

HIV and AIDS Situation & Response Analysis

Update 2006

**Key findings from the
External review of the STD & AIDS response
in Sri Lanka, 2006**

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Acronyms

ANC	Antenatal Clinic	NHAPP	National HIV/AIDS Prevention Project
ART	Anti-Retro Viral Treatment	NIE	National Institute of Education
ARV	Anti-Retro Viral (Medication)	NSACP	National STD/AIDS Control Programme
BSS	Behavioural Sentinel Surveillance	NSP	National HIV/AIDS Strategic Plan
DU	Drug User	NTP	National TB and Respiratory Diseases Control Program
FHB	Family Health Bureau	PEP	Post-Exposure Prophylaxis
FSW	Female Sex Worker	PHI	Public Health Inspector
GFATM	Global Fund against AIDS, TB & Malaria	PLWHA	People Living With HIV/AIDS
GOSL	Government of Sri Lanka	PMTCT	Prevention of Mother to Child Transmission
HEB	Health Education Bureau	SLFEB	Sri Lanka Foreign Employment Bureau
HSS	HIV Sentinel Surveillance	STD	Sexual Transmitted Disease
IDU	Injecting Drug User	STI	Sexually Transmitted Infection
M&E	Monitoring & Evaluation	TB	Tuberculosis
MARP	Most-at-risk Population(s)	UNAIDS	UN Joint Programme on HIV/AIDS
MCH	Mother and Child Health	UNGASS	UN General Assembly Special Session on HIV/AIDS
MO	Medical Officer	UNICEF	UN Children's Fund
MoD	Ministry of Defence	UNODC	UN Office for Drugs & Corruption
MoE	Ministry of Education	VCT	Voluntary Counselling & Testing
MoH	Ministry of Health & Nutrition	WB	World Bank
MoL	Ministry of Labour	WHO	World Health Organisation
MSD	Medical Supplies Department		
MSM	Men who have Sex with Men		
NAC	National AIDS Committee		
NBTS	National Blood Transfusion Service		
NDDCB	National Dangerous Drug Control Board		
NGO	Non Governmental Organisation		

Executive Summary

The 2006 update of the situation and response analysis draws on the external review of the national response, undertaken in October 2006. This report provides policy makers and programme planners with an overview of key findings, lessons from the last five years, and priorities for the HIV/AIDS response in the coming years.

An external review of the national response to HIV/AIDS was carried out by a team composed of members drawn from national programmes and sectors external to the National STD/AIDS Control Programme (NSACP) and staff of international organizations. NSACP and UNAIDS co-sponsor and country office staff provided their extensive experience and knowledge. The objectives of the review were to *"identify the accomplishments of the national response to HIV by reviewing activities of the NSACP, other government organizations and non-government organizations especially in areas related to STD/HIV prevention, care and treatment for the last five years, and to provide recommendations for the revision of strategies and interventions for the development of a new Strategic Plan for 2007-2011".*

The situation analysis indicates that Sri Lanka remains one of few countries in the region with a low level HIV epidemic. Many infections that have been identified are associated with overseas work. HIV prevalence appears to be low even in populations such as sex workers, despite high vulnerability and risk. Some important vulnerability factors are absent or low-level in Sri Lanka. High literacy; relatively high status of women; good access to health care services all act to protect individuals and communities against HIV infection. On the other hand, vulnerability

factors include conflict, high mobility of military, internally displaced persons, and separation of spouses related to overseas employment. Socio-economic development could expand societal vulnerability through expansion of internal free trade zones, and increasing migration of young adults from rural areas to urban centre. There are large gaps in information in many of the above areas. An important follow-up to the 2006 Behavioural Surveillance will be simple methods for district-based mapping to inform local programme design and targeting.

The response analysis indicate that commendable efforts have been made by the NSACP and their partners towards maintaining HIV/AIDS on the national agenda, providing the general population with information on HIV, and some degree of access to the diagnosis and treatment of STDs. The National Strategic Plan (NSP) 2007-11 should be guided by a strong determination to focus programme activities and resources on most-at-risk populations, and sustaining continued low prevalence of HIV and other STDs.

To this end, the review recommended four over-arching lines of action.

1. Prioritisation of targeted intervention for most-at-risk populations.
2. Partnerships with engagement and encouragement of NGOs and private sector
3. Improved Strategic information (including bridging information gap) and establishment of
4. Strengthening of programme structure and management.

The analysis and recommendations are laid out in detail in the full external review report.

1. Introduction

1.1 Background and objectives of the Situation and Response Analysis

This report provides policy makers and programme planners with an update of the HIV/AIDS epidemic in Sri Lanka, and of the national response to prevent new infections and care for those already infected. This situation and response analysis should inform design and

implementation of the national response in the period 2007–11.

This paper contains key findings, lessons and recommendations of an external review that was conducted in October 2006. The full report is available from the National STD/AIDS Control Programme (NSACP).

2. The situation analysis

2.1 Sri Lanka has a very low prevalence epidemic thanks to certain factors

Nearly two decades since reporting its first HIV infection, Sri Lanka remains one of the few countries in the region with a low level HIV epidemic. HIV prevalence appears to be low even in populations such as sex workers despite high vulnerability and risk. HIV sentinel surveillance over the past five years have found an HIV prevalence of approximately 0.01% among antenatal women ($n=116,000$)¹; 0.1% among female sex workers ($n=2,633$) and 0.06% among both STD clinic attenders ($n=4,875$) and TB patients ($n=3,184$)². A total of 24 paediatric HIV have been diagnosed in Sri Lanka. Many reported cases are associated with overseas work.

