STANDARD OPERATIONAL PROCEDURES FOR HIV/STI CARE AND PREVENTION

Sexual Health Clinic Level

National STD/AIDS Control Programme
Ministry of Health
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Foreword

National STD/AIDS Control Programme (NSACP) of the Ministry of Health of Sri Lanka works with a broad vision of providing quality sexual health services including HIV and STI related services for a healthier nation. Sri Lanka has taken the challenge of achieving ending AIDS along with global partners. As the pioneer government institution responsible for the national response to HIV epidemic in Sri Lanka, National STD/AIDS Control Programme provides the leadership and guidance. NSACP has taken important steps towards achieving national and international goals. The country has achieved the WHO certification for the Elimination of Mother to Child Transmission (EMTCT) of HIV and syphilis. National STD/ AIDS Control Programme (NSACP) further scaled up the roll out of its electronic medical record system named Electronic Information Management System (EIMS) during 2020. In addition, a new software named Prevention Information Management System (PIMS) is being developed to monitor the HIV prevention programme which is done in collaboration with the non-governmental stakeholders.

The operational guidelines for HIV/STI care, prevention, and support at National STD/AIDS Control Programme, is a reliable source of reference to both programmatic and clinical services providers at the Programme level and its island wide network of sexual health clinics (SHC) and other stakeholders. All the relevant details of these novel implementations at National STD/AIDS control programme that are necessary for each category of service providers, when functioning at the NSACP is consolidated into this publication.

Publication of this Operational guidelines would not have been possible without the continuous support from the national coordinators, consultants of the District sexual health clinics and the staff in NSACP. I would like to take this opportunity to thank all the contributors of this document. Their dedicated work and the staff of all reporting units of the NSACP are highly appreciated. The information available in this document would be valuable to strengthen the national response to HIV in Sri Lanka.

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Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal clinic
ART	Antiretrovials
ATV	atazanavir
BB	Beach boys
CBO	Community based organizations
CSW	Commercial sex workers
CT	Chlamydia trachomatis
DDG	Deputy director general
DGHS	Director general of health service
DO	Development officer
ECG	Electrocardiogram
EIMS	Electronic information management system
ELISA	Enzyme linked immunosorbent assay
EMTCT	Elimination of mother to child transmission
FBS	Fasting blood sugar
FSW	Female sex workers
GC	Gonococcus
HCP	Healthcare provider
HIV	Human immunodeficiency virus
HLA	Human leucocyte antigen
HSS	HIV sentinel surveillance
HSV	Herpes simplex virus
HTS	HIV testing services
IBBS	Integrated bio-behavioural surveillance
IDI	In-depth interview
IEC	Information education and communication
INAH	Isoniazid
IVDU	Intravenous drug users
IVF	In-vitro fertilization
JMO	Judicial medical officer
KP	Key population
LFU	Lost to follow up
LKR	Lankan rupees
M&E	Monitoring and evaluation
MA	Management assistant
MO	Medial officer
MOH	Medical officer of health

Abbreviations and Acronyms

MOIC	Medical officer in-charge
MRI	Medical research institute
MSM	Men who have sex with men
NAAT	Nucleic acid amplification techniques
NAC	National AIDS committee
NG	Neisseria gonorrhoea
NGI	Non-gonococcal infection
NGO	Non-governmental organizations
NGU	Non-gonococcal urethritis
nPEP	Non-occupational post exposure prophylaxis
NRL	National reference laboratory
NSACP	National STD/AIDS Control Programme
NSP	National strategic plan
OCP	Oral contraceptive pills
OHP	Overhead projector
OI	Opportunistic infections
OPD	Out-patient department
oPEP	Occupational post exposure prophylaxis
PAP	Papanicolaou smear
PCR	Polymerase chain reaction
PCU	Pediatric care unit
PDHS	Provincial director of health service
PEPSE	Post exposure prophylaxis after sexual exposure
PHI	Public health inspector
PHN	Patients health number
PHNS	Public health nursing sister
PHS	public health services
PID	Pelvic inflammatory disease
PIMS	Prevention information management system
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PN	Partner notification
PP	Positive prevention
PrEP	Pre-exposure prophylaxis

Abbreviations and Acronyms

PWID	People who inject drugs
QRSTD	Quarterly return of sexually transmitted diseases
RDHS	Regional director of health service
RDT	Rapid diagnostic tests
SHC	Sexual health clinics
RMSD	Regional medical supplies division
SIM	Strategic information management
SOP	Standard operational procedures
STD	Sexually transmitted diseases
STI	Sexuality transmitted infections
TB	Tuberculosis
TEC	Technical evaluation committee
TGW	Transgender women
TI	Targeted interventions
TPPA	Treponema pallidum particle agglutination
TV	Trichomonas vaginalis
UACR	Urine albumin-creatinine ratio
UFR	Urine full report
UIC	Unique identification code
UNAIDS	United nations programme for AIDS
UPCR	Urine protein-creatinine ratio
VDRL	Venereal disease reference laboratory
VOG	Visiting obstetrician and gynecologist

A. Introduction

Background

HIV/STI services are well established in Sri Lanka with a history running back to 1841 when vagrance ordinance was passed with a view to control venereal disease and establishment of first VD clinics in Colombo, Kandy and Galle in 1886. Currently National STD/AIDS Control Programme (NSACP) is the main government organization under the ministry of health, coordinate the national response to sexually transmitted infections and HIV/AIDS in Sri Lanka with the mission to prevent new infections and provide comprehensive care and treatment. NSACP provide services through 34 sexual health clinics and 24 ART centers, free of charge, covering 24 districts of the country.

In 2012 the Sexual Health Clinic operational guidelines and standards was introduced to improve the quality of services provided by the sexual health clinics. Updating of the standard operating procedure (SOP) fulfills a long felt need and this SOP is developed based on standard clinical care, programme operations, research, training, surveillance, data management, and evaluation by a working group of 25 members.

Existing national strategies, protocols and national guidelines for HIV/STI diagnosis, treatment and prevention are considered during development of SOP to ensure good quality service care to all.

This document consists of several chapters which covers important areas relevant to the HIV/STIs treatment, care and prevention including logistic management and human resources.

Objectives

The purpose of this SOP is to streamline HIV/STI prevention, treatment and care by providing standards in the designing, implementation, and evaluation of services provided through the sexual health clinics island wide.

Target audience

Main target audience for this SOP includes

Sexual health clinic staff: Consultants, medical officers, nurses, public health staff and laboratory staff
Health administrators: Central and provincial levels health administrators and programme managers involve in HIV/STD care
Development partners: Local and international development partners for HIV/STI care
Non-governmental organizations: NGOs working with NSACP

B. Administration and programme management at sexual health clinic level

Introduction

The overall administration and programme management at national level and district level mainly based on the “Three ones’ principle” and its guidance for programme directions. The "Three Ones" are a set of principles for the coordination of national AIDS responses. These principles were endorsed at a high-level meeting held on 25 April 2004 and co-hosted by UNAIDS, the United Kingdom and the United States.[1]

- **One** agreed HIV/AIDS action framework: National strategic plan (NSP) that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority: National AIDS Committee (NAC), with a broad-based multisectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System: National M&E plan

In health, strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way.

As the national focal point for co-ordinating HIV/STI services, national STD/AIDS control programme (NSACP) develop, monitor and evaluate (M&E) the National Strategic Plan (NSP) and re-develop/ edit the plan regularly in every five years. District sexual health clinics, provincial health administration and other relevant organizations need to work in line with the national strategic plan. The sexual health clinics are expected to support the strategic planning cycle which is described in Figure 1.[2]

Figure 1: Strategic planning cycle.

All the districts sexual health clinics are working together with the National STD/AIDS Control Programme to achieve the goals of the national strategic plan to end AIDS by 2030.

[1]Three ones’ principal, UNAIDS, 25th April 2004
[2]http://lynnecarbone.com/strategic-planning

Development of the national strategic plan

- The national strategic plan is developed by a process of broad-based multisectoral collaboration and consultation. The process is the responsibility of the national STD/AIDS control programme (NSACP) supported by local and international consultants
- The steering committee for NSP development is chaired by DGHS.
- DDG PHS1, Director NSACP and focal points for each program area and representatives from district sexual health clinics, Sri Lanka College of Sexual Health and HIV Medicine, NGO/CBOs working with NSACP, people living with HIV (PLHIV), key population groups are the members of the steering committee
- All following program areas are considered for NSP development

PROGRAMME AREAS OF THE NATIONAL STD/AIDS CONTROL PROGRAMME			
Administration and programme management	STI treatment and care services	HIV treatment and care services	Laboratory services
Prevention of mother-to-child transmission of HIV, Syphilis (PMTCT)	Strategic information management	Epidemiology	Multisectoral unit
Key population interventions	HIV testing services	IEC/condom and advocacy	Training, capacity building, research and development

National AIDS Coordinating Authority

National AIDS Coordinating authority is the national AIDS committee (NAC) with a broad-based multisectoral mandate. National STD/AIDS control programme of the ministry of health is the main responsible body to carry out the national response.

Monitoring and evaluation plan

Once implemented, monitoring and evaluation of activities of the strategic plan is done by using routine programmatic data, originated by the data recording and reporting system of the network of clinics in the NSACP including service providers of the NGO sector. Further, the clinic level consultants/MOICs need to monitor performances of the catchment area by using local data. In addition, national responses and performances are assessed by internal and external reviews. Sexual health clinics need to contribute and support as a responsibility for these national level M&E needs.

Organization structure

Sexual health clinics are governed by the Regional Director of Health Services except three Sexual health clinics in Colombo, Galle and Jaffna which are under line ministry. Administrative, financial and human resources are provided through the regional health authorities. The technical guidance, training and capacity building for the staff, laboratory support, and supply of ART and condoms/lubricants are provided by the NSACP. The clinical lead for the sexual health clinic is consultant venereologist. Most sexual health clinics are physically situated within the main hospital premises in most of the district but there are few clinics situated separately away from the hospital. Some districts have more than one sexual health clinic depending on the service need.[3]

[3]Annual report of the NSACP, 2020

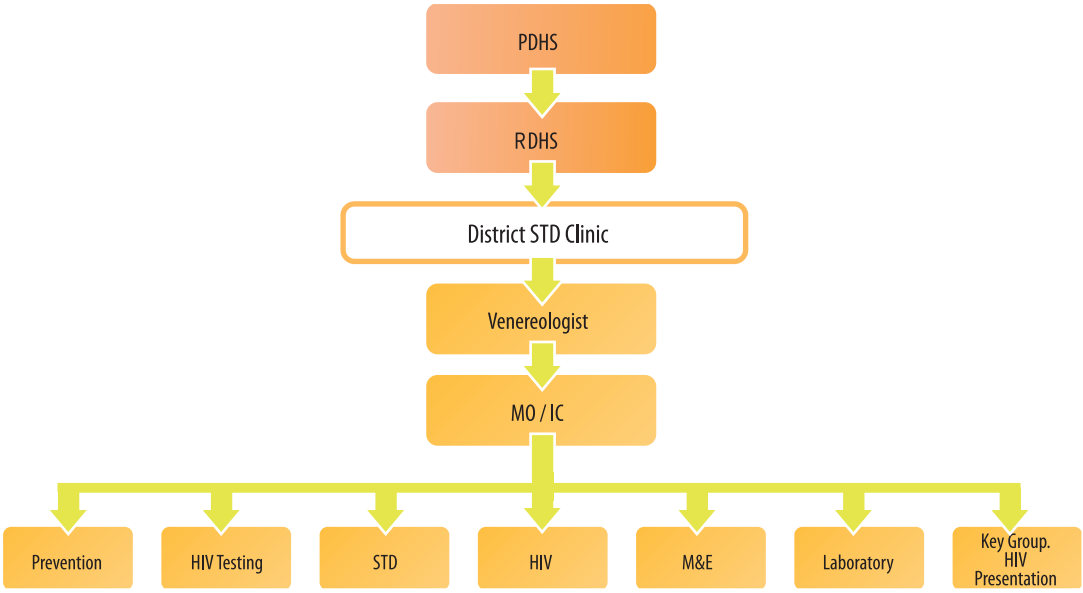


Figure 2: District STD clinic organogram

Advocacy for STI services

Advocacy in health is one strategy to raise levels of familiarity and call for support for an issue and promote health and access to quality health care and public health services at the individual and community levels.[4]

Advocacy is an important component in HIV/STD care in order to;

- Change or create policies or legislations related to HIV and STI care
- Obtain funding and support by government ministries, agencies or other donors
- Implement or change programme objectives, criteria/standards etc
- Increase awareness and understanding (for example, health messages to "the public") which in turn will change attitudes and behaviours
- Change in practice related to HIV/STD

Steps to follow when carrying out an advocacy programme

- Identify advocacy 'issue' and advocacy objectives clearly with the consensus of all stake holders
- Situation analysis by gathering credible and compelling evidence on the advocacy issue.
- Information gathered through key informants, research publications could also be used in this process
- Identify advocacy audience which may include Politicians, Decision-makers – officials of the Department of Health, Health administrators, Donors, Other government organizations (health and non-health sectors), Nongovernmental organizations /community based organizations (NGOs/ CBOs), Media, Corporations and industry, General public.
- Coalition and networking plan appropriate for the advocacy issue.
- Determine how each audience should be advocated.
- Establish measurable objectives for each audience.
- Define messages for each audience.
- Determine the communication activities to deliver those messages.
- Decide what resources are necessary to complete each activity.
- Establish a timeline and responsible party for each activity.
- Evaluate whether you have reached your objectives.

[4] European Centre for Disease Prevention and Control: Health Advocacy

Legislations and ethical considerations

STI/HIV services in Sri Lanka are governed by many policies, legislations and ethical principles. Following table list the important legal and policy documents relevant to STI control in Sri Lanka.

	Policy, and legal documents relevant to STI control in Sri Lanka	Type of the document
1	Constitution of the democratic socialist republic of Sri Lanka	Law
2	National health policy	Policy
3	National HIV/AIDS policy	Policy
4	National policy on HIV and AIDS in the world of work in Sri Lanka	Policy
5	National labour migration policy for Sri Lanka	Policy
6	National maternal and child health policy	Policy
7	National prison policy for HIV/AIDS prevention	Policy
8	Reproductive health care for adolescents (Annex 1)	Circular MoH 01-25/2015
9	Issuance of gender recognition certificate for transgender community	Circular MoH 01-34/2016
10	Penal code of Sri Lanka (section 365, 365A)	Law
11	Penal code of Sri Lanka (section 262, 263)	Law
12	Vagrants Ordinance	Law
13	Brothel Ordinance	Law
14	Poisons, Opium, and Dangerous Drugs Ordinance	Law

The Quarantine and Prevention of Diseases Ordinance of 1897: According to this ordinance every practitioner treating a case belonging to the category of notifiable diseases, should notify such cases to the Medical Officer of Health (MOH) of the area where the patient resides. However, sexually transmitted infections including HIV are not considered as a notifiable disease but viral hepatitis is notifiable under the law.[5]

It is important for all professionals who provide HIV/STI care to be knowledgeable of above policies and legislation.

Minimum Standards for HIV/STI services

Quality STI/ HIV Service Delivery

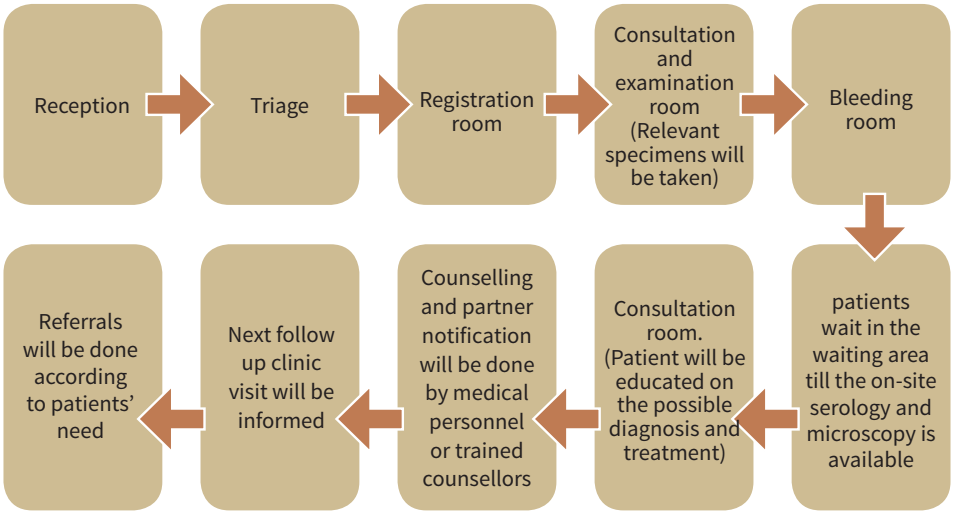
- District sexual health clinics need to be established within the premises of main hospital of the district so that service is easily accessible.
- Sexual health clinics need to be self-referred walk-in clinics.
- Depending on the need, main district sexual health clinic can conduct one or two outreach/ mobile/satellite clinics to extend services.
- Routine working hours are usually from 8 am to 4 pm. Evening clinics and community outreach clinics could be out of working hours for the convenience of clients who cannot attend during routine clinic hours.
- All the services are to be provided free of charge for Sri Lankan citizens. Resident visa holders living in Sri Lanka and who holds a valid health protection plan (HPP) as per circular 01-37/2019 (Annexure 1) are to be provided servicers free of charge. Health protection plan will not cover hospitalization other than emergency care in the government sector.

