



**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 7

**Using an Employer-Based Approach to
Increase Support for and Provision of
Long-Acting and Permanent Methods of
Contraception: The India Experience**

**Melanie Yahner, The RESPOND Project/EngenderHealth
Cindi R. Cisek, The RESPOND Project/Meridian Group International**

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Executive Summary

Description of the Approach

Between January 2011 and June 2012, The RESPOND Project implemented an employer-based approach in Kanpur, Uttar Pradesh, India, with the objective of increasing workers' awareness of and utilization of family planning (FP), particularly their use of long-acting and permanent methods of contraception (LA/PMs¹). This approach involved obtaining support from employers, identifying existing private-sector services as referral sites for employees interested in FP, increasing access to and support for FP through employers, and strengthening knowledge about FP services among employees.

During the project's 18-month implementation period, 10 companies representing a variety of sectors, ranging from waste management to manufacturing to beverage bottling, participated in the project. The employers agreed to support the intervention by providing a venue for project activities and by allowing employees to attend activities during normal working hours. Key features of the RESPOND interventions included:

- Developing and distributing print materials, including posters, brochures, and self-standing poster displays that provided employees with FP information, with a focus on LA/PMs
- Orienting 27 health coordinators from the participating businesses on FP, particularly LA/PMs, and on interpersonal communication skills for discussing FP use with interested employees
- Implementing 61 health talks, which included an orientation to FP and an in-depth discussion of LA/PMs
- Staffing health desks placed in a well-trafficked area of the company with a RESPOND program officer or a trained counselor, distributing materials and answering questions about FP
- Identifying referral sites that provide high-quality FP services, including LA/PMs²
- Providing referrals to interested clients through a phone hotline and project staff

Evaluation Questions

RESPOND sought to evaluate how and to what extent this approach changed employees' knowledge and attitudes about and use of FP, with a focus on LA/PMs. RESPOND collected program data throughout the project period and conducted a retrospective endline survey with a convenience sample of 1,543 employees from six of the companies during May and June

¹ LA/PMs are defined as the intrauterine device (IUD), the hormonal implant, female sterilization, and vasectomy. However, the implant was excluded from this intervention, as it is not available in India.

² RESPOND implemented a quality checklist at private facilities in Kanpur that provided LA/PM services; clients were referred to those that were found to provide quality services. Technical assistance could not be provided to improve services in facilities providing less-than-quality services.

2012 to determine the effect of the RESPOND messages. The study questions from the endline survey were:

- What proportion of employees were exposed to RESPOND's interventions?
- What proportion of exposed employees discussed FP with their spouse?
- What proportion of exposed employees adopted an FP method or switched to a new method, and from what?
- Would employees use FP in the future? If so, would they consider an LA/PM?
- Did FP adoption differ by company, or by participation in more than one intervention (both health talks and health desks)?

Results

In total, RESPOND reached 4,830 employees with information on LA/PMs, reflecting 95% of the total workforce. The majority of the reach (59%) was through health talks, while 41% was through health desks. An informal system to track referrals showed that a total of 172 employees were referred for LA/PM services at affiliated sites over the life of the project. However, findings from the endline survey suggest that acceptance of LA/PMs was likely higher and that employees may have sought services without requesting a referral.

Endline survey

Participant characteristics

The sample for the endline survey consisted primarily of men (96%). Nearly three-quarters (72%) of participants were married and, of those, the majority (98%) had children. Many married participants (43%) were already using FP at the beginning of the intervention, most commonly male condoms (38%) and female sterilization (33%).

Exposure to the intervention

Nearly all (95%) of respondents had heard about the FP health talks in their workplace, and 83% of those had attended one or more of these talks. Most (87%) had heard of the FP health desks in their workplace, and 49% of those had visited a health desk at least once. Nearly all respondents (98%) reported that they had seen at least one of the posters or brochures at their workplace.

Discussion of FP with partners

Among married participants who did not use permanent methods, 78% reported discussing FP with their spouse in the last year. This figure was higher among those who either participated in health talks or visited health desks (85%) than among those who did not (51%). More than half (55%) of participants exposed to the interventions who have no children discussed FP with their spouse, compared with 81% of exposed participants who have children.

Changes in FP use

Switching

Many FP users, both those exposed and those not exposed to the intervention, chose to switch to a new FP method during the intervention year. Among married employees who were

using a nonpermanent method of contraception at the beginning of the intervention, 65% of those who *both* participated in a health talk and visited a health desk and 50% of those who *either* participated in a health talk or visited a health desk switched to a different method. Many of the exposed who switched selected an LA/PM; among pill users who switched, for example, 22% chose an IUD, 41% chose female sterilization, and 14% chose vasectomy. A smaller proportion of the unexposed (44%) switched to a different method.

Adoption

Among married nonusers of FP who visited health desks or participated in health talks, 13% adopted a method during the intervention year. The method most often selected was the male condom (42%), followed by the IUD (28%). No nonusers who were not exposed to the intervention reported accepting FP during the intervention year.

Future FP Use

Ninety-five percent of those who either participated in a health talk or visited a health desk and who were not currently using FP reported that they would consider using an FP method or encouraging their spouse to use a method in the future. This figure did not vary widely based on the level of exposure—96% of those who participated in one element of the intervention, compared with 94% of those who participated in both elements. Far fewer of those that did not participate in the intervention said that they would consider using FP in the future (60%).

The methods most often listed by those exposed to the intervention as potential methods for future use were female sterilization (58%), the IUD (40%), and vasectomy (31%).

Conclusions and Recommendations

The India LA/PM experience demonstrates that workplace initiatives provide a unique forum for achieving attitude and behavior change around FP, particularly for methods that often have strongly associated negative attitudes and misperceptions. Employers' endorsement of FP in the form of on-site activities and compensated time off has the potential to weaken key barriers to LA/PM adoption. Attending a health talk encouraged employees to discuss FP with their spouses and to consider LA/PMs as potential methods for use in the future and provided work time to support this discussion and decision making. Further, the approach appears to have been effective in encouraging behavior change: Many users of short-acting methods switched to the more effective methods, and FP adoption among nonusers was also strong.

