experiences back pain at the end of the workday (ergonomic knowledge) | 41% | 27% | -14 | 41% | 6% | -35 |
| Access to Health Services | Aware of nearby clinics or other women's health services | 86% | 91% | +5 | 50% | 93% | +43 |
| | Used nearby health services | 68% | 75% | +7 | 57% | 64% | +7 |
| Business Outcomes | Missed at least one day of work in the last six months due to illness | 38% | 24% | -14 | 40% | 28% | -12 |
| | Ability to work and meet targets negatively affected by health | 41% | 27% | -14 | 75% | 40% | -35 |

The outcomes assessment focuses on three areas of change for women[4]:

- **Health knowledge demonstrated by women workers,** such as an increase in their ability to name four or more family planning methods. This indicator increased by 17 percent at one pilot farm and 25 percent at the other. The change reflects that more workers understand their available family planning options.
- **Health behavior changes,** such as a reduction in the proportion of workers who experienced back pain. During the pilot project, reported back pain fell by 14 percent for one farm and 35 percent for the other. This indicator underscores workers' ability to use knowledge of ergonomics to change their behavior during activities like lifting and bending over, resulting in less back pain.
- **Health-seeking behavior, or changes in access to health services,** such as workers reporting that they used nearby clinics or other health services. In Kenya, this indicator increased by 7 percent at both pilot program farms, demonstrating a rise in workers' awareness of clinic services and their confidence to take advantage of available services.

Beyond the results seen in the assessments, program participants spoke of other changes related to their sense of self-worth, communication skills, and leadership opportunities in the workplace. These outcomes underscore the program's far-reaching impacts beyond health. For example, peer educators demonstrate more leadership and authority. Their peers and fellow community members often refer to them as "teachers," and one peer educator was promoted to supervisor as the direct result of the abilities she acquired in the program.

On the business side, the project tracks business indicators like rates of **absenteeism, turnover,** and **productivity.** For example, both pilot program farms saw a reduction in reported illness-related absenteeism, by 14 percent at the first farm and 12 percent at the second.

In addition to quantitative measures of business outcomes, BSR collected stories from farm management and project participants about program results. Management comments pointed to a new space for cooperation between managers and workers, saying that HERhealth "opened [their] eyes" to many issues workers face. Workers felt that management was concerned with their needs and that it is "encouraging to work at this organization," which had invested in areas of health.

The impacts for workers and business described above represent the pilot project's positive outcomes and lessons. These findings may also contribute to a more effective expansion of HERhealth within and beyond Kenya. Several

[4] Note: A few indicators from the two programs showed negative progress on indicators. As with any pilot program, HERproject in Kenya faced certain challenges and endeavored to learn from these experiences. Two particular challenges partly explain these negative results. First, Farm 1 experienced significant turnover due to a restructuring of the business, and nearly half of participating peer educators and workers were moved from the site, resulting in lower retention of knowledge. Second, Farm 1 represented the first implementation of HERproject monitoring and evaluation tools by the partner NGO, and there was confusion about methodology and sampling. Improvements in methodology and implementation were evident as early as the pilot's launch on Farm 2.

lessons from the pilot project inform the implementation of HERhealth in the farm setting, as detailed below.

**Implementation of Trainings**

» Farms are located in rural, often remote locations, requiring logistical planning and time for trainers to travel to them. The pilot phase highlighted the importance of incorporating this planning into the timetable.

» Farms are often close to a community, and frequently a smaller rural village. This proximity creates potential pathways for community engagement for the program, which the next phase will explore.

» Trainings must accommodate farms' harvest schedules and peak seasons. Peak seasons vary, but for the flower industry, Valentine's Day and Mother's Day are crunch times at farms. HERhealth adjusted trainings to accommodate peak production and harvesting times.

» Unlike in factories, farm workers can be spread throughout packhouses and distant fields. The training schedule often must include time to gather or even transport workers to a central location.

» Kenyan farms are generally smaller in size than factories, with a workforce between 500 and 1,000 workers, but can be smaller. The next phase experiments with grouping farms together for programs in order to reduce the program cost per worker.

» Supervision by management is comparatively weak on farms relative to factories, given the dispersed workforce. Ensuring effective dissemination with less management supervision requires greater follow-up from the implementing partner.

» Farms in Kenya generally have a more stable workforce than factories do. This stability means that the program's impacts may be more easily sustained than in a context with high turnover.

» The proportion of male workers is relatively high on Kenyan farms. In addition, men have voiced interest in and even participated in the pilot program trainings. The next phase will work on incorporating male engagement into trainings.

**Content of Trainings**

» Worker health knowledge on Kenyan farms is generally higher than for factory workers. Given the knowledge workers already possess, some training topics require implementing partners to focus on specific aspects of the module (such as addressing misconceptions about family planning commodities).

» HIV/AIDS has been a focus of several health initiatives by the Kenyan government, and most workers know quite a lot about it. Thus, HERhealth focused on other health topics in general or built on the information that workers already knew about HIV/AIDS by describing how to care for infected family members, for instance.

» In general, Kenyan farm workers are older than factory workers in Asia, and trainings must be adapted to their circumstances, including being married and raising children. More mature workers benefit from certain topics like cancer and sometimes require less information about or a different approach to other topics, such as family planning. Reproductive cancers are particularly relevant in Kenya as cervical and breast cancer are becoming more common. Conversely, while the basics of family planning might be familiar, trainings can cover how to negotiate with a partner about options.

» Back pain, weakness in the limbs, and stiffness of joints are common symptoms for farm workers, particularly on the vegetable and fruit farms.

HERhealth introduced an ergonomics module to address the needs of Kenyan workers.

**Engagement with Farm Management and Brands**

- The relationships between suppliers and brands for the horticulture sector in Kenya are dominated by auction buying and direct sourcing. In the case of auction buying, such as major Dutch flower auction houses, links between brands and producers are weaker, which makes engagement more challenging. For direct sourcing, a more stable relationship and sense of partnership between brands and suppliers facilitate long-term projects.
- In the case of stable relationships between brands and suppliers, brands were eager to have their suppliers buy in before they implemented HERhealth. Likewise, the involvement of intermediaries like exporters or traders in the supply chain requires additional engagement. A two-step engagement that includes the buyer and supplier became part of the HERhealth model for Kenya and farm programs in general.
- In Kenyan horticulture, basic requirements like food safety and standards are still a priority for CSR and many companies. Food brands and companies may have fewer funds to devote to initiatives like HERhealth given this focus.
- Consumer engagement and pressure are less prevalent for food brands than for clothing brands. There is less external pressure for brands to address supply chain risks through social welfare programs.
- CSR and worker programs are less developed in the agriculture sector than in the garment industry given the former's less mature CSR strategy and food brands' lower profits relative to clothing brands (5 percent versus 10 percent, respectively). Brand recruitment for supermarkets ultimately proved a lengthy process, requiring continuous engagement. Allotting additional time to develop and maintain relationships with brands and their partners was one lesson learned during the pilot.

## Conclusions

The Kenya pilot raised several important factors that could affect the expansion of HERhealth in East Africa, including women's employment status (which ranges from permanent to seasonal or even day laborer), the sector's growth potential and health, and the relevance of the sourcing market to international companies, which are held accountable by their consumers, e.g., U.K. retailers who sell flowers. In addition to the overarching consideration of women's health needs, we applied these factors to our review of three countries to determine the relevance and feasibility of expanding HERhealth.

# Ethiopia Scoping Study

Conditions in Ethiopia demonstrate that economic growth does not necessarily lead to universal benefit. The country has outperformed its neighbors, growing 10.6 percent annually on average from 2002 through 2013, compared to the region's annual average of 5 percent.[xxxi] At the same time, it remains one of the poorest countries in the world with a GDP per capita of only US$470 in 2012, far lower than the regional average.[xxxii] That said, the country's impressive growth has led to a decline in its poverty rate from 39 percent of the population in 2005 to 30 percent in 2011.[xxxiii]

The government, through its Growth and Transformation Plan, has an ambitious GDP target growth rate of 11–15 percent per year through 2015. It hopes to meet this target by promoting foreign investment in the agriculture and industrial sectors with plans to provide basic infrastructure to industrial cluster zones.[xxxiv] However, though it is experiencing impressive growth, the country faces serious challenges, particularly in health and development. Sustained growth will depend on effective mobilization and employment of Ethiopia's large, young, and rural population, amid a challenging environment of high unemployment and low productivity.

Poor health carries significant costs; a new study, the Cost of Hunger in Africa (COHRA), found that the long-term impacts of child malnutrition are estimated to cost 16.5 percent of the country's GDP each year.[xxxv] In order to address this and other serious health challenges, the government's development plan includes a focus on women's health, empowerment, and economic participation.

Ethiopia's exceptional economic growth, combined with government and civil society concern for low health and well-being indicators, presents an opportunity for business. Through responsible investment, business can partake in the country's economic benefits while contributing positively to more inclusive economic growth. Within that context, gender equality and women's empowerment must be prioritized. Formal employment has the potential to support that agenda—for example, findings from a study on the role of the floriculture sector in empowering women in Ethiopia found that the percentage of women reporting that they have decision-making power over household decisions jumped from 16 percent to 83.6 percent once they were employed in the floriculture sector.[xxxvi]

## Research Question 1: Unmet Needs in Women's Health and Empowerment in Ethiopia

Our research findings suggest that women's health and empowerment needs to be promoted, including within the workplace. Ethiopia suffers from high rates of gender inequality, ranking 122nd out of 130 countries surveyed in 2008.[xxxvii] Studies estimate that 59 percent of Ethiopian women will experience sexual violence, including rape, at least once in their lifetime.[xxxviii] Women in Ethiopia face a low life expectancy of 59 years. During their lifetime, women face myriad health challenges, including poor health services infrastructure, widespread stigma regarding HIV/AIDS and contraceptive use generally, malnutrition, and exposure to infectious and non-communicable diseases.

