



**Rapid Needs Assessment for Family Planning Services in Selected Workplaces in Ethiopia**

***Submitted to***: Consortium of Reproductive Health Associations (CORHA), Ethiopia

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# ACRONYMS AND ABBREVIATIONS

C/OCP Combined/Oral Contraceptive Pills

CETU Confederation of Ethiopian Trade Union

CORHA Consortium of Reproductive Health Agencies

CSA Central Statistical Agency

F/MOH Federal/ Ministry of health

FGD Focus Group Discussion

FP Family Planning

GDP Gross Domestic Product

GTP Growth Transformation Plan

HSTP Health Sector Transformation Plan

ICPD International Conference on Population and Development

IEC Information, Education and Communication

IUD Intra-uterine Device

KI/I Key Informant/Interview

SDGs Sustainable Development Goals

SNNP Southern Nations Nationalities and Peoples

SPSS Statistical Package for Social Sciences

TFR Total Fertility Rate

UHC Universal Health Coverage

UNFPA United Nations Population Fund

USAID United States Agency for International Development

WHO World Health Organization

# EXECUTIVE SUMMARY

**Aim of the survey**

The overall purpose of this study is to conduct a rapid need assessment of FP services in selected workplaces.

**Methods**

Due to the multi-faceted nature of the subject and multiple study objectives or questions, the study employed mixed methods approach i.e., a cross-sectional study design using primary and secondary quantitative data (household survey, document review and health facility inventory) analysis mixed with exploratory descriptive design (qualitative approach). Both the quantitative and the qualitative approaches were conducted concurrently.

The target population for this survey was women workers of selected 18 mega factories and farms from Addis Ababa, Oromia, Amhara and SNNP regions. Because of financial and logistical constraints, a mini-survey was conducted i.e., without employing a standard sample size determination approach. A total of 179 women aged 15-49 years participated in the survey from diverse workplaces.

For the quantitative survey, respondents were interviewed using a structured questionnaire. The questionnaire contained a series of questions about the socio-demographic, sexual and reproductive characteristics, contraception, and fertility intention.

The questionnaire was developed to determine the need or unmet need for family planning in line with the current use of family planning services and pregnancy intentions of study participants. Apart from the individual interview survey, key-informant interviews were conducted with service providers at workplace clinics and representatives of the staff management and focus group discussion was conducted with female employees. Besides, inventory checklist was employed to assess availability of FP services at workplace clinics, commodities, equipment, job aids, and staffing in selected workplace health facilities

**Key Findings**

* Injectable and oral contraceptives were the most known FP methods by study participants at 83.4% and 77.1% respectively followed by condom (70.3%) and implants (68.2%).
* Among the non-pregnant currently married/in union women, about one-fourth of them were not using any type of FP method. About one-third of the married/in union women do not want to have any more children. This implies that about the same proportion need contraceptives for limiting but not spacing.
* Repeated unplanned pregnancy and abortion was reported by FGD participants.
* Injectable contraceptive is the most frequently used contraceptive method (43%), similar to evidences obtained from DHS, followed by implants (19%) and OCPs (14%).
* Among the 16 workplaces that have workplace clinics, only a quarter of them had one or more type of contraceptive method (excluding condom). This implies that only one-fifth of the 18 workplaces surveyed are providing any contraceptive method.
* The majority of women (63.3%) are getting FP services from facilities outside the workplaces.
* Slightly more than half (56.2%) of the workplace clinics had private rooms, adequate waiting areas, hand-washing facilities and rooms with adequate lighting for FP services. Less than half had well ventilated rooms.
* About three-fourth of the 16 workplace clinics had at least nurses trained on FP services provision.
* There were shortages of FP IEC materials, registers, guidelines, reporting forms, and kits for IUD and Norplant insertion and removal.
* Some of the major barriers for FP provision at workplace clinics were:
  + Lack of supplies and commodities
  + Poor monitoring and/or follow up and support from local government health offices.
  + Poor and intermittent support from NGO partners.
  + Poor commitment among workplace managers or management staff to introduce FP services at workplaces mainly due to lack of awareness on the effect of FP on enhancing productivity.

**Conclusion**

Though family planning interventions at work places have far reaching advantages for health authorities and employees, in this study, there are significant gaps in terms of availing FP services. The problems manifested in the form of unmet need for FP, lack of contraceptive mixes or choices and IEC materials, job aids and guidelines. Most of the barriers for FP provision are avoidable if partners and government officials give emphasis to workplace FP services.

# INTRODUCTION

## Background

Given that women at workplaces are the main drivers of the economy in Sub Saharan Africa, the gap between family planning need and needs satisfied has a far reaching implication. For women working at industries and other large workplaces, unintended pregnancies have serious implications on their productivity, compromising their families’ livelihood, which ultimately impend the economic growth of countries (Engender Health 2015; Gupta 1972).Health care initiatives at workplaces accelerate access to a broad range of health services, including family planning services. It also helps companies to reduce employee turnover and absenteeism (The RESPOND Project, 2013).

Workplaces have both positive and negative influences on family planning and other reproductive health services. For one thing, as women are formal employees and are self-sufficient in terms of income, it will increase their bargaining power to control over their fertility choices (Miles-Doan & Brewster, 1998). On the other hand, companies often don’t have well organized health care facilities and, hence, workers would not have access to quality services, including family planning services, near to or at their workplaces. Moreover, as the working conditions of most factories are tense and troublesome, women often do not get the time to visit either public or private facilities for family planning services during working hours (The RESPOND Project, 2013).

Family planning interventions at workplaces have far reaching advantages for health authorities and employees. It redoubles the effort to reach more women and men with minimal cost and effort, yet with maximum benefits for employees and the company. Apart from these, workplace interventions give family planning programmers a unique opportunity to reach men and women of reproductive age who are often difficult to reach at ordinary intervention places. Above all, men often have no chance to participate in family planning and other reproductive health information sessions at ordinary service delivery points, due to gender norms that discourage them from seeking reproductive health/family planning related health services or from accompanying their wives (RESPOND Project, 2013). In a wider sense, workplace interventions provide opportunities to men and women to acquire more information and increase their bargaining power to request contraceptives of their choice and, ultimately, to reduce the unmet need for family planning at any place and time.

Many studies depicted that workplace family planning intervention has unprecedented advantages to increase family planning use and reduce the unmet need for family planning, especially for people who are often inaccessible to the traditional health care system. A study conducted in China indicated that implementing sexual health promotion programmes at worksites is likely to have a positive impact on migrant women working in the manufacturing industry (Decat, P., et al, 2012). However, the success of the family planning project at workplaces depends heavily on cooperation of management, supervisors and union representatives (Jamaica Family planning Association, 1987).

## Family planning service provision at workplaces in Ethiopia

Even though unmet need for contraception in Ethiopia declined from 36% in 2000 to 26% in 2011, it is still far from satisfying the population demand (CSA and ICF International 2001, 2012). Recently, the Ethiopian Ministry of Health has launched an ambitious five year Health Sector Transformation Plan (HSTP). The HSTP aims to reduce unmet need for family planning to 10 percent by raising the contraceptive prevalence rate to 55 percent. About 6.2 million additional women and adolescent girls will be reached with family planning (FP) services by 2020 (FMOH, 2015).

To achieve national goals, the Government of Ethiopia has been applying multi-pronged approaches to reduce maternal and newborn morbidity and mortality including the reduction of unmet need for family planning services. One of the targets of the 2006-2015 National RH strategy of Ethiopia was to ensure that all workplace programs provide integrated HIV and FP services by 2015 (MOH 2006). Ethiopia’s National Family Planning Guideline also indicated workplace-based FP service delivery as one of the many strategies identified while considering its importance of accessing an easy-to-reach, known population of workers; its potential to save employees’ time, minimizes lost productivity, and the benefit of reaching more male targets. The guideline underscores that facilities at workplaces must be registered by the ministry of health or regional health bureaus and must function based on the staffing and facility standards of the FMOH (FMOH, 2011). Recognizing the unique circumstances of workplaces, and the remarkably significant number of sexually active workers, workplaces deserve a special strategy that can address family planning needs and aspirations of the workplace community.

Ethiopia’s manufacturing sector makes an important contribution to the country’s economy. It employed about 173 thousand people in the year 2012/2013. In the same year, food and beverage and metal and engineering industries accounted for 51% of the sector’s GDP and the food and beverage sector alone accounted for 38% of the employment in the sector. The manufacturing sector’s contribution to the GDP in 2012/2013 was 4.8%. The performance of the sector has been affected by low productivity of workers and use of outdated technologies (Addis Ababa Chamber of Commerce and Sectoral Association, 2015). Of all the 370 thousand members of the Confederation of Ethiopian Trade Unions (CETU) in 2012, 34.0% of them were females (CETU, 2012). Experience from development partners engaged in workplace FP services in Ethiopia shows some efforts that have been made so far on workplace FP service provision. On this regard, the Confederation of Ethiopia’s Trade Union (CETU) has been undertaking trainings on RH issues for health professionals serving in large factories and rural plantations in Ethiopia in conjunction with advocacy activities to management staff member enterprises. CETU also developed a three-year integrated RH/FP and HIV/AIDS/ STI project to be implemented at 50 workplaces/factories/ plantations located in Oromia, Amhara and Afar regions starting October 2013.

Before the implementation of this project, CETU conducted a baseline survey in 2014 with the overall aim of assessing the status of RH/FP in the intervention area/workplaces. Study participants were selected from the 10 workplaces out of the 50 target enterprises (factories, industrial firms, and plantations) located in Oromia, Amhara, and Afar Regions. According to this survey findings, slightly less than two-third (63%) of the workers used workplace clinics for medical services while less than half (48%) of the clinics provided FP related services (CETU, 2014). About half (52%) of the workers were using any type of modern FP method at the time of the survey. Injectable contraceptives (31%) were used by the majority followed by Implanon (8%) and OCP (6%). Surprisingly, none of the workplace clinics provided any long-acting contraceptive despite about 42% of them had implanon kits. The finding also indicated that the majority of the study participants didn’t have positive attitude towards FP. However, the study didn’t document the reason why many had no positive attitude towards FP.