Lessons learned from the data and programmatic experience and recommendations for scale-up include:

Industry selection and capacity building

- Focus on recruiting companies that demonstrate strong management support for employee health.
- Consider focusing on larger companies, which often have more structured employee welfare programs and may have more flexibility in scheduling activities.
- Ensure that health coordinators are equipped with accurate FP information to best meet potential future users' needs when the time is right.

Employer-based approach

- Encourage employees to visit health desks and participate in health talks.
- Encourage participants to discuss FP with their spouse and suggest key messages to report back to their spouse, or invite spouses to attend health talks, when feasible.
- Encourage all employees, regardless of whether they have children, to discuss their reproductive intentions with their spouse and determine how FP could help to meet their needs for spacing or limiting births or for delaying first births.

Introduction

In the state of Uttar Pradesh, in northeastern India, 29% of all married women currently use a modern method of family planning (FP). This is well below the national average of nearly 49% and is one of the lowest rates in the country. An additional 21% of married women have an unmet need for contraception (9% for spacing births and 12% for limiting births) (IIPS & Macro International, 2007). As Uttar Pradesh is India's most populous state, with 16.5% of the nation's total population,³ this translates to an estimated 8.4 million women with an unmet need for FP in that state alone. A clear need exists for innovative programs that are able to bring FP information and services to couples who currently have an unmet need or who are not using the method best suited to their childbearing intentions.

From January 2011 to June 2012, The RESPOND Project implemented an employer-based approach to increase access to and utilization of long-acting and permanent methods of FP (LA/PMs) in Kanpur, Uttar Pradesh. This approach builds on the global trend among employers to establish health promotion programs that support improved health and well-being for their employees while also increasing worker productivity and reducing benefit costs (Linnan et al., 2008). The RESPOND Project's Supply-Enabling Environment-Demand (SEED) Programming Model™ served as a pillar of the project's design—ensuring the availability and quality of services for LA/PMs; fostering among employers an enabling environment for sexual and reproductive health-seeking behavior; and improving knowledge and demand for services among employees.

Employer-based programs encourage increased employer financing and support for services by making a business case to employers that providing access to a broader range of health care services is cost-effective and that these services help to increase productivity and reduce employee turnover and absenteeism. Some of these initiatives have incorporated reproductive health information and services into workplace settings, to target men and women of reproductive age, who are often difficult to reach. Men, in particular, are often excluded from participating in health information sessions at health care facilities or at the community level, as gender norms may discourage them from seeking health services for themselves or accompanying their wives or children for services. Additionally, work schedules often leave men unavailable to visit health care facilities when they are open.

Recent examples of employer-based initiatives include the Health Enables Returns (HER) Project, which found that training peer educators in factories in Pakistan to discuss health issues, including FP, increased general knowledge of FP from 66% at baseline to 89% at endline (ESD Project, 2011a). Significant increases in FP knowledge were also found through a similar initiative in Egypt (ESD Project, 2011b). Most of these programs, however, have focused on improving access to short-acting contraceptive methods (condoms, the pill), which can be added easily to an employer's existing on-site health services. The more effective

³ India Census 2011, Provisional Population Totals. The Hindu (Chennai, India). Accessed July 10, 2012 at: http://www.thehindu.com/multimedia/archive/00517/India_Census_2011___517160a.pdf.

LA/PMs, however, require a skilled provider. Where on-site services are not feasible, employer-based approaches have also explored offering mobile services, creating special service days, and developing referral mechanisms to link employees with nearby services, where the employer may cover a portion or all of the costs associated with off-site care.

In India, the RESPOND approach was designed to increase access to and use of LA/PMs (the intrauterine device [IUD] and male and female sterilization⁴) with employer support, building upon previous best practices related to working with employers to increase access to reproductive health (RH) and FP services (Wofford & MacDonald, 2009). The approach was adapted, however, to address the unique service delivery requirements of LA/PMs by building upon existing private-sector services as referral sites for employees, increasing access to and support for FP through employers, and strengthening demand for information and services among employees.

LA/PM Employer-Based Approach

RESPOND designed its employer-based approach to build on best practices from employer-based initiatives from several previous projects funded by the U.S. Agency for International Development (USAID), such as the Extending Service Delivery (ESD) and CATALYST projects (Wofford & MacDonald, 2009; Epstein, 1996). With consent from participating companies, RESPOND engaged male and female employees at their worksites by providing FP information and education sessions; by promoting specific LA/PMs through highly visible print materials and through small-group and individual information sessions; and by engaging FP champions from within the companies.

Prior to implementing the approach, RESPOND conducted an assessment in three cities in Uttar Pradesh (Allahabad, Kanpur, and Meerut) to better understand employers' existing health and wellness programs and to identify interest in supporting an FP initiative. The assessment also gauged companies' involvement in other health initiatives, their openness to promoting FP (particularly LA/PMs), and their willingness to support specific interventions.

RESPOND ultimately selected Kanpur as the pilot site for the employer-based approach, due to its large industrial sector and potential for scale-up; Kanpur has more than 1,000 small and medium-sized businesses, with the number of employees per company ranging from 150 to 1,200. The assessment also identified numerous existing private-sector service delivery alternatives for FP and LA/PM services.

Based on findings from its initial assessment, RESPOND established several parameters for soliciting companies' support for the approach. These terms included:

- Providing the venue and allowing employees to attend health talks during normal working hours (Employers agreed to allow health talks on a quarterly basis, at minimum.)
- Covering time off for employees who decide to accept a method (two days of recuperation time for men who adopt vasectomy and five days for female sterilization)

⁴ The contraceptive implant is not available in India.