**STATUS OF WOMEN**

Considerations: *What role do women play in society? What barriers to women's empowerment exist? What barriers to women's employment exist? Does formal sector employment lead to empowerment opportunities?*

Despite the existence of progressive laws promoting their empowerment, women in Ethiopia continue to face significant barriers, including:

» **Customary laws:** Ethiopia's customary laws often exist in parallel and sometimes contradict the nation's civil laws. However, lack of government oversight and commitments to protect certain customary laws, combined with women's limited knowledge of the civil code and access to legal aid, has ensured that they remain.[xxxix]

» **Education:** Education levels are low in Ethiopia, and disproportionately low for girls and women: 52 percent of Ethiopian girls and women have never attended school, compared to 38 percent of men.[xl] This trend is slowly changing, with current female enrollment at the primary school level almost on par with male enrollment.[xli] At the secondary level, however, women experience a significant increase in dropout rates.

» **Gender-based violence:** Ethiopian women suffer high rates of sexual, physical, and emotional violence, often at the hands of their partners. The 2011 Demographic and Health Survey revealed that 68 percent of women believe that their husbands have a right to beat them; however, this rate has declined from 81 percent in 2005.[xlii] Studies estimate that 59 percent of Ethiopian women will experience sexual violence, including rape, at least once in their lifetime.[xliii]

» **Harmful traditional practices:** While many harmful traditional practices have been outlawed, Ethiopian women continue to suffer from some of them. These practices include FGM (which, although declining, was estimated to affect 23 percent of girls under the age of 15 in 2011[xliv]),[5] polygamy, abductions, milk tooth extraction,[6] and wife inheritance. Child marriage is too common with 41 percent of girls marrying before age 18.[xlv]

Broadly speaking, women remain extremely unequal in Ethiopian society and under law. Efforts to address gender inequity and protect women's rights are ongoing. Employers can support these efforts by upholding women's rights at work, practicing nondiscrimination in hiring and compensation, and promoting women's empowerment through programs like HERhealth.

**WOMEN'S HEALTH NEEDS**

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

The low status of women in Ethiopia affects their health. Limited educational opportunities, harmful traditional practices, customary laws, and gender-based violence limit women's confidence and ability to make decisions about their health and that of their family.

[5] While FGM is illegal, the executive director of a consortium of NGOs focused on sexual and reproductive health recounted that, during a visit to a region that reportedly no longer practices FGM, he was informed by the local women that they send their young women to neighboring regions (where the government turns a blind eye to FGM) to be circumcised, saying that the women are going to visit an aunt. Source: Interview with Consortium of Reproductive Health Association (CORHA) in person in Addis Ababa on April 25, 2013.

[6] Milk tooth extraction consists of making an incision in the gums and removing the tooth roots in children as young as 21 days old. It is considered a treatment for diarrhea and fever, as well as a remedy for poorly growing children.

Ethiopia's health system suffers from limited infrastructure and few qualified physicians. Up to 80 percent of the population uses traditional medicine due to the cultural acceptability of healers and local pharmacopoeias, relatively low cost of traditional medicine, and difficulties of accessing modern health facilities, particularly in rural areas.[xlvi]

Ethiopians suffer from a low life expectancy of 59 years.[xlvii] Approximately, 60 to 80 percent of Ethiopia's health burden is from infectious and communicable diseases. Its primary health burdens include tuberculosis, malnutrition, neglected tropical diseases, and, to a lesser degree, HIV/AIDS.

*"Hundreds of girls working at the farm have unwanted pregnancies each year, and the vast majority of them choose traditional medicine [to abort the pregnancy]."*

—Woman farm worker, interviewed by BSR

Women in Ethiopia have the fifth highest maternal mortality rate in the world—676 deaths per 100,000 births—and only 10 percent of births are attended by a skilled health professional.[xlviii] Ethiopian women generally have low levels of awareness regarding their sexual and reproductive health. Despite the widespread availability of contraceptives, there is a cultural taboo against their use which, combined with limited access, means that only 14 percent of Ethiopian women of reproductive age use them. Although the stigma around contraceptives is lower among married women, with 29 percent using them, 25% of married women report an unmet need for family planning services.[xlix] This has resulted in both a high rate of unintended pregnancies (estimated as 42 percent of all pregnancies)[l] and a high fertility rate of 4.8 children per women.[li] Female farm workers interviewed by the researchers said that "hundreds of girls" working at the farm have unwanted pregnancies each year, and the vast majority of them choose traditional medicine [to abort the pregnancy]."[7]

Women engaged in the workforce also face work-related health challenges related to repetitive actions, such as arthritis from continually blending tea, picking coffee, or tending flowers, and workplace safety, including cutting themselves on work equipment and exposure to chemicals.[lii] One woman we spoke to complained of repeated infections from rose pricks, stating "I always go to the clinic because the gloves aren't thick, so I get pricked every day."[liii]

The government's willingness to address health challenges, along with women's general lack of health awareness, provides great opportunities for developing interventions to improve women's health outcomes. While cultural taboos limit discussion on sexual and reproductive health, there are opportunities to tap into existing social structures, such as girls' clubs and women's gatherings, to develop dialogue and foster an environment in which they can share their knowledge; thus, peer education was an approach endorsed by stakeholders we interviewed. Especially when it comes to family planning, women have a limited understanding of related health concerns and the resources available to them, a need the government has made a significant public commitment to address.[liv]

The analysis focusing on relevance for health outcomes suggests that women, including workers, have significant unmet health needs. National health surveys and interviews with civil society and female workers all concur that there is a great need to improve women's health outcomes. With one of the world's highest rates of maternal mortality, Ethiopian women, including working women, remain

[7] The World Health Organization (WHO) defines traditional medicine as "health practices, approaches, knowledge, and beliefs incorporating plant, animal, and mineral-based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to treat, diagnose, and prevent illnesses and maintain well-being." Source: http://ejhd.uib.no/ejhd-v20-n2/127_134_EJHD_20%20no%202%20final.pdf.

especially vulnerable and stand to benefit greatly from increased awareness and links to appropriate resources.

## Research Question 2: Relevance and Feasibility of Workplace-Based Interventions in Ethiopia

Ethiopia presents a case with mixed results in terms of potential relevance and feasibility for workplace-based interventions. On one hand, it shares characteristics with Kenya in terms of the structure of its export sector, NGO partners prepared to take on HERhealth implementation, and women as a significant, valued employee group. However, other factors suggest that implementing workplace-based women's health and empowerment programs in Ethiopia will be challenging.

| Ethiopia's Exports & Labor Force | |
|---|---|
| GDP growth in 2012 | 10.6% |
| Top three exports | 1. Coffee<br>2. Cut flowers<br>3. Fruit and vegetables |
| Percentage of labor force in agricultural activities | 85% |

### RELEVANT SECTORS EXIST FOR PROGRAMS

Feasibility considerations: *What are the primary export industries, and what is their structure? Does government policy promote growth in them? Are exports sold regionally or internationally? Do global buyers purchase directly or through auctions?*

The Ethiopian economy is based largely on agriculture, which makes up 46 percent of the country's GDP,[lv] 90 percent of its exports,[lvi] and 85 percent of total employment.[lvii]

Within the agricultural sector, the major exports include coffee, cut flowers, and fruit and vegetables:[lviii]

- **Coffee:** Ethiopia is the largest producer of coffee in Africa, and per 2005 estimates, this industry engages almost 25 percent of the working population.[lix] From 2010 through 2011, trade figures demonstrated a US$879 million record return on coffee exports.[lx]
- **Floriculture:** The cut flower export industry in Ethiopia is the fastest growing flower industry in Africa,[lxi] accounting for the direct employment of more than 50,000 Ethiopians.[lxii] With export revenues totaling US$178.3 million in 2011, Ethiopia is now the second largest flower exporter (after Kenya).[lxiii]
- **Fruit and vegetables:** Slower but steady growth has occurred in the fruit and vegetable export industries where exports have increased from US$15.95 million in 2004 through 2005 to US$53.15 million in 2011 through 2012.

As in Kenya, the floriculture and fruit and vegetable sectors are important growth areas for the national economy; they represent opportunities for the government to increase women's participation in the labor force. However, due to Kenya's continued dominance of European floriculture purchasing, this study found that the vast majority of exports are sold through regional and international auction houses, limiting direct relationships between buyers and suppliers. If HERhealth is implemented in Ethiopia, this context will require adjustments to the HERproject model, which typically leverages international buyers as influential stakeholders. HERhealth teams will need to identify and engage other key influencers.

### CRITICAL MASS OF FEMALE BENEFICIARIES TO REACH

Feasibility considerations: *Are women employed within export-oriented sectors? Are they employed full-time, seasonally, or on a day-to-day basis? Does their employer value their attendance and retention, or are they considered easily replaceable by unskilled day or seasonal labor?*

In Ethiopia, women make up 47 percent of the total labor force;[lxiv] however, the majority of these women are employed in informal work, such as family farm work and housekeeping, which often goes unpaid. Within the formal agricultural sector, women represent 70–80 percent of the horticulture[8] sector's labor force, including a high percentage of workers in the coffee, floriculture, and fruit and vegetable industries.[9] Women in Ethiopia are often preferred over men in these industries due to reports of their efficiency, punctuality, and high quality of work.[lxv] In addition, women workers are also seen as cost effective, compliant, and less likely to complain about working conditions.[lxvi]

A study conducted by Population, Health and Environment Ethiopia found that employment in the horticulture sector has resulted in some positive outcomes for women; for example, 83.6 percent of female employees in the floriculture sector reported having decision-making power over their household expenses, up from 16 percent before they became employed.[lxvii] As one woman interviewed by BSR stated, "It's better at home now that I earn money from my work; my husband listens more."[lxviii] The high rate of women participating in the horticulture sector suggests that a relevant population in that key sector could benefit from a workplace-based intervention.

