



Ministry of  
Healthcare and Nutrition

# Review of the National Response to Sexually Transmitted Infections and HIV/AIDS in Sri Lanka

16–28 October 2006



**UNAIDS**  
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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**World Health  
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Regional Office for South-East Asia



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# Acronyms and Abbreviations

ADB	Asian Development Bank
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral (drug)
BCC	behaviour change communication
BSS	behavioural surveillance surveys
CBO	community-based organization
CCC	Ceylon Chamber of Commerce
CCM	Country Coordinating Mechanism
CCT	comprehensive care and treatment
CRIS	Country Response Information System
CSW	commercial sex worker
ELISA	enzyme-linked immunosorbent assay
FCCI	Federation of Chambers of Commerce and Industry
FSW	female sex worker
GFATM	Global Fund against AIDS, TB and Malaria
IDA	International Development Association
IDP	internally displaced person
IDU	injecting drug users
IEC	information, education and communication
ILO	International Labour Organization
ISP	Implementation and Support Plan
KAP	knowledge, attitudes and practices
MCH	maternal and child health
MIS	management information system
MO	medical officer
MoH	Ministry of Health
MSD	Medical Supplies Division
MSM	men who have sex with men

NAC	National AIDS Committee
NBTS	National Blood Transfusion Services
NCCSL	National Chamber of Commerce of Sri Lanka
NDDCB	National Dangerous Drug Control Board
NGO	nongovernmental organization
NHAPP	National HIV/AIDS Prevention Programme
NHAPP	National HIV and AIDS Prevention Project
NSACP	National STD/AIDS Control Programme
NSHP	National STI and HIV Programme
NSHPCP	National STI and HIV Prevention and Care Programme
NSP	National Strategic Plan
OI	opportunistic infection
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PHI	public health inspector
PHN	public health nurse
PLHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RRI	Rapid Results Initiative
SARS	severe acute respiratory syndrome
SI-M&E	strategic information, monitoring and evaluation system
SLFEB	Sri Lanka Foreign Employment Bureau
SME	small and medium enterprises
SRH	sexual and reproductive health
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
ToT	training of trainers
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
VDRL	Venereal Diseases Research Laboratory (test)
WFP	World Food Programme



# Executive Summary

An external review of the national response to HIV/AIDS in Sri Lanka was carried out by a team of members drawn from national programmes and sectors external to the National STI/AIDS Control Programme (NSACP), and from the staff of international organizations, overseas HIV initiatives and universities. Senior staff members from the NSACP and several other groups working on HIV provided valuable information to the team. They participated in a series of meetings, discussions and field visits, and enriched the review process by sharing their extensive experience and knowledge. The review was facilitated by WHO, the World Bank, Joint United Nations Programme on HIV/AIDS (UNAIDS) and several other cosponsoring organizations. The contribution of the participants not only informed the review team of the status of the national response but also helped assemble, deploy and support the team throughout its mission.

The external review team had two specific objectives:

1. To identify the achievements of the national response to HIV by reviewing the activities of the NSACP, as well as those of other government and nongovernmental organizations (NGOs), in areas related to sexually transmitted infection (STI)/HIV prevention, care and treatment for the past five years, and
2. To provide recommendations for the revision of strategies and interventions for the development of a new strategic plan for 2007–2011.

Nearly two decades after Sri Lanka reported its first case of HIV infection, it remains one of the few countries in the Region with a low-level HIV epidemic. Many infections are associated with overseas work. HIV prevalence appears to be low, even in populations such as sex workers, despite their higher vulnerability and exposure to risks. It is apparent that some important vulnerability factors are either absent or operating at a low level in Sri Lanka. High literacy rates, the relatively high status of women and good access to health-care services all act to protect individuals and communities against HIV infection. Conditions of high vulnerability, on the other hand, include conflict, high mobility of the military, internally displaced persons (IDPs), and separation of spouses due to overseas employment. Moreover, new economic

developments such as the expansion of internal free trade zones, and broad social changes such as the increasing migration of young adults from rural areas to large urban centres might, in the future, result in further expansion of societal vulnerability factors.

The review team observed significant gaps in information regarding the areas of vulnerability. The NSACP, through the World Bank-funded National HIV/AIDS Prevention Programme (NHAPP), has commissioned behavioural surveillance surveys (BSS) of a number of vulnerable subpopulations, including female sex workers (FSWs) and men who have sex with men (MSM). Mapping of the BSS, however, will have a limited coverage and, as a result, the findings will not have generalized applicability. An important follow-up activity to the surveys would be to devise simple methods for similar district-based mapping surveys that would be conducive to targeting the programme at a local level.

The review concluded that commendable efforts have been made in Sri Lanka by the national programme staff and their partners towards:

- keeping the issue of HIV/AIDS on the national agenda,
- providing the general population with relevant information on HIV, and
- ensuring a satisfactory degree of access to the diagnosis and treatment of STIs.

The forthcoming National Strategic Plan (NSP) should be guided by a determination to focus programme activities and resources on most-at-risk populations. It should also sustain the continued low prevalence of HIV and other STIs. To this end, the review team recommended the following four overarching activities, to be implemented in conjunction with the specific recommendations laid out in the report.

## 1. Prioritization of targeted interventions for most-at-risk populations

The formulation of the new strategic plan for 2007–2011 should involve all stakeholders in a broad and participatory process, led by the NSACP. To facilitate this process, the NSACP should seek appropriate technical support available in Sri Lanka and from international sources, if required. The national strategy should act as a framework for the development of a district-based operational plan, and should contribute to the formulation of provincial and national operational plans. During the planning process, districts should actively seek technical guidance from the centre.

In each district, the highest priority for HIV prevention is to start interventions with sex workers. Existing partnerships in districts between STD clinic teams and NGOs should be further developed. STD clinic teams

should be strengthened and reoriented to have a stronger public health role in the prevention and control of STIs and HIV. Local advocacy should be conducted with district and provincial leaders as well as the police to explain the significance of targeted interventions and to build an enabling environment for prevention activities.

## 2. Partnership and engagement with NGOs and encouragement of private sector participation

A determined effort should be made by the NSACP towards capacity building and revitalization of NGOs by coordinating the existing mechanisms and partnerships. Collaboration with the private commercial sector should also be expanded through joint advocacy and planning by the national programme and local chambers of commerce. By offering incentives such as participation in short courses, private health-care providers should be further encouraged to engage in the nationwide response to HIV.

## 3. Improvements in the process of strategic information collection, dissemination, bridging information gaps, as well as establishment of a monitoring and evaluation system

Comprehensive and up-to-date information on high-risk populations is acutely needed to guide local responses to HIV interventions. District mapping should be conducted and coverage targets set. The highest priority should be given to an extensive mapping of most-at-risk populations such as FSWs, MSM and drug users in each district, with the objective of identifying the size of each population, their location and general characteristics. Key information should be gathered only in ways that are respectful of privacy, non-discriminatory and cognizant of the populations' human rights. These surveys and, if necessary, more detailed situation and needs assessments, should be carried out in the context of programmes providing prevention services to these groups. There is also an urgent need to set up a national strategic information (SI), monitoring and evaluation (M&E) system to be led by a unit in the programme. This unit, headed by a senior consultant of the NSACP, will have access to all SI and be guided by a national M&E framework. The roles and responsibilities of each party involved in the process should be clarified and a core set of indicators defined.

## 4. Strengthening of programme structure and management

The structure of the NSACP and NHAPP should be amalgamated permanently with a single senior management team. Additional staff should support the Deputy Provincial Director of Health Services (DPDHS) in the planning,

management, implementation and monitoring of all STI/HIV-related activities. This restructuring will secure the active participation of health inspectors and public health nurses/midwives.

The development and implementation of STI/HIV programme activities in the provinces and districts will require considerable technical and managerial support. Only teams trained in, and deployed from, the central STI/HIV office would be able to provide the specialized support.

Surveillance, research and management information systems (MIS) will form the core of the SI system and the M&E unit will be a component of this system.

Despite the detection of the first case of AIDS in Sri Lanka in 1987 in a person who had acquired HIV infection overseas, and of the first reported HIV infection attributable to indigenous transmission in 1989, the spread of HIV has remained remarkably low both in the whole population as well as among individuals considered at higher risk of infection on the basis of their occupation, behaviours or practices. Since its inception in 1985 and the launching of its first medium-term plan in 1988, the National STI and AIDS Control Programme (NSACP) has undergone a series of strategic planning exercises as well as programme and project reviews which, combined with epidemiological surveillance, activity monitoring, focal evaluations and research projects, has helped shape and improve the understanding of the dynamics of the national response to the HIV epidemic in Sri Lanka. In March 2003, the Ministry of Health (MoH) launched a five-year National HIV and AIDS Prevention Project (NHAPP) in support of the national response to HIV under a grant from the World Bank/International Development Association (IDA). The project focused on prevention among highly vulnerable subpopulations and the population at large.

Against this background, almost twenty years after the emergence of AIDS in Sri Lanka, the third 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 NSACP and staff of international organizations, overseas HIV initiatives and universities (Annex 1). Senior staff members from the NSACP and from several other groups working on HIV provided valuable information to the review team and participated in a series of meetings, discussions and field visits, enriching the review process by their extensive experience and knowledge. The review was facilitated by the World Health Organization, the World Bank, the Joint United Nations Programme on HIV/AIDS (UNAIDS), which secured the support of several of its cosponsoring organizations to assemble, deploy and support the review team throughout its mission.

The objectives of the review were to:

- identify the achievements of the national response to HIV by reviewing the activities of the NSACP as well as those of other government and nongovernmental organizations (NGOs), especially in areas related

to STI/HIV prevention, care and treatment for the period 2000–2006, and

- provide recommendations for the revision of strategies and interventions for the development of a new strategic plan for 2007–2011.

A local Task Team made available to reviewers specific objectives for the review, scope of work and a list of proposed issues to be probed into.

The review included a series of presentations by the NSACP, meetings with higher authorities, visits to offices and sites in Colombo and two provinces, and extensive review of an abundant documentation originating from a variety of stakeholders, including situation analyses prepared by the Task Team and collaborators. Everywhere, the cooperation and hospitality extended to the review team were outstanding, marked by a high level of interest and awareness, great openness and willingness to engage further in the national response to HIV.

In addition to the review team's own observations and findings, the present report draws on documents originating from a wide variety of sources. Particularly useful was a series of briefs prepared by a working group prior to the review. Collaborating agencies and other stakeholders also supplied the review team with background documents, activity reports and project documentation. To ensure that significant information from these sources was not overlooked, the team constructed a matrix<sup>1</sup> structured in such a way that it laid out key strategic directions arising from (i) the 2000 External Review of the Programme (the latest) and the ensuing consensus workshop; (ii) the 2000–2006 National Strategic Plan (NSP); and (iii) the recommendations arising from the March 2006 review of the NHAPP. The matrix extended the analysis of programme performances and issues by a summary of the external review findings, assorted recommendations that had been formulated in earlier reviews but needed to be reiterated, and collated the new ones arising from the current review.

The national response to HIV in Sri Lanka has benefited from a greater level of attention and resources than many other health and development initiatives in the country. The review team formulated conclusions and recommendations to provide guidance for enhancing programme effectiveness, determining the magnitude of efforts and resources available for best response to current and anticipated needs of HIV/AIDS in a sustainable way, and ensuring that the national response to HIV will contribute maximally to the overall progress in health and human development in Sri Lanka. As the time allocated for the review was short and interrupted by national holidays, the extent of information

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1 The matrix is available on <http://www.searo.who.int/hiv-aids/publications>

collection and analysis was deliberately focused on the most prominent issues relevant to the development of future strategies (2007–2011), but could not be as exhaustive as desired. For reasons related to the situation prevailing in the country at the time of the review, only fragmented information was available from the northern and north-eastern provinces and a site visit to Galle had to be cancelled.

# 2

## The HIV Epidemic

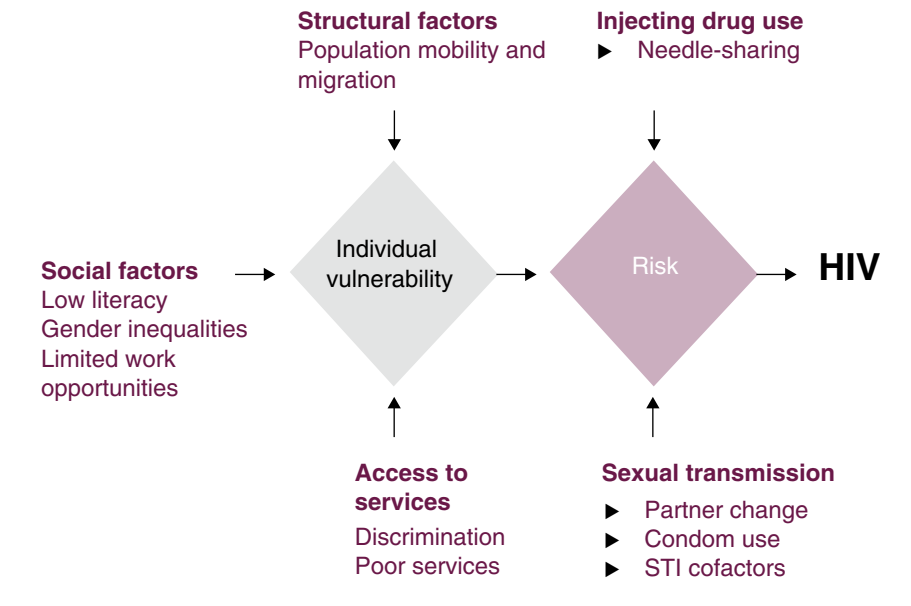
In Asian countries, the HIV epidemic often took off with injecting drug use and then spread through sex work. Even in the absence of drug injecting, however, it is possible for HIV to enter commercial sex networks and spread widely. The size of sex work networks, rates of partner change and condom use, and prevalence of other STIs are all factors that can accelerate the development and spread of HIV epidemics. Apart from sex work, it is possible for HIV to spread through casual sex networks if there are high rates of overlapping sexual partnerships (concurrency). In some places, for example, men who have sex with men (MSM) (noncommercial “pleasure circuits”) may have sufficiently high rates of partner change to be exposed to transmission.

Nearly two decades since reporting its first case of HIV infection, Sri Lanka remains one of the few countries in the region with a low-level HIV epidemic despite sharing some of the conditions mentioned above. In addition, many of the infections that have been identified are associated with overseas work. The prevalence of HIV appears to be low even in populations such as sex workers despite high vulnerability and risk. However, it should be noted that existing HIV prevalence data for sex workers and other vulnerable groups are not based on truly representative samples of these subpopulations, hence it is possible that emerging pockets of transmission have been missed. To strengthen HIV prevention in Sri Lanka, it is worth looking at where infection may be spreading now or in the future. **Figure 1** illustrates how vulnerability factors and risk behaviours can lead to expansion of the HIV epidemic.

It is apparent that some important vulnerability factors are absent or at a low level in Sri Lanka. High literacy rates, the 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 the military, internally displaced persons (IDPs), and separation of spouses due to overseas employment. Moreover, new economic developments such as the expansion of internal free trade zones, and broad social changes such as the increasing migration of young adults from rural areas to large urban centres could result in expansion of societal vulnerability factors.



**Figure 1.** Risk of and vulnerability to HIV infection



Not much is known about risk behaviours and networking such as injecting drug use, sex work and high levels of concurrent sexual partnerships, which could fuel an expansion of the HIV epidemic. The review team assessed these conditions and possible transmission networks in several districts and found only anecdotal information about population sizes and risk behaviours. The NSACP has recognized this need for size estimations of vulnerable groups and included the need in the work plan for 2005–2006. Capacity building of the NSACP staff for the task has also been requested. Considerable programmatic effort is directed at other vulnerable populations such as the military, transport workers, internal and overseas migrant workers. Such groups may well serve as bridging populations for sexual transmission although data on actual behaviours are limited. The review team views isolated imported cases, such as returning migrant workers, as epidemiologically important only if they are able to seed local networks that could sustain transmission.

## 2.1 Epidemic potential: how HIV could start spreading in Sri Lanka

Available evidence indicates that Sri Lanka currently has a low-level HIV epidemic. Several rounds of surveillance over the past five years have found an HIV prevalence of approximately 0.01% among women attending

antenatal clinics based on more than 116 000 samples<sup>2</sup>. Combined data from the 2004 and 2005 sentinel surveillance surveys found that the HIV prevalence was 0.1% among female sex workers (FSWs) ( $N = 2633$ ) and 0.06% among both STD clinic attendees ( $N = 4875$ ) and patients with tuberculosis (TB) ( $N = 3184$ )<sup>2</sup>.

What is not yet well understood is the HIV epidemic potential in Sri Lanka. It is our view that there is a low probability that Sri Lanka will experience a large generalized epidemic. We base this assessment on the following observations: (i) 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 subpopulations; (ii) other Asian countries have not experienced large-scale generalized epidemics, and Sri Lanka does not appear to have

### Anuradhapura, Northern Central Province

Key areas of risk and vulnerability in Northern Central Province appear to be sex work and high-concurrency casual sex among MSM. Demand for commercial/casual sex reportedly comes from large numbers of military personnel, traders visiting the markets and husbands of female overseas migrant workers. Sex work used to be well-established in Anuradhapura prior to the peace agreement in 2002 when large military transit camps closed. The number of sex workers has declined greatly since then but there are few data on how many are currently involved in sex work in the district. Since many brothels closed in 2002, however, sex work is reportedly much more clandestine – with three-wheeler drivers often linking clients to sex workers in hotel rooms or other private venues. Previously, demand for sex work increased around pay-day. Now military salaries are deposited directly into home accounts leaving little for entertainment. This may explain, we were told, why sex work has not rebounded recently despite increased traffic through transit camps.

No mapping has been done to obtain accurate size estimates. High-end estimates are 3500–5000 at peak while at the low end, 300–500 are currently in contact with an STD Clinic and/or NGO. The actual number probably falls somewhere in between. Using clinic figures of 190 new sex worker registrations in 2002 compared with 50 per year since, a rough estimate may be 1000–1500 sex workers districtwide, most of whom are not being reached by prevention services.

Changes may also be factors contributing to increased MSM activity, which is largely non-commercial. The estimated number of MSM is 250 in Anuradhapura district, and 150 are reached by an NGO working with the STD Clinic. This number would be much larger if "active" (insertive) contacts are included; military personnel reportedly represent two-thirds of "active partners". An estimated 54% of MSM are married.

2 *HIV sentinel sero-surveillance survey in Sri Lanka*. Colombo, Sri Lanka, National STD/AIDS Control Programme, 2006.

sexual behaviour patterns that are more conducive to widespread HIV transmission than elsewhere. Instead, we think that two patterns of the HIV epidemic will emerge in Sri Lanka.

*Truncated (persistently low-level) epidemics:* In circumstances where sexual and drug-using behaviours and networks cannot sustain local transmission, the spread of HIV is highly dependent 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. For example, HIV testing data indicate that more than 40% of women who have tested positive for HIV are international migrants. However, these data overstate the importance of this pattern of transmission since many of these out-migrant workers require HIV screening prior to departure so they are highly overrepresented in HIV testing data. Moreover, it is not clear how many of these women have acquired HIV infection abroad, and how many have acquired it within Sri Lanka. There have also been some anecdotal reports of HIV transmission from foreign tourists and other visitors who have had sexual relations with Sri Lankan residents. However, the extent of this pattern of transmission is not documented. It is important to note that unless those who acquire HIV infection abroad or from a foreign visitor are connected to local sexual or drug-injecting networks, the local HIV epidemic will remain truncated at a very low HIV prevalence.

*Concentrated epidemics:* A concentrated HIV epidemic will occur where high-risk behavioural patterns and networks are substantial enough to initiate and sustain local transmission within high-risk subpopulations (e.g. FSWs, high-risk MSM and injecting drug users [IDUs]). 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 subpopulations and their sexual behaviours, including their number of sexual partners, concurrency patterns in sexual partnerships, types of sexual contacts, the prevalence of other STIs 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 shift in drug-use patterns to more injecting, the change 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

## Nuwara Eliya, Central Province

Nuwara Eliya, located in Sri Lanka's central highlands, is a centre of tea plantations and tourism. These two features are potential sources of vulnerability for the region. Increasingly, the youth from the tea plantations seek employment and recreation in urban centres, particularly Colombo. Young men most often find low-paying jobs, and are often without consistent daily work. Young women find employment as domestic workers, in garment factories and in other low-paying occupations. This is bringing about broad-based changes in the tea plantations with an increasing number of out-migrants living alone away from home in large cities. Little information is available regarding the sexual behaviours of these internal migrants, but it seems likely that both males and females would be prone to higher-risk sexual behaviours when staying away from home for extended periods of time. There are currently general HIV awareness programmes for plantation workers, but as yet there have been no assessments of risk associated with out-migrating youth and no targeted programmes for risk reduction in this subpopulation.