Some important vulnerability factors are absent or low-level in Sri Lanka. High literacy rates, relatively high status of women and good access to health care

services all act to protect individuals and communities against HIV infection. On the other hand, conditions of higher vulnerability include conflict, high mobility of military, internally displaced persons, and separation of spouses related to overseas employment. New socio-economic developments such as the expansion of internal free trade zones, and the increasing migration of young adults from rural areas to large urban centres, could result in expansion of societal vulnerability.

2.2 It is unlikely that Sri Lanka will experience a large generalized epidemic.

Despite the likely repeated introduction of HIV from out-migrants and in-migrants the HIV epidemic has remained very low in the general population and high-risk sub-populations. Second, other Asian countries have not experienced large-scale generalized epidemics, and Sri Lanka does not appear to have sexual behaviour patterns that are more conducive to widespread HIV transmission than elsewhere. Instead, a truncated epidemic

¹ NSACP, HIV Sentinel Surveillance Report 2005, Colombo

² NSACP, HIV Sentinel Surveillance Report 2005, Colombo

and concentrated epidemics are likely to emerge in Sri Lanka

2.3 A low level truncated epidemic may emerge in Sri Lanka

Where sexual and drug-using behaviours and networks cannot sustain local HIV transmission, the spread of HIV depends on the movement of individuals to and from other locations where the HIV prevalence is higher. This could include out-migrants who are exposed to higher levels of HIV risk at their destination, or visitors from elsewhere who have sexual relationships with local residents.

In Sri Lanka there is some evidence that this pattern of transmission is occurring. First, more than 40% of women who have tested positive for HIV are international migrants. It must be noted however, these data overstate the importance of this pattern of transmission, since migrant workers require HIV screening prior to departure and are highly over-represented in HIV testing data. Second, there are anecdotal reports of HIV transmission from foreign visitors who have sexual relations with Sri Lankans. The extent of this pattern of transmission is not documented. It is important to note that the local HIV epidemic will remain truncated at a very low HIV prevalence, unless those who acquire HIV infection abroad or from a visitor are connected to local sexual or drug-injecting networks.

2.4 A concentrated epidemic among sex workers, MSM and drug users is possible

A concentrated HIV epidemic will occur where there are substantial enough high-risk behavioural patterns and networks to initiate and sustain local transmission within high-risk sub-populations (e.g. female sex workers, high risk men who

have sex with men and injecting drug users). Expansion to the wider population occurs through the sexual partners of these groups (bridge populations). The ultimate extent of concentrated epidemics will be determined by the size of the high-risk sub-populations and their sexual behaviours, including their number of sexual partners, concurrency patterns in sexual partnerships, types of sexual contacts, the prevalence of other sexually transmitted diseases that amplify HIV transmissibility, and condom use.

There is considerable evidence that Sri Lanka is vulnerable to the development of concentrated HIV epidemics. FSWs are found in most of the major towns and cities, and there are networks of MSM with multiple partners including paying clients. Sri Lanka has a high number of heroin users, and although few of them currently inject drugs, if there is a substantial change in drug use patterns to more injecting this would result in the establishment of another important population at risk for HIV transmission. However, lack of information on all of these parameters makes it impossible to project the potential size of concentrated HIV epidemics in Sri Lanka.

Current estimates of the size of the high-risk key populations vary widely: 3,000 to 50,000 FSWs; 30,000 to 240,000 opiate users of which 0.2 to 2% are injecting drug users³. Estimates of the number of high-risk MSM have not been published. Socio-cultural factors will largely determine the size and characteristics of high-risk groups, and the epidemic potential.

³ Rajagiriya, National Dangerous Drugs Control Board. (2004). Hand Book of Drug Abuse Information 1999 – 2003. Sri Lanka.

2.4 Prisons are potential high transmission settings

In prisons, people with high-risk behaviours come together, especially if drug use, and male-to-male sex are reason for arrest. There are about 7,500 prisoners in Colombo, and 27,000 nationwide. 15,000 are in remand custody, and prisons are overcrowded, reflecting long backlogs in trying cases. About 40% of prisoners are being held for drug-related offences, and 25% of women are being held on prostitution-related charges, most for only a short time until bail can be arranged. All staff openly acknowledge sexual activity in the prison, but injecting drug is reported not to take place. An estimated 75% of inmates have some form of same-sex contact. Condoms are not available, however, only for prisoners who go on family leave.

2.5 Young people are not at risk, unless they sell sex or have unsafe male-to-male sex

Adolescents (10–19 years) account for 3.7 million (19.7%) of Sri Lankan population⁴. Sri Lanka has the highest educational enrolment rates in South Asia. A national survey on emerging issues of adolescents undertaken among 40,000 adolescents (14–19 years) found that knowledge on HIV/AIDS and STDs amongst school students is poor. The percentage of adolescents who knew how to prevent HIV transmission never reached above 50%. Knowledge amongst out-of-school adolescents was significantly better. Only a small proportion, 6% of school students reported sexual experience (14% of males and 2% of females). 11% of respondents had their first sexual intercourse with a commercial sex worker; and the proportion who reported using condoms in their last sexual was 17%. A detailed

mapping and behavioural surveillance of most-at-risk adolescents must be ongoing.