**PRESSURE EXISTS TO IMPROVE WORKING CONDITIONS**

Feasibility considerations: *Are private sector actors interested in investing in women workers? To what degree do factories or farms in the country supply leading multinational companies or other companies concerned with worker welfare in the supply chain?*

Although we found robust export industries in Ethiopia that employ significant percentages of women and otherwise present relevant conditions for program implementation, we discovered that these industries have fewer links to international buyers than those in other countries (product exports are managed by intermediaries at the regional and international levels). This condition reduces the scope of client influence that HERproject traditionally leverages to motivate suppliers to invest in workplace programs.

Existing programs are sporadic and do not necessarily benefit workers. At one farm we visited, the farm nurse shared information about prior trainings on drug use (targeting men), STIs, and family planning. However, because most workers are illiterate and the trainings did not appropriately target their average literacy level, the nurse did not think they were very effective.[lxix]

As such, any programs launched in Ethiopia will need to identify different drivers to promote investment in worker welfare, such as international fair trade standards, industry association certifications, and business benefits from investments.

**WORKPLACE ENVIRONMENT—CONDITIONS FOR PROMOTING KNOWLEDGE TRANSFER**

Key considerations: *Do the work environment, workday activities, and productivity demands facilitate worker participation in ongoing trainings? For*

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[8] *Horticulture* refers to the science and art of growing fruit, vegetables, flowers, or ornamental plants. Source: Ethiopian Horticultural Producer Exporter Association, in-person interview in Addis Ababa conducted on April 24, 2013.

[9] Technically, coffee is part of the horticulture sector; however, in Ethiopia it is often treated separately due to its significance to the economy. For example, the Ethiopian Horticulture and Exporters Association does not cover coffee, as coffee has its own association.

*example, do employees work close to each other or regularly gather at a meeting point, either of which would allow for training outreach without posing an excessive cost burden for the factory or farm?*

Like Kenya, Ethiopia has a significant floriculture and horticulture sector structured in large commercial agriculture plantations, in environments that have initially proven conducive to workplace trainings like HERhealth. Employees are organized in groups, and they work together throughout the day. Furthermore, the geographic spread of farms and processing facilities is small enough that group trainings could be held during the day and reasonably well attended. Based on our observations of floriculture sites in Ethiopia, we determined that the context is similar to Kenya, and a similar implementation model could be used.

The coffee and tea sectors, however, rely on smallholder farmers spread out over a region. Further, it is unclear whether the organization of the tea and coffee sectors allows for a regular, central meeting point, or whether other conditions would allow for regular trainings on topics like health. This condition presents a challenge for ensuring the workplace environment facilitates worker participation in trainings. Overall, our findings regarding feasibility in these sectors were inconclusive; we would need to conduct a sector-specific scoping study to determine how the workplace program model might be adjusted for successful implementation.

**NGO CAPACITY EXISTS TO IMPLEMENT PROGRAMS**

Feasibility considerations: *Is there a robust civil society? Do organizations have the relevant capacity and incentives to carry out the program, and could they do so to private sector standards?*

Ethiopia presents a harsh climate for civil society.[lxx] The country lacks a well-established, vocal local civil society due to its history of dictatorship and current government restrictions on NGOs.[lxxi] In 2009, its national government adopted a highly controversial registration and regulation law, called the Proclamation to Provide for the Registration and Regulation of Charities and Societies (CSP), that has placed significant restrictions on NGOs. In this climate of restriction, international NGOs are banned from participating in activities promoting human and democratic rights; the rights of women, children, and people with disabilities; conflict resolution; and law and justice.[lxxii]

The law bans NGOs engaged in advocacy from receiving more than 10 percent of their funding from foreign sources.[lxxiii] This ban has severely limited the NGOs' ability to openly participate in advocacy work, as this sector relies heavily on international funding for its operations. The law also requires NGOs to spend no more than 30 percent of their operating funds on administrative duties, which is narrowly defined and restrictive.[lxxiv] The stated intention of the new law is to strengthen the transparency, accountability, and effectiveness of civil society.[lxxv] Stakeholders also explained that the government sees work on "rights" as part of its role and, for this reason, has restricted NGO activity in this area. However, many view the law as a blatant attempt to stifle dissent.

While the environment for civil society remains tense, interviews for this study indicated that community engagement efforts targeting women and other groups were continuing, with some adjustments. For example, one NGO representative remarked: "[Since the law was passed,] we don't shout like we used to shout, but we work to empower the young people we work with to shout in our place."[lxxvi] Other NGOs said the law has resulted in communication changes rather than program-level changes. For example, NGOs might refer to "women's education"

in place of “women’s empowerment,” allowing them to continue the same work, under a different name, that they performed before the law was passed.

The local and international health NGOs we consulted all reported working in very close coordination with the government of Ethiopia to improve health services and indicators, with a particular focus on the government’s priorities of maternal and child health. For example, Pathfinder is supporting the government with capacity building through a number of projects, including training government health extension workers at the district and community levels on family planning and HIV prevention and treatment, in addition to running health clinics in the country’s four most populous regions.[lxxvii] Marie Stopes is increasing access to sexual and reproductive health services, including abortion, through 10 mobile teams, 31 of its own clinics, and 550 private clinics that belong to a social franchise network that receives training and management support.[lxxviii] PATH also works closely with the government on health issues ranging from HIV/AIDS to tuberculosis and malaria to help fill the gaps in the government systems by providing services and technical assistance.[lxxix]

The successful health projects in Ethiopia are those that work closely with the government during all phases of a project, from planning through execution. This close collaboration has fostered a common sense of purpose in the health sector. Five NGOs were judged to be potential HERhealth partners based on their background in women’s health, training, and project management, which speaks to the high capacity that exists in Ethiopia.

## Conclusions: Need, Feasibility, and Relevance in Ethiopia

This study found significant, widespread need present in Ethiopia among working women. The HERproject focus and model was found to be relevant and feasible within the floriculture and horticulture sectors, with some limitations due to limited direct engagement by international buyers which program modifications could address. Further potential exists for engagement in smallholder cooperatives, but such an undertaking would require adjustments to the HERhealth model, and we would need to conduct further research to predict its feasibility.

# Rwanda Scoping Study

Landlocked and one of the smallest states in Africa, Rwanda has benefited from a relatively high level of political stability and impressive economic gains since the end of its genocide and civil war in 1994. The national government is generally praised for its development strategy, as well as its commitment to tackle corruption and promote gender equality.

Since the mid-1990s, Rwanda has created a regulatory environment supportive of business, which has resulted in solid economic growth.[lxxx] In 2011, Rwanda had one of the fastest growing economies in East Africa with a GDP that was growing at 8.2 percent per year.[lxxxi]

Despite these strides, approximately 80 percent of the workforce is still engaged in subsistence farming, and 82 percent of the population lives on less than US$2 a day.[lxxxii] Rwanda ranks low on the Human Development Index (an evaluation of basic human development achievements at a country level), and below average within Sub-Saharan Africa (167th out of 186). Moreover, disparities between men and women continue to exist, particularly at the household level and in the rural context.

## Research Question 1: Unmet Needs in Women's Health and Empowerment in Rwanda

Our findings suggest that women's health and empowerment need to be promoted and that the government is quite active and committed to supporting continuing progress in this area. Rwanda suffers from medium-high rates of gender inequality, ranking 78th out of 148 countries surveyed in 2012.[lxxxiii] Violence perpetrated against women in the 1994 genocide was widespread; in the aftermath and rebuilding, significant attention has been paid to reducing gender inequality and improving women's status—for example, attention to parity in political participation has led to more than 50 percent of Rwanda's members of parliament being women.

Women in Rwanda face many health challenges, including higher HIV/AIDS prevalence rates than men, malaria, lack of access to family planning (e.g., 47 percent of pregnancies in the country are unintended), and high rates of maternal mortality and morbidity. That said, the Rwandan government has made significant advances in investing in these health challenges. Lingering health impacts of the 1994 genocide include post-traumatic stress disorder, depression, and substance abuse, and they affect both women and men.

**STATUS OF WOMEN**

Considerations: *What role do women play in society? What barriers to women's empowerment exist? What barriers to women's employment exist? Does formal sector employment lead to empowerment opportunities?*

Rwanda has been described by the African Development Bank as one of the Sub-Sahara African countries that has made the greatest strides in promoting gender equality and the empowerment of women over the past several years.[lxxxiv] While the country has made significant regulatory progress toward gender equity, challenges remain at the household level. This struggle was illustrated during an interview with a female farmer who stated, "My husband makes all the decisions. I want to use money for schooling, but sometimes he takes it to drink."[lxxxv]

The following realities reinforce women's low status in society:

» **Education:** Although Rwanda has achieved gender parity within primary education, girls continue to drop out of secondary school at higher rates than their male counterparts. Stakeholders cited early pregnancies, familial responsibilities, and early marriage as contributing factors.[lxxxvi] Of the dozens of women we interviewed, none had completed secondary school.