In 2012, Marie Stopes International Ethiopia rolled out a workplace programme in partnership with Maranque Flower plc in Oromia Region around Adama. About 88% of the workers were women of reproductive age. During the launching, most of them had low awareness level about sexual and reproductive health services. The implementation approach included sensitization workshops/sessions for the workforce and members of the local community, training of peer educators and heath care providers who were employees of Maranque’s own clinic. Since its launching, family planning services were delivered to over 400 female workers at this farm place. As a result of the encouraging result, MSI developed a brand called “Fit-For-Work” with the aim of promoting and replicating the workplace FP service approach by other factories or farms having large workforces (Marie Stopes International, 2012).

Despite all the efforts made so far, though still very limited, there is critical scarcity of evidences showing the status of family planning or contraceptive utilization among women at workplaces in Ethiopia. Hence, in this rapid survey, it was tried to generate evidences regarding the need for family planning services among women of reproductive age groups working in selected industries (factories and farms) in Ethiopia.

# PURPOSE AND RATIONALE OF THE RAPID ASSESSMENT

While some workplaces have health facility, others do not and all those which have health facilities may not provide FP services. Even those which provide FP services might not be providing the full range of available methods for various reasons. The rationale for the assessment is 1) millions of people are in these workplaces and they have limited access to FP services, as stated in the justification; 2) the FMOH would like to expand services to the workplaces but doesn’t have information on the current status of the health facilities and FP services in the workplaces. The health services may not provide quality and standard services that can also be compromised with lack of proper support and follow up considering that these workplaces employ hundreds of millions of poor workers, large numbers of which are women. Many lack access or connection to the local community or its public health facilities. Based on Ethiopia’s move from agricultural to industrial economy in the next growth and transformation plan (GTP), a number of investments and mega-projects are currently booming by private sectors and the government. Therefore, addressing the real challenge of FP users at industrial/factory workplaces is important both from demand and supply sides. The study seeks to know unmet need for FP of the workers by assessing demand for and supply of FP choices on-site. The overall purpose of this study is to conduct a rapid need assessment of FP services in selected workplaces.

The specific objectives are:

* To assess the needs for FP services in selected workplaces
* Conduct inventory of the FP services, commodities, equipment, job aids, staffing and recording/reporting in selected workplace health facilities
* Assess FP support provided to selected workplace health facility
* Identify barriers/challenges of FP services provision in selected workplace health facilities
* To better understand the health needs and attitudes of workers and management towards FP services

# METHODOLOGY

## Study Area

The rapid assessment covered areas with major industries and farms from Addis Ababa, Amhara, Oromia, and SNNP regional states in Ethiopia. The great number of industries and horticulture farms are found in Addis Ababa and Oromia respectively.

## Study design and methods

A mixed methods approach involving both quantitative and qualitative data collection approaches was used. The quantitative approach used a cross-sectional design while the qualitative approach was an exploratory-descriptive design.

## Sample Size determination and Sampling

***Quantitative approach***

Because of limitations related to finance and logistics, a mini-survey was conducted i.e., without employing a standard sample size determination approach while taking diverse workplaces into consideration. In the selection of the study targets, a two-stage sampling was employed. In the first stage, 18 mega farms and industries were selected; and in the second stage, 179 workers of selected workplaces were interviewed with a non-response rate of 0.5%.

The sampling frame for selection of the study areas/target population was obtained from the 2016 Ethiopia Business Directory. All Factories/farms were considered for this study including food and beverage factories, horticulture sites, textile and leather processing factories among others. Manufacturing industries or workplaces were selected through purposive sampling to make sure that the diversity and geographic distribution of the industries is balanced. In the second stage, a fixed number of women workers (10) were selected from each of the selected industries in consultation with the factory managers. These workers were randomly identified from the list of workers provided by the human resource managers of the respective facilities. Only those who were on duty at the time of data collection were included in the study.

***Qualitative approach***

The total number of FGDs and key informant interviews was determined based on information saturation. Hence, the study team conducted 20 key informant interviews from 12 selected workplaces and six FGDs from six workplaces. For details of number of individuals interviewed through the quantitative survey, FGD, KII and Health Facility Inventory, refer Annex 1.

## Target population

* *Quantitative approach*: included women aged 15-49 years of age regardless of their current marital status
* *Qualitative approach*: women aged 15-49 years for FGD (a total of six sessions); and two key informants per workplace (one representative or key staff of the selected workplace and a health service provider working at health care facilities) from 8 workplaces and one Key informant from other four workplaces. A total of 20 key informants were interviewed.

**Table 1: Sample size distribution by type of data collection approach per Region, Ethiopia, August 2016**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Region | Total # of workplaces visited | #of women interviewed for quantitative study | #Number of respondents for KII | #Number of FGDs |
| Addis Ababa | 6 | 50 | 7 | 1 |
| Oromia | 4 | 40 | 4 | 2 |
| Amhara | 5 | 49 | 5 | 2 |
| SNNP | 3 | 30 | 4 | 1 |
| Total | **18** | **179** | **20** | **6** |

In this survey, it was tried to represent multiple types of industries in all the four regions studied. Table 2 shows the diversity of industries covered in the survey.

Table 2 Types of industries included in the survey, August 2016

|  |  |
| --- | --- |
| Type of industry | Frequency |
| Breweries and wineries | 2 |
| Water/soft drinks | 1 |
| Horticulture | 1 |
| Fruits and vegetables | 2 |
| Leather processing | 1 |
| Textile | 3 |
| Construction | 2 |
| Steel and Metal | 1 |
| Pharmaceuticals | 1 |
| Food Processing | 1 |
| Sugar | 1 |
| Woodwork | 1 |
| Korki | 1 |
| Total | 18 |

## Data collection process

***Desk Review***: To document global and national standards and to assess the level of attention given to workplace family planning services at each level, literature review was undertaken on global FP priorities and initiatives, national policies, strategies, guidelines, implementation reports including SDG, FP2020, national population policy, health policy, the Health Sector Transformation Plan (HSTP), the national RH strategy and other published and unpublished sources. Efforts made by both the government and development partners including non-governmental organizations and other private sectors was examined through this document review process. Initial literature search was used as a reference frame for the development of the data collection tools including the structured survey questionnaire, KII and FGD tools.

***Obtaining permission for field work***: Except one company which requested us to bring a letter of support from MOH, all of the selected factories or farms were cooperative and allowed us to conduct our data collection merely with the support letter we obtained from CORHA. Upon arrival in the field, the officials (Factory/farm managers) were briefed about the aim of the rapid assessment, the methodologies to be applied, level of human activity, and the expected duration needed to finish the data collection.

***Training of data collectors***: The training of data collectors was done in Amharic to ensure concepts and questions are understood easily by each data collector. Data collectors were given the chance to share their experiences including challenges that could be faced in the field from previous similar exposures. Training of the interviewers took only one day. The training was facilitated by the principal investigator with the assistance of the research team members.

**Questionnaire administration**: Before commencement of data collection, the structured questionnaire was translated into Amharic language and was briefly piloted and refined to ensure that the questions can be understood easily by the interviewers and potential respondents (Annex 2a & 2b). During the pre-test, questionnaires were completed by respondents that have similar characteristics with the sample. For the final data collection, experienced interviewers were selected and trained.

***Focus Group Discussion and Key Informant Interview***: Skilled moderators who have a specific training or experience to conduct focus group discussion were hired. Groups were formed in such a way that homogeneity was maintained. It is important to set up groups where participants are likely to share common interests, encounter similar kinds of issues and feel comfortable in expressing their views in front of the other group members. Each FGD session had members ranging from 8-12 female workers. This size gives scope for a large enough range of different viewpoints and opinions while enabling all participants to make contributions without having to compete for time. FGD (Annexes 3) and KII (Annex 4) guides or speaking protocols were developed prior to the field work to collect data from the different stakeholder groups including the management, service providers and workers (service beneficiaries).

## Data Management and Analysis

For quantitative data, paper-based data cleaning was made prior to the data entry which involved checking for completeness of questionnaires and consistency of responses. Data were then computerized using SPSS version 24. Further data cleaning was performed using SPSS before undertaking the required statistical analysis. Analysis of variables was made using descriptive statistics (basic summaries of the respondent characteristics).

The qualitative data was analyzed thematically using ATLASti software qualitative data analysis software). This helped to ensure a systematic way[[1]](#footnote-1)of data analysis. All audio-recorded interviews were translated from the local language into English and transcribed during and after data collection. The English transcripts of key informant interviews and focus group discussions were added into Atlasti as primary documents (PDs). Before coding was initiated for every primary document, a PD family and super family were created and each PD was classified into two super families for KII and FGDs, and four PD families for Amhara, Addis Ababa, SNNP and Oromia regions. Hence, all PDs were included in one of the two PD super families and four of the PD families.

## Data quality measures

The data collection instrument is the major determinant of the validity and reliability of the data. In this survey, due to limited sample size, the external validity/generalization might not be maintained however, the internal validity of the data collection tools were achieved by applying different methods.

Hence, to achieve valid findings, data was collected by skilled data collectors to maximize the response rate. To establish reliability in the mini-survey, data collectors were trained thoroughly to minimize errors that might arise because of misunderstanding of the purpose and content of the instrument and incorrect recording. The questionnaire was pretested to check its consistency and word flow. Timing of the interview was arranged in such a way that the respondent wouldn’t be missed or wouldn’t be in fatigue to reach at an acceptable response rate. On top of that, careful measures were taken during coding and data entry. To evaluate the data collection instrument and the feasibility of the study, the tools were reviewed by staff members of CORHA and MOH.

Besides, appropriate KII and FGD guides and questions were developed which were also validated by the client, CORHA. It was tried to make sure that the questions complied with survey protocol, standard operating procedures, and ethical/other regulatory guidelines. The internal monitors/supervisors tried to insure that:

* All participants met the eligibility criteria to participate in the study;
* Each participant is verbally consented;
* Each interview was audio recorded;
* Quality assurance of the interview transcription were done by having the supervisor compare the transcripts and checking whether the transcripts fitted into the objectives of the survey;
* Translations and transcriptions were labeled and electronically filed appropriately;
* Coding and thematic analysis was done appropriately

In order to avoid haphazard conclusions and generalizations due to poor document review policy and program documents were identified and reviewed to identify current gaps in family planning programs at workplaces in Ethiopia.