Several key informants from Nuwara Eliya also indicated that commercial sex seemed to be rising in the districts that have a strong link to tourism. There are an increasing number of small hotels and some of them are used for sex work. In particular, during the two months of the main tourist "season" in Nuwara Eliya, public health workers have reported an influx of FSWs from the coastal regions, including Colombo. The size of this influx is not clear, but some have estimated that as many as 300 or 400 additional FSWs work in Nuwara Eliya during the "season". As yet, there is no consistent targeted programme response for the emerging sex work network in Nuwara Eliya.

epidemics in Sri Lanka. Current estimates of the size of high-risk key populations vary widely: 3000–50 000 FSWs; and 30 000–240 000 opiate users of which 0.2–2% are IDUs. Estimates of the number of high-risk MSM have not been published. It is also important to note that there is considerable diversity in the demographic, economic and sociocultural contexts within Sri Lanka. Therefore, since these factors will largely shape the size and characteristics of high-risk groups, it is likely that there will be substantial geographical heterogeneity in the distribution of these groups and in the epidemic potential. Moreover, the demographic, social and economic situations in Sri Lanka are changing, and these changes could increase the size and distribution of these subpopulations, thus altering the epidemic potential.

As illustrated in the accompanying text boxes, local conditions influence the structure and patterns of sexual behaviour, as well as the epidemic potential. Therefore, prevention strategies will need to be tailored to the local situation, with appropriate targeting of high-risk networks.

## 2.2 Information gaps

*What information do we have regarding potential transmission pathways that could lead to epidemic-level spread of HIV in Sri Lanka?*

The following tables summarize the assumptions and information gaps about high-risk networks (**Table 1**), risk factors that directly influence HIV transmission (**Table 2**), and some underlying structural conditions that can influence vulnerability (**Table 3**).

**Table 1.** Information gaps in high-risk networks for transmission of HIV

High-risk networks	Information gap
<p><b>Sex workers</b> Estimates of the size of the FSW population vary from as low as 3000 to 30 000. Even this higher estimate (approximately 0.6% of adult women) is low for the region (a recent review reported national estimates of FSWs ranging from 0.2% to 2.6% of the adult female population in Asia). However, sex work is covert in Sri Lanka and estimates are not based on systematic mapping, so the sex worker population may well be underestimated. One organization working with sex workers estimates that there are 20 000–25 000 sex workers in the Western Province alone. Recently concluded behavioural surveillance surveys (BSS) have shown that these numbers are inflated.</p>	<p>Little is known about the size, typology and behaviours of sex workers and their clients.</p>
<p><b>High sex partner concurrency</b> There are reports of casual sex among young workers in various industries (International Labour Organization [ILO] report) but little evidence of partner change rates high enough to sustain HIV transmission. There are insufficient data on numbers or behaviours of MSM although NGOs report networks of MSM with high rates of partner change.</p>	<p>Even less is known about non-commercial concurrent sexual partnerships.</p>
<p><b>Injecting drug use</b> Injecting drug use is believed to be uncommon in Sri Lanka (estimate – 1% of 45 000 heroin users). Most drug users currently report inhalation only. However, such behaviours can change quickly with fluctuations in drug supply – with increased injecting when the drug is scarce or of low potency.</p>	<p>Surveillance to monitor changing drug-use patterns and supply trends should be strengthened.</p>

The following factors directly increase or decrease the probability of HIV infection by increasing exposure or the likelihood of transmission (**Table 2**).

**Table 2.** Information gaps in risk factors for HIV

Risk factors	Information gap
<b>Numbers of partners</b> – Hotel-based sex workers reportedly have up to 5–10 clients per day, and street-based workers up to 15. MSM in contact with one NGO have an average of 6 partners per day.	Little is known about the number of clients in different sex work/MSM settings.
<b>Condom use</b> – STD clinics and NGOs working with sex workers and MSM report moderate-to-high rates (50–80%) of condom use among sex workers and MSM.	Little reliable data exist on condom use rates among high-risk populations.
<b>STI cofactors</b> – Rates of curable STIs have progressively declined since the late 1980s and are among the lowest in the Region. STD clinics serve as a good sentinel surveillance system for monitoring the rates of incident STIs (and as markers of potential sexual transmission of HIV).	Few STI prevalence data are available for high-risk or bridging populations.
<b>Needle-sharing</b> – Although injecting drug use is uncommon, there are reports of IDUs with needle-sharing and multiple-partner sexual behaviour <sup>3</sup> .	Surveillance to monitor changing drug-use patterns needs to be strengthened.

*What do we know about the underlying structural conditions that frequently contribute to sex work and injecting drug use elsewhere in the Region?*

The underlying structural conditions that contribute to sex work are given in **Table 3**.

**Table 3.** Information gaps in vulnerabilities to HIV

Underlying vulnerabilities	Information gap
<b>Migration and mobility</b> Male mobility and migrant labour can increase the demand for sex work. In addition to the military, other groups mentioned as potential clients/partners of sex workers and MSM include men travelling to market towns for business and husbands of female overseas workers.	More information is needed on bridging populations and their behaviours.
<b>Literacy and gender inequalities</b> The status of women greatly influences the supply side of commercial sex. High rates of female literacy and alternative economic opportunities reduce the need for women to turn to sex work for survival. Despite good national indicators in many of these areas, potentially vulnerable women include war widows, women in IDP camps and migrant workers.	More information is needed, especially on vulnerable women.
<b>Access to services</b> Social marginalization and discrimination can limit access to health and social services.	There is little statistical information on coverage of interventions or access to services for highest-risk populations.

3 Reid G, Costigan G. Revisiting “the hidden epidemic”: a situation assessment of drug use in Asia in the context of HIV/AIDS. Melbourne, Centre for Harm Reduction, Burnet Institute, 2002.

There are large gaps in information in many of the above areas. The NSACP with funds from the NHAPP has commissioned a behavioural survey on a number of vulnerable subpopulations, including FSW and MSM, but as the mapping is limited to selected geographical locations it does not have broad coverage and so the generalizability of the findings will be constrained.

### **Recommendations: Forecasting risk and vulnerabilities**

- The ongoing behavioural survey should be vigorously pursued and its results shared with all stakeholders as early as possible in order to facilitate the development of the 2007–2011 National AIDS Strategy.
- Additional information gaps should be filled through focal studies and analyses commissioned by the NSACP.

### 3.1 National Policy and Advisory Committee

A National Policy on HIV/AIDS has been approved by the Minister of Health and will soon be submitted to the cabinet. The policy is consistent with national priorities and international guidelines. It emphasizes the need to expand prevention, care and treatment with a focus on vulnerable communities, among which specifically figure MSM, sex workers and drug users. 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 enhancing the focus on vulnerable populations and those at greatest risk. The draft National AIDS Policy should be submitted to the cabinet at the earliest opportunity. Once adopted, the policy should be widely disseminated across sectors, publicized through the professional and general media, and used in advocacy activities and training courses.

The National AIDS Committee (NAC) has not met for over a year. As an advisory body to the Minister of Health, it should be reactivated and a critical analysis should be carried out of the relevance, usefulness and efficiency of the NAC subcommittees. A National AIDS Council has just been established and has met once. It is chaired by the President and includes senior members from the MoH and other ministries, international organizations and NGOs. The National AIDS Council is not intended to replace the NAC; 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 any terms of reference at this time and these should be formulated to clarify its specific functions. The outcomes of its meetings should be recorded and widely publicized across and beyond the government machinery.

The NAC should continue to oversee the national response to HIV. It should be consulted on all major decisions affecting HIV-related policies, priority-setting and strategic directions, sectoral cooperation and participation of all stakeholders, with a view to guaranteeing the soundness and effectiveness of the national strategy, the timeliness of its implementation and operational accountability. It should be consulted on key decisions affecting the national response to HIV prior to their submission to the line ministry and other concerned



## **Box 1. Structure of the provincial and district AIDS Committees**

### **Provincial AIDS Committee**

Chaired by the provincial Minister of Health

Members:

- Provincial health secretary
- Provincial Director of Health Services
- Representatives from: Police, Army, Education, Social Service, Department of Labour and NGOs
- MO-STI

### **District AIDS Committee**

Chaired by the Government Agent – GA (seniormost government official in the district)

Other members:

- Deputy Provincial Director of Health Services
- MO-STI
- Representatives from: Police, Army, Education, Social Service, Department of Labour and NGOs

The respective responsibilities of the provincial and district committees are not very clear. The membership of provincial and district committees overlap, at least in the districts where the provincial secretariat is situated.

ministries. The logistics/distribution of STI and HIV supplies should be integrated into the Medical Supplies Division (MSD) as per other supplies dispatched to the same facility (with the exception of antiretroviral [ARV] drugs).

Provincial/district AIDS Committees do exist and are functioning in “key” districts such as Anuradhapura and Kurunegala, with the participation of NGOs. But documentation of meeting decisions is not available, and they seem to operate more as an information-sharing forum than a coordination body. There is a need to strengthen the provincial and district AIDS Committees by providing guidelines for planning from the NSACP. The actual provincial and district planning process needs to be launched in line with the national strategy and to fit the local situation and needs assessment.

## **3.2 Planning**

The 2002–2006 NSP served as a broad framework for programme activities although, throughout the period, the emphasis in implementation remained on “proximal” outreach (i.e. focus on easily identifiable, low-risk populations)

rather than on “hard-to-reach” communities (i.e. sex workers, IDUs and MSM). The Plan identified three main objectives and five strategic areas (Section 2.3. of the NSP). It included targets and eight corresponding indicators. Of the targets, one was knowledge-based (awareness of preventive practices); five service-based (STI treatment, voluntary blood donations, screening of blood donations for HIV and syphilis, pregnant women receiving ARV prophylaxis, and districts with voluntary counselling and testing [VCT] services), and the remaining two based on behavioural change (condom use and use of clean injecting equipment by IDUs). Chapter 6 of this report summarizes some accomplishments of the combined efforts of the NSACP and NHAPP. A plan of operations translated strategic directions laid out in the NSP into a workplan and budget.

While implementation plans for the NHAPP were available in the two provinces visited, provincial workplans were not available everywhere, and in the two provinces visited, these plans were generic. They emphasized advocacy and information, education and communication (IEC), but had insufficient focus on highly vulnerable populations. In one district, the staff was not aware of the NSP. The 2007–2011 NSP should create an opportunity to enhance programme efficiency in its ongoing IEC activities, refocus the programme on vulnerable groups, and move towards greater integration of HIV-related activities with other health and sectoral activities.

The 2007–2011 NSP should be formulated at the national level and serve as a framework for the formulation of a plan of operations. The Plan should be developed at the national level with participation of key stakeholders including participants from the MoH, other key sectors, NGOs, the private sector, people with HIV, and delegates from international and bilateral agencies. To this end, the NSACP should seek technical support from sources available in Sri Lanka or internationally. It is important to secure this additional help so that senior staff of the NSACP and NHAPP is not distracted excessively from their implementation responsibilities. Formulation of the NSP should be followed by development of plans of operation from the bottom up: from districts to provinces and from provinces to the national level. Simple planning tools and supporting training materials should be developed for this purpose, and technical assistance extended from the central and provincial levels to the districts. The report submitted for the Universal Access Meeting held in March 2006 may provide useful guidance towards the formulation of the next strategic plan. The report of that meeting was prepared following a national consultation process.

District plans of operation should indicate how and where highly vulnerable populations would be targeted by HIV work. They should also be specific about how each governmental sector, the private sector and NGOs will contribute to these efforts locally.

### Recommendations: Planning

- The formulation of the 2007–2011 NSP should involve all stakeholders in a broad participatory process guided by the NSACP.
- To this end, the NSACP 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 plan contributing to the formulation of provincial and national operational plans.

## 3.3 Programme structure and human resources

The organizational structure of the NSACP changed in September 2006 to integrate more fully the structures and functions of the NHAPP with the NSACP. A single person is now the Director of the NSACP and the Project Director of the NHAPP. The post of Deputy Director General of Health for Public Health is currently vacant. It is understood that this post is about to be filled. The Deputy Director General Public Health Services should play a key role in providing direction to the NSACP and other public health bodies contributing to the health system response to HIV.

The NSACP should remain at the helm of structures providing direction to and overseeing those engaged in HIV/AIDS prevention, care and treatment. It would seem appropriate to reflect on the expanded role of the NSACP by changing its name to the National STI and HIV Programme (NSHP) or National STI and HIV Prevention and Care Programme (NSHPCP). While the appointment of a single director for both the NSACP and NHAPP is a welcome move, the following issues still need clarification: the NHAPP 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, tension between the staff of the two entities and lack of accountability.

The functional task analysis recommended by the March 2006 NHAPP review needs to be completed as soon as the 2007–2011 NSP is produced to reflect new priorities and work areas. This analysis will determine if further changes are required in the structure of the NSACP; whether its central management group should retain eight programme units below the Director or regroup these into three or more pillars (Prevention, Care and Treatment, and Surveillance), each headed by a Deputy (or Assistant) Director/Coordinator. The appointment of Deputy (or Assistant) Directors/Coordinators would create a ground for greater delegation of authority. With respect to the three units named in the NSP 2002–2006, it would be advisable to upgrade the surveillance unit into a

Strategic Information (SI)-Monitoring and Evaluation (M&E) Unit (including surveillance and operational research), while a fourth pillar of the national programme would be assigned coordination and cooperation functions. NHAPP project coordinators (Team Leaders) should be incorporated in relevant thematic units and they should report to the Director of the NSACP directly or through the supervisor delegated to the pillar to which they will be assigned.

The STD clinics serve as the backbone of the NSACP. They diagnose and treat STIs, offer counselling and testing for HIV, as well as prophylaxis and treatment of opportunistic infections (OIs) (referring TB cases to the TB programme), and provide technical support to prevention staff working at the provincial and district levels. Recently, they have begun to refer persons living with HIV/AIDS (PLHA) to Colombo for antiretroviral therapy (ART) which they monitor in their outpatient clinic while cases needing hospital admission are referred to the medicine ward of the provincial hospital.

STI Medical Officers (MOs-STI) and their teams have played a key role in promoting and coordinating STI/AIDS activities at the provincial and district levels, mostly the district level. Reportedly, however, 50% of the working time of the MO-STI in districts is related to clinical work, hence the time available for planning, management, coordination, outreach and intervention services is very limited. At the district level, MOs have been joined by a second MO responsible for school health and it has been proposed that a third senior staff be added with direct responsibility for STI/HIV prevention and care. In each district, the staff-to-population ratio is 1 MO of health per 60 000, one public health inspector (PHI) per 10 000 and one public health midwife per 3000. The HIV work in districts is expected to engage PHIs and midwives already in place in districts, as well as local NGOs and other partners. This will require much stronger collaboration within the MoH between the NSACP and the Family Health Bureau.

The MOs-STI and their teams should continue to be the technical leaders for the AIDS response in the district but their clinic responsibilities need to be reduced to allow more time to be spent on coordination and advocacy. The roles and functions should be shared among team members so that there is a good balance between clinical work and coordination, the advocacy role played by the STD clinic, and programme planning, implementation and monitoring. Consideration should be given to adding a new staff member to the MO-STI team with skills in programme planning and monitoring. To this end, the addition of a third senior staff to every district health team should be promptly implemented. These personnel should play an active role in the managerial aspects of district programmes. Training for these new recruits should be planned as an important element of the new Strategic Plan.

Training at the provincial and district levels continues to be ad hoc, with the use of varied curricula, trainers and materials. Commendable documented efforts have been made by the NSACP and the NHAPP to train a broad spectrum of stakeholders both within and outside the health sector. These activities have emphasized advocacy (e.g. knowledge, leadership, sectoral participation) to the detriment of capacity and skills building (e.g. strategic planning, targeting, problem-solving, outreach, M&E). As a result, a large amount of IEC and advocacy work has been carried out but it has not been standardized. Numerous advocacy and awareness-raising activities have been implemented with the participation of health staff, MOs-STI in particular, without the support of standardized curricula or materials.

The core group of trainers recommended earlier has not been established either at the centre or at the provincial levels. A master training plan leading to the standardization of training packages inclusive of curricula, materials, follow-up activities, M&E should be developed early in the next Strategic Plan. Sectoral training packages should be evaluated and endorsed by the NSACP. Standardized IEC and advocacy material for different target groups should be generated at the central level (with technical inputs from the NSACP), evaluated and disseminated to districts.

Renewed efforts should be made to create core groups of qualified trainers at the provincial and district levels. In order to meet the need for technical support to the provinces and districts, the recommended approach is to establish a roving team of perhaps six to eight members who, after appropriate training, could be deployed to help in district population mapping, priority-setting, planning, training, implementation, monitoring and trouble-shooting.

### **Recommendations: Programme structure**

- The structure of the NSACP and NHAPP should be amalgamated permanently with a single senior management team.
- Additional staff engaged in planning, management, implementation and monitoring of STI/HIV-related activities should support the Deputy Provincial Director of Health Services, securing the active participation of PHIs and public health midwives.
- The development and implementation of STI/HIV programme 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 STI/HIV office.

### 3.4 Partnerships

The participation of PLHA in the NSACP, and through NGOs, is minimal. The NSACP should provide financial and technical support to PLHA to ensure that they play an active role in programme planning, implementation and evaluation.

#### The private sector

The private sector has supported HIV prevention activities that have targeted its workforce and families, although on a limited scale. With collaboration of the International Labour Organization (ILO), an “HIV/AIDS in the workplace” programme has been launched in key sectors, such as tourism, plantation and manufacturing. However, there is little counterpart/collateral funding available for the private sector except in a few specific areas such as plantation, which has some collateral funding under the Plantation Project from the Asian Development Bank (ADB). As a result, the bulk of corporate funding is diverted to their own HIV/AIDS awareness and prevention programmes. These limited activities can be substantially scaled up by strengthening cross-institutional collaboration among donor agencies, the World Bank and the private sector. Involvement of the private sector is particularly crucial as it employs a substantial workforce across all industries, which includes vulnerable subpopulations (e.g. workers in the garment and tourist industry, migrant workers and youth). In addition, the main chambers of commerce (Ceylon Chamber of Commerce [CCC], National Chamber of Commerce of Sri Lanka [NCCSL], Federation of Chambers of Commerce and Industry [FCCI]), through their corporate membership, affiliated organizations and programmes for small and medium enterprises (SME), reach out to several hundred thousand employees. Over a million employees, including the workers in plantations, benefit from these programmes. Also, the private sector has a ready infrastructure in place which facilitates access to these programmes. Support from UNAIDS cosponsors, in the form of technical assistance and capacity building, would enable the private sector to leverage their human resources, managerial capability, skills base and islandwide reach to all communities. There should also be a more substantial representation from the private sector and the chambers of commerce within the NAC, so that it is a truly inclusive, multisectoral programme with active participation of all sectors.

It is estimated that less than half the STI patients are seen in public facilities, with a similar number seen by private care providers. Participation by private STI care providers in STI/HIV work should be stimulated. The contribution of private STI/HIV prevention and care providers could be enhanced through their participation in population mapping, sentinel reporting

and improved case management. Training opportunities in this domain through short courses should be offered to private practitioners.

## Sectoral collaboration

The MoH has spearheaded the national response to HIV and recent years have witnessed the gradual involvement of a number of other sectors, largely owing to the financial support of the NHAPP with additional resources made available from the UN system. Collaborating ministries or organizations include the National Child Protection Authority, Sri Lanka Bureau of Foreign Employment, National Institute of Education, Workers' Education Unit of the Ministry of Labour, Department of Prisons, National Youth Services Council, army, navy, air force and police department of the Ministry of Defence, Vocational Training Authority and Ministry of Fisheries. This list is not exhaustive as ongoing collaboration between national bodies and several UN agencies often include activities relevant to HIV prevention.

