# *MULU WORKSITE HIV PREVENTION PROJECT*

***Cooperative Agreement No: AID-663-A-12-00005***

***Period of Performance: March 6, 2012 – Feb 28, 2018***

## *Final Report*

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## Acronyms

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| BCC | Behavior Change Communication |
| BoLSA | Bureau of Labor and Social Affairs |
| CLA | Collaborating, Learning, and Adapting |
| COP | Chief of Party |
| CSA | Charities and Societies Agency |
| CTC | Community Treatment Centers |
| DATIM | Data for Transparency and Impact Monitoring |
| DIC | Drop In Clinic |
| F/HAPCO | Federal HIV/AIDS Prevention and Control Office |
| FP | Family Planning |
| FSWs | Female Sex Workers |
| FY | Fiscal Year |
| HB | Health Bureaus |
| HIV | Human Immunodeficiency Virus |
| HTC | HIV Testing and Counseling |
| IEC | Information Education and Communication |
| ILO | International Labor Organization |
| IR | Intermediate Result |
| KRA | Key Result Area |
| LIP | Local Implementing Partner |
| M&E | Monitoring and Evaluation |
| MARPs | Most At Risk Populations |
| MoLSA | Ministry of Labor and Social Affairs |
| MOU | Memorandum of Understanding |
| NGO | Non-Government Organization |
| PE | Peer Educator |
| PEPFAR | The U.S. President's Emergency Plan for AIDS Relief |
| PITC | Provider Initiated HIV Testing & Counseling |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PPST | Pre-packed STI Treatment |
| PSI | Population Services International |
| PWCA | Participatory Worksite Capacity Assessments |
| QIT | Quality Improvement Team |
| RH | Reproductive Health |
| RHB | Regional Health Bureau |
| SBCC | Social and Behavior Change Communication |
| SOP | Standard Operating Procedure |
| STI | Sexually Transmitted Infections |
| TB | Tuberculosis |
| TF | Task Force |
| ToT | Training of Trainers |
| TWG | Technical Working Group |
| USAID | United States Agency for International Development |
| USG | United States Government |

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# I. Executive Summary

## 1.1 Background

In Ethiopia, the HIV/AIDS epidemic has for years been a threat to the country's ability to achieve economic growth, reduce poverty, and improve household and community wellbeing. The HIV/AIDS epidemic has typically affected individuals of working age, leaving every economic sector of the economy vulnerable to losses from decreased productivity, absenteeism, high staff turnover, and increased operational costs. Heterogenous in nature, the adult HIV prevalence was estimated at 1.5% in the 2011 DHS report, with a prevalence higher in urban areas (4.2%) than rural areas (0.6%)[1]. The prevalence in small towns, however, is as high as 9.6% for women and 2.3% for men[2].These towns are often marketplaces and trading centers, many having emerged near large-scale industries and within mega development clusters such as Humera and Metema. These newly emerging towns attract economic migrants in search of work and function as a bridging population between cities and rural areas, with a high rate of HIV prevalence.

Individuals, separated from their families and social support networks are more likely to engage in transactional or commercial sex, a significant risk factor for acquiring HIV and other STIs. Many individuals fail to seek treatment for STIs, whether due to a lack of medical services in and around large-scale worksites, a lack of awareness, or an aversion to testing and treatment. Peer pressure and social conformity also contribute to the risk of acquiring HIV[3]. The use of *khat* and alcohol fuel the transmission of HIV in and around workplace sites. Additionally, women working in large-scale worksites are often young, and are at a higher risk of sexual exploitation and gender-based violence, and by engaging in cross-generational sex or transactional sex increase their vulnerability to HIV.A lack of medical services in and around large-scale worksites is another factor that can increase the transmission of HIV.

Amidst this backdrop, in March of 2012, the U.S. Agency for International Development (USAID) contracted World Learning to implement the MULU Worksite HIV Prevention Project (MULU Worksite) to complement MULU MAPRs and provide integrated biomedical, behavioral, and structural services. MULU Worksite focused on improving HIV preventive behaviors within and around large-scale workplace, increasing the availability and accessibility of RH and HIV prevention services and commodities, and building the capacity of public and private large-scale worksites to support HIV prevention and RH services within and around large-scale workplaces. MULU Worksite strengthened HIV prevention endeavors in selected worksites with over 500 employees, supported needed policies and programming to strengthen the HIV/AIDS response, and contributed to the Ethiopian government's goal of reducing new HIV infections by 50%.

World Learning led an international consortium including Population Services International (PSI), FHI 360, along with an additional partner International Labor Organization (ILO), which did not receive funds as part of the MULU Worksite award. The project also worked in close partnership

[1] World Bank. HIV/AIDS in Ethiopia: An Epidemiological Synthesis. April 2008

[2] CSA and ORC Macro. Ethiopia Demographic and Health Survey. Addis Ababa and Maryland, USA; September 2006

[3] Astar Advertising and World Learning. Formative Assessment Report for HIV Prevention in Large-Scale Construction Sites (EEPCO, MOWE and ERA). August 2009.

with regional HIV/AIDS Prevention and Control Offices (HAPCOs), health bureaus (HB), the national Ministry of Labor and Social Affairs (MoLSA), regional Bureaus of Labor and Social Affairs (BoLSA), and zone and *woreda* Labor and Social Affairs offices.

### 1.2 Project Overview

MULU Worksite started on March 6, 2012 and ended on February 28, 2018. Throughout its implementation, the project utilized a comprehensive strategy including biomedical, behavioral, and structural interventions that enabled workplaces to integrate, mainstream and effectively manage HIV prevention services in workplace settings. "MULU" in Amharic means "complete", referencing the comprehensive scope of the prevention interventions under the program. MULU is functioned as an acronym denoting the USG's and its partners' commitment to:

*An employee at Zeway Roses PLC, a worksite in the Oromia region with over 20,000 employees*

- **M**itigate the impact of the epidemic,
- **U**nderstand the dynamics,
- **L**everage resources, and
- **U**nite efforts to reduce the incidence of HIV in Ethiopia

The projects expected results and key objectives were:

- IR 4.1 - Improved HIV preventive and health-seeking behaviors within and around large-scale work places;
- IR 4.2 - Increased availability and accessibility of RH and HIV prevention services and commodities within and around large-scale workplaces;
- IR 4.3 - Improved capacity of public and private large-scale workplaces to support HIV prevention and RH services and large-scale workplaces

To achieve the afore-mentioned interrelated result areas, MULU Worksite developed an assessment tool to collect profiles of the worksites and produced a Rapid Assessment Report; focused on identifying behavioral risk factors and associated practices. Similarly, MULU Worksite conducted a biomedical mapping exercise to identify and work with potential worksite clinics for HTC, STI, TB, and RH service provision and referral networking activities. These mapping and forecasting exercises set the stage for developing appropriate criteria for site selection. The project, in consultation with USAID and partners initially selected 94 large scale public and private worksites representing agriculture, horticulture, textile, leather, cement, dam and irrigation

construction and other economic sectors. Over the course of the project, MULU Worksite accomplished a range of comprehensive HIV prevention services in 88 worksites; nine worksites were bankrupted due to various reasons and the interventions in these nine worksites were interrupted prematurely in consultation with USAID.

Through the continuous assessment and follow-up, the project also made a strategic shift to address the growing populations of workers in the northern and northwestern development corridors of Humera and Metema. These workers are highly mobile, predominantly male, and are at significantly higher risk of HIV than the general population due to their isolation from traditional social support systems, use of alcohol and khat, and the presence of female sex workers. World Learning' strategic shift project resources to focus on these new populations was emblematic of its Collaborating, Learning, and Adapting (CLA) management approach. World Learning worked closely with USAID, government stakeholders including Ethiopia's Ministry of Labor and Social Affairs (MoLSA) and Ethiopia's federal HIV/AIDS Prevention and Control Office (HAPCO), and the worksites themselves to ensure efficient and effective project implementation. This transition enabled World Learning to reach thousands of new, high-risk individuals, while increasing the yield of HIV positive testing results and the project's overall efficacy and efficiency.

As part of this strategic shift towards northern and northwestern Ethiopia, World Learning also began to focus on working with both key and priority populations within given catchment areas, those areas covered by a specific health facility such as a hospital or treatment center. Following, World Learning built clear and strong linkages between testing centers, health care providers, and worksites. World Learning worked closely with the existing health structures to access the technical support and local expertise necessary to guide our efforts in these new locations.

Additionally, by working within geographic areas rather than targeting only specific populations World Learning was able to reach individuals working in different development sectors, including male and female employees, workplace supervisors and managers, as well individuals from the surrounding communities including female sex workers.

This ability to reach different populations and high risks groups was essential in World Learning's efforts to contribute to the President's Emergency Plan for AIDS Relief (PEPFAR) 90-90-90 goals in Ethiopia. The "Triple 90" goals are that by 2020 90% of all people living with HIV will know their HIV status, 90% of all people diagnosed with HIV infection will receive sustained antiretroviral therapy (ART), and 90% of all people receiving ART will have viral suppression. MULU Worksite contributed most directly to the first two goals: testing individuals for HIV and connecting those who test positive with the treatment they need to lead a healthy life.

Led by World Learning, the MULU consortium included two international partners, Population Services International (PSI) and Family Health International 360 (FHI360). PSI, a leading non-profit public health organization with vast experience in procurement and distribution of condoms and STI treatment kits brought an organizational capacity and global experience necessary to successfully distribute the necessary prevention commodities. FHI360 provided technical assistance to the World Learning technical team in the design and development of MULU

*Peer Education at the Suntu Coffee Farm*

Worksite's Social and Behavior Change Communications (SBCC) materials and strategy. ILO, also supported the project, helping to develop practical guidelines to introduce gender-sensitive HIV/AIDS policies to Ethiopian enterprises, ensuring that new policies met international standards for each sector.

World Learning also worked closely with a cohort of Local Implementing Partners (LIPs) including, Beza Posterity Development Organization (BPDO), Initiative for Health Development in Africa (IHDA), Love in Action (LIA), New Millennium Health Development Organization (NMHDO), and the Organization for Social Services for AIDS in Ethiopia (OSSA). These LIPs were essential to the success of MULU Worksite, enabling World Learning to efficiently and effectively expand its geographic reach. With these partners, both international and local, MULU Worksite was able to support and further the HIV prevention work already being done by the government of Ethiopia, building constructive partnerships at the zonal, regional, and national level to implement a coordinated, multi-sectoral intervention against HIV/AIDS in Ethiopia.

### 1.3 Key Achievements

MULU Worksite's life of project achievements realized the objectives set forth by USAID in our PMP, while also supporting Ethiopia's commitment to the Triple 90 goals and their goal to end AIDS in Ethiopia by 2030. MULU Worksite worked in support of these objectives to create a healthier and more prosperous future for the country through an integrated HIV prevention and treatment program focused on employees working in large scale worksites and the surrounding communities. Find some of MULU Worksite's primary accomplishments listed below:

| **Indicator** | **Life of Project Targets** | **Life of Project Achievements** | **% Complete** |
|---|---|---|---|
| **IR 4.1 HIV preventive including health-seeking behaviors impro1ved within and around large-scale workplaces** | | | |
| *KRA 4.1.1 Reduced HIV risk practices of workers and members of surrounding communities* | | | |
| P8.11.N: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months | Decrease by 3% | Pending Final Evaluation | NA |
| P8.12.N: Percent of women and men aged 15-49 who have had more than one sexual partner in the last 12 months and reported the use of a condom their last sexual intercourse | Increase by 10% | Pending Final Evaluation | NA |
| *KRA 4.1.2 Improved knowledge of HIV prevention and transmission methods* | | | |

