



National HIV Strategic Plan Sri Lanka 2013-2017



NATIONAL
STD/AIDS
CONTROL
PROGRAMME

National STD AIDS Control Programme

Ministry of Health

National HIV Strategic Plan Sri Lanka 2013 - 2017



Message from the Hon. Minister of Health

The first case of human immunodeficiency virus was discovered in Sri Lanka in 1986. We are still moving as a low prevalent country in the region while most of our neighbouring countries are grown in to concentrate or generalised epidemics. My sincere gratitude goes to people who contributed to maintain this low HIV epidemic situation in Sri Lanka.

Our country is at a crossroads. Right now, we are experiencing a domestic epidemic that demands are need commitment, increased public attention, and leadership. Ministry of health has taken the leadership of developing National HIV Strategy 2013- 2017 as our road map with a vision of “country free of new HIV infections, discrimination and AIDS related deaths”

The Ministry of health can't task this alone, nor should it. Success will require the commitment of governments at all levels, businesses, faith communities, development partners, the scientific and medical communities, educational institutions, people living with HIV, and others. People living with HIV have transformed how we engage community members in setting policy, conducting research, and providing services. Successful prevention efforts have averted large number of new infections in the Sri Lanka and health care and other services providers have taught to the world how to provide quality services in diverse settings. Now is the time to build on and refocus our existing efforts to deliver better results leading towards the goals of National HIV strategic Plan 2013-2017.

We look forward to working with other ministries, development partners, private sector and other stakeholders of the civil society to support the implementation of this National Strategy that focuses on the areas of greatest need and that provides a clear direction for moving forward together.

Maithripala Sirisena

Minister of Health

Message from the Secretary of the Ministry of Health

National HIV response of Sri Lanka has made a significant progress towards the goal of HIV prevention and Universal Access to HIV and AIDS services. Continuing this progress, Ministry of Health Sri Lanka lead the process of developing this new National HIV Strategic Plan with broader stakeholder consultation. The National HIV Strategic Plan 2013 -2017 (NSP) is the result of more than a year of preparatory work, which sets out the overarching goals for the response to HIV and AIDS as well as reaffirming Sri Lanka's commitment to a multi -sector response.

In addition, a wide range of analyses have helped to ensure that the NSP is based on the most up to date understanding of the epidemic, that the strategies are based on evidence of what works in local social and cultural background are addressed through the NSP. The development of the NSP has been based on broad participation of all of the actors involved in HIV response in Sri Lanka: communities, civil society organizations ministries and development partners. As a result, we are confident that the strategies identified in the plan are those that are the most likely to achieve the ambitious results we are aiming for.

We must all review our working methods with the aim of becoming more effective and more coherent in our common efforts. This document provides strong orientations and evidence-based strategies for achieving the ambitious results we have put forth. It is now our responsibility to rise to the challenge and combine the necessary individual and collective resources in our drive towards zero new infections, zero AIDS related deaths and zero discrimination.

Let us get to work, or rather continue our work with renewed energy and determination.

Dr. Y.D. Nihal Jayathilaka

Secretary to the Ministry of Health

Preface

Sri Lanka is considered a country with a low prevalence of HIV infection with an estimated adult HIV prevalence of less than 0.1%. The estimate number of people living with HIV as at the end of 2011 was around 4200. However, a gradual increase in new cases is being observed. The continuing presence of certain socio-demographic and behavioral factors that have a bearing may change the present HIV landscape.

Over the last two and a half decades various interventions were targeted to the highly vulnerable groups and also the general population and youth without stigmatizing those who are engaging in high-risk behaviors. In addition, programs were carried out to sustain political and societal commitment to HIV prevention, to minimize stigma and discrimination against people living with HIV. A multi-sectoral, multi-disciplinary approach was adopted for its sustainability. The most effective intervention in further transmission of the virus, the antiretroviral therapy was made available for eligible persons since December 2004.

Based on the above factors and the recommendations of the external review carried out to assess the national response against HIV during the five year period that ended in 2011, a new strategic plan for 2013-2017 was formulated. This was completed with the participation of stakeholders from government, non-governmental organizations, business community, religious leaders and people living with HIV. Through these wide ranging consultations, the plan has outlined the main strategic directions based on a set of principles and has identified the programme priorities, and areas in which various sectors need to focus future actions. Monitoring and evaluation will be based on the indicator frame work.

The National Strategic Plan (2013-2017) will be implemented by all sectors of government and civil society, under the technical guidance of the National STD/AIDS Control Programme (NSACP) with high level leadership from the National AIDS Committee(NAC) to accelerate the scale up of HIV prevention, care and treatment services and ensure collecting robust strategic information to monitor and guide the national response to the HIV epidemic.

It is likely that HIV is going to be with us for a very long time, as it shows no signs of weakening its grip but how far it spreads and how much damage it does would entirely depend on us. If we failed to act now we will be faced with far greater consequences.

Sri Lanka has made significant progress in our fight against HIV. The successful implementation of the National Strategic Plan (2013-2017) can provide us with the best possible opportunity to successfully reduce the incidence and impact of HIV in our country.

I cannot overemphasize the fact that only a robust, concerted and committed effort will be able to provide universal access for prevention, treatment, care and support to all who need them. Finally I wish to express my profound gratitude to UNAIDS and WHO for supporting the development and printing of this document and all the others who have tirelessly worked on this document.

Thank you.

Dr Sisira Liyanage
Director of the National STD/AIDS Control Programme,
28.9.2013

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Executive Summary

The National Strategic Plan (NSP) 2013-2017 is designed to guide Sri Lanka's response to HIV/AIDS & STI control in the next five years and has been formulated with broad stakeholder involvement, drawing on the existing strengths and successes and the lessons learned in the last decade. It considers the policy and legal environment, the available scientific evidence, international best practices, and the estimated needs for prevention and treatment and current coverage rates and is informed, as best as possible, by resources that would be available. Linked to the strategic plan is a framework for monitoring and evaluation of progress and achievements.

Currently Sri Lanka remains a low prevalence epidemic, with an estimated HIV prevalence among adults (15-49 years) being less than 0.1% and that among individuals considered at higher risk of infection also being below 1%. The main mode of transmission is due to unprotected sex between men and women (82.8%), with men who have sex with men having accounted for 12.3% of the transmission while mother to child transmission was 4.4%. Though injecting drug use is not a common phenomenon (0.5%), certain socioeconomic and behavioral factors noticed in the country may ignite an epidemic in the future. The presence of a large youth population, internal and external migration, clandestine but flourishing sex industry, low level of condom use, concurrent sexual relationships among key populations are some such factors. Low level of sexually transmitted infections (STI), availability and accessibility to free health services from the state sector, high literacy rate, and a low level of drug injectors are protective factors.