» **Gender-based violence:** Despite progressive policies and measures, such as One Stop Centers,[10] gender-based violence remains significant and widespread. Two in five women report that they have suffered physical violence at least once since they were 15 years old.[lxxxvii] According to UN Women, most of the abuses women experience are perpetrated by their husbands,[lxxxviii] and 56 percent of women agree that a husband is justified in beating his wife.[lxxxix]

» **Land access:** Although customary land tenure systems have traditionally provided high levels of security, Rwanda has a long history of gender discrimination in land access.[xc] According to Rwandan tradition, men control the family's assets, including land. Despite the land reforms adopted by the government in 2004 and 2005, women continue to face serious difficulties pursuing property claims due to their lack of knowledge, the gender bias in inheritance issues, polygamy, and the threat of gender-based violence.[xci]

Women's empowerment in Rwanda remains a challenge, particularly in rural areas outside of the elite Kigali center. Thus, there is an argument for a workplace-based intervention like HERhealth to address gaps in their status.

**HEALTH OUTCOMES**

Considerations: *Do varied, significant health needs, including needs related to health knowledge, behavior, and access, exist for women? Do these needs extend to women who are employed within relevant sectors? Do health burdens limit employment opportunities or women's ability to excel at work?*

| Key Health Statistics: Rwanda | |
|---|---|
| Percentage of women who have an unmet need for family planning | 19 |
| Maternal mortality rate (of 100,000) | 320 |
| HIV/AIDS rate for women | 3.7% |

Increased economic development and Rwanda's investments in the health sector post-genocide, in particular deploying community health workers and ensuring access to health by making sure that more people have health insurance, have brought significant results. Key health indicators have been steadily improving.

Despite this progress, health challenges remain, including low levels of human resources[xcii] and a significant lack of health awareness.[xciii] Hygiene and waterborne diseases, such as dysentery and those caused by parasitic amoebae, continue to be quite common in Rwanda. The HIV prevalence rate remains higher among women (3.7 percent compared to 2.5 percent for men)[xciv] with tuberculosis affecting 60 percent of HIV-positive people.[xcv] While its prevalence has declined dramatically following political commitments, there were still nearly 664,000 malaria cases reported in 2010 with a morbidity rate of 8 percent in 2010 (down from 16 percent in 2009).[xcvi] Finally, 19 years after the Rwandan genocide, the population suffers from significant post-traumatic stress disorder, resulting in depression, social exclusion or isolation, and the abuse of alcohol.[xcvii]

[10] One Stop Centers have been established across the country to provide medical, legal, and psychosocial services to victims of gender-based violence.

In addition, despite significant improvements in sexual and reproductive health in Rwanda, women continue to face specific challenges. While 45 percent of married women use modern contraceptives, the first national study on the incidence of unintended pregnancy revealed that 19 percent of married women have an unmet need for family planning and that 47 percent of all pregnancies in the country are unintended.[xcviii] Only 35 percent of women received the recommended four or more prenatal visits, and more than 80 percent of women do not seek postnatal checkups.[xcix] As a result, fertility rates continue to be high (4.6 children per woman),[c] and maternal mortality remains high (476 per 100,000 women in 2010).[ci]

Additionally, abortions are still largely illegal and heavily stigmatized.[cii] Researchers verified that fact during worker interviews, when women often refused to speak about abortions, stating "that never happens."[ciii] However, according to a recent report from the Guttmacher Institute, each year, approximately 26,000 women are treated in health facilities for complications of both induced and spontaneous abortions.[civ]

In the tea and coffee sectors, no particular occupational health and safety concerns were reported beside those related to exposure to ergonomics and diseases related to lack of hygiene and clean water. One female coffee cooperative employee, for example, stated: "I often have a backache from bending down all day. Sometimes I get headaches too; the sun is so hot."[cv] Lack of information on nutrition, combined with long work hours and transport time, also make women working in agriculture, in particular wage earners, more prone to malnutrition.

Representatives interviewed from the Ministry of Health also insisted that, despite community health workers and the use of innovative participatory education, it remains very difficult to reach women working in agriculture with health services. Community outreach activities are conducted during the daytime, which means that working women cannot participate in these programs implemented by the state and local authorities, particularly programs such as prenatal care, growth monitoring and vaccination of children, family planning, and nutrition education. In addition, health facilities' limited hours of operation, generally from 7 a.m. to 5 p.m., mean that working women are less likely to visit a health center, in particular for preventive care.[cvi]

Although significant progress has been made in recent years, health challenges are still burdensome for women in Rwanda, and they have significant unmet needs. In particular, investment in health promotion in rural areas remains low; within that context, leveraging farms and cooperative networks might yield significant benefits for women employed in those sectors.

## Research Question 2: Relevance and Feasibility of Workplace-Based Interventions in Rwanda

Rwanda presents a challenging context in terms of the feasibility of implementing a HERproject workplace program. Though it has export sectors, the working environment, women's participation in the labor force, and links to international buyers all present factors that limit the program's feasibility.

**RELEVANT SECTORS EXIST FOR PROGRAMS**

Feasibility considerations: *What are the primary export industries, and what is their structure? Does government policy promote growth in them? Are exports sold regionally or internationally? Do global buyers purchase directly or through auctions?*

| Rwanda's Exports & Labor Force | |
|---|---|
| Top three agricultural exports | 1. Tea<br>2. Coffee<br>3. Pyrethrum |
| Percentage of labor force participating in agricultural activities | 79.5% |

Despite a modest 4.7 percent growth in 2011, agriculture continues to be the foundation of Rwanda's economy.[cvii] Agriculture, including industrialized agriculture and subsistence farming, employs 79.5 percent of the population and contributed to 32 percent of the country's GDP in 2012.[cviii] Agricultural products also represent 45 percent of Rwanda's export revenues.[cix]

Within the agricultural sector, Rwanda struggles to attract foreign direct investment, and exports remain modest. Despite the country's efforts to diversify its agricultural exports, the major export crops continue to be tea and coffee. Together they represent approximately 90 percent of the total value of agricultural exports:[cx]

» **Tea:** Generating US$65 million in 2012, tea is the country's largest agricultural export. It continues to be primarily cultivated on large plantations that are often jointly owned by private companies, cooperatives, and the state.[cxi] Rwanda exports more than 70 percent of its tea to Mombasa (Kenya's second largest city) auctions and 25 percent to direct buyers. The government hopes to continue developing the tea industry with plans to boost export revenue by raising yields and quality.[cxii]

» **Coffee:** Coffee has traditionally been one of Rwanda's most important exports, with approximately 15,000 tons of specialty coffee exported in 2011.[cxiii] Coffee development is driven by the growing demand for high-quality Bourbon Arabica, which led to a total of US$60 million of coffee exported in 2012.[cxiv] Approximately 90 percent of specialty coffee is sold directly to buyers and their intermediaries, while traditional coffee (approximately 20,000 of the 25,000 tons, or four-fifths, exported each year) is sold through European auction houses.[cxv] The government plans to further invest in cherry production, increasing the amount of fully washed coffee produced and building exporters' capacity.[cxvi]

» **Horticulture and pyrethrum:** In an attempt to promote export diversification, horticulture products including pyrethrum (a natural insecticide made from the dried flower heads of chrysanthemums) are cultivated**.** Even though climatic conditions are favorable and there are important opportunities in terms of export values, production volumes remain modest.[cxvii] Despite these constraints, the government is looking at increasing the export revenues generated by the horticulture sector, investing notably in cut flowers infrastructure.[cxviii]

Overall, the scale of Rwandan exports is quite small relative to other countries in the region, although the government is working to grow successful sectors and add new ones. The export sector's size limits direct relationships with foreign buyers; most goods are sold through intermediaries. Both of these factors may limit the feasibility of using the HERhealth model in Rwanda.

**CRITICAL MASS OF FEMALE BENEFICIARIES TO REACH**

Feasibility considerations: *Are women employed within export-oriented sectors? Are they employed full-time, seasonally, or a day-to-day basis? Does their employer value their attendance and retention, or are they considered easily replaceable by unskilled day or seasonal labor?*

Women comprise 52 percent of the total labor force in Rwanda, with agriculture serving as their principal source of employment (81.6 percent of women are engaged in agriculture compared to 61.4 percent of men).[cxix] Although most workers are independent farmers or unpaid family labor, it is estimated that 10 percent are wage earners.[cxx] In the coffee sector, women play a large role in

most parts of the value chain, including as wage earners, working in coffee washing stations and at the dry mills.

In the tea sector, in addition to the 40,000 smallholder growers, tea plantations employ approximately 30,000 workers,[cxxi] predominantly women, to pluck tea leaves. Tea plucking constitutes a reliable—though seasonal—complementary source of income that women use to invest in their families, buying medicine, livestock, or school uniforms for their children.

Opportunities in the formal sector are very limited, and women typically lack the skills necessary to secure the available positions.[cxxii] Discriminatory hiring practices also exist. As such, women are more likely to be involved in unpaid, low status work. Working women face the double burden of domestic work and family care; one study of workers in the tea and coffee sector found that domestic work could take up to 20 hours per week per woman.[cxxiii]

Our analysis suggests that while women are active in the agricultural sector, the parameters of their participation are largely informal, seasonal, or based on self-employment (e.g., smallholders). As such, the feasibility of workplace-based programs would need to be assessed within the context of smallholder farms and cooperatives. Applying it in this context would require adjusting the traditional HERproject implementation model, which is built around full-time workforces that are organized around a somewhat confined geographic area.

**PRESSURE EXISTS TO IMPROVE WORKING CONDITIONS**

Feasibility considerations: *Are private sector actors interested in investing in women workers? To what degree do factories or farms in the country supply leading multinational companies or other companies concerned with worker welfare in the supply chain?*

As mentioned, due to the size and scope of the Rwanda export sectors, direct engagement by multinational companies in working conditions and workforce empowerment has been limited. That said, some targeted efforts have been made among smallholder populations to improve yield, negotiating power, and price. For example, SC Johnson has led a program with pyrethrum (insecticide) smallholders since 2009 with a specific focus on women.[cxxiv] Similar programs could be expanded to address women's health needs, which almost certainly exist within the population.