| | | | |
|---|---|---|---|
| Percent of women and men who have comprehensive knowledge about HIV transmission, misconceptions & prevention methods | Increase by 3% | Pending Final Evaluation | NA |
| Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required | 1 million | 886,627 | 88.7% |
| Number of Key Populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards | 10,480 | 10,309 | 96.4% |
| Number of type of peer education manual adapted/developed | 4 | 4 | 100% |
| Number of peer educators trained | 10,000 | 5150 | 51.5% |
| P8.5.D; Number of individuals from target audience who participated in community-wide event | 456,000 | 424,428 (313, 871 M & 110,557 F) | 93.1% |
| *KRA 4.1.3 Increased access to HIV/AIDS prevention information and education* | | | |
| Number of IE/BCC materials distributed | 380,000 | 903,345 | 237.7% |
| Number of mini-medias established in worksites to support interpersonal communication | 40 | 40 | 100% |
| SITE_SUPP Number of PEPFAR supported DSD and TA sites | 100 | 89 | 89% |
| **IR 4.2 Increased availability and accessibility of RH and HIV prevention services and commodities within and around large-scale workplaces** | | | |
| *KRA 4.2.1 Strengthened capacity of worksite clinics to provide MARPs-friendly HIV and RH services* | | | |
| Percent of individuals who received an HIV test in the last 12 months and received their test results | Increase by 10% | Pending Final Evaluation | NA |
| Percent of workplaces with HIV clinical service packages | 100 | 88 | 88% |
| Percent of workplaces providing HIV, FP counseling, and STI services with trained service providers | 100 | 88 | 88% |
| Number of workplaces with established quality assurance systems for HIV and STI services | 50 | 88 | 176% |
| P8.4.D; Number of targeted condom service outlets | 600 | 2730 FY17<br>781 FY16<br>781 FY15<br>600 FY14<br>68 FY13 | 455% |
| H2.3.D; Number of health care workers who successfully completed an in-service training program | 700 | 1566 | 223.7% |
| Number of condoms distributed | 12,500,000 | 11,734,650 | 94% |
| Number of individuals who received testing and counseling (HTC) services for HIV and received their test results. | 446,367 | 387,769 (272,845 M & 114,824 F) | 86.9% |
| Number of clinic clients who are using a family planning method in the reporting period | 70,900 | 202,181 | 285.2% |
| Number of clinic clients who are treated for an STI | 13,750 | 342,359 (235,275 M & 107,084 F) - 4,703 (2,031 M | 2489.9% |

| | | | |
|---|---|---|---|
| | | & 2,672 F) tested positive | |
| *KRA 4.2.2 Strengthened linkages and referral system to surrounding public-private service outlets in improving access to HIV/AIDS, STIs and RH services* | | | |
| Percent of individuals tested positive for HIV and received referrals for care and support in the last 12 months | 100% | 100% | 100% |
| Percent of individuals who tested positive for HIV and received referral services at referral accepting facilities in the last 12 months | 90% | 93% FY 18<br>87% FY 17<br>82% FY 16<br>83% FY 15<br>79% FY 14<br>75% FY 13 | Reached over 90% in FY18 |
| Number of established referral linkages between workplace sites and public-private care, treatment and support sites | 100 | 88 | 88% |
| Number of workplaces and surrounding health facilities supplied with referral directories | 200 | 195 | 97.5% |
| LAB_CAP: Number of PEPFAR supported testing facilities with capacity to perform clinical laboratory tests | 50 | 51 | 102% |
| **IR 4.3 Role and capacity of public and private large-scale workplaces improved to support HIV prevention and RH in large-scale workplaces** | | | |
| *KRA 4.3.1 Strengthened capacity of workplace management to support workplace HIV prevention programs* | | | |
| P10.1.D: Number of enterprises implementing an HIV/AIDS workplace program, providing at least one of the 4 critical components | 100 | 88 | 88% |
| Number of worksites with an allocated budget for HIV activities | 75 | 34 | 42% |
| Number of workplaces with record keeping systems for monitoring HIV/AIDS interventions | 100 | 88 | 88% |
| Number of workplaces with established HIV/AIDS task forces/committees | 100 | 88 | 88% |
| Number of workplace managers and taskforces trained on workplace HIV/AIDS programs | 500 | 523 | 104.6% |
| *KRA 4.3.2 Strengthen mainstreaming of HIV/AIDS programs into workplace core business practices* | | | |
| Number of workplace with gender sensitive HIV/AIDS policies adapted/developed | 100 | 81 | 81% |
| Number of targeted worksites that complete a facilitated assessment of capacity to implement workplace prevention programs | 20 | 20 | 100% |

World Learning made significant progress reaching aggressive testing, peer education, and commodity distribution targets. However, due to the premature closure of several worksites, a strategic shift to focus on high-risk populations, and an inconsistent supply of condoms and HIV test kits MULU Worksite was unable to reach some targets.

World Learning, in collaboration with worksite management was able to establish HIV/AIDS task forces at 88 worksites. Following, 81 worksites adopted gender sensitive HIV/AIDS policies, while 34 worksites allocated budget for HIV/AIDS activities. World Learning worked consistently

to encourage worksites to create sustainable budgets for HIV/AIDS activities and made significant progress in the final two years of the project, however many worksites were unable to dedicate resources, instead relying on strong linkages to government and private health care facilities.

A desire to ensure maximum efficiency and efficacy for the project led USAID to recommend a more targeted approach focused on large-scale agricultural areas in the north and northwest of Ethiopia. World Learning developed new peer education, testing, and referral modalities to effectively reach these mobile populations. Due to the seasonal nature of these development clusters, a lack of HIV tests and condoms during peak-season had a significant impact on World Learning's ability to reach testing targets.

Focusing on these development clusters reduced the total number of intervention worksites while increasing the positivity rates for testing. World Learning was able to consistently increase the "yield" of HIV-positive individuals throughout the life of project, largely due to more targeted testing in high-risk areas in Humera and Metema. In total, 4,697 (1.21%) were found to be first time HIV positives with a 0.87% (2,385) male and 2.01% (2,312) female positivity rate.

Moving forward, there is considerable reason to expect that MULU Worksite's achievements will be sustained after the project's completion. Worksites' Task Forces, Peer Educators, health workers and management have developed the technical ability and capacity to work collaboratively to plan, implement, and monitor combination HIV prevention services. Worksite management staff demonstrated a significant and sustained commitment to HIV prevention efforts. They integrated these services into their core business, allocating time for small group peer education sessions, participating actively during organizing HTC events, and coordinating transportation to link HIV positive individuals to treatment centers. Additionally, continued coordination between worksites and *woreda* HAPCOs in planning, implementing and monitoring the HIV prevention efforts portends for future effectiveness.

### 1.4 Challenges, Lessons Learned, and Recommendations

#### Challenges

MULU Worksite encountered several challenges over the course of the project period that influenced implementation, however through effective management, World Learning was able to identify and implement solutions to minimize their impact. Successfully identifying and addressing these challenges was critical to the overall success of MULU Worksite.

- **Rapid Test Kits** – An inconsistent supply of test kits and regular changes to the HIV testing algorithm was a persistent challenge to the MULU Worksite team, leading the cancellation of planned testing events and lacking distribution.
- **Referral Rate** – World Learning worked to increase confirmed referral rates by accompanying individuals and engaging ART focal persons at testing locations. Individuals preference to seek treatment outside of their catchment area remained a challenge.
- **Worksite Staff Turnover** – High rates of turnover at intervention worksites, especially at the managerial and supervisory level required a significant additional effort to ensure consistent services at worksites and worksite clinics.

- **Epidemiological Data** – A lack of worksite specific epidemiological data hampered efforts to plan effectively and ensure maximum efficiency, especially as it related to HIV testing.

**Lessons Learned**

Throughout implementation of MULU Worksite, World Learning was able to continually adapt its approach, refine its implementation, and focus its efforts to ensure overall project efficacy and efficiency. This experience provided World Learning an opportunity to share lessons learned to future funders and implementers.

- **Integrated Service for Key and Priority Populations** – By combining services for Key and Priority populations, World Learning was able to reach important communities that were previously not being provided necessary education, testing, counseling, or treatment services.
- **Catchment Area Approach** – Utilizing a geographic approach was necessary to properly integrate MULU Worksite services into the existing private and public health infrastructure.
- **Highly Mobile Populations** – In the course of project implementation, World Learning realized the need to provide services to mobile and semi-mobile populations in addition to stable worksite populations. World Learning designed new modalities of outreach, peer education, and testing to effectively reach these mobile populations.
- **Peer Education's Effectiveness** - Peer education was an essential part of project intervention, addressing the needs of worksite populations and FSWs.
- **Worksite Capacity Building** - Due the varied nature, sector, and size of worksites. World Learning used a variety of strategies to build and maintain the capacity of worksites to enact necessary HIV prevention strategies.

**Recommendations**

As a result of World Learning's experience implementing MULU Worksite, the project team created recommendations to guide potential future research, implementation, and evaluation of HIV programming in workplace settings.

- **Strengthened Partnerships –** Building and maintaining strong relationships with woreda, regional, and national partners was essential to the success of MULU Worksite. Additionally, World Learning's ability to work collaboratively with Local Implementing Partners increased the project's efficacy and efficiency while building the capacity of local organizations to sustainably carry on HIV prevention work in the future.
- **Prioritize Growing Industrial Zones** – As Ethiopia's industrial economy continues to grow and evolve it is essential that future HIV prevention efforts target growing industrial zones and large agricultural areas to reach high-risk populations.
- **Site Selection Criteria** – Utilizing updated epidemiological evidence to better inform site selection will ensure that future HIV prevention and treatment implementation provides targeted services while attaining the maximum yield of HIV positive individuals.
- **Rapid Test Kits** – A steady supply of necessary health commodities, and specifically test kits, is critical to successful implementation.
- **New Treatment Modalities** – Building off progress made during MULU Worksite, the project team believes it necessary to continue to develop treatment modalities which can best serve

geographically and structurally diverse priority populations, including the use of Community Treatment Centers (CTCs) and Drop-in Centers (DICs).

## II. Implementation Strategies & Approaches

*An employee working in irrigation construction at a MULU Worksite*

World Learning utilized a consistent management approach and integrated technical strategy to ensure the efficacy and efficiency of MULU Worksite throughout its implementation. At its foundation, MULU Worksite was guided by a recognition that providing an integrated combination of HIV prevention services was critical to Ethiopia's achievement of the Triple 90 goals. MULU Worksite was structured around three pillars: Behavioral, Bio-Medical, and Structural interventions, closely aligned with its three intermediate results, improving HIV preventive behaviors, increasing the availability and accessibility of RH and HIV prevention services and commodities, and improving the role and capacity of public and private large-scale workplaces to support HIV prevention and RH.

World Learning's management approach was designed to ensure the effective implementation of this three-pillar technical strategy. World Learning committed itself to utilizing the CLA Framework to inform project implementation. By collaborating with international partners, local implementers, and government stakeholders, World Learning maximized efficacy while supporting long term sustainability. MULU Worksite was able to refine our approach, making the strategic changes necessary to reach the highest risk populations. This framework was essential for strengthening the three pillars of our technical approach.

### 2.1 Technical Strategy

#### Worksites

World Learning and its partners maintained a strong commitment throughout the project to ensure an effective and sustainable intervention at every worksite. Thus, site selection was of critical importance to the project's success. following a comprehensive mapping and forecasting exercise during the first month of the project. In consultation with USAID, government partners and available data, World Learning initially selected 94 large scale (over 500 employees) public and private worksites representing agriculture, horticulture, textile, leather, cement, dam and irrigation construction and other economic sectors.

Work sites were selected from all the targeted regions, but selection emphasized high-prevalence regions in order to be responsive to the epidemic's regional variation and maximize impact of the project. The site selection process took into account:

- Regional balance (with an emphasis on regions with high HIV/AIDS prevalence rates)
- Sectoral diversity and balance (such that each targeted sector is fully represented)
- The size and mobility of the work force

The weighting system for selection is detailed below:

| Core Criteria | Definition | Value |
|---|---|---|
| 1) High Risk Environment | | 27% |
| 1.A Proximity to hot spots | Presence of FSW, other MARPs in the nearby hot spot areas, local drinking establishments | |
| 1.B Mobile/seasonal workers | Seasonality, demographics (gender, age, marital status), | |
| 2) Isolation from social structures | Geographic location, distance, accessibility, hard-to-reach areas | 21% |
| 3) High HIV prevalence nearby town/ worksite health facility | PITC data from work site clinic, prevalence from nearby town, ART data at worksite | 15% |
| 4) Limited access to HIV combination prevention | Absence of other donor supported programs working on HIV treatment, prevention or mainstreaming activities | 12% |
| 5) Willingness & commitment of site management | Willingness to assign focal person, allocate time for PE and readiness to take over the at the end of project | 15% |
| 6) Regional priority | HIV prevention priority and evidence for a sound justification | 10% |

**Behavioral:** MULU Worksite reduced high-risk behavior and improve health-seeking behavior among key target groups through an evidence-based behavior change strategy focused on empowering individuals through peer education. World Learning utilized a cascade model, training multiple Trainer of Trainers (TOT) who then trained male and female peer educators responsible for leading small group and one-to-one HIV prevention activities, organizing mini-media message dissemination, and motivating their peers to build a larger community commitment to safe and healthy sexual behavior. These peer educators functioned as early adopters of healthy behavior patterns and thus were able to serve as role models for the communities.