- Designating a health coordinator to be the point of contact for employees seeking information about FP, as well as referrals
- Placing signage developed by the project in well-trafficked areas of the company

Partner Industries to the Employer-Based Approach

During the project's implementation period, RESPOND recruited approximately 20 companies from a wide variety of industrial sectors, ranging from waste management to shoe and spice manufacturing to bottling. Ultimately, 10 firms actively supported the approach. Several companies were dropped because they were not supportive of all project interventions. The most critical issue was the scheduling of health talks; some businesses did not fully support holding multiple health talks during working hours. The final group of companies (Table 1) represented both large and small industries.

The largest companies were A2Z and PepsiCo Holding, each with about 1,200 employees. A2Z is an innovative company that has taken over waste management for the city of Kanpur and strives to recycle 100% of the collected waste. The vast majority of A2Z's workforce consists of minimum-wage male workers who collect and process the city's garbage. PepsiCo Holding is a beverage bottling facility located on the outskirts of Kanpur. The smallest company, Asian Exports, has only 130 employees and manufactures leather saddles and riding gear. In total, the 10 participating companies employ more than 5,000 individuals. The majority of employees in the participating businesses are male, but the project also purposefully recruited companies in Kanpur with a female workforce, representing approximately 10% of all employees of participating firms. In nearly all of the companies, the workforce generally consists of low-skilled, minimum-wage employees.

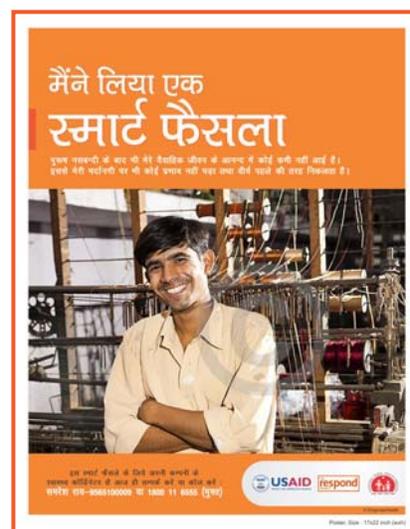
Table 1. Companies participating in the employer-based approach

Company name	Employees		Type of company/product
	Men	Women	
A2Z Group	1,200	0	Waste management
Ashok Griha Udyog Kendra Ltd.	300	50	Spices and pickles
Asian Exports Private Ltd.	108	22	Leather saddles and riding gear
Equiplus India Exports Ltd.	720	80	Leather saddles and riding gear
Indicoat Shoe Accessories	500	250	Shoe manufacturing
Jyoti Capsules Private Ltd.	75	80	Soft generic capsules
Kapoor Polyprint Private Ltd.	200	0	Laminated pouches
Kehr Surgical Private Ltd.	144	6	Surgical blades
PepsiCo Holdings Private Limited	1,200	0	Beverage and bottling facility
RGP Moulds Private Ltd.	150	0	Plastic molds
Total	4,597	488	

Key Interventions

RESPOND's employer-based approach to increasing awareness and use of LA/PMs involved five key interventions: 1) conducting health talks, 2) staffing health desks, 3) developing and distributing information, education, and communication (IEC) materials, 4) training health coordinators, and 5) identifying referral sites.

- **Health talks.** RESPOND led on-site health talks at all participating companies. From January 2011 to June 2012, RESPOND conducted 61 health talks and reached 2,835 employees through those talks. These health talks were group sessions conducted during normal working hours. They were facilitated by the RESPOND LA/PM Program Officer and included a 45-minute orientation on all FP methods, with an in-depth discussion of LA/PMs. In general, participation varied between 30 and 50 employees per health talk. The frequency of the health talks depended on the size of the workforce and on production schedules. In general, RESPOND conducted more health talks among larger companies; smaller companies were reluctant to allow frequent scheduling of health talks, given the heightened impact on productivity. Health talks also helped to encourage more open discussion of FP and LA/PMs and more information-sharing among employees. The company's endorsement of the health talk (by allowing it to occur on company property and during working hours) also strengthened the credibility of the message. It should be noted that at some companies, health talks were offered to all workers on a certain shift; current users of FP methods, including male and female sterilization, were present at those health talks. Although sterilization users' FP needs are considered to already have been met, these workers may have been able to share their experiences with co-workers, to clarify misconceptions.
- **Health desks.** RESPOND supported the establishment of on-site health desks at almost all participating businesses. The health desk included a small table with information materials placed in a well-trafficked area of the company and staffed by the RESPOND program officer or a trained counselor during specified times. The concept for health desks evolved as an alternative or addition to providing health talks, as some businesses were hesitant to allow employees to attend repeated health talks. The health desks allowed RESPOND to have an on-site presence without engaging a large number of employees at one time. They also provided a venue for employees who had questions about FP but who may have been reluctant to ask questions in a large-group setting. From January 2011 to June 2012, RESPOND organized and staffed 86 health desks that reached 1,995 employees.
- **Print materials.** RESPOND designed and produced a series of print IEC materials on FP and LA/PMs. The materials included posters and self-standing poster



displays promoting male sterilization, female sterilization, and the IUD, as well as an all-method brochure that provided in-depth information on LA/PMs in general. The brochure was distributed during health talks and at health desks, and posters and self-standing poster displays were placed in visible, well-trafficked areas of the participating companies.

- **Health coordinators.** RESPOND supported the firms in identifying and training company representatives to serve as sources of information and referrals for FP services. These full-time employees, who provided information about FP to their co-workers, were natural leaders within the companies. Several of RESPOND's health coordinators were also welfare officers or union leaders. RESPOND originally planned to train one health coordinator per company, but during implementation, the project decided that it would be more effective to have several coordinators, particularly in larger companies. RESPOND trained these coordinators on FP and LA/PMs and in interpersonal communication skills. From January to June 2012, RESPOND identified and trained 29 health coordinators. These coordinators provide information to their co-workers through informal discussions, since they are generally well-known in the companies and in some cases had dedicated times for providing information.
- **Referral sites.** To facilitate access to services, RESPOND identified public and private referral sites within the geographic catchment areas of companies that provided high-quality FP services. RESPOND conducted a medical quality assessment at two of the sites but did not provide any other direct support to these facilities.