[5]https://www.quarantine.health.gov.lk/

- Well trained staff is utmost important requirement for all sexual health clinics in order to provide HIV/STI care with non-judgemental attitudes, maintaining confidentiality with minimum stigma and discrimination.

Clinic operations

Once a client enters the sexual health clinic s/he is directed to the following stations in a sequence.



- Once a client enters the sexual health clinic the receptionist is to direct the patient for triaging.

- A trained staff member can fast track to escort clients who need special attention. (e.g: pregnant women, patients in severe pain and psychological distress, ward referrals, positive results, first visits etc)

- Next, the client is directed to the registration room where the details are recorded in the registers and will be given a PHN and a UIC by an appropriately trained public health staff.

- The client is given a token at this point and the 'currently being served' token number is displayed in the screen in the waiting area.

- When the clients' token is being served, the supporting staff member escort him/her to the consultation room.

- Medical officer should ensure there is enough privacy during the consultation and examination. It is good practice to have an assistant or third party during examination (offer chaperone). Also, to ask permission from the client to have any other person (eg: medical students, PG Trainees etc.) to be in the room prior to the consultation, in situations where teaching involved.

- All examinations, procedures and treatments need to be clearly explained and understood by the client.

- The examination bed should be correctly positioned with adequate privacy, lighting and space to perform genital examination. Examination room should have facilities to wash hands with running water.

- After examination, blood for serology (syphilis, HIV, hepatitis B etc.) is to be collected in bleeding room by a nursing officer. PHN should be rechecked and details should be entered in EIMS and appropriate registers before taking the blood sample. Proper infection control measures should be maintained.
- Collected specimens are sent to the laboratory ensuring safety measures. urgent serological test results and microscopy findings will be available on the same day and should be explained to the client/patient.
- Patients should be managed according to the latest national guidelines and patients should be fully informed about the diagnosis, causation, transmission, and prevention of STI/HIV. Prescription will be issued by the medical officer based on the diagnosis.
- The client/patient needs to be counselled on prevention of STI /HIV and partner notification. Condoms and lubricants to be offered. A follow-up plan and date need to be given to the client/ patient and recorded in EIMS. patients can refuse any or all the services at the clinic even after detailed counseling. If so, document the resistance by the patient in the clinic record.
- Prescribed medication is to be dispensed from the clinic pharmacy. Adequate supplies of drugs should be maintained in order to functions the clinics in minimum standards.
- Injection room
  - injections are to be given in the injection room by nursing officers under direct observation of medical officers.
  - Facilities to manage anaphylactic reaction should be available in the injection room. Medical officers, nursing officers and supporting staff should be properly trained on management of anaphylaxis. A poster should be displayed on management of anaphylaxis. Emergency tray, oxygen cylinder and sucker should be checked daily and a chart should be maintained.
- Infection control unit
  - Universal and standard precautions to prevent blood born infections should be maintained in every clinical setup under the guidance and supervision of the infection control team. Its important to have a designated nursing officer for the sexual health clinic who liaise with the hospital infection control unit.

Minimum infrastructure requirement

The internal structure of the clinic should include the following for provision of comprehensive care to patients with STI/ HIV reception desk

Reception area	Should be positioned in an easily accessible place facing the entrance of the clinic. There should be a reception desk for the receptionist
Waiting area	The waiting area should be away from the consultation rooms and with adequate space. clinics can have separate waiting areas for males and females but clients should be allowed to sit according to their gender preference.
Registration room	There should be a table with EIMS installed computer and/ or manual registers and chairs for PHI/PHNS and the patient. This room should have sufficiently thick walls to ensure both auditory and visual privacy.

Patient record keeping room	• A separate room which can be locked should be made available to store patient records. If this is not possible there should be lockable filling cabinets to store patient records safely and securely. • Files should be stored in an order for easy retrieval and should be manned by a responsible staff member.
Consultation and examination room	• The consultation and examination room should have thick walls to ensure both visual and auditory privacy. •There should be a table, EIMS installed computer and chairs for doctor and the patient to conduct the consultation. •The room should have a sink with running water, sufficient countertop area, and an emergency alarm. Clinic rooms should have a comfortable, safe and hygienic environment with separate bins for clinical and general waste. •All equipment should be maintained in good working condition. •Room needs to have adequate light and side table with necessary equipment and trays to collect relevant specimens. •There should be health education material, male and female condoms, lubricants and dildos in the room to facilitate health education and counselling. •Male, female and gender neutral wash rooms for patients should be in place with easy access.
Bleeding and injection room	•There should be a table, EIMS installed computer and chairs for nursing officer and the patient. The room should have a sink with running water, sufficient countertop area and adequate lighting. A bed if giving injections in the same room •Bleeding and injection rooms should have a comfortable, safe and hygienic environment essentially with three separate bins for sharps, clinical waste general waste. •All equipment should be maintained in good working condition. •Some clinics may administer the injections in the OPD/PCU injection rooms of the main hospital if it is very nearby.
Laboratory services	• Please refer section on laboratory services
Counselling and health education room	•This room should have thick walls to maintain visual and auditory privacy. •There should be a table and chairs, condoms and dildos, contraceptive devices, a bell, relevant educational materials, pens, papers etc. •Counselling registers should be maintained properly in a filing cabinet.
Pharmacy	•Pharmacy should have registers, computers installed with EIMS, filing cabinets, shelves, cupboards for storage and a refrigerator. •Pharmacy should be air conditioned particularly the stores. •Please refer chapter I for further details
Storeroom	•There should be adequate space for storage with satisfactory ventilation and pest free. There should be separate space to store non-usable (condemned) items.
Room for cleaning and preparation of swabs etc.	•This room requires adequate space for cleaning, washing, drying, packing and autoclaving clinic equipment. •Adequate work top area is necessary. •There should be an autoclave machine, sink and running water.

Infection control unit	• Please refer laboratory services and infection prevention and control (IPC) chapter
Laundry room	• All soiled/used linen should be collected at the end of the session/day and sent to laundry room. • Washing machine with hot wash cycle and dryer should be installed in the laundry room.
Lecture room	• Lecture room should be a spacious area with table, chairs, screen, multimedia stand and cupboards. • Audio-visual equipment, camera, multimedia projector, OHP, slide projector, magi Board, flipcharts and IEC material should be stored securely.
Office room	• This room needs to be organized in such a way to support administrative functions. • Tables, chairs, cupboards, computers, photocopy machines, printers, fax machines, telephone, internet facilities should be in place.
Consultant room	• This room needs to be organized in such a way to support clinical and administrative functions • Table, chairs, telephone, computer, printers, internet facility, lockable cupboards, filing cabinets, attendance registers, movement registers need to be placed in this room
Changing room and washroom	•There should be changing rooms for minor staff, PHI, Nursing officers and Doctors.
Common eating area and pantry	•Staff should have adequate space to rest in a pleasant environment with tables and chairs, sink and running water.

Human Resources for HIV/STI Service Provision

The clinic should have an adequate number of qualified staff to ensure a smooth flow of patients through the clinic without unnecessary delay. Each staff worker should have a personal file with the qualifications, training received and terms reference etc.

Table B1: List of staff categories for a model sexual health clinic

Administration	Clinical staff	Public health staff	Other staff
• Consultant Venereologist / MOIC • Administrative officers • Data entry operators • Clerical staff • Supportive staff	• Consultant Venereologist • Medical officers • Nursing officers • Supporting staff	• Public health nursing sisters • Public health inspectors • Health education officer • Social service officer linked from Department of social services	• Cinema operator • Drivers • Supportive staff

Laboratory staff	Pharmacy	Cleaning staff
• Medical laboratory technologists • Public health laboratory technicians • Supporting staff	• Pharmacist • Supporting staff	• Supervisor • Laborers • Overall supervision by the PHNS

Medical record keeping

All the staff members are to be trained on their responsibilities and confidential medical record keeping. The relevant staff members require familiarizing themselves with the electronic patient information management system (EIMS) (Refer chapter K for further details). All medical records need to be maintained electronically. In case of failure in electronic system the records can be entered manually. The guide on maintaining hard copies is given in “User manual for STI patient management information system”.

The hard copies of patient records and reports need to be kept under lock and key in the record room. The record room requires to be handled by designated officers and no other person is allowed to access the record room.

C. STI treatment, care and support

Introduction

STI treatment, care and support is an identified programme of the national STD/AIDS control programme. Consultants, MOIC, medical officers and the sexual health clinic staff are collectively responsible for the provision of this service under the technical guidance of the NSACP

STI service need to be comprehensive and complete including the coverage in all relevant areas of sexual health.

- Clinic attendees could be of different categories of patients with various complaints seeking STI /HIV and sexual health care.
- People attend sexual health clinics on voluntary basis or as referrals.
- Referrals could be from wards, OPD, other clinics, general practitioners, JMOs, courts, police, prisons and NGOs and KP screening programmes.
- STD service package could be in different standards such as minimum packages, essential packages, extended packages, standard packages, and comprehensive packages. Standard package at district sexual health clinics should include

Table C1: STI service package

History	Obtain a complete history with non-judgmental attitude, develop a good rapport with the patient and proper documentation ensuring confidentiality of the information.	
Clinical examination	including general, systematic and genital examinations	
Investigations	•	Following investigations are offered to all sexual health clinic attendees: VDRL, TPPA, HIV ELISA, Gonococcal culture
	•	At sexual health clinics where gonococcal culture is not available urethral and cervical smear for microscopy could be performed.
	•	Other investigations need to be performed according to clinical features, risk assessment and availability of laboratory facilities (refer 'Sexually transmitted infection guideline' for further information).
	•	HIV rapid test upon decision of the clinician when results are urgently needed or the client is a key population member.
	•	Pre-employment screening for syphilis for government medicals and prior to foreign employment.

Management (Treatment, Counselling, Health promotion. Partner notification, Prevention)	•	Provision of treatment following etiological diagnosis or with syndromic management protocol according to availability of diagnostic facilities.
	•	Arrangement of follow up visits accordingly.
	•	Contact tracing according to protocols and treatment or prophylaxis for contacts if indicated.
	•	Defaulter tracing at the clinic to trace treatment defaulters
	•	Provision of condoms and lubricants.
	•	Education and demonstration of correct use of condoms.
	•	Provision of health education to improve knowledge on sexual health.
	•	Hepatitis B vaccination for KP groups.
	•	Referrals to other specialists' clinics if indicated
	•	nPEP/oPEP following high risk exposure
	•	PrEP for high risk HIV negative people as indicated by the national protocols
	•	Assessment for psychiatric issues, nutritional problems and NCDs.

Table C2: Essential service package offered for clients attending for STI service at outreach sites should include

History	Obtaining a brief history and risk assessment ensuring confidentiality
Examination	General examination, genital examination if an examination room is available with adequate privacy
Investigations	Rapid diagnostic tests (RDTs) for HIV (dual rapid test to cover HIV and Syphilis if available)
• Management	•Counselling for behaviour modification and risk reduction •Health education on common STIs and HIV and ways to prevent acquiring them •Condom promotion and distribution. •IEC material distribution. •Small group discussions or awareness programmes to address their problems. •Refer to Sexual Health Clinic for complete examination and STI screening

STI services in patient management

Client information management

Registration of the patient should be done by the PHI/ PHNS/NO using

- Electronic registration in EIMS (refer E learning platform for EIMS of NSACP-2020)
  or
- Manual registration (if EIMS is unavailable)
- Following registers need to be used in manual registration (refer guidelines for maintaining registers in sexual health clinics)
    - Main register - for new patients
    - Subsequent visit register - for subsequent visits
    - Out-patient blood testing register - for people who need blood testing only
    - Pre-employment/visa screening register - for those who need blood testing for those purposes
    - Commercial sex worker register for commercial sex workers

Clinical servicers

- History taking, examination, investigation and treatment should be done by the medical officer/consultant venereologist.
- Following guidelines and protocols (latest versions) should be referred in the management of patients with STIs
    - Sexually transmitted infections management guidelines, 2019
    - Sample collection manual for STI/HIV testing, 2019
    - Protocol on the management of nPEP/oPEP/PrEP, PAP smear taking and contact tracing
- When managing a pregnant patient consultant venereologist's opinion should be taken and liaison with the obstetric team is also important. The separate register should be maintained on STIs in pregnancy
- In the management of antenatal mother with syphilis, guideline should be referred (refer the latest guideline of management of pregnant women with syphilis)

Contact tracing/ partner notification

This should be initiated by the medical officer who sees the patient and should be continued by the PHI/PHNS/NO as instructed by the medical officer

Contact tracing also known as Partner Notification (PN) is the process for providing access to persons who may have been at risk of infection from an index patient/case. This includes supportively providing advices to contacts about possible infection, and providing treatments for infection.

- Public health staff should attempt to reach all contacts and see that they are attended to, and registered for care.
- Maintain a register for contact tracing, refer guidelines for maintaining registers and returns in STD clinics.[6]
- According to the national STD guideline contact tracing is indicated for contacts of gonorrhoea, syphilis, chlamydia, non-gonococcal infections (NGI), trichomoniasis, pelvic inflammatory disease (PID) and epididymo-orchitis (consider contact tracing of PID and epididymo-orchitis only if the causative organism is suspected to be an STI)[7].
- Clinician should ensure that patients, who are diagnosed as having above infections, including presumptive cases, are sent 'for an interview' (FI) with PHI/ PHNS.
- When the public health staff is not available, clinician can do the interview and provide contact slips.
- It is essential to maintain confidentiality throughout the contact tracing process.
- There should be an agreed contact action with the index patient about mode of partner referral and which partner to contact.
- The outcome of the agreed contact action should be documented for each index patient within 4 weeks of first partner tracing discussion.
- Documentation and maintaining relevant data manually or EIMS should be done by the responsible officers. At the end of each week, the responsible person for contact tracing should check whether contacts have attended the clinic or not and should enter the outcome

Issuing contact slips

- During interview, the index patient should be given contact slips for all contacts.
- To get the number of contacts treated in each disease, count them in the main register/EIMS under reasons for attendance where you have to mention the reason as a contact of patient, the master number/PHN of index patient and the contact slip number.
- If doctors are giving contact slips, still it is mandatory to send the index patient 'for an interview' (FI).
- Doctor may decide to treat a contact (marital partner, spouse) without bringing the contact to the sexual health clinic (expedited partner therapy). They are not entered in the number of contacts treated in the table 3 of QRSTD. However, it is necessary to send these index patients for an interview (FI) to trace other contacts.

[6]https://www.aidscontrol.gov.lk
[7]Sexually transmitted infections, management guideline, NSACP, 2019

- The period during which contacts need to be traced is called interview period or look-back interval (Table C3)

Table C3: Interview periods (Look-back intervals) for different sexually transmissible infections

Infection	Category	Interview period/look-back interval
Gonorrhoea	Male index cases with urethral symptoms	All contacts since, and in the two weeks prior to, the onset of symptoms (if no contacts in the period: Notify the last contact)
	All other index cases	All contacts in the three months prior to presentation (if no contacts in the period: Notify the last contact)
Chlamydia	Male index cases with urethral symptoms	All contacts since, and in the four weeks prior to, the onset of symptoms (if no contacts in the period: Notify the last contact)
	All other index cases	All contacts in the six months prior to presentation (if no contacts in the period: Notify the last contact)
Non-gonococcal urethritis / Non-gonococcal cervicitis	If Chlamydial infection detected	As in chlamydial infections
	If chlamydia not detected	All contacts since, and in the four months prior to, the onset of symptoms
Epididymo-orchitis OR Pelvic Inflammatory Disease (PID)	If gonococcal infection detected	As in gonococcal infections
	If chlamydial infection detected	As in chlamydial infections
	If gonorrhea or chlamydia not detected	All contacts since, and in the six months prior to the onset of symptoms
Trichomoniasis	-	Any partner (s) within the four weeks prior to presentation should be treated
Chancroid	-	All contacts since and in the 10 days prior to the onset of symptoms
Lymphogranuloma Venereum	Index cases with symptoms	All contacts since, and in the four weeks prior to the onset of symptoms
	Index cases without symptoms	All contacts in the three months prior to LGV detection
Early Syphilis	Primary syphilis	All contacts since, and in the three months prior to, the onset of symptoms
	Secondary and early latent syphilis	All contacts since, and in the two years prior to, the onset of symptoms
Late latent and late syphilis	Sexual partners and Children of female partners	Partner Notification should be done back to the date of last negative syphilis serology, if available. Otherwise, it should extend back over the patient's sexual life time as far as is feasible
HIV infection	Time of infection can be estimated by risk assessment	Include all contacts since, and in the three months prior to the estimated time of acquisition of the infection.
	Time of infection cannot be estimated by risk assessment	All previous partners should be contacted and offered HIV testing

Contact tracing/partner notification (PN) for HIV infection

Refer the section D for details

Defaulter tracing

The term 'defaulter' is used for patients who do not attend for the given appointment. Most of the defaulters do not need any active intervention by the sexual health clinic staff. However, certain defaulters need to be contacted for provision of care as they may be at risk of developing complications due to untreated STIs and may transmit the infection to their sexual partners.