It is unlikely that Sri Lanka will develop a generalized HIV epidemic, but concentrated HIV epidemics among female sex workers (FSW), men who have sex with men (MSM), and their sex partners cannot be ruled out. Similarly, if Drug Users (DU) switch to injecting, rapid transmission of HIV will set in, as experienced in many Asian countries. This scenario is highly probable due to the existence of high transmission settings for HIV in the country, such as prisons and correctional facilities, where there is high occurrence of drug use and unsafe sex. Finally, an estimated 4,200 Sri Lankans already living with HIV are in need of better medical care and a supportive environment, as they often face stigma and discrimination in certain health care settings.

The external review conducted by the review team prior to the formulation of this strategic plan had recommended the prioritization of targeted interventions for key populations and the revision of the implementation mechanism to respond to the epidemic based on evidence. Since one of the most likely reasons for the low level epidemic to progress to a concentrated one is through an epidemic of HIV among people who inject drugs. Therefore, to prevent such a disaster early comprehensive interventions had been proposed. Blood safety, HIV counseling and testing, prevention of mother to child transmission, elimination of congenital syphilis, care, support and treatment for people living with HIV, strengthening community and home based care, TB/HIV collaboration, and laboratory support should be given priority. The importance of the Strategic Information management has also been highlighted by the review team.

Several guiding principles underpin the national strategic plan. They apply to each strategic area, and affect national planning and service delivery equally, as cross-cutting concerns. The main principles that have been articulated include strategies based on evidence, respect for human rights, making gender considerations a priority, involvement of people living with HIV in all stages of policy formulation, programme planning and implementation, and the establishment of partnerships on the basis of equality and mutual respect at all levels.

The National Strategic Plan has identified five Strategic Directions and a list of Key Strategies to meet the needs of HIV prevention, treatment and care and programme management. These are to be monitored and evaluated using a set of core indicators.

1. The first strategic direction that has been identified related to prevention, which includes the optimizing of HIV prevention services with special reference to sexual transmission and injecting drug use and spread among vulnerable groups, detecting and management of STIs, eliminating new HIV infections in children (EMTCT) and preventing HIV transmission in health care settings. Prisoners (and those in incarcerated settings), armed forces and police personnel and those in the tourism trade would require added attention.
2. The second strategic direction addresses diagnosis, treatment and care for HIV aims at optimizing (HIV) diagnosis, treatment and care for children, adolescents and adults. It pays particular attention to antiretroviral treatment (ART), co-infections and co-morbidities among people living with HIV, reducing the burden of Tuberculosis and increased access to HIV testing and counseling.
3. The third strategic direction aims at strengthening strategic information systems for HIV, research to guide health policy and planning, resource allocation, programme management, service delivery and accountability. As countries scale up their HIV response towards universal access, there is an increasing recognition of the need to invest in strategic information to guide programme planning and to sustain national and international commitment and accountability. Clinical/epidemiologic, socio-behavioural and health systems research is also an important component in this strategy.
4. The fourth strategic direction refers to strengthening health systems for effective integration of health services. This addresses the needs in human resources and health financing, equity issues and support for leadership and governance.
5. The fifth strategic direction calls for fostering a supportive environment to ensure equitable access to HIV services and to minimize HIV-related stigmatization and discrimination, promote gender equality, human rights and health equity along with the broad participation and collaboration of stakeholders and for mobilizing resources needed to continue scaling-up of HIV services, and to keep pace with increasing demand to implement the programmes.

The National Strategic Plan (2013-2017) will be implemented by all sectors of government and civil society, under the technical guidance of the National STD/AIDS Control Programme (NSACP) with high level leadership from the National AIDS Committee to accelerate the scale up of HIV testing, prevention, care and treatment services and ensure collecting robust strategic information to monitor and guide the national response to the HIV epidemic.

Acronyms and glossary of terms

| | |
|----------|---|
| ART | Antiretroviral treatment or Antiretroviral Therapy |
| BSS | Behavioural Surveillance Survey |
| CCM | Country Coordinating Mechanism (of the Global Fund) |
| CITC | Client Initiated Testing and Counselling |
| DAMS | Drug Abuse Monitoring System |
| DOTS | Directly Observed Treatment Short course |
| ECS | Elimination of Congenital Syphilis |
| FONGOADA | Federation of Non-Government Organizations Against Drug Abuse |
| GARPR | Global AIDS Response Progress Reporting |
| GFATM | Global Fund to fight AIDS, Tuberculosis and Malaria |
| HIMS | Health Information Management System |
| HTC | HIV Testing and Counselling |
| HDI | Human Development Index |
| IDH | Infectious Diseases Hospital |
| IDU | Injecting Drug User |
| KP | Key Populations |
| MARP | Most At Risk Populations |
| M & E | Monitoring and Evaluation |
| MCH | Maternal Child Health |
| MO | Medical Officer |
| MOIC | Medical Officer in Charge |
| NAC | National AIDS Committee |
| NDDCB | National Dangerous Drugs Control Board |
| NGO | Nongovernmental Organisation |
| NSACP | National STD and AIDS Control Programme |
| NSP | National Strategic Plan |
| PLHIV | People Living with HIV |
| PITC | Provider Initiated Testing and Counselling |
| EMTCT | Elimination of Mother to Child Transmission |
| PWID | People Who Inject Drugs |
| PWUD | People Who Use Drugs |
| SIM | Strategic Information Management |
| SIMU | Strategic Information Management Unit |
| STD | Sexually Transmitted Disease, |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UNAIDS | Joint UN Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session (on HIV) |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| UNODC | United National Office on Drugs and Crime |
| VDRL | Venereal Disease Research Laboratory Test (a blood test for syphilis) |
| WFP | World Food Programme |
| WHO | World Health Organization |

1. Introduction

The National Strategic Plan (NSP) 2013-2017 is designed to guide Sri Lanka's response to HIV/AIDS & STIs control in the next five years. This strategy document draws on lessons learned in responding to HIV and AIDS in the last decade, and more particularly in the past five years. The NSP builds on existing strengths and successes, considers the policy and legal environment, developments in scientific evidence, international practices, estimated needs for treatment and current coverage rates, demonstrable capacities, projects potential achievements by 2016, and is informed, as best as possible, by resources that are likely to be available. It also looks at innovative ways to address areas of weakness, and sets what may seem as ambitious targets to meet the broad aims of the national response to HIV and STIs. Linked to this plan is a framework for monitoring and evaluation. The new National Strategic Plan seeks to strengthen and improve the efficiency of existing services and the health systems infrastructure and introduce additional interventions based on recent advances in knowledge.

Recommendations for the National Strategy and action plan by the external review 2011

The External review has provided a set of observations on the outcomes that were achieved during the previous National Strategic Plan and has made a series of important recommendations that could be taken on board in the formulation of the current Strategic Plan and the implementation details. It is necessary to adapt and modify some of these recommendations to take into account the contextual realities in Sri Lanka. In the area of prevention, the review team has recommended to continue activities to prevent HIV infection among key populations and prioritizes targeted interventions for key populations for the next national strategic plan. The review team has also suggested that the implementation mechanism of the NSACP be revised and strengthened to respond to the epidemic using clear evidence. The team also recommended protection of the rights of all people living with HIV and raising public knowledge about HIV. The team has recommended early comprehensive interventions for the few injecting drug users.