RESPOND also conducted a limited number of health talks and health desks in the general industrial area of Kanpur, but not at the participating businesses.

Methodology

Process Data

During each health talk and one-on-one sessions, the number of participants was tracked, and coverage and estimated number of interactions were estimated for each company. Referrals for LA/PM services were collected by the Program Officer throughout the project; his mobile number was provided to prospective clients through health talks and health desks, and clients could call to ask for more information or a referral. Other potential clients contacted their health coordinator to request a referral for services. These referrals were tracked over time, although they do not provide a complete picture of the numbers of clients that accepted services as potential clients were not required to call for a referral.

Endline Survey

An additional evaluation component for the employer-based approach includes a retrospective endline survey that was administered among 1,543 employees of six companies (see Table 2) to answer the following questions:

- What proportion of employees were exposed to RESPOND’s interventions?
- What proportion of the exposed employees discussed FP with their spouse?
- What proportion of the exposed employees adopted a method of FP or switched to a new method and from where?
- Would employees use FP in the future? If so, would they consider an LA/PM?
- Did FP adoption differ by company or by participation in more than one intervention (both health talks and health desks)?

Table 2. Survey participation, by company

Company	Sample size	% of total sample
A2Z	450	29.2
Ashok	150	9.7
Equiplus	318	20.6
Kapoor	84	5.4
Kehr	65	4.2
PepsiCo	476	30.8

Data were collected in the form of an interviewer-administered survey by 10 graduate students of the Kanpur University School of Social Work. The survey, included as Appendix A, was translated into Hindi prior to administration. Data collectors received a three-day training that covered ethical principles of research, data collection procedures, and data entry; they also conducted a pilot test of the survey at one company (A2Z). Participants were recruited through a convenience sample at the six firms that were willing to allow data collection among their employees. The Program Officer coordinated with management to schedule a time and date for data collection; during that scheduled time, data collectors asked employees if they

would be willing to participate in the survey before taking them to a more private area and obtaining oral informed consent. Participation was voluntary and anonymous; only oral informed consent was obtained from each participant, and no names were collected.

Data were entered into EpiInfo and analyzed using SPSS Version 20. In analysis, respondents were classified as unexposed to the intervention if they had neither participated in health talks nor visited health desks and were classified as exposed if they had participated in either. The exposed were then categorized as having been exposed to one element of the intervention or to both elements of the intervention. Respondents who had adopted permanent methods before the intervention were excluded from several key indicators, including method switching, method adoption, discussion of FP with their spouse, and awareness of FP resources, as their FP needs are considered to have been met through use of sterilization.

Limitations of the Study

Random assignment of businesses to control or intervention groups was not feasible; it is therefore possible that some participants who did not attend health talks or health desks were still exposed to the initiative's messages, particularly since the majority of respondents saw RESPOND's posters, even if they did not attend health talks or visit health desks. The retrospective nature of the study design may have permitted recall bias. Further, the number of respondents unexposed to health talks or health desks was relatively small, and analyses of statistical significance were not possible. Finally, the majority of participants were men; it is possible that levels of FP acceptance may have differed in companies in which the majority of employees are women.

Results

Process Indicators

RESPOND reached a total of 4,830 employees with information on LA/PMs through health talks and health desks, reflecting 95% of the total workforce. The number of health talks per company ranged from one at Jyoti to 26 at A2Z, while the number of health desk sessions ranged from three to a high of 21 at A2Z. At several businesses, employees participated in more than one health talk, resulting in coverage rates of more than 100%. However, coverage of employees still varied significantly by company, with older firms having better coverage and newer businesses still having low coverage. Eighty-five percent of those who participated in health talks and 77% of those who visited a health desks were men.

RESPOND tracked a total of 74 informal referrals for LA/PM services over the life of the project; these included only employees who sought information about services from the RESPOND Program Officer or from the factory health coordinator. Among all referrals, 37% were for female sterilization, 31% were for no-scalpel vasectomy (NSV), 30% were for IUD services, and 3% were unspecified. However, findings from the endline survey suggest that acceptance of LA/PMs may ultimately have been higher, as employees may have sought services without requesting a referral.

Table 3. Measures of RESPOND activities at participating companies

Measure	A2Z	Ashok	Asian	Equi-plus	Kapoor	Jyoti	Kehr	RGP Moulds	Indicoat	PepsiCo	Total
No. of health talk sessions	26	5	4	7	2	1	1	2	2	11	61
No. of employees reached	1,234	230	250	282	72	40	72	99	104	452	2,835
No. of one-on-one sessions	21	17	5	14	6	3	11	3	3	3	86
No. of employees Reached	500	380	135	355	123	74	238	55	78	57	1,995
Total no. of employees reached	1,734	610	385	637	195	114	310	154	182	509	4,830
No. of LA/PM referrals	22	14	2	24	6	1	4	0	1	0	74