- Main purpose of the defaulter tracing is to maintain data on defaulters who needs to be contacted and take necessary actions to bring them for continuation of care.
- A defaulter registers should be maintained in the clinics where there is no EIMS. Clinics with EIMS can obtain details of defaulters directly from the system.
- Proper maintenance of this defaulter register will help to keep track of defaulters and to determine the effectiveness of the defaulter tracing services.
- Only the details of defaulted patients who need contacting are entered into the defaulter register
- To identify the defaulters, each clinic should either maintain a diary on due visits or have the appointment card system.
- After three days of defaulting, the defaulted files should be reviewed by a clinician and he/she should advice PHI/PHNS regarding the mode of default tracing.

Health education and counselling for STIs

Health education (HE) is an important component of comprehensive care for STIs and should be offered to all which could include both symptomatic and asymptomatic clients. HE is more effective with IEC materials and patient should be given leaflets, booklets or electronic information (eg: web sites). Following basics should be covered during health education in STI care

- type of infection and cause
- transmission
- complications, recurrences
- treatment
- important of partner notification and prevent onwards transmission
- how to reduce the risk and stay safe.

Counselling

Counselling for STI/HIV helps to reduce the clients'/ patient's personal risk of acquiring STI/ HIV. Counselling is a two-way process that involves face-to-face, personal, confidential communication in which counsellor helps the client/patient to make decisions and then to act on them.

- Counselling should be carried out by a trained doctor or a trained PHI/ PHNS/NO as requested by the doctor who manages the patient.
- Counsellor should strictly adhere to maintenance of privacy and confidentiality of the client. (Refer the latest version of the Manual of counselling for further details)
- Procedure should be audio-visual as far as possible. Using leaflets, flipbooks, videos on STIs/ HIV with condom demonstration

Counselling clients on condom/lubricant use and its distribution

- A client should receive the following information while condom promotion
  - –Explanation about condoms, what they are made of, how they function and how effective they are.
  - –Demonstration on how a condom is used, including how it is accessed from its package and how it is disposed by using a dildo and condom flipbook
  - –Details on where they can get condoms: From HIV/STI programme and other health organizations free of charge, and the cost if it is bought from outside.
- Clients need to be provided with condoms/lubricants before they leave the clinic, especially those who appear to be shy or insecure about the whole situation.
- Clients should be provided with IEC materials such as brochures and booklets that will give clients additional information
- Clients should be advised on and provided with water base lubricants
- Help clients to overcome resistance to condom use, including negotiating with their sexual partners.

Sexual health services

Following key elements of care are expected to be delivered through a sexual health clinic:
Management of male and female sexual dysfunctions

Sexual dysfunctions	Psychosexual services	Social, physical and psychological issues related to
• Erectile dysfunction	• Sex therapy/ Couple therapy	• Homosexuality
• Ejaculatory problems including premature ejaculation and delayed ejaculation	• Psychosexual counselling	• Transgender
• Hypoactive sexual desire (libido) disorder		
• Chronic pelvic pain syndromes		
• Orgasmic disorders		
• Sexual pain disorders/ vaginismus		

The relevant problem should be addressed and managed by a trained, skilled, and experienced medical officer preferably by a consultant venereologist.

- Assessment, diagnosis and the management should be guided by local and standard guidelines on sexual medicine and psychosexual medicine.
- It is important to identify and liaise with other relevant specialties where multidisciplinary team approach is important
- E.g.- Psychiatrist, gynaecologist, genito-urinary surgeon, endocrinologist etc.
- Relevant clinics/wards should be informed preferably through an internal circular to promote referrals.
- Clinic to be equipped with the medical instruments and infrastructure needed in the assessment and management of sexual problems.eg: Orchidometer, anatomical models, counselling rooms ensuring privacy etc.

- Investigations relevant to the assessment of male and female sexual dysfunctions should be made available and can liaise with the nearest hospital laboratory.
  E.g. FBS, lipid profile, hormone analysis, ultrasound /duplex scans etc.
- The drugs used in the management of sexual dysfunction should be made available at the clinic or in the hospital pharmacy.
- IEC material should be developed at national level and to be used to educate about common sexual problems.
- Media/social media campaigns should be launched at national/local level to educate the people about the services provided by sexual health clinics.
- Public awareness campaigns to be implemented targeting special groups to increase the awareness regarding common sexual problems nationally/locally
  E.g.- In school and out of school youth.

Contraception services

Contraceptive services are provided for key populations and other sexual health clinics attendees as a part of the sexual health package

- The routine and emergency contraception should be made available in the sexual health clinics
- The contraception counselling should be offered to all the clinic attendees
- If the client's choice of contraception is not available in the clinics, the referral should be made after discussing with the relevant family planning clinics
- For clients with or at risk of STI, dual method contraception, which combines condom and another method should be discussed
- The contraceptive chapter of the STD guideline and HIV guidelines can be followed when providing the services
- The training on contraception should be obtained prior to initiation of the services if not competent on prescribing contraception
- The data should be maintained according to the standard formats recommended by the FHB.

Occupational post exposure prophylaxis (oPEP)

- Post exposure prophylaxis after occupational exposure (oPEP)
- Any health care worker exposed to blood or body fluid should be evaluated for risk of acquiring HIV
- Management of exposure during working hours (weekdays 8 am to 4 pm and Saturday 8 am to 12 noon) is done by sexual health clinic.
- District sexual health clinic should maintain a separate register for PEP
- Initial management of exposure outside working hours of sexual health clinic is initiated by designated medical officer of the health care institution
- Starter pack can be initiated in the event of inaccessibility of designated MO in the institute within 2 hours of occupational exposure. Such health care worker to be referred to Venereologist or MO/STD for further assessment on the next working day.
- HIV rapid test facilities should be available in the sexual health clinic and the hospital for initial assessment of source sample
- Timing of PEP should be as soon as possible, ideally within 2 hours. However, initiation of PEP could be done within 72 hours of exposure.
- Recommended regimen for PEP as given in the available standard management of occupational exposures protocol. However, when such regimen is not available or not suitable, consultant venereologist could decide on alternative regimen.
- PEP need to be continued for 28 days

- District sexual health clinic should maintain a stock of ART for PEP purposes.
- Starter pack should be available in an identified place in all the hospital for emergency use in the case of exposure management outside the working hours of sexual health clinic. In charge of such place should be responsible for maintaining stocks and contacting district sexual health clinic for maintaining unexpired ART.
- Baseline testing and follow up of health care worker should be based on the protocol.
- All occupational exposures and management should be recorded in the exposure report or clinic file EIMS

Non-occupational exposure (nPEP)

- Anyone coming with unprotected sexual exposure within 72 hours need to be evaluated for risk of acquiring HIV
- Cumulative risk of HIV transmission need to be considered based on exposure characteristics, the infectivity of the source, and host susceptibility based on the guideline prepared by NSACP on post exposure prophylaxis following sexual exposure.
- PEPSE should be offered and started as early as possible, ideally within 24 hours, but can be offered up to 72 hours.
- Recommendation of PEPSE based on NSACP PEPSE protocol
- District sexual health clinic should have adequate ART stocks in managing clients starting with PEPSE
- PEPSE should be stated after basic STI screening tests, and negative HIV rapid test and with the recommendation of a consultant venereologist
- Those who are started on PEPSE need to be followed up with bio-chemical tests and HIV tests based on recommendations in the guideline.
- Emergency contraceptive should be discussed when appropriate
- Condom promotion and provision need to be done in order to reduce the future risk
- Those who come for repeated PEPSE should be evaluated for Pre-exposure prophylaxis
- PEPSE for other STIs need to be considered and offered based on STI guideline
- If clinically indicated assess for Hepatitis B and offer vaccination when appropriate.

Pre-exposure prophylaxis in Sri Lankan context.

- PrEP pilot is being carried out and the implementation of PrEP will be done based on the pilot project.
- This section of SOP will be updated upon development of guideline on PrEP by NSACP

Services for special population groups

Children

In this document children are considered as persons who are under the age of 16 years and they need special attention at sexual health clinics. If a child is not accompanied by a parent or guardian STD services can be provided if the child has the capacity to give consent and assessed by Gillick competency

Services that required to be made available at the sexual health clinics for children

Consent for health assessment	• Assessing the child for capacity to give consent (Gillick competency). • Assess the ability to understand the proposed management options, emotional and intellectual maturity. • Consent could be obtained from parents or guardian when child is not competent
Obtaining a comprehensive history	• Reassure parents on confidentiality of information. • Create a friendly background to ease the anxious child and the parents. • Sensitive details of sexual exposures should be inquired carefully without traumatizing either the child or the parents.
Examination	• Explain the procedure to parents / child and reassure them. • Keep the parent/ guardian while examining to comfort the anxious child. • Always get the help of a chaperone • Obtain relevant samples at the time of the examination. • Avoid speculum examination in female children to avoid any damage to the hymen. Could take high vaginal swab instead
Laboratory investigations	• Should be arranged according to clinical features. • Screening tests could be performed when indicated.
Treatment	• Appropriate treatment should be provided. • Calculate drug doses according to the age/weight of the child. • Advice on how to crush tablets to get the correct drug dose to minimize the errors in dosing.
Referrals and follow-ups	• Should be made accordingly • Liaise with Pediatrician and VOG when their opinion is required. • Follow up clinic visits need to be arranged considering school hours and convenient time slots. Consider after 2pm on weekdays or Saturdays to avoid school hours

Handling children with a history of sexual abuse

- Ensure privacy of information.
- Discuss with the child prior to disclosure of details to parents or guardian.
- Avoid disclosing details to police/ prison officials when brought by them.
- Protect the human rights of children and prevent stigmatization.
- Commercial sexual exploitation of children is an offence and if such cases are found need to inform the consultant or a senior medical officer to decide on legal interventions.
- Counselling needs to be offered for children, parents and caretakers.
- Always get help from staff members with experience in childcare, when handling children at the clinic.
- Psychosocial issues of children are to be dealt with care and seek psychiatrist's opinion as required.
- Nutritional status should be assessed and arrange referrals to nutrition clinics
- Request support from NGOs and social workers attached to hospitals for children with social problems.

Adolescents

Adolescents are considered to be persons between 10-19 years, while persons between15-24 years are considered as youth. Adolescents and youth are a special vulnerable group for HIV and STI who need special attention.

- Possible challenges in providing sexual health and HIV services to adolescents and youth;
  - Non suitable opening hours
  - Lack of sensitivity of staff in handling adolescent problems
  - Social and religious norms
  - Legal barriers : age of consent for HIV and STI testing
  - Reluctance to accept engage in sex
- Sexual health services and HIV related services should be provided to adolescents considering above challenges
- The General Circular No: 01-25/2015(Annexure 1) gives provision for medical officers to provide such services to clients below 18 years when the caring doctor clearly sees the benefit of providing services to adolescents.
- To overcome the issues related to inconvenient clinic opening hours for school going children, they should always be given appointments convenient for them (weekdays 2-4pm or Saturday)
- All medical officers and staff should be sensitive to adolescents' issues and should be given priority to them when necessary.
- All staff members need to be given adequate pre-service and in-service training to develop skills necessary to deal with adolescents.
- In situations where the relevant medical officer or other staff member feel that he/she is not competent enough to handle the adolescent/ youth or if the client is not comfortable enough the staff member is expected to call a senior member who is much more experienced to provide the services to the minor.

Pregnancy and post-partum

Sexual health clinic needs to be designed towards maintaining high standards for providing STI care with privacy and confidentiality of pregnant and post-partum women.

Prevention of mother to child transmission (PMTCT) of HIV and syphilis
Currently all pregnant mothers in the country are screened for HIV and syphilis under the PMTCT of HIV and syphilis programme during their booking/first visit at the respective ante natal clinic.

Sexual health clinic is responsible for

- Provision of technical support, training of MOH staff in the district and regular supervision of their services in respective of EMTCT programme in liaise with RDHS.
- Documentation and maintaining registers during the period from receiving ANC blood samples to sexual health clinic/lab to issuing results of requested tests to respective MOH staff
- Training of STD staff, supervision of laboratory work and overall supervision of EMTCT programme
- Handling positive reports, management and follow up of respective mothers in accordance to 'Guidelines on management of pregnant women with HIV and syphilis'.
- Screening mothers who have experienced early abortions before screening for HIV and syphilis
- Service provision for mothers who have been missed out from the screening programme prior to admission for delivery and carrying out staff awareness programmes for the obstetric units regarding those incidents.

Once these clients attend the sexual health clinic,

- Welcome and respect the dignity, privacy and confidentiality of mother
- Register the mother in the sexual health clinic.
- Carefully check ante natal records such as H – 512, VOG notes and other medical / referral notes etc.
- Check for any contraindication for internal vaginal examination (Eg: placenta previa)
- History taking, general and genital examination need to be carried out by a consultant / medical officer.
- Appropriate sampling for STI screening needs to be performed during examination.
- Serology for HIV, syphilis, other relevant and available tests for STI screening should be offered after obtaining informed consent.
- STI management needs to be carried out according to the available latest guidelines.
- Contact tracing and epidemiological treatment should be arranged appropriately.
- Counselling of current disease/infection, potential outcomes, prophylactic treatment, risk reduction and other concerns which are directly related to current pregnancy need to be done by the caring officer or other officer assigned for it. Partner can be included when necessary.
- Back referral should be written to the VOG/caring clinician/MOH.
- Any especial observation/management to be performed on the mother and/or new born at the time of delivery or during post-partum period should be clearly mentioned in the back referral note using the standard formats.
- Follow up plan is arranged and discussed with the mother.
- Suitable family planning method should be discussed and offered for mother before the delivery plan if they are interested.

Victims of sexual assault

Sexual health clinics should be designed towards maintaining high standards for providing care with privacy and confidentiality of victims of sexual assault.

- These victims can be presented to sexual health clinics in number of ways.
  - o Referred by JMO /Medico legal staff
  - o Produced by police / courts
  - o Referred by other health unit
  - o Accompanied by NGO / community leader / family member
  - o Voluntarily.
- Following areas should be highlighted when providing services by the STD staff.
  - o Protection of dignity of the victim.
  - o Respect for the victim shall be ensured by
    - Ensuring privacy
    - Maintaining confidentiality
    - Ensuring independent decision-making
    - Obtaining informed consent from victim
  - o Allowing the victim to participate in all decision making pertaining to their life and well-being.
  - o Make sure that medico-legal examination and obtaining samples have been completed before initiation of STI services to prevent loss of evidence.
- Once these clients attend the sexual health clinic,
  - o Welcome and register of the client in the sexual health clinic.
  - o History taking, general and genital examination should be carried out by a consultant / medical officer.
  - o All relevant documentations including drawings where necessary should be done clearly.

- If a female victim is being examined, offering speculum examination should be done according to the situation.
- Procedure of examination and sample collection for STI screening should be clearly explained to the victim and/or bystander.
- Appropriate samples for STI screening need to be performed during examination
- Serology for HIV, syphilis, other relevant and available tests for STI screening should be offered after obtaining informed consent.
- STI management should be carried out according to the clinical judgment and available laboratory findings.
- Contact tracing and epidemiological treatment should be arranged appropriately.
- Potential risk for pregnancy should be explored in female victims. Pregnancy test and emergency contraception should be offered if appropriate.
- Depending on the age, sex, education level, the type of sexual assault and probable STIs contracted, counselling should be carried out by a medical officer or other officer assigned for it. Series of counselling sessions may be required in follow up visits with some clients.
- Risk of contracting HIV infection should be evaluated and PEPSE need to be offered when indicated.
- Follow up plan should be arranged and follow up duration should be decided according to the date of sexual assault, diagnosis made and other relevant issues.
- Initial and final medical report should be sent to the relevant authorities after the completion of follow up assessment.
- Necessary referrals should be arranged as appropriate such as psychiatry referral and social services referral
- If the sexual assault/potential risk of sexual assault is revealed by the victim or other person for the first time to the STD staff, it should be discussed with a senior consultant for further referral to legal authorities. The client should also be informed the plan of management and legal requirements.