In the field of treatment and care for HIV in the health care setting, the team has made recommendations in the areas of blood safety, HIV testing and counselling, the prevention of mother to child transmission of HIV, the elimination of congenital syphilis, care, support and treatment for people living with HIV, strengthening community and home based care, TB/HIV collaboration, and laboratory support.

With regard to the national strategic plan for 2013-2017, the team has suggested that the roles and responsibilities of the health sector be articulated, including the functions and how the various divisions of the Ministry of Health work together to achieve the objectives of the health system response to HIV. Importance of the Strategic Information management has been highlighted by the review team.

1.1 Country context

Sri Lanka is a Democratic Socialist Republic. It is an island in the Indian Ocean southwest of the Bay of Bengal. Sri Lanka is separated from the Indian subcontinent by the Gulf of Mannar and the Palk Strait. It has a population of 21.4 million (July 2012, estimation). Sinhala and Tamil are national languages while English has been recognized as the link language. For administrative purposes, Sri Lanka is divided into nine provinces and 25 districts.

According to the International Monetary Fund, Sri Lanka has a yearly gross domestic output of US\$59 billion as of 2010¹. It recorded a Gross Domestic Product (GDP) growth of 8.3% in

¹International Monetary Fund (www.imf.org) Last accessed November 21st 2012.

2012. The government of Sri Lanka makes substantial investments in health, education and poverty alleviation programmes. The poor segments of the population have been much benefited due to such investments. The community action for health has since been given consideration in planning and management of health services. The armed conflict that was raging for more than two decades in the North and East of the country had been a major constraint to the development of the country. There was migration and displacement of population of severely affected areas to safer places, resulting in problems of food, shelter, sanitation and provision of preventive and curative healthcare. With the ending of armed conflict in 2009, Sri Lanka is currently enjoying a peaceful environment with an economic progress. Sri Lanka's Human Development Index (HDI) is 0.691², which gives the country a rank of 97 out of 187 countries with comparable data. The HDI of South Asia as a region increased from 0.356 in 1980 to 0.548 today, placing Sri Lanka above the regional average.

1.2 Development process of the National Strategy and Action Plan

A national level steering committee and a core-group was formed with representatives from government, developmental partners, non-governmental and community representatives. The co-ordinators of different programme areas of NSACP contributed for the development of this.

An external review was undertaken in order to assess the current situation and make necessary recommendations. This review team comprised of both national as well as international consultants. The report of the external review was shared among the national stakeholders and discussed in detail.

A national consultant was hired to lead the development of the strategic plan in consultation with the stakeholders maintaining clarity and transparency. A series of community consultations were conducted to obtain community perspectives into the national strategic planning process. The final draft was presented to the community to ensure that their concerns were adequately addressed.

An international M&E consultant was hired to develop a National M&E plan in line with the new NSP. Final draft of the NSP was reviewed by a peer review team from the UNAIDS and necessary improvements were carried out.

²[Central Bank of Sri Lanka Annual Report 2011 – Key Economic Indicators](#)". [Central Bank of Sri Lanka](#).

2. Evidence and Response Analysis

Currently Sri Lanka is experiencing a low level HIV epidemic. The estimated number of people living with HIV as at end 2011 is 4,200 and the estimated HIV prevalence among adults (15-49 years) is less than 0.1%. Survey data observes that even among individuals considered at higher risk of infection on the basis of their occupation, behaviors and practices, the HIV prevalence is below 1%. As at end December 2012, a cumulative total of 1,597 HIV persons were reported to the National STD/AIDS Control Programme. The main mode of transmission is due to unprotected sex between men and women (82.8%). Men who have sex with men have accounted for 12.3% of the transmission while mother to child transmission was 4.4%. Transmission through blood and blood products was 0.4%. Injecting drug use in Sri Lanka is not a common phenomenon (0.5%). However, certain socioeconomic and behavioral factors that are present in the country raise the concern of a concentrated epidemic in the future. The presence of a large youth population, internal and external migration, clandestine but flourishing sex industry, low level of condom use, concurrent sexual relationships among key populations are some such factors. Low level of sexually transmitted infections (STI), availability and accessibility to free of charge health services from the state sector, high literacy rate, low level of drug injectors, are factors considered to be protective. It is evident that the major mode of transmission of HIV in Sri Lanka is through heterosexual means³.

Response

Implementation of prevention of spread of HIV is decentralized and individual provinces are responsible for implementing related activities with technical assistance from NSACP. Prevention activities are undertaken by sectoral, NGO and provincial authorities. However, NGO work remains largely uncoordinated and very few of them show interest in working with MARP. STD treatment and care services are provided at the national level through a network of well-established clinics. Blood safety measures have been improving steadily across the nation with enhanced voluntary donation and improved screening procedures. The National Strategic Plan (NSP) for 2007-2011 was prepared during 2007 with participation of all relevant stakeholders and using recommendations from an external review and information from both active and passive surveillance and research studies. It was a comprehensive plan which was intended to re-focus the program on key populations at higher risk, to scale up integration of HIV-related activities with other health, sectoral and civil society activities and to improve the efficiency of the ongoing Behavior Change Communication (BCC) activities. The target groups identified for interventions include FSW, MSM, and PWID. The plan also recognized beach boys and prisoners as special vulnerable groups. Monitoring and Evaluation (M&E) was identified as a priority in the strategic plan 2007-2011. During 2008, a Strategic Information & Management (SIM) Unit was established with six full-time staff. In addition, a national draft M&E plan was developed, with a set of national core indicators incorporating relevant UNGASS and Universal Access indicators. A computerized comprehensive patient information management system (PIMS) for STI has been available since 2011. National AIDS Policy states that voluntary counseling and testing will be promoted. In addition, according to the national STD guidelines, testing for HIV is encouraged for persons attending STD clinics where consent is obtained prior to testing. There are 25 administrative districts in Sri Lanka and each district has at least one STD clinic with laboratory facilities (one central and 30 peripheral STD clinics). Of the 30 public STD clinics offering HIV testing, 22 perform testing onsite (up from 13 in 2007); STD clinics without onsite testing send samples to the National Reference Laboratory or the closest STD laboratory.

According to the findings from the BSS 2006-2007, the percentage of people who were ever

³Strategic Information Management Unit, National STD/AIDS Control Programme (2010).

tested for HIV is still low among key populations at higher risk. In 2011, only 3% of pregnant women were tested for HIV in the previous year and received the results, yet it has been estimated that an overwhelming majority (>95%) of pregnant women have access to antenatal care and institutionalized delivery.