# FINDINGS

## Socio-demographic characteristics of study participants

In this mini survey, all the 18 workplaces covered with the quantitative data collection tool. About 16 of them had workplace health facilities (clinics or hospitals) and hence the inventory survey was administered to these workplaces. From the total 18 facilities, around one-fifth (22.2%) of them provide FP services.

About three-fourth of the study participants were aged 20-34 years, 70.4% of them were married or living in union, 65.4% had at least one child, 94.0% had formal schooling, slightly more than a quarter of them (27.6%) attended at least diploma or degree level college education, and less than half (43.8%) of them had less than one year of working experience at the respective workplaces.

Table 3: Socio-demographic characteristics of study participants, July 2016 (n=179)

|  |  |  |
| --- | --- | --- |
| Variable | Frequency | Percent |
| Age group |  |  |
| 15-19 | 5 | 2.8 |
| 20-24 | 49 | 27.7 |
| 25-29 | 44 | 24.9 |
| 30-34 | 40 | 22.6 |
| 35-39 | 25 | 14.1 |
| 40-44 | 14 | 7.9 |
| Number of living children |  |  |
| 0 | 57 | 31.8 |
| 1-2 | 86 | 48.0 |
| 3-6 | 31 | 17.3 |
| Missing | 5 | 2.8 |
| Region |  |  |
| Addis Ababa | 60 | 33.5 |
| Oromia | 40 | 22.3 |
| Amhara | 49 | 27.4 |
| SNNP | 30 | 16.8 |
| Attended formal schooling |  |  |
| Yes | 168 | 93.9 |
| No | 11 | 6.1 |
| Highest level of formal schooling |  |  |
| Primary | 44 | 26.3 |
| Secondary | 77 | 46.1 |
| Technical/vocational | 30 | 18.0 |
| Higher | 16 | 9.6 |
| Religion |  |  |
| Christian | 165 | 92.1 |
| Muslim | 14 | 7.8 |
| Current marital status |  |  |
| Married/Living in union | 127 | 70.9 |
| Never-married | 37 | 20.7 |
| Widowed/divorced | 15 | 8.4 |
| Duration of experience at workplace |  |  |
| 1-12 months | 77 | 43.8 |
| 2-27 years | 99 | 56.2 |

For the qualitative study, a total of 18 key informant interviews were conducted at workplaces in Amhara, Oromia, SNNP and Addis Ababa City Administration. Overall, 55 female employees aged 19-45 years participated in six FGDs of different size (ranging from 8 to 12 female employees per FGD).

## Level of awareness about family planning

One means of raising the awareness of FP workers about family planning services is by availing FP service in the premises of workplaces. In this rapid assessment, it was found out that many workplace clinics provide some kind of awareness raising activities to their workers. However, many believe that the service is not adequate.

A health provider from Wonji-Shoa Sugar Factory stated that:

*I believe still more effort is needed. Not all women have good knowledge about all methods [of family planning]. It is given less emphasis as compared to [what we give] HIV prevention. For example, there are clubs and Medias for HIV but there is no such media for family planning*.

Fig. 1 presents awareness level of the study participants about traditional family planning among selected workplaces in Ethiopia. Compared to the modern FP methods (Table 4), traditional FP methods are less known among study participants. Less than half of them know ‘standard day method’ as FP method and only a third of them know about withdrawal method.

Fig.1: Awareness of study participants about traditional family planning methods, July 2016 (N=177)

Table 4 presents awareness level of study participants about modern family planning methods. Hence, injectables and OCPs were the most known FP methods by study participants at 83.4% and 77.1% respectively followed by condom (70.3%) and implants (68.2%). Permanent FP methods are the least known by study participants. Emergency contraceptive method is widely known among youngsters (15-19 years of age) compared to all other age groups of women. On the contrary, none of the youngsters were aware of male sterilization and less aware of female sterilization at (20%).

According to the information obtained from the qualitative study, frequent turnover of workers was also pinpointed as one of the challenges for poor level of awareness of individuals that lead to low utilization of services available at workplace clinics. A health care provider from Debire Birhan Textile Factory concurred by saying:

*Female employees leave the company frequently and are replaced with new workers that often have low level of awareness. Sometimes, it is difficult for the new employees to come forward to get family planning service [at workplaces clinics]****.***

One of the main challenges related to the awareness of individuals is lack or complete absence of FP programs at workplaces.

*[Family planning] awareness programs are not adequate. Clear discussion and [family planning] education is needed for young females [workers] from care givers. Young workers should be educated about each family planning method. I hope if they [young workers] get education, they can clearly discuss with health providers and their peers;* (Female FGD participant, Awash Agro-industry).

Table 4: Level of awareness of workers about modern family planning methods by age group, Ethiopia, 2016 (N=175)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age group | Emergency contraception | Condom | OCP | Injectables | Implants | IUD | Female sterilization | Male sterilization |
| 15-19 | 60.0 | 80.0 | 80.0 | 80.0 | 80.0 | 80.0 | 20.0 | 0.0 |
| 20-24 | 33.3 | 62.5 | 70.8 | 83.3 | 63.8 | 50.0 | 20.8 | 22.9 |
| 25-29 | 39.5 | 79.1 | 83.7 | 86.0 | 72.1 | 60.5 | 33.3 | 21.4 |
| 30-34 | 40.0 | 75.0 | 80.0 | 80.0 | 75.0 | 70.0 | 42.5 | 42.5 |
| 35-39 | 25.0 | 56.0 | 68.0 | 84.0 | 52.0 | 40.0 | 12.0 | 16.0 |
| 40-44 | 50.0 | 90.0 | 90.0 | 100.0 | 90.0 | 80.0 | 50.0 | 40.0 |
| 45-49 | 50.0 | 50.0 | 75.0 | 50.0 | 50.0 | 50.0 | 25.0 | 25.0 |
| Total | **37.4** | **70.3** | **77.1** | **83.4** | **68.4** | **58.3** | **29.3** | **26.4** |

## Unmet need for family planning

For women working at industries and other large workplaces, unintended pregnancies attributed to poor access to FP services have serious implications on their productivity, compromising their families’ livelihood, which ultimately impend the economic growth of countries. In this study, the status of FP use, pregnancy status and type of pregnancy and intention to use family planning methods were explored both using quantitative (Table 5) and qualitative data.

About 15.9% of the mini survey participants were pregnant at the time of data collection. Among the non-pregnant and currently married/in union women, about three-fourth of them were using any type of FP method. About one-third of the study participants do not want to have more children; whereas among those who needed more children, about 61.6% of them want to have children after two or more years.

Table 5: Pregnancy status, contraceptive use and pregnancy intention among currently married/in union women (n=126), August 2016

|  |  |  |
| --- | --- | --- |
| Variable | Frequency | Percent |
| Currently pregnant (n=126) |  |  |
| Yes | 20 | 15.9 |
| No | 97 | 77.0 |
| Unsure | 3 | 2.5 |
| Missing | 6 | 4.6 |
| Currently using any FP method (n=100) |  |  |
| Yes | 76 | 76.0 |
| No | 24 | 24.0 |
| Intention to have more child (n=126) |  |  |
| Have another child | 86 | 68.2 |
| No more | 37 | 29.4 |
| Undecided | 3 | 2.4 |
| Interval before the next child (n=86) |  |  |
| 1-2 years | 28 | 32.6 |
| More than 2 years | 53 | 61.6 |
| Don't know | 5 | 5.8 |

*\* Currently not pregnant*

In the qualitative study, FGD participants were asked about some of the consequences of unintended pregnancy and unmet need for family planning. They shared their feelings as well as their experiences while working in the factories and farms. Some of the consequences raised include decrease in productivity of workers, loss of job, abortion, and death.

A focus group discussant from Hawassa Tabor Ceramic Factory said,

*I have been working in this factory for long. There have been women suffering from repeated abortions. I myself suffered from abortion two times since I was employed in this workplace. This is partly because we are not getting services in this workplace.*

*Another FGD participant from* Debire Birhan Textile Factory shared her and her colleagues’ experiences as follows:

*Unintended pregnancy has lots of damaging consequences. If we [employees) become pregnant without prior plan, we [employees] will be forced to quit our jobs. Since our husbands are not capable either to take care of the little child or to provide the necessary payment for baby sitters, we will be forced to leave our jobs until our children grow****.***

A female FGD participant from Fafa Food Complex said,

*We need to have the required knowledge and money before we get pregnant. Otherwise we will become vulnerable to risk of illness and death****.***

Another FGD participant from the same company added,

*Unplanned pregnancy may force a woman to take frequent leave (maternity leave, annual leave, sick leave) which will lower her efficiency. As a result, the company’s productivity will suffer and ultimately she may lose her job*.

## Type of contraceptive used

Figure 2 presents the types of FP methods used by the study participants. Injectable contraceptive is the most frequently used contraceptive method (43%), similar to evidences obtained from DHS, followed by implants (19%). About 14.0% and 8.0% of the study participants were using OCPs and IUDS respectively. ‘Others’ (15%) used standard days method, condom use and lactation amenorrhea.

Study participants associate method preference to availability of method mix. A FGD participant from Upper Awash Agro-industry said,

*In the past it was known that women prefer injectable contraceptive. Previously there were only injections and pills. At that time we used to prefer injectables. Currently, implanon is also available and it has become a method of choice by many women****.*** *Now, I am actually using implanon*.

A workplace Clinic Head from Kombolcha Textile Factory witnessed,

*Oral contraceptive pills are often available at this facility and mostly female employees use them. Like the pills, injectables are the most commonly available and widely used family planning methods at this facility*.

As it was witnessed from the study participants, even these days, it is difficult to get long-term and permanent FP methods at workplace clinics. Hence, the method choice would still be limited to the old ones.

*Family planning methods like Implants, Intrauterine devices, male sterilization and Female sterilization are rarely available at our facility-*Health provider from Debre Birhan Textile Factory).

Fig. 2 Types of contraceptive methods used among current contraceptive users (n=73), August 2016

## Availability of contraceptives, commodities, trained providers, space and supplies and job aids at workplace clinics

In this survey, we conducted a brief inventory of supplies and commodities, availability of space for family planning and trained providers at the surveyed factories and farms that have clinics using an inventory checklist (Annex 5). Among the 18 workplaces surveyed, 16 of them had clinics in their premises.