JMO and court referrals

Sexual health clinics should be designed towards maintaining high standards for providing STI care with privacy and confidentiality for persons who are referred by JMO or magistrate.

- Usually victims of sexual assaults and their perpetrators, sex workers, remand prisoners and prisoners are referred for STI screening and reporting by JMO and magistrates.
- Maintaining their confidentiality, respecting their dignity and being non-judgmental is very important throughout the caring process. In certain occasions, history taking and examination has to be carried out in the presence of security personals considering the security circumstances. Even in such situation similar services should be offered.
- Once these clients attend the sexual health clinic,
  - Welcome and register the client
  - History taking, general and genital examination need to be carried out by a consultant / medical officer.
  - All clinical findings, relevant documentations including drawings should be recorded clearly.
  - Try to arrive at an etiological diagnosis whenever possible by incorporating laboratory findings.
  - STI management is to be carried out according to available latest guidelines.
  - Contact tracing and epidemiological treatment should be arranged appropriately.
  - Depending on the age, sex, education level, counselling should be carried out appropriately by a medical officer or other officer assigned for it. Series of counseling sessions may be required depending on the circumstances.

- Most of the time these peoples are marginalized and service deprived. Therefore, their other issues/concerns need to be addressed appropriately.
  Eg: referring to other health specialties for comorbidities they have or rehabilitation, offering suitable family planning method, linking to NGO for living assistance, etc.
- Risk of contracting HIV infection should be evaluated and PEPSE should be offered when indicated.
- In the back referral/medical report date, name, reference number, diagnosis, details about treatment, time/date for next visit and special remarks if any should be clearly mentioned.
- All reports/referrals should be placed in sealed envelope/s and should be sent securely.
- Follow up plan should be arranged and final medico-legal report should be sent after adequate completion of follow up.
- All medical reports that are issued should be documented in respective patients' medical records with the date, to whom it is addressed, mode of delivery of reports (email / by post / by hand) clearly indicated. Separate register for this is preferred.
- In special occasions where person's risk behaviour which seems to be threatened to public, medical officer could see the magistrate and verbal statement could be given to minimize the damage to public.

Condom programming at sexual health clinic level

Promotion of condoms is an essential component of HIV/STI prevention program. It is important to ensure that quality condoms are purchased, stored, distributed and handled properly, because if condoms leak or break, they cannot offer adequate protection.
Main areas to be focused on condom promotion in sexual health clinics/centers.

- Creating a favorable environment for condom promotion
- Training service providers
- Counselling clients on condom use and demonstration of how to use condoms
- Managing condom supplies and ensuring condom availability

Creating a favorable environment for condom promotion (National/ district level) through advocacy programmes

- Stakeholders need to be provided with the evidence of condoms reducing STI prevalence, and illustrate the cost effectiveness of promoting condoms at national level and district level.
- Media support to be obtained to debunk the myths and increase the awareness about condoms
- Policies that restrict the open promotion and distribution of condoms should be addressed at national level.
- Programmes should be conducted for law enforcement authorities/police whose action might have negative impact on condom promotion among key population groups

Training service providers

- Doctors, nursing officers, public health nursing sisters, public health inspectors, and peer educators who do outreach work are expected to conduct condom promotion and distribution.
- The above categories of staff should have following components of knowledge, skills and attitudes relevant to condom promotion

Knowledge	• Characteristics of condoms and the various types available including female condoms • Effectiveness of condom use in preventing the transmission of sexually transmitted infections, including HIV • How condoms should be used and disposed • How condom supplies and logistics are managed • Common obstacles to condom promotion.
Attitudes	• The attitudes of service providers with regard to condom effectiveness and use should be improved • Myths and misconception on condoms should be debunked
Skills	• Condom demonstration using dildos highlighting the practical points • Communicate effectively with clients and counsel on their issues and obstacles in condom use • Identify high risk groups who do not use condoms and address their reasons for not using condoms. • Manage supplies of condoms at clinics, including checking their validity and identifying stock needs and monitoring utilization of condoms by clients and tracking of problems and constraints.

Managing condom supplies and ensuring condom availability

- There should be a designated service provider at each clinic,who is responsible for managing condom supplies, monitoring stocks, maintaining registers and ensuring continuous condom promotion in the clinic and in the community
- Condom availability should be increased by installing vending machines or dispensers especially closer to cruising sites of key populations.

IEC materials related to condom promotion and other items needed for condom promotion like dildos should be made available for all service providers responsible for condom promotion.

D. HIV treatment, care and support

Introduction

HIV treatment, care and support is an identified programme of the national STD/AIDS control programme. Consultants, MOIC, medical officers and the sexual health clinic staff are collectively responsible for the provision of this service under the technical guidance of the NSACP.

Clinical management for HIV infection

- When a patient's diagnosis is confirmed as HIV infection, with detailed post-test counselling he/she should be transferred from STI care to HIV care (both through paper formats and EIMS). If that clinic is not an ART centre patient should be transferred to an ART centre of his/her preference.
- HIV record/ file should be started according to the clinic code and serial number.
- Detailed history taking and thorough examination should be performed to assess his clinical status, presence of opportunistic infections and other issues/conditions.
- Baseline investigations should be performed (Table D1) according to the Sri Lankan HIV / ART guidelines to assess his immunological and virological status, presence of opportunistic infections (OI), STIs and other comorbidities.[8]
- If any OI is diagnosed treatment should be started in collaboration with relevant specialty.
- Patient should be referred to chest physician for TB screening and INAH prophylaxis
- If CD4 count is <350 cells/microliter, Cotrimoxazole 960mg daily prophylaxis should be started.[9]
- Thorough adherence counselling should be done and patient should be started on ART as early as possible within 1 month of diagnosis.
- Family planning counselling and introduction of appropriate contraceptive method should be arranged for females who are in reproductive age.
- Hepatitis B vaccination should be started according to the recommended schedule (delay if CD4 count is <200 cells/microliter, till CD4 recovery)
- Link to PLHIV organizations if patient need such support / educate and enroll to PLHIV travel allowance if patient is willing
- Regular follow up should be arranged in the clinic for assessment of adherence, side effects to ART with clinical, immunological and virological monitoring
- Patients should receive ongoing support addressing their different needs in the continuum of care.

Table D1: Tests needed for HIV confirmation and at baseline assessment before starting ART.

Test	Available Lab
HIV Western Blot	NRL
HIV DNA PCR	NRL
HIV RNA Viral Load	NRL/Provincial STD lab
HIV Drug Resistance Testing	NRL
CD4 count	NRL/Provincial and District STD labs
VDRL/TPPA	NRL/District STD Lab
Hep B surface Ag	NRL/District Virology lab/MRI
Hep C Ab	NRL/District Virology lab/MRI

[8] Sri Lankan HIV/ART guideline
[9] Guide to HIV care and OI 2017

Microscopy for GC, NGU/NGC, TV, HSV	NRL/District STD lab
GC culture /CG NAAT/CT NAAT	NRL/District STD lab
Pap smear	FHB/Local hospital lab
Full blood count	NRL/Local hospital lab
Liver/Renal function tests	NRL/Local hospital lab
FBS	NRL/Local hospital lab
Lipid profile	NRL/Local hospital lab
UFR/UPCR/UACR	District STD lab/local hospital lab
ESR	NRL/District STD /local hospital lab
ECG(before starting ATV)	Local hospital
HLA- B5701(before starting ABC)	National Blood Transfusion service (NBTS)
TB screening	District chest clinic
Cytomegalovirus antibodies	MRI/District Virology lab
Toxoplasma antibodies	MRI/District Parasitology lab
Cryptococcal antigen	MRI/District Mycology lab

Partner tracing[10]

HIV partner notification/tracing is an important process of HIV care through which contacts of people with HIV are identified and offered HIV testing.

- Partner notification (PN) process should be initiated by the consultant/doctor emphasizing its importance in management and prevention of HIV in partners.
- All newly diagnosed HIV positive patients should be referred to the PHI/PHNS for partner notification interview and a proper plan should be arranged explaining the multiple options available for PN
- PN can be done in 2 methods
  - **Passive PN** - patient is encouraged to disclose their status and bring the partners for HIV testing Services (HTS).
  - **Assisted PN**- patient is assisted by health care provider (HCP) to disclose their status or to anonymously notify their partner(s) of their potential exposure to HIV infection with his/her consent. The HCP then offers HIV testing to these partner(s).

    Assisted partner notification can be done using 3 approaches

    - **Contract referral** -patient enters into a contract with the HCP and agrees to disclose their status and the potential HIV exposure to their partner(s) by themselves and to refer their partner(s) to HTS within a specific time period. If the partner(s) of the HIV-positive individual does not access HTS or contact the HCP within that period, then the provider will contact the partner(s) directly and offer voluntary HTS.
    - **Provider referral** - with the consent of the patient, health care provider confidentially contacts the person's partner(s) directly and offers the partner(s) voluntary HTS.
    - **Dual referral**: Health care provider accompanies and provides support to HIV-positive patients when they disclose their status and the potential exposure to HIV infection to their partner(s). The provider also offers voluntary HTS to the partner(s).

[10] Guidelines on HIV Self-Testing and Partner Notification: Supplement to Consolidated Guidelines on HIV Testing Service Geneva: World Health Organization; 2016

- In circumstances of non-disclosure where PN not happened as planned, this should be discussed sensitively on an individual basis by an expert in the clinic to establish barriers that exist and provide support in addressing these.
- HCP should advise the patient on ways of protecting their sexual partners from infection and explain that it is an offence to knowingly infect another person. (Sri Lankan penal code, marginal notes 262,263) and this may give rise to legal liability if the patient's sexual partner becomes infected as a result.
- If HCP has a reason to think that the partner of a HIV infected patient is at risk of infection due to non -disclosure and cannot be persuaded to do so, HCP may disclose information to a known sexual contact after informing the patient.
- If the sexual contact is also a patient of the HCP it is legally recognized as a duty by a doctor to disclose the HIV diagnosis to the sexual contact. A failure to disclose might therefore be a breach of the duty owed to the sexual contact, if the contact became HIV-positive as a result.
- Proper documentations is essential in both above situations.
- **Look back period:** An estimate, based on a risk assessment, of when infection is likely to have occurred should be made and PN provided to include all contacts since, and in the three months prior to, this estimate. If this is not possible, all previous partners should be contacted and offered HIV testing
- HIV Partner notification should be a part of ongoing care and sexual history should be taken at lease six-monthly intervals after first presentation with HIV infection

Defaulter tracing

Defaulter tracing is also an integral part of HIV care which ensures uninterrupted engagement of the patient in continuum of care.

- For every patient, a follow up date should be given on each visit.
- If they do not attend on the given date, they should be selected as defaulters and an action should be taken to trace them.
- Doctor or responsible nursing officer for HIV care in the clinic should go through the patient notes and identify the defaulters. PHI/PHNS should enter them in the defaulter tracing register and contact them over the phone as the first attempt.
- Failing that the other modes of defaulter tracing via text messages, emails, letters or home visits should be arranged depending on the patient's given choice of contact.
- The outcome of the defaulter tracing should be regularly monitored by the consultant/ doctor and continuous effort should be made to trace the patient and to get them for services
- In difficult cases, support can be taken from area MOH team (MOH/PHNS/HCM/PHI) or PLHIV organizations ensuring the confidentiality of the patient.
- Failing all possible efforts made to link the patient to care, if the patient does not attend within 3 months, file should be labelled as lost to follow-up (LFU). However, continuous effort should be made to trace the patient at regular intervals to get the patient back for services

Positive prevention[11]

Positive prevention (PP) includes strategies that help PLHIV to live longer and healthier lives which is an important element in HIV care management. Positive prevention helps people living with HIV to

- Protect their sexual and reproductive health and avoid other (STIs);
- Delay HIV disease progression;
- Promote shared responsibility to protect their sexual health and reduce the risk of HIV transmission.

Both PLHIV and health care providers have specific roles in PP. Therefore, HCPs should ensure provision of necessary services and PLHIV should be made aware about their role in PP in the initial counselling and follow up sessions.

[11] Positive Prevention: PREVENTION STRATEGIES FOR PEOPLE LIVING WITH HIV. 2010 – IPPF, INP+, FPA indi

Table D2: Role of healthcare providers in each component of positive prevention

Protect their sexual and reproductive health	Delay HIV disease progression	Promote shared responsibility
• Ensure PLHIV has access to sexual and reproductive health information and services with routine screening for STIs. • PLHIV to have access to all contraception methods including, emergency contraceptives within the clinic. • Ensure provision of sexual health services, which includes discussions of relationships, self-esteem, body image, sexual behaviours and practices, sexual satisfaction and pleasure, sexual functioning and dysfunction. • Ensure appropriate access to quality male and female condoms and water-based lubricants • Promote consistent and correct condom use with regular and casual sexual partners; discuss safe sex strategies and the importance of using a dual protection method – combining condoms with another contraceptive to prevent against STIs and unwanted pregnancies. • Provide counselling services and psychosocial support to deal with issues such as disclosure of HIV status, sexual health, sexuality, relationships, addressing gender-based violence, risk reduction and substance use.	• Provide ongoing support for ART adherence in all possible ways including counselling, IEC, etc • Provide support and advice to manage any side effects from drug regimes • Regular follow up and to identify OI and AIDS related cancers early and start treatment • Monitor viral load regularly and refer to resistance assay and expert opinion if detectable viral load in spite of good adherence to ART • Ensure access to TB diagnosis and treatment services screen all PLHIV for TB • Provide diagnostic testing for viral hepatitis and vaccination for hepatitis A and B. • Ensure timely access to treatment for hepatitis B and C, when clinically indicated. • Provide information on nutrition and diet and encourage regular exercise. • Encourage to have regular Pap smears for HIV infected women • Facilitate access to alcohol and substance use treatment, when required	• Inform PLHIV of their rights to privacy, confidentiality and informed consent. • Make PLHIV aware of changes in policies and laws that criminalize HIV transmission. • Promote strategies to address HIV related stigma and discrimination and assist the establishment of support groups • Ensure access to care for victims of violence, and referral to violence prevention programmes • Promote social and personal development that can contribute to increased life skills of people living with HIV and raise awareness on how to take control over decisions affecting their lives. • Promote strategies that link health interventions with micro-credit and skills development strategies to promote economic empowerment and build social capital. • Support people to make decisions regarding disclosure based on the right to choose if and when to disclose their HIV status. • Liaise with the police force and other gatekeepers to ensure PLHIV belongs to key populations are not prosecuted or criminalized due to their positive serostatus. • In the event of the incarceration of people living with HIV, promote ongoing provision of essential health services in prisons, particularly for regular uptake on ART • Involve people living with HIV in the design, implementation and evaluation of positive prevention programmes, the provision of services, and in decision and policy making

Counselling and health education on HIV

Following points should be discussed during counselling sessions after confirmation of HIV and HIV flipbook can be used as a guide.

- Difference between HIV and AIDS
- Natural history of HIV, modes of transmission, modes which cannot transmit HIV
- Antiretroviral treatment, side effects of ART, treatment adherence
- Importance of follow up and investigations done during follow up
- Counselling on healthy living food habits, safe water, alcohol, smoking, exercise, sports activities and having pets
- Communicable and non-communicable diseases
- Immunization
- Safe sexual behaviours and prevention of onward transmission including condoms PEPSE and PrEP
- Pregnancy issues and contraception
- Social and occupational problems
- Stigma and discrimination
- Legal issues

Condom promotion

Condom promotion should be done for each patient as HIV infected patients have several benefits using condoms, such as:

- Contraception
- Prevent other STIs
- Prevent transmission of HIV until he/she gets undetectable viral load
- Prevent transmission of drug resistance strains even partner is HIV positive

Fertility services

- All patients/couples with HIV attending the clinic should be inquired about their fertility desires ideally at all visits.
- With the advancement of ART, fertility issues and requirement of their own children for positive couples could be seen. Fertility options for these couples include:
  - Not having children
  - Adoption of a baby
  - From a donor (sperms or ova)
  - In-vitro fertilization (IVF) with their own sperms/ova
  - HIV positive sero-discordant couple or positive female can have a baby with unprotected sexual exposure if they are on ART with good adherence, undetectable viral load and absence of other STIs.

All PLHIVs attending the clinic should be offered contraception services as appropriate. The method of contraception need to be decided by the patient with correct guidance by consultant venereologist or consultant obstetrician/ gynaecologist.

- Permanent contraceptive methods like ligation and recession of tubes (LRT) could be offered to PLHIV who have completed the family.
- Oral contraceptive pills (OCP) could be prescribed to nulliparous females. Before prescribing, ART regimen should be considered as some ARV agents could interact with OCP and both ARV and OCP activity can be affected.