Behavioural Sentinel Survey 2006 – preliminary findings

- 1. Population size most-at-risk groups**
 - Number of sex workers appears smaller than the estimated 30,000
- 2. Awareness, Knowledge & Attitudes**
 - Awareness is very high in all groups
 - Knowledge about transmission is high, but misconceptions remain
 - General little acceptance of PLWA
- 3. Most at risk groups**
 - MSM have many anal sex contacts, reasonable condom use, few STDs
 - DU hardly inject, but engage in unsafe & commercial sex
 - SW have low STDs, few clients per day & reasonable condom use.
 - Subgroups of sex workers have different vulnerabilities
 - Beach boys have sex with foreigners from gay communities (with higher HIV prevalence), but also with local men and women
- 4. Intermediate and low risk groups**
 - Trishaw drivers have fewer commercial sex than expected
 - Free trade zone workers seem less sexually active than reported
 - Recent male-to-male sex is low among general men
- 5. Services**
 - AIDS info comes mainly from mass media, very little from NGOs
 - Sex workers visit (government) STD clinics; DU and MSM much less
 - Compulsory testing happens
- 6. BSS and strategic information**
 - Qualitative research on contexts and meanings of behaviours

⁴ DCS (Department of Census and Statistics)(2002 b). Statistical Abstracts 2001. Colombo, Sri Lanka.

3. The response analysis: Progress made since the previous Situation and Response Analysis

3. 1 Prevention

The National Strategic Plan (2002–2006) articulated the following prevention priorities: 1) mass media awareness campaigns and condom social marketing; 2) focused behaviour change interventions among most vulnerable populations, including FSWs and their clients, MSM, and injecting drug users; 3) prevention among other vulnerable populations; 4) STD diagnosis and treatment; 5) blood safety; 6) preventing HIV in health care settings; 7) prevention of mother to child transmission.

Targeted interventions

Coverage of key populations (i.e. FSWs and MSM) with targeted prevention programs has remained very low, projects are scattered and without sufficient focus, and they lack adequate supportive supervision or technical support. Previously, some NGOs were conducting some basic outreach and education, but those activities have not received subsequent funding support. None of the 24 prevention grants to NGOs from the NHAPP are focused on these high-risk groups.

Less than 10% of the total FSW population in Sri Lanka are reached by NSACP supported NGOs. 15 out of 26 government STD clinics conduct some education programmes and provide STD management for FSWs.

The overall coverage in absolute or relative terms is of MSM not known. There have been scattered “awareness” programs in Colombo, Kandy and Anuradhapura by

three NGOs that work with MSM. In 2005, the STD clinic also conducted an awareness program for MSM.

Some NGOs conduct HIV awareness and education programs for 1200 drug users (DU). The National Dangerous Drug Control Board (NDDCB) runs 4 drug treatment centres, offering detoxification free of charge. The drug treatment centre conducts regular outreach in ‘shanty’ areas where drug use is common, to promote residential program and to educate about blood borne transmission. Outreach workers know of 57 female sex workers who are also drug users. The NDDCB has a strong system of data collection, that can form the basis for an ‘early warning’ system in relation to movement to greater injection use.

There have been relatively substantial efforts to provide HIV education for prison inmates. One NGO has apparently conducted awareness programs in 15 prisons, and others have received some form of awareness program from local NGOs supported by the local STD Clinic Medical Officer. The central prison in Colombo has well-organized facilities: income-generation for inmates; places of worship; a special unit for female prisoners with infants and comprehensive clinic services. Training activities for both inmates and staff include sessions of STDs and HIV. Some peer education work is supported.

Prevention programs for lesser risk and general populations

A variety of general awareness and education programs has led to an over-emphasis on scattered activities that lack appropriate focus, scale and quality, and are therefore unlikely to have much impact on the HIV epidemic. Different sub-populations including beach boys, factory workers, plantation workers, school children and other youth, trishaw drivers and uniformed services have been reached by NGOs, 24 of these with funding from the NHAPP. Most prevention programs focused on general awareness, with a concomitant lack of focus on effective behaviour change communication.

The extensive HIV/AIDS awareness work with youth has not been based on information on risks and vulnerabilities of adolescents, such as the results of the 2004 survey. The National Youth Services Council and the Plantation Human Development Fund undertook extra-curricular work in schools and through NGOs. Projects targeting vulnerable children through development of drop-in centres are not reaching those most at risk, i.e. without parental care or living on the streets. The Ministry of Education has included sexual and reproductive health, HIV/AIDS and STDs into the secondary school curricula review, as part of life skills. There is however reluctance of administrators and teachers to deal with issues of sex, sexual health and gender in the classroom, despite being in the syllabus.

STD management

Clinical services for STD are high quality and well organized: Sri Lanka has a well-established network of STD clinics at district level. These clinics include usually both clinicians and public health staff (Public Health Inspector and a Public Health Nurse) who have both clinic and

community outreach responsibilities. Clinics are well equipped and have adequate supplies of condoms and essential medicines, although stock outs of some lab reagents were reported.