***Availability and utilization of FP service***: It is not uncommon to observe workplaces where there are not FP services or there is poor utilization where there are services. Among the 16 workplaces that have workplace clinic in this study, only a quarter of them had one or more type of contraceptive method (excluding condom). This implies that only one-fifth of the 18 workplaces surveyed are providing any contraceptive method (Annex 6). Condom is the most widely available supply though it mayn’t necessarily mean it is availed as a FP method.

A KI from Debre Birhan Textile Factory said,

*We do not provide any of the family planning methods including counseling services [for family planning use] but we provide female and male condom [for employees] to protect them from HIV/AIDS*.

*Another KI from* Kombolcha Textile Factory added,

*Male condoms are available at the entrance [of the factory] and employees can get at any time. Any employee can use the condom free of charge. The main purpose of the condom supply is, of course, to prevent the spread of HIV/AIDS****.***

The majority of women (63.3%) are getting FP services from facilities outside the workplaces (Fig. 3). Only a quarter of them are getting services from workplace clinics.

Fig. 3 Usual sources of family planning methods/services for workers, August 2016

One of the FGD participants from Waliya Korki Factory said that*:*

*Unfortunately our factory does not provide any family planning service. We get family planning services from private clinics, health centers, hospitals, and pharmacies outside the workplace premise.*

A key informant from Tabor Ceramics Factory in Hawassa also said,

*I have been working in this clinic for the last five years. There has never been any FP service here.*

Shortage of contraceptives or poor method mix is one critical problem of workplace clinics. A KI from Kombolcha Textile Factory explained

*One of the main and common problems [to provide family planning services] is lack of contraceptive commodities and medical equipment... long-term contraceptive methods including implants and intrauterine devices are not given in our clinic because of lack of the necessary equipment and commodities [kits]. So, because of this we are not providing fairly adequate family planning services [in our workplace clinic].*

Table 6 shows the types of contraceptives available at workplaces at the time of data collection. The result shows that the most available supply in about 81.3% of the workplace clinics was condom followed by injectable contraceptive and projestin-only pills at 25.5% each. IUD and OCPs were the least available contraceptives in the clinics. Since availability of condom doesn’t necessarily indicate availability of family planning, it is very likely that only a quarter of the workplace clinics provide FP services.

Table 6: Availability of contraceptives at workplace clinics (n=16)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contraceptives | Yes, observed | Yes, not observed | No | N |
| Condom | 81.3 | 6.3 | 12.5 | 16 |
| IUD | 12.5 | 6.3 | 81.3 | 16 |
| Implants | 25.0 | 0.0 | 75.0 | 16 |
| Injectable | 25.0 | 6.3 | 68.8 | 16 |
| Projestin-only pills | 25.0 | 0.0 | 75.0 | 16 |
| Combined OCPs | 12.5 | 6.3 | 81.3 | 16 |

Key informants had different excuses for not availing FP service or contraceptives at their workplace clinics.

The Head of Operations at Fafa Food Complex said,

*The need for family planning services [among employees] is limited. Women get the service by their own from different facilities nearer to their residence. They only want to get prenatal and postnatal services in our clinic. As a management, we are ready to provide the [family planning] service here in the clinic because we are covering other major medical costs which is much expensive than contraceptives.*

In contrary to the above claim, a KI from Anbesa Shoe factory in Addis Ababa said,

*The major reasons for not providing family planning services at workplaces are many: first, is ignorance from higher officials of the factory to give any attention to family planning needs of women; possibly lack of awareness about the importance of FP service to workers; second, lack of close follow up from concerned government health offices to ensure whether the factory provides family planning service to their workers or not; third, availability of health centers nearby and as result the workplace clinic refers the workers to the nearby facilities. Thus, the clinic considers it as a normal practice****.***

FGD participants had different reasons for not using the FP services available at workplace clinics including lack of method mix and (perceived) poor quality of services. FGD participant from Debre Birhan Textile Factory said,

*I know for sure our workplace clinic provides family planning service because I am one of the users in this clinic but we have very few choices; only male and female condoms, oral contraceptive pills and injections are available. [For other services] they often refer to other health facilities*.

*Since there are better public and private health facilities outside of our workplace that provides [better] family planning services, I never used the services in our clinic-*FGD participant from Debre Birhan Textile Factory.

***Space availability:*** Table 7 presents space availability for provision of FP services at the studied workplace clinics. Hence, slightly more than half of the clinics had private rooms, adequate waiting areas, hand-washing facilities and rooms with adequate lighting for FP services. Less than half had well ventilated rooms.

Table 7: Space availability for FP service delivery at workplace clinics (n=16\*)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Description | Yes | Yes, not observed | No | Total |
| Private room for FP procedures | 56.2 | 0.0 | 43.8 | 100.0 |
| Well ventilated room for FP procedure | 50.0 | 6.2 | 43.8 | 100.0 |
| Adequate waiting area with chair | 56.2 | 0.0 | 43.8 | 100.0 |
| Adequate lighting available in procedure room | 56.2 | 0.0 | 43.8 | 100.0 |
| Hand-washing available in procedure room | 56.2 | 6.3 | 37.5 | 100.0 |

*\*Inventory was conducted only at the workplaces where there are clinics (16 of 18)*

***Availability of health worker trained on FP***: Fig. 4 shows the availability of health professionals at workplaces trained on FP service provision. About three-fourth of the 16 workplace clinics had nurses and more than one-third had public health officers trained on FP services respectively. Only three of the clinics had a physician and another one a health Extension Worker trained on FP.

Fig.4 Availability of provider trained on FP at workplace clinics by profession (n=16)

***Availability of supplies and job-aids***: Table 8 shows the availability of supplies and job aids that are expected to be essential for FP service provision. The most important supplies needed for FP service provision were not available in most of the workplace clinics. There were shortages of IEC materials, registers, guidelines, reporting forms, and kits for IUD and Norplant insertion and removal. Disposable syringes, gloves and referral forms were available in most of the clinics but these might be because these are supplies that can also be used for other medical services as well.

Similar to the findings from the quantitative survey, findings from KIs also witnessed that there is critical shortage of supplies and job aids including national guidelines, posters and flipcharts.

Health provider from Debrebirhan Textile Factory said,

*There are no [family planning] guidelines, flipcharts and posters that [health] workers can easily get. There are no documents in our facility outlining current recommendations to provide family planning or any other service-*.

Similarly, KI from Fafa Food Complex Factory *added,*

*We do have books for reference for the health staff but there is shortage of brochures and posters on family planning. We do not also have the national [family planning] guideline*.

Another KI from MOHA Soft Drinks Company, Addis Ababa stated,

*In the past we used to get posters from DKT and Marie Stopes but currently we don’t*.

Table 8: Availability of supplies and job aids at workplace clinics (%) (n=16)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Items | Yes, observed | Yes, not observed | No | Total |
| Sharps box | 56.3 | 6.3 | 37.5 | 100.0 |
| Family planning Flip chart | 12.5 | 18.8 | 68.8 | 100.0 |
| IEC materials on wall | 31.2 | 12.5 | 56.3 | 100.0 |
| IEC material available to give to client | 31.2 | 0.0 | 68.8 | 100.0 |
| Disposable syringes with needle | 81.3 | 6.2 | 12.5 | 100.0 |
| Gloves | 81.2 | 6.3 | 12.5 | 100.0 |
| Sterilizer/Autoclave | 66.7 | 6.6 | 26.7 | 92.3 |
| FP Register | 31.2 | 12.5 | 56.3 | 100.0 |
| Referral form | 62.5 | 6.2 | 31.3 | 100.0 |
| Family Planning guideline | 18.7 | 12.5 | 68.8 | 100.0 |
| Family Planning Monthly Reporting Form | 25.0 | 12.5 | 62.5 | 100.0 |
| Requisition book for Family planning | 18.8 | 0.0 | 81.2 | 100.0 |
| Stock Card/Inventory/Bin Card | 37.5 | 0.0 | 62.5 | 100.0 |
| IUD insertion and removal kit | 12.5 | 6.3 | 81.2 | 100.0 |
| Norplant insertion and removal kit | 18.8 | 0.0 | 81.2 | 100.0 |

## Types of support provided to workplace health facilities from partners

Almost all of the key informants and FGD participants confirmed that there is no continuous or sustainable support on FP service provision received from partners including the local government. Regarding this issue a health care provider, Wonji Shoa Health center

*Regarding long-term and permanent methods we refer [clients] to Marie Stopes clinic. For a short period of time in the past, we started the service here at the workplace health facility by inviting doctors from Marie Stopes as we have no trained health personnel. But it was stopped and currently there is no such service here. We refer them to Marie Stopes clinic when they [employees] request permanent [family planning] methods*.

## Barriers for family planning service provision at workplaces/health facilities

In this rapid assessment, some of the major barriers and challenges that affect FP service provision at workplaces in Ethiopia were explored. KIs and FGD participants highlighted the major challenges that they feel are affecting service provision including lack of commitment of the management from the workplaces, absence of FP programs providing services at workplaces, and the poor involvement and engagement of implementing partners among others.

Regarding the absence of commitment from the management, a KI from Moha Soft Drink Factory said,

*There is no budget allocated for family planning services though the factory refunds expenses of the service provided by other health centers outside the workplace.*

*Another KI from Anbesa Shoe Factory complimented the above point by saying,*

*Facility related barriers like absence of budget for FP service are the reasons why we don’t provide the* ***s****ervice at the workplace.*

Regarding lack of partners, KIs from different workplaces reported similar experiences,

A KI from Kombolcha Textile Factory said,

*There is no any development partner that is supporting us to provide workplace family planning services-*.

*Currently we do not have any partner [working with us]. In the past we used to work with NGOs on HIV/AIDS. I am afraid we have become reluctant as a company in the provision of the service-KI from* MOHA Soft Drink Company.

## Attitude of workers, healthcare providers and management staff about FP service at workplaces

There are so many advantages of availing workplace family planning service provision: its importance of accessing an easy-to-reach and many workers at a time; its potential to save employees’ time, increase in productivity, and the benefit of reaching more male targets.

Study participants (women workers, health care providers and managers) were asked about the benefits of providing FP services at workplaces.

*If family planning service is [available] inside the company’s compound, it will save employees’ time and it will be a good solution for them than traveling a long distance to find the service****-***Female FGD participant from Walya Korki Factory.