The NSACP and NHAPP should be commended for having generated interest and commitment from a variety of sectors. Several of the above organizations visited by the review team expressed satisfaction about the collaboration and support extended to them by the national programme and project. The review team was not able to assess the financial contribution these organizations were bringing to HIV work from their own resources but a general impression that the activities completed or under way were largely dependent on external funding (mainly from NHAPP) generated concerns about their long-term sustainability. In order to improve effectiveness, sectoral work should focus on the more relevant sectors and on improving existing interventions. It is hoped that the newly established National AIDS Council chaired by the President will stimulate increased commitment and progress towards more self-reliance across all sectors concerned with HIV.

## Nongovernmental organizations

There is a large number of NGOs in Sri Lanka, many of which are engaged in basic education with only a handful of them engaged in HIV work. Some of these tend to direct their work to easy-to-reach communities such as young people, factory workers or rural communities to whom they offer HIV information and education. Very few NGOs have shown an interest in working with sex workers, MSM and drug users. Under an international HIV/AIDS Alliance project some ten years ago, NGOs benefited from extensive capacity building but the project was suspended. Local NGO coordinating mechanisms were created but with little impact as a result of internal tensions and lack of funding. Today, there is no effective umbrella organization for NGO coordination in the area of STI and HIV prevention and care, and such a structure is urgently needed. Rather than creating a new alliance, mechanisms which existed

previously but are no longer functional should be re-examined, and technical and financial support extended to them by the NSACP and/or the NHAPP, at least initially, to stimulate the impetus needed for their revival. The NSACP should support NGOs willing to engage in work with drug users, sex workers and MSM. It should directly or through the NHAPP technically support and finance NGO capacity building.

The NHAPP invited applications from NGOs in 2004–2005, intending to bolster interest and networking across and between NGOs and other stakeholder. Although over 100 applications were received, only 47 applications were selected and financed after a screening process involving the MoH and UN staff, as the guidelines for submission of proposals exceeded the capacity of most NGOs. Considering the weakness of some of the proposals, a workshop was organized for NGOs to familiarize them with the development of focused interventions (including behaviour change, and those targeting sex workers and MSM), but the applications remained poor. Only 24 of those NGOs received a second year of financing. Among these are such NGOs as Lanka+ (the only organization of PLHA), Companions on a Journey (working with MSM), the Salvation Army and a local NGO (both providing care and support to people infected or affected by HIV), Community Development Services (working with sex workers and training of NGOs), Alliance Lanka and Family Planning Association (engaged in general awareness activities), and Sarvodaya (working with youth and religious leaders). Remarkably, the main focus of these projects was on populations at low or moderate risk of HIV; very few focused on populations at greatest risk during the first round and even fewer during the second round.

Some NGOs receive or are about to receive funding from bilateral development agencies (e.g. the Netherlands and USAID). International NGOs such as Action Aid/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 independently of the NSACP.

The NGOs encountered during this review complained about the lack of funding opportunities from the NHAPP and NSACP. According to them, calls for proposals occasionally generate applications which end up not being funded or even acknowledged. Grant applications to the NHAPP other than for projects funded under the Rapid Results Initiative (RRI) are judged unfavourably and require extensive documentation, which is described as beyond the capacity or time availability of most NGOs. Three such applications were submitted by NGOs to the NHAPP several months ago, none of which has thus far been funded. The process for award of grants by the NHAPP to NGOs should be simplified so as to generate more applications, particularly from groups who belong to, or are already in contact with, the most vulnerable populations.



## UN Agencies and other international sources of support

UN agencies support the country AIDS response through the following means:

- FAO/WFP: HIV awareness-raising among farmers
- ILO: plantation, hotel and manufacturing sectors
- IOM: internal migrants and tsunami-affected communities
- UNDP: women leaders and positive networks
- UNFPA: young people
- UNICEF: life-skills training for young people, prevention of mother-to-child transmission (PMTCT) and paediatric AIDS
- UNHCR: IDPs and returning overseas workers
- UNODC: drug users, especially IDUs
- World Bank: funding of the NHAPP
- WHO: support to surveillance and VCT

A UN Technical Working Group, soon to be transformed into a Joint UN team, meets regularly and is functioning well. A joint UN Implementation and Support Plan (ISP) was developed for 2006, although the joint plan was made in the absence of an updated NSP. The next plan should be strongly linked to the 2007–2011 NSP.

Sri Lanka has received a grant from the Global Fund against AIDS, TB and Malaria (GFATM) and, for the purpose of monitoring ongoing grants for TB and malaria, a Country Coordination Mechanism (CCM) was established. The country has applied to the GFATM for a grant on HIV/AIDS and this will require an expansion of the scope of work of the CCM. The multiplicity of forums and coordinating groups on HIV may be confronted with issues of an overlap of roles and heavy demands on group members. A government-led national partnership forum has been proposed to include the donor community, multilateral and bilateral agencies, key sectors and NGOs. Securing good representation of different stakeholders on boards and coordinating groups should be balanced against the fatigue generated among members by an ever-expanding number of coordinating and advisory groups. Demands on members should be few to make the response more effective. A systematic analysis of the various coordinating forums should be carried out by UNAIDS in consultation with the NSACP and other stakeholders to determine their optimal number, roles, memberships, frequency of meetings and linkages.

### **Recommendations: Partnerships**

- Collaboration with the private commercial sector should be further expanded through joint project advocacy and planning between the NSACP and chambers of commerce.
- The engagement of private health-care providers in the nationwide response to HIV should be stimulated through such incentives as their participation in short courses.
- A determined effort should be made by the NSACP towards capacity building of NGOs and the revitalization of NGO coordinating mechanisms and partnerships.
- UNAIDS and its cosponsors should expand their technical support to the NSACP in the areas of planning, targeting and monitoring, and focus their technical and financial support on programme components for priority populations.
- UNAIDS should examine emerging needs and propose mechanisms best suited for effective coordination with a view to optimize participation of stakeholders in essential HIV-related coordinating boards and committees.

## **3.5 Financing**

The resources currently available to the NSACP either from national sources or multilateral and bilateral agencies seem sufficient to meet the current needs, given the prevailing implementation capacity. The resources that can be contributed by the private commercial sector, both operational and financial, could be further expanded if effective partnerships are established and sustained. The capacity of the NSACP to work with collaborating entities – NGOs and the private commercial sector – and create co-financing opportunities should be expanded through the creation of an NSACP unit specializing in this field.

The expected grants from the GFATM and services from the Clinton Foundation will alleviate some of the constraints to the procurement of ARV drugs, thus far procured at high cost at local market rates through World Bank funding. Complexities in procurement mechanisms imposed both by the government machinery and funders have constrained the timely implementation of programme activities.

The performance, financing and procurement of the NHAPP were reviewed in 2006. Last September, an Aide Memoire issued by the World Bank set out the most pressing issues facing the project and made recommendations to overcome some of the critical obstacles to project implementation. The review team took note of these recommendations and stressed the urgent need to implement them.

The World Bank funded the NHAPP with a US\$ 12.5 million grant over five years starting in March 2003. The Government is sharing costs with an additional US\$ 1.96 million. It remains the single largest source of financial support for STI/HIV prevention and care work in Sri Lanka. As of May 2006, US\$ 5.1 million of this grant had been disbursed.

Additional funding budgeted by UN agencies, affiliated and other funding agencies amounted to US\$ 3.3 million in 2005, in addition to technical support extended to the programme through their Colombo-based and regional staff (**Table 4**).

**Table 4.** Planned contributions to the nationwide response to HIV by source of funds (2005)

Agency/ Organization	Budgeted (in US\$)	Target group	Geographical or activity area
Government	292 000	NSACP	Staff salaries
FAO/WFP	9500	Ministry of Agriculture	
ILO	13 500 (Programme Acceleration Funds – UNAIDS)  91 000	Ministry of Labour, employers, employees	Plantation, hotel and manufacturing sectors
IOM	14 133 (Programme Acceleration Funds – UNAIDS)  9000	Internal migrants, tsunami-affected populations	
UNDP	26 000  13 000 (Regional centre)	Women leaders Members of Lanka+	North and east
UNFPA	204 500	Young people	
UNHCR	NA	IDPs, returnees	Eight districts in the north and north-east
UNICEF	239 000	Young people	
UNODC	50 000	Drug users	Five areas
World Bank	Approximately 13 million	Prevention, diagnosis and care	Islandwide
WHO	11 000	NSACP staff for surveillance and VCT	
Asia-Pacific Leadership Forum	150 000	Leadership	
<b>Total</b>	<b>US\$ 13.8 million</b>		

(Source: UNAIDS, *UN HIV/AIDS Strategy Note*, Colombo, Sri Lanka, internal document, 2006)

Government counterpart funding covers half of the operational costs, part of staff salary, 15% of local equipment/medical supplies/drugs, 25% of the costs of individual consultants and 20% of consulting firms, and 15% of subprojects. The total amount of government funds allocated to the NSACP in 2005 to cover operational costs and supplies as counterpart funding to international funds (mostly for the World Bank project) is estimated at US\$ 500 000. It was revealed that 87% of this government counterpart fund was spent by August 2006, compared with 39% of external grant funds.

The Finance Department assumed that the gap in the projected counterpart funds would be bridged from other internal sources. It informed the external review team that given the recent military conflict in the north-east and other places, and the current “financial crisis”, it is unlikely that the Government will substantially increase its allocation of domestic funds to STI and AIDS programmes in the near future, but it would be willing to seek additional World Bank funding when the currently funded project comes to an end in June 2008.

### **Recommendations: Financing**

- The terms and conditions set out in the World Bank/NHAPP Aide Memoires of March and September 2006 should receive the utmost attention of the MoH.
- Given that the funding of the NHAPP is due to come to an end in mid-2008, options for financial sustainability should be examined by the NSACP with the support of UN agencies as well as all other stakeholders. The 2007–2011 NSP and the corresponding plan of operations should serve as a basis for cost projection and resource mobilization from internal (governmental) sources and external funding agencies at the national and provincial levels.

## 4.1 Overall assessment and strategic focus

Previous assessments have highlighted the importance of saturating three populations at highest risk of STI/HIV with intensive prevention interventions. The review team found only isolated examples of interventions reaching such populations.

The NSP 2002–2006 articulated the following prevention priorities:

1. Promoting safe sexual behaviour and condom use through mass media awareness campaigns and social marketing;
2. Focused prevention through behaviour change among the most vulnerable populations, including FSWs and their clients, MSM and IDUs;
3. Prevention through behaviour change among other vulnerable populations, including IDPs, people in custodial settings, workers in free trade zones and other industries, persons seeking foreign employment, workers in the plantation sector, fishing community, beach boys and staff working in the tourist industry, taxi and three-wheeler drivers, police and military forces, adolescents and youth, children in and out of school, trade unions/societies and health-care workers;
4. Strengthening STI diagnosis and treatment;
5. Improving blood safety;
6. Preventing HIV in health-care settings; and
7. PMTCT.

This strategy has resulted in prevention activities that are widely scattered and has not yielded the scale or intensity required to produce sufficient behaviour change in key populations to effectively prevent the emergence of concentrated epidemics. Specifically, it is the review team's assessment that:

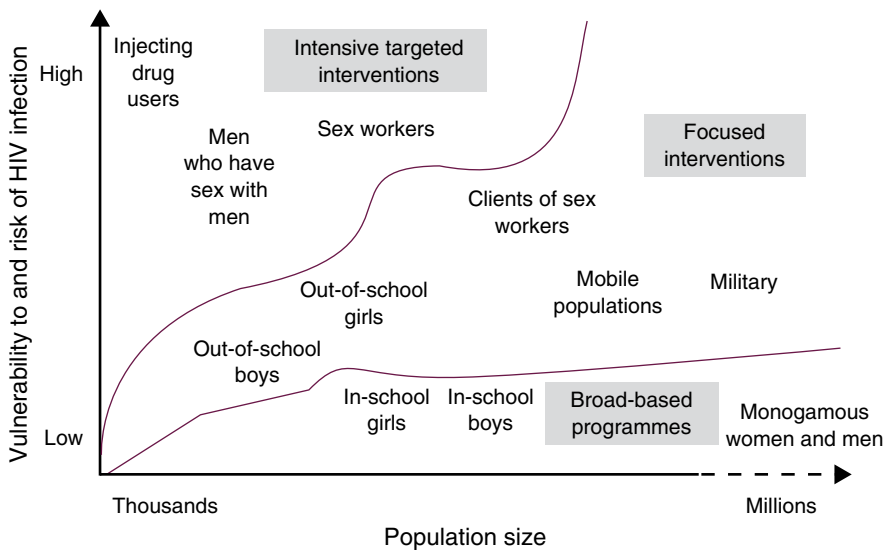
- Whereas targeted interventions for high-risk groups are clearly identified in the Strategic Plan as a prevention priority, coverage

of key populations (i.e. FSWs and MSM) with targeted prevention programmes has remained very low. Projects are scattered and without sufficient focus, and they lack adequate supportive supervision. Although there are no well-founded estimates of the size of these key populations, prevention programmes that have been supported by the NSACP or the NHAPP do not appear to have covered more than a few hundred FSWs, which would amount to less than 10%, even with a lower-end estimate, of the total FSW population in Sri Lanka. Currently, none of the prevention grants to NGOs from the NHAPP are focused on these high-risk groups.

- The emphasis on prevention programmes for “other vulnerable populations” such as industrial workers, transport workers, plantation sector workers and youth is overly broad and not based on substantive local evidence of HIV risk and vulnerability. This has led to an overemphasis on scattered activities that lack appropriate focus, scale and quality and are, therefore, unlikely to have much impact on the HIV epidemic.

The current strategic focus does not consider the relative size and vulnerability of different subpopulations (**Figure 2**). Based on the available information, it is the review team’s assessment that the highest priority should be given to scaling up intensive targeted interventions for those with greatest vulnerability. In Sri Lanka, the two key groups in this regard are sex workers and high-risk MSM.

**Figure 2.** Interventions appropriate to risk and size of population



## 4.2 Information to guide the response

Key information about important populations is lacking, as described above. Information gaps exist in the following areas: *mapping of key networks; information on the size/location of highest-risk populations; patterns of behaviour; and STI/HIV prevalence data.*

Information is specifically required in several key areas to support future strategic prevention priorities and guide the prevention response, including:

- *Size and location of the most vulnerable key populations:* Estimations of the size and location of the most vulnerable populations are critical for planning, implementing and monitoring targeted preventive interventions. However, to date, neither the NSACP nor the NHAPP has conducted a comprehensive mapping of FSWs, high-risk MSM or IDUs, and there are no concrete plans to do so. This is perhaps the most critical knowledge gap constraining the national response in Sri Lanka. The NHAPP had planned to obtain mapping data from NGOs implementing targeted interventions by including a mapping component within their contractual scope of work. However, as yet, none of these contracts have been awarded and, even though some NGO grants were disbursed, the subsequent mapping would have only focused on the local area of operation. Recently, a separate mapping and behavioural survey project has been initiated through a contract from the NHAPP, but the design of that project does not include comprehensive mapping, but rather a limited mapping in a few cities to develop a sample frame for the behavioural survey.
- *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 and do not appear to be representative. A new behavioural survey study commissioned by the NHAPP is currently under way and data from the first round should be available within the next few months. However, the sample frame for this study is not founded on a broad-based mapping exercise and, therefore, the sample might not be representative. There have also been a few studies of the knowledge, attitudes and practices (KAP) of various populations, but the data on sexual behaviours have not been consistent.
- *HIV and STI prevalence in different subpopulations:* Many rounds of HIV sentinel surveillance have been carried out over the past decade in different populations including FSWs, STD clinic attendees and TB patients. In this regard, Sri Lanka has ample evidence to show that the HIV prevalence has remained very low in all subpopulations. Data from government STD clinics suggest good control of curable

STIs (*see* STI section below), although there are little prevalence data from key high-risk populations.

### **Recommendations: Bridging information gaps**

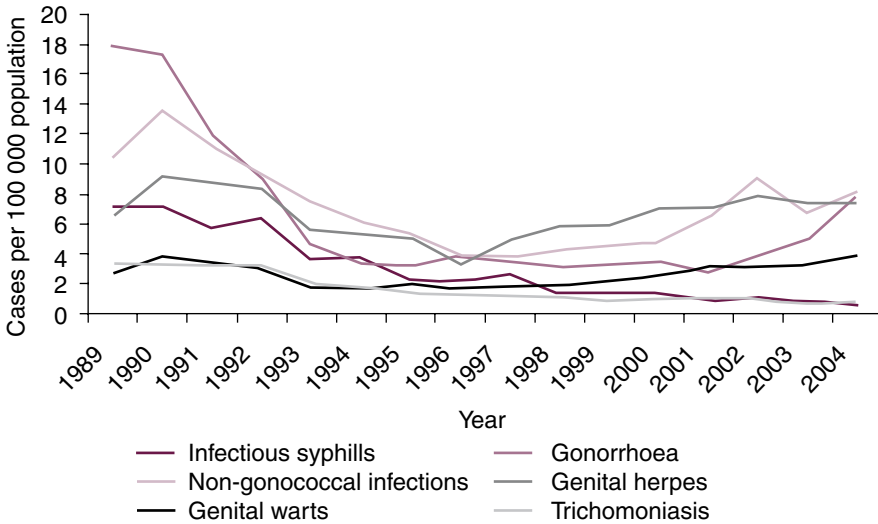
- More information on high-risk populations is needed to guide the local response. District and local mapping should be conducted and coverage targets set. The highest priority should be given to a comprehensive mapping of high-risk groups in each district, with the objective of identifying the size, location and general characteristics of FSWs, high-risk MSM and IDUs.
- Rapid behavioural surveys of these high-risk groups should be conducted based on representative samples. Key information should be gathered on the number and types of partners, types of sexual acts with partners and condom use. These surveys, along with other more detailed situation and needs assessments, should be carried out in the context of programmes providing prevention services to these groups and with utmost respect for privacy, non-discrimination and other human rights.
- District-level resource mapping and capacity assessments (government, NGOs, community groups), and role analysis should be undertaken using common assessment methods and tools.
- An information base on "medium"-risk groups should be gathered to identify target groups.

## **4.3 Services for sexually transmitted infections**

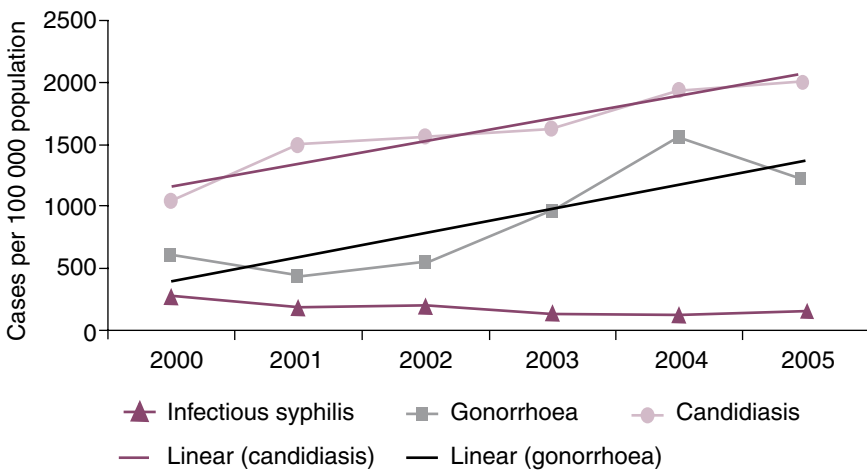
The reporting of STIs is largely dependent on the 26 STD clinics operating throughout the country. **Figures 3–5** show the trends in STIs reported in the country.