- DMPA is the most suitable contraceptive method with minimum interactions with ART but it should be given regularly with 90 days intervals.
- Other feasible method for PLHIV is intra uterine contraceptive device (IUCD) which is very effective and can be kept for long period which can go upto 10 years. IUCD facility is available in few sexual health clinics and patient might need a referral to MOH or gynaecology clinic for most of the time.
- It's ideal to have all types of contraception within the sexual health clinic but if not, need to refer to a facility in which it is available
- If any of these temporary contraceptive methods are initiated, condoms need to be used regularly for the first 7 days.
- Clients who are not willing to use above methods have to wear condoms regularly and consistently as a contraceptive method.
- Traditional contraceptive methods are not encouraged

Cervical screening

Many sexual health clinics provide PAP smear for HIV infected females and it should be repeated annually. If it is not available at clinic settings females more than 35 years should be referred to the gynaecology clinic/well woman clinics.

Sexual health services

- All HIV positive patients should have to undergo STI screening annually. It includes screening for gonorrhoea, chlamydia, syphilis, trichomoniasis, candida and bacterial vaginosis
- In addition, health education on safe sexual practice and emphasis on personal hygiene is important to avoid other infections

E. Laboratory services, and infection prevention & control (IPC)

Introduction

Laboratory services and infection prevention is an identified programme area of the national STD/AIDS control programme. Consultants, MOIC, medical officers and medical laboratory technologists are collectively responsible for the smooth functioning this service under the technical guidance of the programme area coordinator of the NSACP.

Laboratory service areas

Each sexual health clinic should have a well stablished laboratory system to diagnose main STIs. The laboratory services in the sexual health clinics have been categorized based on the facilities available in the laboratories. National reference laboratory (NRL) is the main national level laboratory for STI services. Sub national level laboratories include provincial STI laboratory and district STI laboratory or clinic STI laboratories.

Service areas	Facility level
Microscopy facilities	should be available in all the district level sexual health clinics.
The gonococcal culture	should be available at least in provincial levels
Serological tests	Basic STI screening (HIV/Syphilis/Hepatitis B & C) should be done by all the district level clinics
Additional tests	All the additional tests (HSV testing, CT/NG PCR) can be made available depends on the capacity of the laboratory There should be well established mechanism to get done all the other relevant tests from the hospital laboratories/MRI or NRL
Rapid diagnostic services	Introduce rapid test kits for HIV and syphilis screening at clinic level or community level (outreach)
Quality assurance	Calibration of equipment, quality assessment panels etc Accreditation processes for NRL as it plays a pivotal role in HIV/STI testing services in Sri Lanka
Laboratory biosafety	Use the standard biosafety guidelines
Recording and reporting system	Data management in the laboratory is an important area to be maintained at all levels
Infection prevention and control	Cleaning, disinfection, sterilization Immunization, post exposure prophylaxis
Laboratory waste management	Standard waste management to be used at all levels
Documenting and file handling	Every clinic should have a separate file for each equipment and its maintenance. Laboratory staff member should also have a personal file maintained at the clinic

F. PMTCT Services for HIV and Syphilis

Introduction

Prevention of mother to child transmission (PMTCT) is an identified programme area of the national STD/AIDS control programme. Consultants, MOIC, medical officers and clinic staff with the collaboration of the maternal and child health unit at the regional director of health services (RDHS) and other stakeholders are collectively responsible for the elimination and the maintenance of eliminated levels at the responsible geography of the clinic.

Sri Lanka was certified by the World Health Organization as a country that has eliminated mother to child transmission of HIV and Syphilis in 2019. This is an important milestone in the health services of the country as it is a proof of the high quality STI and HIV services as well as maternal and child health services in the country.

- All pregnant mothers are to be screened before 12 weeks of gestation for Syphilis and HIV (preferably at the first visit).
- All pregnant women with high risk of acquiring syphilis (female sex workers, women with STI symptoms) need to be retested at 28 weeks of gestation.[12]
- Antenatal clinic services (MOH clinics and Hospital ANC clinics) have to arrange collection of blood and transport to the relevant sexual health clinic for Syphilis and HIV testing. Please refer 'Sample collection manual for antenatal clinics 2018' and 'EMTCT MCH guidelines 2017' for more details
- All pregnant mothers should be encouraged to get tested for HIV and Syphilis through ANC.
- Sexual health clinics have to carry out Syphilis and HIV screening tests on the blood samples received from ANC clinics according to the national Syphilis and HIV testing algorithms and send reports to the relevant ANC using the standard formats given in the guidelines
- Measures should be taken to maintain strictly the confidentiality of the information.
- All pregnant women with positive screening tests need to be referred to sexual health clinic for further management.
- Women with positive syphilis or HIV test results should be managed according to the national guidelines.
- All women with positive syphilis or HIV test results should be screened for other sexually transmitted infections.

EMTCT of Syphilis [13]

- Refer to the latest 'Guidelines on management of pregnant women with Syphilis.
- Once a pregnant woman is diagnosed as having syphilis she should be managed by a venereologist according to the national guidelines in collaboration with an obstetrician of a tertiary care unit and the relevant medical officer of health.
- Follow the basic principles of nonjudgmental attitude, confidentiality and respect for patients' rights.
- Screen spouse/partner and older siblings and manage according to the national STI guidelines.

[12] General circular letter No, 02- 02/2014, ministry of health, Sri Lanka
[13] Guideline on the management of pregnant women with syphilis, 2016

EMTCT of HIV[14]

- Refer to the latest 'Guidelines for the management of pregnant women with HIV infection, Sri Lanka.
- All pregnant women with HIV should have an individualized, regularly updated plan of care which summarizes mutually agreed obstetric and HIV management plan with the collaboration of a venereologist, obstetrician and the relevant medical officer of health.
- Follow the basic principles of nonjudgmental attitude, confidentiality and respect for patients' rights.
- Screen spouse/partner and older siblings and manage according to the national HIV guidelines.
- The following areas need to be covered in counselling.
  - ART and adherence to treatment
  - Choice of infant feeding
  - Antiretroviral treatment for infant prophylaxis
  - Partner disclosure/screening
  - HIV testing of other children
  - 100% Condom use to prevent acquiring other STIs, entry of other strains of HIV and onward transmission to a negative partner
  - Postpartum family planning

Data Management in EMTCT of HIV/Syphilis

Accurate and timely management of data is an essential component of the EMTCT services in order to monitor and to evaluate the EMTCT of HIV and syphilis programme.

- Data management should begin once the pregnant mother is registered at the sexual health clinic (EIMS or Manual data management).
- Patient's clinic record (STD patient form and / or the HIV clinic record) is the most important document in extracting data for the EMTCT data management. Therefore, clinic notes should be accurate, comprehensive and up to date. If EIMS is established all relevant details should be entered properly.
- Details of all the ante-natal mothers who are confirmed positive for syphilis should be entered into the "Ante-natal syphilis register" which is maintained at the sexual health clinic.
- A register should be maintained at the sexual health clinic to document the ante-natal mothers who become screening positive for HIV. This is used to document the steps of tracing the mother through the MOH and events occurred up to confirmation/exclusion of the HIV infection.
- Once a case of antenatal syphilis or HIV positive mother is confirmed, the relevant Medical Officer of Health (MOH) should be informed by a confidential letter. (Annex 3)
- Details of all the ante-natal mothers who are confirmed positive for HIV should be entered into the "Pre-ART Register" and then into the "ART Register" which are maintained at the sexual health clinic.
- Once the pregnant mother who is confirmed as HIV/syphilis is registered at the sexual health clinic, a "Case investigation forms for pregnant women with HIV and Syphilis" should be filled by the PHNS/ NO/PHI under the guidance of the consultant/medical officer. There are two separate forms available for HIV and syphilis. (Annex 4 and 5)
- These forms cannot be completed at the time of registration. Therefore, the initial details available at the enrollment should be mentioned and the form should be sent to the EMTCT unit NSACP within 14 days of registering the patient at the clinic. A copy of the form should be attached to the patient's clinic records.

[14] Guidelines for the management of pregnant women with HIV infection, Sri Lanka

- An excel data base is maintained at the central level (NSACP) of those diagnosed mothers.
- Thereafter, the form will be updated at several points through active surveillance done by the EMTCT unit, NSACP. (E.g. At the completion of treatment, after the delivery etc.)
- To complete the "Case investigation form" it is essential to include details of the sexual partner/partners of the index patient (ante-natal mother) and the details of previous children. Therefore, it is important to register them at the sexual health clinics and maintain their clinic records up to date.
- Once the baby is born he or she should be registered at the sexual health clinic. Correct and comprehensive documentation of baby's birth details, management details and investigation results are very important and essential in completing the "Case investigation form".
- At the end of each quarter, the "Quarterly returns of sexual health clinics (STD/ART return)" should be filled and send to the SIM unit, NSACP, indicating
    - the number of pregnant women diagnosed during the quarter
    - the number of children diagnosed during the quarter
    - number of ante-natal mothers treated for HIV/syphilis during the quarter
    - number of antenatal HIV and syphilis tests done during the quarter
- Further, "Case reports" giving detailed description of children diagnosed with congenital syphilis and paediatric HIV should be prepared and sent to the EMTCT unit, NSACP.
- For the convenience of extracting data, ante-natal syphilis patients', their respective partners' and babys' clinic records will be arranged as a one set (one set for each family) and all such sets should be kept separately according to the year of diagnosis.
- In addition to the registers and records mentioned above, PMTCT register and the Paediatric HIV case register are maintained at the central level (EMTCT unit, NSACP). These will be updated using "Case investigation forms for pregnant women with HIV and syphilis" and "Case records".
- "Data on Pregnancy and Sexually Transmitted Infections" should be filled at the sexual health clinic level and sent to the EMTCT unit quarterly. It contains numbers of ante-natal mothers registered for the management of HIV, early Syphilis, late Syphilis, GC, NGC, genital herpes, genital warts and other STIs. Data is categorized according to the MOH area where each mother belongs to.

G. HIV/STI services for key populations

Introduction

Key population services have been recently identified as a different programme area of the national STD/AIDS control programme. Consultants, MOIC, medical officers and primary care staff and other stakeholders and relevant NGOs are collectively responsible for HIV/STI services within the geography of the clinic.
key population is referred to communities with high-risk for HIV transmission. Key populations includes Men who have Sex with Men(MSM), commercial sex workers (CSW), People who inject Drugs (PWID), and members of Transgender(TG) community.
NSACP undertake Targeted interventions for KPs for prevention and care of HIV/STI at national and district level as a main component of the NSP.

Targeted interventions for HIV/STIs

Definition of targeted interventions (TIs): Interventions that are aimed at offering prevention and care services to high risk populations within communities by providing them with the information, means and skills they need to minimize HIV/STI transmission and improving their access to care, support and treatment services.

Targeted interventions (TIs) should:

- Be resource-effective and cost-effective
- Focus people within the community who are most at risk of HIV and STI infection.
- Mainly targeted to behaviour and practices not the identity
- Involve them and their issues within the broader framework of interventions
- Culturally and socially appropriate to the target audience.
- Focus on limited resources
- Accept/acknowledge that the existence of stigma and discrimination and barriers to accessing health-care access

Steps to be followed for a targeted intervention

First clearly define the target audience e.g. **Sex workers:** are women, men and transgendered people who receive money or goods in exchange for sexual services, and who consciously define those activities as income generating even if they do not consider sex work as their occupation.
Men who have sex with men (MSM): Men who engaged in male to male sex as a practice or preference in the community

Understand the diversity or the typologies of the target audience. E.g. male sex workers, female sex workers, transgender sex workers (lady boys, shemales), and based on age (young sex workers, old sex workers etc), Based on client volume (high volume, medium volume, low volume sex workers etc)

Components of a targeted intervention

- **Situation analysis:** analysis of socio-demography and epidemiology by case reports, case studies, clinic files, clinic data analysis, previous studies, planning studies, informant interviews, In-Depth Interviews (IDIs) etc. Situation analysis is basically the study of the epidemiology and demography.
- **Identify issues/problems after the situation analysis:** make problem statements
- E.g. HIV/STI awareness among sex workers 40%, HIV transmission knowledge is low (25%), Condom use at last sex was 30%.
- **Identification of interested parties (Stakeholder analysis):** is a process of systematically gathering and analysing qualitative information to determine whose interest should be taken into account when developing and/or implementing targeted interventions.
- Stakeholder analysis can be done using different tools such as: (a). Simple stakeholder analysis tool, (b). Power/dynamism matrix[15]

(a). Simple stakeholder analysis tool

Stakeholder	Stakeholder interest in the project	Assessment of impact	Potential strategies for obtaining support or reducing obstacle

Mapping of stakeholders by power/dynamism matrix (Gardner et al 1986) is a useful practical tool for further analysis of stakeholders with a view to understand the potential support and obstacles

(b). Stakeholder mapping; power/dynamism matrix (Gardner et al 1986)

		Dynamism (interest)	
		Low	High
Power	Low	Monitor (minimum effort)	Keep informed
	High	keep Satisfied	Manage Closely

- **Identification and segmentation of target populations** (where necessary): The process of audience segmentation will help you divide the audience of interest (MSM, CSW, TG) in to more homogenous segments e.g. street, brothel, lodge and home-based sex workers, consistent condom users, inconsistent condom users, occasional condom users, never users etc
- **Setting and define objectives:** what change you want to make to prevent HIV/STIs among the key population (objectives should ideally be SMART)
  e.g. Increase the condom use at last sex by 50% from the baseline in 2 weeks among street sex workers
- **Design targeted intervention strategy**
  - **Design and channel of communication:** Awareness programmes, health education programmes, counselling services, mass communication, social media communication, outreach programs, freestanding clinics, drop-in centres etc.
  - **Content of the intervention:** in awareness programmes, for example, include
    - Core knowledge, skills and attitudes
    - Additional knowledge, skills, and attitudes

[15]power/dynamism matrix, Gardner et al 1986

  - **Development of the content:** based on the design of the targeted intervention, develop messages, demonstrations, role plays, hands on skill developments etc. These products should ideally be pre-tested before implementation or can also be tested during or after implementation for the effectiveness.
- **Implementation:** is defined as an execution of specified set of tasks or activities designed to put into practice in an activity or program of known dimensions.
- **Monitoring and evaluation** For the monitoring and evaluation purpose each part of the chain of project implementation can be used to develop M&E indicators such as input indicators, process indictors, output indicators, outcome indictors and impact indicators. However, for most of the project done at the provincial or district level at least outcome need to be measured to see whether the program or the activity is effective in achieving its objectives.
  E.g. whether participants gained the knowledge: you can plan pre and post-test questionnaires
- **Analyze feedback and revision:** whether actual expectations of the project achieved (effectiveness) if not adequate then the project should be revised and re-planned

Modalities for HIV/STI service delivery for KPs

Service models	Definition / description
Government STI service delivery points (sexual health clinics)	Sexual health clinics are service delivery points for the provision of STI prevention, treatment and care services to the people including key populations. The ministry of health under the national STI/HIV control programme maintains over 50 number of such clinics as a network covering the island
Non-governmental STI service delivery points	There are other STI service delivery points run by NGOs for the provision of services including care for key populations (e.g. FPA clinics)
Private sector hospitals and clinics	Key population members can approach private sector clinicians for services. Doctors trained in sexual health/ STIs are capable of handling KP related issues
Drop-in-centre approach	Drop-in centre is “a facility specifically designed to mobilize key populations to access and make use of a comprehensive package of services that include Information, education and communication services (IEC), behavioral change communication (BCC); Condom distribution; STI screening and treatment; HIV testing services (HTS) and HIV/STI referral services. This model is currently available for MSM, FSW and PWIDs in selected districts.
Outreach approach by a healthcare worker	In this model, trained healthcare worker is reaching the key population as an individual or as a group to deliver HIV prevention services. The government mainly carries out this model by Healthcare workers such as medical doctor, public health inspectors (PHI), and public health nursing sisters (PHNS).
Outreach approach by a community worker	In this model key population groups are reached by a trained KP members, or other community workers with KP experiences for STI/HIV prevention services

Peer group model approach	In this model, peer educators (PE) are identified from key populations. PEs are trained with necessary skills and employed to maintain a regular contact with another 15-30 peers forming a peer group (PG). These peer educators (PEs) have to deliver HIV prevention service package to KPs in the PG. Based on the number of such PGs immediate supervisors and district level coordinators are employed. This model can also be included the escorting services to an Sexual Health Clinic for testing and treatments This model is the main service delivery approach used by FPA under GFATM grants
Social contracting approach	In this approach, community worker is contracted to outreach key population groups and provide HIV prevention services. This approach is used by the government for some selected groups in selected districts. This approach has been introduced as a transition strategy of the project from non-government led programs to government led programs
Case finding team approach (case finding model)	This is the new version of key population led intervention introduced in the 2019-2021 phase of the GFATM HIV project after a field trial conducted by Scott Berry and the team in Sri Lanka. The defined geographical area of this project is termed as a zone (zone could be a district or a sub division of a district). A trained team of service providers (community or mix of community-non-community) reaching out to provide services to key population groups in the defined zone with the main view of finding positives and networking them to find more members of key population groups for services. Further, in this model, different responsibilities of the service package can be assigned to different team members i.e. some team members main responsibility could be the provision of IEC/BCC and Condom services while others main responsibility is to refer or escort clients for HIV testing and STI services.
Hybrid model (peer group together with case finding model)	This is a combination of the peer group intervention and the case finding model
Community based testing (CBT) models	Is a kind of HIV testing model done by community outreach, or in drop-in centres
Escorting of key populations for services	In this method, KP members are brought to the nearest STI service delivery point by peer educators, or peers

H. Multi-sectoral collaboration

Introduction

Multi-sectoral collaboration has been identified as a different programme area of the national STD/AIDS control programme. Consultants, MOIC, medical officers and primary care staff and other stakeholders and relevant NGOs are collectively responsible for the implementation of multi-sectoral collaborations as a concerted effort to provide STI and HIV services in the responsible geography of the clinic.
NSP includes identified strategic areas under the multi-sectoral interventions. Therefore, the district level clinics have to follow and implement all projects, activities, and tacks in order to achieve the national objectives under the multi-sectoral interventions.