This idea was further supported by a health provider from Kombolcha Textile Factory*.* He said,

*Since our health facility is inside the company’s compound, it saves our employee’s time and it is a good opportunity for them [employees] than going a long distance to find [family planning] service****.***

Another FGD participant fromWalya Korki Factory *stated that:*

*Availing family planning service in our workplace may help the company a lot by avoiding unnecessary leave requests from female employees*.

Another KI added,

*Most factory workers are not doing well economically and they are engaged in household chores including caring children besides the factory works. Hence, they may not have enough time to go to health centers*-Female FGD participant from Fafa Food Complex.

However, the mere availability of FP services at workplaces doesn’t guarantee the workers to use the services. The services should be availed in good quality including method mix.

*Though we have FP services at our company, when I need to get family planning service, I usually visit Marie Stopes International which is very near to our company. There is no satisfactory [family planning] service at our workplace clinic-*Female FGD participant from Debire Birhan Textile Factory.

# CONCLUSION AND RECOMMENDATION

## Conclusion

In this study, the needs for FP services at workplaces; inventory of the FP services, commodities, equipment, job aids, and staffing of workplace health facilities; FP supports provided to selected workplace health facilities; the health needs and attitudes of workers and management towards FP services; and barriers/challenges for FP services provision in selected workplace health facilities were explored.

The findings responded to the sated study objectives, the results of which will be used to expand services to the workplaces based on evidences on the current status of the health facilities and FP services in the workplaces.

The findings of this rapid assessment show that the awareness level of the study participants was fairly higher especially about OCPs and injectables. However, significant portions (one-fourth) of the non-pregnant women at the time of data collection were not using any FP method. Another slightly less than one-third of the study participants do not want to have any more children.

Although the majority of employees have stated that they did not come across with unplanned pregnancy in recent years, there were employees who underscored that they themselves encountered unintended pregnancy or observed some unplanned pregnancy from their close friends. They emphasized that unwanted pregnancy often results in miserable or life events especially for employees at factories because they often lose their jobs for many reasons when they are pregnant or just after giving birth.

Most workplaces reported, through the key informant interviews, that they have family planning awareness programs for employees. Nonetheless, it seems that the awareness program does not target some important actors. The awareness program often missed men employees despite the fact that men have a significant impact on family planning use. They also reported that they have lack or shortage of posters, IEC materials and counseling charts.

As regards to availability of FP services at workplace clinics, the quantitative data findings show that the most frequent supply available in the majority of the workplace clinics was condom followed by injectable. However, despite its wide availability, condom might not be used as a FP method by many of the clients. On the other hand, only about half of the clinics had space for FP service provision and this might indicate the low degree of attention given to FP.

Similarly, key informants and FGD participants indicated that family planning services are available in most workplace clinics. However, most providers and employees have concerns on the quality of the service delivered at workplace clinics because of various reasons. Most importantly, workplaces offer a limited contraceptive choice among the overwhelming family planning methods available to date. Providers and employees alike reported that the method mix is not adequate and the long acting and permanent contraceptive methods and/or services are often missing at workplace clinics. Permanent methods are not available in almost all workplace clinics whereas long-term methods are available only in a few workplace clinics. Overall, workplace clinics often offer limited contraceptive methods, most of which are short term methods requiring clients to have frequent visits to service delivery points.

Lack of trained family planning providers is another major challenge to provide good quality and reliable family planning services at workplaces. Most health care providers have not attended an in-service training on family planning and cannot provide good quality and reliable services unless there is a mechanism to provide technical updates on modern contraceptive methods. Even among those who reported that they have attended some sort of training on family planning, the training was conducted many years back and they have not attended refreshment training in recent times.

Almost all employees reported that they receive family planning services for free either from workplace clinics or from public health facilities. Most of the workplaces provide family planning services for employees as far as they receive commodities from Woreda health offices and NGOs for free. They do not allocate budget to provide family planning services neither for their employees nor to the surrounding population as a corporate social responsibility. Worth mentioning here is that Woreda health offices rarely supervise workplace clinics for availability of contraceptive services and do not ensure the quality of the services by providing feedback in a regular basis though they are often providing contraceptive commodities to them.

Apart from availability of commodities and trained health providers, lack of family planning job aids is another obstacle to provide good quality family planning services at workplaces. The vast majority of workplace clinics stated that they lack the national family planning guideline.

Overall, this survey has come up with important findings that have implications to actors at different levels including policy-makers, programme planners and practitioners or service providers as evidence base on which to build strategies or on which to focus activities to FP service delivery. The identified overall poor availability of FP services and significant unmet need manifested by repeated occurrence of unplanned pregnancies will serve as inputs for formulation of appropriate strategies and measures to reach the most affected segments of the workforce in the studied areas. The tendency of workplace women towards public health care facilities attributed to low awareness on the availability and eligibility to the FP services at workplace health facilities; the limited contraceptive method mix or choice; the perceived poor quality of services; and poor commitment among the management staff of the workplaces or factories for the study population is a concern for policy makers and programme managers as well as implementers. The major findings indicate where the service providers have to concentrate to satisfy their clients.

## Recommendation

The findings of this study provided invaluable information on workplace family planning with regards to service gap or unmet need for FP, availability of trained manpower, availability of supplies and commodities, and service utilization among women of reproductive age groups in Addis Ababa, Oromia, Amhara and SNNP regions. Over all, although many workplaces are striving to provide family planning services for their employees at the vicinity of the workplace, much work should be done to improve the services. The workplace clinic should provide a wide range of contraceptives, diversify the method mix and train providers to deliver a service with maximum quality. Apart from the many advantages family planning can offer for clients, it can also benefit factories/workplaces in many ways. It prevents frequent absentees and the loss of skilled manpower from unintended pregnancy. Obviously, it reduces turn over, motivates employees to stay long as workers and increases productivity. Hence, the authors recommend the following to deliver quality family planning services at workplace health delivery points:

**Recommendations for policy makers, programme designers and implementers**

* As more and more industries are established over time in Ethiopia, it is clear that huge number of people will be employed by these factories and farms. Most importantly, employees from factories are often young, migrating from other parts of the country and are sexually active. Hence, the ministry of health should develop a strategy that takes into account the unique circumstance of workplaces and workplace populations.
* FP programmes and strategies should always incorporate every segment of the population including workers of manufacturing industries (factories and farms).
* Access to contraceptive services and related information and communication should be improved so as to reduce the percentage of unintended pregnancies and improve quality of life of workers.

**Recommendations to Regional Health Bureaus and Woreda Health Offices/health facilities**

* As workplace clinics are the nearest facilities for the majority of the workforce at factories and or farms, availing reproductive health services including FP at workplaces either through outreach or by providing contraceptives supplies and commodities to workplace health facilities should be one area of intervention for the government.
* The respective regional Bureaus of Health and Woreda Health Offices should make sure that an effective monitoring system is established to make sure that the reproductive health rights of workers of factories and farms is protected and make sure that women receive the services entitled to them.
* Strong advocacy for stakeholders including service providers on enhancing the provision of FP services at workplaces.
* Health service providers at workplace health facilities should be provided with basic and refresher training on RH/FP and the national FP guideline so that they can provide full package FP services.

**Recommendations for manufacturing industries (factories and farms), workplace health facilities and service providers**

* Workplaces should strengthen and ensure the accessibility, availability and sustainability of family planning services at workplaces by allocating budget to purchase commodities and train health workers.
* Workplaces should ensure that a broad range of family planning services including method choices are available at workplace clinics, including long acting and permanent family planning services in collaboration with civic societies and government health offices. Availability of contraceptives should go beyond condoms.
* Workplaces should develop family planning awareness programs to their employees and their families targeting both men and women. This may be done in consultation with organizations engaged in FP program implementation.
* One of the observations from the study findings is that there are women that are not aware whether they are entitled to the FP services provided at workplace clinics either because they never ask or information may not be given to them. Therefore, efforts must be made to improve women’s awareness about availability of FP services through improved communication by the service providers at workplace clinics or within the premises.

**Recommendations to Professional Associations, NGOs and partners**

* Developments partners can have an enormous role to improve quality of family planning services at workplaces. Even though the primary responsibilities of delivering family planning services lies on local authorities and the workplace clinic, development partners should technically assist workplace clinics to develop awareness programs, to train health care providers and to improve logistic information systems.
* Strengthen advocacy on the rights of workplace women for provision of FP services at workplaces. Availability of FP services at workplaces will increase productivity.
* NGO partners (local and international) should target workplaces as important outlets as this would allow them to reach large number of people in specific locality. Availability of health facilities at workplaces is a great opportunity for those interested to contribute on FP service provision.

**Recommendations on future research**

* There should be continued effort on implementation research to examine the appropriate application or use of national protocols and guidelines on service provision at workplaces.
* This study should be replicated in other parts of the country with more representative sample size to see the availability and levels of FP services including method mix, availability of FP supplies and commodities, and magnitude of unmet need for family planning.