As part of this peer education process World Learning helped to build a health-aware and health-promoting culture at worksites and in communities throughout Ethiopia. Participants in the peer education process learned to embrace safer sexual practices, question traditional gender norms that put women at increased risk, as well as how to access condoms, HIV Testing & Counseling (HTC), and treatment for Sexually Transmitted Infections (STIs).

MULU Worksite developed and utilized a Social and Behavior Change Communication (SBCC) strategy in consultation with FHI360, preparing three peer education models tailored to the availability of differing worksite populations, including stable, semi-mobile, and highly mobile.

In addition to peer education World Learning also utilized community edutainment, mini media, and SBCC material distribution to improve the HIV prevention behaviors as well as health seeking behaviors in and around large-scale workplaces.

World Learning and FHI360 developed IEC/BCC materials tailored to each target group, with the following seven behaviors were promoted for all target groups:

- Correct and consistent condom use
- Reduction in the number of partners and avoiding multiple concurrent partnerships.
- Avoiding cross-generational sexual contacts.
- Accessing HIV testing services and disclosing test results to partners.
- Seeking prompt treatment for STIs.
- Restricting or eliminating use of alcohol and khat.
- Showing acceptance of people living with HIV and other stigmatized people (e.g., those with physical disabilities) without bias or discrimination.

MULU Worksite mobilized 424,428 (313,871 Male & 110,557 Female) workers through large group edutainment and distributed 903,345 IEC/BCC materials for employees and surrounding communities of various types (leaflets, posters and stickers) with HIV prevention messages. In total World Learning reached a total of 886,627 (803,627 Male and 83,353 Female) individuals through peer led small group discussion using the standardized curriculum. The project reached a total of 10,309 Female sex workers in selected hotspot towns around Humera and Metema development corridors through peer led small group discussion using a standard curriculum.

**Biomedical:** The MULU Worksite strategy sought to achieve impact by improving both the supply of and the demand for condoms, RH services and other biomedical prevention services. World Learning and its partners utilized a variety of strategies to increase the supply of quality supplies, services, and commodities.

*A condom dispensary location at one of the MULU Worksites*

World Learning, early in the project, conducted an assessment finding that many worksite health clinics were not capable of providing satisfactory HIV testing and treatment services. As a result, World Learning identified and supported on-site clinics to improve their capacity to provide biomedical and clinical services to their respective workforces. These clinics provided targeted HIV testing and linkage services, screening for STIs/TB, while also maintaining a steady supply of necessary health commodities. In total, MULU Worksite distributed 11,734,650 male condoms. World Learning also implemented a targeted HIV testing service using an outreach

modality while still ensuring referral linkages to treatment centers for those who tested positive. These events were planned in coordination with worksite management and woreda level HAPCO offices to ensure maximum effectiveness.

Throughout the project, STI screening services were provided to 342,359 (235,275 Males & 107,084 Females) individuals; of whom 4,703 (2,031 Male and 2,672 Female) were screened positive and referred to worksite clinics and other public/private facilities for treatment. 202,181 (128,241 Male and 73,940 Female) individuals were counseled for family planning. TB Screening was provided for 308,145 (211,979 Male and 96,166 Female) individuals, based on the national screening protocols. Of those screened, 1,254 (798 Male and 456 Female) tested positive and were referred for further assessment and management.

Linking HIV positive individuals to care and treatment services was a challenge in some workplace settings, especially in hard to reach areas. World Learning made a concerted effort to improve confirmed linkages to treatment centers, seeking to overcome inaccessibility, client refusals, and client's preference to seek services outside the testing catchment areas. During outreach testing events MULU Worksite included an ART focal point, case manager, and adherence counselors as part of the testing team, which helped to ensure that those who tested positive for HIV would be immediately connected with community HIV treatment services.

Joint planning with district HAPCO and health facility staff tasked with monitoring outreach testing events was also essential to improving linkage to treatment, care, and support services. In doing so, World Learning was able to directly contribute to the goal that 90% of those who test positive for HIV are able to access antiretroviral therapy. Due to these efforts, the rate of confirmed linkages increased throughout the life of project, such that over 93% of individuals who tested positive had a confirmed referral in FY18.

**Structural:** MULU Worksite conducted a participatory assessment of each company's existing capabilities, and then designed and executed a carefully tailored skills-building program that enabled them to implement HIV/AIDS policies. The assessment utilized in MULU Worksite was informed by World Learning's Participatory Institutional Analysis, a unique performance assessment tool and organizational capacity development framework. As part of this assessment, worksites were challenged to develop a strategic action plan focused on improving their capacity to support HIV prevention in their workplace. Following, HIV/AIDS Task Forces were established and trained on HIV mainstreaming, monitoring, quality recording, and reporting practices, as well as on gender's significant role in the overall reduction of new HIV infections.

*Gizework Haile (far right), Site Coordinator and Clinic Head with other clinic staff*

World Learning assisted 81 worksites to develop gender sensitive HIV/AIDS and discrimination policies in line with international standards and local recommendations. These HIV/AIDS policies outlined each worksite's response to the AIDS epidemic, set a foundation for a workplace prevention, care and treatment program, and defined the steps for its implementation. They specified workplace HIV prevention practices as well as procedures for supporting employees already affected by HIV/AIDS and for combating stigma and discrimination. The policies were meant to guide managers and supervisors on how to handle HIV/AIDS related issues among those they were responsible for; and inform employees about their rights, assistance available to them, and their responsibilities and expected behavior (i.e. nondiscrimination or gender equity).

MULU Worksite also assisted 88 worksites to establish an active HIV/AIDS Task Force (TF) and Quality Improvement Team (QIT) and followed the functionality of TF and QIT through supportive supervision and mentoring. Additionally, World Learning established AIDS funds in 34 worksites to finance HIV prevention, care and treatment efforts. These two results highlight MULU Worksite's long-term sustainability, creating lasting change throughout Ethiopia by building the capacity of individuals, creating new management structures, and funding mechanisms to ensure an effective effort against the HIV/AIDS epidemic in Ethiopia.

### 2.2 Management Approach

**Decentralized Operations:** World Learning decentralized operations from Addis Ababa office and instead opened several regional offices to efficiently manage and support the implementation of combination HIV prevention activities in a given catchment area and population. Cognizant of the ambitious life of project (LOP) targets, MULU worksite engaged five local implementing partners including: Beza Posterity Development Organization (BPDO), Initiative for Health Development in Africa (IHDA), Love in Action (LIA), New Millennium Health Development Organization (NMHDO), and the Organization for Social Services for AIDS in Ethiopia (OSSA). LIPs organized testing events, provided peer education trainings, and distributed HTC in hard to reach areas and worksites with seasonal workforces. Through joint planning World Learning built the capacity of LIPs and efficiently reach project targets.

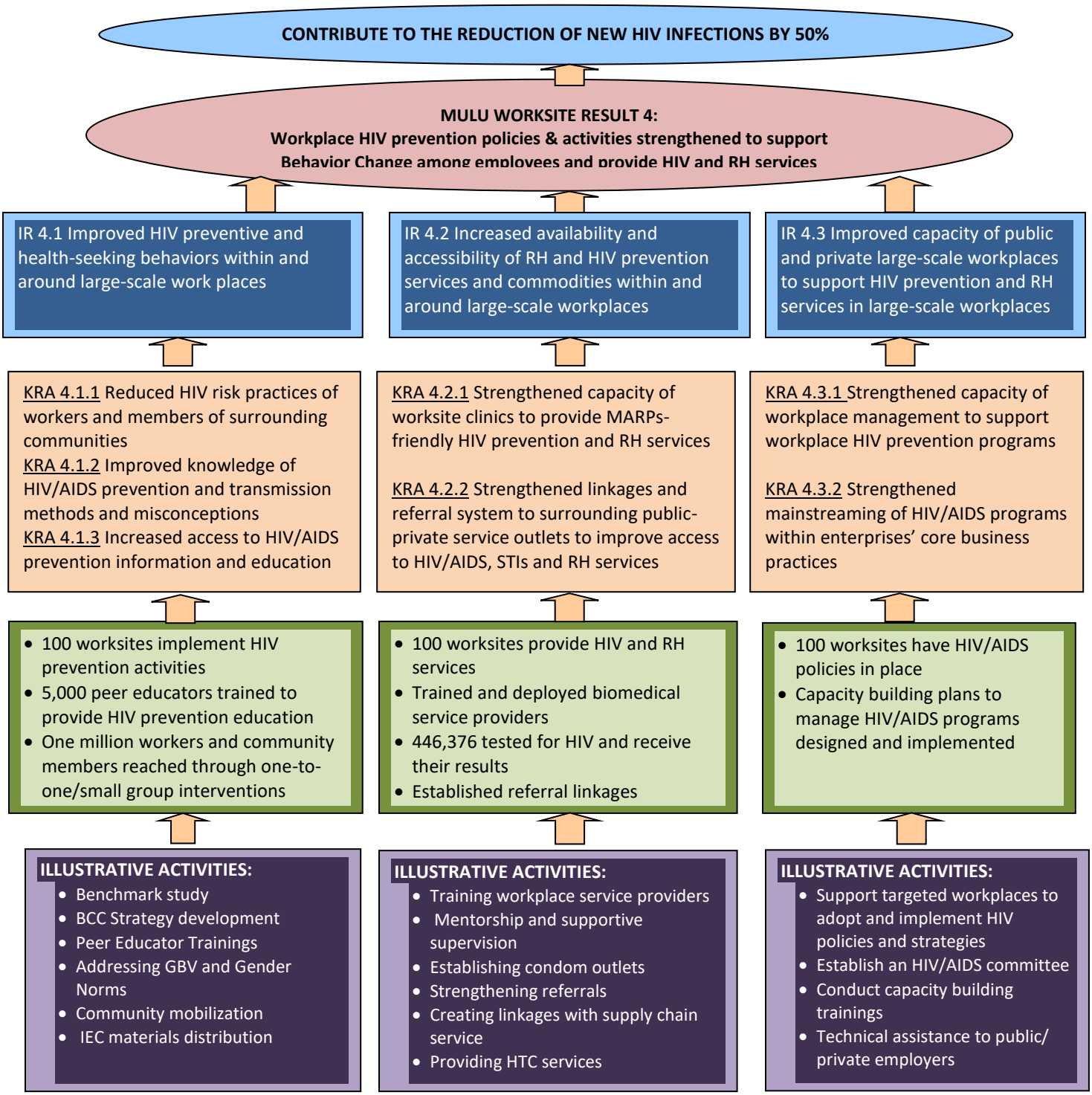
**Partnerships & Coordination:** MULU Worksite worked closely with USG and non-USG partners, including the MULU MARPs Project to share resources, expertise, and detailed implementation strategies to ensure targeted testing and service linkages. The project management team organized multiple meetings with LIPs and project offices to review performance and implementation strategies and refine approaches and service delivery models. Similarly, joint planning meetings were held with woreda HAPCOs to and review of implementation strategies and align the project's testing plan with new PEPFAR guidelines that demanded an improved HIV testing yield as a contribution to the Triple 90's. The MULU Worksite team also participated in regular activity management meetings with USAID/E HIV Team Lead and the project's designated AOR to exchange updates and improve program performance.

## III. Project Monitoring, Evaluation and Learning

MULU Worksite worked continually through the life of the project to support efforts to reduce new HIV infections by 50%. While other projects focused on different populations, World

Learning's desired result was: "Workplace HIV prevention policies & activities strengthened to support behavior change among employees and provide HIV and RH services." MULU Worksite was guided by a Results Framework designed around the three pillars of our intervention: behavioral, biomedical, and structural, each corresponding to one of three intermediate results. Find a detailed representation of our results framework below:

### 3.1 MULU Worksite Results Framework



### 3.2 Project Monitoring

The MULU Worksite project established a robust M&E system to guide HIV prevention programming and inform evidence-based and responsive program intervention. Collecting data, performing data quality checks, and regularly conducting supportive supervision visits all helped to ensure the validity of our data and ensure that World Learning made the most informed decisions possible.