STD clinic attendance increased following activities to raise awareness of STDs and HIV within communities. NGOs working with sex workers or MSM report good collaboration with the local STD clinic team, including provision of condoms and clinical services. PHI and PHN provide important outreach work including STD contract tracing and visits to sex work venues. With their other responsibilities, however, they have limited ability to maintain regular contact with high-risk populations without the assistance of NGOs. STD clinic staff are very active in the community conducting awareness and risk reduction trainings for groups from intermediate to low risk, such as military, 3-wheel drivers, domestic workers en route to Middle East, school children, teachers, community groups, etc.

It is estimated that less than half of STD patients are seen in public facilities, with a similar number seen by private care providers. STD doctors conduct professional seminars for private sector doctors on referring STD patients to STD clinics rather than promoting syndromic case management at first point of care, so some patients probably do not get treated given distances to STD clinic.

Condom programming

There has been an increase of approximately 19% in the distribution of condoms (from 11.5 million in 2000 to 13.7 million in 2005), excluding commercially sold condoms in the marketplace. The government has resisted the promotion of condoms through mass and mid-media campaigns, due to concerns about public sensitivities.

Planned awareness campaigns have as yet not been carried out.

In 2005, NSACP distributed approximately 785,000 condoms, 52% to the Armed Forces, 20% to STD clinics and 14% to NGOs. The Family Health Bureau distributed just over 5 million condoms for family planning through public health staff and family planning clinics. Family Planning Association distributed almost 7.9 million condoms through social marketing in pharmacies and other shops.

Prevention of mother-to-child transmission of HIV (PMTCT)

Sri Lanka has very high antenatal care coverage, strong infrastructure of public health midwives in every community. A PMTCT working group, including NSACP and FHB has developed PMTCT protocols and guidelines for four prongs including 1) primary prevention for women of child-bearing age; 2) prevention of unwanted pregnancy among HIV infected women; 3) interventions to reduce MTCT; and 4) care and support to HIV-infected women, their children and family members. Paediatric ARV doses and regimens are registered. There is not yet comprehensive clinical PMTCT training curricula/modules along with non-clinical modules and HIV counselling manual and tools plus training programmes for ANC and FP staff. The external review found very limited knowledge of nurse midwives and MO-MCH on HIV, MTCT and risk factors.

PMTCT services have been piloted in two districts in 2005–06. After counselling, over 90% of the pregnant women agreed to an HIV test and all 3,232 tested were HIV-negative. The pilot project used the opt-out approach, although in very low HIV prevalence situations, it is not recommended to test every pregnant woman, but instead to raise awareness of MTCT and identify risk factors, using “opt-in” approach for those with risk factors.

Blood safety

Good progress is being made towards achieving 100% voluntary donations. Total voluntary donations per year have increased from around 154,000 units in 2001 to 207,000 units in 2005. There is still substantial replacement donation (in Colombo 8% and nationally 37%), but this is declining. NBTS developed ‘Guidelines for clinical use of blood’ and a ‘Handbook of blood transfusion practice for nurses’ to improve rational use of blood in hospitals.

From 2007, external quality assurance includes ‘centralised’ testing to Colombo and 5 regional blood banks. All blood units collected are screened for HIV, syphilis, hepatitis B & C and malaria. HIV testing is done using ELISA. Blood units that test positive are destroyed and a sample sent to the central STD laboratory for confirmation. If confirmed, the donors are contacted by the central STD clinic for follow up.

Prevention of HIV transmission in health care settings

HIV infection control has received particular attention during recent years. Most larger hospitals have developed infection control teams that have received training on relevant policies and procedures. These staff educate other staff, supervise supplies and coordinate needle-stick injury management. Clean needles, syringes and gloves are available at most times in most health facilities, but shortages exist in supply of sharps containers and goggles. Current practice is, however, insufficiently evidence-based, but strongly influenced by fear. In particular, there is inadequate use of *standard* precautions and persistence of unnecessary infection control procedures.

A Post-exposure Prophylaxis protocol exists since 2001. ARV for PEP have been

procured, but are not yet available in many hospitals due to difficulties with distribution. Despite awareness, underreporting is still the norm, as well as delays in availability of the source patient HIV test result. There are also reports that source patients are tested without their knowledge.

3.2 Care, treatment, support and impact mitigation

Voluntary counselling and counselling

Despite good VCT systems, uptake is poor due to limited availability of health staff with up-to-date skills in HIV pre- and post-test counselling and by the use of HIV testing without informed consent. The high quality of the national HIV testing program is effectively supporting accurate diagnosis of HIV in an environment of very low prevalence. The national HIV testing algorithm is consistent with international norms, and uses ELISA and particle agglutination tests. VCT is available at blood banks (in 2005, 76% of reported HIV tests), at 26 STD clinics (14%) and at 30 private laboratories (10%). Very few NGOs provide VCT, besides a few offering pre- and post-test counselling. Many private health facilities offer HIV testing. Of 26 STD clinics, 12 perform testing on site, 7 send samples to the National STD Reference Laboratory and 7 to another hospital laboratory. The National STD Reference Laboratory administers quality assurance for the public sector testing services.

Counselling guidelines exist since 2003, and 970 health care workers at the NSACP and major hospitals around Colombo have received pre- and post-test counselling training since 2000, as part of a two day Comprehensive Care and Treatment training workshop. Pre- and post-test

counselling is provided predominantly by doctors at STD clinics. Routine testing without consent is reported to occur for health insurance medical assessments, for workers prior to departure to the Middle East and in the armed forces pre- and post-overseas deployment. HIV testing in health care facilities commonly occurs without the knowledge of the patient, for example following needle-stick injuries.