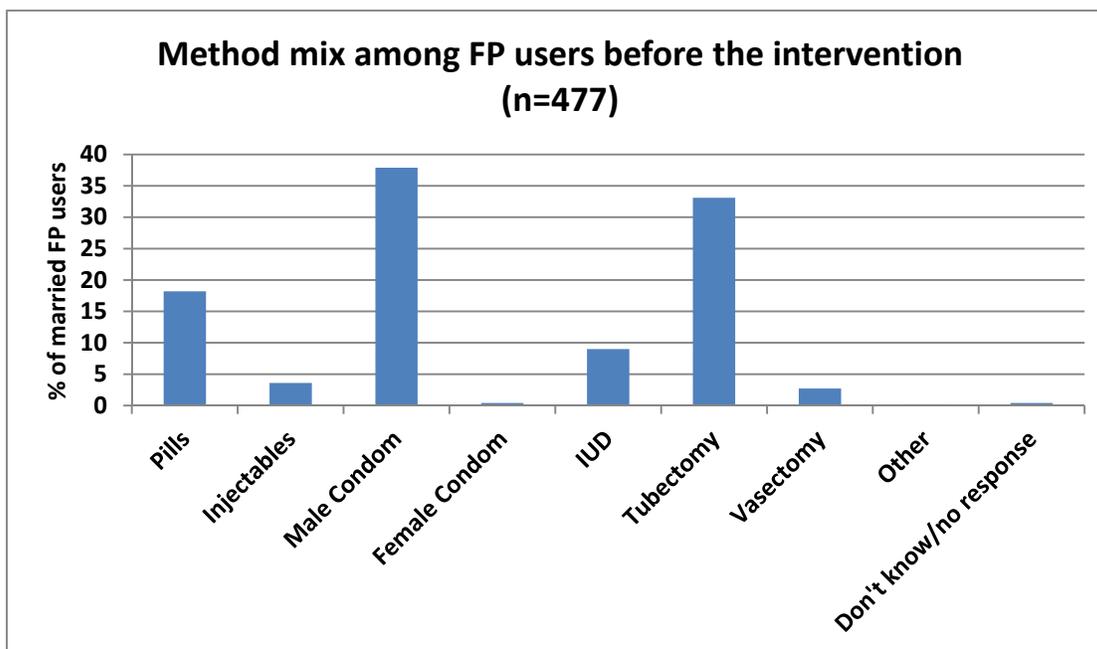
Endline Survey

Employee profile

The sample for the endline survey consisted primarily of men (96%). Respondents' ages ranged from 18 to 60, with a mean age of 29.1. The majority of participants were full-time employees of their companies (97%), and 92% had been employed at the business for at least one year, with an average length of employment at the firm of 3.0 years. Nearly three-quarters (72%) of participants were married; of those, the majority (98%) had children, with an average of 2.5 children.

A high proportion of all married respondents (43%) were already using FP, including LA/PMs, at the beginning of the intervention. The method most commonly used before the intervention was the male condom (38%), followed by female sterilization (33%) (Figure 1).

Figure 1. Among FP users prior to the intervention, percentage using various modern methods*



* Percentages add to more than 100%, as participants were allowed to provide multiple responses.

Exposure to the intervention

RESPOND achieved a high rate of participation in health talks and health desks: Nearly all (95%) of the respondents had heard about the FP health talks at their workplaces. Of those, 83% had attended one or more health talks, with an average of 1.75 health talks attended per respondent. Most (87%) had heard of the FP health desks at their workplace, and 49% of those had visited at least one health desk, with an average of 1.53 health desk visits per respondent. Many respondents (39%) had both participated in health talks and visited health desks. However, 17% had done neither.

Participation in health talks ranged from 25% of Kehr employees to 100% of employees at both Ashok and Equiplus. The percentage of employees who visited health desks ranged from 13% at PepsiCo to 75% at A2Z (Table 4).

Table 4. Percentage of employees who visited health desks or participated in health talks, by company

	A2Z	Ashok	Equiplus	Kapoor	Kehr	PepsiCo	Total
Health desk	75.3	57.3	30.8	53.6	49.2	12.6	42.8
Health talk	81.3	100.0	100.0	86.9	24.6	63.0	79.3
Both	70.4	57.3	30.8	50.0	6.2	12.2	39.2
Neither	13.8	0.0	0.0	9.5	32.3	36.6	17.2

In the analysis, respondents were classified as “exposed” to the intervention if they reported having either participated in health talks or visited health desks and “unexposed” if they did neither. Some “unexposed” participants may have seen RESPOND’s posters at their workplace; however, these posters alone are not expected to have motivated behavior change.

Awareness of FP resources

RESPOND also explored employees’ awareness of the FP-related resources in their workplace. Interviewers showed respondents printed copies of RESPOND’s LA/PM posters and brochure and asked if they had seen them; 98% reported that they had seen at least one at their workplace. Most (91%) said that they knew who their workplace health coordinator was, and 95% of those were able to correctly name the health coordinator at their workplace. (Users of permanent methods were excluded from these analyses.)

Discussion of FP with partners

Discussion of FP was higher among those exposed to the intervention than among those who were not. Among employees who were not already using a permanent method before the intervention, 85% of those who either participated in health talks or visited health desks and 78% of those who did both reported discussing FP with their spouse in the last year, compared with just 51% of those that did not participate in the intervention. More than half (55%) of exposed participants with no children discussed FP with their spouse, compared with 81% of exposed participants with children.

Changes in FP use

Switching

The interviewers asked participants who reported at the beginning of the intervention that they were using an FP method whether they or their spouse had switched to a new method during the previous year. Although FP use was high even at the beginning of the intervention, many users of nonpermanent methods⁵ switched to a new method, including an LA/PM, during the intervention year.

Among exposed married participants who were using nonpermanent methods at the beginning of the intervention, a total of 59% switched to a different method during the intervention year. Switching varied widely based on exposure to one or both elements of the intervention: Sixty-five percent of those who both participated in a health talk and visited a health desk and 50% of those who participated in one of these switched to a different method, compared with 44% of those who did neither (Table 5).

Table 5. Percentage of married survey participants using a nonpermanent FP method, by whether they switched methods in the past year, according to exposure to the intervention

	Switched methods	Did not switch methods	Do not know
Unexposed	44.4	50.0	5.6
Exposed	58.5	32.6	8.5
Exposed to one	49.5	39.6	10.8
Exposed to both	64.8	27.7	6.9

⁵ Users of male and female sterilization were excluded from these analyses, as their FP needs are assumed to have been met.

Many of the exposed participants who switched to a different method over the last year chose an LA/PM, particularly users of short-acting methods. For example, among pill users who switched, 22% chose an IUD, 41% chose female sterilization, and 14% chose vasectomy (Table 6). Among male condom users who switched, 26% chose an IUD, 26% chose tubectomy and 19% chose vasectomy. Even some long-acting method users chose to accept a permanent method; a large proportion of IUD users chose female sterilization (43%) or vasectomy (36%).