Key responsibilities of the sexual health clinics

- Understand clearly the strategic areas coming under the purview of the multi-sectoral coordination and its objectives. Read the NSP and understand the scope at district level clinics.
- Identify and map key coordinating sectors (stakeholders) at district level and maintain contact details. Other sectors may include, Education sector (Government and Private School), Higher education sectors, Police, Prison sector, National youth council, Armed services, Tourism and hotel sector, Sectors involved in interventions for key populations and vulnerable populations etc.
- Support in the implementation of projects of national interest under the multispectral interventions which include routine and mainstreamed projects and activities for different sectors such as prison, police, education sector etc.
- Sexual health clinics can identify local issues in addition to the national objectives when and where relevant and conduct prevention interventions based on strategic directions and local issues.

I. Pharmacy and drug dispensing

Introduction

Pharmacy and drug dispensing has been identified as an important area in STI and HIV care. Depending on the approved cadre, district sexual health clinics may or may not have pharmacists or dispenser locally. Where a pharmacist or dispenser is available, medicines and other consumables should be managed by them. Whenever the pharmacist or dispenser is not available, an officer (preferably a nursing officer) named by the consultant venereologist or MOIC, should attend to the management of drugs and relevant surgical consumables.

District sexual health clinic pharmacies regularly manage medicines, contraceptives, condoms, lubricants and other consumables (such as gauze, wadding etc.). Medicines include antibiotics, antivirals, NSAIDs, local applications and antiretroviral medicines. Some district sexual health clinics handle only ART and cooperate with the hospital pharmacy for other medicines while some clinics have their own pharmacy.

Proper estimation, ordering and dispensing needs to be done according to the instructions provided by Regional Medical Supplies Division (RMSD) and storage should be done according to the product specifications.

Estimation and ordering requirement of item manage by the pharmacy

Anti-retroviral medicines	•	**Estimation:** The ART estimates are done at central level using the patient details available at the NSACP pharmacy. Therefore, estimation of ART is not needed at district clinic level
	•	ART should be ordered from NSACP on individual patient basis. NSACP has records for all the HIV patients registered in care based on the quarterly returns sent by district clinics.
	•	ART should be requested from NSACP by filling the Antiretroviral Drug Requesting form (Annex 6).
	•	NSACP pharmacy, usually provide ART stocks enough for 3 months per person depending on the availability.
Other medicines	•	Other medicines should be ordered from RMSD.
	•	Individual sexual health clinics need to liaise with the RMSD and submit the estimates of medicines and consumables through locally adopted systems.
	•	Usually the estimates are called in August every year. RMSD will inform regarding the estimations and procedures of requesting.
	•	There is a code for usual medicines and consumables which are available at RMSD. These code numbers should be used while estimating and ordering the next year requirements.
	•	If a new medicine is required, it should be informed to the chief pharmacist of RMSD and ordering should be arranged.
	•	If the new estimates are considerably higher than the previous years' requirement, a realistic reason needs to be mentioned. Otherwise RMSD will not approve the requested amount

	•	Once the estimates are submitted before the deadline, it will be approved by RMSD. Thereafter a stock appropriate for a specified period should be requested from RMSD. Once received, their expiry dates and specifications should be checked and stored properly.
Condoms and lubricants	•	Based on the estimates done at central level, each sexual health clinic can order condoms and lubricants from NSACP pharmacy. Estimates depend on previous year requirement and key population estimates for the district. Request format should be filled and handed over to NSACP pharmacy when collecting the items. (Annex 7)
PEP	•	The annual estimation for ART regimen for starter pack, PEP for occupational (oPEP) and non-occupational (nPEP) exposures should be sent to the Director/NSACP by January for the next year. The estimation should be based on the data provided by the quarterly returns prior to national estimation of ART. District sexual health clinics can order ART for PEP separately from NSACP at the beginning of the year depend on the requested estimation.
	•	**oPEP:** Adequate stock of ART for the starter packs should be order from NSACP pharmacy and make sure the availability in the district. ART regimen based on the updated protocol for the continuation of oPEP can be ordered for the year or split orders.
	•	**nPEP:** Adequate ART for nPEP depend on the updated protocol can be ordered at the beginning of the year or split delivery can be done based on the need of the clinic. ART should be requested from NSACP by filling the Antiretroviral Drug Requesting form specially mentioning the need as PEP

Storage of medicines and consumables

- Storage should be done according to the manual on management of drugs published by the Ministry of Health.
- All the medicines and consumables should be stored considering their product information.
- Medicines and consumables need to be stored under lock and key and the responsible officer should maintain stock registers.
- They need to be issued on “first in first out” basis whilst considering the expiry dates.
- Stock maintenance registers should be updated regularly.
- If there are medicines or other consumable products near expiry, responsible officer needs to notify either NSACP pharmacy or RMSD before 6 months of expiry date and necessary actions need to be taken to replace them or return to the respective institute.
- If any item is expired, they must be brought into the consideration of condemning process.
- There are separate sections available in the EIMS to maintain the medicine stocks. Once the stock received from NSACP, it should be entered to the main stock section and then a percentage to be taken to the pharmacy section for daily use. Once the pharmacy stock is low, should be refilled from the main store.
- The officer responsible for maintaining the pharmacy should comply with the stock verification team whenever required.

Issuing medicines and other items

Issuing medicines

- Medicines should be issued as prescribed by paper or through EIMS.
- If there is any discrepancy, always need to clarify from the prescriber before issuing.
- If EIMS is not implemented, all the medicines should be balanced at the end of each day. Detailed accountable book for drugs and surgical consumables (Health 287) should be used for this purpose. 'Health 287' book could be collected from general stores of RDHS office.
- When issued through EIMS, individual prescriptions are appeared in the system and medicines could be issued from the system directly thus, medicine stocks are balanced automatically.

Issuing of surgical non-consumables and inventory items

- Surgical non consumables and inventory items should be requested from RMSD. Depending on the local procedures the request can be online or through hard copies.
- Once received, all items should be entered into the main inventory book.
- Then issue the items to the respective sections of the clinic after entering in the sub-inventory relevant to that section (e.g. bleeding room, laboratory, microscopy room etc.). Person responsible for maintaining sub inventory should sign in the main inventory when receiving items. Person who is maintaining the main inventory should sign in the sectional inventories, when issuing items.

J. Training and Capacity building

Introduction

Training and capacity building is an identified programme area of the national STD/AIDS control programme and a separate unit has been established to carry out its responsibilities. Training and capacity building is also a responsibility of the district level sexual health clinics. Ideally all training programs should be based on the updated training manuals.
Training and capacity building plays an integral role in the provision of quality STD services. All the staff attached to the district sexual health clinics need to undergo training appropriate for their level of service. Training and capacity building involves training of both medical personnel as well as other service providers who works closely with the STD services.

Categories of staff to be trained

Sexual Health Clinic staff

- Categories of sexual health clinic staff to be trained include, Medical Officers, Nursing officers, Public Health Inspectors (PHI)/Public Health nursing sisters(PHNS), Medical Laboratory Technicians, Public Health Lab Technicians, Pharmacist/Dispensers, Other supportive staff
- These staff categories need to receive pre-service and in-service training on regular basis.
- These training programmes need to be tailor made for each category

Other staff categories

- Health staff (non-STI clinics): nursing officers, MLTs, PHLTs, Medical and nursing students, MOH/field health staff who work outside the STD/HIV services may receive training when required.
- Other governmental staff members: Officers from tri-forces, police, prisons and government officers are trained on demand basis according to their requirements
- Key populations: NGO members or any other service providers

Types of training programmes

All staff appointed to sexual health clinics, need to undergo proper training preferably before assuming duties or within 6 months of duty assumption to ensure provision of quality services. The training and capacity building unit at the National STD/ AIDS Control Programme provides training for all staff categories at the central level which is designed to be appropriate for each and every category. This training is conducted biannually at the central level.

National level training programmes for sexual health clinic staff

There are routine training programmes for the Sexual Health Clinic staff including pre-service and in-service training which are mandatory and other training programs depending on the need and availability of resources.

Table J1: Training programmes for sexual health clinic staff conducted by central level

Routine Training		
Staff category	Training period	Remarks
Medical officers (MOIC and MO/STD)*	2 months	2 weeks mandatory training at NSACP. Remaining 6 weeks could be at NSACP or in a recognized district Sexual Health Clinic**
Nursing officers	2 weeks	2 weeks of compulsory training and observation of relevant units of NSACP on rotational basis
Public Health Inspectors	2 weeks	
Medical Laboratory Technologists	2 weeks	Tailor made to requirement of the staff category
Public Health Lab Technicians	2 weeks	
Other supportive staff	2 weeks	
In-service training		
•	Refresher training for all STD staff is conducted annually at provincial level / district level. This training is coordinated by the consultants serving in the district sexual health clinics of the respective provinces.	
•	Monthly capacity building programmes/ Webinar for STD major staff are arranged by the training unit, NSACP. These programmes are conducted as virtual meetings.	
•	Monthly meeting at each sexual health clinic need to be conducted. Staff members of each category can present on rotational basis. Topics can be decided by the consultant/MOIC of the clinic	
•	Virtual clinics - Monthly virtual clinics are arranged to discuss the complex and interesting cases by the Sri Lanka College of Sexual Health and HIV Medicine (SLCOSHH)	
•	Monthly CPDs to update the knowledge of post graduate trainees/Medical officers arranged by Sri Lanka College of Sexual Health and HIV Medicine (SLCOSHH)	
Other training programmes		
•	Training unit of NSACP provide opportunities of sexual health clinic staff to participate in the overseas training programmes. This depends on availability of funds (refer central level SOP for further details).	

* All medical officers should undergo compulsory training if they have not received this training within preceding 4 years.
**recognized Sexual Health Clinic is a district Sexual Health Clinic manned by a consultant Venereologist and approved by the training and capacity building unit/ NSACP.

Training conducted by sexual health clinics

Training can be provided within the sexual health clinics or through outreach programmes for different categories working closely with sexual health services to improve their capacity. This can be in the form of providing training and teaching, providing material such as posters, leaflets, training material/ condoms etc.

The groups that are trained through the sexual health clinics include:

- **Post graduate doctors:** Selected sexual health clinics provide training for post graduate students of Venereology, Dermatology, Microbiology, Community medicine and Transfusion Medicine. Training should be in line with the PGIM prospectus.

- **Hospital staff:** Sexual health clinics should provide training for their respective hospital staff on STI /HIV service related topics whenever needed. Funds may be granted by NSACP/ GFATM
- **Field health staff:** Sexual health clinics should provide training for MOH staff on STI /HIV and EMTCT service related topics whenever needed. Funds may be granted by NSACP/ GFATM
- **Paramedical staff:** Sexual health clinic should provide training for paramedical staff / trainees whenever necessary. Training should be designed according to their training requirements.
- **Medical students /Nursing students:** Sexual health clinics should provide training for medical students/NTS students when referred by the respective universities / Nurses training schools. The training should be in line with their training manuals.
- **Other government staff:** Officers from tri-forces, police, prisons and government officers are trained on demand basis according to their requirements.
- **Key populations:** Sexual health clinics should provide training for peer leaders / peers and other identified persons from key populations on STI prevention strategies. These training programmes should always be communicated with relevant coordinators of NSACP.
- **NGO members / any other:** Sexual health clinics provide training on STI/HIV prevention strategies for NGO members and any other related service providers who work closely with STI/HIV prevention programmes

K. Strategic Information Management

Introduction

Strategic information management is an identified programme area of the national STD/AIDS control programme and a separate strategic information management unit (SIM unit) has been established to carry out its responsibilities at national level. Information management at sexual health clinic level is the collective responsibility of the clinic staff under the supervision of consultant or the MOIC.

In view of protecting the confidentiality, STIs & HIV are excluded from the routine notification system of other notifiable diseases in the health system of Sri Lanka, thus giving the sole responsibility of collection, analysis and dissemination of data related to STIs and HIV to the National STD/AIDS control programme (NSACP). The Strategic Information Management (SIM) unit of the NSACP carries out the national and district level data management.

Data collection and reporting

Data recording formats

A set of standard registers are maintained in STD/HIV clinics in order to maintain the uniformity of these returns sending from different STI/HIV clinics.

Table K1: Registers in sexual health clinics

Main Register	The most important register in an sexual health clinic, which is to maintain data on new patients attending to sexual health clinics and on those attending subsequently with a new complaint or with a new diagnosis
Subsequent Visit Register	The main objective of the Subsequent visit register is to identify the number of subsequent visits made by already registered patients including commercial sex workers.
Outpatient Blood Testing Register	The main purpose of this register is to maintain data regarding patients who are getting tested for Syphilis, Hepatitis B, Hepatitis C and HIV without opening a clinic file.
Interview and Contact Tracing Register	Main role of this Interview and Contact tracing register is to maintain data regarding patients whom contacts are needed to be traced. Contact tracer should ensure that all contacts are attended and registered for care.
IEC, BCC and Awareness Programme Register	This register is used to maintain data on Information, Education, Communication activities/Behavioral Change Communication/ Awareness programmes carried out by the staff for different population groups.
HIV Testing and counseling register	The purpose of maintaining this register is to keep track of persons who undergo HIV testing and counseling in sexual health clinics. This register also gives us information on whether the person came to get their result and their risk group category.
Condom Distribution Register	This register is maintained to record information regarding bulk issue and receipts of condoms at sexual health clinics
Commercial Sex Worker Register	The main purpose of maintaining a CSW register is to keep information on sex workers separately from the Main register

Outreach Blood Survey Register	This register is used to keep records on special blood surveys carried out by the Sexual Health Clinic and study participants are expected to attend the clinic for results.
Defaulter Register	Main purpose of the defaulter register is to maintain data on defaulters who needs to be contacted and take necessary actions to bring them for continuation of care.
Antenatal Syphilis Register	Main objective of this register is to record information on antenatal mothers who were screened and positive for Syphilis, in order to follow up and prevent congenital syphilis.
Pre-employment/Visa screening Register	Main role of this register is to maintain information on those who are coming for syphilis and HIV screening required for pre-employment or visa screening purposes.
Pre-ART register	Maintain information on HIV positive patients who are waiting for ART. Patient details should be entered immediately after diagnosis.
ART register	Information on HIV positive patients on ART.

Information about and instructions for completion of these returns are provided in the 'Guidelines for Maintaining Registers and Returns in sexual health clinics, 2014'.

Data reporting formats

The flow of data is maintained using four types of quarterly returns, which should be sent to the SIM unit by 20th of the following month of each quarter.

- **STD Quarterly return** – Quarterly sent to the SIM unit from all sexual health clinics.
- **ART Quarterly return** – Quarterly sent to the SIM unit from ART centers island wide.
- **Quarterly PLHIV Cross-sectional data base** – A computerized data base maintained in ART centers which is updated and submitted to the SIM unit quarterly.
- **KP Quarterly return** – Quarterly sent to the SIM unit by the GF funded and recruited staff of 'KP units' in each district.

Electronic Information Management System (EIMS)

Despite having a well-organized paper-based data management system, NSACP launched the EIMS in 2017, aiming for a fully computerized patient care and data management system which is more compatible with modern technology.