Beyond such examples, the government may be a relevant actor to engage, given its achievements to date on gender equity and continued focus on women's equality and economic participation. Expanding its community health worker program to link it with cooperatives and plantations represents a good opportunity. However, the traditional HERproject approach of engaging international buyers as partners is unlikely to be feasible at scale in Rwanda.

**CONDITIONS FOR PROMOTING KNOWLEDGE TRANSFER**

Key considerations: *Do the work environment, workday activities, and productivity demands facilitate worker participation in ongoing trainings? For example, do employees work close to each other or regularly gather at a meeting point, either of which would allow for training outreach without posing an excessive cost burden for the factory or farm?*

Unlike in Kenya and Ethiopia, plantation settings are limited in Rwanda. Tea and coffee, the largest export sectors, are most often produced on smallholder farms, many of which are organized into cooperatives. These farms are mostly owned by men and remain geographically dispersed. Where plantations are organized,

formal employment opportunities remain limited, and women tend to work on a seasonal basis, with tea plucking as one of the most reliable seasonal employment opportunities.[cxxv] Thus, organized workplaces where a year-round, traditional HERproject program could be implemented feasibly are limited. The modalities of delivering regular trainings to peer educators in the HERproject model and then organizing and monitoring dissemination would be complicated in the Rwandan context.

Within these cooperatives of smallholder farms, there are women's associations. The latter could possibly be leveraged using a different implementation model; however, we would need to conduct additional targeted research to assess and design a model for that context.

**NGO CAPACITY EXISTS TO IMPLEMENT PROGRAMS**
Feasibility considerations: *Is there a robust civil society? Do organizations have the relevant capacity and incentives to carry out the program, and could they do so to private sector standards?*

The civil society sector in Rwanda is robust, active, and closely tied to the government. Civil society organizations (CSOs) working in the health sector rely heavily on public health infrastructure and funding, and the majority of aid in Rwanda is distributed through the government.

Our researchers identified several professional NGOs with the capacity to carry out a workplace-based intervention on women's health and empowerment. It was unclear whether CSOs had sufficient capacity to carry out programs within the private sector context. This is a common area of capacity building within HERproject and not seen as a significant barrier.

## Conclusions: Need, Feasibility, and Relevance in Rwanda

Overall, working women in Rwanda would benefit from additional workplace-based health education and training, particularly those based in rural areas and those working in agricultural sectors. The project was found to be relevant but to have limited feasibility within the export sectors identified in the country. Small-scale activity in collaboration with existing private sector initiatives, such as the SC Johnson project in the pyrethrum sector, may be possible. However, broader expansion of HERhealth into Rwanda would require a new program model designed specifically for implementation in smallholder cooperatives.

# Uganda Scoping Study

A former British colony and current member of the British Commonwealth, Uganda is a small country on the northern tip of Lake Victoria. It is marked by high levels of unemployment, an overwhelmingly young population, and a dependence on agricultural activity. The result is high levels of poverty with 24.5 percent of the population living below the poverty line.[cxxvi] Uganda ranks 161st out of 187 on the Human Development Index, behind most of its neighbors, but slightly ahead of Rwanda.

Unlike Ethiopia and Rwanda, Uganda has neither exceptional economic growth—its 2012 GDP growth rate was 4.2 percent—nor impressive advances in gender equality. Rather, the country continues to struggle with high levels of corruption, a lack of political will to implement gender reforms, and a heavy health burden. However, as it formalizes its export sectors, investors are primed to contribute to greater transparency and efforts to promote gender equity.

## Research Question 1: Unmet Needs in Women's Health and Empowerment in Uganda

Our research findings suggest that women's health and empowerment needs are very high in Uganda. Their status is quite low—with women expected to play traditional roles in society and largely prevented from decision-making and economic and political participation.

Uganda's health system is considered to be broken; women tend to suffer a disproportionate burden from this systemic gap, as well as from the primary health challenges of HIV/AIDS, malaria, and tuberculosis. Their access to family planning and maternal health care remains insufficient, with 33 percent of women reporting that they need access to family planning methods and with high rates of unsafe, illegal abortions conducted every year. Through interviews, researchers also identified occupational health challenges, suggesting that workplace-based interventions, such as HERhealth, could support the dual needs of personal and occupational health.

**STATUS OF WOMEN**

Considerations: *What role do women play in society? What barriers to women's empowerment exist? What barriers to women's employment exist? Does formal sector employment lead to empowerment opportunities?*

Uganda suffers from high rates of gender inequality, ranking 116th out of 146 countries surveyed in 2012 for the Gender Inequality Index ranking.[cxxvii] Women are marginalized in Ugandan society through legal, economic, and sociocultural means.

Women's low status in Uganda is reinforced through the following realities:

» **Customary laws:** While the Ugandan constitution awards women equal rights to land, customary practices often result in violations to these rights. A study by the Centre on Housing Rights and Evictions found that "rural women are still largely at the mercy of customary practices and traditional legal systems that often look to men as sole owners of property—including land."[cxxviii]

» **Education:** Throughout Uganda, girls attend school at lower rates than their male counterparts and drop out at higher rates, especially at the secondary level where marriage and the onset of menstruation force girls out of the

classroom. It is estimated that 12 percent of women aged 25 to 29 have never attended school.[cxxix]

» **Gender-based violence:** While domestic violence is illegal in Uganda, 60 percent of women older than 15 have experienced physical violence, including 15 percent who suffer abuse during their pregnancies.[cxxx]

Traditional gender roles require women to focus on the home—tending to the children and household chores. This focus, however, has not translated into household decision-making power as men remain the primary decision-makers; only 14 percent of household decisions are made jointly by men and women.[cxxxi] As one woman interviewed during BSR's engagement in Uganda stated, "My father makes the decisions, and my mother listens. I expect it will be the same when I marry."[cxxxii]

**HEALTH OUTCOMES**

Considerations: *Do varied, significant health needs exist for women, including needs related to health knowledge, behavior, and access? Do these needs extend to women who are employed within relevant sectors? Do health burdens limit employment opportunities or women's ability to excel at work?*

The health infrastructure remains largely broken in Uganda with a significant lack of adequate health infrastructure, facilities, trained personnel, medical supplies, and medicine.[cxxxiii] Chronic underfunding of the healthcare system has put the poor at a disadvantage, especially with the system of cost sharing whereby hospital and clinics charge for access to medical care.[cxxxiv]

The country faces three primary health burdens: HIV/AIDS, whose prevalence has climbed to 6.5 percent overall and 8.3 percent among women; malaria, which remains the leading cause of morbidity and mortality;[cxxxv] and tuberculosis, with Uganda ranking 16th among the 22 countries most affected by it.[cxxxvi]

As in other countries in this study, women in Uganda tend to suffer disproportionate health burdens. Their sexual and reproductive health remains a significant challenge because they often lack the necessary awareness and must battle cultural stigma. As the 2011 Demographic Health Survey notes, women's empowerment plays a powerful role in determining female sexual and reproductive health:[cxxxvii]

> *A woman's ability to control her fertility and the method of contraception she uses are likely to be affected by her self-image and sense of empowerment. A woman who feels that she is unable to control other aspects of her life may be less likely to feel she can make decisions regarding fertility.*[cxxxviii]

The use of modern contraceptives among married women has increased to 26 percent, but only one in three married women report that they have an unmet need for contraception, and 33 percent of women report that they have an unmet need for family planning.[cxxxix] As a result, many women bear children before they are ready and have more children than they can care for.

While abortion is illegal in Uganda, in the words of one stakeholder, "Unsafe abortions are a silent issue that no one wants to talk about, but remains very real."[cxl] The Guttmacher report on abortion in Uganda found that nearly half of all pregnancies are unintended and a third of those, roughly 300,000 each year, end in termination.[cxli] Despite these figures, women interviewed by BSR repeatedly stated that abortions "don't happen in Uganda," where religious stigma leads many to have private abortions.[cxlii] Of those women who carry their pregnancies to term, 438 out of every 100,000 live births result in the death of the mother.[cxliii]

One of the primary causes of maternal mortality is the lack of qualified pre- and postnatal care, as well as a lack of medical personnel qualified to deliver babies.

In addition to challenges related to their sexual and reproductive health, many women face occupational health challenges. The greatest ones surface in the floriculture industry where exposure to chemicals has resulted in skin irritation, dizziness, nausea, headache, blurred vision, and more severe effects like asthma and even death.[cxliv] One woman reported to BSR that she constantly "has infections from working. I always get cuts and they hurt my skin."[cxlv] Women also suffer reproductive effects, including miscarriages and birth defects.[cxlvi] Additionally, women working in export sectors report back pain, respiratory problems, and infections from the lack of safety equipment.

Despite the fact that 80 percent of households live within five kilometers of a health facility, utilization rates of these services are low due to poor infrastructure, limited access to transport, and lack of available medicines, supplies, and human resources.[cxlvii] A Global Health Initiative report highlights this problem, stating that:

> *As of September 2010, only 56 percent of the approved positions at the national level were filled, with even lower levels in rural or hard-to-reach areas. High levels of absenteeism (estimated at 37 percent) compound these recruitment, deployment, and retention issues. The end result is that when citizens arrive at a facility to receive services, often at significant time and expense in rural areas, staff is not available to serve them.*

Infrastructural challenges, low levels of awareness, lack of female decision-making power, religious beliefs, and provider bias have all resulted in underutilization of healthcare services—further burdening the Ugandan population.

## Research Question 2: Relevance and Feasibility of Workplace-Based Interventions in Uganda

Uganda presents limited feasibility for HERhealth implementation—relevant sectors exist for programs, but on a smaller scale. Larger sectors, such as coffee, lack the organized female labor force participation, type of workplace environment, and links to international buyers that facilitate HERproject implementation within the current model.