Table 6. Percentage of exposed participants who switched FP methods in the previous year (n=144)

Method used previously	Method adopted						
	Male condom	Pill	Injectables	IUD	Female sterilization	Vasectomy	Do not know
Male condom (n=58)	0.0	20.7	8.6	25.9	25.9	19.0	0.0
Pill (n=63)	17.5	0.0	4.8	22.2	41.3	14.3	0.0
Injectables (n=9)	0.0	0.0	0.0	33.3	44.4	11.1	11.1
IUD (n=14)	7.1	7.1	7.1	0.0	42.9	35.7	0.0

Although the rate of method switching among the unexposed was lower, several unexposed participants did switch to an LA/PM during the intervention period. One-third of unexposed condom users who switched methods adopted female sterilization during the intervention period.

Discussion of FP seemed to influence switching behavior. Exposed FP users who discussed FP with their spouse more often switched to a different method (61%) than did those who did not (45%). This measure varied by the level of exposure: Sixty-nine percent of those exposed to both elements of the intervention who discussed FP with their spouse switched to a different method, compared with 51% of those exposed to only one element.

Adopting

RESPOND also asked respondents who were not using FP at the beginning of the intervention whether they or their spouse had started to use a method during the intervention period. Of married nonusers who visited health desks or participated in health talks, 13% adopted an FP method during the last year. This adoption rate varied little by the level of exposure to the intervention (13% of those exposed to one element, versus 12% of those exposed to both elements). No nonusers who were unexposed to the intervention (n=58) adopted a method.

The method most often selected by adopters was the male condom (42%), followed by the IUD (28%). As with method-switchers, discussion of FP with a spouse correlated with adoption: All respondents who reported adopting FP also reported that they had discussed FP with their spouse in the previous year.

Variation by company

Method switching and adoption varied widely by company. Switching rates among exposed FP users ranged from 56% at Equiplus to 75% at Kapoor. (It should be noted that Kapoor, which had the highest percentage of exposed users switching to a new method, also had one of the highest percentages of respondents indicating that they both participated in health talks and visited health desks [50%.]) Method adoption rates ranged from 0% at Kapoor to 28% at Equiplus (Table 7).

Table 7. Percentage of participants exposed to the intervention who switched FP methods or who adopted method use, by company

	A2Z	Ashok	Equiplus	Kapoor	Kehr	PepsiCo
Switched	56.3	66.7	55.6	75.0	57.1	60.2
Adopted	0.6	26.1	28.0	0.0	23.5	0.0

Facilities visited by switchers and adopters

When participants indicated that they had either accepted an FP method or switched to a new method, interviewers asked for the name of the facility at which they sought services. The majority of the exposed switchers and adopters visited the facilities affiliated with the employer-based approach to receive their method; these were the facilities that RESPOND had found to provide quality services. The most frequently visited facility was the J.L. Rohatgi Hospital, where 34% of switchers and 46% of adopters reported receiving their method. However, many switchers and adopters visited other, unspecified facilities that were not affiliated with the employer-based initiative (Table 8).

Table 8. Percentage of exposed respondents reporting identity of facility visited for FP services

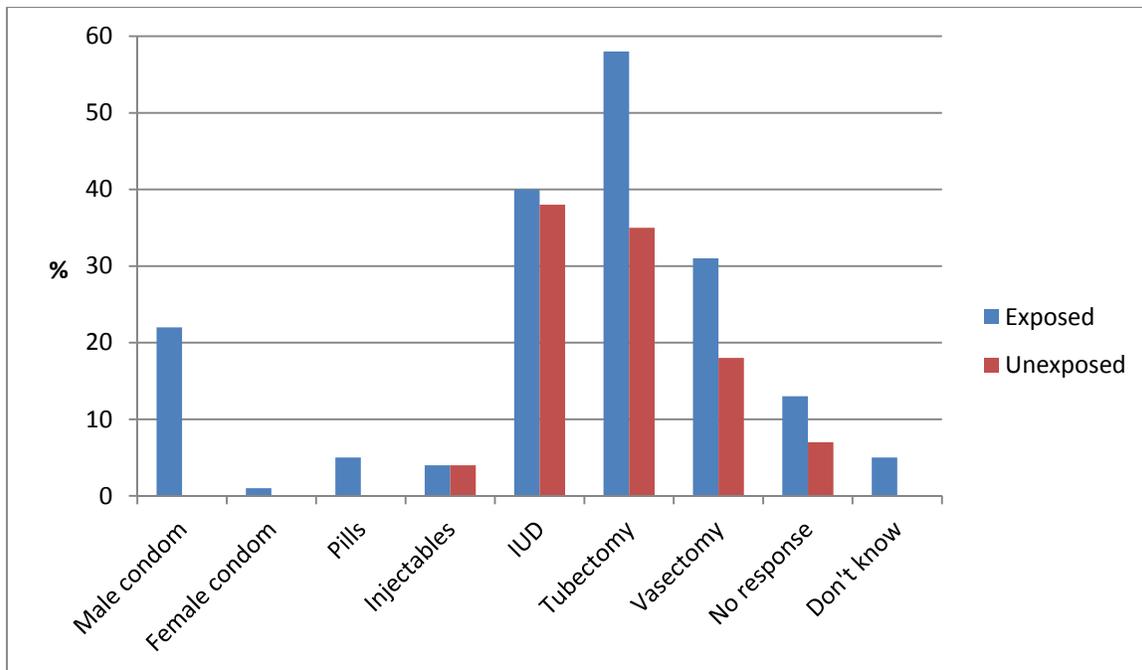
	Visited by switchers (n=144)	Visited by adopters (n=65)
J.L. Rohatgi	33.9	46.2
NSV Satellite Centre	3.7	0.0
PSS	17.4	0.0
Upper India Sugar Exchange Maternity Hospital	7.3	11.5
Ursala Horsman Hospital	22.0	5.8
Other (unspecified)	15.6	36.5

Future use of FP

RESPOND also asked all nonusers of FP (those who were not using a method before the intervention began and who did not adopt a method during the intervention) whether they would consider using an FP method in the future or if they would encourage their spouse to consider doing so. The majority (95%) of those who either participated in a health talk or visited a health desk reported that they would consider FP use in the future, with no variance based on the level of exposure (96% of those who participated in one element and 94% who participated in both elements). The proportion saying that they would consider using FP in the future was somewhat lower those who did not participate in the intervention (60%).