The low community uptake of HIV testing is likely due to a combination of (appropriately) low perceived risk of HIV infection; limited availability of services; stigma associated with attendance at STD clinics; and absence of programs integrating access to HIV testing into services for people with higher-risk for HIV infection.

Clinical care

The establishment of freely available public sector provision of ART since 2004 is a major achievement. Expansion is now planned. There is no official estimate of coverage, or people estimated to be in need of ART. As of June 2006, out of 785 people were diagnosed with HIV, 303 were registered at the Central STD Clinic and 80 commenced ART. 24 children have been diagnosed with HIV, of which 8 are under follow up at the Central STD Clinic and 3 are receiving ART.

HIV clinical care is provided at the central and district STD clinics. All diagnosed patients are referred to the Central STD (outpatient) Clinic for evaluation. Follow up is at the local STD clinic, but in the case of ART treatment mostly from the Central STD Clinic. When admission is needed, patients are referred to specialist hospitals in Colombo. All health facilities are instructed to offer care without the use of separate wards. There is little provision of HIV care in the private sector. Expansion of clinical care is planned to the STD clinics in Colombo South, Colombo North and

Kandy, followed at a later date by Galle and Anuradhapura. The key challenge for expansion is the development of a national model for comprehensive HIV care that overcomes the difficulties imposed by the separation of outpatient STD clinics from hospital inpatient services and the relatively limited involvement of community groups.

There is no government policy on private provision of HIV care or prescription or sale of ARV. ARV are not available in private pharmacies, but can be purchased directly from the Cipla distributor, with a doctor's prescription. HIV supplies are procured through the Medical Supplies Department (MSD) and World Bank/NHAPP processes. Distribution of STD clinic supplies is performed outside the MSD distribution system. ARV forecasting capacity is limited and procurement requests are often ad hoc. Government of Sri Lanka has started a process to introduce TRIPS facilities in its Intellectual Property laws with the support of WHO.

Supportive and adherence counselling is currently delivered by clinicians, with little involvement of paramedical counsellors, or NGOs counsellors. Adherence support activities are limited to peer support group meetings organized independently by Lanka+ at their offices. There are reports of ongoing fear, stigma and discrimination in health care facilities.

CD4 and HIV viral load testing is available at the national STD and HIV reference laboratory exists at the Central STD Clinic. The laboratory is sometimes unable to perform CD4 or HIV viral load tests due to stock out of reagents. The Medical Research Institute monitors the laboratory. At provincial level, inconsistent maintenance and technical support for laboratory instruments may limit laboratory support for ART.

National guidelines on HIV clinical care in adults were issued in 1998 and national ART guidelines were issued in 2005, based 2003 WHO guidelines. There are no national guidelines for paediatric care, use of ART pregnant women or management of TB/HIV co-infection. So far, 970 health care workers are trained through a two-day Comprehensive Care and Treatment training program on HIV facts, counselling, infection control and treatment. Several medical specialists received training in Thailand, including venereologists, physicians, two paediatricians and an obstetrician. HIV is included in various parts of medical school curricula and a working group is currently developing a common HIV curriculum for all medical schools. The Independent Medical Practitioners Association is developing a distance education program on HIV for general practitioners.

TB/HIV co-infections

The 2005 HSS identified a prevalence of 0.07% (2/1528 patients). No formal mechanism has been developed for collaboration between the TB and HIV national programs. No policy exists on HIV testing for TB patients, but all patients newly diagnosed with HIV are referred to Chest Clinics for TB screening. National clinical guidelines on the management of TB/HIV co-infection are under development. Sri Lanka currently has an effective response to the tuberculosis epidemic: in 2002 the national incidence of TB was 46.9 per 100 000 population per year; in 2005 case detection was 86% and treatment success 85%.

Home, community and palliative care

A community-based response to the needs of people living with HIV is evident with a small group of organizations engaged and experienced in addressing the challenges for people and families living with HIV. Lanka+, the national network of PLWHA,

provides peer support, weekly meetings and home and hospital visits. Salvation Army provides home visit and counselling services, transportation costs for follow up visits, and a drop-in centre in Colombo. NEST provides psychosocial support for PLWHA and addresses stigma and discrimination. Other organizations provide care and support integrated within other program services. Palliative care services are predominantly provided by families, in hospitals and by some general practitioners. Significant additional resources exist within society that are not yet engaged in the provision of care and support for PLWHA. Medical officers, public health nurses and midwives have not been involved in care for people living with HIV. Nor are there initiatives by faith-based organizations.

3.3 Multisectoral involvement and decentralization

Sectoral involvement

NSACP generated interest and commitment from a variety of sectors, largely owing to the financial support of the NHAPP with additional resources made available through the UN system. Collaborating Ministries or entities include the Bureau of Foreign Employment and the Workers' Education Unit of the Ministry of Labour; National Institute of Education; Department of Prisons; National Child Protection Authority and National Youth Services Council; the Army, Navy, Air Force and Police Department of the Ministry of Defence; the Vocational Training Authority and the Ministry of Fisheries. This list is not exhaustive as ongoing collaboration between national entities and several UN Agencies often include activities relevant to HIV prevention. Activities were largely dependent on external funding, raising

concerns about their long-term sustainability.