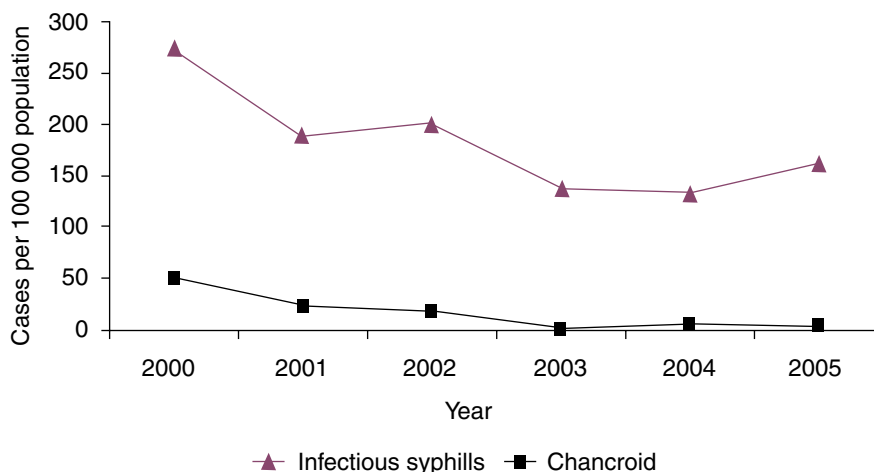
**Figure 3.** Declining STI incidence rates from the late 1980s to 2004. Subsequently, there is an apparent increase in incidence of several STIs. This could be due either to a real increase in STI transmission or to increased detection as a result of better awareness and health care-seeking behaviour. (STD clinic attendance increased during this period.)



**Figure 4.** Comparison of the incidence of gonorrhoea to that of candidiasis (which is a reproductive tract infection of relatively stable incidence). The increasing trends of both conditions are nearly identical, suggesting that the observed increases are due to increasing numbers of people attending clinics.



**Figure 5.** Large declines in two important STIs during the same period (2000–05). Ulcerative STIs such as chancroid and syphilis are potent cofactors that can amplify HIV transmission. Control of these infections reduces the likelihood that HIV will spread within high-risk populations.



Sri Lanka has a well-established network of STD clinics at provincial and district levels. These clinics include both specialist and non-specialist clinicians and public health staff – usually a PHI and a Public Health Nurse (PHN) who have both clinic and community outreach responsibilities.

Clinical services for STI are of high quality and well-organized. Clinics are well-equipped and have adequate supplies of condoms and essential medicines. However, there have been reports of reagents being out of stock in some laboratories.

STD clinic attendance is increasing, following improvements in infrastructure and recent activities to raise awareness of STIs and HIV within communities. NGOs working with sex workers or MSM reported good collaboration with the local STD clinic team. The NGO generally makes regular contact and organizes trainings while STD clinic staff conduct risk-reduction sessions and provide condoms and clinical services. The PHI and PHN provide important outreach work including STI contact tracing and visits to sex work venues. With their other responsibilities, however, they would 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 and conduct awareness and risk-reduction trainings for a range of groups, from intermediate- to low-risk.

These include military personnel (those passing through transit camps, peace keepers en route to overseas deployment), three-wheeler drivers, domestic workers en route to the Middle East, schoolchildren, teachers, community groups (e.g. funeral committee), etc.

STD clinic doctors also conduct professional seminars for doctors in private practice. These seminars are informational but the emphasis is on referring STI patients to STD clinics rather than promoting syndromic case management at the first point-of-care. As a result, it is likely that some patients do not get treated, given the distances to the STD clinic.

Consultant venereologists and MOs working in STD clinics are in a good position to manage the routine care of PLHA including routine ART follow-up visits.

### **Recommendations: STI and public health services**

- STD clinics, as the focal points for HIV prevention and STI control in districts, should be strengthened.
- Capacity building of PHI/PHN and NGOs would be needed to build skills for mapping, estimating population size and organizing peer outreach.
- Training of private providers in the district by STD clinic staff should continue but with the objective of building wider capacity. As more public and private sector providers share the load of routine visits, STD clinic staff would be able to spend more time on community work, HIV care and treatment, and referrals.
- Strengthening the capacity of STD clinic teams to support community outreach and prevention activities, in collaboration with NGOs, is essential. This may involve increasing the numbers of PHI/PHN and revising job descriptions.
- Professional training provided by STD clinic staff to other MOs and the private medical community should promote initial syndromic management. With only one STD clinic per district, it makes sense to strengthen STI management at the primary-care level (public and private sector) and reserve referrals for difficult cases.
- STI surveillance should be strengthened (as part of second-generation surveillance) to provide early warning of sexual transmission. STI prevalence surveys should be planned for high-risk populations.
- Consultant venereologists and MOs working in STD clinics should be incorporated into the system for routine care of PLHA including routine ART follow-up visits.

## 4.4 Current activities and future strategic priorities

*Targeted interventions for the most vulnerable populations:* Currently, there is very little being done to provide targeted prevention programmes and services for the most vulnerable populations, including FSWs, MSM and IDUs. Previously, some NGOs were conducting basic outreach and education, but those activities did not receive subsequent funding support. The work being done is unfocused, of low volume and without technical support or supervision. There are reportedly a few NGOs who continue to conduct outreach activities for FSWs, mostly around Colombo, but they lack resources and technical support. In 15 out of 26 government STD clinics, the MOs conduct some education programmes for FSWs and provide STI management, but this is on a small scale. Only a very small proportion of these FSWs regularly visit the STD clinics.

Over the past few years, there have also been scattered “awareness” programmes for MSM, mainly in three cities (Colombo, Kandy and Anuradhapura). In earlier years, most of these programmes were conducted by three NGOs that worked with MSM. In 2005, the STD clinic also conducted an awareness programme for MSM in one city, and the STD clinic MOs often

### **Box 2.** Information, education and communication versus behaviour change communication

#### Changing behaviour

The concept of information, education, communication (IEC) has been reduced in practice to the development of a variety of information-based materials (that may or may not be research-based), which are generally used in a one-way communication process (for instance, lectures, presentations, self-reading material, posters on walls, television and radio announcements). IEC materials are effective vehicles for transmission of information, and their impact can be measured by an increase in knowledge of the specific content. This can include, for example, knowledge of the availability of services.

Behaviour change communication (BCC) is a process with specifically defined behavioural outcomes that links the participatory processes of learning (information), development of skills required to make informed decisions and practise the behaviour and, for many desired behavioural outcomes, ensures access to services and commodities. BCC approaches also work to ensure an environment that supports the adoption of or change in the specific behaviour/s, including the legal, policy and psychological accessibility to the necessary services. While virtually impossible to attribute behavioural change or adoption solely to the impact of one or more BCC interventions, it is important to measure changes in the defined behaviour.

An important feature of behaviour change approaches and interventions is their strong reliance on individual and community participation.

served as resources for NGO awareness programmes. The overall coverage, in absolute or relative terms, is not known.

Over the past several years, a number of NGOs and several other organizations have been conducting HIV awareness and education programmes for drug users. Among these organizations is the National Dangerous Drug Control Board (NDDCB). The nature of these programmes is not clear, but they do not appear to be well structured and do not include outreach services.

There appear to be at least two important reasons for the lack of progress in scaling up targeted intervention programmes. First, there appear to be few NGOs with the capacity and inclination to undertake such programmes. Only three out of 23 NGOs applying to the NHAPP for focused prevention grants proposed to work with FSWs, and none of them was found to be technically sound enough. The second reason for the lack of progress appears to be the process for awarding NGO contracts. Unless proactive steps are taken to identify potential NGOs, build their capacity and then develop a suitable contract with them, it is difficult to envisage how to break this gridlock. There have been some suggestions that these interventions with high-risk groups would be best implemented through STD clinics, but it seems unlikely that they could do this work without the strong support of an NGO to mobilize the community, conduct peer outreach and education, and provide referrals to clinical care.

*Prevention programmes for other populations:* Numerous general awareness and education programmes have been organized for different subpopulations including beach boys, factory workers, plantation workers, schoolchildren and three-wheeler drivers. Most of these have been conducted by NGOs, many with funding from the NHAPP. Some sectoral initiatives financed by the NHAPP also cover youth, factory workers, uniformed men and foreign employment workers. Overall, coverage of the target populations is very low, and there does not appear to be any focus on risk. In most cases, the MOs-STI are used as resource persons for these awareness programmes. STD clinics also supply condoms in a number of settings. There have been relatively substantial efforts to provide HIV education to prison inmates across the country. One NGO has apparently conducted awareness programmes in 15 prisons, and inmates have received some form of awareness programme from local NGOs supported by local STD clinic MOs. The NHAPP is also financing prevention activities through the Prisons Department.

The review team observed that most prevention programmes focused on general IEC, with a concomitant lack of focus on effective BCC. This lack of focus was particularly seen in the many programmes directed at populations such as schoolchildren, factory workers, military and other occupational groups.

## Recommendations: Strategic priorities

1. In each district, the highest priority for HIV prevention is to start interventions with sex workers. Initial steps include (i) district mapping to identify sites of sex work and estimate numbers and types of sex workers, and (ii) simultaneous development of peer outreach as part of an “essential service package” for sex workers, which includes provision of clinical services for STIs and promotion of condom use. Engagement and mobilization of local sex worker groups should be a key ingredient of this intervention.
2. Partnerships between STD clinic teams and NGOs should be developed at the district level. STD clinic teams should be strengthened and reoriented to have a stronger public health role in the prevention and control of STIs and HIV. Interventions with sex workers should be demystified – mapping and peer support activities can be carried out by NGOs without previous experience if there is capacity building and coordination by the STD clinic team (PHI/PHN/MO-STI).
3. A capacity-building mechanism to support the above activities should be developed at the central and provincial levels. Key areas that require technical support are mapping methodology and peer outreach, and would involve both NGOs and STD clinic staff (PHI/PHN/MO-STI).
4. Local advocacy should be conducted with district and provincial leaders, and the police to explain the public health importance of interventions and build an enabling environment for prevention activities.

*Prevention for drug users:* There are four drug treatment centres run by the NDDCB in different parts of the island. Services are exclusively engaged in detoxification (Detox) with 14-, 21- and 30-day programmes, all free of charge. Room and board are provided, as is counselling. Detox is usually unassisted although diazepam is available, if needed. According to drug users, detox is mild and lasts only two to three days because of the low potency of the drug and low-level addiction of non-IDUs. Attendance is both voluntary and court-imposed, and reportedly seasonal with low periods around holidays.

The drug treatment centre conducts regular outreach in “shanty” areas where drug use is common. Objectives of outreach are to promote residential programmes but also to provide education on bloodborne transmission and facilitate non-residential detox (involving local medical practitioners in the community). Through this outreach, the centre has current information on drug prices and drug-taking patterns. Outreach workers are reportedly in contact with 57 FSWs who are also drug users.

The NDDCB has a strong system of disaggregated data collection which can form the basis for an “early warning” system in relation to shifts in drug-use patterns and movement from smoking of heroin to injecting.

## Recommendations: Drug users

- Outreach and prevention programmes and services should be initiated in all locations where significant social networks of drug users exist. These programmes should focus on sexual risk reduction and education regarding the health risks associated with drug injecting.
- An active programme of monitoring drug-use patterns should be integrated with outreach activities, with a particular emphasis on rapidly identifying any shift towards drug injecting.
- The national programme and the NDDCB should interact with authorities and programme managers in neighbouring countries that have witnessed a significant shift to injecting (the Maldives, for example) to better understand the social context and patterns of this shift.

*Prevention programmes for prison inmates:* The main prison complex in Colombo was designed for 1500 but currently holds 4500 inmates, including 600 women. There are about 7500 prisoners in total in Colombo and 27 000 nationwide. About 15 000 are in remand custody, reflecting long backlogs in trying cases. About 40% of prisoners are being held for drug-related offenses. This percentage is higher among women. About 25% of women are being held on prostitution-related charges, most for only a short time until bail can be arranged.

Despite overcrowding, the central prison in Colombo visited by the review team has well-organized facilities with a range of recreational and income-generating activities for inmates. There are places of worship for four major religions. Female prisoners with infants are accommodated in a special unit and there is a pre-school for children under five years of age.

Clinic services are comprehensive and large scale with 16 doctors and 14 nurses. TB patients are kept in a closed ward for six months for treatment. Laboratory services are being set up to enable screening and diagnostic testing on site. STI data on prisoners, collected in a previous screening, are kept by the Central STD clinic.

There was no evidence of systematic HIV testing in the prisons. The prison commissioner reported that only three HIV-positive inmates have been identified, two of them foreigners who were extradited.

All staff openly acknowledge that sexual activity occurs in the prison but injecting drug use is not reported to take place. A prisoner estimated that 75% of inmates have some form of same-sex contact. Condoms are not available, however, although prison officials are looking for ways of doing this without appearing to condone homosexuality. Condoms are distributed to prisoners who go on family leave every six months, depending on good behaviour.

Training activities for both inmates and staff include educational sessions on STIs and HIV. Some peer education work is supported.

### **Recommendations: Prevention among other vulnerable groups**

- Prevention programmes for other vulnerable populations should be targeted, based on a local assessment of transmission dynamics, to ensure that these activities cover known bridge populations. Broad-based programmes for occupational groups should be avoided unless there is good local evidence that a high proportion of those groups are part of high-risk networks, usually as clients or sexual partners of FSWs or high-risk MSM.
- Risk-reduction interventions should increasingly focus on clearly identified bridge populations such as military personnel, three-wheeler drivers, transport workers, internal migrants, with priorities guided by local data on sexual behaviours and networks. The highest priority should be given to groups that are frequently clients or sexual partners of sex workers and high-risk MSM.
- Focused interventions should support behaviour change (condom use, STI symptom recognition, early health care-seeking behaviour, etc.) beyond simple awareness (see Box 2). Peer-support activities should be developed together with NGOs, STD clinic staff and target populations.
- Education and awareness programmes for the general population should focus more on reducing stigma and discrimination against PLHA and members of highly vulnerable groups. In this regard, specified programmes should be conducted with police and other groups to produce an enabling environment for targeted interventions among FSWs, MSM and IDUs.
- Foreign employment – The excellent initiative of the Sri Lanka Foreign Employment Bureau (SLFEB) should continue. Introducing pilot workshops on family and community reintegration for returnees, including routine offer of STI and HIV testing, should be considered.
- Efforts to make condoms easily available within prisons should be supported. Dispensers or simple open containers could be made available in medical stations to start with, for use mostly by those going on leave but not restricted to them alone.
- The feasibility of initiating a peer-leadership programme for prison inmates, particularly those who are drug users, should be looked into. These peer leaders could then provide HIV prevention education for drug-user networks upon release.
- Improvement in clinical and counselling services in prisons should be supported by the NSACP.



## 4.5 Prevention activities among young people

Adolescents (10–19 years of age) account for 3.7 million (19.7%) of the Sri Lankan population (Department of Census and Statistics, 2002). Sri Lanka has the highest educational enrolment rates in South Asia: over 98% on average. The completion rates in the 2003/04 school year were primary education, 98%, and secondary school, 84%. Around 18% of children fail to complete grade nine schooling, the majority of them coming from conflict-affected areas, tea estates, or from very poor communities. While there is good access to education data, there are concerns about the quality of education. The Ministry of Education is taking action to change the curricula and the teaching–learning approach by introducing more participatory, interactive, life skills-based approaches.

A national survey on emerging issues of adolescents in Sri Lanka was undertaken in 2004. The survey consisted of two main components. The first component was carried out among 29 911 school-going adolescents representing 25 administrative districts of Sri Lanka. The second component was carried out among 10 079 out-of-school adolescents (mean age of 17.6 years) representing five sectors, namely Colombo Metro, Other Urban, Rural, Estate and the North-East. The survey found that knowledge on HIV/AIDS and STIs among adolescents in school was poor: 59% were aware of HIV/AIDS and the percentage of adolescents who were aware of how to prevent HIV transmission did not reach above 50% in any district. The knowledge level among out-of-school adolescents was significantly higher than of those in school.

A limited proportion of adolescents in school admitted that they were sexually active. Of those aged between 14 and 19 years, 6% indicated they had had heterosexual intercourse; with a large gender difference (14% of males and 2% of females). The mean age at first sexual intercourse was 15.3 years among males and 14.4 years among females. Eleven per cent of respondents had their first sexual intercourse with a commercial sex worker (CSW); and the proportion who reported using condoms during their last sexual intercourse was 17%. Over 18% of males reported homosexual relations; however, the scope of the questionnaire did not allow for information on the type of relationship.

While the survey looked at a cohort of out-of-school adolescents and indicated some high-risk behaviours, there has not been any follow up with more detailed mapping and behavioural surveillance of these most-at-risk adolescents. With 28% of 15–19-year-olds officially unemployed, coupled with issues of internal displacement due to conflict, monitoring of the behaviours of adolescents and youth in relation to HIV risk and vulnerability must be ongoing.

Different government and parastatal agencies that work with adolescents and youth have undertaken significant HIV awareness work through extracurricular activities in schools. Among the agencies are the National Youth Services Council (with 171 106 members in 4994 clubs), the Plantation Human Development Fund

and many NGOs. The focus of the work has been on general awareness-raising among adolescents and young people at the district level. Led by the MO-STI, the campaign uses skills-based approaches and peer leaders.

The review found that education administrators and teachers were reluctant to deal with issues of sex, sexual health and gender in the classroom, despite the subjects being included in the syllabus. MOs were regularly asked to give lessons/lectures to students. The Ministry of Education has taken the important decision to move away from donor-dependent extracurricular initiatives to include sexual and reproductive health (SRH), HIV/AIDS and STIs into the process of secondary school curricula review. The current curriculum revision process follows a competency-based approach and will integrate life skills into all subjects (two skills for each subject). The challenge of overcoming the knowledge gaps and increasing the confidence of teachers during in-service and pre-service training in the new teaching–learning methods will be critical. Until recently, the extensive HIV/AIDS awareness work has not been based on information regarding the risks and vulnerabilities of adolescents, including HIV and AIDS. Apart from the curriculum revision of the Ministry of Education, the results of the 2004 survey (above) published in 2005 indicated a clear need for a skills-based approach to reducing risk and enhancing protective factors linked to specific behavioural outcomes.

The review team found that the ongoing projects targeting vulnerable children through the development of drop-in centres was not reaching those most at risk or most vulnerable. Children attending the centres tended to be from poor families or those that could not provide after-school care, but the children who were deprived of parental care or living on the streets were not accessing these centres.

### **Recommendations: Prevention among young people**

- Ensuring accelerated in-service and pre-service teacher training is necessary to increase the capacity and confidence of teachers to undertake skills-based learning approaches on such topics as SRH, HIV and STIs. The Ministry of Education with support from the MoH should identify and train one or two teachers in each secondary school to become subject matter experts on SRH, HIV and STIs.
- Reinforcement should be undertaken through the development of age-specific, user-friendly supplementary reading materials. Specific sessions should be organized for young people after they leave school.
- Integration of information on HIV and core skills, along with SRH, into professional training programmes and tertiary-level education for young people should be considered.
- Integration of HIV prevention packages into existing outreach child-protection interventions of NGOs, with focus on children living on the street, should be supported.

## 4.6 Condom promotion

Condoms are distributed through three main channels in Sri Lanka. The NSACP distributes condoms through government STD clinics, NGOs, the armed forces and various other provincial and community programmes. In 2005, approximately 785 000 condoms were distributed by the NSACP, with approximately 52% going to the armed forces, 20% to STD clinics and another 14% to NGO programmes. The Government's Family Health Bureau distributed just over five million condoms in 2005. This condom supply is intended for the family planning programme with distribution through 27 regional medical supply divisions to the field through public health staff and family planning clinics. The only substantial social marketing of condoms is done by the Family Planning Association. In 2005, they distributed almost 7.9 million condoms, mostly through sales in pharmacies and other shops. Overall, there has been an increase of approximately 19% in the distribution of condoms through these three organizations. In 2000, the total distribution was 11.5 million and in 2005 it was 13.7 million. Priced condoms from other manufacturers are also available in the marketplace.

The review team noted that the Government has resisted the promotion of condoms through mass and mid-media campaigns, due to concerns about public sensitivities. Therefore, although such awareness campaigns have been proposed, as yet none has been carried out.

### **Recommendations: Condom programmes**

- Condom programmes should be introduced through social marketing and structured interventions (100% condom programmes for specific vulnerable groups) should be strengthened, where possible.
- Seeking high-level political support for this agenda through the development and implementation of an advocacy strategy is necessary. This would enable local action with the police, hotel management, etc. to support condom use in highest-risk settings.
- Organizations working with the most vulnerable groups should specifically determine if condom supplies are adequate and, if not, develop targeted strategies to ensure there is a sufficient supply and appropriate distribution system.
- Identifying innovative ways to address the cultural and religious sensitivities in condom promotion is recommended.

## 4.7 Prevention of mother-to-child transmission of HIV

With the strongest health system in South Asia, Sri Lanka has very high antenatal care (ANC) coverage, a strong infrastructure of public health midwives in every community and highly committed staff.