Key facilitatory factors

- High literacy rates among the general population, particularly women.
- The quality of health care and access of health services, particularly in public sector
- Existence of a National HIV/AIDS Strategy, which promotes human rights of vulnerable and affected populations
- Existing multi-sectoral approach for HIV prevention with the involvement of 13 ministries.

Key inhibitory factors

- Securing commitment for action has been a challenge in low prevalence setting
- The lack of clear information on MARPs and key vulnerability issues makes it impossible to project the trajectory of the HIV epidemic in Sri Lanka.
- Prevention interventions for MSM and male prisoners are strained in a restricted legal environment.
- Non-existence of an enabling environment has created a restricted access to preventive services of all key populations.

3. Guiding principles for the National HIV/AIDS response

Several guiding principles underpin the national strategic plan. They apply to each strategic area, and affect national planning and service delivery equally, as cross-cutting concerns. They remain similar to those adopted in the earlier NSP with the addition of the urgency to involve and work with people living with HIV.

- 1. Strategies based on evidence:** Evidence is needed to ensure that all activities are effective, i.e. contribute to the national goals of preventing new infections and improving the lives of those affected. Evidence will guide the design of the programs, prioritization of strategies and approaches, as well as monitoring of the program.
- 2. Respect for human rights:** The National Strategic Plan and the National AIDS Policy mirror the Sri Lankan constitution as guiding principles of universal human rights and dignity of all Sri Lankans, including their sexual and reproductive rights. There should be no discrimination on the basis of gender, HIV status, sexual behaviour and/or sexual orientation. HIV testing without prior informed consent is not acceptable (unless anonymous unlinked for screening purposes), and each HIV test result has to be confidential.
- 3. Gender equality:** HIV risk is generated within sexual relationships, which are influenced by underlying gender norms. In general, women generally have less control over their sexual behavior and choices; less access to services, and they are more likely to suffer stigma due to HIV infection. Research also indicates relatively high levels of sexual violence against women (and boys). The NSP will address the gender norms and inequalities that drive HIV risk. Gender-responsive approaches will be integrated into the activities that support the goals, objectives and strategies of the National Strategic Plan. Sex-disaggregated data will be used for monitoring and evaluation. Understanding of the links between gender, HIV and uptake of services will be built into trainings, programs and policies.
- 4. Meaningful involvement of people living with HIV:** The experience, insights and efforts of people affected by HIV, including women, young people and key populations, are valuable resources in the national response and as members of decision-making bodies. The NSP recognizes the importance of the participation of communities in the design, implementation and evaluation of services. People Living with HIV (PLHIV) and affected people have an important role in prevention and care, and their experiences and involvement make interventions more effective and relevant. The meaningful involvement of PLHIV is needed in all aspects of the national response, including the design, implementation, monitoring and evaluation of HIV programmes. Community involvement also results in a sense of ownership and responsibility for HIV programmes and initiatives.
- 5. Three Ones' Principles:** The national programme for STD and AIDS, will be implemented following UNAIDS Three Ones' Principles, which means one national multi sectoral strategy, one national coordinating authority and one monitoring and evaluation framework.
- 6. Multi- sectoral partnerships:** The response needs to be holistic and multi-dimensional. National response to HIV and AIDS is therefore multi-sectoral and involves strong and growing partnerships between the government and key government ministries, civil society and the private sector. Existing partnerships will be strengthened and new mechanisms will be established on the basis of equality and mutual respect at all levels.

4. National Strategic Plan 2013–2017

Vision

“Country free of new HIV infections, discrimination and AIDS related deaths”

Goal

Prevent new HIV infections and provision of comprehensive care and treatment for people living with HIV

Strategic direction 1

Prevention

Strategic direction 2

Diagnosis, treatment and care

Strategic direction 3

Strategic information systems

Strategic direction 4

Health systems

Strategic direction 5

Supportive environment

Core indicator framework

| Strategic Direction | Name of Indicator | Type | Reporting requirement | Source of Data | Numerator | Denominator | Reporting Schedule | |
|---------------------|-------------------|--|-----------------------|----------------|------------------------|--|--|-------------------|
| 1 | Prevention | Percentage of key populations, FSW, MSM, PWID living with HIV | Impact | MDG, GARPR | SS/IBBS | Number of key populations who test positive for HIV | Number of key populations who were tested for HIV | Once in 2 years |
| 2 | Prevention | Percentage of key populations reached with HIV prevention programmes | Outcome | MDG, GARPR | BSS, special study | Number of key populations who replied yes to both questions (on condoms, know where to go for testing) | Total number of key populations surveyed | Once in 2 years |
| 3 | Prevention | Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of condoms during their last intercourse | Outcome | MDG, GARPR | BSS/IBBS/Special study | Number of respondents (15-49) who reported having had more than one sexual partner in the last 12 months who also have reported that a condom was used in the last sexual act. | Number of respondents who reported having had sex more than one sexual partner in the last 12 months | Once in 2-5 years |

| Strategic Direction | Name of Indicator | Type | Reporting requirement | Source of Data | Numerator | Denominator | Reporting Schedule | |
|---------------------|----------------------------------|--|-----------------------|----------------|---------------------------|---|--|------------------------------------|
| 4 | Prevention | Percentage of antenatal care attendees positive for syphilis | Outcome | NSP, UA | ANC data/NS ACP | Number of antenatal care attendees who tested positive for syphilis | Number of antenatal care attendees who were tested for syphilis | Annual |
| 5 | Diagnosis, Treatment and Care | Percentage of eligible adults and children currently receiving antiretroviral therapy | Outcome | GARPR | NSACP Program Coordinator | Number of people receiving antiretroviral therapy | Number of people eligible for to treatment according to national guidelines | Annual |
| 6 | Diagnosis, Treatment and Care | Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | Impact | GARPR | Coordinator /SIM unit | Number of adults and children who are still alive and on antiretroviral therapy after 12 months after initiating treatment | Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12 months outcomes within the reporting period | Annual |
| 7 | Strategic information Management | Availability and accessibility to complete information on indicators listed in the strategic plan document | Outcome | NSP | Coordinator /SIM unit | Number of indicators in the NSP for which complete information is available and accessible | Total number of indicators in NSP | Annual or as given in the schedule |
| 8 | Health systems | Number and Percent of designated government sectors that have implemented HIV/AIDS activities | Outcome | NSP | NSACP Program Coordinator | Number of designated government sectors that have HIV/AIDS included in their plan | Number of designated ministries that are expected to implement HIV/AIDS plan (Health, education, youth, prison, uniformed services, tourism, legal, Immigration, media.. etc.) | Annual |
| 9 | Supportive environment | People Living with HIV Stigma Index | Outcome | GARPR | NSACP Program Coordinator | Number of respondents who report that they were denied health services, including dental care, in the previous year because of their HIV status | Total number of PLHIV respondents who have sought healthcare during the reporting period | Once in 2-5 years |

Strategic Direction 1: Prevention

Strategy 1.1: Prevention of transmission of HIV among key affected populations

Rationale:

| Key populations at risk | National size estimate range | National estimate |
|-------------------------|------------------------------|-------------------|
| FSW | 35,000 – 47,000 | 41,000 |
| Clients of FSW | - | 261,000 |
| MSM | 24,000 – 37,000 | 30,500 |
| Drug Users | - | 45,000* |

*Note: Estimated that 2.5 % of Drug Users inject (= 1200PWID)

Among the key affected populations of female sex workers (FSW) and their clients, men who have sex with men (MSM) and people who use drugs (PWUD), the HIV prevalence has consistently been below 1%.