NGO, community and PLWHA involvement

Only a handful of the many Sri Lankan NGOs are engaged in HIV work, and those who are tend to direct their work to easy-to-reach communities. Very few NGOs show interests in working with sex workers, MSM and DUs and even fewer are actively working in this field. NGOs will need significant capacity building to enable them to be effective implementers of targeted interventions for vulnerable populations. There is no effective umbrella organization for NGO coordination in the area of STD and HIV although such a structure is urgently needed. Mechanisms existed previously, but no longer function need technical and financial support from the NSACP for their revival.

NSACP provided grants to NGOs through the NHAPP. To-date, 24 funded NGOs have received funding. Among these are such NGOs as Lanka+ (the only organization of people living with HIV), Companions on a Journey (working with men who have sex with men), the Salvation Army and NEST (both providing care and support to people infected or affected by HIV), Community Development Services (working with sex workers and training NGOs), Alliance Lanka and Family Planning Association (engaged in general awareness activities) and Sarvodaya (working with youth and religious leaders). The main focus of these projects was on populations at low or moderate risk of HIV, very few on populations at greatest risk. Seven NGOs receive funding from bilateral development agencies (Netherlands and USAID). International NGOs such as ActionAid/Sri Lanka, Plan International, Christian Children's Fund and the Red Cross are contributing some of their efforts and resources to the nationwide response to HIV. These projects are run rather independently from the NSACP.

3.5 Strategic Information

The participation of People living with HIV in the NSACP is minimal.

Private sector involvement

The private sector supports HIV prevention activities targeted at their workforce and families. The majority of the companies fund their own HIV/AIDS programmes. "HIV/AIDS in the work place" programmes have been commenced in collaboration with the ILO in key sectors such as tourism, plantation and manufacturing. In addition, the main chambers of commerce through their corporate membership and SME, reach out to several hundred thousand employees, and inclusive of plantations, to well over a million employees.

3.4 Policy development

A National Policy on HIV/AIDS has been approved by the Minister of Health and will be submitted to Cabinet and Parliament in the near future. The policy is consistent with national priorities and international guidelines. It emphasizes the need to expand prevention, care and treatment with a focus on most-at-risk communities. It upholds the protection of human rights and the need to combat HIV-related stigma and discrimination. This long-awaited policy will play an important role in stimulating greater cohesiveness across sectoral strategies and enhanced focus on populations at greatest risk and vulnerability. There are no plans as yet on how the National Policy, once adopted will be disseminated widely across sectors, publicized through professional and general media, and used in advocacy activities and training courses.

National M&E framework

There is no national HIV/AIDS/STD M&E framework, and the concept of Strategic Information and Monitoring & Evaluation seems not widely accepted. An M&E system could help to provide a better understanding of the epidemic to inform policy development and programming, and to measure effectiveness of the response. One single M&E mechanisms could minimize the need for duplicative reviews that impose an unnecessary burden on the programme staff, and could typically includes:

1. An M&E unit with full-time staff to coordinate M&E activities, and conduct in-depth analysis of the data collected.
2. A national M&E Working Group to dealing with day to day technical issues
3. A multisectoral M&E framework, defining authorities, and lines of reporting
4. A national set of standardized indicators
5. A surveillance system following WHO/UNAIDS 2nd Generation Surveillance System
6. A national health management information system supported by a functional database
7. Information flow from sub-national to national level, and good feedback
8. M&E capacity building
9. Research and training agenda which meets the country specific needs
10. Resources for SI/M&E work

The NAC subcommittee on surveillance and laboratory services is presently defunct.

Human resources and institutional capacity for M&E

NSACP does not have a national Strategic Information/ M&E unit to coordinate the overall work. Roles and responsibilities of staff in relation to strategic information and M&E are not clearly defined. There is only one part-time position, which also deals mainly with HIV/STD and behavioural surveillance. The NHAPP has a full time M&E specialist position to monitor the World Bank sponsored projects and supporting the design of national M&E frame work. There is confusion between the M&E functions of the NSACP and NHAPP

Surveillance and health management information systems

HIV Sentinel Surveillance System has been conducted regularly since 1993, with WHO support. Sentinel groups include vulnerable populations such as STD clinic attendees, TB patients, army service personnel and most-at-risk groups including female sex workers and drug users, not men who have sex with men. STD surveillance is included in the HSS, but consist mainly of case reporting from government STD clinics. Behavioural Sentinel Surveillance is piloted in 2006, and includes most-at-risk populations, such as female sex workers, men who have sex with men, drug users and beach boys.

The NHAPP has a reporting system for information and financial tracking of the project, but there is not a national system to monitor service coverage and quality. A country level Universal Access consultation was held in March 2006, resulting in 45 national UA targets for 2010⁵. Data related to activities conducted by other players (donor agencies, UN and INGOs) are largely lacking.

⁵ NSACP, Universal Access report, 2006

Reporting and feedback

A set of 78 national ore indicators was drafted by the NHAPP project, requires further prioritisation. Sentinel surveillance reports are published annually. Data from HSS and ad hoc surveys up until mid 2005 were being well shared with stakeholders at NAC and subcommittee meetings. NSACP developed the 2005 UNGASS country progress, but much of the data needed was not available⁶. There is one-way information flow from district and province to central, but no clear mechanism for feedback. Information related to donor funded projects and various NGO activities are in many cases not well shared between the local and central level. There is a lack of consultation of civil society in planning and conducting M&E work.