**RELEVANT SECTORS EXIST FOR PROGRAMS**
Feasibility considerations: *What are the primary export industries, and what is their structure? Does government policy promote growth in them? Are exports sold regionally or internationally? Do global buyers purchase directly or through auctions?*

| Uganda's Exports & Labor Force | |
|---|---|
| **Top three exports** | 1. Coffee<br>2. Tea<br>3. Cotton |
| **Percentage of labor force in agricultural activities** | 80% |

Uganda suffered significant economic and political setbacks between 1971 and 1986 under and as a consequence of the dictatorship of Idi Amin and the presidency of Milton Obote. However, since 1986, the government has instituted reforms with the goal of improving economic prosperity. Between 2006 and 2011, the country's growth in GDP has fluctuated between 5.6 percent and 7.1 percent per year.[cxlviii]

Employing approximately 80 percent of the workforce, agriculture is the most important sector of the Ugandan economy.[cxlix] While some of the country's agriculture has been formalized, most workers are employed in the informal sector—often serving as unpaid labor on family farms. The vast majority of

agricultural products are exported, with coffee and tea serving as the largest revenue-generating products:

» **Coffee:** Uganda produces 3 million bags of coffee per year, totaling approximately US$448 million, and is the second largest producer in Africa after Ethiopia.[cl] The coffee sector employs 2.8 million workers, 93 percent of whom labor on smallholder farms.

» **Tea:** Tea for export is produced by small and large estates, with five large estates employing between 5,000 and 10,000 workers each. Approximately 90 percent of the tea produced in Uganda is exported internationally with the vast majority sold at auctions in Mombasa.[cli]

Uganda's agricultural export sector is larger than some in the region, notably Rwanda. However, though Uganda is the second largest African exporter of coffee, it earns approximately half as much as the largest exporter, Ethiopia. Additionally, the vast majority of Uganda's agricultural exports are sold through regional and international auction houses, limiting direct relationships between buyers and suppliers. Thus, similar to Rwanda, direct relationships with foreign buyers are limited; most goods are sold through intermediaries. Thus, HERproject's traditional leverage point of international business may be less effective in this context.

**CRITICAL MASS OF FEMALE BENEFICIARIES TO REACH**

Feasibility considerations: *Are women employed within export-oriented sectors? Are they employed full-time, seasonally, or on a day-to-day basis? Does their employer value their attendance and retention, or are they considered easily replaceable by unskilled day or seasonal labor?*

Formal sector employment has proven to be a powerful tool for women's empowerment. Unfortunately, informal agricultural activities remain the largest employer of women in Uganda—employing 77.4 percent of the female workforce—with the majority of women contributing labor at the smallholder level.[cliii] Although the division of labor in agriculture depends on the region and changes over time, men in Uganda tend to handle more remunerative activities in agriculture, such as tending to cash crops or delivering produce to market. Women generally take on the more tedious, time-consuming tasks of crop production, for example, completing 85 percent of planting and weeding, 55 percent of land preparation, and 98 percent of food processing.[cliii]

Unlike other areas of smallholder production, organized tea and coffee cooperatives seeking international market exposure tend to be more formalized, providing women more secure livelihoods. Tea associations formed by cooperatives of smallholder farmers produce tea for factories they own and receive direct returns on the sold produce. Women tend to be active in the committees and management of organized cooperatives, especially those holding certifications like Fair Trade.[cliv] Women can represent approximately 15 percent of cooperative members in the certified farmer-grower model of tea production Uganda.[clv]

While they remain the labor of choice in some industries, including floriculture, women continue to face barriers to formal sector employment. One primary barrier is the perception among employers, expressed by one interviewee, that "Men can deliver better than women because they can offer labor year-round, while women are absent to meet family duties and when they are pregnant."[clvi] This perception is reinforced by lower rates of educational achievement among women, higher levels of household responsibilities, and lack of accommodation during pregnancy, forcing many women to leave the formal workforce. One

woman reinforced this belief, stating "When I was pregnant, I had to do the same amount of work. My boss didn't give me a break."[clvii] Additionally, sexual harassment continues to be a barrier for women in the workforce; a 2008 study by Ignitus Worldwide Uganda and Youth Crime Watch Uganda found that 58 percent of women experienced sexual harassment at work.[clviii]

**PRESSURE EXISTS TO IMPROVE WORKING CONDITIONS**
Feasibility considerations: *Are private sector actors interested in investing in women workers? To what degree do factories or farms in the country supply leading multinational companies or other companies concerned with worker welfare in the supply chain?*

The poor health of the Ugandan population, combined with antiquated agricultural practices, remains challenging for the country as it tries to spur economic growth. It is estimated that the agricultural sector experiences losses of US$201 million per year as a result of declining worker health.[clix] In response, the Ugandan government has adopted some economic development policies that include investments in education, health, and employment. The government has a stated goal to "increase enterprise efficiency," which it is promoting through incentives to the private sector, especially the agriculture sector, to increase production and productivity.[clx] Thus, government engagement on worker welfare investments is likely to be feasible.

As mentioned earlier, due to the size and scope of Uganda's export sectors, direct engagement by multinational companies in working conditions and workforce empowerment has been limited. There is less of an opportunity for buyers to leverage their commercial relationship to encourage their suppliers to invest in women workers. Thus, the traditional HERproject approach of engaging international buyers likely has limited feasibility in Uganda.

**CONDITIONS FOR PROMOTING KNOWLEDGE TRANSFER**
Key considerations: *Do the work environment, workday activities, and productivity demands facilitate worker participation in ongoing trainings? For example, do employees work close to each other or regularly gather at a meeting point, either of which would allow for training outreach without posing an excessive cost burden for the factory or farm?*

As this case study suggests, agriculture is primarily organized into smallholder plots and informal labor in Uganda. In the coffee sector, a new delivery model would need to be developed to effectively implement a program like HERhealth. Tea plantations, on the other hand, have a more centralized, formalized workforce and could provide a supportive setting for ongoing trainings. The floriculture sector remains relatively nascent, but it could present an opportunity for traditional HERhealth implementation in the future. Given Uganda's small number of tea plantations and floriculture farms, scaling a workplace intervention beyond a few sites would be a challenge.

**NGO CAPACITY EXISTS TO IMPLEMENT PROGRAMS**
Feasibility considerations: *Is there a robust civil society? Do organizations have the relevant capacity and incentives to carry out the program, and could they do so to private sector standards?*

Civil society organizations (CSOs) in Uganda are robust, partially as a result of the high rates of government corruption.[clxi] CSOs have taken a stand against corruption, advocating for donor money to be funneled into their organizations, which they believe often produce better results than government. Referring to their relationship with government, more than one CSO director stated that their

organization “has a seat at the table.” [clxii] CSOs have taken a strong position on women’s empowerment and education, with organizations active in promoting these issues through advocacy and in partnership with government.[clxiii]

Civil society in the health sector faces some government challenges and restrictions with additional regulations forthcoming.[clxiv] The government has imposed a moratorium on mHealth and eHealth programs until a strategy is established that will enable cooperation between health organizations and the government, halting many initiatives that were under way.[clxv]

An additional challenge for some health organizations is restrictions on data collection. The government has prohibited data collection outside of the national system, stating that public health workers cannot gather additional information without prior government approval. [clxvi] All NGOs must undergo a registration process that includes an approval process.[clxvii] Despite these restrictions, Uganda does not present a prohibitive environment for NGOs, and many NGOs provide much needed health services, especially in remote areas where the government does not offer sufficient services.

## Conclusions: Need, Feasibility, and Relevance in Uganda

This study found significant needs present in Uganda. A workplace-based intervention approach was found to be relevant but to have limited feasibility within the export sectors identified in the country. Potential exists for smaller scale activity in the tea sector or floriculture sector, or for a redesigned pilot program in the coffee sector. Both would require additional research to ensure successful pilot implementation.

## Conclusions from the Country Scoping Studies

In all three countries assessed in the scoping study, as well as the pilot country (Kenya), BSR found significant need for private sector investments in women's health and empowerment. Moreover, we found limited examples of existing efforts to make such investments in the workplace. Given the dominance of agricultural activities in regional labor force participation, as well as the generally low access to health information and services among rural communities, programs focused on women and men working in agricultural sectors would likely be relevant and fill a gap in the system.

Based on the results of the scoping study, we found high potential for continued expansion of the HERhealth program in Kenya, and potential to pilot the program within the floriculture and horticulture sectors in Ethiopia. The BSR team has already begun pursuing these near-term, high potential priorities.

More medium term, we found need and potential to consider adaptations to the HERhealth model for application within the smallholder and cooperative context. Such an adaptation will require additional research specific to the tea and coffee sectors and a unique pilot. Based on demand and efficiency, BSR decided to run such a pilot in Kenya, and then explore expansion to additional countries in the region based on the potential we assessed. Uganda, Rwanda, and Ethiopia all present potential locations for such expansion should the pilot prove successful.

Africa is a growing market for most BSR members, and the countries included in this study represent strategic sourcing locations in a variety of sectors. As this research shows, significant need exists for workplace-based women's empowerment programs. HERproject, and the HERhealth program in particular, can address these needs. However, to fully meet the identified needs, different stakeholders must make broader investment efforts to ensure that women are able to participate in and benefit from the growing economies in East Africa.