The methods most often listed as potential methods for future use by respondents who participated in the intervention were female sterilization (58%), the IUD (40%), and vasectomy (31%) (Figure 2). The exposed often listed multiple methods as candidates for future use, naming an average of 1.75 potential methods for future use. The unexposed also demonstrated interest in LA/PMs, with 37.9% naming the IUD and 34.5% naming tubectomy as preferred methods for future use. The unexposed, however, gave an average of only one potential method for future use.

Figure 2. Percentage of FP nonusers reporting that they would consider using a method in the future, by whether they were exposed or not exposed to the project (n=348)*



* Percentages add to more than 100%, as participants were allowed to provide multiple responses.

Discussion

The employer-based approach described here was successful in achieving a high level of exposure to FP messages within the participating companies during its relatively short implementation period, with many employees reporting exposure to LA/PM information through exposure to print materials, participation in health talks, visits to health desks, or all three. These findings are consistent with the initial project indicators tracked through monitoring data. Participating in health talks or visiting health desks appear to have encouraged employees to discuss FP with their spouse. The strategy was also effective in providing FP information to current nonusers and at suggesting that LA/PMs may be methods to consider for future use. During implementation, RESPOND increasingly focused its efforts on strengthening the capacity of company-designated health coordinators to provide information and referrals for LA/PM services. These coordinators are likely to be key to promoting FP and LA/PMs within companies over the long term, by ensuring that new behaviors are sustained and by motivating new acceptors. In addition, since the effort linked LA/PM referrals to existing private and public facilities, access to services may also be sustained beyond the life of the project. In those companies in which health coordinators are strong, referrals for services have been continuing even when there are fewer health talks and health desk sessions.

Further, the approach appears to have been effective in communicating information about LA/PMs to current FP users, with many users of short-acting methods switching to the more effective methods during the intervention. The approach appears to be particularly effective for employees who already used an FP method but were open to considering switching to another method that could better meet their needs. FP adoption among nonusers was also strong, indicating that the intervention was effective in encouraging nonusers to take this step. The majority of new adopters, however, chose short-acting methods rather than LA/PMs, suggesting that new users may prefer to begin with such methods. These results demonstrate that reaching men and women in their workplace is an effective way to improve knowledge about and increase use of LA/PMs—and that employees are willing to seek services at nearby facilities, provided that they offer quality, accessible services.

Lessons Learned and Recommendations for Scale-Up

The profile of workers appears to be well-suited for FP interventions, as most workers are married with children. Further, employers' endorsement of FP, in the form of on-site activities and compensated time off, has the potential to remove key barriers to LA/PM adoption.

A variety of lessons learned regarding the feasibility and effectiveness of introducing LA/PMs through employer-based initiatives and recommendations for scale-up can be identified from the process data and endline survey.

Employer-based approach

- Future initiatives should continue to communicate FP messages to employees in multiple settings. Exposure had a positive impact on FP use: Participants who both participated in health talks and attended health desks more often switched to another method than did those who attended only one (65% versus 50%).
- Respondents who discussed FP with their spouse in the last year more often switched to a new method of FP than those who did not. Future applications of the approach could encourage participants to discuss FP with their spouse and suggest key messages to report back to spouses. When feasible, spouses could be invited to attend health talks.
- Exposed respondents reported a strong intent to use FP, particularly LA/PMs, in the future. Ensuring that company-affiliated health coordinators continue to have accurate information on FP and that they remain active in promoting FP at the companies is essential to ensuring that potential future users' needs are met when the time is right for their families to consider FP.
- Discussion of FP was lower among married participants without children than among those with one or more children. Future health talks could encourage all employees, regardless of whether they have children, to discuss their reproductive intentions with their spouse and determine how FP could help to meet their needs for spacing or limiting births or delaying first births.
- It is important to ensure that quality services are available and that they facilitate linkages between employees and services. Had quality LA/PM services not been available in Kanpur, employees would not have been able to meet their needs.

Industry selection

- Businesses had varying degrees of commitment to the project; RESPOND had to adapt its recruitment process to be more selective and recruit “progressive” companies, particularly by identifying human resources managers who demonstrated strong support, and even by seeking direct referrals from company to company.
- Supportive and creative companies can be encouraged to take extra steps to become “champion” businesses. The India experience reveals, “champion” businesses tend to be larger companies, such as A2Z and PepsiCo. PepsiCo, for example, despite being a younger company, is already exploring a number of additional activities, such as developing an employee referral hotline, reprinting its own IEC materials, and conducting health activities in nearby villages.
- Larger companies tend to have more structured employee welfare programs, including health. While smaller companies may have supportive human resources managers, they may find it difficult to allow repeated contacts with employees because it more directly affects their productivity.

Conclusion

Workplace programs can reach large segments of the population that normally would not be exposed to and engaged in health programs. Men in particular are an important target group, as they are frequently decision makers within their family, yet are often excluded from receiving information about FP at health facilities or during household visits. Workplaces

represent a concentrated group of people who live and work in relative proximity and share a common subculture. When people begin to change their attitudes toward LA/PMs, the social and organizational support that co-workers and employers provide is important. Employers also tend to have long-term relationships with their employees; their endorsement of FP messages, by allowing on-site health talks and health desks and by providing paid time off for LA/PM acceptance, increases the credibility of those messages. These new behaviors will be sustained through a supportive workforce, health coordinators who continue to provide information and referrals, and ongoing access to health services through existing public and private facilities.