In Sri Lanka, the male-to-female ratio of reported HIV-positive persons is 1.4:1, and the proportion of women reported infected in 2002–2005 was 47%. This is primarily attributed to increased testing of women, particularly as a pre-employment requirement for overseas work in many countries. A total of 24 paediatric HIV cases have been diagnosed in Sri Lanka.

Sri Lanka has adopted the comprehensive four-pronged PMTCT strategy, which includes primary prevention for women of childbearing age, prevention of unwanted pregnancy among HIV-infected women, interventions to reduce MTCT, and provision of care and support to HIV-infected women, their children and family members.

Comprehensive PMTCT was piloted at Gampaha and Kandy districts in 2004–2006. After counselling, over 90% of the pregnant women who attended the hospital and health centres in these districts agreed to an HIV test (through an opt-out approach). Of the 3232 tested, all were HIV-negative. A follow-up pilot in another district is soon to commence using an opt-out approach to testing.

Little or no information is provided to pregnant women on HIV, and MTCT in particular, at ANC clinics. The review found very limited knowledge of nurse midwives and all MOs working in maternal and child health (MCH) on HIV, MTCT and risk factors.

Sri Lanka has developed PMTCT protocols, guidelines and has registered paediatric ARV drugs (syrups) and regimens in place. A PMTCT working group has been established and is functioning. A senior venereologist has been appointed as PMTCT Coordinator in the national programme and will be the focal person to carry out all coordination and integration efforts under the management of the NSACP.

With a very low HIV prevalence, it is not recommended to test every pregnant woman in Sri Lanka. The focus should be on non-test dependent primary prevention, and a comprehensive PMTCT approach, which would be available only at specific referral hospitals. However, PMTCT offers a unique opportunity to provide women with HIV prevention information and services.

The primary prevention approach should look at stronger integration into ANC, STD clinics and family planning systems at all levels. In ANC settings, there is underutilization of midwives for ANC visits (limited generally to recording/paperwork) and overreliance on doctors. Midwives or the MO-ANC should use the contact with pregnant women for raising awareness of

MTCT and identifying risk factors. An opt-in approach for VCT for those with agreed/defined risk factors should then be adopted. Women identified to be HIV-positive should be referred to one or two hospitals in the country with vertical transmission PMTCT services and trained staff.

The feasibility of providing PMTCT or site assessment must be carried out to identify facilities for comprehensive PMTCT. The selected site/s (in a phased manner) should preferably be *tertiary* or *referral hospitals* with all specialties, upgraded laboratory facilities and capacity to provide ART for those who need it, plus paediatric care. Selected facilities need to be strategically located, i.e. within the reach of people with high-risk behaviours and the ability to provide outreach services.

There is a need to develop comprehensive clinical PMTCT training curricula/modules along with non-clinical modules, HIV counselling manuals and tools, plus training programmes for ANC and family planning staff.

### **Recommendations: Prevention of mother-to-child transmission**

- An updated PMTCT strategy and operational plan should be developed based on pilots and focusing on primary prevention integrated into ANC, MCH and family planning services.
- Building on the strength of community reach by PHNs and midwives, non-test dependent primary prevention should be established in all ANC and family planning settings. This means building stronger linkages with the Family Health Bureau and MCH services so that in all ANC clinic visits the potential risk of HIV exposure for pregnant women is identified, the essential elements of counselling offered and HIV testing performed by an opt-in approach to testing after providing pre-test informed consent.
- A small number of vertical transmission interventions in tertiary facilities should be established in a phased manner using a whole-site training approach. These would be located at the same facility as ART centres.
- Contacts and referrals should be developed with NGOs working with sex workers and private clinics offering STI services.

## **4.8 How the work is being done**

Generally, there is little focus and local-level coordination of prevention activities. The three main approaches are:

- *Specified programmes funded by the NHAPP (through annual workplans):* The NHAPP funds general education and awareness programmes, mostly directed at various occupational groups such

as garment factory workers, military personnel, three-wheeler drivers and fisher people. These activities are carried out through central line ministries, provincial- and district-level STD clinics and public health staff, with support from NGOs in some regions. They also include blood safety and TB control activities.

- *NGO projects funded by the NHAPP:* The NHAPP funds a number of NGOs in various regions of the country to conduct basic outreach and education programmes. There is a potential to build on a strong network of health services with a public health focus.
- *NGO and government sector projects funded by external donors or directly implemented by international NGOs:* The majority of this work is information- and communication-based and often not coordinated with the NSACP or district HIV committee.
- *STD clinic and public health staff:* The MOs-STI conduct outreach and education for a number of groups, ranging from schoolchildren to prison inmates to sex workers. Much of this appears to be ad hoc, often based on requests for lectures on STIs and HIV. In some areas, this work is coordinated with local NGOs (both with and without NHAPP funding), but it appears that close coordination with local NGOs is not very common.

In addition to these activities, some line ministries are instituting prevention programmes, often drawing upon local MOs-STI as resource persons. For example, the Labour Ministry has instructed Divisional Managers to initiate HIV awareness programmes.

An important deficit in the national response is a severe lack of national funding for NGO-led targeted preventive interventions for the most vulnerable populations: FSWs, high-risk MSM and drug users. Although this activity was meant to be a cornerstone of the NHAPP, after three years not a single NGO contract has been awarded for these targeted interventions. The main reasons cited by the NHAPP and NSACP for the lack of such funded programmes is a lack of qualified bids from NGOs, and unrealistic budget proposals from those NGOs who have applied for these programmes.

In an attempt to jump-start project implementation, in 2004 the NSACP and the NHAPP launched the “Rapid Results Initiative” (RRI). The concept was to have intensive local prevention activities initiated in a number of locations which would generate capacity, leadership and momentum that could be scaled up. To date, three phases of the RRI programme have been completed, with only a small number of these initiatives focusing on the most vulnerable populations (one FSW RRI in Phase 1, one FSW and one MSM RRI in Phase 2 and no programmes for FSWs or MSM in Phase 3). In the few places where they were implemented, these RRI programmes could provide a starting point

for a scaled-up targeted intervention, but this has not occurred and the future of the RRI programme is unclear.

### **Recommendations: Prevention in the general population**

- Awareness to ensure complete and accurate knowledge of HIV among the general public should continue but not at the expense of priority actions for comprehensive prevention for high-risk and highly vulnerable populations. The quality of knowledge provided needs to be assessed and a quality assurance mechanism introduced and monitored.
- Broad-based programmes for occupational groups and for those undergoing professional training or higher education should be integrated (programmatically and financially) into existing workplace and training activities rather than as stand-alone activities of the national HIV programme.
- Strategic communication plans for change agents, trusted communicators and media leaders should be developed and implemented (including for advocacy activities).
- Communication initiatives for general awareness should focus more on promoting services and reducing discrimination.

## **4.9 Capacity**

The review team found that the overall capacity of key institutions and organizations to develop a strategic and effective response was mixed. In general, the level of training of key personnel in the basics of HIV and AIDS was high. Key areas where more capacity building is required include:

*Strategic planning:* A stronger emphasis on strategic planning is required to focus the programme on those activities that are most important for interrupting transmission. The overall lack of focus of the programme at the national, provincial and district levels suggests that capacity building is required at all levels to ensure that policy-makers and programme managers are able to acquire and utilize SI to set priorities and measure results.

*Programme management:* Much of the programme leadership is in the hands of medical doctors, many of whom have public health training. However, there is an overall lack of programme management expertise within this group, and little reliance on experts in programme management to help ensure efficient and effective programme functioning. The lack of programme management capacity is also seen at the provincial and district levels where consultant venereologists and MOs-STI have broad responsibilities in programme planning, delivery and monitoring.

*NGO capacity:* There are few NGOs working in the HIV sector, and the review team was, therefore, unable to make a clear assessment of their capacity

to implement programmes. However, there is a general lack of experience among NGOs, and only one clearly identified effort has been made to raise capacity by training peer educators. Therefore, the review team's assessment is that NGOs will need significant capacity building to enable them to be effective implementers of targeted interventions for vulnerable populations.

*SI and M&E:* A plan is needed for building capacity to conduct most-at-risk group mapping, population size estimation, epidemic projection, data triangulation and utilization, and costing for SI and M&E staff at the central and provincial levels. A training of trainers (ToT) programme for the central training team and regional support team might be considered and conducted in the future.

### **Recommendations: Implementation roles, partnerships and support**

- Local partnerships should be urgently promoted to advance this work. STD clinics as the focal points for HIV prevention and STI control in districts should be strengthened (*see below*). NGOs should be encouraged to work with highest-risk populations including sex workers, MSM and IDU in collaboration with local STD clinic and public health staff.
- Public health staff should work with local NGOs and community groups to develop regular community outreach to vulnerable groups to promote access to and utilization of public health services.
- The NSACP, in particular STD clinic teams (clinicians and public health staff), should provide training and educational support to NGOs and peer educators to improve their knowledge and skills as they reach out to vulnerable populations (sex workers, MSM and drug users). Teaching aids for training/awareness sessions and reference materials for trainees should be developed.
- Local STD clinic and public health staff should work closely with local NGOs and community-based organizations (CBOs) to provide education and sensitization programmes for local police officers to create a more enabling environment for programmes and services for sex workers, MSM and drug users.
- The NSACP and NHAPP should establish a regional supportive supervision system to support the scaling up of HIV prevention programmes at the provincial and district levels. This could include the MOs-STI, but should also include appropriate programme support for implementing targeted interventions.
- A robust process for monitoring these targeted interventions should be instituted, with a specific emphasis on measuring outreach coverage of the key populations and service utilization.
- Where effective RRI activities have taken place, local scaling up should be encouraged based on district-level plans for increasing the coverage of vulnerable key populations.



## 5.1 Blood safety

All blood donations are non-remunerative but replacement donations are substantial. In Colombo, replacement donations account for 8% and the national figure is 37%. Over the years, there has been a declining trend in the percentage of replacement donations while the total number of donations per year has increased from around 154 000 units in 2001 to 207 000 units in 2005. Those who come in as replacement donors are turned back in many instances after they are counselled about voluntary donation. Blood donation collectors are used to recruit voluntary donors.

All blood units collected are screened for HIV, syphilis and hepatitis B. Hepatitis C testing is performed in Colombo, with plans for islandwide expansion from January 2007. Blood is also tested for malaria, but there are often delays. HIV testing is done using enzyme-linked immunosorbent assay (ELISA). Blood units that test positive are destroyed and a sample sent to the central STI laboratory for confirmation. If confirmed, the donors are contacted by the Central STD clinic for follow up. The central blood bank and larger regional blood banks participate in an external quality assurance programme run by the National Reference Laboratory in Melbourne.

The blood bank has printed two books – *Guidelines for clinical use of blood* and *Handbook of blood transfusion practice for nurses* – to improve rational use of blood in hospitals.

Good progress has been made towards achieving 100% voluntary donations. It appears that some doctors and nurses outside the transfusion service are not aware of this policy of voluntary donations. Smaller blood banks do not participate in the external quality assurance programme but this problem is expected to be resolved after testing is “centralized” in Colombo and five other regional blood banks.

### **Recommendations: Blood safety**

- Efforts to increase voluntary blood donations should continue until the target of 100% is achieved. Doctors and nurses working outside the transfusion service should continue to be educated on avoidance of replacement donations. Where voluntary blood donation is low, blood banks should be encouraged to have specific blood donation drives and camps to increase voluntary blood donation.

## **5.2 Prevention of HIV transmission in health-care settings**

HIV infection control has received particular attention in recent years. Most large 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. Significant shortages exist in the supply of sharps containers and goggles. Sharps containers are distributed by specific programmes for use by their programme staff, but there was evidence in a base hospital that these containers are not always shared when shortages exist in other programmes.

A circular entitled “Management of health-care worker exposures to HIV and recommendations for post-exposure prophylaxis” was issued in 2001 based on the recommendations of the Centers for Disease Control (CDC), USA. This includes guidance on the management of needle-stick injuries. In facilities with infection control staff there is awareness of the need to contact the infection control team whenever a needle-stick injury has occurred, but underreporting is still the norm. Delays were also reported with up to two days between the incident and availability of the HIV test result of the source patient. The review team received reports that source patients are often tested without their knowledge. Forms on which needle-stick injuries are reported are forwarded to the NSACP for data entry and analysis. Staff from major hospitals in Colombo have received some training regarding post-exposure prophylaxis (PEP) and awareness in these facilities is adequate. ARV for the purposes of PEP have been procured, but are not yet available in many hospitals due to difficulties with distribution. Once distributed, drugs are replenished regularly from the stock at the Central STD clinic.

These efforts are, however, not grounded in adequate understanding and use of standard precautions. No national policy or protocol on standard precautions exists and extra precautions are often taken with people known or suspected to be living with HIV such as the use of double gloves. These modifications of normal practice have been shown in other countries to be associated with an increase in potential HIV exposure.

Unnecessary routine screening before medical procedures still occurs in some hospitals. Similarly, some unnecessary infection control procedures are still in existence. These procedures include immediate notification of the hospital administration if a person with HIV is admitted, burning of linen, fumigation of operating rooms and strict adherence to instructions (indicated in the national *Guidelines for the disposal of dead bodies of persons with HIV/AIDS* issued in 2000); the Director of the NSACP should be notified of all deaths of people with HIV and that “the body should be cremated/buried preferably within 24 hours (cremation is strongly recommended)”.

These policies and procedures are likely to contribute to the fear associated with the relatively rare occasions that a person with HIV is diagnosed in hospital, admitted or undergoes surgery. Most informants felt that the situation had improved in recent years, but there were still reports of health staff or facilities trying to avoid providing care to PLHA.

There have been significant improvements in awareness, procedures and supplies to prevent transmission of HIV in health-care settings in recent years. Current practice is not, unfortunately, sufficiently evidence-based; it is strongly influenced by high levels of fear. In short, the use of standard precautions and needle-stick injury protocols is inadequate and unnecessary infection control procedures persist.

### **Recommendations: Prevention of HIV transmission in health-care settings**

- Strong policy leadership is needed from senior levels of the MoH regarding the use of standard precautions and cessation of unnecessary infection control procedures. Implementation of this policy needs to be led by local champions who can promote and be used as models for practising standard precautions, and care for people with HIV without fear. Strengthening support and training for infection control nurses is a key factor for improving HIV infection control practices.
- The use of needle-stick injury protocols should be improved with emphasis on HIV testing of source patients with pre- and post-test counselling, rapid processing of blood specimens for HIV testing of the source patient and development of rapid referral procedures for PEP at the nearest available site. The supply of infection control commodities, particularly sharps containers, should be improved using either a health sectorwide distribution programme or a sharing arrangement between programmes at service delivery level. The use of standard precautions and needle-stick injury protocols, and availability of essential commodities should be monitored.

### 5.3 HIV counselling and testing

During the twenty years since the first person was diagnosed with HIV in Sri Lanka, HIV testing capacity has gradually expanded to approximately one public health site per district.

In 2005, HIV tests were reported on 266 786 specimens of which 76% were from blood banks, 14% were from STD clinics and 10% were from private laboratories. Of these, 129 (0.05%) were confirmed to be HIV-positive. More detailed data regarding national HIV testing were not available. In the same year, the National STD Reference Laboratory performed HIV testing on 36 113 samples. This included 13 838 from hospitals and clinics, of which 134 (0.97%) screened positive and 94 (0.68%) were confirmed positive using western blot. In addition, 110 tests were performed for foreign employment or education, none of which were confirmed positive. Unlinked HIV testing was performed on 14 476 antenatal specimens sent for Venereal Diseases Research Laboratory (VDRL) testing with no confirmed positive results. Testing of 7443 samples for the purposes of sentinel surveillance gave negative results. Of 163 specimens sent for confirmation from blood banks only 5 (3.05%) were confirmed positive, and of 192 specimens sent from private laboratories, 39 (20.31%) were confirmed positive.

HIV counselling training began in 1993 with a five-day preventive and supportive counselling workshop. HIV pre- and post-test counselling training began in 2000 using a five-day workshop. Recently, most counselling training has been delivered in a two-day comprehensive care and treatment training workshop. The workshop includes a module on HIV pre- and post-test counselling and has been delivered to 970 health-care workers based at the NSACP and major hospitals in and around Colombo. No specific counselling refresher training programme has been established. National counselling guidelines were developed in 2003. A senior venereologist has been appointed as the Counselling Coordinator in the national programme to carry out all coordination and integration efforts under the management of the NSACP.

HIV pre- and post-test counselling is provided predominantly by doctors at STD clinics. HIV counselling and testing is offered to first attendees at STD clinics, the small number of self-referred people for HIV testing, as part of pre-overseas employment programmes and for the diagnosis of HIV in hospital inpatients. HIV testing in health-care facilities commonly occurs without the knowledge of the patient, for example, following needle-stick injuries. In situations where this test is positive, the patient then receives pre-test counselling for a repeat HIV test. For patients confirmed to have HIV infection, there is a strong awareness of the need to refer to the Central STD clinic for assessment and follow up.

The involvement of NGOs in the provision of HIV counselling and testing has been limited to a few organizations offering pre- and post-test counselling. In contrast, many private health facilities offer HIV testing. An attempt to establish HIV pre- and post-test counselling for factory workers in Colombo failed due to poor demand. Routine testing is reported to occur without consent as part of medical assessments for health insurance. Routine testing also occurs for workers prior to departure to some, but not all, countries in the Middle East and in the armed forces before and after overseas deployment.

A clear national HIV testing algorithm exists consistent with international norms and based on ELISA and particle agglutination tests. There is a clear understanding and procedures in place to send indeterminate samples to the National STD Reference Laboratory for confirmatory testing by western blot. Peripheral laboratories without ELISA perform a single particle agglutination test and, if positive, send the sample to the National STD Reference Laboratory for further testing. The National STD Reference Laboratory is the sole laboratory able to perform HIV diagnostic tests on infants. Currently, p24 antigen and HIV RNA polymerase chain reaction (PCR) tests are available and DNA PCR kits have been ordered.

Of the 26 peripheral public laboratories offering HIV testing, 12 perform testing on site, seven send samples to the National STD Reference Laboratory and seven send to another STI or hospital laboratory. The national HIV testing quality assurance programme is administered by the National STD Reference Laboratory and includes nine STD clinic laboratories, nine blood banks and three hospital laboratories. The four STD clinic laboratories in the north-east which perform HIV testing on site do not participate in the quality assurance programme. Since the quality assurance programme began in 2004, six rounds have been performed with 14–19 laboratories participating in each round. One laboratory in each of the first two rounds reported an incorrect result for one sample. Since the third round of quality assurance, all laboratories have correctly identified all samples. The National STD Reference Laboratory has received satisfactory results from international HIV testing quality assurance programmes every year since 1989.

It is estimated that at least 30 private laboratories offer HIV testing. There are no data available on the volume of testing performed at these laboratories and they do not participate in the national HIV testing quality assurance programme. Although it is thought that these laboratories routinely send samples that test HIV-positive to the National STD Reference Laboratory for confirmatory testing, the review team was informed that at least one private laboratory does not send samples for this purpose.

In summary, systems have been developed for access to HIV counselling and testing throughout the health-care system, but uptake is limited by the non-availability of health staff with up-to-date skills in HIV pre- and post-test counselling and obtaining informed consent for HIV testing. The low community uptake of HIV testing is likely to be due to a combination of appropriately low perceived risk of HIV infection in many individuals, limited availability of services, stigma associated with attendance at STD clinics and absence of programmes integrating access to HIV testing into services for people at higher risk for HIV infection. The high quality of the national HIV testing programme effectively supports accurate diagnosis of HIV in an environment of very low prevalence.

### **Recommendations: HIV testing**

- High-level policy guidance from the government is necessary to further strengthen HIV testing with informed consent. Implementation of this guidance needs to be supported by the highest levels at the MoH. Local advocates for HIV testing with pre- and post-test counselling need to be identified and supported. Leading clinicians involved in HIV care have a critical role to play in advocating for and explaining the importance of testing with consent.
- Although many medical staff members have appropriate skills, the use of pre- and post-test counselling is likely to be more widespread if designated "nurse-counsellors" are identified within each health-care facility, receive refresher training on HIV pre- and post-test counselling and are available after hours in larger institutions. The NSACP should support this cadre by systematically identifying, training and re-training selected personnel from all health facilities from the level of the base hospital and above.
- The Government should mandate that all laboratories conducting HIV testing whether public or private, must participate in the national HIV testing quality assurance programme and report to the NSACP. Public laboratories currently sending samples for HIV testing elsewhere should be progressively supported to establish HIV testing on site. Infant diagnosis should continue to be centralized at the National STD Reference Laboratory and a consistent supply of HIV DNA PCR test kits should be ensured for this purpose.