## A Call to Action: Business Responsibilities and Opportunities

East Africa's economic growth presents great opportunities for business and for women's empowerment. For women, widespread formal sector employment has tremendous potential to support gender equality and their empowerment in the region—if those jobs provide decent working conditions and opportunities for improved well-being. For business, women's participation in the labor force and increased income can contribute to healthier workers and families, better educated children, and more stable communities. As summarized in this report, formal employment is proving to be a critical factor in improving the status of women and expanding the opportunities available to them and their families—as evidenced by the study of Ethiopia's floriculture sector, which found that the percentage of women reporting decision-making power over household decisions jumped from 16 percent pre-employment to 83.6 percent post-employment.[clxviii]

Across the sectors and countries included in this study, the researchers found that women are the "labor of choice" in certain sectors, but remain underrepresented in others. More women than men are employed in temporary and informal work, such as day labor on small family farms. Moreover, where women are formally employed, issues disproportionately impacting them—such as sexual harassment, maternity benefits, equal pay, and access to health information and services—aren't being adequately addressed or provided.

Interviews and site visits revealed that working women's health needs are significant and consistent with government-articulated health needs throughout each country and within the region. Infectious diseases, reproductive health, nutrition, and occupational health issues are critical areas of unmet needs among the working women we interviewed. Stakeholders confirmed that in many cases workplace interventions would contribute to better health outcomes by arming women with knowledge, connecting them to resources, and engaging management on the importance of investing in a healthy workforce.

This research focused on women's labor force participation in export-oriented sectors, women's needs vis-à-vis rights protections and health, and the existing capacity of civil society, business, and government to respond to those needs. However, in conducting our research, we also uncovered some cause for concern regarding supply chain compliance practices, particularly related to transparency and supplier engagement.

Related to that issue, we found that many industries in the region export through regional and international auctions, limiting direct engagement with the farms and factories that employ women and men. These circumstances result in limited oversight and transparency over working conditions and other compliance issues; they also reduce the potential for innovative collaborations to improve well-being and contribute to the community-wide benefits that may result from employment.

In this context, ensuring transparency and accountability for ethical employment practices is critical and seemingly absent. In Kenya, BSR is working with a number of international companies who have direct relationships with their suppliers; in the other countries included in this research, those relationships are less common. Moreover, the majority of farms and factories in Kenya continue to supply auctioneers and other intermediaries, rather than international companies directly. The floriculture and horticulture sectors in particular should undergo greater scrutiny with regard to its accountability systems and compliance with international standards.

Within East Africa, as across their value chains, businesses have both responsibilities and opportunities to protect direct and indirect employees and to promote women's empowerment within an inclusive economy. We have outlined recommendations based on our findings related to each of these areas.

## Ethical Job Creation with Equal Opportunities for Women

A primary responsibility of business is ensuring that their business partners follow ethical practices. These four areas of improvement support this objective:

1. **Improve supplier engagement and increase transparency and accountability:** In order to ensure that women and men are employed under compliance with national law and international standards, business must deepen its engagement with suppliers. Rather than sourcing exclusively through regional or international auctions, businesses should seek to make their supply chains in East Africa more transparent—wherever possible establishing relationships with suppliers in order to ensure greater accountability over working conditions, among other issues. Through direct buying, businesses will increase their oversight and accountability and can develop more stable supplier relationships that are critical to improving the latter's quality and sustainability, as well as ensuring risk mitigation.
2. **Ensure compliant working conditions:** Through our research, we found that the relatively low levels of direct supplier engagement have reduced accountability and incentives for suppliers to comply with international best practice vis-à-vis ethical trade. Our researchers did not directly evaluate compliance-related issues, but based on our interviews with workers, such issues as sexual harassment, improper contracting practices (e.g., firing workers every three months to avoid paying benefits), and occupational health and safety risks were widespread. We strongly recommend that companies purchasing products made in the countries examined in this study increase their monitoring practices and their expectations of direct and indirect suppliers in the region to promote ethical trade practices.
3. **Promote gender-sensitive employment:** Gender inequality is a widespread, serious concern in East Africa, and it impacts business in myriad ways. Sectors that employ large numbers of women should develop policies and monitoring practices related to gender-based violence issues in particular, as sexual harassment was found to be a common occurrence at work and in the community in all the countries we visited. Also, maternity leave was rarely provided, even when the law requires it.
4. **Protect informal workers:** Many of the sectors observed in this research employed large numbers of informal workers (e.g., seasonal and day laborers, as well as smallholder farmers and the people they employ). Due to the other challenges observed—related to lack of transparency and accountability at many employers—these workers are insufficiently protected by current practices and policies. We recommend that companies examine the best practices in other sectors and regions, and test or implement them in these countries.

## Inclusive, Profitable and Stable Supply Chains

Given the significant need for worker welfare programs, especially those focused on improving female health outcomes, business should invest in workplace interventions and promote Fair Trade certification.

1. **Promote job creation:** With several export sectors growing in the region, foreign direct investment can help diversify their economic activity, and provide much needed formal sector jobs. In addition to agriculture, investments in ICT and manufacturing show strong potential.
2. **Invest in worker well-being programs, especially general and women's health:** Women are disproportionately vulnerable to the health challenges present in the region—investments in health information and access to services will provide social and business returns. Moreover, women are also less likely to have access to formal financial services, especially where mobile banking is less readily available (as compared with Kenya). The wages earned by women are critical to community welfare and stability, as women are more likely than men to invest their earnings in the health, education, and nutrition of their children and family members. Women who are healthier are also more productive, and may be absent less from work. Investments in female employee well-being are, therefore, also investments in workplace productivity and community stability and prosperity.
3. **Support Fair Trade certification processes:** Fair Trade businesses create value for all participants in the trade chain; they often invest in worker welfare programs and local community initiatives that disproportionally benefit women (e.g., supporting the development of a local well and community health programs). Stakeholder visits confirmed that worker well-being at Fair Trade farms and cooperatives is significantly higher than it is on other farms, suggesting that Fair Trade businesses may offer greater opportunities for women's empowerment.
4. **Support supplier diversity:** Women-owned businesses face significant challenges related to starting up, as well as growth. All else equal, international brands can institute preferential status or quotas for women-owned and/or managed businesses to ensure greater gender diversity within supplier relationships and promote women's empowerment.
5. **Create professional advancement opportunities for women:** For example, with smallholder production dominating export markets, businesses have an opportunity to promote female participation in and management of cooperatives. Too often, BSR found that while women were doing most of the work in the fields, their participation within cooperatives was marginal. Stakeholders engaged during the field visits also explained that women-led cooperatives were often better managed and more successful. Investors can work with government representatives and cooperatives directly on ways to promote women's participation. Alternatively, all else equal, they can give preferential status to women-led and gender-equitable cooperatives. Market incentives are powerful tools to elevate women's status and can lead to significant empowerment opportunities.

Business can also empower female cooperative workers in these ways:

1. **Promote alternative income-generating activities:** Working with women on alternative income-generating activities, such as handicrafts, for them to take on during the low season can help strengthen their economic empowerment throughout the year. Women can use the cash generated through such activities to invest in the development of their associations within their cooperatives, as well as to develop their own export routes.
2. **Ensure that existing programs and projects include women:** Many government and NGO programs, trainings, and extension services are available to smallholder cooperatives and should explicitly invite women to participate. Stakeholder interviews indicated that women were often more attentive (than men) during such trainings, and women benefit greatly from their delivery. However, women often cannot access these trainings because

of the domestic chores they have to attend to. Providing incentives for women to attend trainings can help ensure their participation and encourage them to hold greater leadership positions within cooperatives.

By investing in women through each of these different channels, business has the ability to catalyze the development of inclusive economies that empower women throughout East Africa.

## What Actions Do We Hope to Inspire Readers to Take?

Based on our findings, we feel that women employed in export-oriented sectors in East Africa are benefiting from and have the potential to benefit significantly more from their employment. Improved transparency and labor rights compliance, as well as investments in critical areas of social need, are required to help realize these benefits' maximum potential. Furthermore, based on HERproject findings from working in factories in Asia, as well as from our pilot on two farm sites in Kenya, evidence suggests that local suppliers and multinational buyers will obtain business benefits from supply chain–based investments in female employees, and in workplace-based health interventions in particular.

We hope that readers of this study will be inspired to take the following actions:

» Global business will strive to support ethical labor practices, based on transparent supply chains, within East Africa and globally, which ensure decent, safe working conditions for women and men.

» Local businesses will follow equal employment practices and aspire toward gender diversity, equal pay for equal work, and workplaces free of harassment and discrimination.

» Global and local businesses will collaborate to provide additional benefits to meet female employees' unique needs, including but not limited to benefits that support their general and reproductive health.

» Civil society organizations and governments will partner with businesses to help them employ women fairly, and to foster workplace environments that support women's empowerment, and help improve gender equality and reduce poverty.

Based on our findings, BSR will expand HERhealth programs within Kenya and into Ethiopia in 2014. In Kenya, we will pilot a study exploring the feasibility and impact of HERhealth within the structure of tea cooperatives. We will also explore expanding HERhealth into the tea sector in Uganda in 2015, depending on our ability to secure financial support for that effort. Because women's participation in export-oriented sectors remains limited in Rwanda, it is unlikely that we will expand programs there at this time, though we encourage businesses operating there to contact us if they know of suppliers or direct operations employing large numbers of women.

Many of the findings in this study are transferrable to other countries in Africa and within Asia; we encourage interested companies to contact us regarding program participation in countries where they have strategic supply chain operations. BSR has also published a suite of publically available resources to help companies implement their own women's health programs, and we encourage readers to explore, distribute, and use these resources.