MULU Worksite's Performance Monitoring Plan was the cardinal working document that guided the project's overall M&E functions at each level of implementation. World Learning developed a suite of M&E documents and tools throughout the life of the project, including an M&E guide for project staff, the M&E guide for worksite Site Coordinators, the M&E guide for Peer Educator, the Unified Reporting System-Database, and other Data Quality Assurance manuals. This package of M&E tools served to measure program performance and quality improvement activities at all levels. It had also helped to strengthen the capacity of the HIV/AIDS taskforces and LIPs, enabling them to monitor their own progress and evaluate the effectiveness of their activities. Multiple integrated supportive supervision and mentoring activities were carried out to implementation sites, local implementing partners and key stakeholders to ensure quality program implementation using standard checklists.

The MULU Worksite M&E team systematically tracked progress relative to targets and identify necessary programmatic changes or corrective actions to improve performance. The M&E team ensured that the information generated was not only accurate and verifiable, but also relevant and actionable, enabling World Learning to properly manage MULU Worksite within the CLA framework. MULU Worksite developed a user-friendly SQL database that was well aligned and synchronized with the PEPFAR Data for Transparency and Impact Monitoring (DATIM) to be responsive to data quality standards and reporting requirements. MULU Worksite submitted quarterly, semi-annual and annual reports, to USAID, MoLSA, FHAPCO, RHAPCO/RHB and BoLSA on a regular basis. MULU worksite regularly conducted a detailed expenditure analysis (EA) using the USAID's format to inform its program implementation and regularly submitted its annual EA report as per the donor's requirement and standard.

MULU Worksite was careful to develop gender sensitive M&E guides and disaggregate data by gender and age to ensure that women were proportionally represented as peer educators, discussants, biomedical service users, and members of HIV mainstreaming task forces. In addition, the MULU Worksite project collected gender sensitive data from HIV testing sites to specifically analyze gender and other demographic related risk factors for HIV.

In addition to understanding the demographic risk factors for HIV, the project also conducted a mapping and size estimation exercise to identify hotspot locations and populations based on perceived and observed risks. The project collected the Global Positioning System (GPS) coordinates from each worksite, along with updated workforce size, number of target groups received HIV combination intervention services. Based on these information, a program coverage map was developed to understand the density of the target groups in each project worksite. This process enabled MULU Worksite's senior management team to develop and revise its targeted HIV testing strategies and implementation models for a better, yield-oriented result.

In order to ensure data quality, World Learning utilized a variety of strategies to audit, review, and improve the project's data collection, management, and analysis procedures. It was a regular practice to conduct routine data quality audits (DQAs) to ensure the accuracy and validity of all data as per requirements and the project's DQA guideline. Key indicators of the PMP that were essential to PEPFAR's reporting mechanism were selected for routine DQAs, generating a report which was shared with the central office and regional teams to ensure high quality data.

As an integral part of its continuous quality improvement endeavors, MULU Worksite project organized quarterly, semi-annual and annual performance review meetings with project staff, key stakeholders and LIPs to evaluate progress against targets and the implementation plan, identify new challenges and develop plans to overcome them in a timely fashion. The project also conducted multiple sessions on performance improvement planning with Peer Educators and Site Coordinators to encourage them through a performance appraisal system where role models are identified and get motivated. These review meetings helped volunteers to share experiences and updates with their peers as well as from quality assurance and mentoring officers.

**Documentation of success stories and best practices:**

The project documented and shared best practices and success stories in coordination with regional offices to reflect beneficiary's perspectives on the project significance. A selected number of success stories are detailed in Section 4.4 of this report. A documentary film that covered a wide range of project services and interventions was produced with the objective of documenting project lessons and experiences that could be used by similar projects in the future. The film can be accessed on Youtube here: https://www.youtube.com/watch?v=RtRBAwzuH1M

**Rapid Behavioral Assessment & Benchmark Study**

As a means to inform the project's programmatic activities and overall operations, MULU Worksite conducted a Rapid Behavioral Assessment and a Bio-Behavioral Benchmark Study in 2013 and 2014 respectively. A baseline study, which was to be financed separately by USAID and conducted by a third-party organization was not conducted. In lieu of a baseline study, World Learning utilized the information gathered in the Benchmark Study to best understand the rates of HIV prevalence within the project's target populations.

### 3.3 Rapid Behavioral Assessment

The Rapid Behavioral Assessment was conducted in 27 health facilities to better understand the target workplace population and explore the health-related behavior of employees. A total of 394 worksite employees, including daily laborers, support staff, and technical staff from a variety of agricultural and industrial sectors were included in this rapid assessment with a response rate of 93 percent. The participants were 50.5% male and 49.5% female with a median age of 29 years, with ages ranging from 16 years old to 60. Respondents were asked a variety of questions regarding HIV, STIs, sexual practices, worksite health practices, and gender-based violence. Key findings include:

When asked to identify the health problems affecting employees at their respective worksites HIV (43.4%) was cited as the most affecting health problem in the worksites; followed by Malaria (42.9%), Hygiene/sanitary problems (20.6%), TB (16.2%), and worksite accidents (8.1%). Apart from HIV, accidents and addiction to khat and alcohol were also considered major health problems within certain industries.

Worksite employees were asked about how people get infected with HIV. Accordingly, a significant majority of males (87.9%) and females (87.2%) identified that having unprotected sex with an infected person is the most frequently cited way of HIV transmission; followed by sharing sharp instruments like needles, razor blades, tooth brushes; having more than one sexual partner at a time; unscreened blood transfusion; and mother to child transmissions. 6.4% of respondents (7.5% of male respondents and 5.1% of females) had misconceptions on HIV transmission, wrongly identifying ways of HIV infection such as sharing a meal with a person who acquired HIV, mosquito bites, eating raw meat, and a curse from elders.

A large proportion of males (69.3%) and females (61.0%) believed that STIs increase the likelihood of contracting HIV. However, approximately 10% of respondents believed that STIs have no effect or decrease the likelihood of contracting HIV, while the remainder said they did not know of any relationship between STIs and HIV. Such answers revealed a large knowledge gap in the relationship between STIs and HIV, highest among respondents from industries such sugar factories, farm-flower, and farm agriculture.

Of similar concern were respondents' beliefs regarding the effectiveness of condoms in preventing HIV transmission. Less than two-thirds (61.2%) of respondents believed that using a condom prevents HIV transmission. In the floriculture sector, less than one-third of respondents believed that using a condom prevents HIV transmission. Overall, men had better knowledge of condoms than women, however in floriculture and sugar factories, women exhibited better knowledge of condoms than men.

When asked how their sources of information about HIV/AIDS, Peer Education appeared to be the preferred source of HIV/AIDS information for all surveyed worksites as cited by 40% of respondents. More than a third of cited Radio/TV and health facilities as their common sources of HIV/AIDS information. Posters/pamphlets/banners, outreach services, newsletters/magazines were other sources of HIV information as explained by nearly one-tenth of the respondents.

When asked whether violence against women is a problem in their respective worksites, a little higher than one-fifth (21.6%) of men and about one-tenth of women revealed that there is violence against women in their respective worksites. However, respondents were not comfortable citing the specific types of violence against women. Violence against women is a sensitive question within the cultural and traditional contexts of Ethiopia, such violence is often underreported or misidentified.

Bearing in mind all the underreporting of sexuality and behavioral information, the Rapid Behavioral Assessment did provide information that had significant programmatic implications. More than four-fifths of the respondents in the surveyed worksites indicated that they are sexually active (ever had sex). 7% did not respond to the question. Of those who were sexually active, 15.2% expressed that they do have extramarital sexual relationships, however 15% of the respondents were not willing to respond to this question.

Asking a question of using a condom during last extra-marital sex also turned out lower proportions of respondents. Of the 49 that did respond to the question, only 63.3% answered that they used a condom during their last sex with a non-marital sex partners. Likewise, only 6.1% and 13.4% of sexually active respondents identified that their most recent sexual partner was either a living together/partner or fiancé, respectively. More than three-quarters (76.8%) were not willing to share such information.

When asked where to get HIV testing services, more than two-thirds (67.0%) of the respondents stated that health facilities outside the worksites are the ones to get HIV testing services followed by health facilities within worksites (56.4%). A similar proportion distribution was consistent across worksites except cement factory, whereby respondents indicated that they get HIV testing services within the worksite than outside. Almost one tenth of the respondents also mentioned that outreach/mobile facilities are entities to get HIV testing services.

According to the qualitative findings of this rapid assessment, majority of the worksites had no workplace HIV/AIDS policy. Few indicated the existence of a non-operational HIV/AIDS policy and internal HIV Guidelines. Considering the importance of worksite specific HIV/AIDS policies, many of them pointed that the need for one to help to implement HIV prevention efforts and provide care and support to PLHIV at worksites. Most worksites visited provide healthcare services including medical care, family planning, health education, HIV counseling and testing, ART and Prevention of Mother to Child Transmission (PMTCT) in some sites, and referral services. However, it was observed that there are no strong IEC/BCC, peer education, or other behavioral activities carried out in the worksites.

**Conclusions & Recommendations**

The Rapid Assessment revealed a variety of behavioral, biomedical, and structural deficiencies addressed through project interventions:

**Behavioral**

The assessment illustrated the dramatic knowledge gaps and misconceptions that may have been leading employees to exhibit high-risk health behaviors. Additionally, the need for SBCC regarding gender norms was apparent due to the existence of gender-based violence at worksites. The assessment confirmed necessity for correcting employees understanding and use of condoms through condom promotion.

**Biomedical**

Most worksites visited lacked comprehensive HIV/AIDS related services and commodities including RH and STI kits. Following worksites requested partners, including the government to help deliver quality services to those in need. The assessment showed the imperative to address HTC demands and misconceptions associated with knowing one's HIV status through HTC campaigns, other IEC activities, and through proper counseling and testing modalities in the worksite clinics as well as referral networks. The need to increase condom access at worksites was also revealed. Establishing linkages with surrounding care and support facilities and awareness creation activities was deemed critical as many of the worksite respondents were not willing to share meals and dorms/rooms with a person they knew had HIV.

**Structural**

The assessment revealed a clear need for MULU Worksite to build the capacity of worksites to provide integrated HIV and other related services as many explicitly cited that HIV, Malaria, TB, Hygiene and Accidents are the top health problems of their work places. Having a functional work place HIV/AIDS policy was another bottle-neck observed in the worksites; thus, adapting/developing workplace HIV policies and its implementation guide was a critical.

### 3.4 Benchmark Study

In 2014, MULU Worksite conducted a cross-sectional benchmark survey with worksite employees at 18 randomly selected worksites to assess HIV prevalence and risk behaviors among the worksite population. Employees were interviewed in three types of worksites: highly mobile mega-sites, semi-mobile large-scale sites, and less mobile stable worksites. A two-stage stratified sampling design was implemented, selecting worksites in the first stage and employees in the second stage. The primary sampling units were large-scale worksites (with populations 500 workers or more). A total of 1,285 interviews and 1,261 HIV tests with response rate of 95.2% and 98.1% of interview participants respectively were completed. The study population was predominantly male (86.8%), and two-thirds were below the age of 30. Key findings include:

**HIV Prevalence:**
The HIV prevalence in the worksite population was found to be 2.1%, higher than 1.2% projected adult prevalence in the general population in Ethiopia from 2014. HIV prevalence varied across different segments of the worksite population and was higher among workers whose age was greater than 40 years (5.2%), those who were divorced or separated (10.5%). Among the study population, HIV prevalence was higher (7.5%) among those who had paid sex in the last three months than those who had not had paid sex (1.8%), $p<0.05$. Likewise, HIV prevalence was higher among those who had had sex with a casual partner in the last three months than those who didn't ($p<0.001$). The frequency of using drugs/khat also had a significant association with HIV prevalence ($p<0.001$). HIV prevalence was 17.6% among those who consumed drugs/khat every day, 6.3% among those who consumed drugs/khat a couple of times per week, 8.9% among those who used less than once per week, and 1.5% among those who never used drugs/khat. Those who had never been tested for HIV were more likely to test positive for HIV ($p<0.05$). The HIV prevalence among who had never been tested for HIV was 5.2% versus 2.0% among those who had been tested.