## UNAIDS/WHO Policy Statement on HIV testing

The 2004 UNAIDS/WHO Policy Statement on HIV testing states that "the conditions of the '3 Cs' advocated since the test became available in 1985, continue to be the underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be:

- Confidential
- Be accompanied by counselling, and
- Only be conducted with informed consent, meaning that it is both informed and voluntary."

Furthermore, "the minimum amount of information that patients require in order to be able to provide informed consent consists of the following:

- The clinical benefit and the prevention benefits of testing
- The right to refuse
- The follow-up services that will be offered, and
- In the event of a positive test result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection."

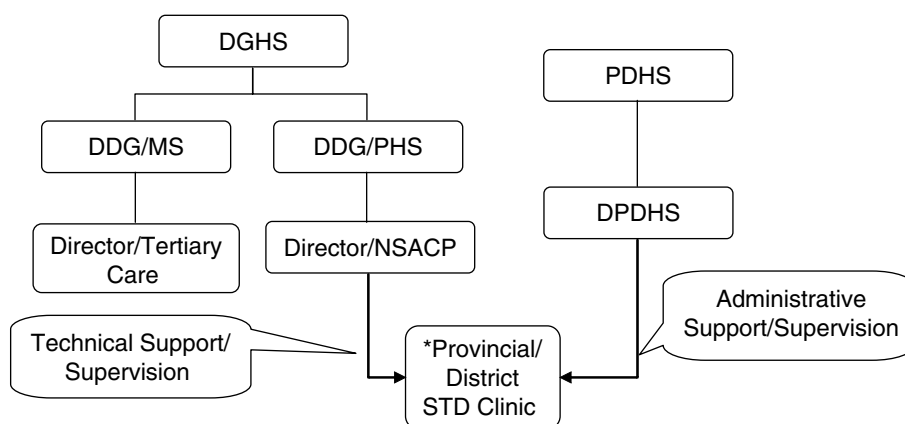
In an appendix provided by the UNAIDS Global Reference Group on HIV/AIDS and Human Rights, the Statement emphasizes that "the voluntariness of testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits".

Key factors in voluntary testing include "ensuring an ethical process for conducting the testing, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information".

## 5.4 Organization of care services

The people of Sri Lanka have universal access to a health system which delivers strong primary health care, specialist services and preventive interventions. Most hospitals are under the administration of the Deputy Provincial Director of Health Services at district level and the Provincial Director of Health Services at provincial level. Some teaching hospitals, however, are directly under the administration of the central ministry and are known as "line ministry" hospitals. STD clinics, given their dual curative and preventive roles, are located within the grounds of hospitals, but come directly under the district- or provincial-level health administration (**Figure 6**). Only three STD clinics outside of Colombo are staffed by a consultant venereologist,

**Figure 6.** Structure of the health system relevant to provincial STD clinics



\*The provincial STD clinic is located in the provincial hospital and the district STD clinic is located within the main hospital in the district, which is usually administered by the provincial health authorities except when the hospital is a teaching hospital. All teaching hospitals are administered by the line ministry – DGHS, DDG/MS, Director Tertiary Care.

DGHS Director General of Health Services, DG/MS Deputy Director General/Medical Services, DDG/PHS Deputy Director General/Public Health Services, PDHS Provincial Director of Health Services, DPDHS Deputy Provincial Director of Health Services

the others are led by an MO-STI who is usually a junior government doctor rotated between posts every four years.

In 1998, the Ministry of Health and Nutrition issued a circular instructing all health facilities to offer care to PLHA without the use of separate wards. As the number of people diagnosed with HIV has remained very low, most health facilities have had only sporadic involvement in the provision of care for PLHA. Clinical care services are centralized in Colombo with outpatient services provided at the Central STD clinic and inpatient services provided at the Infectious Diseases Hospital, the National Hospital of Sri Lanka, the Lady Ridgeway Hospital for Children and other specialist hospitals.

All people diagnosed with HIV are referred to the Central STD clinic for evaluation. If ART is not indicated some patients are referred back to the nearest STD clinic for follow up, otherwise patients travel to the Central STD clinic each month. Home- and community-care services are linked primarily to the Central STD clinic and the Infectious Diseases Hospital.

The Central STD clinic is co-located with the NSACP and the National STD Reference Laboratory, close to major specialist hospitals in central Colombo. A team of consultant venereologists, nurses and laboratory staff provide outpatient services including ART. Many staff members have dual clinical and national programme responsibilities.



The Infectious Diseases Hospital is located on the outskirts of Colombo and acts as a base hospital for the local population. It has a designated national role in the treatment and isolation of patients with suspected epidemic diseases, such as severe acute respiratory syndrome (SARS) and avian influenza. PLHA have been admitted there since 1992 and services have improved over time, particularly since the appointment of a physician in 2003 and the advent of public sector access to ART in 2004, and with the involvement of community-based groups. The poor facilities at the hospital are currently being improved using government funds.

HIV care services have been planned for some time to be expanded to the STD clinics in Colombo South, Colombo North and Kandy, to be followed at a later date in Galle and Anuradhapura. The planned expansion will initially be based upon provision of HIV care by the consultant venereologists currently stationed at the first three STD clinics listed.

There has been little provision of HIV care in the private sector to date and no government policy exists on private provision of HIV care or prescription or sale of ARVs. Some private hospitals and general practitioners have been involved in HIV diagnosis and provision of specific services, but primary HIV care has remained within the public sector and with a small number of specialist venereologists with private practices. The review team heard consistent reports that ARVs are not available in private pharmacies, but can apparently be purchased directly from the Cipla distributor, with a doctor's prescription, for LKR 5000–15 000 per month.

In summary, the foundation for a national HIV care programme has been established in Colombo and expansion is now planned. The key challenge 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. The role of the private sector in provision of HIV care services also remains to be defined.

### **Recommendations: Organization of care services**

- A national model for comprehensive HIV care should be developed which defines complementary roles for hospitals, STD clinics, NGOs, groups of PLHA, public health staff and general practitioners. STD clinics could provide an appropriate "hub" for HIV care activities, but mechanisms need to be developed that minimize the stigma associated with attendance at these clinics. Close links need to be built with community-based care providers and groups of PLHA. Furthermore, a hospital physician should be engaged in the provision of HIV outpatient care, particularly where the STD clinic is staffed by an MO, in order to acquire the skills necessary for the care of HIV inpatients and to

provide greater staff stability. Consideration should be given to bringing STD clinics under hospital management. Clinical services for the armed forces and institutionalized groups should be linked to specialist public sector HIV care providers. The Government should consider available policy options regarding use of ART in the private sector including prohibition or regulation.

- HIV clinical services should be expanded to regional centres outside of Colombo, guided by local HIV care needs. Relying upon the availability of specialist venereologists is not feasible in the medium term. New ART sites should be initiated once there are sufficient patients requiring ART in the area, enabling sufficient comfort, confidence and competence to be built in local care providers and beneficiaries.
- Specific mechanisms should be used to continue building close collaborations between the Central STD clinic and inpatient services, including the Infectious Diseases Hospital and the National Hospital. The development of paediatric HIV care services should remain centralized at this stage and involve appropriately trained staff from the Central STD clinic and Lady Ridgeway Hospital.

## 5.5 Clinical care including ART

Public provision of ART began in November 2004 and is available for all individuals diagnosed with HIV and identified to be in need. No official estimate has been made of the coverage of people estimated to be in need of ART. A senior venereologist has been appointed as coordinator for comprehensive care and treatment (CCT) in the national programme, to carry out all coordination and integration efforts under the management of the NSACP.

Between the diagnosis of the first case of HIV in Sri Lanka in 1986 and June 2006, 785 people were diagnosed with HIV in Sri Lanka, 303 were registered at the Central STD clinic and 80 commenced ART.

In a recent analysis of the first 66 patients commenced on ART with at least six months of follow up, the median age was 42 years, median baseline CD4 count was 107 cells/mm<sup>3</sup>, median CD4 cell increase at 6 months was 128 cells/mm<sup>3</sup>, overall mortality was 12% and lost to follow up was 6%. Patients are monitored using six-monthly CD4 counts and HIV viral load when it is available. Testing for HIV drug resistance is not available in Sri Lanka.

To date, 24 children have been diagnosed with HIV. There are currently estimated to be 100 children living with HIV of which eight are currently under follow up at the Central STD clinic and three are receiving ART.

National guidelines on HIV clinical care in adults were issued in 1998 and national ART guidelines were issued in 2005, based on the 2003 edition of the

WHO guidelines and including some guidance on prophylaxis and treatment for OIs. There is currently no national guidance regarding clinical care or use of ART in children or pregnant women, or management of TB/HIV coinfection.

Following many years of health-care worker training on the basic concepts of HIV and counselling, a CCT training programme was initiated to sensitize health-care workers regarding HIV facts, counselling, infection control and treatment. This two-day workshop has been delivered to 970 health-care staff from the NSACP and major hospitals in and around Colombo. Several medical specialists have received a two-week training organized by Bamrasnaduras Institute in Thailand. The specialists included venereologists, physicians, paediatricians, obstetricians and chest physicians. There are currently no domestic training programmes on the use of ART in adults or children. HIV is included in various subjects of medical school curricula such as microbiology, internal medicine and community medicine, and a working group is currently developing a common HIV curriculum for all medical schools. A distance education programme on HIV is being developed for general practitioners by the Independent Medical Practitioners Association.

Although a wide range of health-care workers have received training on HIV supportive counselling and the Central STD clinic previously employed a counsellor, most supportive and adherence counselling is currently delivered by medical staff. There are no additional adherence support activities apart from peer support group meetings organized independently by Lanka+ at their offices. Due to the very few children receiving care, there has been very limited experience gained in the psychosocial issues relevant to children living with HIV and their families. The review team heard several reports of ongoing fear, stigma and discrimination in health-care facilities. Significant improvements were reported to have occurred at the Infectious Diseases Hospital and to a lesser degree at other Colombo hospitals.

A national HIV clinical care data collection form has been developed. HIV clinical data will be collected at all HIV clinical sites using this form and entered into an electronic database. These data will then be collated and analysed centrally.

The MoH has a strong MSD dealing with procurement and supply chain management. STD clinic supplies, including HIV supplies, are requisitioned and procured through the MSD and World Bank/NHAPP processes. Distribution of STD clinic supplies is performed outside the MSD distribution system. The review found that STD clinic staff generally collect supplies on a quarterly basis from the Central STD clinic in Colombo. Forecasting capacity for ARVs is limited and ARV procurement requests are often performed on an ad hoc basis. At present, the Government of Sri Lanka has not introduced facilities for the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in its intellectual property laws but the review team was informed that a process has commenced with the support of WHO.

In summary, the establishment of freely available public sector provision of ART is a major achievement. Satisfactory short-term treatment outcomes have been achieved and there is now a core group of clinicians with training and experience in HIV clinical care in Colombo. A medical approach to the support of ART adherence has been developed with limited involvement of other health-care workers or community groups. National systems to support expanded provision of HIV clinical care and ART, including capacity-building programmes, data and supply management systems, have not yet been developed.

### **Recommendations: HIV care and treatment**

- A national HIV training programme should be established for the capacity development of multidisciplinary HIV care teams at planned ART sites, including doctors, nurses, "nurse-counsellors" and pharmacists. This should include interactive classroom-based activities, supervised outpatient and inpatient experience, and continuing education activities including a distance support system. Although the number of health-care workers requiring training is not large, a systematic approach will ensure optimal transfer of existing in-country expertise and lay the foundation for the development of additional HIV care teams in the future. Once trained, HIV care teams could assist in the delivery of CCT training for health-care staff working in their area.
- Adherence to ART is the key determinant of long-term individual and programme treatment success and cost-effectiveness. A multidisciplinary approach should be developed, driven by the needs and experiences of people taking ART. In particular, dedicated, trained counselling staff can develop particular expertise, and peer support group activities are highly effective and not expensive.
- Fear, stigma and discrimination in health-care settings remain major obstacles to the expansion of quality HIV care. Health-care workers with positive attitudes towards PLHA are crucial for the cultural change needed to provide an enabling environment for HIV care. These advocates need to be identified and supported. Presenting models of comfortable and compassionate care for PLHA is an important component of HIV care training.
- A core multidisciplinary team should be developed at the Central STD clinic and Lady Ridgeway Hospital with experience in the treatment, care and psychological support of children living with HIV and their families. Recently developed regional guidelines and training modules for the care of children with HIV could be used until greater numbers of children are in need of care.
- Distribution of STI and HIV supplies, with the exception at present of ARV, should be integrated into MSD procedures.

## 5.6. Home- and community-based care

A very few NGOs have begun to provide home visits and social support services for PLHA. Lanka+ is the national network of PLHA. The organization provides peer support, including weekly meetings at their offices in Colombo, and home and hospital visits. The Salvation Army covers a large geographical area and has established links with the Central STD clinic, and provides home visits and counselling services to individuals and families living with HIV. They also provide support for transportation costs to attend the Central STD clinic and run a drop-in centre in Colombo, which provides simple primary care and referral for PLHA. The Salvation Army also delivers five-day HIV training workshops to other organizations, which include modules on HIV home- and community-based care. A local NGO provides integrated psychosocial support for PLHA and addresses stigma and discrimination. Other organizations also provide care and support for PLHA, integrated within other programme services.

A key challenge for the delivery of home- and community-based care services are the low numbers of people diagnosed with HIV dispersed throughout the island. Additionally, although reported assessments of HIV-related stigma and discrimination vary, most people have not disclosed their status beyond their trusted immediate family because of a fear of negative reactions from the wider community. PLHA reported to the review team that “living with HIV is easy, living with the community is difficult”. This reinforces the importance of confidentiality when support is provided within the community. PLHA also highlighted the importance of finding and retaining paid employment rather than social support and part-time income-generation schemes. Another important issue is the lack of support for accommodation for individuals and their companions in Colombo when attending the Central STD clinic.

Public health staff such as MOs, PHNs and midwives have not been involved in the care of PLHA. Similarly, the review team was not aware of any initiatives by any faith-based organizations or by temples, churches or mosques.

Palliative care services are predominantly provided by families, in hospitals, and by some general practitioners. The MoH has recently included “elderly care” in the package of activities for public health midwives. This consists primarily of advice and referral rather than direct care.

In summary, a community-based response to the needs of PLHA is evident, with a small group of organizations engaged and experienced in addressing the challenges for people and families living with HIV. Linkages exist between these organizations and HIV clinical services in Colombo. Significant additional resources exist within society that are not yet engaged in the provision of care and support for PLHA, including the government primary health-care network, large nongovernmental health and development organizations, and religious groups.

### **Recommendations: Home- and community-based care**

- NGOs involved in the lives and needs of PLHA should be encouraged and funded to continue and further strengthen their work. In particular, support for transportation and accommodation costs, and opportunities for paid employment are effective ways to improve the lives of PLHA.
- PLHA are closest to the issues of those who share their status. As individuals and as organizations they should be involved and enabled to contribute meaningfully to national and local responses.
- As HIV clinical care services are established outside Colombo, NGOs should be encouraged to form close links with the clinical services and develop community-based services to support PLHA in the area. Public health midwives could play a role in outreach and follow up.

## **5.7 Tuberculosis and HIV**

Sri Lanka has made substantial progress in reducing the burden of disease due to TB. In 2002, the estimated national incidence of TB was 46.9 per 100 000 population per year. Internationally accepted targets for programme effectiveness have been achieved with an estimated case detection rate in 2005 of 86% and a treatment success rate of 85% in the same year.

The national TB programme has been based on the directly observed treatment, short-course (DOTS) strategy since 1997 and an estimated 97.6% of the population is covered. Microscopy is available at all district and most base hospitals. Treatment is initiated by TB officers or chest physicians at district or base hospitals and during outreach visits to branch clinics. Intensive phase therapy is observed daily by health staff at any health facility and continuation phase therapy is dispensed weekly. Twenty-two districts have some community DOTS activity, but this has not developed rapidly due to the relatively low case burden, geographical proximity of the majority of the population to strong public health facilities and stigma associated with TB. A rifampicin-based six-month regimen is used as initial treatment. In 2005, a total of 32 cases of MDR-TB were identified and a TB drug resistance study is ongoing.

HIV sentinel surveillance includes TB patients. In the 2005 survey, 1528 patients with TB were tested for HIV and 2 (0.07%) tested positive. No policy exists on HIV testing for TB patients. All patients newly diagnosed with HIV are referred to chest clinics for TB screening. No formal mechanism exists for interaction between the TB and HIV national programmes. National clinical guidelines on the management of TB/HIV coinfection are under development.

In summary, Sri Lanka currently has an effective response to the TB epidemic. Although TB/HIV coinfection is currently not a significant health issue in Sri Lanka, the greatest threat to TB control in the longer term is expansion of the HIV epidemic.

### **Recommendations: TB and HIV**

- A formal mechanism for collaboration between the TB and HIV national programmes should be established. A system for routine, confidential collection of data on HIV testing and diagnosis in TB patients, and TB disease in HIV patients should also be established. Local partnerships between HIV and TB care providers should be encouraged and supported.
- A national policy that offers HIV counselling and testing for people diagnosed with TB should be developed. Given the strong evidence showing a very low prevalence of HIV in TB patients, the counselling and testing should be targeted rather than made universal. Patients with a clinical suggestion and self-identified risk of HIV infection should be targeted, rather than carrying out routine HIV risk assessment. Systems for access to HIV counselling and testing by people diagnosed with TB should be integrated into existing HIV counselling and testing programmes.

## **5.8 Laboratory support**

The National STD Reference Laboratory provides reference laboratory services for STI and HIV laboratory testing throughout the country. The national HIV testing programme is described above in “HIV counselling and testing”.

Laboratory monitoring of ART is currently centralized at the National STD Reference Laboratory. CD4 testing is performed using a BD FASCOUNT instrument and HIV viral load is performed using a Roche Amplicor instrument. The average CD4 testing volume is approximately one test per day and less than one test per week for HIV PCR. The National STD Reference Laboratory does not yet participate in any international quality assurance programmes for these investigations. Currently, the laboratory is unable to perform CD4 testing or HIV viral load due to stock-out of reagents. The Medical Research Institute and a private hospital also perform CD4 testing. No other laboratories offer HIV viral load testing.

Laboratory investigations to support other aspects of HIV clinical care, such as haematology, biochemistry, sputum smears and basic microbiology are available in most large public hospitals. The Medical Research Institute implements a quality assurance programme for many of these investigations. The review team saw evidence that ongoing maintenance and technical support for laboratory instruments are inconsistent in some hospital laboratories.

In summary, a strong national reference laboratory exists which offers CD4 and HIV viral load testing. The functioning of the laboratory is limited by inadequate reagent supply. General laboratory services are supported and

monitored by the Medical Research Institute. Inconsistent maintenance and technical support for laboratory instruments may limit laboratory support for ART in provincial areas.

### **Recommendations: Laboratory support**

- CD4 testing should remain centralized at the National STD Reference Laboratory at present, as testing volumes are currently insufficient to warrant the use of additional instruments. Systems for movement of blood samples rather than patients should be established. A single functioning HIV PCR instrument is sufficient for national requirements with regard to infant diagnosis and confirmation of suspected HIV treatment failure. The National STD Reference Laboratory should participate in international CD4 testing and HIV viral load quality assurance programmes.
- Provincial laboratories should be strengthened with an emphasis on maintenance of instruments, adequate supply of reagents and quality assurance. Plans to integrate STD clinic laboratories into hospital laboratories should be reviewed and accompanied by a clear policy that HIV testing and STI investigations should receive due priority.



# Strategic Information, Monitoring and Evaluation

# 6

Strategic information gaps have been commented on in Chapter 2 of this report. This chapter examines the M&E systems contributing to bridging these gaps while ensuring greater rigour in management and operational accountability.