# Appendix I: Stakeholders Consulted

**Kenya**
CHAK
CTC International
DSW
Embassy of Sweden, Sida
Ethical Trading Initiative
Fair Trade
FIDA Kenya
Hivos
Karen Roses
KENWA
Kenya Flower Council
Kenya HIV/AIDS Business Council
Kenya Human Rights Commission
IPL
Maggie Opondo
Mama Na Dada
Marks & Spencer
Ministry of Gender
Ministry of LabourNational Gender and Equality Commission
NOPE
Office of the Prime Minister
Richard Ankers
Sainsbury's
TechnoServe
VegPro Group

**Ethiopia**
Consortium of Reproductive Health Association (CORHA)
DSW
Embassy of the Netherlands, Ministry of Foreign Affairs of the Netherlands
Embassy of Sweden, Sida
Ethio Agri-CEFT PLC (tea packaging plant)
Ethiopian Horticulture Producers and Exporters Association
Family Guidance Association of Ethiopia (FGAE)
Girl Hub
Hilina (factory visit)
Lafto Roses (rose plantation and packaging plant)
Marie Stopes International (MSI)
National Federation of Farm, Plantation, Fishery, and Agro-Industry Trade unions of Ethiopia
PACT
PATH
Pathfinder
Population, Health, and Environment (PHE)
Talent Youth Association
TechnoServe
VegPro Flower Farm

**Rwanda**
ARBEF (Association Rwandaise pour le Bien-Etre Familiale)
CARE Rwanda
COOPAC (Cooperative pour la Promotion des Activities Café)
Delegation of the European Union
Embassy of the Netherlands, Ministry of Foreign Affairs of the Netherlands

Embassy of the United Kingdom, Dfid
Embassy of the United States, U.S. Agency for International Development
Engender Health
Fate Consulting
Girl Hub
Health Development Initiative
JHPIEGO
Ministry of Health
National Agricultural Export Board
Rubaya (tea estate)
Rwanda Development Board
Rwanda Mountain Tea
Rwanda Pyrethrum Program (SC Johnson)
RWASHOSCCO (smallholder in Rwanda focused on specialty coffee)
TechnoServe (phone interview)
Ventures Strategy Innovation
Women for Women International

**Uganda**
DSW
Embassy of Sweden, Sida
Engender Health
JHPIEGO
Kyagalanyi (coffee plantation)
Mairye Estates (flower farm)
Marie Stopes International (MSI)
National Union of Plantation and Agricultural Workers—Uganda (NUPAWU)
Partners in Population and Development
Pathfinder
Strides
Tea plantation owner (unnamed)
TechnoServe
Trademark East Africa
Uganda Manufacturers Association (UMA)
Uganda Workers Education Association

# Appendix 2: HERhealth Steps and Methodology in Kenya

The HERproject model delivers a series of general and reproductive health trainings based on curriculum designed by international health experts and adapted to the specific health needs, knowledge, and sensitivities of each country where the program is implemented. BSR works with the local implementing partner to tailor the global curriculum to the local context and beneficiaries. For example, in Kenya, BSR and NOPE developed a module on ergonomics to respond to the needs of farmworkers performing repetitive motions and lifting as part of their duties. The module on HIV/AIDS was adapted to focus on transmission and caring for the infected, given the relatively high awareness of HIV/AIDS in Kenya. With our local partners, we also work to situate HERhealth programs with respect to other community health initiatives and services, as well as services provided in the workplace, to create links for health at the farm level and beyond.

## Step 1: Introduction to Farm Management

The participating buyer is responsible for providing a brief introduction to the farm management. Once the farm has agreed to participate, NOPE will conduct an initial introduction to HERhealth. Wherever possible, this meeting should take place in person, although it can be conducted via phone if necessary. The purpose of this initial meeting is to discuss the following:

» Activities that will be conducted on the farm

» Possible training times

» Selection of the farm's HERhealth Team

» Selection of the peer health educators (PHEs)

» Introduction to a work plan template

## Step 2: Selection of the HERhealth Team

The farm management will designate an internal HERhealth team to support the project's activities. The HERhealth team will include relevant farm staff, e.g., a clinic nurse or doctor, designated HR staff, or production manager. The HERhealth team is responsible for ensuring that the PHEs have designated time to train their peers. This time should be coordinated with the production manager to ensure that these activities do not hinder production. BSR has found it most effective for the HERhealth team to have direct oversight of a set group of PHEs. For example, each HERhealth team member may be responsible for 10–15 PHEs.

Throughout the project, the HERhealth team will meet briefly (from 30 minutes to an hour) once per month concurrent with the monthly peer educator meetings, and will serve to ensure farm needs or concerns are being heard and addressed. The HERhealth team is also responsible for promoting farm ownership and participation in program activities.

The HERhealth team should be selected before the kick-off meeting.

## Step 3: Selection of the PHEs

The farm will select 3–10 percent of the female population to act as

PHEs. PHEs can be selected in many different ways (e.g., farm management selects them, women employees volunteer, or colleagues nominate them). In all cases, being a PHE should be voluntary.

PHE selection can occur before or after the kick-off meeting.

### Step 4: Development of the Farm Work Plan

To ensure the program's smooth implementation and that it does not significantly affect production, the HERhealth Team will develop a work plan to map when trainings will occur in collaboration with the production manager. This plan should include the following components:

» *PHE trainings:* The set trainings last approximately three hours and occur every two months (e.g., January, March, May, etc.)

» *PHE refresher trainings:* Refresher trainings last one hour and occur every two months. They allow the PHEs to ask you (the trainer) questions.

» *Worker trainings:* PHEs must have time to train their peers. They should be responsible for a set group of peers.

### Step 5: Business Return on Investment

NOPE will work with farm management to select three to five key business indicators to be tracked during the course of the program (e.g., absenteeism rates). The farm will use the HERhealth ROI toolkit to track the data.

### Step 6: Orientation Kick-Off Meeting

To ensure stakeholder alignment, NOPE will work with farm management to organize a project kick-off that includes upper management, NOPE, and buyer representation (when feasible). BSR will participate when available. The kick-off event will solidify project buy in and ensure alignment by clarifying roles, responsibilities, and expectations among project partners.

The farm and NOPE will present and finalize the HERhealth farm work plan during the kick-off meeting.

### Step 7: Middle Management Engagement

NOPE will train line supervisors in order to introduce HERhealth to middle management, explain the forthcoming activities associated with the project, and explore the role of supervisors in making such programs successful. In addition, line supervisors will be provided examples from other factories to address their queries and concerns.

### Step 8: Baseline Assessment of Health Knowledge

In an effort to identify topics that need to be addressed during trainings at each farm and to effectively measure the project's impact upon conclusion of the peer awareness program, NOPE will develop and administer a survey at the farm prior to peer health education training. The survey informs the baseline measurement of workers' knowledge about women's general and reproductive health for comparison with a post-training survey. It will also include some business indicators, including absenteeism due to health-

related issues.

» NOPE conducts a survey with a randomized, stratified sample of workers (10 percent). BSR provides a standardized questionnaire to allow for global comparability and covering demographic information, worker health knowledge and behavior, women's empowerment, and farm management perceptions.

» NOPE will assess the baseline results and report these findings in the HERhealth baseline report.

### Step 9: Peer Educator Training

NOPE will administer a series of trainings (six altogether), conducted every other month on general and reproductive health topics identified in the baseline, as well as ongoing instruction on communication skills. These trainings should be hands on and participatory. We recommend that only 20–50 PHEs are trained at a time. Trainings should include the following components:

» Training on one or two health topics (e.g., nutrition and hygiene)

» Reviewing the last health topic covered (e.g., by administering a quiz)

» Training PHEs to communicate key messages with their peers

» Reviewing the PHE work plan for sharing information with peers

» Allowing time for PHEs to practice sharing information and for questions

Check-in meetings also occur every other month, during which NOPE should do the following:

» Observe a PHE training.

» Check in with farm management and the HERhealth team.

» Review the number of women trained.

» Answer PHEs' questions.

» Review the referral system of the farm nurse (as relevant).

### Step 10: Farm-Based Awareness Raising

Following each PHE training, peers are responsible for sharing health messages with their colleagues according to the HERhealth work plan. Outreach methods may include:

» Lunchtime, break time, or otherwise scheduled formal peer-to-peer training sessions

» Casual outreach to a fixed number of women (i.e., 50 PHEs need to each share information with 40 of their peers)

» Weekly drop-in sessions at the clinic (PHEs are assigned an hour to sit in the clinic, where peers can visit them to seek advice)

Peer educators and the HERhealth team will monitor outreach activities, and report back to the NGO during monthly meetings or trainings. Data to be gathered includes:

» The number of female employees trained
» The amount of health information materials distributed
» The number of referrals made to health or rights services
» Qualitative list of types of requests made by women (e.g., nutrition, contraception, sanitary napkins, overtime, or harassment, etc.)
» Qualitative list of monthly successes and challenges

### Step 11: Impact Measurement

Upon completion of all farm trainings, the NGO will conduct an endline survey. It will then compare these results to the baseline to assess the project's impact. All endline results should be presented to the farm in a closing meeting, with the sponsoring brand in attendance if possible.

### Step 12: Sustainability (Ongoing)

We want to enable all farms participating in HERhealth to sustain investments in health after the official program has come to a close. In order to fulfill this objective, we recommend the following:

» During the kick-off meeting, the NOPE explains to management that this program is ongoing. NOPE will be working with farm management to develop a health management system that works for them over the course of the program.
» After three trainings, NOPE meets with farm management to discuss a draft Health Management Plan. Ask the farm the following questions:
    - What is working well?
    - What is not working?
    - After NOPE has finished, who will be responsible for continuing activities?
    - Which activities would you like to continue?
    - How will new workers be trained?
    - How will new PHEs be trained?

    NOPE is responsible for helping the farm develop a Health Management Plan, which outlines how and when the farm will continue to promote health. The program should be tailored to the local context to ensure that the farm has the capacity to carry out the plan.
» Closing meeting: The farm will present a final Health Management Plan. It is also presented to the buyer.
» Brands are responsible for checking in with farm management six months and one year after the close of the program.

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