**Sexual behavior and condom use:**
The majority of the study population (73.2%) had engaged in sex. Of those who had sex, 30.2% had sex with a non-marital regular sexual partner in the last three months, 5.5% had sex with a casual partner and 5.2% had sex with a paid partner. Condom use at last sex with a paid sexual partner was 81.6%, compared to 57.7% with a casual partner and 7.9% with non-marital regular partner. The main reported reason for not using condoms with a non-marital regular partner was low risk perception (90.8%). While the main reported reason for not using condom at last sex with a casual partner in the last three months was lack of access to a condom (36.4%).

**HIV Counseling and testing:**
More than two-thirds (67.4%) of the study population had been tested for HIV, 97.2% of them had received the test result and 0.7% had a positive test. Among those who previously taken a test in

the past 12 months, the average number of tests was 1.6. Of those who had been tested in the past 12 months, the majority (74.1%) reported they were tested in a public hospital/clinic; 12.6% were tested in a mobile center and 11.8% were tested at a worksite clinic. Of those who had never been tested for HIV, the main reasons for not testing were feeling healthy/not sick (67%), low perceived risk (47.1%), and don't know where to test (6.5%).

The majority (71.6%) of the study population agreed that HIV counseling and testing services were easily available. Most (97%) thought that counseling at the HIV testing center would provide the information needed to prevent HIV transmission; 94.8% agreed that HIV testing and counseling services were affordable. However, only a small proportion (10.7%) did not fear that s/he would be treated poorly by health worker at an HIV testing center.

**Sexually transmitted infections (STI):**
Less than one in ten (8.4%) in the study population had had STI symptoms in the past 12 months. About half (45.2%) of those with symptoms sought treatment. A very small percentage (3%) of the study population had received a screening/checkup for STIs in the past 12 months. Of those who had had STI checkups, nearly half (54.1%) had the test at a facility outside of the worksite.

**Gender based violence:**
About one in ten (10.1%) female respondents reported that they felt it was justified for a male sexual partner to beat his female partner if she refused to have sex with him; 6% reported that they felt it was justified for a male sexual partner to beat his female partner if she argued with him. Similarly, 6.8% of female respondents reported that they knew a woman in the worksite who had been physically beaten or hurt in the last 12 months and 4.2% reported that they knew a woman in their worksite who had been raped/forced to have sex against her will. According to the respondents, the main perpetrators of any type of workplace GBV were colleagues (75%).

**Exposure to HIV interventions:**
The clear majority (85%) of the study population had heard or seen HIV prevention messages in the previous year. About half (50.7%) had heard HIV prevention information in the previous six months within their worksite and 32.4% had received formal HIV/AIDS education by an expert at the worksite. In the last six months, less than one-fifth (17.6%) had received free/low cost condoms, just 4.1% had received HIV counseling and testing, and less than one percent had received STI services.

**Conclusions and Project Implications:**

Based on this benchmark study, World Learning was able to make several conclusions, forming recommendations for the program to ensure its long-term efficacy, efficiency, and sustainability.

- Worksite HIV prevalence was found to be relatively higher than the HIV prevalence of the general population in Ethiopia; and it was much higher in certain segments of the worksite population (particularly semi-mobile employees and those aged 30-39). This finding influenced the project to focus on particular segments of worksite populations, refining our approach to target groups with highest prevalence rates.

- World Learning found that the rates of condom use with a non-marital regular partner were found to be low, informing the need for MULU Worksite's interventions to address the low perceived risk of having sex with -marital regular partners.
- A lack of access to condoms was the main reported reason for not using a condom during sex with a casual partner. Thus, World Learning aimed to increase the accessibility of condoms to worksite populations
- To address the low level of comprehensive knowledge on HIV among worksite populations World Learning prioritized behavioral change communications to combat misperceptions on the risks, transmission, and impacts of HIV.
- World Learning committed itself to strengthening worksite HTC services based on the fact knowing one's HIV status has an inverse relation with HIV prevalence. Improved HTC services served a dual purpose, improving HIV prevention efforts while also reducing the impact of HIV/AIDS. Similarly, World Learning worked to improve STI screening and treatment services to achieve parallel results.

### 3.5 Participatory Worksite Capacity Assessment:

World Learning, in collaboration with worksites across Ethiopia facilitated Participatory Worksite Capacity Assessments (PWCA) These self-assessments were designed to help management units of private sector organizations self-assess their capacity to mitigate the risk of negative HIV impacts through workplace prevention and support programs that reflect international standards. The PWCA reflects World Learning's unique approach to capacity assessment by mirroring its proprietary Participatory Institutional Analysis (PIA).

Rather than a solely external evaluation, the PWCA engages worksite management and key stakeholders through a joint problem identification and planning process which results in an agreed upon capacity assessment level incorporating worksite policies, programs, practices, and staffing. World Learning's approach enables worksite management to understand their level of vulnerability to negative impacts of HIV and the capacity they need to mitigate that vulnerability. World Learning assisted worksites to target specific policy and programmatic responses that supported a healthy workforce and are in alignment with national and international standards Following, World Learning and the worksites jointly developed action plans to strengthen the worksites' capacity, including the technical assistance required.

World Learning developed a rapid mapping protocol that enabled the MULU worksite team to assess the facilities' status, and 54 worksite facilities were selected to be a part of the PWCA process. The selection of these worksites was meant to ensure a sectoral distribution that would inform World Learning's work in a variety of industries, knowing that within some sectors, populations, policies, risks, and capacity would be similar.

### The PWCA Tool

The PWCA tool uses a set of qualitative questions and workers survey that enable the company to calculate their level of operational risk to negative impacts on productivity due to HIV. This risk is calculated as the contrast between company's vulnerability and capacity:

Organizational Risk = Vulnerability / Capacity

Reflecting the complexity of the two variables, vulnerability and capacity, these are further defined as the compounded effects of three factors the work together.

Vulnerability = Workforce Size + Worker Characteristics + Work Hazardous

Capacity = Policy structures + Programs + their effect on worker Practices

A signature characteristic of World Learning's assessment approach is its use of qualitative and quantitative data in the self-assessment. Rather than basing judgments on perception or individual agreement alone, World Learning helps the company collect and analyze information to better inform their assessment score. For this tool, two data-gathering templates were developed to assist both World Learning and the company quickly structure and complete the data-gathering to prepare for the complete assessment. These three tools were:

• Data Gathering Template: Structured to help gather key qualitative and quantitative indicators on the three vulnerability and three capacity factors. This develops a picture of the current company response to HIV operational risk. This forms the basis of the assessment itself.

• Worker Survey Template: Rather than relying solely on the internal views of policy and program effectiveness, a survey gathers worker views of these programs to give a more realistic understanding of the impacts of their efforts. The survey is conducted by World Learning staff if agreed to with leadership and there are policies and programs in place.

**The PWCA Process**

The PWCA process followed a four-step process that began with the initial PWCA engagement and negotiation with the company's leadership to a reporting of the results to that leadership in order to reach agreement on participation in the HIV workplace prevention program (e.g. MULU). In between these two points, a group of individuals appointed by the leadership, with guidance from the facilitation team, collected and analyzed data to determine their level of risk. They then prioritized actions to take to address identified gaps.

Step 1: Engagement - As with any effective workplace intervention, the process starts by engaging the company's senior management and orienting those conducting the assessment. This short but crucial step builds a sense of ownership and understanding of the process and outcome.

Step 2: Data collection - The company then collects information on a short set of customized indicators on their company's policies and practices within an agreed upon timeframe, using the templates as a guide. This is a joint effort by the Facilitation Team and Assessment Team.

Step 3: Data analysis and planning - At a short, participatory workshop, World Learning facilitates a process to help the company understand the meaning of their data. The outcome is the determination of their level of operational risk and prioritization of capacity strengthening interventions that will leverage the greatest mitigation of that risk.

Step 4: Implementation and monitoring - The process concludes with a follow-up meeting with the Senior Management to finalize and agree upon the capacity gaps identified in step 3 and developed into a full technical assistance plan by World Learning. The action plan is implemented

and monitored for effectiveness and adjustments needed. The assessment may be repeated at the end of the program to understand progress made.

**PWCA Findings**

The assessment findings revealed several critical risks and priority areas, informing World Learning's work throughout the project. While worksite management and staff commitment to supporting HIV prevention activities was strong, World Learning found that many worksites had no plan or budget for HIV prevention, no basic knowledge of integrated clinical service delivery, faced a shortage of supplies (HIV test kits, STI commodities, FP products), and many lacked a standardized referral and linkage system. Based on the identified gaps, immediate joint action plans were developed to address the project's three pillars of intervention: behavioral, bio-medical, and structural. Through BCC provision, HTC distribution, and the establishment of personnel structures such as HIV Taskforces, World Learning was able to address the risks found during PWCA and implement sustainable solutions in dozens of worksites, including those that were unable to be a part of the PWCA process.

MULU Worksite's PWCA exemplified World Learnings CLA approach to project implementation, as the project team sought to collaborate effectively with worksites, government agencies, and other critical stakeholders to identify and implement solutions. As a result of PWCA results, World Learning facilitated the establishment of HIV Taskforces at each worksite to provide a capable, autonomous and sustainable oversight of each worksite's HIV prevention efforts. By working to provide training to staff, create reports on HIV prevention activities, and build partnerships with regional government agencies, these taskforces were a critical component of MULU Worksite's structural intervention. Additionally, World Learning ensured that Worksites were able to develop and implement a Workplace HIV/AIDS policy document to ensure gender equality, non-discrimination, and confidentiality to help recruit, retain and promote People Living with HIV (PLHIV).

## IV. Project Accomplishments

Since the project's inception in March 2012, World Learning fostered partnerships with workplace management bodies as well as government stakeholders, working collaboratively to ensure the success of MULU Worksite and the greater national HIV multi-sectoral response. Worksite management, HAPCO, and MoLSA were partners that ensured the project's continued success as World Learning continually sought to find opportunities to expand the project's reach and impact. The strategic shift to focus on high-risk workforces in the regions of Humera and Metema was critical to the project's ability to target high yield populations while also offering needed BCC and HTC services while building the capacity of worksites throughout the country.

*As a result of MULU Worksite, Aynalem Hunde participated in peer education, was tested for HIV, found positive, and began ART. She has been able to continue working while raising an HIV-free child*

Without data from an end-line evaluation, measuring the project's full impact remains incomplete. The end-line evaluation is meant to be conducted by a third-party organization utilizing separate funds than those provided MULU Worksite, however it was completed by the end of the project. The following data represents MULU Worksite's Life of Project achievements, summarizing data found in our succession of quarterly and annual reports. Considerable progress was made throughout the project, illustrating the effectiveness of an integrated behavioral, bio-medical, and structural intervention. Find some of MULU Worksite's primary accomplishments listed below:

- Reached a total of **886,627** (**803,627** Male and **83,353** Female) individuals through peer led small group discussion using a standard curriculum.
- Reached a total of **10,309** Female sex workers in selected hotspot towns around Humera and Metema development corridors through peer led small group discussion using a standard curriculum
- Tested **387,669** individuals (**272,845** Males and **114,824** Females) for HIV, through worksite clinics and targeted outreach services or modalities. All of them received their test results. Of those tested **4,697** (**1.21**%) were found to be first time HIV positives with 0**.87% (2,385)** Male and **2.01**% (**2,312**) Female positivity rate, respectively.
- Mobilized **424,428** (**313, 871** Male And **110,557** Female) workers through large group edutainment with key HIV prevention messages as part of the behavioral interventions;
- Distributed **11,734,650** male condoms
- Distributed **903,345** IEC/BCC materials for employees and surrounding communities of various types (leaflets, posters and stickers) with HIV prevention messages.

- STI screening services provided to **342,359** (**235,275** Males & **107,084** Females) individuals; of whom **4,703** (**2,031** Male and **2,672** Female) were screened positive and referred to worksite clinics and other public/private facilities for treatment;
- Counseled **202,181** (**128,241** Male and **73,940** Female) individuals for family planning
- TB Screening provided for **308,145** (**211,979** Male and **96,166** Female) individuals, based on the national screening protocols. Of those screened, **1,254** (**798** Male and **456** Female) tested positive and were referred for further assessment and management;
- Provided Training of Trainers (TOT) for **163** (**135** Male and **28** Female) outreach workers to reach more target group using standard curriculum.
- Provided basic peer educators (PEs) training for **5,150** (**3,794** Male and **1,356** Female) workforces to cascade small group peer lead discussion using standard curriculum.
- Provided basic peer educators (PEs) training for **315** FSWs to cascade small group peer lead discussion using standard curriculum.
- Assisted **81** worksites to develop gender sensitive HIV/AIDS and Anti stigma & discrimination policies and programs in line with international /local recommendations and MULU Worksite policy development guidelines for their workers;
- Established AIDS funds in **34** worksites to finance HIV prevention, care and treatment efforts in the worksites.
- Assisted **88** worksites to establish active HIV/AIDS Task Force (TF) and Quality Improvement Team (QIT) and followed the functionality of TF and QIT through supportive supervision and mentoring.