## 6.1 Current situation in monitoring and evaluation

### Coordination body and staffing

There is no national SI and M&E unit to coordinate the overall work in this field. According to the current NSACP organizational structure, M&E falls under the jurisdiction of the Surveillance Unit, together with HIV sentinel surveillance, behavioural surveillance and STI surveillance. Only one staff member works on M&E as a part-time assignment. However, there is a full-time M&E specialist in the NHAPP who monitors the World Bank-financed project and supports the design of the national M&E work.

*Strategic information (SI)* refers to all needed information to capture the status and trend of the HIV epidemic, status of the response and the overall social, economic and policy environment that underline the risk-taking behaviour and the response. Monitoring is the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from record-keeping and surveys – both population- and client-based. Evaluation is the systematic and objective assessment of an ongoing or completed project, programme or policy, its design, implementation and results. SI and M&E together will enable decision-makers and stakeholders to have a complete picture on the current situation of the epidemic, the response to it, how effective it is and where the epidemic is going.

### Operational framework and database

Section 9.1 of the NSP (2002–2006) mentions that a “management information system” (MIS) will be developed and constantly updated to meet the growing demands of M&E. It also mentions that information that is collected will be consolidated and distributed to all relevant sectors. This MIS is also to be linked with the other health information systems of the Government. The system

envisaged also mentions the links with the provincial system through quarterly monitoring forms that will be submitted by each province to the NSACP. All other organizations in the public and private sectors, as well as NGOs carrying out HIV/AIDS activities, are also to be linked with the NSACP through the submission of their quarterly reports on a prescribed form. An annual internal mechanism for programme review is mentioned, which will be supported by external review with the involvement of multilateral and bilateral agencies.

The team observed that the system of internal review is not regularized and an M&E framework has not been formalized for execution of the strategic plan. The World Bank-assisted HIV/AIDS Prevention Project has a reporting system for information on financial tracking of the project. It also collects and uses some input- and output-level information for its physical progress reports (e.g. how many condoms distributed and how many people trained). Data related to activities conducted by other players (donor agencies, UN and NGOs) are largely lacking.

A private firm was contracted to develop an MIS not only for capturing the process information within the project but also to include a patient management information (PMI) system for the clinics, laboratory system and pharmacies. In theory, it enables the NSACP to link up with provinces, other sectors, NGOs, etc. Although the system has been on test-run for about three months, it could not be installed due to lack of “infrastructure” at the NSACP.

A set of key indicators was drafted by the NSACP/NHAPP over a year ago but has not been finalized. The 78 indicators listed will require further prioritization and will need to be reduced in number to capture the most SI for national M&E work. Information in this regard was made available to the review team.

## Surveillance system

The HIV Sentinel Surveillance System was established 1993 and surveillance has been conducted regularly since then. The WHO Guidelines on Sentinel Surveillance have been followed, with sampling from a wide range of groups including vulnerable populations such as STD clinic attendees, TB patients, armed forces personnel, transport workers and most-at-risk groups such as FSWs.

The external review team was concerned that although efforts had been made to implement procedures to “de-link” the identifiers of samples and testing results, some forms used for collecting the information still contained names and addresses of individuals. This practice does not add value to the surveillance work, and may even become a barrier to the cooperation offered by target populations, due to fear of being identified after the test.

STI reporting was conducted on a quarterly basis from only government STD clinics.

Behavioural Surveillance Surveys (BSS) are still in their infancy in Sri Lanka. A pre-surveillance assessment on populations at risk conducted by the Community Development Services in 2005 provided useful qualitative baseline information. The NHAPP, on behalf of the NSACP, has contracted a BSS which commenced in 2006 and includes a mapping component of a number of most-at-risk populations, such as FSWs, MSM, drug users, garment factory workers and three-wheeler drivers (see “Summary of mapping activities and revised sampling frame”, July 2006). The external review team welcomed this initiative and recommended that the mapping exercise on most-at-risk populations (FSWs, MSM and IDUs) be extended to cover all districts of the country.

## Report and feedback

Sentinel surveillance reports are published annually. The surveillance data and data from various ad hoc surveys up until mid-2005 were being well shared with stakeholders at NAC and subcommittee meetings<sup>4</sup>.

A report on the progress of implementation of the Declaration of Commitment from the UN General Assembly Special Session on AIDS was submitted by the Government of Sri Lanka in early 2006. It was acknowledged that much of the data needed were not available in the format required for the report in the existing reporting system of the NSACP. Some information was not available, as the data were not collected through any existing system. In other cases, some of the data included (e.g. condom use rate with last clients by sex workers) might be overoptimistic<sup>4</sup>.

A country-level Universal Access consultation was held in March 2006. The resultant report identified 45 national targets for moving towards Universal Access by 2010, covering a wide area. The report identifies current and potential obstacles with suggested solutions but it was not able to make any reference to the national M&E system and the core set of national indicators.

Despite the work on surveillance and progress on the development of an MIS, the following concerns were identified by the external review team:

- The concept of SI and M&E does not seem to be widely accepted. Besides surveillance, case-reporting and financial reports, there is very limited information available on the size of most-at-risk populations, their risk behaviours, and the quality and coverage of services.
- The roles and responsibilities of staff in relation to SI and M&E are not clearly defined within the national AIDS response. There is confusion

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4 UNGASS. *Country report – Sri Lanka on follow up to the Declaration on Commitment on HIV/AIDS*, 2005. Available at [www.ungasshiv.org/index.php/en/shadow reports 2006/panos/sri\\_lanka](http://www.ungasshiv.org/index.php/en/shadow_reports_2006/panos/sri_lanka)

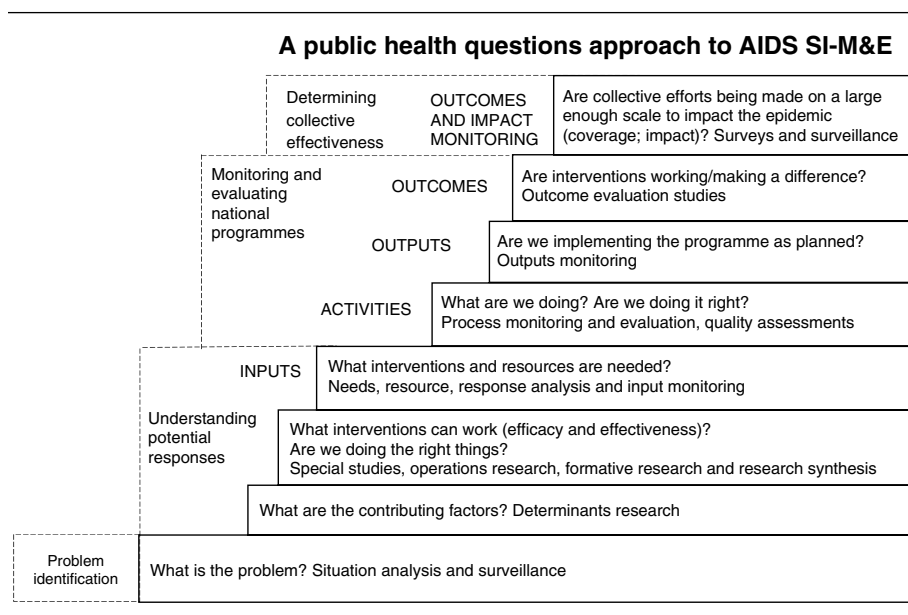
between the M&E functions of the NSACP and NHAPP, and there is a lack of support for provincial- and district-level M&E functions.

- Currently, there is no national HIV/AIDS/STI M&E framework; hence, the authority, roles and responsibilities of each player in the response are not well-defined. In addition, there is no clear set of indicators which would serve as a base for information collection, dissemination and data storage (e.g. MIS database and Country Response Information System [CRIS]).
- Except the ad hoc information feedback, there is only one-way information moving from unit/division, district, province to the central level 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 levels of the STI and AIDS programme.
- There is a lack of consultation with, and participation of, the civil society and PLHA in planning and conducting M&E work<sup>4</sup>.

## 6.2 Questions and answers to guide national programming

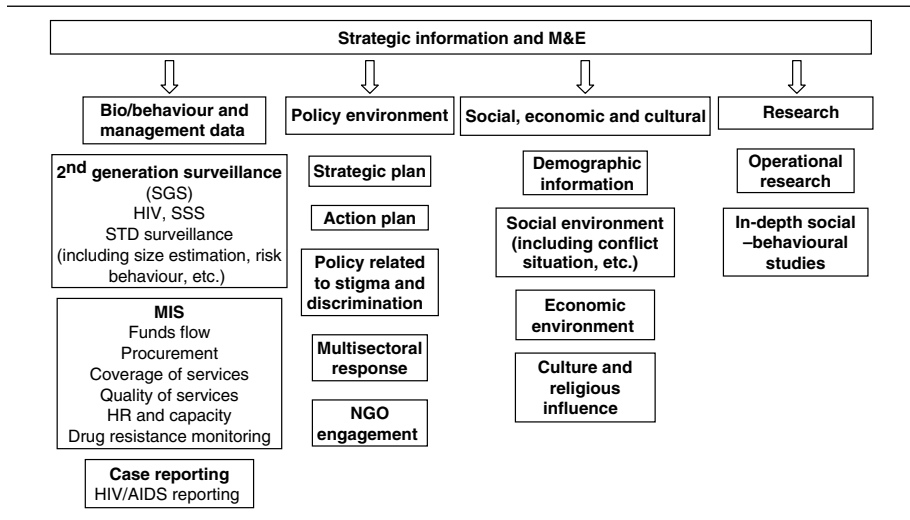
The key questions listed in **Figure 7** should guide national STI/AIDS programming.

**Figure 7.** Key questions to guide national STI/AIDS programming



To be able to answer these questions, an SI and M&E system needs to be set up. **Figure 8**, based on common knowledge and practices, illustrates what an SI and M&E system comprises.

**Figure 8.** Strategic information and monitoring and evaluation system



The system aims to provide a better understanding of the status of the epidemic and trends, and informs policy development and programming, as well as helps to guide interventions and services, and measure the effectiveness of the response.

The “Three Ones” principles to which countries and international agencies have subscribed should be adhered to. The key principle is the development and use of a single M&E mechanism, which should minimize the need for duplicative reviews that impose an unnecessary burden on programme staff.

The One National M&E system refers to:

- One M&E unit with full-time staff who coordinate M&E activities and conduct in-depth analysis of the data collected;
- One multisectoral M&E framework (or a national M&E master plan), with a well-defined authority, line of reporting and feedback, surveillance system, and a set of core indicators;
- One national set of standardized indicators;
- One national information system supported by a functional database, fed by subnational data. (Most of these data stay at the subnational level for local programming and monitoring.)
- A well-established surveillance system which follows the WHO/UNAIDS Guide on Second-generation surveillance system;
- Flow of SI from the subnational to the national level and good feedback;
- Harmonized M&E capacity building;

- Functioning M&E Working Group for dealing with day-to-day technical issues;
- Research and training agenda to meet country-specific needs; and
- Secured fund for supporting the SI-M&E work.

A functioning national M&E system will thus address a country's needs in monitoring progress in a timely manner and adjust the overall programme according to the lessons learnt or in a changed situation. It can also make the UNGASS Report easily available and benefit monitoring of the progress of the universal access process.

Given the increasing need for evidence and data for the development of the new strategic plan, it would be advisable to build on what is already functioning in the country. The draft design of the national M&E system should realign the set of indicators and the SI collection plan to fill the information gaps mentioned earlier. The draft can then contribute significantly to country programming and the universal access process, which is unfolding.

### **Recommendations: Strategic information, and monitoring and evaluation system**

- To establish a national SI-M&E Unit (which includes the surveillance function) the current surveillance unit should be restructured. The restructured unit should be headed by a senior NSACP staff member, with an M&E specialist and surveillance staff as the core staff, supported by an IT assistant and a data manager. The function of the unit will be to manage the flow of information, to conduct data analysis (including data triangulation) and produce annual reports and quarterly updates. Full-time staff need to be designated at the district level for SI-M&E work and they should be technically guided by the Unit.
- The roles, authorities and responsibilities of M&E staff in the programme should be clearly defined. The SI-M&E Unit shall be given the authority to access all information needed from the current system, donor-sponsored projects and NGOs. Information feedback through annual and quarterly reports should be guaranteed.
- As the new NSP is developed, it will be critical to ensure that a national SI-M&E framework be developed as an integral part of the NSP, and that the core procedures are set and additional indicators finalized. An indicator manual would need to be developed to assist with the standardization of information and data collection. Installation of the computerized MIS database and the use of an indicator-based CRIS should complement the MIS as an indicator and resource-tracking composite.
- A capacity-building plan should be developed for building staff capacity at different levels, according to the NSP and SI-M&E framework, with the needed skills for information collection.

# Conclusions and Recommendations

# 7

The review team was satisfied that the information it received from the NSACP, the NHAPP and other stakeholders, complemented by the information gathered through interviews, site visits and observation of project activities was sufficient to help it arrive at its conclusions and recommendations. The team was of the opinion that the HIV epidemic in Sri Lanka remains of low intensity, affecting individuals and their immediate sexual contacts with little spread to the population at large. Several factors continue to create an unfavourable ground for HIV to spread as rapidly as has been experienced in other South and South-East Asian countries. However, the situation may change rapidly as a consequence of evolving patterns of sex work and drug use, high mobility of the civilian population and uniformed personnel, exacerbated by political and social uncertainty, and high concentration of young adults around industrial and agricultural production sites.

There is little doubt that the national prevention efforts undertaken over twenty years ago have contributed to lowering the spread of HIV in Sri Lanka. The high literacy rate and health-seeking behaviour of the population may have contributed to limiting the spread of HIV. An economic and social structure in which the gender gap is narrower than in many countries with similar (or lower) per capita income may be another contributing factor. While the combination of these factors seems to have kept the vulnerability of the Sri Lankan population at bay over the years, evolving factors affecting this vulnerability demand a major effort to refocus the programme on emerging populations that are at greatest risk: women and men participating in sex work, MSM and substance users. The recommendations below include four overarching and several specific recommendations grouped by thematic areas. Unless otherwise indicated, these recommendations are addressed to the NSACP, including the NHAPP, with the aim of providing guidance for the formulation of the 2007–2011 NSP and subsequent plans of operations.

## 7.1 Overarching recommendations

### 1. Prioritization of targeted interventions for most-at-risk populations

The formulation of the NSP for 2007–2011 should involve all stakeholders in a broad and participatory process, led by the NSACP. To facilitate this process, the NSACP should seek appropriate technical support available in Sri Lanka and from international sources, if required. The national strategy should act as a framework for the development of district-based operational plans, and should contribute to the formulation of provincial and national operational plans. During the planning process, districts should actively seek technical guidance from the centre.

In each district, the highest priority for HIV prevention is to start interventions with sex workers. Existing district partnerships between STD clinic teams and NGOs should be further developed. STD clinic teams should be strengthened and reoriented to have a stronger public health role in the prevention and control of STIs and HIV. Local advocacy should be conducted with district and provincial leaders as well as the police to explain the significance of targeted interventions and to build an enabling environment for prevention activities.

### 2. Partnership and engagement with NGOs and encouragement of private sector participation

A determined effort should be made by the NSACP towards capacity building and revitalization of NGOs by coordinating the existing mechanisms and partnerships. Collaboration with the private commercial sector should also be expanded through joint advocacy and planning by the national programme and local chambers of commerce. By offering incentives such as participation in short courses, private health-care providers should be further encouraged to engage in the nationwide response to HIV.

### 3. Improvements in the processes of SI collection, dissemination, bridging information gaps, as well as establishment of an M&E system

Comprehensive and up-to-date information on high-risk populations is acutely needed to guide local responses to HIV interventions. District mapping should be conducted and coverage targets set. The highest priority should be given to an extensive mapping of most-at-risk populations in



each district, with the objective of identifying the size, location and general characteristics of FSWs, MSM and drug users. Key information should be gathered only in ways that are respectful of privacy, non-discriminatory and cognizant of the populations' human rights. These surveys and, if necessary, more detailed situation and needs assessments, should be carried out in the context of programmes providing prevention services to these groups. There is also an urgent need to set up a national SI and M&E system to be led by a national SI-M&E unit. This unit, headed by a senior consultant of the NSACP, will have access to all SI and be guided by a national M&E framework. The roles and responsibilities of each party involved in the process should be clarified and a core set of indicators defined.

#### 4. Strengthening programme structure and management

The NSACP and NHAPP structure should be amalgamated permanently with a single senior management team. Additional staff should support the Deputy Provincial Director of Health Services in the planning, management, implementation and monitoring of all STI/HIV-related activities. This restructuring will secure the active participation of PHIs and PHNs/midwives.

The development and implementation of STI/HIV programme activities in the provinces and districts will require considerable technical and managerial support. Only teams trained in, and deployed from, the Central STD/HIV office could provide the specialized support.

Surveillance, research and MIS should form the core of the SI system and the M&E unit should be a component of this system.

## 7.2 Specific recommendations

### 7.2.1 Drug users

Outreach and prevention programmes and services should be initiated at all locations where there are significant social networks of drug users. These programmes should focus on sexual risk reduction and education about the health risks associated with drug injecting. An active programme of monitoring drug-use patterns should be integrated with outreach activities, with an emphasis on rapid identification of any shift to drug-injecting behaviour. The national programme and the NDDCB should interact with authorities and programme managers in neighbouring countries (e.g. the Maldives) to better understand the social context and patterns of this shift.

## 7.2.2 Prevention among other vulnerable groups

Prevention programming for other vulnerable populations should be targeted, based on a local assessment of transmission dynamics to ensure that these activities cover known bridge populations. Broad-based programmes for occupational groups should be avoided unless there is adequate local evidence that a high proportion of those groups are part of high-risk networks, usually as clients or sexual partners (FSWs or high-risk MSM). Risk-reduction interventions should be increasingly focused on clearly identified bridging populations such as military personnel, three-wheeler drivers, transport workers, internal migrants, with priorities guided by local data on sexual behaviours and networks. Priority should be given to groups that are frequent clients or sexual partners of sex workers or are high-risk MSM.

Focused interventions should support behaviour change (condom use, STI symptom recognition, early health care-seeking behaviour, etc.) beyond simple awareness. Peer support activities should be developed together with NGOs, STD clinic staff and target populations.

The ongoing excellent initiative by the Foreign Employment Board towards preparing candidates for foreign employment should continue. Pilot workshops on family and community re-integration, including a routine offer of STI and HIV testing, should be introduced for returnees.

Efforts to make condoms easily available within the prison system should be pursued. Dispensers or simply open containers could be made available, starting in medical stations, ostensibly for use by those going on leave, but not restricted to them. The feasibility of initiating a peer leadership programme for prison inmates, particularly those who are drug users, should be assessed. These peer leaders could then provide HIV prevention education for drug-user networks upon release. Improvement in clinical and counselling services in prisons should be supported by the NSACP.

Education and awareness programmes for the general population should focus on reducing stigma and discrimination against PLHA and members of highly vulnerable groups. In this regard, specified programmes should be conducted with the police and other support-providing groups to produce an enabling environment for targeted interventions among FSWs, MSM and IDUs.

## 7.2.3 Prevention among young people

In-service and pre-service teacher training should be accelerated to increase the capacity and confidence of teachers to undertake skills-based learning

approaches to deal with such topics as SRH, HIV and STIs. The Ministry of Education, with support from the MoH, should identify and train one or two teachers in each secondary school to become subject matter experts on SRH, HIV and STIs.

Reinforcement should be undertaken through the development of age-specific and user-friendly supplementary reading materials. Specific sessions should be organized for young people leaving school or afterwards. HIV information and core skills should be integrated with SRH into professional training programmes and tertiary-level education for young people. HIV prevention packages should be integrated into existing outreach child protection interventions of NGOs, with a focus on children living on the street.

#### 7.2.4 Condom programmes

Condom programmes through social marketing and structural interventions (100% Condom Programmes) should be strengthened where possible. High-level political support should be sought for this agenda through the development and implementation of an advocacy strategy. This would enable local action with the police, hotel management, etc. to support condom use in highest-risk settings. Organizations working with the most vulnerable groups should specifically determine if condom supplies are adequate.