Female sex workers are categorized into three types: brothel-based, street-based, and others (i.e. those based at massage parlours, karaoke bars and casinos). HIV is currently low among FSW. The last behavioural surveillance survey among female sex workers was conducted in 2006/7 and demonstrates the diversity of risk behaviour by place of solicitation. Consistent condom use (every time or almost every time) with clients was greater than 80% as reported by brothel, massage parlour, and street based sex workers, but lower among those working from karaoke bars (66%) and casinos (48%).

The current size estimate for MSM is 30,554 and they make up a key vulnerable population in Sri Lanka where 11% of the reported HIV infections are attributable to homosexual transmission. The MSM population was included as a surveillance group beginning in the 2008 HIV Sentinel Sero-Surveillance Survey (HSS) and, up until this point, HIV prevalence among this group was 0% in 2008, 0.48% in 2009 and 0.9% in 2011⁴. Some key indicators that determine the risk among MSM include: mean number of sexual partners in the past year is 11 (n=300); 23% had sex with a woman in the past year; 61% used a condom the last time they had anal sex with a male partner; 14% were tested for HIV in the past year and knew their results.

Current estimates of opiate users range from 30,000 to 240,000 individuals and the majority of heroin users inhale or snort heroin⁵. A study carried out in 2006-2007 among 278 drug users in three prisons in Sri Lanka found that the prevalence of intravenous drug use was higher than has been officially reported (15.8% vs. 1%). In addition, there was a high prevalence (53%) of risk-taking sexual behaviour – lifetime prevalence of sex with an FSW was high (67%) and regular condom use with an FSW was low (14%)⁶. Beyond estimating the population's size of injecting drug users, Sri Lanka must monitor the transition from oral and inhalation methods to injecting methods among drug users.

The term 'beach boys' refers to young men who work near or on the beaches, typically tourist beaches, and who offer sexual services in exchange for some form of payment. They also include those working in restaurants, hotels, guesthouses and boat-related tourism. They are at risk of HIV infection due to low levels of condom use and having unprotected sex with male and female sexual partners including tourists from high HIV prevalence countries⁷.

⁴National STD/AIDS Control Programme. (2010). UNGASS Country Progress Report: Sri Lanka

⁵World Bank. (2008). HIV/AIDS in Sri Lanka .

⁶National STD/AIDS Control Programme. (2008). Report of the 2007 Survey: HIV Sentinel Sero-Surveillance Survey in Sri Lanka .

⁷Rawstorne, P., & Worth, H. (2007). Sri Lanka Behavioural Surveillance Survey: First Round Survey Results 2006 - 2007 . Colombo: National STD/AIDS Control Programme, Ministry of Healthcare and Nutrition

Expected Outcomes by 2017

- 1.1.1. HIV Prevalence less than 1% among FSW,MSM,PWUD/PWID and Beach boys
- 1.1.2. At least 80% of FSW,MSM, PWUD/PWID and Beach boys reached by prevention services
- 1.1.3. At least 80% of FSW, MSM, PWUD/PWID and beach boys report consistent condom use
- 1.1.4. Less than 5% of PWID report sharing of needles

Strategies:

Comprehensive interventions for FSW, MSM, PWUD/PWID and Beach Boys

- Improve access to HIV testing and counseling
- Condom programming
- Behaviour change modification through outreach and peer education
- STI prevention and diagnosis: testing, and treatment
- IEC through mass media, community awareness, radio and street plays etc.
- Community involvement and implementing a comprehensive program for People Who use drugs and people who inject drugs.

Strategy 1.2: Prevention of transmission of HIV among vulnerable groups

Vulnerable groups in Sri Lanka have been identified as:

1. Migrant populations
2. Prisoners
3. Armed forces and police personnel
4. Tourist industry workers

Rationale:

1. Migrant populations

More than half of reported HIV-positive cases in Sri Lanka are migrant workers, according to a UN report, HIV and Mobility in South Asia., published in November 2010; an estimated 1.2 million Sri Lankans work in the Middle East and 79.1% of unskilled migrants are women⁸. HIV testing data does shows that, of all the women in Sri Lanka who tested positive for HIV, 40% had been international migrants⁹. This data does not show, however, if they were infected while abroad, or prior or since their return. Thousands of people each year migrate within and outside the country. Increased vulnerability to HIV associated with displacement and the disruption of families and social and community structures has been evident in many settings in the country.

⁸The World Bank. HIV/AIDS in Sri Lanka. August 2006. Available at: <http://web.worldbank.org>

⁹ UNAIDS. UNGASS Country Report – Sri Lanka, on Follow up to the Declaration of Commitment on HIV/AIDS. 2007

2. Prisoners:

Many factors (including drug use, unsafe sexual practices, overcrowding, inadequate nutrition, poor health services, violence, corruption and poor prison management) make prisons a high-risk environment for the transmission of HIV, tuberculosis and other communicable diseases. The lack of education among prisoners about the risks of contracting and transmitting HIV increases the risk of infection.

3. Armed Forces and police personnel:

Police personnel are playing a critical role in creating a safe and favorable environment for HIV prevention programmes for key populations. In addition, armed forces and the police are considered a vulnerable group because of the unsafe behaviors practiced amongst certain individuals. Evidence has shown that consistent condom use among male military personnel was low with their casual sexual partners.

4. Tourist industry workers

The people who are employed in the entertainment and hospitality trade for tourists have considerable access to risky sexual behaviors with their clients.

Expected Outcomes by 2017

- 1.2.1. HIV prevalence is less than 0.1% among vulnerable populations
- 1.2.2. 80% of vulnerable populations receive at least one exposure to an HIV awareness programme
- 1.2.3. At least 80% of military and police personnel are reached with HIV prevention programmes

Strategies:

- IEC and BCC programs on improving awareness among migrants
- Ensure diagnostic, treatment and care services for returnee migrants
- Provision of continuity for HIV treatment for prisoners, HIV related policy for prisoners
- IEC and BCC programs on improving awareness among military and police
- Implement a range of HIV preventive services for persons who are working in the hospitality sector

Strategy 1.3: Prevention of transmission of HIV among general population including young people

Rationale

The low level of awareness leads to risky behaviours. It is imperative that even in a low prevalence setting, that general population is made aware of the risks of HIV transmission. All young people need to be aware of HIV and sexual/ reproductive health issues before they become sexually active, and possess life skills to reduce their vulnerability not only to HIV, but also to sexual violence and unwanted pregnancies.