Per MULU Worksite's Results Framework (See Section 3.1) there were three key Intermediate Results (IR), each corresponding to the Behavioral, Biomedical, and Structural components of the project respectively. In that order, they are:

- IR 4.1 - Improved HIV preventive and health-seeking behaviors within and around large-scale work places;
- IR 4.2 - Increased availability and accessibility of RH and HIV prevention services and commodities within and around large-scale workplaces;
- IR 4.3 - Improved capacity of public and private large-scale workplaces to support HIV prevention and RH services and large-scale workplaces

Our results are organized by these IRs and the corresponding Key Result Areas (KRA) that fall beneath each IR.

## 4.1 Intermediate Result 4.1 - Improved HIV preventive and health-seeking behaviors within and around large-scale workplaces.

### *KRA 4.1.1 Reduced HIV Risk Practices of Workforce and Surrounding Communities*

For the PMP indicators within KRA 4.1.1 (P8.11.N & P8.12.N) World Learning is unable to report end results due to delays in the end-line evaluation. However, World Learning is confident that the peer education, BCC, and increased availability of condoms will lead to a decrease in the percentage of men and women who have sexual intercourse with more than one partner in the

last 12 months, and an increase in the percentage of individuals who used a condom during their last sexual intercourse.

***KRA 4.1.2 Improved knowledge of HIV prevention and transmission methods***

Evidence from HIV interventions across the globe, including the MULU Worksite project suggests that workplace interpersonal communication interventions, as part of a comprehensive combination prevention program, contribute to the capacity of workers to protect themselves against HIV infection by influencing attitudinal and behavioral change.

World Learning, through its peer education program was able to reach almost 900,000 individuals with an approved HIV prevention curriculum addressing the key drivers of the HIV epidemic and high-risk behaviors identified through the informal rapid assessment and other bio-behavioral research. The total number of individuals was divided into Priority and Key Populations and MULU Worksite reached 886,627 and 10,309 respectively throughout the life of project. These totals represent 88.7% and 96.4% of project targets respectively.

*A MULU Worksite peer education session in progress at Wush Wush Tea Development*

These individuals participated in a peer education curriculum led by peer educators trained by trainers. World Learning trained 163 trainers (135 Male and 28 Female) who cascaded training to 5,150 peer educators (3,794 Male and 1,356 Female). Each peer educator each received 2-5 days (Minimum of 2 for Humera/Metema while 5 days will be dedicated for the relatively stable locations) of peer education training. Participants were assessed through pre and post-training test to ensure understanding of the subject matter. All PEs were provided with kits including session guides, job aids, and M&E tools.

Due to large cohort size of peer education groups (limited to 25), World Learning only needed to train 51.5% of the peer educators target to reach 88.7% of the individual target. The project, according to the evidence chart developed in Year 2, used three different peer education models (generic peer learning model for stable workforces, peer learning intermediary model for semi mobile workers and accelerated peer learning model for highly mobile populations) in different worksites depending on the degree of mobility of the workforce and their duration of stay.

- **Peer based small group discussion guide for stable workforce**: This peer learning guide was meant for target populations in stable development sectors having limited mobility. One interactive session was held every week for a minimum of two hours and lasted six weeks and was customized, where appropriate.
- **Peer based small group discussion guide for Semi-Mobile workforce** (Mining, road construction, etc.): This guide was used for mobile workers in the mining and road construction sectors. Three interactive sessions were held in a one-week period with each session lasting two hours. The peer learning guide focused on the skill based thematic areas (condom use, HTC, STI, Alcohol and gender) and was complemented by community wide events, mobile mini media and IEC material distribution.
- **Peer based small group discussion guide for highly mobile populations:** This guide was used for migratory seasonal workers serving in mega development farms. Two interactive two-hour sessions were held in a one-week period. The peer learning guide focused on the skill based thematic areas (condom use, HTC, STI, Alcohol and others) and was complemented by community wide events, mobile mini-media and IEC material distribution.


*A chart showing one worksite's commitment to the behavioral intervention*

MULU Worksite was primarily focused on Priority Populations, as the majority of worksite employees fell within this designation, however the project's catchment area approach necessitated a more holistic intervention to ensure that surrounding communities were also provided with key prevention information. Following, World Learning led a targeted intervention with Key Populations in the areas surrounding worksites and development clusters. World Learning's achievement of 96.4% illustrates the project's effectiveness in quickly reaching this population.

Considering the sexual networks that prevail in and around mega development clusters which attract large numbers of female sex workers (FSWs), the project identified hot spot towns in Humera, Metema, and other worksites of high epidemiologic importance. This strategy allowed the project to reach a cross-section of vulnerable populations in a confined geographic location and thereby contributed to the containment of HIV transmission among the bridging population. The project implemented this key activity since Year 2 in areas where MULU/MARPs or other service providers were not working. World Learning Provided basic peer educators (PEs) training to 315 FSWs who cascaded small group peer discussion using the standard curriculum to 10,309 Female sex workers in selected hotspot towns around Humera and Metema development corridors.

Due to political and security limitations, MULU Worksite was repeatedly limited in its ability to coordinate peer education and community wide events. Notwithstanding the difficulties imposed by states of emergency, World Learning as able to reach 424,428 individuals through community wide events, 93.1% of the 456,000 target (P8.5.D).

For many businesses, World AIDS Day represents the culmination of their HIV prevention work throughout the year and serves as an opportunity to showcase their commitment and receive acclaim and acknowledgement from important stakeholders. MULU Worksite leveraged this opportunity by assisting worksite management each year of the project to commemorate the occasion by distributing condoms and SBCC materials to employees. The MULU Worksite team also provided technical assistance to HAPCO structures to disseminate information to high volume workforces during the commemoration. World Learning printed tens of thousands of posters and fliers to promote World AIDS Day. Additionally, the MULU Worksite team would participate in various commemoration activities.

One PMP Indicator – "Percent of women and men who have comprehensive knowledge about HIV transmission, misconceptions & prevention methods" does not have a final data due a delay in the end line evaluation.

***KRA 4.1.3: Increased access to HIV/AIDS prevention information and education for workplace employees and surrounding communities***

MULU Worksite distributed various SBCC materials to support the interpersonal communication component of the project and combination HIV prevention services. The project distributed various materials on thematic areas such as HIV basics, risk assessment, condom use, STI, gender, and substance abuse. The project also reprinted various MULU MARPs standard packages of FSWs materials and distributed in non MULU MARPs hotspot towns.

In total, World Learning distributed 903,345 IEC/BCC materials for employees and surrounding communities of various types (leaflets, posters and stickers) with HIV prevention messages. This

represented 237.7% of the established target, underscoring World Learning's commitment to risk reduction and HIV prevention.

Additionally, World Learning, provided mini-media resources to 40 worksites, while also training staff on how to use necessary equipment. World Learning selected appropriate worksites with the ability to utilize mini-media

## 4.2 Intermediate Result 4.2 - Increased availability and accessibility of RH/FP and HIV prevention services and commodities among populations within and around worksites

### *KRA 4.2.1 Strengthened capacity of worksite clinics to provide user-friendly HIV and RH services*

**Worksite Capacity Building**

Based on the gaps identified during capacity assessment and supportive supervision, MULU Worksite provided technical support on the quality of HIV prevention and other RH services across all 51 static worksite clinics. The supports provided include availing commodities such as HIV testing kits and STI pre-packed treatment kits; gap filing trainings; mentoring, coaching and orientation for healthcare providers and addressing coordination/leadership constraints. All 51 worksite clinics received on-site technical support, at least once per quarter.

The MULU Worksite team ensured the quality of integrated clinical services through supportive supervision with the use of checklists and procedures developed in previous years. Both the central and regional teams provided quality assurance and mentoring support across all 88 static worksite clinics and expansion worksites. Over the course of the project MULU Worksite continued ensuring the availability of the following guidelines, checklists, and standard operation procedures:

- **Facility-assessment guidelines:** Checklists and procedures have been adapted and produced for clinical inspection to ensure adequate infrastructure, equipment and environmental conditions for worksite healthcare facility-based service delivery.
- **Supportive supervision and proficiency certification guidelines for providers:** Standard evaluation criteria and checklists were adapted and implemented to assess practical proficiency of trained service providers, as well as guidelines for timing and frequency of assessments using respective regional laboratory technologists. The remedial actions that pertain to the overall service setup and requirement were joint responsibilities of the worksite management and World Learning.
- **Routine service implementation checklists and wall-posters for providers:** Visible protocols and guidelines were disseminated to support clinical service provision, including client rights to confidentiality, PEP protocols, hand-washing protocols, and service provision algorithms and procedures.

As part of the transition and exit preprocess, MULU Worksite printed and distributed copies of monitoring and evaluation tools that will enable the worksites to document and report their activities for a minimum of one year after the end of the project. Moreover, soft copies of all

checklists, guidelines and monitoring and evaluation tools were provided to all worksites for their future use.

MULU Worksite provided in-service training to 1566 health care workers over the life of project. The healthcare providers were drawn from worksite clinics and public and private referral health facilities around the worksites. MULU Worksite conducted the selection of trainees/trainers jointly with *woreda* health offices /HAPCOs during. Trainees were also provided with SOPs, manuals and IEC materials to support their subsequent HIV prevention service provision.

**HTC and RH Services**

MULU Worksite implemented a mix of service delivery models (static and targeted outreach services and approaches to provide confidential and voluntary HIV Testing and Counseling (HTC) services as the primary entry-point for worksite beneficiaries. MULU Worksite collaborated with relevant government bureaus to adopt the HIV testing algorithm that outlines the steps and procedures for offering HTC services. The project provided programmatic support to ensure that worksites provide a comprehensive set of essential services in an integrated fashion (including family planning counseling, STI, and referrals to follow-on services, care and support). To increase access to all potential target groups, the project used both static worksite healthcare clinics and targeted outreach services.

*An example of a test kit used as part of MULU Worksite's intervention*

Mobile/Outreach HTC services delivery model had been applied to reach mobile workforces who were migrating to worksites in search of temporary work in seasonal bases. These mobile/outreach activities were also benefiting other population such as female sex workers residing at the vicinity of worksites. Collaboration efforts of partners, stakeholders and worksite managements were highly observed while organizing such activities. And such joint efforts were proven to ensure the services quality and effective referral and linkage system.

The project has employed different approaches to keep the service quality as per the standard expected. The proficiency of the participating counselors was tested and confirmed by the respective Regional lab before assigning the providers to the services. Prior orientation was also provided to the assigned providers about the program expectation and familiarization of tools and procedure they should provide. Continuous supervision, mentoring and couching was also provided throughout the program. SOPs, Guidelines, and Protocols were also provided to ensure the services quality was not compromised during the events.

Over the life project, World Learning:

- Tested 387,669 individuals (272,845 Males and 114,824 Females) for HIV, through worksite clinics and targeted outreach services or modalities. All of them received their test results. Of those tested 4,697 (1.21%) were found to be first time HIV positives with 0.87% (2,385) Male and 2.01% (2,312) Female positivity rate, respectively.
- Provided STI screening services to 342,359 individuals (235,275 Males & 107,084 Females); of whom 4,703 (2,031 Male and 2,672 Female) were screened positive and referred to worksite clinics and other public/private facilities for treatment;
- Counseled 202,181 (128,241 Male and 73,940 Female) individuals for family planning
- Provided TB Screening for 308,145 individuals (211,979 Male and 96,166 Female) individuals, based on the national screening protocols. Of those screened, 1,254 (798 Male and 456 Female) tested positive and were referred for further assessment and management;

The original target of 1,500,000 was judged to be unrealistic and the PMP was revised in consultation with USAID such that the target was revised to 466,367. The achievement of 387,669 thus represents 86.9% of the target. Underachievement was almost entirely the result of changing testing formulas and an inconsistent supply of HIV test kits.

Additionally, in January 2016 USAID advised the MULU Worksite team to revise its approach to conduct more targeted testing services in order to contribute most effectively to the 90-90-90 objectives. Accordingly, new strategies were implemented to increase HIV yield results in workplace settings. Yield increased as did confirmed referral rates, illustrating World Learning's capacity to execute this strategic shift.