Strategic information gaps

Key information about most-at-risk populations is lacking. Information gaps include:

1. Size and location of the most vulnerable key populations. Recently, a separate mapping and behavioural survey project has been initiated through a contract from the NHAPP, but that was not include a comprehensive mapping for intervention planning. Rather, it was a limited mapping in a few cities to develop a sample frame for the behavioural survey.
2. Risk behaviours of key populations – A few small-scale surveys have been done to assess the behaviours of high-risk groups, but the data are not consistent. A behavioural survey is completed⁷. However, the sample frame for this study is not based on a

⁶ UNGASS report 2005

⁷ Data from the first round were shared in May 2007

broad-based mapping exercise and therefore the sample might not be representative.

3. HIV and STD prevalence in different key high-risk populations, especially MSM.

3.6 Programme management

Governance

A National AIDS Council has been established in 2006 and has met once. It is chaired by HE the President and includes senior members from all ministries, international organizations and NGOs. The National AIDS Council is not intended to replace the National AIDS Committee: it is a higher body erected to provide direction to all sectors through their line-Ministries and take decisions on controversial issues. The National AIDS Council does not have terms of reference.

The National AIDS Committee (NAC) is an advisory body to the Hon. Minister of Health. The NAC has not met since mid 2006. There are concerns about the relevance, usefulness and efficiency of NAC and its subcommittees.

Coordination

The National STD and AIDS Control Programme (NSACP) provides direction and oversight to those engaged in the national HIV/AIDS response. Since September 2006 a single person is Director of the NSACP as well as Project Director of the World Bank supported NHAPP⁸, because there was little cooperation before between NSACP and NHAPP. Some issues are still unclear: NAHPP reporting channel and line of

accountability as well as the roles of the eight focal points within the NSACP central team and their relationship to the NHAPP staff working in the same areas. The lack of clarity in roles and functions has caused delays in action, tensions between the staff of the two entities and lack of accountability.

Provincial/district AIDS Committees function in "key" districts with the participation of NGOs. They seem to operate more as an information-sharing forum than a coordination body. The provincial and district AIDS Committees do not have guidelines for planning from NSACP for planning in line with the national strategy, adjusted to local needs.

The Central and District level STD are the backbone of the NSACP. The central STD clinic offers STD care, VCT, prophylaxis and treatment of opportunistic infections; and staff provide technical support to provincial and district level prevention staff. District level STD Medical Officers (MO STD) and their teams play a key role in promoting and coordinating the STD/AIDS activities at provincial and district level. However, 50% of the work of MOs STD in districts is clinical, so very limited time is available for planning, management, coordination, outreach and intervention services. It has been proposed that staff be added with direct responsibilities in STD/HIV prevention and care. The MO STD is expected to engage Public Health Inspectors and midwives already in place in districts, as well as local NGOs and other partners. This will require much stronger collaboration within the Ministry of Health between the NSACP and the Family Health Bureau.

Capacity building

The overall capacity of key institutions and organizations to develop a strategic and effective response is mixed. In general, the level of training of key personnel in the

⁸ National HIV/AIDS Prevention Project

basics of HIV and AIDS was high. Key areas where more capacity building is required include 1) strategic planning – to focus the program on those activities that are most important for interrupting transmission; 2) programme management – to help ensure efficient and effective program functioning; 3) NGO Capacity – to increase their capacity to implement programs; 4) Strategic Information and M&E – for most-at-risk-group mapping, population size estimation, epidemic projection, data triangulation and utilization, and costing.

3.7 Resource and support mobilisation

The resources available to the NSACP from national sources, multilateral and bilateral agencies seem sufficient to meet current needs, given the prevailing implementation capacity. The World Bank funded the NHAPP on the level of US\$12.5 million over five years starting in March 2003, with US\$9.6 million grant. It is the single largest resource of financial support on STD/HIV prevention and care work in Sri Lanka. As of May 2006, US\$5.1 million of this grant had been disbursed.

The expected 1.8 million US\$ grant from the GFATM (round 6) and services from the Clinton Foundation will alleviate some of the constraints to the procurement of antiretroviral drugs (ARV), thus far procured at local market rates.

Additional funding budgeted by UN Agencies, affiliated and other funding entities amounted to US\$3.3 million in 2005. In addition, technical support is extended to the Programme through their Colombo-based and regional staff. Besides the World Bank grant, UN agencies are supporting the country AIDS response through the following ways: FAO/WFP: HIV awareness raising among farmers; ILO: plantation sector, hotel sector and manufacturing sector; IOM: internal migrants and Tsunami-affected communities; UNDP: women leaders and positive network; UNFPA: young people; UNICEF: life skill training for young people, prevention of mother-to-child transmission (PMTCT) and paediatric AIDS; UNHCR: internally displaced people and returning overseas workers; UNODC: drug users, especially injecting drug users; World Bank; WHO: support to surveillance and VCT

4 Lessons learnt: obstacles to the response

Good access to good quality public health and education service help create a favourable environment for HIV prevention and care.

Compared to other countries in the region, access and quality of health services is good, including primary health care, antenatal care, STD treatment, blood transfusion and TB control. Similarly,

almost universal access to education, and introduction of life skills- based teaching methods, contributes the high awareness levels in the general population.