Expected outcomes by 2017

1.3.1. 80% of young women and men aged 15–24 both correctly identify ways of preventing the sexual transmission of HIV and who reject all major misconceptions about HIV transmission

Strategies:

- Awareness programmes among general population including young people
- Ministry of Education to expand life-skills education in schools, and include HIV and sexual health
- Expand HIV interventions in the workplace
- Expand and strengthen the provision of good quality STI services ensuring correct diagnosis based on laboratory testing or by syndromic approach
- Condom promotion programmes
- Improving access to HIV testing and counseling services

Strategy 1.4. : Elimination of mother to child transmission of HIV (EMTCT) and congenital syphilis

Rationale

In 2011, only 3% of pregnant women were tested for HIV and received the results while estimated coverage of EMTCT was 6%. However, it has been estimated that an overwhelming majority (95%) of pregnant women have access to antenatal care. In 2011, five HIV-positive pregnant women received ARV to reduce the risk of mother-to child transmission, and two infants born to HIV-infected mothers received ARV and cotrimoxazole prophylaxis within two months of birth.

Expected outcomes by 2017

- 1.4.1. Over 50% of ANC attendees received Provider Initiated Counselling and Testing (PICT)
- 1.4.2. 100% of identified HIV-positive pregnant women received antiretroviral medicines to reduce the risk of mother-to-child transmission
- 1.4.3. 100% of infants born to identified HIV-infected mothers received ARV drugs
- 1.4.4. Syphilis prevalence is less than 1% among antenatal women

Strategies:

- Primary prevention of HIV transmission among women in childbearing age
- Prevention of unintended pregnancies among women living with HIV through enabling them to make informed choices
- Ensure high level commitment and advocacy to eliminate the incidence of congenital syphilis
 - to ensure that the programme receives adequate political, financial and logistical support through advocacy

- to strengthen linkages between MCH and STI and HIV services to enable more accurate forecasting of needs, procurement and supply of diagnostics and essential medicine.
- Increase access to and quality of syphilis and HIV services at maternal and child health services
 - Expand provider initiated testing and counseling for HIV in ANC settings.
 - Ensure all antenatal mothers are screened for syphilis and HIV and results given without delay.
 - Test mothers who have not been tested for syphilis and HIV during pregnancy or have no documented evidence of treatment, at delivery
 - Maintain quality of testing by ensuring training, continuous supply of reagents and establishing quality control systems
 - Improve STI and HIV services at MCH settings through regular training of primary health care workers and maintaining non stigmatizing referral system
- Prevention of HIV transmission from women living with HIV to their children by promotion and integration/linkage of EMTCT with related services
 - Ensure that all positive mothers and partners are treated or managed adequately by referring to the closest STD clinic.
 - All babies born to mothers with syphilis or HIV should be managed appropriately according to guidelines with the support of the venereologist/ MOIC of the STD clinic and paediatrician.
- Strengthen surveillance, monitoring and evaluation systems
 - Improve collection of data and flow of information regarding syphilis and HIV in pregnancy from MCH services and STD clinics to the district level and to the central level
 - Strengthen the system for monitoring progress of elimination of mother to child transmission of HIV and congenital syphilis programmes

Strategy 1.5: Prevention of transmission through infected blood

Rationale:

Transmission due to contaminated blood transfusion accounts for less than 0.3% of reported HIV cases. Maintaining efficient screening of donated blood and its rational use will prevent transmission of HIV infections and other blood borne infections such as hepatitis viruses.

Expected outcomes by 2017

- 1.5.1. 100% blood units will be screened for HIV in quality assured manner and will be collected as voluntary non-remunerative donations.

Strategies

- Support and maintain efficient screening of donated blood, its rational use and assure quality to prevent transmission of infections (HIV, hepatitis viruses, and other infectious agents).

- Strengthen the implementation of secondary prevention measures such as post-exposure prophylaxis for occupational exposure to HIV among health care workers.

Strategy 1.6 Maintain quality and coverage of STI services

Rationale:

Currently over 95% of HIV is transmitted due to unsafe sexual contacts. In addition, having untreated STIs will facilitate the transmission and acquisition of HIV. Strengthening STI care through a network of STD clinics of NSACP remains the corner stone of HIV prevention in Sri Lanka.

Expected outcomes by 2017

- 1.6.1 80% of the STD clinics to have facilities to provide comprehensive care to STD clinic attendees including essential STI screening facilities
- 1.6.2 80% of the staff delivering STI care at government STD clinics to be trained within 6 months of reporting to duty.

Strategies:

- Upgrade all STD clinics to provide comprehensive STI care for MARPS as well as general population.
- Continue training government and private providers in delivering quality STI care
- Provincial Health administration to support maintaining comprehensive STI care at provincial STD clinics.
- Strengthening the monitoring and provide technical support to provincial STD clinics.

Strategic direction 2: Diagnosis, Treatment and Care

Rationale:

National AIDS policy states that HIV counselling and testing will be promoted. In addition, according to the national STD guidelines, testing for HIV is encouraged for persons attending STD clinics where consent is obtained prior to testing¹⁰. There are 25 administrative districts in Sri Lanka and each district has at least one STD clinic with laboratory facilities (one central and 30 peripheral STD clinics). Of the 30 public STD clinics offering HIV testing, 22 perform testing onsite (up from 13 in 2007); STD clinics without onsite testing send samples to the National Reference Laboratory or the closest STD laboratory. In 2006, the country agreed upon a universal access coverage target of 80% for key populations at higher risk and at least 90% of eligible patients are targeted to be receiving ART by 2010. An estimated 510 adults and children were in need of ART in 2009 with an estimated coverage of 20%¹¹. At the end of December 2012 the total number of adults and children currently on ART was 412.

Continuum of care, adherence to long term ART, prevention counseling, address of social issues, zero tolerance of stigma and discrimination are the major milestones achieved in the NSACP clinic setting since December 2004. In addition, Base hospital Angoda (IDH) has contributed immensely in the management of patients with late diagnoses and (opportunistic infections) OIs and is continuing with long term ART care for these patients. Through a concerted effort, expansion of patient management with OIs was introduced into the national and major provincial and district hospitals in the island. The continuation of these services and the expansion into the other care settings is of paramount importance to all relevant stakeholders.

Many positive people rely on the three networks for PLHIV which are Lanka plus, Positive Women's Network and Positive Hope Alliance, although the reach of these networks are not comprehensive due to limited resources. The importance of care of affected and infected children is well recognized by all stakeholders and provision of good nutrition, education, and livelihood for unemployed parents will be the responsibility of relevant service providers. It is the need of the hour to ensure organizational model of continuum of care, referrals, linkages, integration within the health care system and coordination by different stakeholders not only for children but affected and infected adolescents and adults as well.