**Referrals and Linkages**

HTC as HIV Prevention Strategy proved to be very complete if and only if effective referral and linkage system was established. However, it was evident that there was a significant challenge in the detection and linkage of HIV positive individuals to care and treatment services. This challenge was more pronounced in workplace settings.

Therefore, MULU Worksite HIV prevention Project supported both the static and outreach service delivery models to implement innovative strategies to enhance linkage. These innovative strategies included a joint micro-planning, accompanied referral, engaging ART/Case managers/adherence counselors at each of the outreach testing service delivery points.

In addition, the following key activities were undertaken during the life of the project:

- Consultative Workshops on referral and linkage system were organized in which providers from worksite facilities, public facilities, Woreda Health Offices, Regional Health Bureaus were participating.
- Referral Directory were produced and distributed to the worksites to facilitate easily tracing of referral receiving facilities and collecting feed backs. Onsite support had been given to worksite providers and those counselors participating at every event organized at mega worksites where Referral & Linkage was compromised.
- Referral slips were developed for use and some referral boxes prepositioned at selected referral receiving institutions from where a confirmatory process took place by having a feedback information.

An accompanied referral system was put in place, particularly in the highly mobile workplace settings, in coordination with district health offices, nearby health facilities and farm investors who facilitate transport services. As a result of these concerted efforts, confirmed linkages increased from 75% in FY 13, 79% in FY 14, 83% in FY 15, 82% in FY 16, 87% in FY 17, and ultimately to 93% in FY 18.

**Condom Distribution**

Over the life of project World Learning distributed 11,734,650 condoms, representing 94% of the project target, 12,500,000. Free condom distribution was guided by the total market analysis approach for both MULU Worksite and MULU MARPs. MULU Worksite assessed the capacity of worksites to forecast their condom requirements according to pre-determined demand-based standards; prepare distribution plans with specific target groups and distribution points; and provide feedback to make sure each worksite had the capacity to manage its own condom programming independently. To ease condom access, a number of condom outlet were established, and condom dispensary boxes were distributed to the worksites. Based on changing strategies, World Learning was able to establish up to 2730 condom service outlets in FY 17, far exceeding the target of 600.

The project worked continually to ensure a proper supply chain management system was in place at all times. However, there were times that condom supply chain was compromised due to quality issue. Though the initial target was 25,000,000 condoms, after an in-depth discussion with USAID, the target was lowered to 12.5 million.

**HIV Test Kit & PPST Kit Distribution**

Based on annual demand and capacity analysis, MULU Worksite distributed HIV test kits to worksite facilities and during Mobile/Outreach HTC services based on WL Area Offices micro-plans. HIV test kits were supplied through the USAID supply management mechanism based on the annual quantification and request submitted to USAID. Multiple changes in the HIV testing algorithm at the national level interrupted distribution, leading to critical shortages in the HIV test kit supply across the country and serious interruptions in HIV testing in most sites. Test kits supply was facilitated by USAID from MOH to key partners to enhance HIV testing after the approval of the new algorithm and rollout of training.

Additionally, STI screening and syndromic management was part of the integrated clinical service delivery (ICSD) at worksite facilities and during HTC. PPST kits were issued to the worksite clinics and public pharmacies to provide easy access for the STI positive clients for STI syndromes. However due to the transition of STI kits packaging from PSI to PFSA and change of national STI treatment algorithm for 'Urethral and Vaginal Discharge' caused delay of distribution nationwide which also caused shortage of STI treatment kits at the worksites. Below is summary of commodities distributed through MULU II HIV prevention project.

Please see below for an annual breakdown of HIV Test Kit and PPST Kit Distribution:

In FY 2018, the project received and distributed 15,394 HIV screening test kits (1,200 First Response and 14,194 Bejing wanti),560 confirmatory and 1,128 Tie breaker tests. In addition, MULU Worksite received and distributed 27,000 capillary tubes, 11,037 lancets, 126,900 examination gloves, 80 safety boxes and 100 biohazard bags to MULU WS Area Offices based on their needs and testing schedules for static and outreach service delivery modalities.

In FY 2017 World Learning received and distributed 100,000 Bejing wanti (screening HIV test kits), 3,756 UniGold and 837 Vikia (confirmatory test). In addition, the project received and distributed 121,557 capillary tubes, 250,756 examination gloves, 8,478 lancets, 620 biohazard bags and 530 safety boxes to MULU Worksite clinics and outreach service delivery points as per the demand and testing schedule of Area Offices. Additionally, in FY17 World Learning distributed a total of 519 pre-packed STI kits (189 Addis Cure, 217 Addis Cure Plus and 113 U1Cure) were distributed to worksite clinics for the continuum of STI diagnosis and treatment based on their demand.

In FY 2016 World Learning distributed 6,350 KHB HIV test kits, 2,270 Stat Pack, 2,220 UniGold, 276, 400 capillary tubes, 20,672 First Response, 129,950 lancets, 266,200 examination gloves, 744 safety boxes and 752 biohazard bags were distributed to 38 worksite clinics and off-site worksites. Additionally, a total of 5,620 pre-packed STI kits (1,720 Addis Cure, 1,920 Addis Cure Plus and 1,980 U1 Cure) were distributed to worksite clinics for the continuum of STI diagnosis and treatment based on their demand.

In FY 2015 World Learning distributed 161,750 KHB HIV test kits, 4,860 Stat Pack, 560 UniGold, 323,100 Capillaries, 161,650 Lancets, and 144,100 Gloves, 48 safety boxes, and 92 Biohazard bags to worksite clinics and outreach points of service deliveries.

In FY 2014 World Learning distributed 2,795 pre-packed STI kits (918 Addis Cure Kit, 1155 Addis Cure Plus and 712 U1 Cure) were distributed to worksite clinics for the continuum of STI diagnosis and treatment based on demand. Additionally, a total of 81,650 KHB HIV test kits, 2,781 Stat Pack, 336,950 Capillaries, 165,050 Lancet, and 440,100 Gloves were distributed to 55 worksite clinics and 30 worksites as per demand for static and outreach service delivery modalities.

### *KRA 4.2.2 Strengthened linkages and referral system to surrounding public-private service outlets in improving access to HIV/AIDS, STIs and RH services*

World Learning worked continually to establish and strengthen linkages between worksites and relevant private and public service outlets. In doing so World Learning was able to ensure that every individual who tested positive for HIV, STIs or TB was properly referred to facilities which could offer them the necessary care and support. 100% of individuals who tested positive for HIV received referrals, however not all sought the necessary treatment, whether due to fear of social stigma, inconvenience, or lack of permanent employment.

World Learning utilized a variety of strategies to increase confirmed referral rates throughout the project. Whether by ensuring the presence of ART case managers, adherence counselors at testing sites or by accompanying individuals to local facilities, we saw significant gains in confirmed rates. The rate of confirmed referrals increased throughout the life of project from 75% in FY 13, 79% in FY 14, 83% in FY 15, 82% in FY 16, 87% in FY 17, and ultimately to 93% in FY 18.

MULU Worksite was able to establish 88 referral linkages between workplace sites and public-private care, treatment and support sites. This represents 100% of the worksites covered by MULU Worksite, however only 88% of the original target of 100. Due to the pre-mature closure of several worksites and the strategic shift to focus on the mega development clusters in Humera and Metema, World Learning only worked with 88 worksites. World Learning distributed referral directories to workplaces and surrounding health facilities to ensure effective linkages and communications. Out of the target of 200, World Learning was able to distribute 195 referral directories.

World Learning was also able to support testing facilities, building their capacity to perform clinical laboratory tests. MULU Worksite supported 51 such facilities, meeting and surpassing the target of 50. MULU Worksite conducted on-site coaching and mentoring visits to worksite static clinics and outreach/mobile point of care sites to ensure quality service delivery. All worksites received technical support at least once every quarter.

**Training**

To strengthen the quality of comprehensive integrated clinical services for workforces, basic training on Provider Initiated HIV Testing & Counseling (PITC), STI syndromic managements and RH components were provided for worksite providers and providers from public facilities those receiving referred clients and even sometimes participated in the HTC services. The training also embraced components of condom programing, supply chain managements, referral and linkage, proper documentation and use of reporting materials. Basic skill and knowledge of Total Marketing Approach were provided in training content so that the focal persons will be able develop condom programing strategy after the project ended. To improve the capacity of bio-medical team, the project facilitated training on:

- Comprehensive Condom Programing
- Condom and Bio-medical DELTA
- Clinical Franchising DELTA
- Prevention Product DELTA
- Monitoring and Evaluation data base and its application
- Performance Improvement Planning

**Integrated Supportive Supervision**

MULU worksite utilized a supportive supervision checklist to assess worksites' health responses in the provision of ICS minimum package services for employees and nearby communities. The checklist was designed to reveal healthcare providers' skills and challenges in administering HTC, STI, TB, and RH services. The project team had kept implementing periodic integrated supervision jointly with the worksite team and individually as per the required need. This was implemented at 51 static sites and 37 TA sites.

**External Quality Assurance test (EQA)**

Quality assurance is a cornerstone for any program delivery. As per the national requirement the providers should pass through proficiency testing at once in a year and every health product should pass a regulatory test before issuing them for use.

Having this is mind the project confirmed certification of regulatory test for each health product and the bio-medical team again assisted the regional lab to conduct batch test of the HIV test kits before implementing the services.

The counselors who were coming from public/private facilities have been required to pass the proficiency test prior to their assignment. And as per the national protocol, they would continue or sent off according to their results. During the project years, series of proficiency test were provided to health care providers working at all 51 sites receiving bio-medical support through MULU II.

## 4.3 Intermediate Result 4.3 - The role and capacity of public and private large-scale workplaces improved to support HIV prevention and RH in large-scale workplaces.

*Employees at Wush Wush Tea Development*

### *KRA 4.3.1 Strengthen the capacity of workplace management to support workplace HIV programs & KRA 4.3.2 Strengthen mainstreaming of HIV/AIDS programs into workplace core business practices*

Throughout the life of the project, World Learning worked to build the capacity of workplaces to support a sustainable vision for an HIV free Ethiopia. By identifying organizational gaps in managing effective HIV prevention activities at the worksite level, World Learning was able to provide targeted technical and administrative support to worksites throughout the country. The project also worked with key stakeholders at the national and local levels including MoLSA, CETU, HAPCO, and umbrella sector organizations and associations to ensure that a supportive environment prevails at every worksite. MULU Worksite employed a highly collaborative model to help worksites continue implementing workplace HIV programs independently. The major

strategies were (1) a participatory workplace capacity assessment to build consensus on identified gaps and interventions; (2) obtaining worksite's senior management policy commitment and human resources to champion the cause; (3) designing and implementing a tailored approach to build internal capacity and leadership on HIV prevention; (4) assisting the development and implementation of workplace HIV policies and action plans that effectively support worksites to leverage their resources to fight against HIV, stigma, and discrimination.

The MULU Worksite project established HIV taskforces in all 88 worksites, which worked to coordinate and support HIV combination prevention activities implemented by the project. Each worksite utilized MULU guidelines on how to establish and operate effective taskforces with clear roles and responsibilities for each taskforce member, including a minimum of one female member to ensure gender sensitivity. The MULU Worksite team conducted regular supportive supervision visits and provided technical support to assess the implementation capacity of each taskforce and provide appropriate support to sustain implementation after the project phased out.

The project also conducted stakeholder consultative meetings in the Metema and Humera development areas to identify and coordinate HIV prevention efforts at these large farms that lack traditional HR and management systems. These meetings resulted in recommendations to strengthen the existing HIV prevention board by adding relevant sector offices. The MULU Worksite team ensured the functionality of these structures and organized capacity development workshops that resulted in better understanding of defined roles and responsibilities, communication mechanisms, and decision-making procedures.

Considerable progress was made throughout the life of project to institute gender sensitive HIV/AIDS policies at worksites, ensure that there were record keeping procedures for HIV/AIDS interventions, and allocate budget for HIV activities. While 88 worksites established record keeping systems, only 81 adopted gender sensitive HIV/AIDS policies. These policies represent the foundation for a workplace prevention, care and treatment programs, and defines the steps for its implementation. They specify workplace HIV prevention practices as well as procedures for supporting employees already affected by HIV/AIDS and for combating stigma and discrimination. These policies guide managers and supervisors on how to handle HIV/AIDS related issues. It informs the employees about their rights, assistance available to them, as well as their responsibilities and expected behavior (i.e. non-discrimination or gender equity). After adopting these policies, MULU Worksite worked to ensure an ongoing commitment and allocation of human and financial resources. 34 worksites allocated budget for HIV activities.