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# ANNEXES

## Annex 1: Number of study participants by workplace and type of data collection approach

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Region** | **Name of workplace** | **#of women interviewed** | **#Number Key Informants** | **#Number of FGDs** | **Health Facility Inventory** |
| Addis Ababa | Anbesa Shoe Factory | 10 | 1 |  | 1 |
| Awash Winery | 10 | 2 |  | 1 |
| Fafa Food Processing | 10 | 2 | 1 | 1 |
| MOHA Soft Drinks | 10 | 2 | 1 | 1 |
| Shoa Cotton Ginning Factory | 10 | 1 |  |  |
| Ethiopian Pharmaceuticals Factory | 10 |  |  | 1 |
| Oromia | Wonji-Shoa Sugar Factory | 10 | 2 | 1 | 1 |
| Merti fruits and Vegetable processing plant (Awash Agro-industry) | 10 | 2 | 1 | 1 |
| Dangote Cement Factory | 10 |  |  | 1 |
| Holeta Dream Flower Farm | 10 |  |  | 1 |
| Amhara | Debre Birhan Textile Factory | 10 | 2 | 1 | 1 |
| Kombolcha Textile | 10 | 2 |  | 1 |
| Kombolcha Steel Products Industry (KOSPI) | 10 |  |  | 1 |
| Walya Korki | 10 |  |  | 1 |
| Debre Birhan Dashen Brewery | 9 |  |  | 1 |
| SNNP | Tabor Ceramic | 10 | 2 | 1 | 1 |
| Alata Land Groups | 10 | 1 |  |  |
| Hawassa Chipwood | 10 | 1 |  | 1 |
| **Total** |  | **179** | **20** | **6** | **16** |

## 

## Annex 2: Structured questionnaire (English)

**STRUCTURED QUESTIONNAIRE**

***CORHA-Rapid Needs Assessment for FP Services in Selected Workplaces in Ethiopia***

|  |  |  |
| --- | --- | --- |
| ***INTRODUCTION***  Hello. My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I am working with theConsortium of Reproductive Health Associations (**CORHA).** We are conducting rapid needs assessment for family planning services in work places in Ethiopia. The information we collect will help the Ministry of Health to plan family planning services in work places in Ethiopia. Your factory/farm was selected for the assessment. The assessment will take about 10 to 15 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our study team. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.  May I begin the interview now?  **🞎***Yes, permission is given* ⇨*Begin the interview.*  **🞎***No, permission is not given* ⇨*End.* | | |
| WP1. Factory/Farm Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | WP2. Factory/Farm Code\_\_\_\_\_\_\_\_\_\_ | |
| WP3. Interviewer’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | WP4. Interviewer’s #\_\_\_\_\_\_\_\_\_\_\_ | |
| Date of interview | dd/mm/yyyy\_\_\_ \_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ | |
| WP5. Type of Industry | breweries and wineries  WATER/soft drinks  HorticalturE  FRUITS AND Vegetables  Leather processing  Textile  Construction  steel and metal  OTHER (SPECIFY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1  2  3  4  5  6  7  8  98 |
| WP6. Region where the factory/farm is found | Addis Ababa  Oromia  Amhara | 1  2  3 |
| Interview Start time :  HrsMts | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No | QUESTIONS AND PROBS | | | CODING CATEGORIES | | | | | | | | SKIP |
| **SECTION 1: SOCIO-DEMOGRAPHICS, SEXUALITY AND Reproductive Health CHARACTERISTICS**  *In the next few minutes, I will be asking you about some questions related to you and your family including fertility, sexuality and reproductive health issues.* | | | | | | | | | | | | |
|  |  | |  | | | | | | | | |  |
| 101 | How old are you in complete years? | | Years | | | | | | | | |  |
|  |  | |  | | | | | |  | | |  |
| 102 | Have you ever attended formal schooling? | | Yes  No | | | | | | 1  2 | | | ***If = 2🡪104*** |
| 103 | What is the highest level of formal schooling you have completed? | | Primary  Secondary  Technical/vocational  Higher | | | | | | 1  2  3  4 | | |  |
| 104 | What is your religion? | | Orthodox  Catholic  Protestant  Muslim  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Refused | | | | | | 1  2  3  4  5  99 | | |  |
| 105 | What is your current marital status? | | Married  Living in union  Widowed  Divorced  Separated  Never married/never in union | | | | | | 1  2  3  4  5  6 | | | ***🡪107*** |
| 106 | Is your husband/partner living with you now or is he staying elsewhere? | | Living with her  Staying elsewhere | | | | | | 1  2 | | |  |
| 107 | Have you ever given birth? | | Yes  No | | | | | | 1  2 | | | ***If = 2🡪109*** |
| 108 | How many living children do you have currently? | | Number of children \_\_\_\_\_\_\_\_\_\_ | | | | | |  | | |  |
| 109 | Are you pregnant now? | | Yes  No  Unsure | | | | | | 1  2  3 | | | ***If =*** |
| 110 | How long have you worked in your present job for your current workplace? | | Less than 6 months  6-12 months  Enter years: \_\_\_\_\_\_ | | | | | | 1  2 | | |  |
| 111 | Which of the following best describes your usual work schedule? | | Day shift  Afternoon shift  Night shift  Rotating shifts | | | | | | 1  2  3  4 | | |  |
| 112 | Is there a clinic in your work place? | | Yes  No | | | | | | 1  2 | | |  |
| 113 | What services are provided in the clinic? (Multiple answers possible) | | Voluntary counselling and testing  Treatment of HIV  Contraceptives  Condoms distributed at the workplace  Treatment diseases  Others | | | | | | 1  2  3  4  5  6 | | |  |
| 114 | Have you ever visited the clinic at your work place? | | Yes  No | | | | | | 1  2 | | | ***If = 1🡪116*** |
| 115 | If “No”, why wouldn’t use of the clinic? (Multiple answers possible) | | I don’t know much about it  I don’t trust the confidentiality  The services are insufficient  The services are unnecessary  The services are not accessible  Others | | | | | | 1  2  3  4  5  6 | | |  |
| 116 | Have you visited the clinic at your work place in the past 1 month? | | Yes  No | | | | | | 1  2 | | |  |
| 117 | What were the reasons for going to the clinic? | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | | |  |
| 118 | Does the clinic provide FP and other health-related products to workers? | | Yes  No | | | | | | 1  2 | | |  |
| 119 | Are workers required to pay for FP and other health-related products? | | Yes  No | | | | | | 1  2 | | |  |
| 120 | What types of activities do you want the clinic to strengthen/ continue/ scale down? (Multiple answers possible) | | Staff education  Providing materials (Leaflets and posters)  Promoting the clinic services | | | | | | 1  2  3 | | |  |
| 121 | Are all employees, including temporary, contract, and seasonal workers, allowed to use the clinic? | |  | | Y | N | | |  | | |  |
| Permanent Workers | | 1 | 2 | | |
| Temporary workers | | 1 | 2 | | |
| Contract workers | | 1 | 2 | | |
| Seasonal workers | | 1 | 2 | | |
| **SECTION 2: CONTRACEPTION**  *Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.* | | | | | | | | | | | | |
| 201 | Which types of family planning methods (means to avoid pregnancy) have you ever heard of?  PROBE to hear as many responses as possible. | | Withdrawal method  Emergency contraception  Standard Days Method  Lactational Amenorrhea method  Condom  Pill  Injectables  Implants  IUD  Female sterilization  Male sterilization  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 1  2  3  4  5  6  7  8  9  10  11  98 | | |  |
| 202 | Are you currently doing something or using any method to delay or avoid getting pregnant?  *[DON’T ASK THIS QUESTION IF WOMAN IS PREGNANT. REFER Q114 ABOVE]* | | Yes  No | | | | | | 1  2 | | | ***If = 2 🡪206*** |
| 203 | Which method are you currently using?  Circle all mentioned if combined methods are being used. | | Withdrawal method  Emergency contraception  Standard Days Method  Lactational Amenorrhea method  Condom  Pill  Injectables  Implants  IUD  Female sterilization  Male sterilization  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 1  2  3  4  5  6  7  8  9  10  11  98 | | |  |
| 204 | Where do you usually get the FP methods? *"PROBE TO IDENTIFY THE TYPE OF SOURCE.*  *IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE." NAME OF PLACE)*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | Workplace clinic  Public health facility outside workplace  Private health facility outside workplace  From community health workers  From Health Extension Workers  Other, (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 1  2  3  4  5  98 | | | ***🡪301*** |
| 205 | Why you are not using the workplace clinic for FP services? | | Service not available  Lack of trained provider  Preferred method not available  Lack of supplies or equipments  Service not friendly  Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 1  2  3  4  5  6 | | |  |
| 206 | Which modern family planning services are available in your workplace clinic?  PROBE | | FP counselling  Condom  Pill  Injectables  Implants  IUD  Female sterilization  Male sterilization  Other specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t know | | | | | | 1  2  3  4  5  6  7  8  98  95 | | |  |
| 207 | Is there a special time arrangement at your workplace clinic for provision of FP services to workers like you or those who need it? | | Yes  No  Don’t know | | | | | | 1  2  95 | | |  |
| 208 | What is the best time of the day for workers to get FP services at workplace the clinic? | | During working hours  Off-working hours during week days  Weekends  No special arrangement needed  Have no idea | | | | | | 1  2  3  4  5 | | |  |
| 209 | Is there any service charge for FP related services at your workplace clinic? | | Yes  No  Don’t know | | | | | | 1  2  95 | | |  |
| 210 | Has there been any external partner (service provider from NGOs or public facilities outside this workplace) that has visited workers in this farm/factory to provide FP services in the last 6 months? | | Yes  No  Don’t know | | | | | | 1  2  3 | | |  |
| 211 | What were the major FP services provided at your workplace clinic? | | FP education  Counselling on FP  Contraceptives distribution (pills)  Condom distribution  Other specify, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 1  2  3  4  98 | | |  |
| 212 | Check 202: Is respondentcurrently doing something or using any method to delay or avoid getting pregnant? | | Yes  No | | | | | | 1  2 | | | ***If = 1 🡪301*** |
|  |  | |  | | | | | |  | | |  |
|  |  | |  | | | | | |  | | |  |
|  |  | |  | | | | | |  | | |  |
| 213 | How hard is it to take time off during your work to visit the clinic for FP service? | | Not hardat all  Not too hard  Somewhat hard  Very hard | | | | | | 1  2  3  4 | | |  |
| **SECTION 3: FERTILITY PREFERENCE**  **Now, I would like to ask you some questions related to your fertility preferences or pregnancy or childbirth intentions** | | | | | | | | | | | | |
| 301 | Now I have some questions about the future. Would you like to have a child, or would you prefer not to have any more children? | | Have another child  No more/None  Undecided/don’t know | | | | | | 1  2  88 | | | ***If 2 🡪304*** |
| 303 | How long would you like to wait from now before the birth of (a/another) child?  Provide the exact month or year the respondent intends to wait  If Months  If years | | Less than 6 months  1-2 years  More than 2 years  Don’t know  Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 1  2  3  4  88 | | | ***All responses🡪 307*** |
| 304 | Check 109:  Is respondent pregnant now? | | Pregnant  Not pregnant or unsure | | | | | | 1  2 | | | ***If = 1🡪307*** |
| 305 | Check 202:  Using a contraceptive method? | | Not Currently using  Currently using | | | | | | 1  2 | | | ***If = 2🡪End survey*** |
| 306 | You have said that you do not want (a/another) child soon/any (more) child  Can you tell me why you are not using a method to prevent pregnancy?  Any other reason?  RECORD ALL REASONS MENTIONED. | NOT MARRIED  FERTILITY-RELATED REASONS  Not having sex  Infrequent sex  Menopausal/hysterectomy  Can't get pregnant  Not menstruated since last birth  Breastfeeding  Up to god/fatalistic  OPPOSITION TO USE  Respondent opposed  Husband/partner opposed  Others opposed  Religious prohibition  LACK OF KNOWLEDGE  Knows no method  Knows no source  METHOD-RELATED REASONS  Side effects/health concerns  Lack of access/too far  Costs too much  Preferred method not available  No method available  Inconvenient to use  Interferes with body's normal processes  Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don't know | | | | | A  B  C  D  E  F  G  H  I  J  K  L  M  N  O  P  Q  R  S  T  U  X  Z | | | ***For all responses 🡪307*** | | |
| 307 | Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future? | Yes  No  Don’t know | | | | | | 1  2  88 | | |  | |
| Interview end time :  HrsMts | | | | | | | | | | | | |

This ends of the interview. Thank you so much for sharing your thoughts with me.