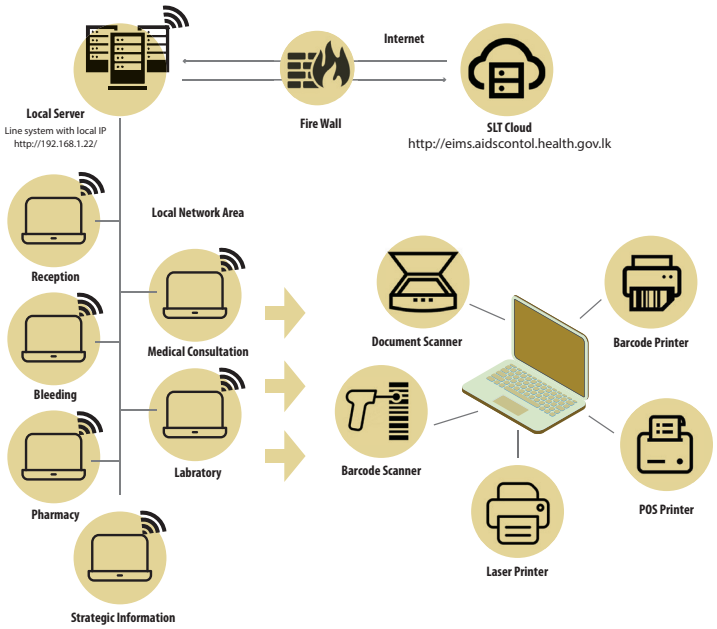


Figure 3: Data flow in EIMS

A significant number of clinics including the central clinic in Colombo are incorporated to EIMS by early 2021 and will be further extended soon to get merge with all clinics island wide.
Online access to the system is via **eims.aidscontrol.health.gov.lk** and E-Learning System for the EIMS (ELS) is accessible through **http://eims.nsacp.headstartcloud.com/** to self-study of the system.

Prevention Information Management System (PIMS)

Prevention Information Management System (PIMS) is one of the new software projects initiated by the Strategic Information Management unit of the National STD/AIDS Control Programme, which is still under development. The purpose of the PIMS software is to develop an electronic system for monitoring key population related HIV prevention programmes conducted by the sexual health clinics and NGO partners.

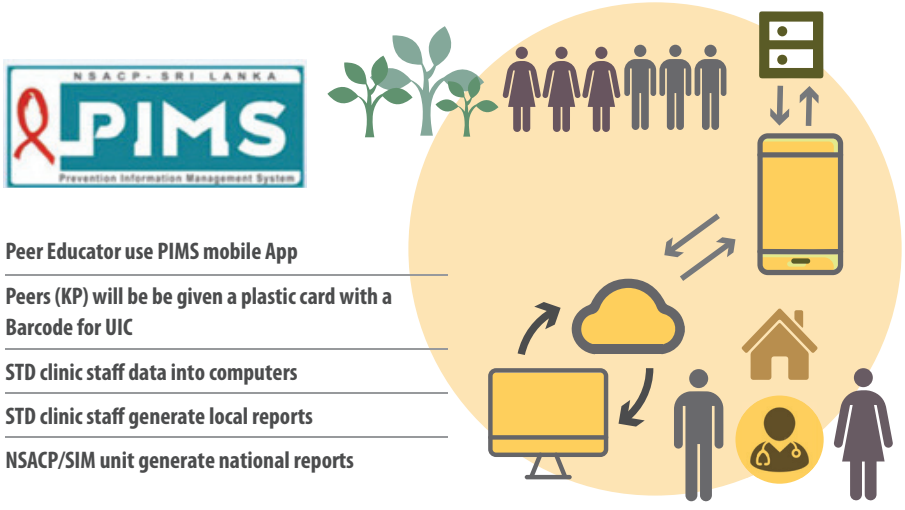
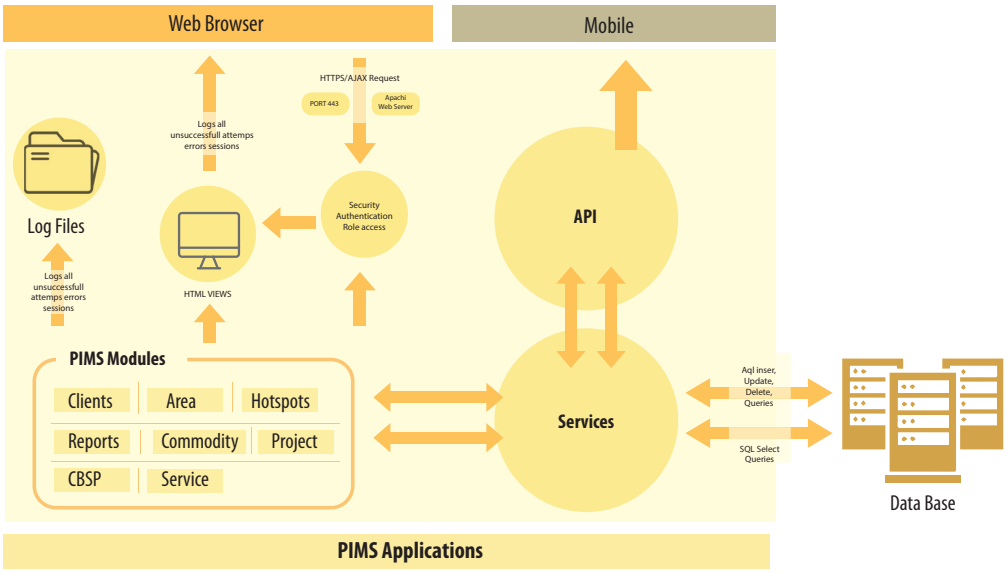


Figure 4: Prevention Information Management System

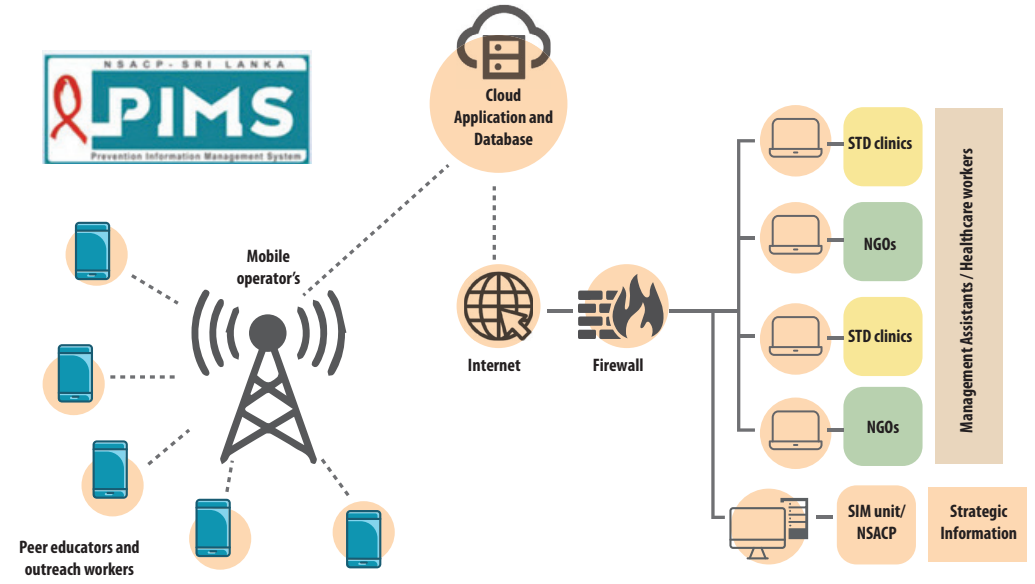
At present, NSACP is using a paper-based monitoring and evaluation (M&E) system to monitor key population interventions in the country. This will become more efficient and complete once the PIMS is implemented by relevant sexual health clinic and NGO staff who are working with key populations.



Above diagram is an abstract of the overall outline of the software system. All Mobile and Web users communicate with the system via an authentication layer. All functionalities are modularized. Database access happens only through a secure service layer. All the transaction logs are kept for audit purposes

Figure 5: PIMS System Architecture

A built-in dashboard will provide real time progress of KP population monitoring to programme management and implementers. PIMS is expected to go live before the end of 2021 and will eventually help to mitigate the paper-based monitoring and evaluation system to an automated data monitoring system.



Above diagram is the physical layout of the system. Application and database server are secured by firewalls. End users have acces to the web and systems via internet.

Figure 6: Data flow in PIMS

L. Epidemiology

Introduction

Epidemiology is an identified programme area of the national STD/AIDS control programme and a separate epidemiology unit has been established to carry out its responsibilities at national level. Epidemiology unit is constantly scrutinizing the STI and HIV epidemic in the country using the routine programmatic data and data generated by surveys and surveillances. In parallel with the national technical guidance sexual health clinics also play a major role at district level to generate data and forecast the epidemic patterns and the identification of determinants.

National STD/AIDS Control Programme of Sri Lanka continues to maintain a standard system of STI/HIV surveillance over a long period of time in order to understand the pattern of epidemic and carry out effective planning, implementation and evaluation within the programme. Major components of this surveillance system include HIV sentinel surveillance(HSS), HIV case reporting, Integrated Biological and Behavioural Surveillance (IBBS), Behavioural Surveillance Survey (BSS) and Population Size Estimation(PSE). Other routine data sources include HIV and STI testing and case reporting data, PMTCT and blood donor data, etc.

Although Sri Lanka is currently having a low-level HIV epidemic, it's important to continue monitor the pattern and contribution of key population, towards the current HIV epidemic particularly the MSM. Therefore, all categories of health care workers hand in hand with the national programme should have a basic knowledge about the current epidemic pattern. Annual report is available in the NSACP official web site for reference.

Surveys and Surveillance

Surveillance in epidemiology is the process of systematic collection, analysis and dissemination of the data of health. The main purpose of this is to simply apply this data for the implementation and evaluation of public health programs. In contrast, survey in epidemiology refers to the process which is undertaken to find the root cause of a problem.

Objectives of HIV surveillance

HIV and STI surveillance encompass the collation and analysis of data and that data to be used for:

- Characterize the epidemic in terms of modes of HIV transmission
- Detect geographic areas where new cases of HIV may be emerging
- Provide data to prioritize the prevention response for different populations in different geographic locations
- Track the trajectory of the epidemic among different populations in priority locations
- Produce data for estimating the number of people living with HIV
- Provide data for M&E indicators

Components HIV surveillance system

Major components of the HIV surveillance system include

HIV sentinel surveillance	•	Main objective of the HIV sentinel surveillance (HSS) is to measures the sero-prevalence of HIV in selected populations. To be done biennially among sexual health clinic attendees and female sex workers.
	•	HIV surveillance among ANC mothers and TB patients are not included because of routine systematic screening.
	•	Sample collecting centers are island wide STD clinics and should be adhered to the HSS protocol, during survey period.
	•	The number of sentinel sites (provinces) that have HSS for FSWs has expanded over time to include all provinces. MSMs are enrolled in 4 sentinel sites and IVDUs in 2 sentinel sites. Last HSS was conducted in 2019.
	•	HSS protocol development and staff training prior to the survey will be accomplished in order to achieve uniform survey implementation. Survey implementation is supervised by site visits.
HIV case reporting	•	Regardless of where the testing is done, all initially positive samples should undergo confirmatory testing at the central laboratory in Colombo
	•	For all people who screen positive, basic demographic and risk profile data should be recorded in the H1214 form at the time of specimen collection for the confirmatory test at the central reference lab
	•	For patients who are confirmed positive at the central lab, an attempt to fill in missing demographic, risk profile or mode of transmission information in the H1214 form is made by the epidemiology unit of NSACP by following up with referring providers
	•	Blood bank data for HIV, Hepatitis B/C and syphilis are available for all units tested (currently not possible to disaggregate by district).
IBBS and BSS surveys	•	IBBS track sero prevalence and risk behaviours at the same time in order to correlate both attributes. Surveillance strategy specifies to conduct IBBS Once in 4 years.
	•	Last IBBS was conducted in 2018.
KP population size estimation	•	Mapping is the primary method for size estimation of key populations in Sri Lanka
	•	In 2018 round multiplier method using unique object was carried out and coupled with mapping population sizes estimated finally with consensus with the key stakeholders.
	•	FSW, MSM, BB, TGW and IVDU sizes were estimated.
AIDS deaths Surveillance	•	Objective of AIDS deaths surveillance is to examine and take corrective measures from the HIV diagnosis till the death.
	•	Reporting units collect and send AIDS death information in a special form, to the Epidemiology unit to scrutinize to categorize in to AIDS related and non-AIDS related deaths.

Other routine data sources

The sources include

- EMTCT HIV/STI screening
- Blood donor HIV/STI screening
- Screening of newly diagnosed TB patients for HIV
- HIV and STI testing and case reporting data from
  - o Sexual health clinics
  - o Private hospitals and labs
  - o Blood banks
  - o Out-reach sites including prisons
- Basic demographic information and risk profile data (e.g. sex worker, client of sex worker, MSM, drug user, prisoner) to be collected from all sexual health clinic patients who undergo HIV screening at sexual health clinics. The information is recorded in the STD Patient Form/ EIMS.

M. Financial Management

Introduction

Financial management is an important area of the headquarters of the national STD/AIDS control programme as well as sexual health clinics at sub-national level.

Financial matters are handled at sexual health clinics with the help of the assigned staff members (e.g. PHI, PHNS, DO, MA, MO) of the clinic under the supervision of the consultant/MOIC. Expenses and settlement or the statement of expenditures depend on the source of the allocation or the funding and its governing financial guidelines and regulations.

Important areas of financial management at sexual health clinic level.

Sources of funding

Sexual health clinics are government organizations which receive allocations from the following revenues for their annual activity plan:

- Government of Sri Lanka
- International funding agents such as GFATM, WHO, UNICEF and UNFPA
- Other donors

Local procurement guides

All procurements by the sexual health clinics should be done according to the below mentioned guidelines and regulations

- Procurement guidelines 2006, work and goods, Ministry of finance.[16]
- Financial regulations, Sri Lanka for the given year (published on 1st January of the said year)

Approval limit

Regional Heads or officers in charge of separate units who ARE delegated authorities by heads of department can approve:

- Purchase of goods or services including equipment of smaller value not exceeding Rs. 15,000/- per event per day (total of such purchases during any calendar month should not exceed Rs. 60,000/-)
- Repair motor vehicle to a value not exceeding Rs. 50,000/- per month

Requirement for quotations

If the purchasing items' payment receipt value is

- <5000LKR – No need of quotation, receipt is enough.
- 5000-15000LKR – Require to obtain three quotations from justifiable suppliers. Agree for minimal amount with the approval of the Regional Head/ Officer in-charge. If there are already approved suppliers for the given year, need to call quotations from those suppliers.

[16]https://www.treasury.gov.lk/documents/procurement/ProcurementGuidelines2006_amded12June.pdf

- 15000-50000 LKR - Need minimum three quotations. Need to form a technical evaluation committee (TEC) and their report is sent with the approval of the regional head/ officer in-charge to the vendor
- For further details, please refer
  - Procurement guideline for Democratic Socialist Republic of Sri Lanka.[17]
  - Procurement manual for Democratic Socialist Republic of Sri Lanka and relevant supplementary documents.[18]
  - The circulars and procurement guidelines issued by the Ministry of Health time to time

Financial management in conducting programmes

All financial management in the sexual health clinic need to be conducted according to circular:1822 (15/03/94); and in accordance to financial regulations, Sri Lanka for the given year (published on 1st January of the said year)

The approvals need to be taken as described above and the officer in-charge could request advances.

Requesting advance to conduct a programme

There is a limit to the maximum amount of an advance can be given for an activity or any other work

- The regional heads can approve maximum of Rs. 100,000.00 per officer in-charge of the sexual health clinic
- If the activity exceeds Rs. 100,000.00 other bulk payments can be done directly from RDHS by cheque or money transfer.

Advance request procedure

- Officer in-charge of the sexual health clinic has to submit a General 35 voucher to the regional head for approval of the payment with the copy of the approved proposal and budget.
- After approval has been given by the regional head, it should be submitted to the finance branch four days before the activity.
- Finance division will pay the voucher two days before the activity to the RDHS
- The sexual health clinic will receive the money through RDHS

Settlement of Advance

- Soon after completion of the relevant work, the balance money need to be handed over within 10 days (maximum), with a paying in voucher (PIV) to RDHS.
- The settlement voucher needs to be sent to the RDHS for approval with following documents.
  - Expenditure statement mentioning the budgeted and actual expenditure.
  - Relevant bills and documents to confirm the expenditure
  - Other documents such as quotations, quotation request letters.
  - Official receipts of the balance money deposited
  - If there was an additional cost the reimbursement letter addressed to accountant through RDHS, needs to be attached to the settlement form.
  - If the cost is 15% less than the budgeted amount, a statement of reasoning requires to be filled.

[17]https://www.treasury.gov.lk/documents/procurement/ProcurementGuidelines2006_amded12June.pdf
[18]http://oldportal.treasury.gov.lk/web/guest/Procurement-Manual

Handling funds released through the programme coordinators from NSACP

- Time to time programmes coordinators from NSACP will release funds for programmes to be conducted by the sexual health clinic.
- Same documents and procedures should be used when handling these funds
- The settlement documents or the completed statement of expenditure (SOE) need to be handed over to the programme coodinator.