Worksites with dedicated and adequate HIV resources helps to protect employees from HIV and to ensure provision of treatment, care and support for the already infected and affected employees and their families; and will contribute to prevention efforts and minimize the vulnerability of the community. To this end, MULU Worksite team encouraged worksite owners and managers to establish AIDS funds or allocate annual budget for HIV/AIDS program implementation or finance HIV related activities in the worksites. This was materialized through continuous supportive supervision and establishing strong working relationships with worksite managers and owners.

To ensure MULU Worksite's sustainability, the project designed an exit plan for each worksite encompassing both programmatic and operational activities. Exit plans were developed after

evaluating each worksite's structure, capacity, and relevant HIV epidemiological data. A detailed exit service plan focusing on the following key areas was implemented for all applicable worksites:

- Provide mini-media equipment with prevention messages along with training for future use
- Organize gap filling trainings on HIV mainstreaming, peer education, and HTC
- Improve condom programming and referral services
- Build worksite's supply chain management capacity
- Link worksites with respective *woredas* on planning and reporting
- Ensure financial resource allocation
- Ensure the availability of required M&E tools and the functionality of the recording and reporting systems

### 4.4 Individual Success Stories

**Finding a Second Chance at Life Through the MULU Worksite Project**

Aynalem Hunde, 34, a laborer at the Wush Wush Tea Plantation in the Southern Nation Nationalities Peoples Regional State, has witnessed the devastating impact of HIV/AIDS first hand. Aynalem's life was transformed by the death of her husband at the hands of HIV/AIDS, leaving her to fend for herself and her young family. She began working at the tea plantation to support her family, but the stigma surrounding her husband's death led Aynalem to feel despondent and depressed. "I was counting down the days of my life ever since I learned that my life partner had from HIV," she remembers. For Aynalem, "life was a dead-end."

Aynalem remembers the day her supervisor first asked her to attend a MULU Worksite peer education session as an event that changed the course of her life. Aynalem agreed to attend the first session, primarily to satisfy her supervisor, but decided on her own to continue participating in the peer education sessions, where she learned more about her prospects for living a healthy productive life.

She decided to get tested for HIV at a clinic supported by MULU Worksite and started antiretroviral therapy upon learning that she was HIV positive. Knowing her status and getting treatment gave Aynalem new hope. Aynalem believes that MULU Worksite gave her the knowledge, courage, and support to move forward with her life. "Before the peer training, I didn't know it was possible for a woman living with HIV to have a healthy baby." Excited to start a new family, Aynalem remarried and gave birth to a healthy, HIV-negative baby.

The MULU Worksite peer education program also empowered Aynalem to help change her co-workers' attitudes towards people living with HIV. Aynalem is now one of the hundreds of dedicated peer educators who facilitate peer learning sessions at MULU worksites. throughout Ethiopia. Aynalem has successfully trained 29 individuals and is now able to help HIV-positive individuals get the care and treatment they need through referral and linkage systems developed by the MULU Worksite program. Aynalem's participation in MULU Worksite's comprehensive HIV/AIDS program provided her with the education, support, and opportunity necessary to change her life and help create a healthier, stronger future for Ethiopia.

**Changing One's Behavior to Become a Leader in the Community**

Throughout Ethiopia, the MULU Worksite project provides critical education and support services, helping individuals to address and change their personal behavior. For Arefayne Hadgu, 32, MULU Worksite's peer education sessions helped create a better future for himself and his coworkers. For years, Arefayne had abused alcohol and khat and had multiple sexual partners, "everything that put my life at higher risk of contracting HIV and STIs," he says.

It was not until he attended a peer education session at the Baker cluster worksite that he began to think more critically about how his actions were impacting his health and his future. Arefayne said "Like its name, MULU led to a complete overhaul of my life". According to Arefayne, the peer discussions "helped me to change the risky lifestyle I used to practice" and stop drinking and chewing khat.

Now, Arefayne is a trained peer educator who exemplifies the behavioral change fostered by MULU Worksite. He trained almost 250 discussants and helped get 80 of his coworkers tested for HIV. Arefayne believes that MULU Worksite helped him to become a well-respected member of the community. Now, when conflicts arise amongst his coworkers and friends, he is selected as a mediator. Arefayne is a testament to the potential for peer education to change an individual's behavior and transform them into an advocate for change in their community.

**MULU Worksite Paves the Path to a Healthier Life**

Many individuals' behaviors put them at a unique risk for HIV/AIDS infection, and the MULU Worksite project has worked tirelessly to promote behavior change throughout the country. Getnet Tseganeh, 28, spent much of his young adult life drinking alcohol, chewing khat, smoking, and having sex with multiple sex workers.

Getnet dropped out of school after the 6th grade before moving to the Metema area in search of work. For the last ten years he has worked on the Metema farm site at the Dellelo Cluster, but it was not until the MULU Worksite project began that he and his coworkers began to reconsider their negative habits and behaviors.

Getnet says that the "MULU worksite HIV prevention program has been an ice breaker intervention that helped daily laborers to openly discuss HIV/AIDS. It opened my eyes and paved the path to my healthier life." Prior to MULU Worksite, most individuals lacked a firm understanding of HIV/AIDS and the risk factors most commonly associated with it. For Getnet, MULU Worksite was "the first HIV prevention training that I ever had."

After participating in the small group discussions, Getnet got tested for HIV, found that he was HIV-negative, and decided to stop engaging in the behaviors that had put him at risk. In hopes of being a model to others, Getnet became a peer educator, and has now trained more than 350 discussants. Of particular importance to Getnet is condom use, something which was previously not a topic of discussion amongst his coworkers. His unique advocacy position in the community has led some to give him the nickname "Condom." By advocating for safer sexual practices, Getnet has transformed himself into a leader in his community, illustrating the change happening on a national level in Ethiopia.

## V. Challenges, Lessons Learned, and Recommendations

Throughout the course of implementation, World Learning encountered several challenges that influenced implementation, however through effective management, World Learning was able to identify and implement solutions to minimize their impact. As a result of these challenges and the experience of the MULU Worksite team, World Learning also developed a set of lessons learned and recommendations to guide future research, implementation, and evaluation of HIV programming in workplace settings.

### 5.1 Challenges

**Rapid Test Kits** – Persistent irregularity in the supply test kits coupled with frequent changes to the HIV testing algorithm resulted in the cancellation of planned testing events throughout the project and denied opportunities to provide critical HIV testing and counseling services to target populations during peak seasons. As a solution, World Learning implemented a test kit redistribution strategy to redeploy unused test kits to areas of critical need. This alleviated some short-term test kits shortages, but World Learning at times was unable to provide testing due to a

lack of supplies. However, without greater continuity in test kit supply, implementation will remain challenging in the future.

**Referral Rate** - Ensuring confirmed referral service was a challenge due to the high mobility of clients and the inaccessibility of the treatment centers. World Learning implemented an accompanied referrals and tracking strategy to ensure confirmed referrals. By engaging the ART focal person at the testing location, World Learning was able to increase the rate of confirmed referrals and increase linkages with local treatment centers. World Learning confirmed its results by calling the health facility or going to review the health facility register, however this was a labor-intensive process. By building the capacity of worksites and treatment centers, the potential for increased referrals in the future is possible utilizing World Learning's approach.

**Worksite Staff Turnover** – There was a high attrition rate of worksite Managers, Site Coordinators, along with clinic staff, Peer Educators and Supervisors who had been trained by the project. These individuals, prepared to lead and coordinate activities, would leave their positions or move to a new area, requiring additional training by MULU Worksite to achieve project objectives. World Learning provided frequent gap-filling trainings for replacement individuals to ensure the viability of workplace clinics and HIV Taskforces.

**Epidemiological Data** – A lack of worksite specific epidemiological data affected MULU Worksite's ability to plan strategically and implement most efficiently. During implementation World Learning worked to collect detailed work site information to develop specific micro-plans. Future implementers along with government partners and worksites would benefit from accurate, up-to-date, and accessible epidemiological data.

### 5.2 Lessons Learned

**Integrated Service for Key and Priority Populations –** MULU Worksite's focus was serving priority/bridging populations, however in some geographical areas surrounding Humera and Metema development clusters, key populations including Female Sex Workers were not being provided peer education, testing, counseling, or treatment linkages. In these areas MULU Worksite pursued an integrated strategy to provide service to both populations. A holistic effort is needed to mitigate risk for bridging populations.

**Catchment Area Approach** – The need to provide integrated services was also supported by our geographic approach which identified high risk areas and provided treatment to the area as a whole rather than focusing on just select groups within that area. Such a geographic approach was critical for long term sustainability as it helped build regional linkages between worksites and woreda and zonal level HAPCO.

**Highly Mobile Populations** – Based on MULU Worksites' population evaluation and risk analysis, we found it critical to provide HIV programming targeting migrant workers in addition to stable worksite populations. Without MULU Worksite, these highly mobile populations would have had no access to testing services, nor linkages with treatment centers, increasing the possibility of HIV transmission to the general population upon leaving the worksites.

**Peer Education's Effectiveness** – Peer education proved an incredibly useful tool in addressing

the needs of worksite populations and FSWs. By creating groups of peers, individuals were more willing to be honest and forthcoming in their discussions on HIV, ensuring that the sessions were productive and effective. By designing differing modalities of peer education for different workforces, MULU Worksite was able to reach a variety each population with an education that reflected the nature of their work and living situation.

**Worksite Capacity Building** – Building the capacity of worksites, the HIV Task Forces and QIT is necessary to ensure long term sustainability of HIV prevention efforts in a workplace setting. Due the varied nature of worksites within this project, World Learning had to use a variety of strategies to build and maintain the capacity of these teams to enact necessary HIV prevention strategies. Working in industrial and agricultural sectors, MULU Worksite was able to develop a comprehensive strategy to ensuring the sustainability of our intervention in Ethiopia. Utilizing an effective exit process to identify challenges and opportunities with worksites was critical to this effort. Utilizing exit meetings and workshops as forums for discussion and planning was necessary to conclude the project successfully.

### 5.3 Recommendations

**Strengthened Partnerships** – Key to the sustainability and long-term effectiveness of MULU Worksite was the project's emphasis on promoting cooperation and linkages between worksites and HAPCO's regional and woreda-level multi-sectoral structure. Similarly, World Learning worked closely with Local Implementing Partners to increase the reach of the project while efficiently using resources. Moving forward it is important to build on this progress, working closely with local partners and empowering HIV Taskforces to coordinate efforts between worksites and government stakeholders. Ensuring the strengthening of integrated management information system is also necessary to ensure effective decision making by all partners.

**Prioritize Growing Industrial Zones** – World Learning worked to address the needs of mobile and semi-mobile workforces through MULU Worksite, highlighting the team's responsiveness to changing dynamics. With the growth of industrial zones and large agricultural areas, it is critical that future HIV prevention and treatment programs serve these populations who are potentially at higher risk.

**Site Selection Criteria** – As a result of our experience implementing MULU Worksite, the importance of clear, well-defined site selection criteria based on clear epidemiological evidence was made apparent. World Learning recommends that a thorough epidemiological study be conducted to inform future HIV prevention and treatment implementation and provide targeted services.

**Rapid Test Kits** – Ensuring a consistent availability of Rapid Test Kits is critical to the smooth operations of future programs. Testing serves an entry point for providing other services, and thus will be critical to the success for future treatment and prevention programs.

**New Treatment Modalities** – World Learning worked to build integrated HIV prevention and treatment services through the MULU Worksite project and we believe it is essential to further develop treatment modalities which can best serve geographically and structurally diverse priority populations. World Learning recommends the consideration of modalities such as Community

Treatment Centers (CTCs) and Drop In Centers (DICs). DICs have previously been utilized in urban areas for FSW but never in hard to reach rural areas such as Humera and Metema. In worksite areas where there is no clinic and highly mobile seasonal populations, CTCs and DICs could efficiently provide essential services to key and priority populations alike.

**Risk Profile Study** – Gathering as much information as possible when conducting testing will help future implementers to better understand the characteristics of high risk individuals and lead to long term efficiencies.