Interviewer comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

## Annex 3: FGD Guide and Questions

**FOCUS GROUP DISCUSSION GUIDE**

***CORHA-Rapid Needs Assessment for FP Services in Selected Workplaces in Ethiopia***

1. **Project owner:** The Consortium of Reproductive Health Associations (CORHA)
2. **Objectives of the Focus Group Discussions:**
3. To assess, from the perspective of factory or farm workers, the major family planning services and related concerns and or challenges at workplaces in Ethiopia.
4. To obtain detail information on aspects of FP service availability, service delivery (quality) and barriers hampering FP service delivery and/or utilization.
5. ***Focus Group Script for adult women and men***

*Materials needed*

* One tape recorder (for backup)
* Copies of consent form for participants (group oral consent to be taken)
* A print copy of focus group guide and FGD questions
* Notepad and pens for note taking

1. *Initial contact*

Make sure you have a homogenous group of participants (female-only groups). Initial contact is an important part of the interview process for the interviewers to establish rapport with participants. It is the right time to create a conducive atmosphere so that participants are able to willingly communicate their views and opinions with no reservation.

1. *Start introductions and Focus Group Process (5-10 minutes):*
2. **Welcome participants as they arrive at the focus group venue. Get them seated around a table in a room or under a tree. Since we are using tape recorders, we may not need extra note-taker unless, after giving the consent, participants will not want to be tape-recorded. In the latter case, the research assistant/recorder should sit outside the round table to minimize disturbance among the group while taking notes.**
3. **The facilitator and recorder introduce themselves.**
4. **Explain the purpose of the focus group session as follow (to the facilitator: *start tape recording by loudly telling the place of visit e.g. Now we are in Upper Awash Agro-Industry. This will make identification of audio files easier during transcription and analysis*):**

***Welcome to this focus group discussion. The information that you provide would later help CORHA and its member associations or partners and the respective government health offices to design appropriate strategies and activities to improve family planning service provision at workplaces in Ethiopia. We asked you to come to this FGD session because we would like to hear from you about your perceptions, opinions and ideas on the current FP related problems, service availability, service utilization and associated challenges in your workplace. You are the right people that can tell us the reality on the ground, and we are willing to learn from you about the FP related issues in your workplace. We do expect your genuine opinion, be it negative or positive or good or bad, associated to FP issues. You are free to share your views and opinions regarding types of FP service deliveries at this work site. We would like to note of what each of you say in this short discussion and write a report that will be used as input for the upcoming project implementation. Please be aware that there is nothing right or wrong answer. Every opinion of yours is valid. We are grateful for your participation in this important FGD session.***

**5. Take consent from participants:** **explain the issues indicated under the consent form (Annex), answer questions, if any, and obtain oral consent from participants.**

***Group Rules (5 minutes)***

Develop group rules to protect participants’ confidentiality (see the following examples):

* Be respectful
* Only one person talks at a time
* Honesty (genuine opinions, views or reporting of observations)
* Maintain confidentiality
* Don’t mention names of individuals you are talking about while sharing experiences/views

***Focus Group Observations - To be done by the research assistant***

The observations of the group dynamics should include the following:

* 1. Flow of group interaction (similar ideas over-talked, diverse ideas and views coming out, etc.)
  2. Tone of the group interaction (happy, smiling, angry, bored, etc.)
  3. Consistency of participants’ observations
  4. Body languages

***Wrap up (5 minutes)***

The ideas, opinions and views you shared to me/us are very important. They will be of great importance for improving FP services in workplaces (factories and farms). Thank you once again for your active participation and time. END.

**Information sheet and Consent for FGD participants**

***CORHA-Rapid Needs Assessment for FP Services in Selected Workplaces in Ethiopia***

*Dear FGD participant:*

We are seeking your assistance with a Rapid Needs Assessment, where we would like to have your perceptions and experiences for family planning services *(use the respective names of workplaces)*.

If you agree to participate in this study, you will be asked to participate in a focus group discussion that will take approximately 45-60 minutes. Only the group participants and the interviewer (researcher) will be present in the room where the discussions are taking place. There are no known or expected risks associated with this study. Participation is completely voluntary. You may refuse to participate, refuse to answer any questions or end the discussion as you wish with no effect on your right to get healthcare services.

Information about participants will be anonymous and reported for as grouped data only. Your individual responses will be confidential to the research team. With your permission, we would need to tape record the discussion, for the accurate use of the information you would be sharing with us.

The information will only be used for baseline assessment purpose and only the members of the research team will have access to the data. The results of the study will be presented in publications and presentations without identifying you personally thus maintaining your confidentiality. Upon completion of the study, all of the data and consent forms will be shredded in line with the data policy of CORHA.

Do you have any question which you wish me to clarify?

Are you willing to participate in the study? 1) Yes 2) No

Your participation in the FGD will serve as a testimony that you have agreed to participate in the study.

Thank you for your time!

**FOCUS GROUP GUIDING QUESTIONS (45 MINUTES)**

***CORHA-Rapid Needs Assessment for FP Services in Selected Workplaces in Ethiopia***

1. **Background information**
2. Number of participants in the group (t*ake 8-12 participants per session*): \_\_\_\_\_\_\_\_\_
3. Age of each participant (no name is required):

|  |  |
| --- | --- |
| **Participant code** | **Age** |
| Participant 1: |  |
| Participant 2: |  |
| Participant 3: |  |
| Participant 4: |  |
| Participant 5: |  |
| Participant 6: |  |
| Participant 7: |  |
| Participant 8: |  |
| Participant 9: |  |
| Participant 10 |  |
| Participant 11 |  |
| Participant 12 |  |

1. **Workplace family planning service related questions**

***Instruction***: *Do not use jargon terms or words and try to make sure participants do understand what you are asking or talking about.*

|  |  |  |
| --- | --- | --- |
| **Theme** | **Question** | **Probing points** |
| 1. **Common FP Problems** | What are the most common FP service related problems in your work place? | Unplanned pregnancy  Lack of supplies  Trained provider  Distance from facility |
| How common is unplanned or unintended pregnancy among your areas or colleagues? | Experience to be shared |
| What do you think are the consequences of unplanned or unintended pregnancy?  What do you think is the best solution to avoid such problems? | Morbidity (illness to woman)  Pregnancy risks  Timely utilization of FP methods |
| 1. **FP service availability** | Is there FP service delivery in your workplace clinic?  What types of FP service are provided in this workplace clinic? | FP counseling  Short-term contraceptives  Long-term FP methods  Referral to other health facilities |
| What has been the role of your company (employer) (*Industry name*) in providing FP services at this workplace? | Invites providers from other facilities  Availing FP services  Giving referral to other places for FP service |
| What do you think your company can do better to provide appropriate FP services in your workplace? | State the missing part |
| Do you think special efforts are needed to avail FP service at this workplace in addition to the services provided by public or private facilities in the community (rural-urban) outside this workplace? |  |
| 1. **Health seeking/service utilization** | When do you think a woman should seek for FP services to avoid unplanned pregnancy? | Immediately postpartum (after birth)  After six months |
| Where do you usually first go when you need FP services? | Workplace clinic  Public health centers  Other places |
| What is your opinion of the service being provided by the workplace clinic? | Quality of service in terms of:  -Availability of trained provider  -Method mix/choice  -Availability of equipment |
| Which FP/contraceptive method do you think should be widely available at your workplaces? Why? | Oral pills  Injectable  Long acting FP service  Permanent (sterilization)  Rumors  Side effects related to the method |
| What factors contribute to poor or low utilization of FP services by workers of this factory/farm? | Supplies,  Trained providers  Distance, cost |
| 1. **Quality of FP service** | What kind of FP services would you expect from health care providers at work places? | Quality issues? |
| What is your opinion or experience regarding the service providers’ approach in the health facilities in your workplace? | Respectful, client-centered  Culturally-sensitive  Youth-friendly practices |
| In your opinion, what are the characteristics of a good health service? |  |
| 1. **Role of partners and the community for FP service at workplace** | What is the role of community health promotors in your locality in reaching workers like you in providing FP services (IEC/BCC, counselling)? | Health education  Counseling  Contraceptives |
| Are there partners (NGOs) that have been providing FP services at this workplace? | Names of partners  Types of services provided  Frequency of service (routine/occasional) |
| 1. **Other FP related issues** | Do you have any other concerns related to FP services that you want to share with us? |  |
| What is your advice to the local government, health partners NGOs, the health professionals and the community to improve FP service at workplaces in factories, farms or other industries? |  |

END BY THANKING PARTICIPANTS!

## 

## Annex 4: Key Informant Interview Guide and Questions

**KEY INFORMANT INTERVIEW GUIDE: WORKPLACE-BASED FAMILY PLANNING SERVICE PROVIDERS OR MANAGERS**

***CORHA-Rapid Needs Assessment for FP Services in Selected Workplaces in Ethiopia***

**Objective** of the Key Informant Interview:

To gain perspectives, about workplace family planning services including service availability (supply, quality of service, method mix), not covered in detail by other instruments (survey questionnaire & FGD) but seen as having an important role in improving access to FP services.

***Instructions to the interviewer***: Questions are listed in the left-hand column. Possible probes are listed in the right-hand column. Wait for the interviewee to respond before asking any probes. Use your judgment when asking probes, adding necessary prompts, asking them out of order or omitting those that are not relevant.