RESPOND's experience in India demonstrates that it is possible to provide information about the importance of FP in workplace settings when health coordinators and co-workers provide important psychosocial support for behavior change. Not only is engaging companies on RH/FP issues important from the perspective of leveraging private-sector resources for services (employee time for participation in discussions, time off for procedures, etc.), but employers and workplace initiatives also provide a unique forum for achieving attitude and behavior change for methods that often have strongly associated negative attitudes and misperceptions.

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Appendix A

Employer-Based Approach Endline Survey

READ ALOUD: The RESPOND Project, which is managed by an international NGO called EngenderHealth, is conducting a survey to evaluate a family planning program that was conducted in industries in Kanpur. We would like to ask for your participation in this survey, which will take about ten minutes of your time. We will not ask for your name or any other information that could be used to identify you, and we will not contact you afterward. There is no penalty to you if you do not wish to participate in this survey. If you agree to participate, you do not have to answer any questions that you do not want to, and you are free to stop the interview at any time. If you have any questions about this study, you can contact Samresh Rai (*give contact card*). Do you have any questions for me?

Do you agree to participate in this survey? Yes
 No *If participant does not agree to participate, do not continue.*

Interviewer signature: _____

Date of interview: ____/____/____ Interviewer name: _____
 Day Month Year

Sex of interviewee (*Tick one*): Male Name of industry: _____
 Female

1	Are you a full-time employee of this industry?	Yes	No	
1a	How long have you worked at this industry?	<input type="text"/> <input type="text"/>	<i>Tick one:</i> Years <input type="checkbox"/> Months <input type="checkbox"/>	
2	Are you married?	Yes	No	Don't know
				If no, skip to Q4
3	Do you have any children?	Yes	No	Don't know
				If no, skip to Q4
3a	How many children do you have?	<input type="text"/> <input type="text"/>		
4	What is your age?	<input type="text"/> <input type="text"/>	Years	

Employer-Based Approach Endline Survey (cont.)

5	Did you hear about the family planning health talks that were held in your workplace?	Yes	No	Don't know	If no or don't know, skip to Q6	
5a	In the last year, did you attend any health talks about family planning in your workplace?	Yes	No	Don't know		
5b	How many did you attend?	Estimated #		Don't know		
6	Did you hear about the family planning health desks that were held in your workplace?	Yes	No	Don't know	If no or don't know, skip to Q7	
6a	In the last year, did you attend any health desks about family planning in your workplace?	Yes	No	Don't know		
6b	How many did you attend?	Estimated #		Don't know		
7	Did you see any of these posters in your workplace in the last year? Interviewer: Show images of RESPOND posters.	Yes	No	Don't know		
8	Do you know who the family planning coordinator is at this industry?	Yes		No	If no, skip to Q9	
8a	What is the name of the family planning coordinator at this industry?					
9	In the last year, did you and your spouse discuss using family planning?	Yes	No	Don't know		
10	Before 2011, did you or your spouse use any method of family planning?	Yes	No	Don't know	If no or don't know, skip to Q13	
10a	Which method did you or your spouse use? <i>Check all methods mentioned. If not listed here, specify under "Other."</i>	a	Pills			Tick if mentioned
		b	Injectables			
		c	Male condom			
		d	Female condom			
		e	IUD			
		f	Tubectomy			
		g	Vasectomy			
		h	Other <i>Specify:</i>			
		i	No response			
		j	Don't know			

Employer-Based Approach Endline Survey (cont.)

11	In the last year, did you or your spouse begin to use a different method of family planning?	Yes	No	Don't know	If no or don't know, skip to Q15	
11a	Which method or methods did you or your spouse begin to use? <i>Check all methods mentioned. If not listed here, specify under "Other."</i>					Tick if mentioned
		A	Pills			
		B	Injectables			
		C	Male condom			
		D	Female condom			
		e	IUD			
		f	Tubectomy			
		g	Vasectomy			
		h	Other <i>Specify:</i>			
		i	No response			
j	Don't know					
12	What facility did you or your spouse visit to receive the method? <i>Tick the facility mentioned. If not in the list, please write the name in "other".</i>	a	PSS		Skip to end	
		b	J.L. Rohatgi			
		c	NSV Satellite Centre			
		d	Upper India Sugar Exchange Maternity Hospital			
		e	Ursala Horsman Hospital			
		f	Other:			
		g	Don't know			
13	In the last year, did you or your spouse begin to use a method of family planning?	Yes	No	Don't know	If no, skip to Q15	
13a	Which method or methods did you or your spouse adopt? <i>Check all methods mentioned. If not listed here, specify under "Other."</i>					Tick if mentioned
		a	Pills			
		b	Injectables			
		c	Male condom			
		d	Female condom			
		e	IUD			
		f	Tubectomy			
		g	Vasectomy			
		h	Other <i>Specify:</i>			
		i	No response			
j	Don't know					

Employer-Based Approach Endline Survey (cont.)

14	What facility did you or your spouse visit to adopt the method? <i>Tick the facility mentioned. If not in the list, please write the name in "other".</i>	a	PSS			
		b	J.L. Rohatgi			
		c	NSV Satellite Centre			
		d	Upper India Sugar Exchange Maternity Hospital			
		e	Ursala Horsman Hospital			
		f	Other:			
		g	Don't know			
15	Would you ever consider using, or would you encourage your spouse to use family planning in the future?	Yes	No	Don't know	If no, skip to end	
15a	Which method or methods would you consider using in the future? <i>Check all methods mentioned. If not listed here, specify under "Other."</i>				Tick if mentioned	
		a	Pills			
		b	Injectables			
		c	Male condom			
		d	Female condom			
		e	IUD			
		f	Tubectomy			
		g	Vasectomy			
		h	Other Specify:			
		i	No response			
		j	Don't know			

Thank the employee for taking the time to participate in the survey. Remind them to contact the RESPOND Program Officer if they have any questions.