#### 7.2.5 Prevention of mother-to-child transmission

Based on pilot projects, an updated PMTCT strategy and operational plan should be developed to focus on primary prevention-integrated ANC, Maternal and Child Health (MCH) and family planning services. Building on the strength of community outreach, non test-dependent primary prevention services, to be conducted by public health midwives, should be established in all ANC and family planning settings. This will mean (i) establishing a stronger role for the HIV strategy and building linkages with the Family Health Bureau and MCH services so that the potential risk of exposure of pregnant women to HIV is identified in all ANC clinic visits, (ii) offering essential counselling, and (iii) performing HIV testing with informed consent for an opt-in approach to testing and pre-test counselling. A small number of tertiary facilities with interventions for vertical transmission and a whole-site approach should be established in a phased manner. These facilities would be located at ART centres. Contact with and referrals between NGOs working with sex workers and private clinics providing STI services should be implemented and, if such contact is not possible, targeted strategies should be developed to ensure that there is a sufficient supply and appropriate distribution system.

## 7.2.6 STI and public health services

STD clinics should be strengthened as the focal points for HIV prevention and STI control in districts. Capacity building of PHI/PHN and NGOs would be needed to build skills for mapping, population size estimation, and organizing peer outreach and education. Training by STD clinic staff of private service providers should continue in the district but with the objective of building wider capacity to provide syndromic case management for STIs. As more public and private sector providers share the load of routine visits, STD clinics would be able to spend more time on community work, HIV care and treatment, and referrals. Strengthening the capacity of STD clinic teams to support community outreach and prevention activities, in collaboration with NGOs, is necessary. This may need the involvement of increasing numbers of PHI/PHN and revision of job descriptions. Professional training provided by STD clinic staff to other MOs and the private medical community should promote initial syndromic management. With only one STD clinic per district, it makes sense to strengthen STI management at the primary care level (in both the public and the private sectors) and reserve referrals for difficult cases. STI surveillance should be strengthened (as part of second-generation surveillance) to provide early warning of sexual transmission. STI prevalence surveys should be planned for high-risk populations. Consultant venereologists and MOs working in STD clinics should be included in the system for providing routine care to PLHA, including routine ART follow-up visits.

## 7.2.7 Prevention in the general population

Awareness-raising among the general population to ensure complete and accurate knowledge of HIV should continue but not at the expense of priority actions for comprehensive prevention among high-risk and highly vulnerable populations. Broad-based programmes (not merely stand-alone activities of the national HIV programme), meant for occupational groups as well as for those in professional training or higher education, should be integrated (programmatically and financially) into existing workplace and training schedules. In-service and pre-service training courses increase the capacity and confidence of teachers to undertake skills-based learning approaches to such topics as SRH, HIV and STIs. The Ministry of Education, with support from the MoH, should identify and train one or two teachers in each secondary school to become subject-matter experts on SRH, HIV and STIs. Reinforcement should be undertaken through development of age-specific, user-friendly supplementary reading materials and specific sessions organized after leaving school. Strategic communication plans for change agents, trusted communicators and media leaders should be developed and implemented. Communication initiatives for increasing general awareness should focus on promoting services and reducing discrimination.

### 7.2.8 Implementation roles, partnerships and support

Local partnerships should be urgently promoted to advance the new direction and activities. STD clinics in districts should be strengthened as the focal points for HIV prevention and STI control (see 7.2.12 Organization of care services). NGOs should be encouraged to work with highest-risk populations including sex workers, MSM and IDU, in collaboration with local STD clinic and public health staff. Public health staff should work with local NGOs and community groups to develop regular community outreach to vulnerable groups in order to promote access to, and utilization of, public health services. STI and public health clinic staff should provide training and educational support to NGOs and peer educators to improve their knowledge and skills in communicating with vulnerable populations (sex workers, MSM and drug users). Local STD clinic and public health staff should work closely with local NGOs and CBOs to provide education and sensitization programmes for local police officers to create a more enabling environment for programmes and services for sex workers, MSM and drug users. The NSACP and NHAPP should establish a regional supportive supervision system to support the scaling up of HIV prevention programmes at the provincial and district levels. This initiative could include the MO-STI, but should also include appropriate programme support for implementing targeted interventions. A robust process of monitoring these targeted interventions should be instituted, with a specific emphasis on measuring outreach coverage of the key populations and service utilization. Where effective RRI activities have taken place, local scaling up should be encouraged, based on district-level plans for increasing the coverage of vulnerable key populations.

### 7.2.9 Blood safety

Efforts to increase voluntary blood donations should continue until the target of 100% is achieved. Doctors and nurses working outside the transfusion service should continue to be educated on avoiding replacement donations. Where voluntary blood donation is low, blood banks should be encouraged to have specific blood donation drives and camps to increase voluntary blood donation.

### 7.2.10 Prevention of HIV transmission in health-care settings

Strong policy leadership is needed from senior levels of the MoH regarding the use of standard precautions and cessation of unnecessary infection control procedures. Implementation of this policy needs to be led by local champions who can promote and use model standard precautions, and care for PLHA without fear. Strengthening support and training for infection control nurses is a key mechanism to improve HIV infection control practices. The use of needle-

stick injury protocols should be improved with emphasis on HIV testing of source patients with pre- and post-test counselling, rapid processing of source patient blood specimens for HIV testing, and development of rapid referral procedures for PEP at the nearest available site. The supply of infection control commodities, particularly sharps containers, should be improved using either a health sectorwide distribution programme or sharing between programmes at the service delivery level. The use of standard precautions and needle-stick injury protocols should be monitored.

### 7.2.11 HIV counselling and testing

High-level policy guidance from the Government is necessary to further strengthen HIV testing with informed consent. Implementation of this guidance needs to be supported by the highest levels at the MoH. Local advocates for HIV testing with pre- and post-test counselling need to be identified and supported. Leading clinicians involved in HIV care have a critical role to play in advocating and explaining the importance of testing with consent. Although many medical staff have the appropriate skills, the use of pre- and post-test counselling is likely to be more widespread if designated “nurse-counsellors” are identified within each health-care facility, receive refresher training on HIV pre- and post-test counselling, and are available after hours in larger institutions. The NSACP should support this cadre by systematically identifying, training and re-training selected personnel from health facilities from the base hospital level and above. The Government should make it mandatory for all HIV testing to be conducted in laboratories and, whether public or private, they must participate in the national HIV testing quality assurance programme. Public laboratories currently sending samples for HIV testing elsewhere should be supported to establish HIV testing on site. Infant diagnosis should continue to be centralized at the National STD Reference Laboratory using a consistent supply of HIV DNA PCR test kits.

### 7.2.12 Organization of care services

A national model for comprehensive HIV care should be developed, which should define complementary roles for hospitals, STD clinics, NGOs, groups of PLHA, public health staff and general practitioners. STD clinics could provide an appropriate “hub” for HIV care activities, but mechanisms need to be found to minimize the stigma associated with attending these clinics. Close links need to be built with community-based care providers and groups of PLHA. Furthermore, a hospital physician should be engaged in the provision of HIV outpatient care, particularly where the STD clinic is staffed by an MO, in order to acquire the skills necessary for the care of HIV inpatients and to provide greater staff stability. Consideration should be given to bringing STD clinics under hospital management. Clinical services for the armed forces and

institutionalized groups should be linked to specialist public sector HIV care providers. The Government should consider available policy options regarding the use of ART in the private sector including prohibition or regulation. HIV clinical services should be expanded to regional centres outside Colombo, guided by local HIV care needs. Relying upon the availability of specialist venereologists is not feasible in the medium term. New ART sites should be initiated once there are sufficient patients requiring ART in the area, enabling sufficient comfort, confidence and competence to be built in local care providers and beneficiaries. Specific mechanisms should be used to continue building close collaborations between the Central STD clinic and inpatient services, including the Infectious Diseases Hospital and the National Hospital. The development of paediatric HIV care services should remain centralized at this stage and should involve appropriately trained staff from the Central STD clinic and Lady Ridgeway Hospital.

### 7.2.13 HIV clinical care including ART

A national HIV training programme should be established for the capacity development of multidisciplinary HIV care teams (doctors, nurses, “nurse-counsellors” and pharmacists, for instance) at planned ART sites. This should include interactive classroom activities, supervised outpatient and inpatient experience, and continuing education activities including a distance support system. Although the number of health-care workers requiring training is not large, a systematic approach will ensure optimal transfer of existing in-country expertise and lay the foundation for the development of additional HIV care teams in the future. Once trained, HIV care teams could assist in the delivery of CCT training for health-care staff working in their area. ART adherence is the key determinant of long-term individual and programme treatment success and cost-effectiveness. A multidisciplinary approach should be developed, to be driven by the needs and experiences of people taking ART. In particular, dedicated and trained counselling staff can develop specific expertise and peer-support group activities that are highly effective and not expensive. Fear, stigma and discrimination in health-care settings remain major obstacles to the expansion of quality HIV care. Health-care workers with positive attitudes towards PLHA are crucial for the cultural change needed to provide an enabling environment for HIV care. These advocates need to be identified and supported. Modelling of comfortable and compassionate care for PLHA is an important component of HIV care training. A core multidisciplinary team should be developed at the Central STD clinic and Lady Ridgeway Hospital with experience in the treatment, care and psychological support of children living with HIV and their families. Recently developed regional guidelines and training modules for the care of children with HIV could be used until greater numbers of children are in need of care. Distribution of STI and HIV supplies, with the exception at present of ARV, should be integrated into MSD procedures.

#### 7.2.14 Home- and community-based care

Individuals and NGOs involved in the lives and needs of PLHA should be encouraged and funded to continue and further strengthen their work. In particular, support for transportation and accommodation costs, and opportunities for paid employment are effective ways of improving the lives of PLHA. As care-providing individuals and organizations, they should be involved and enabled to contribute meaningfully to national and local responses. As HIV clinical care services are established outside Colombo, NGOs should be encouraged to form close links with the clinical services and develop community-based services to support PLHA in the area. Public health midwives could play a role in outreach and follow up.

#### 7.2.15 TB and HIV

A formal mechanism for collaboration between the TB and HIV national programmes should be established. A system for routine, confidential collection of data on HIV testing and diagnosis in TB patients, and TB disease in HIV patients should also be established. Local partnerships between HIV and TB care providers should be encouraged and supported. A national policy on provision of HIV counselling and testing for people diagnosed with TB should be developed. Given the strong evidence of a very low prevalence of HIV in TB patients, this policy should be targeted (not made universal). The policy could target patients with a self-identified risk and clinical suggestion of HIV infection rather than engage in routine HIV risk assessment. Systems for access to HIV counselling and testing by people diagnosed with TB should also be integrated into existing HIV counselling and testing programmes.

#### 7.2.16 Laboratory support

For now, CD4 testing should remain centralized at the National STD Reference Laboratory; current testing volumes are insufficient to warrant the use of additional facilities. Systems for movement of blood samples rather than patients should be established. A single functioning HIV PCR instrument is sufficient for national requirements with regard to infant diagnosis and confirmation of suspected HIV treatment failure. The National STD Reference Laboratory should participate in international quality assurance programmes for CD4 testing and measurement of HIV viral load. Provincial laboratories should be strengthened with emphasis on maintenance of instruments, reagent supply and quality assurance. Plans to re-integrate STD clinic laboratories into hospital laboratories should be accompanied by a clear policy that HIV testing and STI investigations should receive sufficient priority.



### 7.2.17 Strategic information, monitoring and evaluation system

An SI-M&E Unit should be restructured to include the function of surveillance. This unit must be **headed by senior NSACP staff**, with both an **M&E specialist** and **surveillance expert** as core staff, and supported by an IT assistant and data manager. The function of the unit will be to manage the flow of information, conduct data analysis (including data triangulation), and produce annual reports and quarterly updates. Full-time staff needs to be designated at the district level for SI-M&E work and the Unit should technically guide them.

The roles, authorities and responsibilities of M&E staff in the programme should be clearly defined. The SI-M&E Unit shall be given the **authority** to get access to all the information needed from the current system, donor-sponsored projects and NGOs. Information feedback through annual and quarterly reports should be ensured. As the new NSP is developed, it will be critical to ensure that a **national SI-M&E framework is developed, the modus operandi established and additional indicators are finalized**. An indicator manual would need to be developed to assist in the standardization of information and data collection. Installation of the computerized MIS database and use of an indicator-based CRIS should complement the MIS as an indicator and resource-tracking composite.

**A capacity-building plan** should be developed in accordance with the NSP and the SI-M&E framework to build up staff capacity, including the skills for information collection at different levels.

#### **Acknowledgment**

The Review Team would like to acknowledge the openness displayed by, and the effective support it received from, all staff in the public and private institutions it visited. The Review Team wishes to thank particularly the staff of the NSACP and NHAPP for their excellent contribution to the review, both at the preparatory and implementation stages.

# Review Team and Facilitators

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- Professor Daniel Tarantola – The University of New South Wales, Australia (Team Leader)
- Mr Richard Steen – WHO SEARO, New Delhi, India
- Dr Sun Gang – UNAIDS Regional Support Team Asia and the Pacific, Bangkok, Thailand
- D. Jullian Elliot – National Centre in HIV Epidemiology and Clinical Research, Australia (Freelance Consultant)
- Mr James Blanchard – India–Canada Collaborative HIV/AIDS Project, Bangalore, India
- Mr Ian MacLeod – UNICEF ROSA, Kathmandu, Nepal
- Mr Sarath Medagama – World View, Sri Lanka
- Dr A. Pathmeswaran – University of Kelaniya, Sri Lanka
- Ms Renuka Peiris – Ministry of Education, Sri Lanka
- Dr Chris Nonis – Mackwoods, Sri Lanka
- Dr Nihal Abeysinghe – Ministry of Health, Sri Lanka Persons living with HIV

## Facilitators from the National AIDS Programme

- Dr Nimal Edirisinghe
- Dr Iyanthi Abeyewickreme
- Dr Susie Perera
- Dr Janaki Withanapathirana
- Dr Neelamani PUNCHIHewa
- Dr K.A.M. Ariyaratne

## Facilitators from UN agencies in Sri Lanka

- Dr Kumari Navaratne – World Bank
- Dr Supriya Warusavithana – WHO
- Dr Kulasiri Buddhakorale – WHO
- Mr David Bridger – UNAIDS
- Ms Surovi Salgado – UNAIDS

The list of persons met is not exhaustive and limited to the main speakers during the visits conducted to the institutions. During some visits the names were not compiled. The review team members would like to thank all those who participated and who are not quoted in the list.

### 16th October 2006

- Team Meeting at the Cinnamon Grand
- Meeting with Director General Health Services – Dr Athula Kahandaliyanage
- Meeting with staff of the National STI/AIDS Control Programme (NSACP) and the National HIV/AIDS Prevention Project (NHAPP)
- Meeting with the UN System (Technical Working Group and Theme Group)

#### ***Persons met***

- Dr Indira Hettiarachchi – ILO
- Pramo Weerasekera – ILO
- Jeanne Samuel – UNHCR
- Dr Yakandawala – UNICEF
- Dr Kumari Navaratne – World Bank
- Visakha Tillekaratne – WFP
- Dr Supriya Warusavithana – WHO
- Representative from the HIV+ Community
- Dr Buddhakorale – WHO
- Meeting with the Deputy Provincial Directors of Health from the North and East
- Discussion

### 17 October 2006

- Visit to the Central STD clinic and the National HIV/AIDS Prevention Project
- Visit to the Ministry of Finance

***Persons met***

- Mr Abeygunawardena – Director General
- Mr Abeygunasekera – ERD (Additional Director General)
- Visit to the Ministry of Education

***Persons met***

- Secretary of Education
- Secretary General – National Institute of Education
- Assistant Secretary General – National Institute of Education
- Visit to the National Hospital

***Person met***

- Director – National Hospital
- Meeting with the Surveillance Team of the NSACP
- Meeting with the NHAPP
- Visit to the Colombo North Hospital, Ragama

***Persons met***

- Dr G. Weerasinghe – Consultant Venereologist
- Dr Rajamanthri – Director
- Visit to a local NGO – Community Strength Development Foundation

***Persons met***

- H.A. Lakshman
- Kanthi
- Visit to Lanka+
- Visit to the Salvation Army

***Persons met***

- Swarna De Silva
- Major Noel Lapena
- Visit to the Behavioural Surveillance Study and field visit to behavioural surveillance surveys (BSS) sites

***Person met***

- Patrick Rawstorne

**18 October 2006**

- Visit to the NSACP to review advocacy, provincial and sector activities
- Visit to the Sri Lanka Foreign Employment Bureau
- Visit to the National Child Protection Authority drop-in centre

- Visit to the Teaching Hospital, Colombo South
  - Person met**
    - Dr Lilani Rajapaksa – Consultant Venereologist
- Visit to the Infectious Diseases Hospital
  - Person met**
    - Dr Ananda Wijewickrama – Consultant Physician
- Visit to the National Blood Transfusion Services (NBTS)
  - Persons met**
    - Dr Bindusara – Director, NBTS
    - Dr Sarukkali – Director, NPTCCD
- Visit to the TB Hospital

## 19 October 2006

- Field visit to Kandy
  - Persons met**
    - Dr Ganga Pathirana – Venereologist
    - Dr Gamini Samarasinghe – Director, Teaching Hospital, Kandy
    - Dr A. Harith Wimalarathna – Consultative Physician
    - Dr Anoma Siribaddhana – Chest Physician
    - Dr Dissanayake – Deputy Director, Teaching Hospital, Kandy
- Field visits to Anuradhapura
  - Persons met**
    - Dr Azmi Thaibudeen – MO-STI and the STD clinic staff
    - Dr Lakshman Gamlath – Director, Teaching Hospital, Anuradhapura
    - Dr W. Atapattu – Provincial Director of Health Services/North Central Province
    - Dr Dhammika de Silva – MO/Planning, Provincial Director of Health Services Office/North Central Province
    - Mr Palitha Liyanawadu – Director, Rajarata Gamini Pahana
    - Mr Mohamed Rasik – Director, Community Development Services

## 20 October 2006

- Field visits to Nuwara Eliya
  - Persons met**
    - MO-STI – Dr H.A.C.W. Appuhamy
    - Dr R.K. Herath, Director General Hospital Nuwara Eliya
    - Public Health Midwife – Estate Hospital

- MoH, Nuwara Eliya
  - Public Health Nursing Sister – MoH Office, Nuwara Eliya
  - Director Welfare – Welfare Trust, Nuwara Eliya
  - Welfare Officer – Welfare Trust, Nuwara Eliya
  - Field visits to Kurunegala
- Persons met**
- Dr Sunil de Silva – MO-STI
  - Dr Wijeratne – GP
  - Dr A.K.B. de Alwis – PDHS/North-western Province
  - Mr Rashmika P. Fernando – Manager, World Vision Lanka, Walasena, Galgamuwa
  - Mr M.H.B.K.M. Bandara – Athugalpura Foundation, Kurunegala (only visited the place could not meet Mr Bandara)

### 21 October 2006

- Team Meeting – Discussion on field visits and observations

### 22 October 2006

- Reading

### 23 October 2006

- Visit to the Ministry of Health
- Visits to the prisons and the National Dangerous Drug Control Programme (NDDCP)
- Meeting with the Armed Forces HIV Prevention Programme
- Meeting with members of the Independent Medical Practitioners Association (IMPA)

**Persons met**

- Dr S. G. Jayasuriya
- Dr W.A. Ferdinand
- Dr S.A.P. Gnanissara
- Dr N.K. Ashubodha
- Dr (Mrs) V.M.M. Amath
- Dr T.P.J. Amath
- Visit to a private hospital – Durdans Hospital

**Person met**

- Dr Aruna Rabel, Medical Director



Almost twenty years after the emergence of HIV and AIDS in Sri Lanka, the third review of the national response to sexually transmitted infections (STIs) and HIV/AIDS was carried out by a team composed of members drawn from national programmes and sectors external to the National STI/AIDS Control Programme and staff of international organizations, overseas HIV initiatives and universities, the World Health Organization, the United Nations Children Fund, the World Bank and the United Nations Programme on HIV/AIDS. The objectives of the review were to identify the achievements of the national response to HIV by reviewing the activities of the National STI/AIDS Control Programme as well as those of other government and nongovernmental organizations, especially in areas related to STI/HIV prevention, care and treatment for the period 2000–2006, and to provide recommendations for the revision of strategies and interventions for the development of a new strategic plan for 2007–2011.

This document describes the findings of the review team, the conclusions it arrived at and recommendations.



Ministry of  
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