Poor targeting of prevention is neither effective nor cost-effective.

The prevention strategy has resulted in prevention activities that are widely scattered and not attaining the scale or intensity required to produce sufficient behaviour change in key populations to effectively prevent the emergence of concentrated epidemics. The current strategic focus does not consider the relative size and vulnerability of different sub-populations. Based on available information, the highest priority should be on scaling up intensive targeted interventions for those at greatest vulnerability. In Sri Lanka, the two key groups in this regard are sex workers and high-risk MSM, as well as drug users. Prisons are potential high transmission settings

Strategic information is required for planning and intervention design.

National planners and policy makers, but also local service provider, need information in order to make decisions on who to target and how to design services. This information is largely absent. A national M&E framework is necessary to identify national indicators and research priorities; systems for generating, analysing and disseminating information; human development and institutional structures required; capacity building needs, etc. For the first national priority, targeted interventions, key information is lacking. Information gaps include: mapping of key sexual networks; the size of most-at-risk risk populations; patterns of behaviours; and STD/HIV prevalence data from key high-risk populations.

Government alone cannot reach most-at-risk populations.

Most at risk groups are not accessing government services, even if these services are good. Sex workers are arrested and harassed by police if they carry condoms; male-to-male sex and drug use are illegal. Non-government organisations are in a better position to reach out to marginalized communities, and to support community building among these groups. To capitalize on the potential contribution of NGOs and CBOs to the response, they need capacity building and sensitisation. Providing a platform for NGO-GO coordination, and encouragement of donor funding for NGOs, could unleash the potential of NGOs.

Strong national programme management is required

Although the World Bank supported project was designed to strengthen the NSACP through systems development, it has led to duplication of organisational structures, systems and human resources, and increased internal communication challenges. Combining clinical and programme management duties is a challenge for NSACP staff, especially in the absence of job descriptions, clear lines of responsibility and authority, and a human development strategy to improve public health management skills for clinicians.

5 Opportunities for an enhanced response to HIV/AIDS

Prioritisation of targeted intervention for most-at-risk populations

The formulation of the 2007–2011 should involve all stakeholders in a broad participatory process guided by the NSACP. To this end, the NASCP should seek technical support from sources available in Sri Lanka or internationally. The National Strategy should serve as a framework for the development of a District-based operational planning contributing to the formulation of provincial and national operational plans. In each district, the highest priority for HIV prevention is to start interventions with sex workers. District partnerships between STD clinic teams and NGOs should be developed to carry out this work. STD clinic teams should be strengthened and reoriented to have a stronger public health role in prevention and control of STDs and HIV. Local advocacy should be conducted with district and provincial leaders and police to explain public health importance of targeted interventions and to build an enabling environment for prevention activities.

Partnerships with engagement and encouragement of NGOs and private sector participation

A determined effort should be made by the NSACP and the NHAPP towards capacity building of NGOs and the revitalization of NGO coordinating mechanisms and partnerships. Collaboration with the private commercial sector should be further expanded through joint project advocacy and planning between the National programme and the Chambers of

Commerce. The engagement of private health care providers in the nation-wide response to HIV should be stimulated through such incentives as their participation in short courses.

Improved Strategic information (including bridging information gap) and establishment of M&E system

Information on high-risk populations is acutely needed to guide the local response. District and local mapping should be conducted and coverage targets set. The highest priority should be given to a comprehensive mapping of most-at-risk populations. In each district, with the objective of identifying the size, location and general characteristics of female sex workers, men having sex with men and injecting drug users. Key information should be gathered in ways that are respectful of privacy, non-discrimination and other human rights. These surveys, along with other more detailed situation and needs assessments should be carried out in the context of programs providing prevention services for these groups. There is an urgent need to set-up the national Strategic Information and M&E system, which will be led by a national SI M&E Unit authorized to have access to all needed information, guided by a national M&E framework. The role and responsibility of each involved party should be clarified and a core set of indicators defined.

Strengthening of programme structure and management

The NASCP and NHAPP structure should be amalgamated permanently with a single senior management team. To reflect the broadening of its scope, consideration should be given to rename the national programme the National STD and HIV Programme. The functional task analysis recommended by March 2006 NAHPP review should be conducted once the 2007–2011 National Strategic Plan is produced, so as to reflect new priorities and work areas. This analysis will determine if further changes in the structure of the NASCP central management group should retain eight programme units below the Director or regroup these. The appointment of Deputy (or Assistant) Directors would create ground for greater delegation of authority. NHAPP Project coordinators (Team Leaders) should be incorporated in relevant thematic units and report to Director of the NSACP directly or through

the supervisor assigned to the pillar to which they will be assigned.

The District Medical Officers of Health need support from additional staff to do planning, management, implementation and monitoring of STD/HIV-related activities, and to secure active participation of health inspectors and public health nurses/midwives. The development and implementation of STD/HIV programming activities in provinces and districts will require considerable technical and managerial support. This could be provided in the short term by roving teams trained and deployed from the central STD/HIV office. There is an urgent need to set-up the national Strategic Information and M&E system, which will be led by a national SI M&E Unit authorized to have access to all needed information, guided by a national M&E framework have role and responsibility of each involved party clarified and a core set of indicators defined.

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