Petty cash payments

- Petty cash is handled by the administrative branch of relevant RDHS/ Sexual health clinics. Small expenses can be incurred from the petty cash up to maximum of Rs. 5,000.00 per bill.
- Any expense could be paid from petty cash except voucher payments such as overtime, travelling and other expenses below Rs.5, 000.00.
- If the petty cash is managed by the RDHS
    - o If any officer requires to buy an item below Rs. 5,000.00 from the petty cash, should submit a letter explaining the requirement and get the approval of the RDHS.
    - o After approval has been given, submit it to the petty cash handling officer. Then petty cash handling officer will do necessary action to purchase and supply the item.
    - o If any officer incurred some amount expense for official matter, should get the written approval of the RDHS and submit to petty cash handling officer to reimburse.
- If the petty cash is handled by the sexual health clinics, the in-charge could approve the payment

Annexes

Annexure I: ***Providing sexual and reproductive health services to adolescents,***

Annexure II: ***Implementation of health protection plan (HPP) for the residence visa applicants to Sri Lanka***

Annexure III: ***Letter informing confirmed positive HIV status to MOH or VOG***

Annexure IV: ***EMTCT HIV case investigation form***

Annexure V: ***EMTCT congenital syphilis case investigation form***

Annexure VI: ***Antiretroviral drug requesting form***

Annexure VII: ***Condom requesting form***

Annexure I: Providing sexual and reproductive health services to adolescents

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சுகாதாரம் மற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health & Indigenous Medicine

General Circular No:- 01-25/2015

All Provincial Secretaries of Health
All Provincial Directors of Health Services
All Regional Directors of Health Services
All Directors/Officers in Charge of Medical Institutions
All Directors of Special programmes
Director, National Institute of Health Science
All Medical Officers of Maternal and Child Health
Chief MOH, Municipal Council, Colombo
All Medical Officers of Health
Presidents of Professional Colleges

Providing Sexual & Reproductive Health (SRH) Services to Adolescents

This is further to the DGHS circular on the same bearing Gen. Circular No: 02-29/2011 dated 07.03.2011.

Adolescents comprise one fifth of our population. Adolescence is a period of exploration and experimentation. Adolescents engage in various risk behaviors resulting in unexpected and unwanted consequences. Society expects them to grow in to responsible, productive and healthy adults. The majority of adolescents fulfill our expectations respecting cultural norms and societal values. However there is a minority, who need the specialized attention of service providers warranting secondary and tertiary prevention efforts.

We have observed several issues pertaining to legal aspects of health service provision for adolescents and legal clarifications were sought from the Attorney General's Department.

We would like to draw your attention to the following points highlighted by the Attorney General's Department by the letter dated 28.05.2013 bearing Reference No CH/CM3/353/10 the letter dated 26.01.2015 bearing Reference No: E-100/2014.

385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත, කොළඹ 10. 385,வணக்கத்துக்குரிய பத்தேகம விமலவங்சதேரோ மாவத்தை, கொழும்பு 10.

- Since non-disclosure of rape does not fall within the ambit of section 21 of the Code of Criminal Procedure Act and is therefore not punishable under section 199 of the Penal Code, healthcare workers including Medical Officers do not have a legal duty to inform law enforcement authorities of pregnancies among adolescents aged below 16 years, who access ASRH services.
- When providing reproductive health services to adolescents, **the best interest of the child** should be the basic concern of Medical Officers who provide such services. Decisions on best interest should be assessed by the Medical Officers on a case by case basis.

  For example, the Medical Officer could consider providing Adolescent Sexual & Reproductive Health (ASRH) services to a minor (a person below the age of 18 years), if it is likely that such minor would begin or continue to engage in sexual intercourse which is detrimental to the physical or mental health of such minor, if such reproductive health services are not provided. Considering the norms of the country, the Medical Officer must take all reasonable measures to obtain parental/guardian consent prior to providing such services. However, where the Medical Officer is unable to obtain parental/guardian consent, reproductive health services should be provided even in the absence of parental consent, in the best interest of the child.

  Adolescent Sexual & Reproductive Health (ASRH) Services in this document includes :Pre pregnancy care; Care for the pregnant mothers (antenatal care) ; Care during delivery (intra natal care); Care for lactating mothers including Post Natal care; Contraceptive /Family planning services; Post abortion care; Prevention, Care and management of STI and HIV/AIDS; Prevention, care and management of Gender Based Violence.

  We are grateful for your support in providing equitable and adolescent-friendly health services for our young persons. For more details, please refer the "Guidelines for health staff on providing adolescent sexual and reproductive health services". Further information can be obtained from the Family Health Bureau (Tel: 0112692746).

Thank you,

Dr. P. G. Mahipala
Director General of Health Services
Ministry of Health & Indigenous Medicine
385, "Suwasiripaya"
Rev Baddegama Wimalawansa Thero Mawatha,
Colombo 10.

Dr P.G. Mahipala
Director General of Health Services

Cc: Secretary / Health & Indigenous Medicine

385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත, කොළඹ 10. 385,வணக்கத்துக்குரிய பத்தேகம விமலவங்சதேரோ மாவத்தை, கொழும்பு 10.

Annexure II: Implementation of health protection plan (HPP) for the residence visa applicants to Sri Lanka

General Circular Number: 01-37 /2019

My No: PA/DDG PHS II/1/MHD/2019

Ministry of Health, Nutrition and Indigenous Medicine,

Colombo 10.

03/07/2019

Deputy Director Generals of Health Services

Provincial Directors of Health Services,

Directors of Ministry of Health/ Specialized Campaigns/ Epidemiology Unit

Regional Directors of Health Services,

Directors of Line Ministry Hospitals, Provincial General Hospitals,

Medical Superintendents of District General Hospitals, Base Hospital A & B,

DMOO of Divisional Hospitals,

MOOIC of Primary Medical Care Units,

Medical Officers of Health.

Circular on Implementation of Health Protection Plan (HPP) for the Residence Visa Applicants to Sri Lanka

Reference is made to the National Migration Health Policy of Sri Lanka and the previous Cabinet decisions CP No. 11/2140/509/159 dated 14.12.2011. Cabinet also granted approval to authorize the Ministry of Health, Nutrition & Indigenous Medicine to enter into the Memorandum of Understanding (MoU) with the International Organization for Migration (IOM) on the establishment and implementation of an Inbound Health Assessment Programme for Residence Visa applicants to Sri Lanka, (reference CP No. 18/0431/718/023 dated 20.03.2018). MoU was signed on 04.05.2018.

1. The Health Protection Plan (HPP) for migrants to Sri Lanka, applies to all the residence visa applicants (Exempted categories are mentioned in the web site of Department of Immigration and Emigration web site). The HPP includes a mandatory health assessment and a health protection cover through the government sector described under section 6.

2. The HPP is coordinated by the Immigration Health Unit (IHU) of the Quarantine Unit, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka in collaboration with the In-bound Health Assessment Center/IHAC (currently operated by the designated panel physician - International Organization for Migration/IOM). The selected applicants will be issued an HPP card by the IHU at a charge of USD 75 and is valid for a period of one year.

General Circular Number:

3. IHAC is currently established at No: 80A, 10th floor, IBSL building, Elvitigala Mawatha, Colombo 08.

4. The health assessment comprises screening for Malaria, Tuberculosis, HIV and Filariasis. The technical instructions for the designated panel physicians for the health assessments (screening) for these four diseases have been developed by the national disease control programs of the Ministry of Health, Nutrition and Indigenous Medicine.

5. Those who screen positive for Malaria, HIV, Filariasis and Tuberculosis will be referred to the respective national disease control programs for confirmation, treatment and follow up.

6. The respective national disease control program will refer the patients for follow up to the decentralized units of the control program in the district of residence of the applicant. The community follow up should be done by respective MOOH and PHIs similar to the follow up of a Sri Lankan citizen.

7. The HPP in addition to the health assessment covers emergency care and ambulatory primary care at all government health institutions in Sri Lanka. The applicants with a valid HPP card are eligible to avail the above health services free of charge at the point of delivery.

8. The HPP will not cover hospitalization other than for emergency care in the government sector. For any non- emergency hospitalization, the existing conditions and fees applicable to any non-citizen accessing government services will apply. The HPP does not cover any services obtained from the private sector.

9. The HPP card carrying the Government of Sri Lanka logo gives the personal identification information and the period of validity (It includes name, date of birth, nationality, passport no, relevant agency/sponsor, residential address, contact number and photo of the Residence visa holder).

10. All Provincial Directors of Health Services and Regional Directors of Health Services should instruct heads of all health care institutions/ decentralized campaign units in their provinces / districts accordingly. All heads of institutions (Directors / Medical Superintends / DMOO / Medical Officer in-charge and MOOH) should inform their staff about the services provided to HPP card holders with approved residence visa.

General Circular Number:

11. The HPP is intended to adopt an inclusive approach for health services whilst preserving public health in Sri Lanka and is aligned with the efforts to keep Sri Lanka Malaria free, eliminate Filariasis and to reduce the burden of TB and HIV/AIDS.

.....

Dr. Anil Jasinghe

Director General of Health Services

Dr. Anil Jasinghe
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine,
"Suwasiripaya"
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.

CC:

1. Secretary - Ministry of Health, Nutrition and Indigenous Medicine

Annexure III: Letter informing confirmed positive HIV status to MOH or VOG

දුරකථන අංක
தொலைபேசி
Telephone
011 2667029
011 2667163

අධ්‍යක්ෂ
இயக்குநர்
Director
011 2696183

කාර්යාල
காரியாலயம்
Office
011 2696433

ෆැක්ස්
பக்ஸ்
Fax
011 5336873

Email: dir@aidscontrol.gov.lk
Web: www.aidscontrol.gov.lk

ජාතික ලිංගික්‍රීත රෝග හා එච්චස් මර්දන වැඩසටහන
தேசிய பாலியல் நோய்/எயிட்ஸ் தடுப்பு வேலைத்திட்டம்
National STD/AIDS Control Programme

29 ද සේරම් පෙදෙස කොළඹ 10 (ශ්‍රී ලංකාව)
29 ய சேரம் இடம், கொழும்பு 10, இலங்கை
29 De Saram Place, Colombo 10, Sri Lanka

මගේ අංකය
எனது இல:
My No:

ඔබේ අංකය
உமது இல:
Your No:

දිනය
திகதி
Date:

URGENT & CONFIDENTIAL

……..
……..
……..
Dear Sir/ Madam

Confirmatory test result of ANC blood samples

ANC clinic area/ PHM area: ……

ANC clinic number: ……..

This is to inform you that the above antenatal blood sample was found to be in HIV confirmatory testing. The necessary measures to prevent baby getting infected will be arranged from the STD clinic. Further, details of shared care will be informed in due course.

We would appreciate, if you could take necessary measures to maintain confidentiality.
The copy of the report is attached herewith

Thank you.

……..
Consultant/MOIC
Sexual Health Clinic

Annexure IV: EMTCT HIV case investigation form

EMTCT HIV: Case Investigation Form

National STD/AIDS Control Programme, Ministry of Health HIV_V 11.10.2018

Name of the STD clinic:_____ Mother's file number :_____

Baby's file number :_____

Completed by (name & designation): _____ Date :_____

Note: Fill this form to all HIV confirmed pregnant women registered in the clinic

A. Details of the pregnant woman with HIV			
1. Age in years			
2. District of residence			
3. Nationality	1. Sri Lankan 2. Foreign (country:_____)		
4. Ethnicity			
5. Risk & vulnerability factors (e.g. FSW, DU, Psychosocial etc.)			
6. Past obstetric history (parity, miscarriages, still births etc.			
7. Date of HIV confirmation			
Details of the current pregnancy			
8. LRMP		9. EDD	
10. POA of pregnancy at registration		11. POA at registering for EMTCT services	
12. 1st CD4 count during this pregnancy & date		13. 1st VL during this pregnancy & date	
14. Other relevant diagnosis (TB/Syphilis/other)		15. Date of ART initiation	
16. ART regimen during this pregnancy			
17. Adherence (>95%, 80-95%, <80%)		18. CD4 count at third trimester	
19. Viral load closest to 36 weeks of POA		20. Number of ANC visits	
21. Post-partum family planning method			
Details of the sexual partner/s			
22. Partners HIV status		23. If positive file no.	
24. Partners ART regimen			
B. Details of the baby			
25. Date of birth		26. Facility/Place of birth	
27. Mode of delivery		28. Gestational age at delivery	
29. Baby's birth weight		30. Infant feeding (exclusive formula/ breast feeding)	
31. ARV prophylaxis for baby (Type/dose/duration)			
32. HIV PCR at birth (result/not done)			
33. 1st DNA PCR of the baby		Date	
34. 2nd DNA PCR of the baby		Date	
35. Baby's HIV ELISA around 18 months		Date	
36. Baby's final diagnosis			

Other relevant information (Describe attempts to follow-up, adherence if available):

Annexure V: EMTCT congenital syphilis case investigation form

EMTCT Congenital Syphilis: Case Investigation Form

National STD/AIDS Control Programme, Ministry of Health CS_V 11.10.2018

Name of the STD clinic:_____ Mother's file number :_____

Baby's file number :_____

Completed by (name & designation): _____ Date :_____

Note: Fill this form for all pregnant women with positive TPPA results, (including previously treated inactive syphilis) and for children diagnosed with congenital syphilis.

A. Details of the pregnant woman with syphilis			
1. Age in years			
2. District of residence			
3. Nationality	1. Sri Lankan 2. Foreign (country:_____)		
4. Ethnicity			
5. Risk & vulnerability factors (e.g. FSW, DU, Psychosocial etc.)			
6. Past obstetric history (parity, miscarriages, still births etc.			
7. Date and Stage of syphilis diagnosis			
Details of the current pregnancy			
8. LRMP		9. POA of pregnancy at registration	
10. POA at VDRL testing		11. POA at registering for EMTCT services	
12. VDRL result (initial)		13. VDRL result (closest to delivery)	
14. TPPA result		15. Results of additional syphilis tests	
16. Treatment (date /medication/dose/route):			
17. POA at treatment (weeks)		18. Gestational age at delivery (weeks)	
19. Pregnancy outcome		20. Mother's HIV test result	
Details of the sexual partner/s			
21. File number/s of the partner/s			
22. VDRL/TPPA and syphilis stage of the partner/s			
23. Partner/s' treated and date:	1. Yes 2. No	Date:	
B. Details of the baby			
24. Date of birth		25. Facility/Place of birth	
26. Mode of delivery		27. Birth weight	
28. Date of first VDRL		29. Titre of first VDRL	
30. Management of the baby (prophylaxis or treatment details.)			
31. If treated as congenital syphilis, reasons for diagnosis? (clinical, inadequate/non-penicillin treatment of mother etc.)			
32. Date, type and results of additional tests (DG, IgM, CSF VDRL, X-Ray etc.)			
33. Baby's VDRL & TPPA result around 18 month		Date	
34. Baby's last available VDRL & TPPA result		Date	
35. Baby's final diagnosis		Date	
Other relevant information (Describe attempts to follow-up, if available):			

Annexure VI: Antiretroviral drug requesting form

Antiretroviral Drug Requesting Form

Name of the STD clinic/hospital :
Date :
Name of the Consultant : **Page No:**

Serial No:	Patient's Number	EFV 600mg	ATV 300mg	RTV 100mg	RAL 400mg	DRV 300mg	EFV 200mg	LPV 200mg/r 50mg	LPV 100mg/r 25mg	LPV 100mg/r 25mg	AZT 300mg + 3TC 150mg + NVP 200mg	AZT 60 mg + 3TC 30mg	TDF 300mg + FTC 200 mg	ABC 60mg + 3TC 30mg	TDF 300mg +FTC 200mg + EFV 600mg	AZT 60mg + 3TC 30mg + NVP 50mg	AZT 300mg + 3TC 150mg	ABC 300mg	3TC 150mg	NVP 200mg	Sy. NVP 5mg/5ml; 240ml	Remarks (New patient/ Drug regimen changed)	If drug regimen changed, Pervious regimen
Total for patients																							
Current stock at Clinic																							
Total - stock = Required amount																							

Consultant Venereologist

Pharmacist

Annexure VII: Stock management form for condoms and lubricants

Stock Management form for Condoms and Lubricants

A.Name of the STD clinic/Institute: **Date:**

B. B. Name of the Consultant/Authorizing person:

Item	Number Requested	Number Issued
Flavored Condoms		
Non flavored Condoms		
Lubricants		
Female Condoms		
	..... Signature Requesting officer	..... Signature Issuing officer

Approved by

..... Director NSACP

Received by

Name.....

NIC Number.....

Designation.....