To be read ***aloud***:

*Thank you again for agreeing to participate in this interview today. As we discussed, the purpose of our conversation is to learn about family planning services in your workplace (industry or farm). The ideas and information you will provide are very important to this survey and will help us understand the service gaps in such areas and make evidence-based decision.*

Ask the Key Informant if he has any objection in using tape recorder. Try to clarify everything to the informant and the ethical issues to be considered in relation to confidentiality.

Do you have any questions before we begin?

Date of interview: (dd/mm/yyyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of industry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Region \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of industry: 1. Public 2. Private

Interviewer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **The questions in this interview will be more like a conversation. I am interested in your thoughts and opinions on the topics I’ll be asking you about. There are no right or wrong answers. I won’t be writing down all of your responses, but I may take notes some times to make sure we accurately record what you are saying.** | | |
|  | **Main questions** | **Probing points** |
|  | What health related services are available at this facility? | * General medical services * Maternal and child health services * Family planning services * Youth SRH services * HIV/AIDS |
|  | In your opinion, what are the top five reasons for female workers to visit the clinic? |  |
|  | If no FP service has been provided, why? | * Trained provider * Supply related problems * No interested user * Low level of awareness of workers * Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | What FP methods are available at this facility? | Availability of:   1. Male/female condom 2. Oral contraceptive pills 3. Injectable 4. Implant 5. Intrauterine device (IUD) 6. Male sterilization 7. Female sterilization 8. Fertility awareness/standard days method (SDM) 9. Education on the lactational amenorrhea method (LAM) 10. Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Have you had stockouts of or expired family planning products in the past 3 months/ last week? | 1. Male/female condom 2. Oral contraceptive pills 3. Injectable 4. Implant 5. Intrauterine device (IUD)   Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | What days of the week is the clinic open and provide FP service?  What are the operating hours of the clinic? | (Monday, Tuesday………Sunday) |
|  |  |  |
|  | Which FP or contraceptive method is most commonly selected for use by workers? Why? | * Oral pills, Injectable, IUCD, etc. * Myths/misperceptions regarding other methods * provider bias, social norms, * Recommendation from friends/family * Availability of method mix * Availability of trained provider |
|  | Do you refer women to outside services? If yes, what are the top two health issues you refer workers for? |  |
|  | Are there fee(s) associated with certain methods? Are clients asked to cover costs related to FP services? Why? | * Types of methods paid for * Reasons for payment * What if the client cannot afford the payment |
|  | Do you think special effort or approach is needed to reach workers at factories or farms (workplaces) for FP services? Why? | * Challenges * Opportunities |
|  | Are you trained/do you have providers trained on FP? Which methods?  If Yes, when was the last time you were trained in providing the FP services?  Are there adequate number of trained staff to provide FP services? | * How many trained staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Areas covered: * FP basics * Individual and couples counseling * Youth-friendly services * Integration of FP services with other MCH services * Logistics/commodity management |
|  | Which methods are not being provided because of lack of equipment and supplies though you have trained providers? | * IUD * Sterilization * Insertion and removal * Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | What are the most common barriers for FP services in the workplace? | * Clients’ perspective * Providers’ perspective * Facility perspective (supplies and equipment, convenience on time of service provision) * Management issue (organizational policy, leadership awareness and commitment) * Geographic location (accessibility) |
|  | Do you have job aids to facilitate FP service provisions? What job aids are lacking? | * Guidelines (FP counseling, contraceptive) * Flipcharts, posters * Others, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_? |
|  | One of the major challenges in Ethiopia with regards to FP service provision is that some places like industry or farm centers (workplaces) are not easily reached. What are you doing to fill gaps or improve FP services at your workplace? | * Workplace FP policy * Staff training * Method mix * Partnership and networking |
|  | Is there any development partner (Civil Service Organization, Non-governmental or bilateral organization, donor) that is supporting your office in providing workplace FP services?  If any, what types of services are you receiving? | * Names of organizations providing support * Types of support (IEC/BCC, delivery of supplies and equipment, staff training) * Continuity of support |
|  | Overall, how do you judge the quality of FP service at your workplace?  Any areas of improvement you propose?  How? | * Method mix * Qualified provider * Logistics (method mix, equipment, supplies) * Refresher training for providers |
|  | Any support that you need from the government/MOH or NGOs? | * Training of providers |

**OBSERVATION:**

* Availability of health facility/clinic in the workplace (check for convenient space or classes, availability of weight scale, blood pressure apparatus, examination bed, etc.)
* Availability of job aids for family planning service (guidelines, posters, flipcharts, etc.)
* Signs on display that indicate types of services provided, hours of service, and/or fees

## 

## Annex 5: Facility Inventory checklist



## Annex 6: Family planning service availability by name of workplace

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of workplace** | **Condom** | **IUD** | **Implants** | **Injectable** | **Projestin-only pills** | **Combined OCP** |
| Kombolcha Textile | 1 | 0 | 1 | 1 | 1 | 0 |
| Kombolcha Steel Products Industry (KOSPI) | 1 | 0 | 0 | 1 | 0 | 0 |
| Debre Birhan Textile | 0 | 0 | 0 | 0 | 0 | 0 |
| Dashen Brewery | 1 | 0 | 0 | 0 | 0 | 0 |
| Waliya Korki Factory | 0 | 0 | 0 | 0 | 0 | 0 |
| Wonji Shoa Sugar Factory | 1 | 1 | 1 | 1 | 1 | 1 |
| Merti Fruits and Vegetable Processing Plant | 1 | 0 | 1 | 0 | 1 | 0 |
| MOHA Soft Drink S.C | 1 | 0 | 0 | 0 | 0 | 0 |
| Dangote Cement (Ethiopia) | 1 | 0 | 0 | 0 | 0 | 0 |
| Fafa Food Complex | 1 | 0 | 0 | 0 | 0 | 0 |
| Holeta Flowers PLC | 1 | 0 | 0 | 0 | 0 | 0 |
| Ethiopian Pharmaceutical Factory | 1 | 1 | 1 | 1 | 1 | 1 |
| Awash Winery | 0 | 0 | 0 | 0 | 0 | 0 |
| Anbesa Shoe Factory | 1 | 0 | 0 | 0 | 0 | 0 |
| Tabor Ceramic | 1 | 0 | 0 | 0 | 0 | 0 |
| Hawassa Chipwood | 1 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **13** | **2** | **4** | **4** | **4** | **2** |

## Annex 7: Team composition

BZY’s study team for this assignment comprised of individuals of Public Health and Demography backgrounds. Team members have proven experience on operations research and monitoring and evaluation of programs and projects. The Principal Investigator provided professional leadership, coordinated the activities of the study team; and communicates project development needs and tasks. The PI prepared action plans for the consultancy assignment; provided professional leadership to the survey and gave direction and/or developed and produced reports (Inception and Final).

For this assignment, three highly experienced data collectors were hired who were responsible for contacting the selected enterprises at Head Quarters and Filed Office levels, identification of study participants in consultation with the companies’ human resource units, facilitating the FGD, and interviewing the Key Informants, and transcription of the qualitative data. The data collectors worked closely with the study team and reported to the Lead Consultant.

**Table: Team composition, summary of qualifications and task assignment`**

|  |  |  |
| --- | --- | --- |
| **Name and area of expertise** | **Qualification summary** | **Tasks assigned** |
| **Yibeltal Tebekaw (PhD)**, Demographer, Public Health Expert and Researcher | The team undertaking this assignment will be led by YibeltalTebekaw (DPhil). Dr. Yibeltal has both Public Health and Demography background. He has BSc in Public Health and MSc in Population Studies with RH specialization from Addis Ababa University. He got his PhD in Health Studies from the University of South Africa, an internationally renowned University.  Dr. Yibeltal was working with different organizations including government Health sector, NGOs (Ethiopian Aid, Family Guidance Association of Ethiopia and International Training and Education Center for Health (I-TECH)) and World Health Organization at national and international positions. Currently, he is working for Jhpiego-Ethiopia in the capacity of Research Advisor for the Maternal and Child Survival Program (MCSP) based in Addis Ababa. He is responsible to lead the Research and Evaluation activities in the organization.  Dr. Yibeltal has ample experience on MNCH, SRH, Gender Based Violence and HIV/AIDS program management and research. He has built his professional qualification through short-term trainings including Global Program Management and Evaluation (by University of Washington), Health Finance Management, Analyzing Disrupted Health Systems in Countries in Crisis and others. He has also proven track of record on research on maternal and child health care, FP/fertility and women’s decision-making autonomy.  Previously, he has Worked as a team leader for multiple SRH projects, and as a Lead Consultant for consultancy services on situational assessments, final impact evaluations, mid-term evaluations, organizational capacity assessment, baseline surveys, and KAP assessments on SRH/HIVAIDS, GBV, STIs, FP, Immunization programs for different organizations. | Team leader researcher; coordinate overall activities; review relevant government policy documents; lead in data collection instruments development; supervise data collection, entry and cleaning; and participate in data analysis and report writing. He will also handle all administrative issues of the assignment. |
| **Muluneh Yigzaw (PhD Fellow, MPH)**, Public Health Expert and Researcher | Mr. Muluneh has BSc degree in Public Health and MPH in Epidemiology from Addis Ababa University.  Mr. Muluneh has worked as a clinician, as a person in charge of a Health Centre, and as head of HIV/AIDS and others STIs prevention program at North Shoa Health Department in Amhara Region. He has also worked as a Public Health Specialist for Merlin-Ethiopia, as a Research Coordinator for ICAP in Ethiopia and as a Project manager for EPHA.  Currently, he is working for Jhpiego-Ethiopia in the capacity of Research Advisor. He has marked background and experience in implementation research and evaluation of public health programs. He has participated in multiple research activities in Ethiopia, and published his research findings in local and international journals. He would be serving as a core team member in this evaluation particularly on review of relevant literatures and project documents, development of data collection instruments, designing data quality checks, data entry and analysis and write up of the draft report.. | Review relevant literature and project documents; assist in data collection instruments review and design; supervise data entry and cleaning; and participate in data analysis and report writing. |
| **Enumerators**: MA/MPH in Public Health, Sociology, and Economics | Those with rich experience on data collection community based surveys like DHS will be hired for this assignment | Collect household level data  Report challenges from the field |

1. Attride-Stirling J: Thematic networks: an analytic tool for qualitative research. Qual Res 2001, 1(3):385–405. [↑](#footnote-ref-1)