Key Expected Outcomes by 2017

- 2.1. 80% of key populations report having received an HIV test and know the results in the last 12 months
- 2.2. 80% of those estimated eligible are given ART
- 2.3. 100% of HIV patients tested for TB and vice-versa by using PICT approach, according to guidelines

Strategies:

- Review existing HIV testing policies and update guidelines for HIV Testing and Counselling.

¹⁰ Ottosson, D. (2011). State-Sponsored Homophobia: A World Survey of Laws Criminalising Same-Sex Sexual Acts between Consenting Adults : The International Lesbian, Gay, Bisexual, Trans and Intersex Association

¹¹ WHO, UNAIDS, & UNICEF. (2010). Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector

- Develop human resource and mobilize support to improve infrastructure to allow quality testing and counseling services
- Improve the support for relevant sectors/agencies to increase demand for HIV testing and counseling
- Promote Provider Initiated Testing and Counselling in relevant clinical settings (STI clinics, TB Clinics and antenatal settings).
- Model of continuum of care to be developed, so that PLHIV is in the center and there is a continuum between the care facilities, community, home and other services
- Strong community involvement in planning, treatment adherence, complementary services that improve the quality of life of the infected and affected
- Scale up ART services to all PLHIV included in the categories of sero-discordant couples, pregnant women and selected key population members, irrespective of their CD4 counts
- Strengthen prophylaxis, diagnosis and treatment for co-infections and co-morbidities in all treatment and care programmes
- Ensure HBV vaccinations availability to all persons at risk.
- Scale up coverage, through the decentralization of HIV care services
- Increase awareness and implementation of good practices of health staff regarding issues related to PLHIV to reduce discrimination
- Strengthen the mechanisms for collaboration between HIV and TB activities to ensure that HIV positive TB patients are identified and treated appropriately, and to prevent TB among HIV positive persons

Strategic direction 3: Strategic Information Management Systems

Rationale:

Strategic information guides health policy, planning, resource allocation, programme management, service delivery and accountability. It is essential for action at all levels of the health system. As countries scale up their HIV response towards universal access, there is an increasing recognition of the need to invest in strategic information to guide programme planning and sustain national and international commitment and accountability.

Expected outcomes by 2017

- 3.1. Integrated behavioural and biological surveillance (IBBS) of key populations are undertaken on a regular basis and reported to measure outcomes and the impact of the response
- 3.2. Regular monitoring of HIV services (including ART, EMTCT, condom programming, blood safety) is integrated into the HIMS and reported regularly
- 3.3. HIV related operational research is coordinated and prioritized by the Strategic Information unit with the concurrence of relevant coordinators

Strategies:

- Implement the National Strategic Information Management Plan (National M&E plan)
- Improving the mechanisms of monitoring HIV related data from all sectors including civil society organizations.
- Strengthen HIV surveillance, second generation HIV and STI surveillance through capacity and systems strengthening
- Adapt the surveillance methods and activities to detect the potential for a rising epidemic among the key populations and bridge populations that can spread the HIV infection to general population.
- Mode of HIV transmission studies to be systematized and regularized.
- Integrated biological and behavioural data among key populations in the country to be scaled up, systematized and conducted
- Periodic national population-based surveys (e.g. demographic and health surveys);
- HIV and HAMS data integration
- Develop and implement research agenda particularly in areas where vulnerabilities are known but risks and prevalence are lesser known e.g. prisoners, military personnel, young people, etc.
- Build research capacity within Sri Lanka
- Regular mapping exercises for key affected populations.
- Strengthen drug resistance monitoring
 - Establish an HIV DR working group
 - Promote the rational use of ART regimens and monitor adherence of ARV drugs.
 - Conduct and expand monitoring of Early Warning Indicators.
 - Conduct HIVDR surveys regularly including, where relevant, surveillance for transmission, and monitoring emergence in treated populations

Strategic direction4:Health Systems Strengthening

Rationale:

HIV program is integrated with the health systems in Sri Lanka. In order to ensure quality and reach, the health systems need to be strengthened through increase in institutional capacities as well as human resources capacities. Community, home and peer support is one of the important areas of support for people living with HIV whose medical needs are being met. While the STD/HIV public health programme can do outreach and follow up patients, home and community support by peers is important to reinforce long term compliance to care and treatment.

Expected outcome by 2017

- 4.1. HIV/AIDS is included in the training curriculum for all health workers
- 4.2. Supportive supervision and quality assurance system for HIV services institutionalized
- 4.3. NGOs report increased organizational, financial and technical support from the government as well as development partners.

Strategies:

- Build capacities of existing health infrastructure to cater to all needs of counseling, testing and treatment for STI, HIV and opportunistic infections
- Build capacities of civil societies (NGO and community based organizations) to ensure access through demand generation and improve quality of services through monitoring and advocacy and to provide continuum of care.
- Strengthen laboratory support tool for the monitoring of antiretroviral therapy, diagnosis of HIV and associated infections and evaluation of response to therapy in the individual and various public health interventions.
- Strengthen management capacity in the health sector to ensure an adequate number of personnel with appropriate competencies are placed at all levels of the health system, and provide them with necessary management support systems and enabling working environments.
- Establish quality management systems to address clinical care, laboratory testing and workplace improvement whether in government or in private sector facilities.
- Develop national standard practices of employment in health care institutions to improve quality of work plan, establish occupational health and safety standards, procedures and systems to reduce risk of contracting HIV and other blood borne diseases
- Review, development, implementation and adaptation of strategic policy frameworks, policies, legislation/regulations that create the environment for an effective response to HIV, and partnerships that contribute to a better response.

Strategic direction 5: Supportive environment

Rationale

People living with HIV and civil society organizations representing them and key affected populations face a number of issues related to seeking and receiving treatment at the state sector health care institutions and facilities. The respondents to the stigma index, members of three networks of HIV positive people, have reported poor knowledge of their rights, reluctance to disclose their status to family friends, lack of social support and total dependency on the health sector for treatment. Over seventy per cent of respondents had concerns that the government may not continue providing antiretroviral therapy free of charge. Constructive discussions with health care providers regarding HIV related treatment options were reported only 49% of respondents. The fear of marginalization at village and household level, verbal insults, assaults, threats, harassment and loss of jobs and income were reported by people living with HIV at the meetings the review team held with them and their networks. Among the reasons that were thought to lead to the stigma and discrimination and failure to be treated with dignity and respect were: poor knowledge, especially among the general population, policy makers, health professionals and legal profession. Lack of awareness among health personnel of the availability of post exposure prophylaxis and failure to practice universal precautions consistently have led to fear of infection. In addition to the stigma faced by people living with HIV, key affected population also face a lot of stigma in the society as well as through the legal environment. It was of the opinion of the stakeholders that an enabling environment should be in place for a comprehensive care and treatment and prevention program by reforming some punitive laws in the country in the context of FSW, MSM, and PWID.

Expected outcomes by 2017

- 5.1. HIV/AIDS Law and policies containing non-discrimination principles are widely disseminated and implemented.
- 5.2. 80% of PLHIV revealing accepting attitudes towards them
- 5.3. Zero deaths reported due to refusal of treatment

Strategies:

- Development and implementation of culturally sound and evidence-based campaigns that combat stigma and discrimination against PLHIV and promote positive examples of living positive
- Advocacy and capacity building of healthcare workers and social service providers to enhance access of services for PLHIV and marginalized groups like sex workers, men who have sex with men, drug users, migrant workers, etc.
- Support relevant ministries to develop supportive sectoral policies on the basis of the national AIDS law and national AIDS policy, for example the ministries of health, education, labour and social welfare
- Provide organizational and technical support to community-based organizations of marginalized groups and young people, so that they can contribute to the national response and advocate for their needs
- Reviewing, and where necessary, revising policies and programmes to reduce gender-based inequities, and ensuring human rights protection for key populations
- Leverage broad participation and collaboration of stakeholders through building coalitions and partnerships with a range of stakeholders which are essential for scaling up efforts towards universal access

- Strengthen collaboration between HIV and other health programmes to facilitate programme coordination and to align programme targets, guidelines, services and resources
- Advocate with local governments to ensure adequate funding for HIV programme at provincial and district levels under the decentralized health system
- Implement and monitor the programmes supported by internal and external funding sources for the maximum use of resources
- Social protection interventions targeted for PLHIV
- Strengthen policy to create an enabling environment for the national response to HIV and AIDS
- Involvement of police and other law enforcing agencies to create enabling environment for carrying out interventions for high risk and vulnerable populations

5. Management and Governance

Strong governance and coordination are crucial in ensuring harmonization and alignment of the multitude of stakeholders involved in the implementation of the National Strategic Plan. The National STD/AIDS Control Programme is a special programme of the Ministry of Health with direct responsibility to lead the national response to sexually transmitted infections and HIV in Sri Lanka under the Deputy Director General Public Health Services in the Ministry. The NSACP is the focal organization tasked with planning and implementing the activities of the National Strategic Plan in cooperation with stakeholders. Programme implementation is carried out through a team of coordinators who head the programme units, which carry out specific activities related to STI and HIV prevention and control.

There are two governance structures for the AIDS program in Sri Lanka:

- National AIDS Committee
- Country Coordinating Mechanism

National AIDS Committee:

The external review report of the National AIDS Program revealed and recommended the roles that could be played by the committee. The terms of reference of the National AIDS Committee, a high level policy making body to take HIV/AIDS related decisions, have been drawn up. The NAC is chaired by the Secretary of the Ministry of Health and meets twice a year. The membership is drawn from other ministerial secretaries, development partners, and civil society, including nongovernmental organizations and community-based organizations, people living with HIV, and the private sector, providing for an effective mechanism for involvement of stakeholders. Representation and participation of community-based organizations in the NAC could be enhanced as their role and capacity in decision making appears to be low.

It's imperative that the NSACP will have an advocacy agenda in its work with the NAC and play a role in getting support for major issues such as harm reduction and the elimination of discrimination against people living with HIV. The NAC is supported by five technical subcommittees on: 1. information/education/communication, and prevention; 2. policy, legal and ethical issues; 3. Multi-sectoral issues; 4. HIV care, treatment, counseling, and laboratory services; and 5. strategic information management.

It is necessary to ensure that these subcommittees play a more technical role and that they are aligned with the priorities of the National Strategic Plan and the proposed functional areas of the NSACP. Five programme coordinators attached to the NSACP are ex officio secretaries of the sub committees, and this dual role as well as the presence of the Director of the NSACP on the NAC provide feedback to the NSACP management for implementing the recommendations of the NAC and vice versa. However, the matters discussed and issues related to the NAC should be discussed as an agenda item of the meeting of the senior management team of the NSACP to formalize the process and ensure implementation.

Country Coordinating Mechanism (CCM):

The Country Coordinating Mechanism (CCM) of the Global Fund is intended to reflect the principles of national ownership and participatory decision making. This mechanism is the governing body for the use of Global Fund resources in recipient countries. Currently CCM of Sri Lanka comprises 25 members with Secretary, Ministry of Health as the Chairperson and meets once in two months.

Given that a significant portion of the HIV funding is through Global Fund, the CCM plays an important role. Although the CCM monitors all three diseases (HIV, TB and Malaria), strong linkages between CCM and NSACP, in terms of evidence, actions, continuity should be strengthened.

6. Policy and Legal Environment

The National HIV /AIDS Policy was ratified by the cabinet of ministers recently in 2011. It lays emphasis on two major objectives, which have been identified as being within the framework of the Millennium Development Goals, bearing in mind that the Target seven of the Millennium Development Goal is on HIV/AIDS. The National AIDS policy states that “the policy objectives will be achieved through a national strategic plan with the participation of the government, nongovernmental and international organizations, the private sector and civil society”. The National AIDS policy indicates in its name that it is an HIV/AIDS policy, although one of its strategies does explicitly refer to prevention and control of other sexually transmitted infections and hence the shortcoming evident in the title of the policy in only referring to HIV/AIDS has been overcome.

The existence of certain punitive laws has been a draw back in the comprehensive care, treatment, and prevention for key populations in the country. Therefore, the importance of review of these legal provisions is mandatory to create an enabling environment for key populations to come forward for these essential services. As long as these laws are in operation members of the key populations will face discrimination as service recipients and as a result further spread of HIV and other STIs is inevitable in society. It is continuously emphasized that a complete overhaul of existing legal provisions is essential to maintain the low prevalence of HIV in the island.

7. Partnerships and Coordination

An ambitious development plan cannot be successfully implemented without relevant multi-sectoral partnerships. Sri Lanka has shown the way where successful partnerships can lead to impact. NSACP has partnered with other government departments, civil society, academia, the UN co-sponsors, bilateral partnerships with governments as well as development agencies like the World Bank and the Global Fund.

In addition to the National Blood Transfusion Services (NBTS) and the National Programme for Tuberculosis Control and Chest Diseases (NPTCCD), NSACP also engaged in 12 line Ministries including the National Institute of Education, the Ministry of Labour, the Foreign Employment Bureau, the Vocational Training Authority, the Ministry of Fisheries, the National Child Protection Authority, the National Youth Services Council, the Army, the Navy, the Air Force and the Police. Their work includes advocacy, increasing of HIV prevention awareness and knowledge of available facilities, encouraging condom use with casual and unknown partners among the armed services, other vulnerable populations, and members of the general population introducing HIV testing and counseling services, and referral network .